FOURTH AGE TRUST

Individual Needs Collective Responses

The Potential of Social Enterprise to Provide Supports & Services for Older People:

Assessment of National Business Case

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Mission Statement: To promote the right of older people to social protection and to promote respect for their freedoms and inherent dignity through the development of quality supports and services by means of social enterprise, community participation and civic innovation.

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Foreword

"Then indecision brings its own delays,
and days are lost lamenting o'er lost days.
Are you in earnest? Seize this very minute;
What you can do, or dream you can, begin it;
Boldness has genius, power and magic in it."

Goethe 1749 – 1832

As Ireland slowly recovers from the crisis which began in 2008 many challenges remain and new ones are emerging. One of our greatest challenges, ageing, also brings a significant opportunity. That opportunity is to boldly reimagine public services and contribute to the development of a smarter society supported by a smart economy. To achieve this we need to identify, understand and appreciate the best of what we have, consign some approaches and facilities to history, and develop ways to ensure that the individual needs of older people are met through effective collective responses involving public resources, self and mutual help, family and community support, social enterprise, private business and civic innovation.

The analysis informing this report suggests a way forward. A way which focuses on overall quality of life and relationships, and on the things necessary to maintain and enhance them. It suggests a shift from a mindset of 'command and control' to one of 'consult and enable' and, most importantly, it suggests that social enterprise – business with a social purpose – can be used to protect and enhance the added value of community participation and civic innovation in the context of increased outsourcing of health and social care and the development of public service 'markets'.

Social enterprise, is a necessary but not sufficient requirement for progress. It is not a stand-alone solution to be paraded in virtuous contrast to the public and private sectors. It is a means to an end not an end in itself. If the term is to mean anything it has to mean enterprise and innovation in the public interest and not the replication of the state in another guise. It has real challenges to address with, and on behalf of, older people. Support networks have been damaged by emigration; memory impairment and dementia are on the increase; people wanting to live longer in their own homes need those homes adapted and their gardens maintained; transport for shopping, socialising, and medical appointments need to be easily available; home helps need to be responsive to the broad range of peoples' needs rather than the narrow rules of commissioners; group purchase schemes are needed to enhance buying power for services such as respite care breaks, home heating, communications and technology; employment services need to be developed to enable people hire their own carer without the worries of being an employer; 'circles of care' are needed to support people in the transition from hospital to home and from nursing homes into hospitals; some old 'county homes' need to be turned into care hotels and high support villages; some nursing homes need support to make the move from purely residential facilities into sub-acute hospitals and hospices. This is a long and far from complete list. Guiding all developments must be a constant concern with the quality of peoples' experiences and the impact of the social investment made from public and community funds.

This report, which has been superbly crafted by Dr Kieran McKeown, is informed by significant and sophisticated data analysis undertaken by Trutz Haase and Jonathan Pratsche. Members of the broadly based reference group have provided many important insights and the National Economic and Social Council has been generous with its time and a pleasure to collaborate with. Our funders, comprised of a number of leading NGOs and local area partnerships, have also been generous and this report, and the related data analysis and legal work, would not have been possible without them.

Finally, to honour the memories of family, friends, neighbours and service users whose experiences of life, and the leaving of it, provided the reason to 'begin it'.

Mervyn Taylor
January 2014

Executive Summary

This report assesses the national business case for a social enterprise to provide services for older people in Ireland. The proposed social enterprise will be constituted as a 'charitable trust' under the Charities Act 2009 and will have a different legal status to a public or private body. It will trade commercially but with a social rather than a private purpose and its surplus will be re-invested in this social purpose. The proposed social enterprise is informed by the same vision for older people that also informs national policy, namely, "to enhance the quality of life of older people, maintain their full potential, support them in their homes and communities"[1] and enable them "to live in their homes for as long as possible rather than go into residential care"[2].

Overview of National Business Case

The assessment of the national business case for the proposed social enterprise indicates that this is a viable business proposition. There is strong and growing demand for services for older people and there are significant revenue streams to sustain a viable and sustainable social enterprise. The proposed social enterprise fits within wider national goals, including public sector reform (as this relates to health and social services); the evolution of services for older people, including greater focus on innovation, quality and value for money through public procurement; job creation through social enterprises; and the use of evidence to design and deliver services which promote the well-being of older people. The proposed social enterprise also responds to the wider set of challenges which Ireland faces at this time, namely population ageing; aligning resources to policies; aligning services to people's needs and preferences; improving health system efficiency; reducing health inequalities; and developing the long-term care sector.

Alignment of Social Enterprise with National Context and Priorities

Population Ageing

Population ageing typically refers to an increase in the share of population aged 65+ and 85+, due to rising life expectancy and falling fertility. Our analysis shows that the share of population aged 65+ in Ireland was remarkably stable throughout most of the last century at around 11%. Since the turn of the century, there is a noticeable trend towards population ageing and the CSO's projection is that, over a period of just 35 years, the population aged 65+ will more than double from 11.6% in 2011 to 27.9% in 2046. The share of population aged 85+, though much smaller, will grow even more rapidly from 1.3% in 2011 to 5.2% in 2046. In practical terms, this means that, for the next 35 years, the population aged 65+ is projected to increase by nearly 25,000 every year, including an increase of nearly 6,000 in those aged 85+. This is in keeping with OECD and EU projections which anticipate that Ireland's public spending on long-term care will at least double by 2050. At the same time, the number of people of working age (15-64) for each person aged 65+ has continued to fall since the turn of the century and, over the next 35 years, the number of persons of working age for each person aged 65+ will fall from 5.8 in 2011 to 2.0 in 2046. It is clear that population ageing will create pressure on Ireland's health and social care systems which are beyond its current capacity to withstand. The challenges are considerable – in terms of pensions, healthcare and long-term care – but they are also predictable, and therefore amenable to a rational response. Key elements of that response are already visible, including public sector reform. The proposed social enterprise is also part of the response to population ageing.

Public Sector Reform

Public sector reform, as defined by the Department of Public Expenditure and Reform, involves five major commitments to change: (i) placing customer service at the centre of all activities; (ii) maximising new and innovative service delivery channels; (iii) radically reducing costs to drive better value for money; (iv) leading, organising and working in new ways; and (v) focusing strongly on implementation and delivery. One of the vehicles for bringing about public sector reform is to stimulate the growth and differentiation of service providers outside the state sector, going beyond the distinction between public and private, and avoiding the negative consequences of the 'purchaser/provider split'. The proposed social enterprise has the potential to develop innovative and cost-effective ways of providing support and care services to older people, while also enhancing the quality of service and the employment conditions of its staff.

Providing Quality Service and Value for Money

The challenge of providing quality services which are also value-for-money is substantial but is not unique to services for older people. It applies to all services where human interaction is a central component including, for example, health, education, hospitality, and the arts. At the heart of this challenge is the fact that quality depends on a service being tailored to each person's needs, delivered on time and sensitively, and connected to other elements of care on which the person may depend. Quality services in this sense are relatively costly because the main input is staff time and, although there may be some scope for improving productivity, there appears little or no scope for reducing wages, particularly in the home-care sector for older people, much less competing with private companies on wage-costs. In that sense, the national business case for the proposed social enterprise does not rest on reducing costs but on offering quality and value-for-money. Recognising that a service is only as good as its staff, the proposed social enterprise aims to recruit and retain highly qualified and motivated staff but will also include experienced staff who are less formally qualified, providing them with in-house training and mentoring to ensure they have capacity to deliver a quality service. This approach has the potential to yield improvements in the health and well-being of older people – and improve standards in the voluntary and community sector generally - which can be justified in terms of cost effectiveness, and will be attractive to high-achieving professionals who see social care as a rewarding career path.

Services for Older People

Services for older people are underpinned by the policy goal of helping people remain in their home environment for as long as possible, where this is what they prefer, rather than entering long-term residential care. That is precisely the aim of the proposed social enterprise. Across the OECD, there is substantial variation in the number of long-stay beds per 1,000 population aged 65+, ranging from 17.8 in Italy to 51.8 in Ireland and 72.3 in Sweden. This indicates how much long-stay care provision varies across countries with broadly similar levels of prosperity while also underlining how each country finds a different balance between supporting older

people to live at home and in long-stay care. This does not imply that living at home is better, in all cases, to living in a long-stay care since there is almost no data on the well-being of older people in long-stay care to compare with 'equivalent' older persons at home. However it suggests that the policy goal of supporting older people to live at home for as long as possible, and they prefer, is achievable but more could possibly be learned from those countries which actually achieve it such as Italy, Spain and Denmark.

Social Enterprise and Job Creation

Job creation is one of the biggest challenges facing Irish society and the proposed social enterprise may be seen as part of the response to this challenge. The programme of government recognises that the social enterprise sector has an important part to play in creating viable and sustainable jobs which offer satisfying and stable employment. Many areas of care work are associated with female employment, which implies that the proposed social enterprise can play a role in increasing female labour force participation rates and facilitating the entry/re-entry of vulnerable social groups within employment (women, people with low qualifications, immigrants, older workers). By providing career paths for both highly qualified workers as well as those who are less qualified, including access to on-the-job training, the social enterprise can sustain labour force participation rates, improve social inclusion, and raise the overall status of social care as a profession. Furthermore, by reducing the care burden which is disproportionately assigned to women, this innovation can further boost female participation, which has been recognised as a key way of reducing child poverty and a step towards achieving greater gender equality.

Service Design and Performance Linked to Evidence on Well-Being

The purpose of services for older people is to improve well-being and these services are more likely to be effective if aligned with the known determinants of well-being. Our analysis of TILDA (The Irish Longitudinal Study on Ageing) indicates that the largest and most significant direct determinants of personal well-being among older people involve social connections (notably the quality of relationships with partners, children, relatives and friends as well as an active participative lifestyle). The proposed social enterprise will build on these 'naturally occurring' processes of well-being to strengthen the protective factors which sustain this within the older population. The TILDA findings also suggest that services for older people, as currently funded by the HSE – namely NHSS, HCPS, HHS, Day Care - may not adequately reflect all, or even the most important, risk and protective factors affecting personal well-being. Our analysis suggests that while hospital and residential services to meet the needs of older people are important, they may have assumed disproportionate importance relative to the social connections which sustain the well-being of older people in their home environment. This, in turn, invites reflection on the question of whether the right services are being commissioned in all cases, and whether there is need to create a more innovative stream of commissioning which, on the evidence presented, addresses a wider set of influences on the personal well-being of older people. More generally, our analysis of TILDA points towards an understanding of personal well-being – and of ageing – that is wider than the 'health perspective', which tends to be the predominant focus of existing policy and service provision for older people. Moreover, the so-called 'health perspective' is often and in practice an 'illness and disability perspective', since service interventions for older people are often triggered by an assessment of illness and disability, and may not give due consideration to personal well-being and the role of social connections in sustaining it. This perspective is consistent with other studies which have concluded that "the most pressing effects of ageing are likely to be on demands for a range of community-based health and social care services." The proposed social enterprise builds on this body of evidence.

Responding to Challenges in Services for Older People

Aligning Resources to Policies

The evidence presented in this report suggests that the goals of public policy for older people may not be sufficiently aligned with the corresponding allocation of resources to services for older people. For example, the largest share of the HSE budget on services for older people (72%) is spent on long-stay care under the Nursing Home Support Scheme (NHSS), whilst less than a third (28%) is spent on supporting people to live at home through the Home Care Package Scheme (HCPS), the Home Help Scheme (HHS) and Day Care. The need to review this situation is recognised and helps to explain why a substantial review is currently being undertaken of NHSS. The policy goal of facilitating older people to live well in their own homes can be achieved, but will require significant re-allocations within the existing budget of services for older people. The proposed social enterprise creates new possibilities for reallocating resources in this way.

Aligning Services to People's Needs and Preferences

In Ireland, as elsewhere, surveys show that people typically prefer to live at home and to be supported to live there for as long as possible, preferably to the end of their lives. Despite that, a gap remains between what people prefer, and what is provided by the existing system of services and supports. In keeping with national policy, the proposed social enterprise seeks to reduce this gap by adopting an integrated, individualised and person-centred approach to service provision.

Improving Health System Efficiency

There is evidence that the existing system of support and care for older people in Ireland is not as efficient as it could be. One indicator of this is the number of 'delayed discharges' from acute hospitals, where patients remain in hospital after their treatment has finished. The vast majority (87%) of these are patients aged 65+. In 2012, the number of hospital days lost due to delayed discharges from Ireland's acute hospitals was substantial (243,673), higher than in 2008 (223,704 bed days) or 2009 (144,565). In many cases, this could have been avoided if adequate alternatives to hospital treatment existed for specific categories of patient. An estimated 40,612 additional inpatients could have been treated in 2012 if there were no delayed discharges. Under the new system of hospital financing, to be implemented from 2014 onwards, it is likely that hospital groups will have a stronger financial incentive to reduce or eliminate delayed discharges. The proposed social enterprise could collaborate with hospital groups to facilitate the discharge of patients to 'step-down' facilities or to their own homes, by providing adequate support.

Addressing Health Inequalities

There are substantial inequalities in health across the Irish population. Given the remarkable increase in life expectancy at age 65 in Ireland during the first decade of this century (3 additional years over the space of a decade), the impact of social class on life expectancy (6 years) is doubly remarkable and confirms the CSO's observation that "Our socio–economic status is a stronger determinant of how we age than our chronological age." The approach proposed by the social enterprise will involve both a population-centred and person-centred approach to addressing the unequal impacts of ageing by expanding access to care services amongst vulnerable groups.

Developing the Long-term Care Sector

The supply of long-term care for older people in Ireland, as in many EU countries, relies heavily on the 'informal sector', a term denoting unpaid care which is usually provided by relatives (mainly partners and adult-children) and is outside any 'formal' contractual arrangements. There are a number of reasons why this model of provision may not be sustainable (primarily due to changes in family structure, geographical mobility, activity rates and expectations), while the corresponding demand for paid care is likely to grow. One of the immediate consequences of a growth in paid care is a corresponding growth in costs, both public and private, and in social inequalities. The EU Commission has estimated that the effect of an annual 1% increase in the proportion of dependent elderly who receive formal care over a 50-year period till 2060 would imply increasing public expenditure on long-term care across EU-27 from 1.8% of GDP in 2010 to 2.6% in 2060 . The study found that in Ireland the effect would be much greater, and would lead to a tripling of public spending from 1.1% of GDP to 3.4% in 2060. As with the other challenges considered here, the need to shift the balance of resources towards supporting older people to live at home, and supporting carers, is highlighted by this report.

Estimating Demand for Services for Older People

The term 'demand' has both a wide and a narrow meaning. In its wide meaning, demand is synonymous with need – both met and unmet – irrespective of whether this is achieved formally through payment or entitlement, or informally, through the care provided by family and friends. In its narrow meaning, demand refers to services that people are currently able and willing to pay for or have an entitlement to receive. This report estimates current and likely future demand, as well as unmet need, and concludes that demand for services for older people is substantial and growing and, from that perspective, the proposed social enterprise represents a sound business idea.

Current Demand for Services for Older People

Currently about 20% of the population aged 65+ is in receipt of some service for older people, either NHSS, HCPS, HHS or Day Care[3], equivalent to 105,093 people. Almost half (49%) of the HSE budget for older people is commissioned from private providers, while voluntary provision represents a small part of the overall budget (14%). This pattern suggests that there is considerable scope to increase the share of

voluntary provision through a social enterprise, particularly if direct HSE provision is reduced in the coming years.

Future Demand for Services for Older People

Future demand for services for older people, based on CSO population projections and a continuation of current service utilisation rates, suggests that over the next 13 years (2013-2026), the number of people in residential long-term care is likely to grow by an average of about 1,000 new residents each year, with similar proportionate increases in demand for community-based services. From the perspective of the proposed social enterprise, our estimates indicate that a substantial opportunity exists to contribute to providing services for older people, both within the existing budgetary framework and through innovative configurations of services, including the use of NHSS for a wider range of services to support older people to live at home.

Demand Arising from Reducing Delayed Discharges in Acute Hospitals

From 2014, Ireland's 49 acute hospitals will be re-configured to form six hospital groups which, in time, are destined to become hospital trusts. Under the new system of hospital financing, these groups will have a much clearer financial incentive to reduce or eliminate delayed discharges. Delayed discharge represents a particular problem for larger hospitals in the Dublin area, and gives rise to a substantial opportunity cost or 'opportunity lost' (estimated at €343m). As a result of these changes, hospital groups will have an incentive to collaborate with social care providers – including the proposed social enterprise – to deliver safe, supportive and speedy transitions between hospital, home, convalescent home or nursing home, as required, bearing in mind that many patients are likely to need more intensive and sustained support compared to the average service user in the community. This could be a significant source of demand for the social enterprise.

Dementia and Unmet Demand

The programme for government (2011-2016) contains a commitment to develop a national dementia strategy by 2013 and, in preparation for this, a comprehensive review of research and a public consultation have been carried out. Given that the risk of dementia increases exponentially with age, and given that the population is ageing, dementia is set to become a 'worldwide epidemic' if a cure is not found. The overall prevalence of dementia among those aged 65+ in Ireland, based on European rates, is 8.2%. Applying this overall prevalence to the projected population aged 65+ in Ireland, it follows that the number of persons with dementia is likely to more than double over the next 35 years (2011-2046), implying an annual increase of about 5%. The majority of people with dementia (63%) live in the community and are cared for by family and friends, with most of the remainder (34%) in long-stay residential care. Compared with other caring roles, it is generally recognised that caring for a person with dementia can place greater demands and strains on family members. The proposed social enterprise will contribute to the development of community-based services for persons with dementia and their families.

Disability and Unmet Demand

The number of people with a disability who are not receiving care – either formal or informal – is an indicator of unmet need. The TILDA study shows that more than a tenth (12%) of those who have both ADL[4] and IADL[5] difficulties do not receive any help, either formal or informal. This leads the authors of the most recent TILDA report to comment that "these people constitute a potentially very vulnerable group". If this rate of unmet need is applied to the population aged 65+ who have both ADL and IADL, it suggests that 2,679 older people may have an unmet need for care.

Social Isolation, Loneliness and Unmet Demand

Social isolation and loneliness are known to have negative consequences for quality of life and mortality. Based on international evidence, this report estimates the prevalence of social isolation and loneliness to be around 5%. Applying this rate to the population aged 65+ living in private households, it follows that 25,000 older people in Ireland may experience social isolation and loneliness. This is an area of unmet need that could be addressed through the proposed social enterprise, particularly in light of its focus on developing person-centred, community-based supports and services.

Carer Needs and Unmet Demand

The needs of carers who provide unpaid and informal care for older people are a source of unmet demand. In 2009, the CSO carried out a special survey of carers and found that a significant minority (21%) provide care for 57+ hours per week. Many of these carers are looking after another member of the household, and over a quarter of all carers (27%) showed evidence of 'caregiver strain'. Applying this rate of caregiver strain to the population in private households aged 65+ who are being cared for yields an estimate of over 27,000 carers who may have an unmet need for support. This level of need underlines the opportunity that exists for the social enterprise to develop supports for carers, building on the national carers strategy and recognition that 'helping carers is one of the most effective ways of helping those in receipt of care'. Identifying and satisfying the needs of carers requires a proactive approach rooted in local communities and sustained by public funding.

Estimating Sources of Revenue for Social Enterprise

Revenue from Public Procurement of Services for Older People

Over the next 13 years (2013-2026), the HSE budget for services for older people, based on conservative population projections and no change in current service utilisation rates, is expected to increase by €829 million, equivalent to an annual increase of €64 million. In percentage terms, this represents an increase of 60% over 13 years, equivalent to nearly 5% per annum. The challenge of maintaining the budget for services for older people will therefore be substantial, particularly given that the projected rate of growth in Ireland's GNP, under the ESRI's most optimistic 'recovery scenario', will be around 3.5% a year in the second half of the decade, and against a backdrop of a 10% fall in national income between 2007 and 2012. This lends particular significance to the review of NHSS, since it constitutes 72% of the budget for services for older people whilst meeting the needs of just 22% of those in receipt of these services. At the same time, the HSE budget for services for older people (especially HCPS, HHS and Day Care) could be a major source of revenue for the social enterprise.

Revenue from Collaborating with Hospital Groups to Reduce Delayed Discharges

Reducing delayed discharges from acute hospital is a possible area of collaboration between hospital groups and social care providers and a potential source of revenue for the social enterprise. The estimated cost of delayed discharges to the Irish health system in 2012 is substantial (€343m), with nearly three quarters of these costs (73%) in the Dublin Academic Teaching Hospitals (DATHs). The vast majority of patients involved in delayed discharges are aged 65+ (87%) and form the principle client group of the social enterprise.

Revenue from Other Sources

A major challenge for the social enterprise, as for any new business, is to find start-up capital in order to develop an organisation with the capacity to successfully tender for public service contracts. As observed in the 2013 Forfás report, "Given the nature of its activities (which often require a level of subvention, especially at the start of the company lifecycle), funding and finance is critical to social enterprise". For that reason, a start-up investment is the preferred option for putting the social enterprise on a viable and sustainable footing.

Concluding Comment

This report establishes that there is a strong national business case for the proposed social enterprise. There is solid and growing demand for services for older people and, despite the economic and fiscal challenges facing the country, there are substantial revenue streams to sustain the social enterprise as a viable business. The proposal is aligned with the requirements of public sector reform and the need to find more innovative ways of supporting older people to live well at home for as long as possible. In addition, the social enterprise will create sustainable, stable and high-quality employment for relatively vulnerable social groups, and is likely to generate multiplier effects by cooperating with other local and community development initiatives. In these respects, the proposed social enterprise can contribute to the national priority of recovery and reform.

This report is a significant milestone in the evolution of a business concept, but is only a first step. Having established that there is a robust national business case for the proposed social enterprise, the next stage requires investment to allow development of a business plan and to enable this enterprise to become self-sustaining.

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Organisation	Website
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The idea of a social enterprise to provide supports and services for older people was suggested in a review of quality in eldercare services by the National Economic and Social Council (NESC)[6]. In light of NESC's interest in this area, we have had a number of valuable discussions with its secretariat, and particularly express our thanks to Rory O'Donnell, Anne-Marie McGauran and Barry Vaughan.

In accordance with time-honoured tradition, we assure everyone who contributed to this report, particularly those named above, that they are not responsible for any errors of omission or commission that the report may contain, which are the sole responsibility of the authors.

Kieran McKeown, Jonathan Pratschke and Trutz Haase
January 2014

"The Irish Hospice Foundation committed to the development of this national business case as it believes that alternative models of care are required in order to realise the wishes of the very many people who want to be cared for, and to die, at home"

Introduction

This report assesses the national business case for a social enterprise to provide services for older people in Ireland. The proposed social enterprise is informed by the same vision for older people that informs national policy, namely "to enhance the quality of life of older people, maintain their full potential, support them in their homes and communities"[7] and enable them "to live in their homes for as long as possible rather than go into residential care"[8]. The social enterprise proposes to provide a range of services, including but not confined to[9], personal care, health care, practical care and house care. The services will be individualised to meet the needs and preferences of each person and integrated with their existing networks of support and care, both formal and informal.

The proposed social enterprise will be a public interest trust and constituted as a charitable trust under the Charities Act 2009[10]. It will be a social enterprise, in the sense that it will trade commercially but with a social rather than a private purpose and its surplus will be re-invested in the social purpose[11]. In practice, the social enterprise proposes to tender to become a HSE-approved provider of community services for older people – including the Home Care Package Scheme (HCPS)[12], Home Help Scheme (HHS)[13] and Day Care – but will also seek other sources of revenue to develop supports and services for older people beyond those currently funded by the HSE.

This report assesses the national business case for this proposal. Specifically, it assesses the need and demand for this kind of social enterprise and the potential revenue streams that could support it as a viable and sustainable business. In that sense, the assessment rests on an economic analysis of the demand and supply of services for older people, current and future. But the report is more than an economic analysis or business assessment, at least in the narrow sense of the term. The proposed social enterprise will operate within the wider context of public sector reform in Ireland, including the national priority to create sustainable jobs. For this reason, it is necessary to examine the wider policy context of the proposal and how it fits with the challenges which Ireland faces at this time.

The idea of a social enterprise is not new. Ireland has a long tradition of social enterprise and the programme of government (2011-present)[14], including its Action Plan for Jobs[15], and the Forfás report on social enterprise[16], express a commitment to supporting this model of business. These are changing times for all sectors of Irish society, and the concept of 'business as usual' no longer applies, mainly because this approach is unaffordable and, in many cases, not good enough[17]. That is why this proposal merits consideration as an innovation in how services for older people are organised and delivered.

It is government policy to promote innovation in the design and delivery of public services in order to improve quality and value for money[18]. In this vein, the National Economic and Social Council has suggested that a social enterprise to provide services for older people merits serious consideration: "If one takes as an example the field of care for older people, is there a better way of delivering services? … what if the total amount of money available for different kinds of care for older people, within a distinct geographical area, was available for tender to social enterprises? These enterprises could demonstrate how they would use the funds to meet audited needs, having also raised matching funds from the private and/or philanthropic sector. … Facilitating alternative models of care could prove to be a stimulus for innovation … It might prove to be a crucial feature of the expansive notion of a 'performance dialogue' that is concerned with the overall functioning of a policy area and the best use of resources therein."[19]

It is intended that the proposed social enterprise will complement existing providers of services for older people while also adding diversity and innovation to what is currently available. Over recent years, there have been radical changes in services for older people, particularly associated with the expansion of long-stay care facilities under the Nursing Home Support Scheme (NHSS)[20] and a shift from public to private providers. As a result, more than half the 2013 budget for services for older people will be delivered by private providers (56%), more than a third by the HSE (38%), and less than a tenth by community/voluntary providers (7%). The proposed social enterprise is intended to strengthen the role of community/voluntary provision while also supporting conditions conducive to innovation, improvements in quality and greater value for money. These are the hallmarks of public sector reform whose ultimate beneficiaries are the older people who receive these supports and services.

The ageing of Ireland's population is the pervasive background context shaping not just the proposed social enterprise but many aspects of public sector reform. This is because population ageing is creating pressures on existing health and social care systems which, without radical reform, are destined to encounter growing difficulties. The population aged 65+ will grow by around 5% per annum over the next few decades[21], well ahead of projected growth in the labour force or economy[22], and against the backdrop of a 10% fall in national income over the past five years (2007 and 2012)[23]. Faced with these challenges, a key element of reform is to improve the supports and services for people to live at home for as long as possible by maintaining their health and well-being. This is the aim of the proposed social business and, although it has also been a public policy objective for at least 20 years, this has never been sufficiently aligned with the allocation of resources to ensure effective implementation.

The methodology used to prepare this report involved completing a number of tasks, each designed to assess different aspects of the national business case. These tasks involved a review of evidence – policy documents, datasets, research reports - relevant to services for older people and their wider socio-economic and policy context. In addition, this report has been informed by consultations with individuals and organisations with an interest in services for older people (these are listed in the Acknowledgements).

Chapter One reviews the context of the proposal, focusing on some of the priorities which Ireland faces at this time, namely population ageing, public sector reform, evolution of services for older people, job creation through social enterprise, and designing evidence-based services to promote well-being[24].

Chapter Two reviews some specific challenges for services targeted at older people, in order to assess how the proposal might contribute to overcoming them. The challenges discussed are: aligning resources to policies; meeting people's needs and preferences; improving health system efficiency; reducing health inequalities; and developing the long-term care sector.

Chapter Three outlines the proposed business concept and includes a statement of the principles which will inform this: individualisation; integration; innovation; and institutional learning. It also considers the type of organisational structure that may be necessary to generate economies of scale to achieve cost effectiveness.

Chapter Four assesses demand for the proposed social enterprise since the essence of an enterprise – public, private, or social – involves supplying goods and services for which there is a need or demand. We use the term demand in both its wide and narrow sense. In its widest sense, demand is synonymous with need – both met as well as unmet need – and encompasses all needs, including those met formally through payment (directly or indirectly) and those met informally and without payment through the care of family and friends. In its narrower sense, demand refers to the amount of services that people are able and willing to pay for – directly or indirectly – and is sometimes referred to as 'effective demand'. Using the term in its narrow sense, we estimate the number of people who currently receive services for older people and, on that basis, estimate likely future demand. In its broader sense, we use the concept to estimate the scale of unmet need among older people arising from: (i) dementia; (ii) disability; (iii) social isolation and loneliness; and (iv) the burden on carers.

Chapter Five estimates the potential revenue streams that could be available to support the social enterprise. There are many potential sources of funding for social enterprises, at least in theory. These sources are reviewed, maintaining a focus on revenue streams which are available through public procurement, since these are likely to be core sources of revenue for the social enterprise. Specifically, we focus on potential revenue streams arising from the HSE budget for older people's services and from collaboration with hospital groups to reduce delayed discharges. Relative to the size of the proposed social enterprise, these revenue streams are substantial.

Chapter Six summarises the findings of the report and makes an overall assessment of the national business case. To anticipate, our assessment is that there is a strong national business case for the proposed social enterprise, essentially because there is solid and growing demand for services for older people and, despite the economic and fiscal challenges facing the country, there are substantial revenue streams to sustain a viable social enterprise. The proposed social enterprise is aligned with national priorities including public sector reform, finding innovative ways of supporting older people to live well at home and creating sustainable employment. In these respects, therefore, the proposed social enterprise will contribute to national recovery and reform. The next stage requires a detailed business plan to guide the developing enterprise to a point where it can be self-sustaining through public procurement contracts and other revenue streams. This requires an immediate equity investment to support the start-up.

Footnotes

1 Department of Health, 2013a:18.
2 Department of Health, 2013b:ii.
3 Health services per se are not considered.
4 ADL refers to basic tasks of everyday life pertaining to personal care, such as eating, bathing, dressing, toileting, and moving about.
5 IADL refers to activities performed by a person in order to live independently in a community setting, such as managing money, shopping, using the telephone, housekeeping, preparing meals, and taking medications correctly.
6 See notably National Economic and Social Council, 2012a; 2012b; 2012c.
7 Department of Health, 2013a:18.
8 Department of Health, 2013b:ii.
9 The proposed social enterprise will develop innovative responses to the needs of older people and these may include: community navigators to advise and support on accessing services; re-visioning traditional services such as meals-on-wheels, day centres and respite; micro-working systems to manage paid, bartered and donated time; organising volunteers; transport; greater use of assistive technology; group-purchasing schemes to reduce the cost of heating or respite breaks; befriending service; telephone contact and support services; urgent adaptations to a person's home to enable return from hospital; care and repair for home and garden; advice and assistance with financial and legal matters; emergency response in situations where home-based supports are threatened or the family is unable to cope; advance planning when the end of life is known to be approaching.
10 The Charities Act 2009 defines a 'charitable trust' as a trust: (a) established for a charitable purpose only; and (b) established under a deed of trust that requires the trustees of the trust to apply all of the property (both real and personal) of the trust in furtherance of that purpose except for moneys expended in the management of the trust (Section 2). A 'charitable purpose' is defined as: (a) the prevention or relief of poverty or economic hardship; (b) the advancement of education; (c) the advancement of religion; (d) any other purpose that is of benefit to the community (Section 3).
11 The defining features of a social enterprise are clarified in the Forfás report on social enterprise in Ireland: 'Social enterprises differ from traditional charities as they earn some income from trading and so are not reliant solely on fundraising or grants, although it is recognised that some charities do engage in traded activities. The social purpose and the re-investment of the surplus in the social objective should be the delineating factor between social enterprises and conventional enterprises. Where a social enterprise is trading and uses a business model to deliver a social good or service it can be deemed to be operating within the commercial sphere.' (Forfás, 2013:10).
12 'A Home Care Package (HCP) consists of community services and supports which may be provided to assist an older person, depending on their individual assessed care needs, to return home from hospital or residential care or to remain at home. A HCP refers to the enhanced level of community services and supports above the normal levels available from mainstream community services. HCPs do not replace existing services. The actual HCP provided to any individual may include paramedical, nursing, respite and/or home help and/or other services depending on the assessed care needs of the individual applicant. Enhanced level of community services is any additional level of services, over and above mainstream level of service, which is provided to support the assessed needs of the applicant.' (HSE Guidelines on Home Care Packages 2009:8).
13 'Home Help Service provides personal and/or essential domestic care to dependent people to support them to live at home. It should support and complement the informal care already been provided.' (HSE Guidelines on Home Care Packages 2009:8).
14 "The Government will promote the development of a vibrant and effective social enterprise sector. We will instruct agencies to view social enterprises as important stakeholders in rejuvenating local economies." (Department of Taoiseach, 2011:14).
15 "Social Enterprises are businesses models set up to tackle social, economic or environmental issues. While they are driven primarily by social and/or environmental motives, they engage in trading or commercial activities to pursue these objectives and produce social and community gain. There is a strong Social Enterprise base in Ireland which could be further examined with a view to determining its potential for job creation. While driven very much by local ideas, the Government will examine the role it can play in supporting the further development of Social Enterprises in Ireland." (Department of Jobs, Enterprise and Innovation, 2012:65).
16 "It is timely to bring forward a coherent policy for social enterprise in Ireland, with full recognition of the societal, enterprise and employment dimensions of the sector, led by the Department of the Environment, Community and Local Government and local authorities." (Forfás, 2013:4 and 21).
17 This observation echoes a statement in the Strategic Framework for Reform of the Health Service, 2012-2015: "The scale of the challenges now facing the health service ... means that taking a "business as usual" approach is simply not possible. Reform, as a result, is no longer optional – it is essential." (Department of Health, 2012b:3). At EU level, a similar note was sounded in the Preface to the Europe 2020 Strategy: "The crisis is a wake-up call, the moment where we recognise that "business as usual" would consign us to a gradual decline, to the second rank of the new global order. This is Europe's moment of truth. It is the time to be bold and ambitious." (European Commission, 2010:5). At OECD level, a departure from business as usual is also signalled: "The world economy is slowly, and unevenly, coming out of the worst crisis most of us have ever known. ... . A return to "business as usual" would indeed be unwise and ultimately unsustainable, involving risks that could impose human costs and constraints on economic growth and development." (OECD, 2011c:3).
18 The Department of Public Expenditure and Reform has stated the agenda for public sector reform as follows: "At the heart of this reform agenda is a focus on five major commitments to change: (i) Placing customer service at the core of everything we do; (ii) Maximising new and innovative service delivery channels; (iii) Radically reducing our costs to drive better value for money; (iv) Leading, organising and working in new ways; and (v) Strong focus on implementation and delivery." (Department of Public Expenditure and Reform, 2011:3).
19 National Economic and Social Council, 2012c:65.
20 The Nursing Homes Support Scheme (NHSS) commenced in October 2009 with the aim of ensuring that long-term nursing home care is accessible and affordable for everyone and that people are cared for in the most appropriate settings. A review of NHSS is being undertaken in 2012/13 in line with the programme for Government: 'The Fair Deal system of financing nursing home care will be reviewed with a view to developing a secure and equitable system of financing for community and long-term care which supports older people to stay in their own homes.' (Department of Taoiseach, 2011:32).
21 Specifically, under the CSO's 'most pessimistic scenario , the population aged 65+ is projected to grow at an annual average of 5% over the next 35 years compared to about 0.25% annually for the entire population (Central Statistics Office, 2013). This means that the population aged 65+ is expected to grow by 24,500 each year between 2011 and 2046. The impact of this can be seen graphically through the 'inverse dependency ratio' which is the number of people aged 15-64 for each person aged 65+. In 2011, there were 5.7 persons for every person aged 65+; in the decade to 2021 this will fall to 4.1; by 2031 it will fall further to 3.1 and by 2046 it will be 2.0. In other words, the number of people in the workforce is diminishing relative to the number of older people.
22 The ESRI's medium-term (2013-2020) projected rate of growth in Ireland's GNP, under the most optimistic 'recovery scenario', will be 'around 3.5 per cent a year in the second half of the decade' (FitzGerald and Kearney, 2013:viii).
23 Callan, Nolan, Keane, Savage and Walsh, 2013.
24 Well-being is about the enjoyment of life and offers a way of describing the quality and satisfaction of life, and the happiness experienced by individuals, families, communities and society itself. The concept has deep roots in almost every philosophical tradition, and has been revived in recent times as a way of offering a more holistic understanding of what constitutes a 'full life'. In the area of health, for example, it has been used to promote an understanding of health as 'more than the absence of illness' (Department of Health, 2001a:15) just as mental health is 'broader than the absence of mental disorders' (Expert Group on Mental Health Policy, 2006:16). Well-being happens as a naturally-occurring part of life and that is why it is important, in designing services for older people, to consider the evidence generated through basic research about the processes that influence the well-being of older people. This is because services are more likely to be effective if they support and strengthen these 'naturally occurring' processes. That is why, as part of the national business case for the proposed social enterprise, an in-depth analysis was undertaken of the TILDA dataset.

1

Context of Social Enterprise for Older People

1.1 Introduction

The proposal to set up a social enterprise for the purpose of providing home-based services for older people needs to be understood and assessed in the wider context of the priorities which Ireland faces at this time. This chapter examines five relevant aspects of this context, namely population ageing, public sector reform, evolution of services for older people, job creation through social enterprise and using evidence on health and well-being to design and deliver services. We begin by documenting the scale of population ageing and providing some indicators of associated need (Section 1.2). We then summarise the main features of public sector reform as it affects health and social care services (Section 1.3), including its likely implications for the evolution of services for older people (Section 1.4). We summarise national policy for creating jobs through social enterprise (Section 1.5). We report findings on the determinants of well-being among older people, based on analysis of TILDA (The Irish Longitudinal Study on Ageing), since services for older people are more likely to be effective if aligned with the known and 'naturally occurring' processes associated with well-being (Section 1.6). We conclude with a summary of findings (Section 1.7).

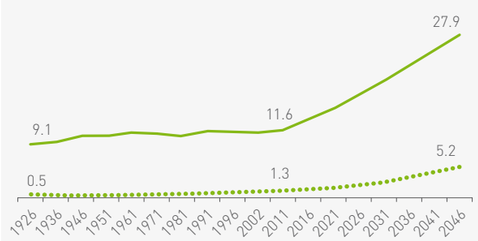
1

Context of Social Enterprise for Older People

1.2 Population Ageing

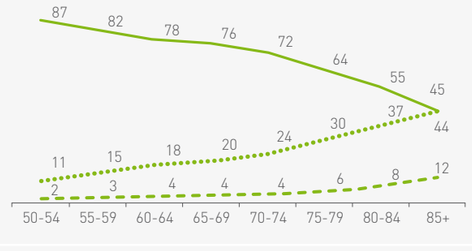
Population ageing typically refers to an increase in the share of population aged 65+ and 85+, due to rising life expectancy and falling fertility. It is a relatively recent phenomenon in Ireland as in other developed countries due mainly to increased life expectancy. Figure 1.1 shows the population aged 65+ and 85+ over the nearly a century since 1926, including projections until 2046[25]. This shows that the population aged 65+ has been remarkably stable throughout most of the last century at around 11%. Since the turn of the century, there is a noticeable trend towards population ageing and the projection is that, over a period of just 35 years, the population aged 65+ will more than double from 11.6% in 2011 to 27.9% in 2046. The share of population aged 85+, though much smaller, will grow even more rapidly from 1.3% in 2011 to 5.2% in 2046; though large, these are somewhat less than in other OECD[26] and EU[27] countries. In practical terms, this means that for the next 35 years, the population aged 65+ is projected to increase by nearly 25,000 every year, including an increase of nearly 6,000 in those aged 85+. It is clear that population ageing will create pressure on Ireland's health and social care systems which are beyond its current capacity to withstand.

Figure 1.1
Population Aged 65+ & 85+ in Ireland, 1926-2046



Sources: (i) Data for 1926-2002 taken from Census 2002: Volume 2 Ages and Marital Status (Central Statistics Office, 2003); (ii) Data for 2011-2046 taken from CSO Population and Labour Force Projections 2016-2046. (Central Statistics Office, 2013).

Figure 1.2
Self-Reported Health of Population at Selected Ages (50-85+), 2011



Source: Derived from Census of Population 2011 (Central Statistics Office, 2012b: Table 10a, p.63). Based on the question: How is your health in general? Answer: very good, good fair, bad, very bad.

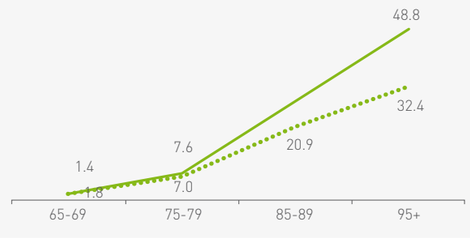
The significance of population ageing can be illustrated in terms of three indicators – self-reported health, dementia and living in long-stay care – and how they change as people get older. Figure 1.2 shows the slowly-changing gradient in self-reported health at each ascending age category although even at 85+, the vast majority of people self-report good or very good health (45%), or fair health (44%), with a small but significant minority (12%) self-reporting bad or very bad health.

Figure 1.3 shows that 'the risk of developing dementia increases exponentially with age' so that by age 95, half of all women (49%) and a third of men (32%) are expected to have dementia[28].

Figure 1.4 which shows that the likelihood of living in communal establishments (mainly nursing homes) increases with age; by age 85 a minority of people live in a communal establishment (15%) but this rises to nearly half (46%) for those aged 95 and over.

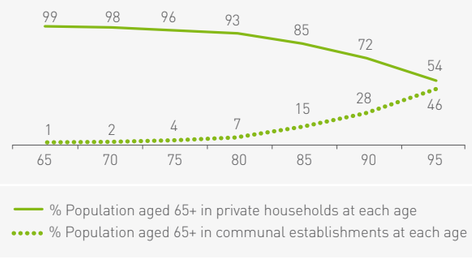
The significance of population ageing can also be seen when related to the working age population (15-64), since this includes the workforce whose earnings are needed to

Figure 1.3
Prevalence of Dementia at Selected Ages in Europe



Source: Cahill, O'Shea and Pierce, 2012:29, Table 2.1. These are European (EuroCoDe) age-specific and gender specific prevalence rates for dementia.

Figure 1.4
Population Aged 65+ Living in Communal Establishments at Each Age, 2011



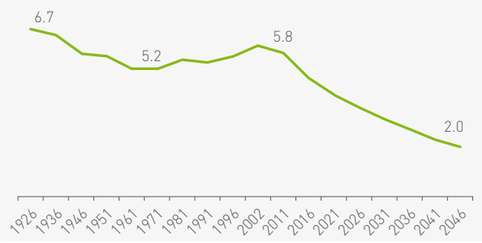
Source: Derived from Census of Population 2011 (Central Statistics Office, 2012a: Table 7a, p.47).

support, at least in part, the ageing population. Figure 1.5 expresses this through the inverse dependency ratio, which is the number of people aged 15-64 for each person aged 65+. As with population ageing, we trace this over more than a century beginning in 1926 and including projections until 2046. This shows that for most of the last century there were approximately 6 persons of working age for every person aged 65+. Signs of change are clear after the turn of the century and, over the next 35 years, the number of persons of working age for each person aged 65+ will fall from 5.8 in 2011 to 2.0 in 2046. In other words, based on the CSO projections, the working age population will fall rapidly relative to the population of older people.

An important driver of population ageing is life expectancy at age 65, which increased in Ireland by three years during the first decade of this century – almost twice as fast as in the EU more generally – to 17.8 years for males and 21.0 years for females, converging on the EU average[29]. Expressing this more intuitively, the average Irish person aged 65 in 2010 received an extra three years of life by comparison with the same average Irish person in 2000[30]. The projection of the EU Commission is that life expectancy will continue to rise by one year per decade for the next 50 years till 2060[31]. The impact of this on services for older people is not easy to estimate, since it depends on whether increased longevity is accompanied by more good health or less; if accompanied by an increasing number of healthy life years, then longevity may not translate into rising costs for health and social care[32]. However, if no change is assumed in the level of age-related disability and dependency, then increased life expectancy will result in greater demand for health and other care services, particularly among the older old (80+), since "it is still likely that there will be no change in the proportions of people entering or time spent in nursing homes, nor average lifetime health care costs"[33]. This is probably the most realistic scenario in the short-term and draws attention to the public health dimension of ageing. In particular, it draws attention to the need for cost-effective interventions which can improve the general health of the population while also improving the management of chronic conditions, thereby contributing to healthy ageing and reducing the overall burden of disability associated with ageing[34]. With these considerations in mind, the EU Commission created the European Innovation Partnership on Active and Healthy Ageing in 2011 with "a target of increasing the healthy lifespan of EU citizens by 2 years by 2020, and aims to pursue a triple win for Europe by improving health and quality of life of older people, improving the sustainability and efficiency of care systems and creating growth and market opportunities for businesses."[35]

The challenges posed by population ageing are considerable – in terms of pensions[36], healthcare[37] and long-term care[38], but they are also predictable challenges and therefore amenable to a rational and proportionate response. These challenges cannot be met if the current system remains unchanged[39]. Even without the demographic pressures referred to above, there are a number of reasons why radical changes are needed in Ireland's health and social care system, as we will now argue.

Figure 1.5
Working Age Population (15-64) to Each Person Aged 65+ in Ireland, 1926-2046



Sources: (i) Data for 1926-2002 taken from Census 2002: Volume 2 Ages and Marital Status (Central Statistics Office, 2003); (ii) Data for 2011-2046 taken from CSO Population and Labour Force Projections 2016-2046. (Central Statistics Office, 2013).

The process of public sector reform is still in its early stages in Ireland

1.3 Public Sector Reform

Public sector reform is a major element of the programme of government (2011-present) and is underpinned by a commitment to public service as a core value: "Public service is, and must remain, about serving the public, not making a profit. It is about serving the common good, not sectional interests. Real reform of the public sector will require a commitment from the whole of government to become more transparent, accountable and efficient. ... Rather than giving fixed budgets to traditional public service providers like the HSE, VECs and FÁS, we will put resources into the hands of citizens to acquire services that are tailored to better suit their needs and less expensive for the taxpayer. ... We will establish a new model of financing social interventions – called Social Impact Bonds – that share audited exchequer savings with charitable and voluntary organisations."[40]

The Department of Public Expenditure and Reform has lead-responsibility for public sector reform and has the following agenda: "At the heart of this reform agenda is a focus on five major commitments to change: (i) Placing customer service at the core of everything we do; (ii) Maximising new and innovative service delivery channels; (iii) Radically reducing our costs to drive better value for money; (iv) Leading, organising and working in new ways; and (v) Strong focus on implementation and delivery."[41]

The process of public sector reform is still in its early stages in Ireland and, as first steps towards health service reform illustrate, this involves a complex set of interdependent changes. Public sector reform may involve some diminution in the State's role as service provider but, echoing the perspective of the National Economic and Social Council (NESC)[42], its wider role remains central in setting policy to determine availability and eligibility for services, as well as ensuring that high quality services are delivered by non-state organisations, that there is value for money and that the best possible outcomes are achieved for both individual service users and the population at large. Public sector reform therefore involves improving the capacity of the state to both commission and deliver care, involving public or private providers (including voluntary organisations and social enterprises) as appropriate.

The health strategy suggests that services for older people, people with disabilities and those with mental health difficulties might benefit from market-based reforms: "International research suggests strongly that the most effective way to meet the needs of individuals in these care groups is through an integrated system where there is a common funding source as part of a purchaser/provider split, a single care assessment framework, a robust governance and accountability framework, a greater emphasis on individualised budgeting and quality assurance/regulatory underpinning. Such a system will help deliver lower costs, enhance quality of care and give individuals much greater control over their own care. The sustainability of social and continuing care provision, particularly in light of the current budgetary climate and the changing demographic profile, means that increasingly scarce resources must be efficiently managed, targeted at areas of greatest need, and delivered at the point of lowest complexity."[43]

For many State services, including the Health Services Executive (HSE), purchasers and providers have traditionally been the same entity. That is why the reform of health services involves abolishing the HSE and "the creation of a formal purchaser/provider split within the health sector

For many State services, including the Health Services Executive (HSE), purchasers and providers have traditionally been the same entity. That is why the reform of health services involves abolishing the HSE[44] and "the creation of a formal purchaser/provider split within the health sector"[45]. This reform is being implemented across all forms of health and social care provision, including services for older people and people with disabilities[46]. In the hospital sector, the country's 49 acute hospitals have been reconfigured to form six groups of hospitals (to become 'hospital trusts') and, from 2014 onwards, will be paid by a 'healthcare commissioning agency' for the care they provide to individual patients, replacing the previous block-grant funding system[47]. This new system is referred to as 'Money Follows the Patient' and, in due course, will be extended to all care settings in order to "support integrated, patient-centred delivery of an episode of care across different settings"[48]. Already, many services for older people are premised on a split between purchaser and provider and, as we shall see, nearly two thirds of services for older people are provided by entities which are different from the purchaser.

These developments, in addition to enabling the emergence social enterprises, are also expected to encourage the development of innovative ways to deliver public services. The business case for the proposed social enterprise therefore depends on how well public sector reform achieves the goal of delivering quality services and value for money, addressing the individual needs of each person.

1.4 Services for Older People

The policy objective informing services for older people is stated in the Department of Health's strategy statement as follows: "To enhance the quality of life of older people, maintain their full potential, support them in their homes and communities, provide access to respite care and day care and, when required, provide access to appropriate quality long-term residential care."[49] A similar policy objective is stated in the HSE's 2013 National Service Plan: "Our goal is to help people remain in their home environment rather than entering long term residential care, except in exceptional circumstances when their care needs become so great that those needs cannot be catered for in the community or primary care setting."[50] The main aim of the proposed social enterprise is to support older people to stay in their own homes and, in that sense, it is fully aligned with the objectives of public policy.

The HSE budget to implement this policy is summarised in Table 1.1. This shows that overall expenditure on services for older people amounts to approximately €1.4 billion, equivalent to 10% of the total HSE budget for 2013 (€13.4 billion)[51].

The largest share of the HSE budget (72%) is spent on long-stay care under the Nursing Home Support Scheme (NHSS), also called 'Fair Deal'. Beneficiaries of NHSS constitute just over a fifth (22%) of all clients of the budget and represent 4.3% of the population aged 65+ in nursing homes.

The remainder of the HSE budget (28%) is spent supporting people to live at home through the Home Care Package Scheme (HCPS), the Home Help Scheme (HHS) and Day Care. Collectively these constitute 78% of recipients of the services for older people. The largest of these community programmes, in terms of budget and clients, is HHS which covers nearly a tenth (9.3%) of those aged 65+, much higher than either HCPS (2.0% of those aged 65+) or Day Care (4.0% of those aged 65+).

The size of the NHSS budget and its rapid growth since it was introduced in 2009 has led to a review, which forms part of the programme for government: "The Fair Deal system of financing nursing home care will be reviewed with a view to developing a secure and equitable system of financing for community and long-term care which supports older people to stay in their own homes."[52] Further details of this review are in the health strategy published in November 2012, which states: "The Nursing Homes Support Scheme (Fair Deal) is the first national scheme where money follows the patient. The Programme for Government promises a review of the scheme with a view to developing a secure and equitable system of financing for community and long-term care, which supports older people to stay in their own homes. The scheme will also be examined with a view to extending it to the disability and mental health residential sectors. The extension of a Fair Deal type model to any additional sectors will be carefully examined for feasibility, sustainability and impact. However, many of the principles enshrined in the scheme (money follows the patient, national care assessments, and patient choice) will inform the future policy direction of community services as a whole. The review of Fair Deal has now commenced and will include the on-going sustainability of the scheme and the viability of extending it to other sectors."[53]

An important question to be addressed by the review of NHSS – which is also a perennial question in any policy review – is whether the goals of public policy are correctly aligned

Table 1.1
HSE Services for Older People: Budget and Clients for 2013

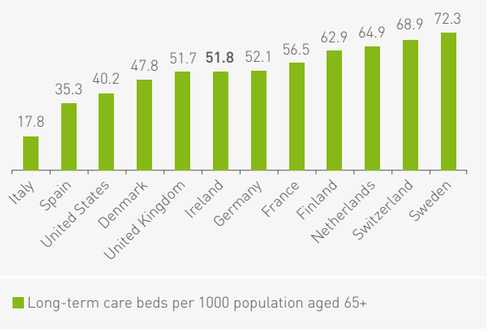
Budget Heading	Budget		Clients		(iii) % Pop 65+
	€m	%	€m	%	
1. NHSS: Nursing Home Support Scheme (i)	998	72	22,761	22	4.3
2. OP Services of which (i):	392	28		78	
2.1 HCPS: Home Care Packages Scheme(ii)	130	33	10,870		2.0
2.2 HHS: Home Help Scheme (ii)	190	48	50,002		9.3
2.3 Day Care + Other (ii)	72	18	21,460		4.0
Total	1,390	100	105,093	100	19.6

Sources: (i) Health Services Executive, 2013a:57; (ii) The budget is estimated based on data in EPS Consulting, 2013:9; the number of clients is based on Health Services Executive, 2013a:60; (iii) Central Statistics Office, 2012a. Notes: There may be some double-counting of clients since some Day Care clients may also be in receipt of HCPS and HHS.

with the resources allocated to achieve them. An easy and frequent answer to this question, though limited in value, is to use international benchmark comparisons on resource allocation such as the 'OECD average'. Generally speaking, this is not a useful answer since it assumes the benchmark represent an effective way of achieving the desired policy outcomes. A more useful approach is to examine evidence about what works to achieve policy outcomes and allocate resources accordingly. In the specific case of long-stay care for older people, the benchmark of 'OECD average' is of particularly limited value because of large variations in the provision of long-stay beds between countries[54].

Figure 1.6 summarises the number of long-stay beds per 1,000 population aged 65+ in selected OECD countries in 2011[55]. This shows that Ireland had 51.8 long-stay beds per 1,000 population aged 65+, higher than Italy (17.8), Spain (35.3) or Denmark (47.8), similar to UK (51.7) and Germany (52.1), but lower than Finland (62.9), Netherlands (64.9), Switzerland (68.9) or Sweden (72.3). Such substantial variation across OECD countries - ranging from 17.8 in Italy to 72.3 in Sweden - indicates how much long-stay care provision varies across countries with broadly similar levels of prosperity and underlines how each country finds a different balance between supporting older people to live at home and in long-stay care. Given the Irish policy commitment to supporting older people to live at home for as long as possible and preferred, the evidence in Figure 1.6 suggests that this is achievable but more could be possibly learned from those countries which actually achieve it such as Italy, Spain and Denmark. This does not imply that living at home is better, in all cases, to living in a long-stay care[56] since there is almost no data on the well-being of older people in long-stay care to compare with 'equivalent' older persons at home, such as those in TILDA (The Irish Longitudinal Study on Ageing).

Figure 1.6
Long-term care beds per 1 000 population aged 65+ in Selected OECD Countries, 2011



Source: OECD, 2012.

Tables 1.2a and 1.2b show that nearly two-thirds of the HSE budget for older people (63%) is used to purchase services from independent entities, mainly private providers (49%). This is heavily influenced by the preponderance of private providers in NHSS (61%) and HCPS (60%). Services provided by voluntary not-for-profit organisations represent more than a tenth of the overall budget (14%), rising to 30% for HHS[57], although the HSE remains the largest provider of HHS (70%). The proposed social enterprise aims to increase the share of services for older people which are provided by the not-for-profit sector.

The effectiveness of the above reforms, in terms of ensuring that the customer receives the highest quality service at the most economical price, depends on the public procurement process and associated service agreements. This process has been well developed for HCPS and is relevant to the proposed social enterprise, since this is could become the template for all services for older people including HHS and Day Care were a similar distinction between purchasers and providers implemented more generally. Since June 2012, the HSE has signed service agreements with 26 'approved providers' of HCPS across the country, four in each of the HSE's 32 LHO areas; these are listed on the HSE website and those of providers. Approximately 15 per cent of these are voluntary not-for-profit organisations, 50 per cent are for-profit home care companies operating under franchise agreements and the remainder are for-profit non-franchise companies[58].

A more useful approach is to examine evidence about what works to achieve policy outcomes and allocate resources accordingly

As a result of this process, clients can choose their service provider from the list of approved providers in their area, once their health care professionals agree that a particular approved provider can meet their needs. From 2014, these needs will be assessed using the Single Assessment Tool (SAT) , the same tool which will be used to determine need and access to all services for older people (NHSS, HCPS, HHS). It is also of note that the HSE has drafted National Guidelines for the Standard Operation of the Home Help Service for Older People[60]. The HIQA standards, National Standards for Safer Better Healthcare, are also applicable to services for older people, where these services are delivered in hospitals and clinics (but not private facilities) and in primary care centres (but not home care).

The service agreement for HCPS providers is noteworthy because it gives an indication of the infrastructure that is now in place to help ensure that services are of high quality and value for money. This agreement comprises 10 schedules, as listed in Table 1.3, and indicates the substantial capacity that provider organisations must have in order to tender and become approved providers. Commenting on the overall procurement process, the National Economic and Social Council noted that it as an example of how to improve standards in home care: "The provisions in the tender for home care packages do 'raise the bar' by requiring more comprehensive, and nationally consistent, standards in terms of what is expected from home care providers by the HSE. However, the tender only covers some types of home care. It covers home care packages paid for by the State, but does not cover home care provided by the HSE through the home help system, or home care paid for by private individuals."[61]

Table 1.2a
HSE Services for Older People: Budget and Clients for 2013

Budget Heading	HSE Provision	Voluntary Provision	Private Provision	Total
1. NHSS: Nursing Home Support Scheme (i)	€	€	€	€
2. OP Services of which (i):	289	100	609	998
2.1 HCPS: Home Care Packages Scheme(ii)	222	92	78	392
2.2 HHS: Home Help Scheme (iii)	39	13	78	130
2.3 Day Care + Other (iv)	133	57	0	190
Total (€)	50	22		72
Total (%)	512	191	687	1390

Table 1.2b
HSE Services for Older People: Budget and Clients for 2013

Budget Heading	HSE Provision	Voluntary Provision	Private Provision	Total
	%	%	%	%
1. NHSS: Nursing Home Support Scheme (i)	29	10	61	100
2. OP Services of which (i):	57	23	20	100
2.1 HCPS: Home Care Packages Scheme(ii)	30	10	60	100
2.2 HHS: Home Help Scheme (iii)	70	30	0	100
2.3 Day Care + Other (iv)	70	30	0	100
Total (%)	37	14	49	100

Sources for Tables 1.2a and 1.2b:
(i) Department of Health, 2012c, Table B1, p.12; HSE, 2013a:57-61; HSE, 2012a:44-47. Note that HSE provision is an estimate based on the number of beds in public residential care settings for older people (about 7,000).
(ii) HSE, 2013a:57-61; National Economic and Social Council, 2012a:32. Note that this is an estimate based on the proportion of 'approved providers' of HCPS which are voluntary (15%) and private (85%).
(iii) HSE, 2013a:57-61; EPS Consulting, 32013:9.
(iv) This is an estimate based on the assumption that 'Day Care + Other' is the same as HHS.

1.5 Job Creation and Social Enterprise

One of the biggest challenges facing Ireland is to create jobs in order to reduce unemployment. In 2013, the unemployment rate is 14% of the labour force and is not expected to fall below 10% before 2016 under the ESRI's most optimistic 'recovery scenario'[62]. Part of the response to this challenge is expected to come through social enterprises such as that proposed in this report, since it involves creating new jobs to meet a growing demand for services for older people as a result of population ageing. This is in line with the programme of government (2011-present) which has set job creation as a top priority and has identified social enterprises as one of the vehicles for achieving it: "The big challenge for Ireland is to develop a strategy that will allow job growth and sustainable enterprise. ... The Government will promote the development of a vibrant and effective social enterprise sector. We will instruct agencies to view social enterprises as important stakeholders in rejuvenating local economies."[63]

Table 1.3
HSE Service Agreement for Home Care Package Scheme, 2013

Schedule	Title	Details
1	**Contact Details**	Name, legal entity, owner, etc
2	**Quality and Safety**	Service standards and quality assurance including corporate and clinical governance
3	**Service Delivery Specification**	Description of service including care planning, outcomes, staff qualifications, performance indicators, etc.
4	**Performance Monitoring**	Monthly and annual reports to be provided
5	**Information Requirements**	Annual reports, audited accounts and other evaluation reports
6	**Funding**	Details of funding, payments and financial monitoring
7	**Insurance**	Public liability, employers liability, professional indemnity, motor insurance
8	**Complaints**	Complaints policy including complaints handling and resolution
9	**Staffing**	Employment numbers as per agreed levels for delivery of services
10	**Change Control**	Procedure for changes to service agreement

Source: www.hse.ie

Building on this, and a commitment in the Action Plan for Jobs 2012[64], Forfás has estimated that jobs in the social enterprise sector could at least double from the current 25,000 if Ireland were to achieve the EU average of 6% of GDP contributed by social enterprises[65]. In its report, Forfás makes recommendations which, if implemented, would create conditions conducive to growth in this sector; specifically, it makes recommendations in the following areas: policy[66]; building capacity[67], public procurement[68]; funding and finance[69]; leaders and community support[70]; and governance[71].

It is well known that many areas of care, formal[72] as well as informal[73], are associated with women. Social participation and gender equity are boosted by female labour force participation[74], which implies some shift of the care burden either from women to men (remaining within the sphere of informal caring) or from unpaid women to paid women/men (thus shifting from informal to formal caring). Public provision of care for older people is important from this perspective because: it can free up women to enter/return to the labour market; it can provide employment for women at all levels of qualification, boosting participation; and it can contribute to reducing social inequalities (and child poverty) by facilitating dual-income earning in poorer, larger families. These are core elements of the strategy for social inclusion, in Ireland[75] and the EU[76].

The proposed social enterprise can contribute to greater social inclusion by increasing female labour force participation rates and facilitating the entry/re-entry of vulnerable social groups to employment (women, people with low qualifications, immigrants, older workers). By providing career paths for both highly qualified workers as well as those who are less qualified, including access to on-the-job training, the social enterprise can sustain labour force participation rates, improve social inclusion, and raise the overall status of social care as a profession. Furthermore, by reducing the care burden which is disproportionately assigned to women, this innovation can further boost female participation, which has been recognised as a key way of reducing child poverty and a step towards achieving greater gender equality.

The main revenue streams to support the proposed social enterprise, as discussed in Chapter Four below, are associated with public procurement. The procurement process is therefore an important consideration in assessing the national business case. The Forfás report on social enterprise recommends that Ireland should adopt and extend the reforms already proposed by the European Commission's Social Business Initiative for ERDF and ESF, to give 'investment priority for social enterprises' including 'reserved contracts for social enterprises'[77]. Building on the EU initiative, Forfás recommends that "Ireland fully implements the range of options that can favour social outcomes"[78]. Implementation of this recommendation for all public procurement would create conditions conducive to growth of the social enterprise sector, facilitating innovation in service provision and strengthening the national business case for the proposed social enterprise.

Forfás has estimated that jobs in the social enterprise sector could at least double from the current 25,000 if Ireland were to achieve the EU average of 6% of GDP contributed by social enterprises

The focus of the proposed social enterprise is on creating jobs by providing services to meet the needs of older people in each local area. This proposal has already found resonance with some local development partnerships, since one of their core functions is to address social exclusion and unemployment through local and community development. The Local & Community Development Committee in each local authority, as recommended in the report of the Local Government/Local Development Alignment Steering Group[79], is expected to prepare a five-year local and community plan for their area[80]. The methodology recommended for preparing these plans is also the same as for preparing a business plan for the proposed social enterprise: "The Plans should be based on meaningful community involvement, careful needs-analysis, matching resources to identified needs and delivering bespoke solutions for the communities involved."[81] The Forfás report recommends that local and community plans "take account of the critical role of social enterprises in local growth and development"[82]. This is also one of the recommendations of a cross-border study on social exclusion and ageing in rural Ireland[83].

The role of social enterprises as vehicles for both employment creation and service provision is increasingly recognised internationally. As indicated, the European Commission launched the Social Business Initiative in 2011 "to support the development of social enterprises" in light of "the capacity of social enterprises and the social economy in general to provide innovative responses to the current economic, social and, in some cases, environmental challenges"[84]; this was followed in 2013 by a regulation on investment funds for "social undertakings"[85]. Social investment is also on the agenda of G8 countries – Canada, France, Germany, Italy, Japan, Russia, USA and UK – largely promoted by the UK Presidency of G8 in 2013, which sees social enterprises as an important aspect of public service reform and a way of promoting innovative and responsive solutions to local needs[86].

1.6
Understanding Health and Well-Being

The idea that public policy and services should be 'evidence-based', or at least 'evidence-informed', and should also be 'outcome-focused', is now accepted as the basis for assessing their performance and usefulness[87]. It is not an entirely new idea, but has gained particular currency in Ireland since the OECD reviewed the public service in 2008 and called for a greater focus on managing performance, and improving dialogue on performance targets: "Instead of focusing on inputs and processes, more information needs to be gathered on outputs and outcomes and what has actually been achieved, so that this can better feed back into measuring how the Public Service is meeting overarching targets and objectives."[88] In light of the OECD review, and against the backdrop of the collapse of the Celtic Tiger, the programme of the current Government (2011-present) lays particular emphasis on performance management and the use of performance information to inform decisions about how resources are allocated to policies and services[89]. This is reflected in a new approach to public expenditure involving 'performance-based budgeting', which links the spending of each Government Department to its strategic programmes and associated performance indicators, rather than traditional accounting 'sub-heads' and 'block-grants'[90].

In addition to using evidence to assess the performance and outcomes of services, it is arguably even more important to ensure that the design of services, and even the decision about what services are to be provided, should also be informed by the best scientific evidence available. Given that the raison d'être of health and social services is to improve well-being, it is appropriate to give further consideration to what this means in the context of designing services for older people. Well-being is about the enjoyment of life and offers a way of describing the quality and satisfaction of life, and the happiness experienced by individuals, families, communities and society itself. The concept has deep roots in almost every philosophical tradition[91], and has been revived in recent times as a way of offering a more holistic understanding of what constitutes a 'full life'. In the area of health, for example, it has been used to promote an understanding of health as 'more than the absence of illness'[92] just as mental health is 'broader than the absence of mental disorders'[93]. Well-being happens as a naturally-occurring part of life and that is why it is important, in designing services for older people, to consider the evidence generated through basic research about the processes that influence the well-being of older people. This is because services are more likely to be effective if they support and strengthen these 'naturally occurring' processes. That is why, as part of the national business case for the proposed social enterprise, an in-depth analysis was undertaken of the TILDA dataset.

TILDA is The Irish Longitudinal Study on Ageing and comprises a sample of 8,504 people aged 50+ living at home; the sample excludes those with dementia and those living in residential care. The data for wave 1 of TILDA was collected between 2009 and 2011[94]. Our analysis is based on a sub-sample of TILDA respondents (3,661) for whom complete data existed from the three main sources (interview; self-completion; health assessment but excluding home assessment) and were aged 50+[95]. The main effect of this attrition is to bias the sample slightly towards those who participated in health assessments and these were somewhat healthier than those who did not (23% of those who participated self-reported 'excellent' health, compared to 17% of those who did not). All sources of bias are likely to be minimised by statistical analysis which controls for the influence of many characteristics.

Our analysis used Structural Equation Modelling (SEM)[96] to estimate the explanatory role of various potential determinants of health and personal well-being in TILDA. Unlike classical linear regression analysis, SEM allows multi-dimensional constructs (like personal well-being, overall

health, active lifestyle and social class) to be measured using latent variable modelling techniques[97], as represented by the oval shapes in Figure 1.6[98]. The full methodology and results of this analysis are detailed in a separate report[99]. Here we present statistically-significant results on personal well-being only (Figure 1.6) along with details of relevant concepts and measurements (Table 1.4).

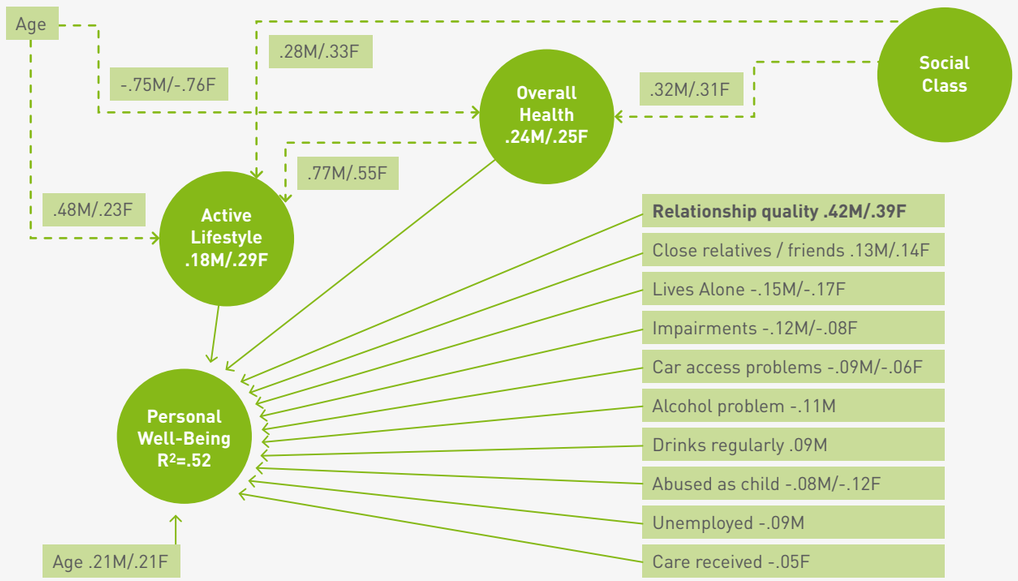
Figure 1.7 contains the estimates generated by our model of the unique influence of each predictor (or independent) variable on personal well-being (the dependent variable), controlling for all other influences. This is expressed as a standardised regression coefficient and indicates how much change in the dependent variable, measured in standard deviation units, is associated with a one standard deviation change in the independent variable. Many effects detected in human sciences, including the effects of public services and programmes, tend to be substantively small. In practice, this means that statistically-significant effects of 0.2 and above are also highly likely to be substantively important[100]. At the same time, the cumulative effects over a lifetime of smaller effects (such as early childhood experiences or the effectiveness of pre-school programmes) may also be substantively important when all such effects are taken into account[101]. These considerations draw attention to importance of interpretation and identifying findings that are substantively significant and not just statistically significant.

Figure 1.7 summarises all direct influences on personal well-being (using solid lines) with the letters 'M' and 'F' denoting the size of influence for males and females respectively. A small number of indirect influences on the dependent variable (using broken lines) are included to indicate how these operate via a third variable to mediate or moderate its influence on the dependent variable. The model explains 52% of the variability in personal well-being.

> In addition to using evidence to assess the performance and outcomes of services, it is arguably even more important to ensure that the design of services, and even the decision about what services are to be provided, should also be informed by the best scientific evidence available

Given that this analysis is based on the first wave of TILDA only, and therefore based on cross-sectional data, it is necessary to make some theoretical assumptions about the direction of causality – and therefore the temporal sequence in which influences come into play – in order to provide an interpretation of results. Our assumption is that personal well-being, which measures the person's self-assessed well-being at the time of the interview, is influenced by their overall health which in turn influences their active lifestyle, and all of these are influenced by a wider set of background influences, notably social class, early childhood experiences and selected long-

Figure 1.7
Determinants of Well-Being for Older People: Analysis of TILDA Data 2010/2012



Note: All results are statistically significant. N=3,661.

Table 1.4
Concepts and Measurements in TILDA Results

Concept	Instrument	Details
Personal Well-being	Latent variable constructed from TILDA scales	- Depression (20-item CESD) - Loneliness (5-item UCLA Loneliness Scale) - Life Satisfaction (single item scale) - Self-Concept (19-item CASP scale)
Relationship Quality	TILDA 7-item scale applied to relationship quality with spouse, children, other relatives and friends	- Positive indicators: understands my feelings; can be relied upon; can open up to him/her - Negative indicators: makes too many demands, criticises, lets me down; gets on my nerves
Health status	Latent variable constructed from TILDA data	- Cholesterol (Low Density Lipoprotein) - Movement - Neuropsychological health - Visual acuity for both eyes - Self-rated sensory function (vision, hearing, smell and taste)
Active Lifestyle	Latent variable constructed from TILDA data	- Frequency of participating in activities - Involved in clubs, groups or associations - Currently working, studying or volunteering - Amount of physical exercise
Social class	Latent variable constructed from TILDA data	- Third level qualification - Highest occupational groups - Gross household income - Total household assets
Close friends / relatives	TILDA indicator	Number of close relatives and friends, excluding children, defined as "People you feel at ease with, can talk to about private matters, and can call on for help"
Impairments	Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) scales	Total number of ADL and IADL impairments reported by the respondent
Care received	Constructed from TILDA data	Hours of assistance received per month by the respondent from spouse, children or other people to overcome impairments, plus hours of assistance received to help with household chores or paperwork
Alcohol problem	CAGE scale	CAGE is an acronym for the 4-items in this scale about feeling the need to Cut down, Annoyed, Guilty, and an Eye-opener moment
Drinks regularly	Constructed from TILDA data	Respondent consumes, on average, 7 or more standard drinks per week
Smoker	Constructed from TILDA data	Respondent currently smokes or quit within the past year having smoked for 10+ years
Car access problems	Constructed from TILDA data	Not driving has negatively affected respondent in past year in social activities, daily activities, healthcare appointments
Unemployed	Constructed from TILDA data	Respondent's current activity status is 'unemployed'
Abused Childhood	Constructed from TILDA data	Before respondent was 18, he/she experienced either physical or sexual abuse

TILDA Design Report, 2010.

standing behaviours such as smoking and drinking. These are necessarily simplifying assumptions – since, for example, personal well-being and health may mutually influence each other – and will need to be tested in subsequent waves of TILDA; for the time being, these assumptions provide a meaningful and useful way of interpreting the first wave of TILDA data.

One of the most significant findings of the analysis is that social connections, in the broadest sense, have a particularly large influence on personal well-being among older people. These involve the quality of relationships with partners, children, relatives and friends (.42M/.39F); an active lifestyle (.18M/.29F); the number of close relatives and friends (13M/.14F); not living alone (-.15M/-.17F); drinking regularly (for men), presumably with family and friends (.09M); and being able to drive a car to do daily activities (-.09M/-.06F). All of these influences show that a person's sense of being well is intimately connected with their web of social relationships, perhaps because these link them to a wider sense of self which, in turn, enhances self-concept and life satisfaction and protects against depression and loneliness. The quality of these relationships (and in some cases their quantity), has a substantial influence on personal well-being. This direct influence is strong, but it is worth bearing in mind that relationship quality also influences health and, through health, improves personal well-being in an indirect fashion[102]. Conversely, whilst living alone is not the same as loneliness[103], this analysis indicates that living alone (which is the situation in which 17% of men and 27% of women in TILDA find themselves[104]) is a risk factor which directly reduces personal well-being, as well as having an indirect effect by virtue of its negative effects on men's health. Also of note is how childhood experiences of physical and/or sexual abuse (involving 12% of men and women in TILDA[105]) have direct life-time consequences for personal well-being (-.08M/-.12F). They are also likely to have an indirect influence, as they appear to impair the quality of relationships. Alcohol problems (which affect 19% of men and 9% of women[106]) also have a direct negative influence on the personal well-being of men (.11M).

Overall health has a significant influence on personal well-being (.24M/.25F). This is exercised directly but also indirectly through its huge influence on active lifestyle (.77M/.55F), since being healthy enables people to participate in a range of activities including physical exercise which are associated with personal well-being. However health itself is strongly influenced by a person's age (-.75M/-.76F) and social class (.32M/.31F). In that sense, it could be said that the body's physical and cognitive functioning reflects not just the ageing process per se, but also the impact of access to resources over an entire lifetime (such as education, occupation, income and assets) coupled with the 'downstream effects' of social class on smoking[107], activities and the uptake of medical screening. Thus, although social class does not have a significant direct influence on personal well-being, it has a pervasive and powerful influence on other factors which influence personal well-being.

A noteworthy result is that once we control our health, lifestyle and other factors, age is directly and positively related to personal well-being, implying that personal well-being improves as people get older, ceteris paribus, but inversely related to overall health (because health tends to decline as people get older). However, when all of these effects of age on personal well-being are considered – both direct as well as indirect – the overall effect of age is slight and significant only for women. The net effect of social class on personal well-being is also statistically significant for women only, albeit larger in size. This finding opens up a wider set of questions about the meaning of 'age' and 'ageing' and suggests that it is not a simple independent variable exercising a linear or chronological influence on personal well-being. Rather age seems to provide a background context against which personal well-being and its determinants play out – in the foreground, so to speak – their mutually reinforcing causal sequences. Ageing, in this sense, might be seen as the movement or evolution of a person's well-being over time. It could be said, with the support of this data, that ageing in the chronological sense of the term, controlling for various processes of physical and mental decline, is associated with increasingly positive assessments of one's self and one's life, which itself supports a more traditional view of ageing as accumulated 'wisdom of years'. In a similar vein, it might also be seen as providing evidence for the increasingly popular term 'positive ageing' which, from a well-being perspective, is largely synonymous with 'ageing'[108]; in other words, for those who live at home ageing is a journey towards improved personal well-being.

A key insight from this analysis is that, while all influences on personal well-being are interconnected, a person's social connections exercise a greater influence on personal well-being than overall health

A key insight from this analysis is that, while all influences on personal well-being are interconnected, a person's social connections exercise a greater influence on personal well-being than overall health. On reflection, this is not wholly surprising, since the self's reflection on itself – out of which well-being is constituted as a cognitive and emotional assessment of how one experiences life and the world – is richer and more inclusive than a simple assessment of physical and mental functioning. In that sense, these findings prompt and encourage a more holistic and human perspective on what makes a person well and, for those who are unwell, what might help to make them better. More generally, these findings indicate that when ageing is seen through the eyes of the whole person and not just their illness and disability characteristics, it is a positive process associated directly with improvements in personal well-being. Knowing the risk and protective factors which influence well-being provides an important foundation stone for the design and delivery of services for older people. In that sense, the analysis of TILDA has implications beyond the proposed social enterprise because it draws attention to the need for a paradigm shift in all services affecting older people[109].

The wider significance of these findings merit reflection since they point towards an understanding of personal well-being – and of ageing – that is wider than the 'health perspective', which tends to be the predominant focus of existing policy and service provision for older people. Moreover, the so-called 'health perspective' is often and in practice an 'illness and disability perspective', since service interventions for older people are often triggered by an assessment of illness and disability, and may not give due consideration to personal well-being and the role of social connections in sustaining it. There are some signs that a wider perspective is becoming more influential, particularly with the introduction by the HSE of the Single Assessment Tool from 2014 for the purpose of assessing needs and determining the "provision of resources under the Nursing Home Support Scheme (NHSS), the Home Care Package Scheme (HCPS) and for home Help Services"[110]. SAT is based on the InteRai[111] suite of instruments and includes a similar set of domains to those in TILDA. However, much will depend on how SAT is implemented, the algorithms used to determine levels of need and the range of personal and community-based supports for relationships and active lifestyle. More generally, the findings presented here suggest that services for older people, as currently funded by the HSE – namely NHSS, HCPS, HHS, Day Care - may not adequately reflect all or even the most important risk and protective factors affecting personal well-being. This, in turn, invites reflection on the question of whether the right services are being commissioned in all cases, and whether there is need to create a more innovative stream of commissioning which, on the evidence presented, addresses a wider set of influences on the personal well-being of older people.

The national implications of our analysis suggest that while hospital and residential services to meet the needs of older people are important, they may have assumed disproportionate importance relative to the social connections which sustain the well-being of older people in their home environment. As already indicated, almost no data exists on the well-being or social connections of older people in long-stay care[112] and, for that reason, it is virtually impossible to say if their well-being is better, worse or the same as 'equivalent' older persons at home[113]. As indicated elsewhere in this report (especially Chapter Two), the scale of resources allocated to keeping people in hospital or residential care is disproportionately large compared to the resources used to support them to live well at home. Moreover, it is doubtful if this model and level of service provision for older people is sustainable to meet the challenges of population ageing (see Section 1.2 above). The good news from the TILDA analysis is that this model may not even be desirable, at least in its present form, as an earlier report on TILDA findings has also suggested: "Despite the widely held belief that ageing will lead to large increases in the demands for hospital care which will be hard to accommodate, the evidence from TILDA suggests that increased demands will be modest, and will be driven primarily by the health of the population as opposed to the age structure. As found in other studies ... the most pressing effects of ageing are likely to be on demands for a range of community-based health and social care services."[114]

These findings will inform the proposed social enterprise in the design and delivery of its services for older people. It will adopt a well-being perspective because it is a more appropriate and inclusive paradigm for understanding the needs of older people, based on human development principles[115]. This is not a new insight, since the centrality of well-being is recognised in the field of health and beyond[116] and indicators of human development are increasingly used as global measures of a country's progress[117]. Re-orienting services for older people to promote personal well-being, and not just manage illness and disability, will require a clearer articulation of this paradigm including its national implications for service design and delivery[118].

1.7 Summary

This chapter examined the context for the present proposal, focusing in particular on national priorities such as population ageing, public sector reform, commissioning services for older people, job creation through social enterprise and using evidence to design and deliver services. Our review suggests that this is an appropriate and timely proposal in the context of national priorities and has the potential to contribute to national recovery and reform. Specifically, it merits further consideration and support since it has the potential to address some of the emerging challenges associated with population ageing and, informed by analysis of TILDA, identifies ways in which services for older people could be more effective if aligned with the known and 'naturally occurring' processes associated with personal well-being. It is also aligned with national policy for creating jobs and supporting a vibrant and innovative social enterprise sector, alongside private and public enterprise. The proposed social enterprise is travelling in the same direction as public sector reform which is premised on the need to commission services from a wider range of providers which are more innovative and cost effective in helping older people to live at home with the support of their families, friends and communities.

Footnotes

25 Central Statistics Office, 2013. The CSO projections from 2011 to 2016 are based on six different scenarios (high and low fertility; high and low positive net migration, continued negative migration). Given that uncertainty surrounds each scenario, we adopt the forecast of least population increase - described by the CSO as 'the most pessimistic scenario (M3F2)' (Central Statistics Office, 2013:33) - based on low fertility (F2) and continued negative migration (M3). The purpose of adopting this scenario is simply to illustrate the minimum likely future requirements for services for older people. Even if future population exceeds this lowest possible estimate, services for older people must at least meet this minimum basic level of demand, if current levels of service provision are to be maintained.

26 OECD forecasts that the percentage of those aged 80 and over is likely to more than double from 4% in 2010 to nearly 10% in 2050 in OECD countries (Colombo and Mercier, 2011:3).

27 EU Commission, 2012:26.

28 The higher prevalence of dementia among women in the older age categories is 'mainly due to the disproportionate number of women in the population at older ages' (Cahill, O'Shea and Pierce, 2012:31).

29 Department of Health, 2012c:9. One of the factors contributing to increased life expectancy is the reduction in cardiovascular-related deaths itself associated with increased prescribing of cardiovascular medicines such as ace inhibitors, beta blockers and statins. As a consequence, "thousands of people are alive today who would otherwise have died" (Layte, 2010; also Layte, O'Hara and Bennett, 2010). Other consequences of increased prescribing are also noted: "It is likely that these cardiovascular medications are also contributing to the significant decrease in disability among older Irish people experienced in recent years. The effect also underlines the important role played by primary care in the Irish health care system. As well as keeping many people alive, this prescribing also prevented many older Irish people from experiencing the heart attacks and strokes that would have otherwise occurred and in so doing, saved the Irish hospital system a great deal of resources. This is a good example of the importance of treatment protocols since some of the change is attributable to the cardiovascular strategy and secondary prevention. However, the change in prescribing was most marked after the change in eligibility for the medical card. This shows the benefits that accrue from providing primary care free at the point of delivery and keeping prescribing fees modest. Early use of primary care prevents more serious illness later and helps to move healthcare from expensive public hospitals to relatively less expensive primary care settings." (Layte, 2010).

30 This testifies to the malleability of the ageing process and explains why most demographic forecasts have been mistaken in assuming that life expectancy in developed countries had reached a ceiling. 'The reason previous forecasts proved wrong is simple. It used to be assumed that the ageing process was programmed, that some inner clock set a limit to life. But advances in the understanding of evolutionary mechanisms, and the experimental dissection of the genetics of ageing and longevity, reveal that this is not so. Instead, the genetic control of longevity comes through regulation of the body's survival mechanisms — those essential maintenance and repair processes that slow the build-up of the molecular and cellular faults that will eventually undo us' (Kirkwood, 2006).

31 'In the EU as a whole, life expectancy at age 65 is projected to increase by 5.2 years for males and by 4.9 years for females over the projection period [2010-2060]. In 2060, life expectancy at age 65 will reach 22.4 years for males and 25.6 for females' (EU Commission, 2012:25).

32 EU Commission, 2012:161-162.

33 Murphy and Martikainen, 2011:20.

34 "With the ageing of OECD countries' population over coming decades, maintaining health in old age will become increasingly important. ... . Looking at specific programmes, the material covered by this review also suggests that important improvements to the health and welfare of older cohorts seem possible from some combination of: delaying retirement, increased community activities, improved lifestyles, health-care systems that are better adapted to the needs of the elderly, particularly where they are combined with more emphasis on cost-effective prevention. However, this study also finds that, while there is considerable evidence that certain policy instruments can help improve the health status of the elderly, it remains unclear as to which are the most (cost) effective." (Oxley, 2009:3).

35 European Commission, 2012b:3.

36 The scale of the pensions challenge is recognised in the 2010 National Pensions Framework: "The task of financing increasing pension spending will fall to a diminishing share of the population as demographic projections indicate that there will be less than two people of working age to every person aged 65 or over by the middle of the century, compared to almost six people today. ... The projected increase in spending on public pensions (social welfare pensions and public service occupational pensions) from approximately 5½ per cent of GDP in 2008 to almost 15 per cent in 2050. This rise in public expenditure is the equivalent of over €8 billion in 2009 present value terms" (Government of Ireland, 2010:13). In response to this, the state pension age has been raised to 66 in 2014, to 67 in 2021, and to 68 in 2028.

37 The scale of the health care challenge is recognised by the 2011 Strategy Statement of the Department of Health: "this reform programme must be progressed in what is economically and financially the most challenging period in the history of the State. Overall resources are falling: - total current expenditure for the public health service is being reduced by nearly €1.1 billion in nominal terms over the period 2011-2014. ... Other pressures also intensify the challenges facing us. We have an increasingly ageing population, with all that this implies in terms of health and social care needs and cost of provision. While new treatments and improved technologies offer better medical outcomes for many, they can also increase costs for the system. The characteristics of many modern lifestyles have implications for population health, and consequently for the levels of demands made on our health system. Healthcare requirements will increase to unsustainable levels unless action is taken to address chronic diseases. A new model of care is being developed which provides structured and integrated care for patients with long-term chronic conditions. Primary care needs to play a central role in this. Allied to this is the need for prevention and early intervention to promote health and reduce reliance on our hospital system. This will require the mobilisation of the many organisations and sectors that impact on health and wellbeing outcomes." (Department of Health, 2011:9-10).

38 The scale of the long-term care challenge is recognised in the 2013 National Service Plan of the HSE: "In order to meet increasing population need and deliver sustainable services within available resources, innovative models of care are required to further advance the development of equitable integrated care for older people across community-based services, intermediate care options and quality long term residential care services (supported by a robust and well-funded scheme, presently the NHSS). The provision of intermediate care options and the provision of clear pathways of care for older persons accessing the health care systems will continue to be developed in 2013, with specific emphasis on the provision of transitional/intermediate type care to address the issue of unnecessary admissions to acute hospitals and the requirements for long stay care." (HSE, 2013:15).

39 Demographic projections by the ESRI reached similar conclusions about the health services: "The increased demand for health care likely to stem from demographic and epidemiological change in the Irish population is significant. Even if national finances improve substantially, the current way in which care is delivered will be unsustainable within any reasonable budget given the nature of demographic change. This demands a reconfiguration and intensification in the use of health care resources and improvements in levels of efficiency. ... A transition to a healthcare system focused more on care in the community than acute public hospitals will require development of both primary and long-stay services, as well as social care services, if it is not to lead to severe degradation in the level and quality of service" (Layte, 2009b:62-3; Layte, 2009a). It might also be noted that this scenario is not unique to Ireland but applies to almost all developed countries: "The increase in the ageing population, with correspondingly higher levels of co-morbidity, will likely mitigate against home deaths and in favour of hospital deaths, unless innovative approaches can be developed to support those with complex co-morbidities in the community" (Murtagh, 2012:23 and 219).

40 Department of Taoiseach, 2011:28-30.

41 Department of Public Expenditure and Reform, 2011:3.

42 One aspect of the state's role in human services, according to NESC, is to act as a policy centre in promoting quality: 'the 'policy centre' must not only insist that frontline providers engage in serious monitoring of outcomes and processes, but combine this with a more supportive stance. The enhanced and modified role of the policy centre would include ... the centre leading the consideration of alternative institutional models of provision such as social enterprises that could act as a stimulus for wider change in a given policy area.' (National Economic and Social Council, 2012c:67).

43 Department of Health, 2012a:37.

44 The Programme for Government states: "The Health Service Executive will cease to exist over time" (Department of Taoiseach, 2011:32).

45 Department of Health, 2012b:21.

46 A comprehensive review of disability services by the Department of Health noted the limitations of the 'block-grant' finding system and the need to move to a more competitive procurement process which gives greater priority to the needs of the service-users: "The block-grant approach to funding had a pragmatic historical basis, but is not sufficient to address the degree of accountability and transparency expected of the modern Disability Services Programme. ... The Review recommends that a resource allocation framework be developed, which would consist of a standardised assessment of service user needs, a means of costing those needs prospectively, a framework for identifying how much of those needs will be met and the facility to identify the quantum and cost of the services actually received. A resource allocation model should take into account service user needs, on the one hand, and the amount of resources available at national level, on the other. The model should be predicated on finite resources and should provide a framework for the distribution of available resources to meet assessed need in as fair and transparent a way as possible. It should also include protocols for determining eligibility and prioritisation. Resource allocation should be on a programme budget basis, where the objectives, outputs and outcomes of each element of the budget are specified, rather than incremental budgeting based on the calculation of changes to the previous year's baseline. The position of funding places rather than people should reverse over time." (Department of Health, 2012d:xxvi-xxvii).

47 Department of Health, 2013a; 2013b.

48 Department of Health, 2013a:65.

49 Department of Health, 2013a:18.

50 HSE, 2013a:57.

51 This does not include the average contribution of residents to NHSS which in 2012 was about €275 per week (email from HSE to Mervyn Taylor, 22 February 2013). Applying this amount to the number of persons on NHSS in 2013 generates an additional expenditure on long-stay care of €325 million, bringing the NHSS 'budget' to €1.3 billion and the overall expenditure for older people's services to €1.7 billion.

52 Department of Taoiseach, 2011:32.

53 Department of Health, 2012a:41.

54 Long-stay care refers to persons who live in what the OECD calls 'long-term care institutions'. These are nursing and residential care facilities which provide accommodation and long-term care as a package. They include specially designed institutions or hospital-like settings where the predominant service component is long-term care and the services are provided for people with moderate to severe functional restrictions.
Inclusion:
- Persons who receive long-term care by paid long-term care providers, including non-professionals receiving cash payments under a social programme
- Recipients of cash benefits such as consumer-choice programmes, care allowances or other social benefits which are granted with the primary goal of supporting individuals with long-term care needs based on an assessment of needs.

Exclusion:
- Persons receiving long-term care in hospitals (HP.1)
- Disabled persons of working age who receive income benefits or benefits for labour market integration without long-term care services
- Persons who need help only with instrumental activities of daily living (IADL), that is, receiving only long-term social care as defined under the Health Accounts questionnaire (HC.R.6-type services). (OECD Health Data 2012, Definitions, Sources and Methods).

55 OECD Health Data 2013.

56 An exception is a report on end-of-life care in acute and long-stay settings which included some qualitative interviews with residents in nursing homes (O'Shea, Murphy, Larkin, Payne, Froggatt, Casey, Ní Léime and Keys, 2008:135-140). This report provides an illustration only and does not permit generalisation to long-stay residents generally: 'In some care settings, there was a sense among the patients that the facility was a "home away from home", particularly if they lived there for many years. ... . However, not everyone shared this view, and some patients just longed to be at home. These patients did not feel that their current accommodation was "home-like" and suggested that their care was focused on the routine of the staff, rather than their personal wishes. ... . Other patients just wanted to be in their own home and it was this desire to be at home rather than anything particularly lacking in the care setting that prevented them from feeling at home. ... . Sometimes the sense of belonging stemmed from relationships between patients. ... . Many of the patients experienced personal losses on admission to long-stay care. Relationships changed upon admission and in some cases were lost altogether. In one case in particular, the patient was admitted to the nursing home on the day of her husband's death and attended his funeral from there. She never returned to her own home again.' (ibid, 135-140).

57 These organisations are funded under Section 39 of the Health Act 2004 which states, inter alia, that "The Executive may, subject to any directions given by the Minister under section 10 and on such terms and conditions as it sees fit to impose, give assistance to any person or body that provides or proposes to provide a service similar or ancillary to a service that the Executive may provide."

58 National Economic and Social Council, 2012a:32.

59 SAT is based in part on the InterRAI suite of assessment tools (www.interrai.org) plus a carer assessment and will be part of a computerised system called SATIS (Standardised Assessment Tool Information System).

60 See National Economic and Social Council, 2012a:34.

61 National Economic and Social Council, 2012a:50.

62 FitzGerald and Kearney, 2013:viii.

63 Department of Taoiseach, 2011:7 and 14.

64 Department of Jobs, Enterprise and Innovation, 2012.

65 "In 2009, there were approximately 25,000 direct jobs in the social enterprise sector in Ireland. ... Although it is difficult to provide concrete evidence (given the amorphous nature of the sector), social enterprise appears to be a growing enterprise sector that can bring further job gains and deliver economic potential. ... Estimates for potential employment growth are for up to a tripling of the number currently employed if the conditions are conducive for the growth of the sector. Social enterprise accounts for about 6% of GDP across

the EU. If Ireland's social enterprise sector, as defined in Section 2, were to approach mean EU levels of output, it is estimated that there would be approximately 65,000 jobs in social enterprises; this figure could grow to as much as 100,000 jobs if Ireland achieved the 9% goal set by the EU under the 'Europe 2020' Strategy." (Forfás, 2013:18).

66 "It is timely to bring forward a coherent policy for social enterprise in Ireland, with full recognition of the societal, enterprise and employment dimensions of the sector, led by the Department of the Environment, Community and Local Government and local authorities." (Forfás, 2013:4 and 21).

67 "In order for the sector to grow, social enterprises need to develop their business, leadership and management skills, as well as harnessing community, stakeholder and volunteer involvement." (Forfás, 2013:5 and 22-23).

68 "Public procurement can be used to influence social outcomes. In this context, social enterprises currently are at a disadvantage in accessing public procurement opportunities due to, inter alia, capacity constraints. Thus, there is a need to advance measures, as for all SMEs, to improve access and to build the capacity of the sector in accessing tendering procedures." (Forfás, 2013:6 and 24-26).

69 "Social enterprises can currently access many funding opportunities; however, in order to reduce reliance on grant-aid, the sector needs to focus more on developing business opportunities. Where social enterprises provide a service to government, consideration needs to be given to classifying this income as fee-for-services and not grants. It was established during Forfás consultations that credit unions in Ireland wish to establish a central social finance facility but are currently prohibited from doing so. In addition there is a need for Ireland to actively engage with the European Commission's Social Business Initiative to ensure that all benefits for Ireland are realised." (Forfás, 2013:6-7 and 26-30).

70 "Consideration needs to be given as to how best to develop sectoral 'champions' nationally and to improve local awareness about the benefits of social enterprise to local communities." (Forfás, 2013:7 and 31).

71 "Currently, social enterprises are generally established as companies limited by guarantee. However, the role of the co-operative model has potentially wide application in the sector and should be further examined by those involved in the sector and promoted. As many social enterprises have charitable tax-exempt status, the commencement of the Charities Act will mean that for the first time registered charities will exist in Ireland, and will help ensure quality assurance in the sector as well as improved data." (Forfás, 2013:7-8 and 32-33).

72 For example, the vast majority of care / home-care workers (87%) are childcare workers (97%) but so too are nurses / midwives (91%) and primary teachers (89%) (FÁS, 2013:82 and 88).

73 In 2009, the CSO carried out a survey of carers, defined as those providing unpaid help and excluding those who 'help in a paid capacity or where the support provided is financial only' (Central Statistics Office, 2010b: 3). It found that nearly two thirds of carers (64%) are women.

74 In the 2011 Census, the male participation rate was 69.4% while the female participation rate was 54.6%. Commenting on this, the CSO noted, "In 2011 the difference in rates between males and females was at its lowest point ever at 14.8 percentage points." (Central Statistics Office, 2011:10).

75 See notably the programme of government (Department of Taoiseach, 2011).

76 See notably the Europe 2020 Strategy: A strategy for smart, sustainable and inclusive growth (European Commission, 2010).

77 Forfás, 2013:6 and 20.

78 Forfás, 2013:6 and 25.

79 Local Government/Local Development Alignment Steering Group, 2012:5.

80 Local & Community Development Committees will be set up in all local authorities in 2014 beginning with 10 'front-runner' areas: Dublin City, Dun Laoghaire Rathdown, South County Dublin, Cork County, Limerick City & County, Galway County, Mayo, Roscommon, Leitrim, and Offaly. Operating Guidelines and Terms of Reference for these Committees have been prepared (Department of Environment, community and Local Government, 2013).

81 Local Government/Local Development Alignment Steering Group, 2012:19; see also Department of the Environment, Community & Local Government, 2012.

82 Forfás, 2013:4.

83 "Social entrepreneurship is an important element in the development of social progress for older people in rural areas. ... However, more will have to be done by government to encourage and support people with socially innovative ideas in rural communities. This means the introduction of seed capital and start-up grants for social production, using similar schemes to those currently available to economic entrepreneurs. Entrepreneurs should be given support in identifying commercial social opportunities and generating realistic business plans that match economic imperatives with the realities of social economy provision. ... Consequently, social organisations and community agencies have a key role to play in creating and meeting the expectations of older people in regard to ageing well in later life in rural areas." (Walsh, O'Shea, and Scharf, 2012:93).

84 European Commission, 2011:2 and 5.

85 Social undertakings "act as drivers of social change by offering innovative solutions to social problems, ... Social undertakings include a large range of undertakings, taking various legal forms, which provide social services or goods to vulnerable, marginalised, disadvantaged or excluded persons. Such services include access to housing, healthcare, assistance for elderly or disabled persons, child care, access to employment and training as well as dependency management. Social undertakings also include undertakings that employ a method of production of goods or services which embodies their social objective, but the activities of which be outside the realm of the provision of social goods or services. Those activities include social and professional integration by means of access to employment for people disadvantaged in particular by insufficient qualifications or social or professional problems leading to exclusion and marginalisation. Those activities may also concern environmental protection with a societal impact, such as anti-pollution, recycling and renewable energy." (European Commission, 2013:Articles 1 and 14).

86 Further details at www.gov.uk

87 McKeown, 2013.

88 OECD, 2008:13.

89 Department of Taoiseach, 2011:24.

90 Department of Public Expenditure and Reform, 2012:74-75.

91 A perennial question in all wisdom traditions – what is the source of well-being? - has relevance for how one seeks it. It is true that well-being is associated with inner states and outer circumstances, but these are not constant over time or between individuals. For example, social class is normally associated with well-being, directly and/or indirectly, but its influence on well-being varies between people and can change according to context and circumstance. This suggests that well-being, as the term implies, may be a quality of being itself; to be is to be well. In this perspective, well-being is experienced because it already exists, not because it is created anew. Arguably, it could not be experienced unless it already existed, and would not be sought unless it was known to be part of who we are. In the same way as educators speak of intelligence as being revealed through the process of learning and unlearning, so well-being may be seen as manifested through removing obstacles which block one from experiencing it. This perspective suggests that well-being may be like the sun; it never ceases to shine even though we speak of it as rising and setting, and also of shining only when the sky is cloudless. Similarly, well-being shines but thoughts, feelings and experiences cloud its presence. This could be seen as the metaphysical foundation of positive thinking because it frames life's adversities as passing difficulties rather than permanent deficits, recognising that since well-being is the condition which sustains life itself, everyone is already well but just not fully aware of it or able to experience it. This way of thinking about well-being has strong resonance with eastern philosophy but similar stands may be found in the western philosophy of Socrates, Spinoza and Schopenhauer.

92 Department of Health, 2001a:15.

93 Expert Group on Mental Health Policy, 2006:16.

94 'The first interview took place on 18 October 2009, with a steady accrual until the last interview was conducted on 22 February 2011. ... . Successful interviews were obtained in 6282 households, leading to a response rate of 62.0%. ... . Each participant was also left a 'self-completion questionnaire' (SCQ) including potentially sensitive questions for them to fill in and return to TILDA by mail. ... . This dataset includes CAPI data from all 8507 TILDA respondents (from 6282 households), of whom 8178 were aged 50 and over. ... . Up until 27 Feb 2011, 3907 health centre assessments of those aged 50 and over had been completed ... .. Home assessments are also ongoing ... .' (Barrett, Savva, Timonen and Kenny, 2011:295-298).

95 A small number of mainly female partners (in the region of 200 individuals) were excluded because not 50+.

96 All models were estimated using EQS 6.1 Structural Equation Modelling Software (Bentler, 2001).

97 Latent variables are based on the understanding that some phenomena, such as those considered in this analysis, are not directly observable but can be observed indirectly through their measurement. In this case, for example, personal well-being is the latent variable manifested by the person's responses to scales measuring self-concept, life-satisfaction, depression and loneliness. Similarly, overall health is the latent variable manifested through independent health assessments while social class is manifested through education, occupation, income and assets. This understanding assumes that a latent variable exists, at least as a theoretical construct, and is the cause of each respondent's observed scores. That is why, in latent variable analysis, the graphic representation shows the direction of causality from the latent variable to the manifest measurements. Leaving aside the philosophical question of whether a latent variable is 'real' (or different from anything else that is claimed to be 'real'), the advantages of latent variable analysis are that it facilitates greater conceptual clarity about apparently different measurements, allows for reduction of multiple data points to more simplified conceptual and statistical aggregates, and these in turn give rise to more robust measurement which yields more reliable estimates of statistically and substantively significant findings.

98 The analysis includes most of the TILDA database but excludes consideration of medications, health service utilisation (health insurance, visits to GP, hospital, nursing home; other services from chiropodists, OTs, public health nurses), healthcare expenses, formal home care (Home Help, Home Care Packages, paid care), home environment.

99 Pratschke, Haase and McKeown, 2013.

100 In the area of children and families, for example, the Promising Practices Network run by the Rand Corporation defines a programme's effectiveness as 'proven' where, inter alia, "at least one outcome is changed by 20%, 0.25 standard deviations or more" (http://www.promisingpractices.net) (see also Shonkoff and Phillips, 2000:342-343). Others set a higher effect size such as The Centre for the Study and Prevention of Violence at University of Colorado in USA which requires that its 'Blueprints Model Programs' have 'at least moderate effect sizes' (http://www.colorado.edu/cspv/blueprints).

101 In the field of childcare and pre-school services, for example, one of the most effective programmes is High Scope Perry Pre-School Programme. The original evaluation of this programme in the US found that its overall effect size was 0.36 when participants reached the age of 23 (Schweinhart and Weikhart, 1997; Schweinhart, 2004; Schweinhart, Montie, Xiang, Barnett, Belfield, Nores, 2005). A cost-benefit analysis of this programme, led by Nobel laureate James Heckman, estimated that the lifetime rate of return to the High Scope Perry Pre-School Programme in the US – based on data to age 40 – was between 7% and 10%, which was above the post-World War II stock market rate of return on equity which is about 5.8% (Heckman, Moon, Pinto, Savelyev and Yavitz, 2009).

102 This is consistent with the findings of positive psychology as summarised in the phrase "other people matter" whose author explains: "it is actually a good summary of what positive psychology research has shown about the good life broadly construed. It is in the company of others that we often experience pleasure and certainly how we best savour its aftermath. It is through character strengths that connect us to others – like gratitude – that many of us find satisfaction and meaning in life. It is with other people that we work, love, and play. Good relationships with other people may be a necessary condition for our own happiness, even in markedly individualistic cultures like contemporary United States." (Peterson, 2012:127). The pervasive influence of social connections on personal well-being also mirrors the findings of large scale national surveys in the US, Canada and Europe carried out by Gallup World Poll on 'experienced well-being' as measured by 'emotions experienced during the previous day'. Nobel laureate Daniel Kahneman offers an interpretation of the findings: "The gigantic samples allow extremely fine analysis, which have confirmed the importance of situational factors, physical health, and social contact in experienced well-being. Not surprisingly, a headache will make a person miserable, and the second best predictor of the feelings of a day is whether a person did or did not have contacts with friends or relatives. It is only a slight exaggeration to say that happiness is the experience of spending time with people you love and who love you." (Kahneman, 2011:395).

103 "Although social isolation is sometimes equated with loneliness, loneliness and social isolation are separate concepts and do not necessarily co-occur. Social isolation refers to the absence of relationships, and is related to objective characteristics. Loneliness is the feeling of missing intimate relationships or missing a wider network, which is conceptualised as an individual's subjective evaluation of their degree of social participation or isolation. ... . In TILDA, loneliness is assessed using a modified version of the University of California-Los Angeles Loneliness Scale. We selected four negatively-worded questions (e.g., How often do you feel left out?) and one positively-worded question (How often do you feel in tune with the people around you?), each with a three-point response scale of hardly ever or never; some of the time; or often. The responses to the five items are summed, with higher scores signifying greater loneliness. The average score for older adults is 2, on a scale from 0 (not lonely) to 10 (extremely lonely)." (Barrett, Savva, Timonen and Kenny, 2011:61).

104 In the 2011 Census of Population, 11% of men aged 65+ (49,000) and 16% of women aged 65+ (87,000) were living in a one person household (Central Statistics Office, 2012a:26-27).

105 In 2001, a survey of 3,000 randomly selected adults in Ireland found that 20% of women and 16% of men reported "experiencing contact sexual abuse in childhood" (McGee, Garavan, deBarra, Byrne and Conroy, 2002:xxxii).

106 The 2010/2011 Drug Prevalence Survey commissioned by the National Advisory Committee on Drugs (NACD), based on a sample of 5,134 persons aged 15-64 in both parts of Ireland, found that: 'One in five drinkers reported that they had experienced harm in the previous 12 months as a result of their drinking, with men almost twice as likely as women to report harm, such as harm to health, work and friendship (26% vs. 14%).' (National Advisory Committee on Drugs, 2012).

107 It might be noted that while smoking has a statistically significant influence on the overall health of men (but not women), it is the least important of all statistically significant influences on health which are: age (-.75), social class (.32), care access problems (-.18), living alone (-.16), relationship quality (.09), smoking (-.08). This does not contradict the public health perspective on smoking but points to a wider set of influences on health, at least among older people. In the TILDA sample, the prevalence of smoking is 17% for men and 16% for women compared to the national prevalence of 29% (OECD

Health Data 2013). The National Institute for Health and Clinical Excellence (2012) has commented that: 'Smoking is currently the main reason for the gap in life expectancy between rich and poor; and tobacco use is the single greatest cause of preventable deaths in England. Furthermore, with rising levels of obesity, physical activity remains essential for maintaining good health, with research suggesting inactivity could soon have the same impact on health as smoking.'

108 The foreword to the National Positive Ageing Strategy states: "At its core, this National Positive Ageing Strategy seeks to create a shift in mind-set in how we, collectively and individually, conceptualise ageing and what needs to be done to promote positive ageing. ... At a national level, the Strategy seeks to highlight that ageing is not solely a health issue – it requires a whole of Government response. ... So, this Strategy is a call to action to individuals of all ages to think positively about their own ageing." (Department of Health, 2013e:4).

109 A similar perspective is reflected in the concept of 'active ageing' as defined by the World Health Organisation: "Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (World Health Organisation, 2002:12). Building on this definition, the Active Ageing Index has been developed for EU-27 to support development of active ageing policies in each country. The Active Ageing Index has four domains: (i) employment (ii) participation (iii) independent, healthy and secure living (iv) capacity and enabling environment for active ageing. In 2013, Ireland was in 3rd overall position in EU-27 on the Active Ageing Index; 1st for participation in society; 6th for capacity and enabling environment; 7th for independent, health and secure living; and 11th for employment (Zaidi, et al, 2013:23). In a global comparison involving 91 countries, albeit with slightly different domains and fewer indicators, Ireland was in 12th overall position on the Active Ageing Index; 3rd on enabling environment; 14th on health status; 24th on income security; and 32nd for employment and education (HelpAge International, 2013:39).

110 HSE, 2013b:4.

111 The InterRAI suite of instruments is the result of an international collaboration between health professionals and clinical researchers [www.interrai.org]. These assessment tools are in use in over 30 countries, and used extensively in Canada and New Zealand. The tools have been in development since the 1990s and have been tested with proven reliability, validity and sensitivity. The suite of tools is designed for use with older persons in a range of settings including residential care and community home care, disability services, hospital care, palliative care, and mental health services Each instrument in the InterRAI family of tools has been developed for a particular type of client/resident/patient population and are designed to work together to form an integrated health information system. The InterRAI instruments share a common language which enables clinicians and providers in different care settings to improve continuity of care, as well as to integrate care and supports for each individual. Common language also allows families, advocates and public payers to track the progress of program participants across settings and over time. In time, this information could yield important findings regarding what works to improve the health and well-being of older people.

112 An exception is a report on end-of-life care in acute and long-stay settings which included some qualitative interviews with residents in nursing homes (O'Shea, Murphy, Larkin, Payne, Froggatt, Casey, Ní Léime and Keys, 2008:135-140). This report provides an illustration only and does not permit generalisation to long-stay residents generally: 'In some care settings, there was a sense among the patients that the facility was a "home away from home", particularly if they lived there for many years. ... . However, not everyone shared this view, and some patients just longed to be at home. These patients did not feel that their current accommodation was "home-like" and suggested that their care was focused on the routine of the staff, rather than their personal wishes. ... . Other patients just wanted to be in their own home and it was this desire to be at home rather than anything particularly lacking in the care setting that prevented them from feeling at home. ... . Sometimes the sense of belonging stemmed from relationships between patients. ... . Many of the patients experienced personal losses on admission to long-stay care. Relationships changed upon admission and in some cases were lost altogether. In one case in particular, the patient was admitted to the nursing home on the day of her husband's death and attended his funeral from there. She never returned to her own home again.' (ibid, 135-140).

113 The second wave of TILDA contains some data on persons who have entered long-stay care. A recent review of data on care home residents in Ireland and the UK explained the paucity of data as follows: 'The paucity of data available from participants in care homes is understandable, when the challenges to conducting research are considered. Many residents have poor mental and physical health; levels of cognitive impairment and dementia are high. Careful assessment of adults' capacity to consent to participate in research is particularly important in this setting. ... . The principle underpinning such guidance is that any action should be in the best interests of the person who lacks capacity. ... However, as the proportion of older adults in the population rises and the number of people receiving institutional care grows, the need for systematic data on health in care homes will become more important. In the future, funders of research should take into account the extra resources that will be needed to include care home residents in surveys.' (Moore and Hanratty, 2013:4).

114 Barrett, Savva, Timonen and Kenny, 2011:216-217.

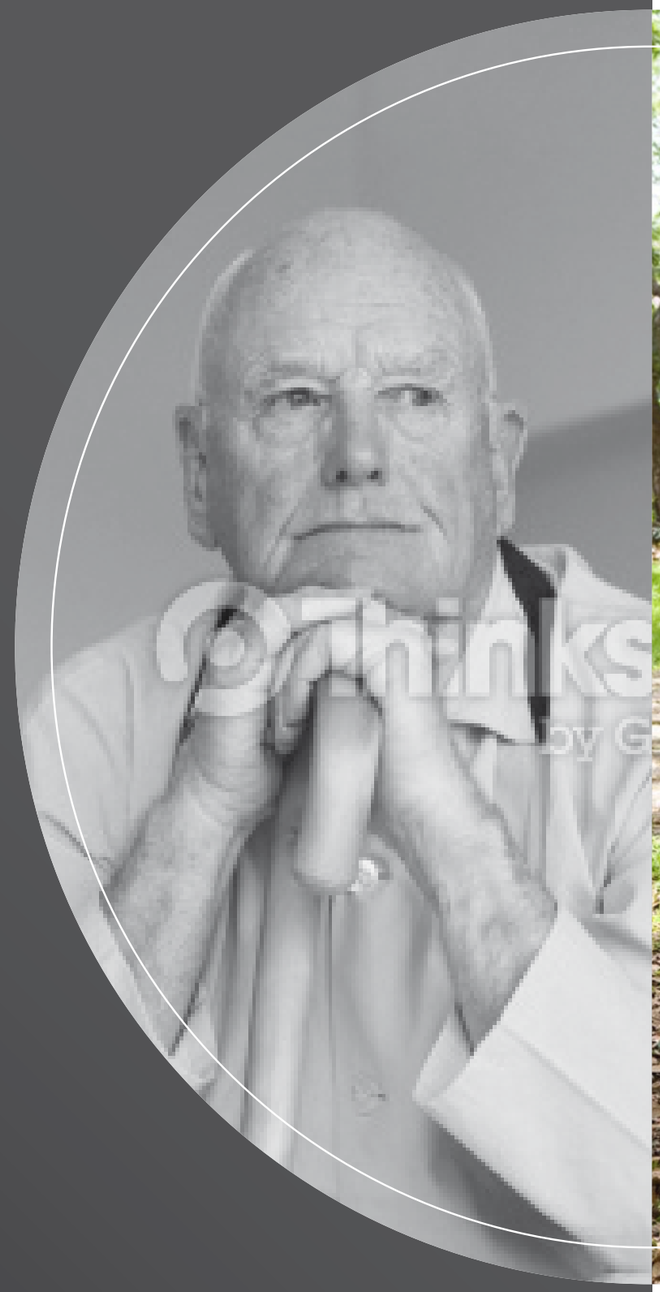
115 An influential proponent of the human development perspective, albeit in the context of child development rather than ageing, is Uri Bronfrenbrenner (1917-2005) who wrote: 'Especially in its early phases, but also throughout the life course, human development takes places through processes of progressively more complex interaction between an active, evolving biopsychological human organism and the persons, objects and symbols in its immediate environment. To be effective, the interaction must occur on a fairly regular basis over extended periods of time. Such enduring forms of interaction in the immediate environment are referred to as proximal processes.' (Bronfrenbrenner and Morris, 2006:797).

116 For example, the OECD has developed methodologies for countries to measure well-being (OECD, 2011b) as part of a wider set of indicators for tracking the outcomes of growth in social (including health and well-being), environmental and economic domains (OECD, 2011c). Similarly, Nobel laureates in economics have written extensively about the importance of well-being: Amartya Sen, Winner of Nobel Prize in 1998; Joseph Stiglitz, Winner of Nobel Prize in 2001; Daniel Kahnman, Winner of Nobel Prize in 2002. 'What we measure affects what we do; if our measurements are flawed, decisions may be distorted. ... . The time is ripe for our measurement system to shift from measuring economic production to measuring people's well-being.' (see Commission on the Measurement of Economic Performance and Social Progress, 2009, written by Stiglitz, Sen and Fitoussi). 'It is now conceivable, as it was not even a few years ago, that an index of the amount of suffering in society will someday be included in national statistics, along with measures of unemployment, physical disability, and income. This project has come a long way' (Kahnman, 2011:410). 'It is only a slight exaggeration to say that happiness is the experience of spending time with people you love and who love you. ... . Can money buy happiness? The conclusion is that being poor makes one miserable and that being rich may enhance one's life satisfaction, but does not (on average) improve experienced well-being' (Kahnman, 2011:395-6)

117 The UN's Human Development Index (HDI) is an example of this, being a composite measure that includes indicators along three dimensions: life expectancy, educational attainment, and command over the resources needed for a decent living. In 2012 Ireland's HDI was ranked 7th out of 187 countries, above the OECD average (United Nations Development Programme 2013).

118 Awareness of the need for a new paradigm is also being articulated in the case of end-of-life care through the concept of "compassionate communities": "In the last 100 years ... we have witnessed a rising dependency on professional health services. Today, that set of cultural developments has led to a polarized view of care for older people, the chronically and terminally ill, as well as the bereaved. ... . This polarized view is both an incorrect and unsustainable cultural and health policy position. Communities are able to do more to support families and health services and to bring practical resources and important supports to both. We have witnessed the success of these types of contributions in wider public health movements and we are now seeing the beginnings of them in end of life care. ... . Health promotion and community engagement in end of life care is an extension of the growing acknowledgement of modern populations that to achieve optimal health and wellbeing in the 21st century a community engagement approach to health must extend its active concern to the end of life itself." (Kellehear, 2013:7)

2



Challenges in Services for Older People

2.1 Introduction

This chapter focuses on the challenges which Ireland faces in terms of providing services for older people. Understanding these challenges, and ways of potentially overcoming them, provides a wider frame of reference for assessing the proposed social enterprise. Five specific challenges are examined: aligning resources to policies (Section 2.2), aligning services to people's needs and preferences (Section 2.3), improving health system efficiency (Section 2.4), reducing health inequalities (Section 2.5) and developing the long-term care sector (Section 2.6). The chapter concludes with a summary of the main findings (Section 2.7).

2

Challenges in Services for Older People

2.2 Aligning Resources to Policies

Aligning the goals of public policy with the resources allocated to achieve them is a significant challenge. As detailed above (Section 1.4), there is evidence that the goals of public policy for older people are not sufficiently aligned with the corresponding allocation of resources to services for older people. This challenge is recognised and is the reason why a substantial review is being undertaken in 2012/2013 of the system for funding services for older people.

One of the reasons why policy and resources become misaligned is that it seems easier to change policy than to change systems for allocating resources. This is suggested by the fact that, as documented in a number of recent studies[119], the main influence on resource allocation in Ireland has tended to be precedent rather than policy or the needs of populations or service users. This is underlined by the fact that decisions about the amount of resources allocated to areas, to services, or to agencies has been mainly determined by previous allocations, with some modifications made for new service developments or for specific problems[120]. This is not unique to Ireland since health spending in many OECD countries prior to 2008 has been summed up by just one word 'more'[121]. As a consequence, systems for allocating resources to health services are poorly linked to policy or need. As observed in a recent report: "Decisions on the future allocation of resources is dominated by the previous year's allocations and, as a result, many elements of the structure of Irish healthcare delivery demonstrate an impressive continuity from prior to World War II and, to an extent, from prior to World War I to the present day. This produces a system that is both opaque and indefensible. There is no focused attempt in Ireland to link allocation of resources to health needs"[122].

One of the reasons why policy and resources become misaligned is that it seems easier to change policy than to change systems for allocating resources

As part of public sector reform, significant changes are being made in this area, informed by the idea that public policy and services should be 'evidence-based', or at least 'evidence-informed', and should also be 'outcome-focused'. This idea has gained currency in Ireland since the OECD reviewed the public service in 2008 and called for a greater focus on managing performance, improving dialogue on performance targets, adding: "Instead of focusing on inputs and processes, more information needs to be gathered on outputs and outcomes and what has actually been achieved, so that this can better feed back into measuring how the Public Service is meeting overarching targets and objectives."[123]

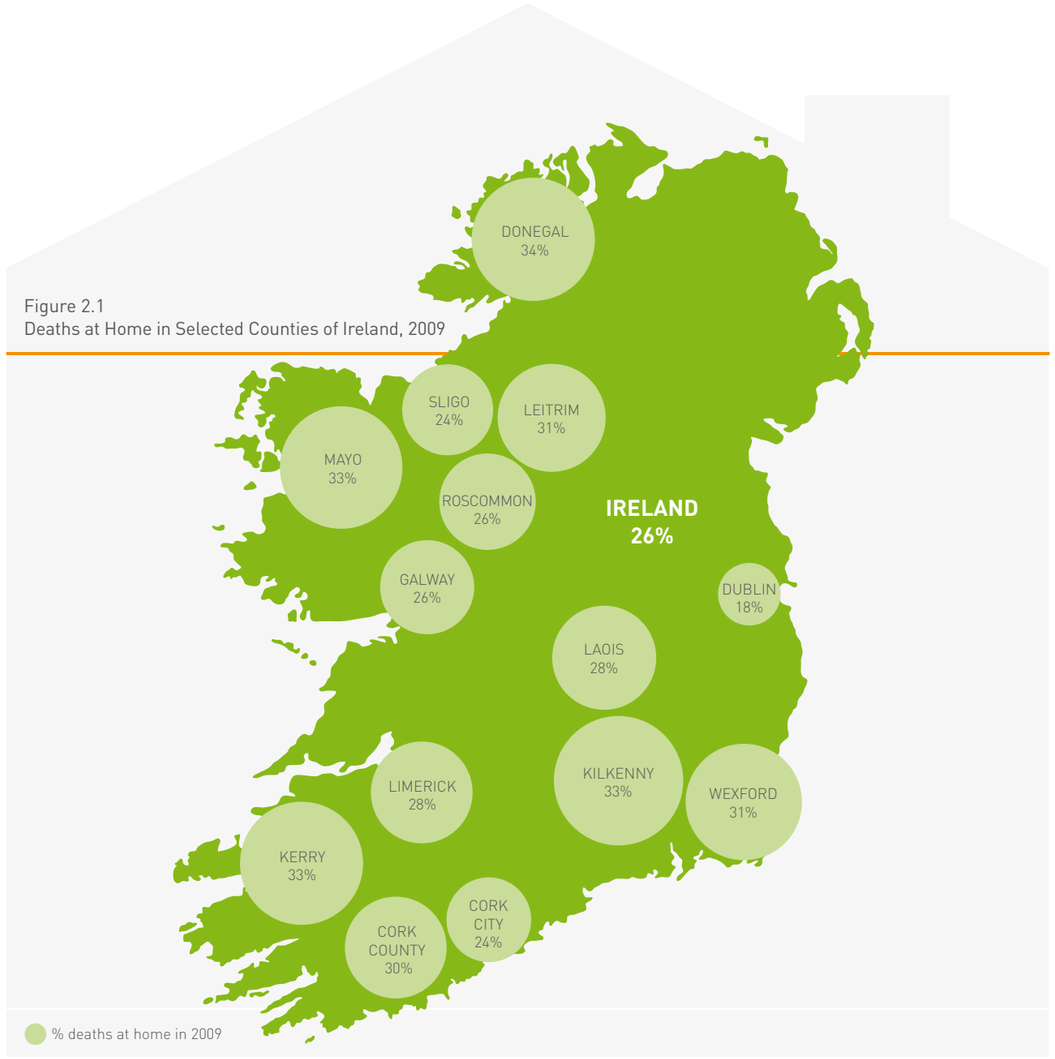
In light of the OECD review and the more recent collapse of the Celtic Tiger, the programme of the current Government (2011-present) lays particular emphasis on performance management and the use of performance information to inform decisions about how resources are allocated to policies and services[124]. This is reflected in a new approach to public expenditure involving 'performance-based budgeting', which links the spending of each Government Department to its strategic programmes and associated performance indicators, rather than traditional accounting 'sub-heads'[125]. This is likely to influence the funding of services for older people – and health services generally – and may require the introduction of performance indicators which specifically measure the extent to which each part of the health service contributes to the goal of supporting people to live at home and eventually to die at home, if that is possible and preferred. These kinds of performance indicators are now being used in England[126] and Scotland[127] to monitor how services and therefore resources are aligned to policy, particularly at the end of life.

2.3 Aligning Services to People's Needs and Preferences

In Ireland, as elsewhere, people prefer to live at home and to be supported to live there as long as possible, preferably right to the end. A Eurobarometer survey published in 2007 found that the vast majority people across the EU-27 (>75%) expect and prefer to live in their own home or the home of a relative "if one becomes dependent and needs regular help and long-term care"[128]. The same survey also showed that the vast majority (>75%) of Irish people share the same set of expectations and preferences. Similar findings have emerged from studies about the place where people would prefer to die. These show that most people in Ireland[129], England[130], and Europe[131] would prefer to die at home, including those who are terminally ill, even though most will actually die in hospital[132]. Significantly, the preference to die at home is even stronger among doctors and nurses than among the general population[133]. Given that most people die in hospital rather than at home, this implies that people's preferences are often not facilitated by the health system[134]. In Ireland, for example, about two thirds of the population would prefer to die at home but only a quarter actually die there. This is despite the fact that a substantial proportion of those who die in hospital in Ireland could die at home if appropriate supports were available[135]. These findings indicate that a gap exists between what people need and prefer and what is provided by the existing system of services and supports.

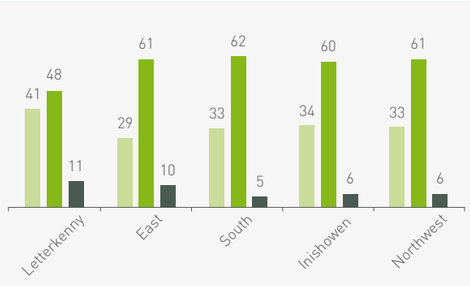
The challenge of aligning services to people's needs and preferences is not straightforward because the relationship between 'supply' and 'demand' of health and social care is not straightforward either. This is because many aspects of health and social care are 'supply sensitive' – as opposed to 'demand sensitive' – in the sense that services which patients receive

Figure 2.1
Deaths at Home in Selected Counties of Ireland, 2009



Source: CSO Vital Statistics 2009.

Figure 2.2
Place of Death in Each Primary Care Network in Donegal, 2009



Source: Special tabulations prepared by CSO based on deaths registered in Donegal in 2009. There were 1083 deaths in Donegal in 2009. Of these, 1039 had an address in Donegal which could be coded to one of the primary care networks in Donegal.

are often determined by what is supplied, and therefore what is available and accessible, rather than by what is needed and preferred. Evidence for this can be seen by mapping geographical variations in the supply of healthcare resources and their corresponding usage by populations and patients in those areas. This type of analysis shows that variations in the utilisation of services tend to be influenced by what services are (and are not) available, with the result that populations and patients with similar needs and preferences may receive quite different services.

Numerous studies have illustrated this by mapping variations in the place where people die. It is true that needs and preferences also play a part in where people die, but the degree of variation between and within countries suggests that supply factors are significant[136]. For example, US evidence shows that the concentration of hospital resources (beds, doctors, nurses, etc) influences the likelihood of dying in hospital[137]. In European studies, availability of alternatives to hospital (long-stay, home care, hospice) has been highlighted as an influence on the likelihood of dying in hospital[138]; this is also reported in a US study[139]. A common factor influencing place of death across many contexts is the role of policies to promote deaths at or closer to home, including the clinical culture and practice of promoting patient choice and autonomy[140].

Within Ireland, there is significant variation in the place where people die. Focusing on deaths at home, Figure 2.1 reveals that people in Dublin are least likely to die at home (18%) while those in Donegal are most likely (34%), a difference of 16 percentage points. This suggests that the likelihood of dying at home may be inversely related to access to hospitals (and possibly also hospices and long-stay facilities), since Dublin has greater access to hospitals and fewer deaths at home compared to any other part of the country.

Within Donegal, the influence of healthcare resources on place of death can also be observed in variations between the county's five primary care networks (PCNs). Figure 2.2 shows that the proportion of deaths in hospital is highest in Letterkenny PCN (41%) – where the hospital is located - and lowest in East PCN (29%), a difference of 12 percentage points. Deaths in hospice also vary significantly between the highest, which is again Letterkenny PCN (11%) – where the hospice is located –, and the lowest in South PCN (5%), a difference of six percentage points. There is also significant variation in the proportion of deaths in the patient's usual place of residence (home or long-stay) between Letterkenny PCN (the lowest at 48%) and South PCN (the highest at 62%), a difference of 14 percentage points; again this may be related to the fact that Letterkenny PCN has fewer community hospital beds per population than any other PCN while South PCN has the highest.

These variations raise a question about whether they are warranted or unwarranted. Unwarranted variation has been defined as follows: "Variation in the utilization of health care services that cannot be explained by variation in patient illness or patient preferences"[141]. By contrast, variation is warranted when populations or patients have different levels of need[142].

Table 2.1
Number and Cost of Delayed Discharges from Acute Hospitals, 2012

Delayed Discharges (DDs)	Dublin Academic Teaching Hospitals (DATHS) *	Other Acute Hospitals	All Acute Hospitals
Total Days Lost (i)	130,643	113,030	243,673
Average Cost per Day (ii)	1,917	825	-
Total Cost of DDs (€million)	250.4	93.2	343.7
Total Cost (%)	73	27	100
% DDs aged 65+ (i)	86	87	87

Sources: (i) HSE, Business Intelligence Unit, Personal Communication, July 2013. Note that the number of delayed discharges is not the same as the number of patients (ii) PA Consulting Group, 2007:155.
*Dublin Academic Teaching Hospitals (DATHs) Group comprise: Tallaght Hospital, James's Hospital, Beaumont Hospital, Mater Hospital and Vincent's Hospital.

Variations in the utilisation of services tend to be influenced by what services are (and are not) available, with the result that populations and patients with similar needs and preferences may receive quite different services

If it is assumed that population needs and preferences in this respect do not vary substantially within Ireland or within counties, and if it is assumed that there is a general preference among the population to die at or near home – in their usual place of residence – then the variations observed give grounds for questioning whether existing arrangements for end-of-life care are optimal and cost effective. As observed in a recent editorial of the Journal of the American Medical Association, "the goal is not to eliminate variation but to guarantee that its presence throughout health care systems derives from the needs and preferences of patients"[143]. The first requirement for addressing this issue is to improve the quality and timeliness of data on the distribution of needs and services, combined with a system for monitoring the outcomes of services in different parts of the country. The TILDA study, which is being undertaken as part of this project, is a step in that direction.

2.4 Improving Health System Efficiency

There is evidence that the existing system of support and care for older people in Ireland is not as efficient as it could be. The evidence for this relates mainly to inappropriate use of acute hospitals, where care could be provided in other less expensive settings or where patients remain in hospital after completion of treatment ('delayed discharge').

Table 2.1 summarises the number of delayed discharges in Ireland's acute hospitals in 2012, defined as "patients who have completed the Acute Phase of their care and are medically fit for discharge"[144]. This shows that the number of hospital days lost is substantial (243,673), and higher than in 2008 (223,704 bed days) or 2009 (144,565), when the issue was examined by the Expert Group on Resource Allocation and Financing in the Health Sector[145]. The practical implication of delayed discharge is that fewer patients are treated, creating delays for patients waiting for essential treatments. Given that the average length of stay in hospital is about 6 days[146], the effect of delayed discharges is that an estimated additional 40,612 inpatients could have been treated in 2012 if there were no delayed discharges. This is higher than in 2009 when an estimated additional 24,000 inpatients could have been treated[147].

Hospital groups will have a clear financial incentive to reduce or eliminate delayed discharges, given the substantial costs involved

In addition to the cost which is borne directly by patients in terms of longer waiting times for essential treatments, the cost to the health system is also substantial (€344m). Nearly three quarters of these costs (73%) are concentrated in the Dublin Academic Teaching Hospitals (DATHs). Under existing funding arrangements, hospitals do not have a clear financial incentive to reduce or eliminate delayed discharges, but this is destined to change under the new system of hospital financing, based on the principle that 'Money Follows the Patient'. In the new system, to be implemented from 2014 onwards[148], hospitals will be paid for each episode of care on the basis of 'best practice prices', so that "hospitals are actually paid for the care they deliver rather than receiving a historically determined block grant"[149] and "money can follow the patient out of hospital settings where appropriate and towards the provision of safe, timely treatment in primary care"[150]. One of the consequences of this is that hospital groups will have a clear financial incentive to reduce or eliminate delayed discharges, given the substantial costs involved.

Another illustration of system-level difficulties can be found in the way healthcare professionals sometimes assess the needs of older people for long-stay care. The findings of a recent audit of assessments for the Nursing Home Support Scheme (NHSS) using the Common Summary Assessment Report[151] revealed that a substantial proportion of those deemed eligible for NHSS – and therefore eligible for admission to a nursing home – did not have the highest levels of dependency[152] and only a minority were known to have been considered for a Home Care Package[153]. As the report concludes: "the audit has certainly highlighted two potentially serious issues i.e. the approval of persons for long term care although they are not falling into the maximum dependency category and secondly the availability of Home Care Packages and how these are being used to support people and

prevent them requiring long term care."[154] This is likely to change from 2014 onwards, with the introduction of a new method for assessing need for all services for older people, called the Standardised Assessment Tool (SAT), and this will "considerably improve the rigour of decisions made regarding provision of resources under the Nursing Home Support Scheme (NHSS), the Home Care Package Scheme (HCPS) and for home Help Services"[155].

One reason for these inefficiencies is that different providers within the system – acute hospitals, general practitioners, community services, community hospitals, nursing homes, etc. – do not appear to have the capacity to deliver an individualised care pathway to each person who needs support and care, despite the generally high quality of care. This situation is due to a range of forces – multiple professional cultures and practices, weak management and incentive systems, inadequate IT systems – with the consequence that there is often greater use of intensive and expensive services than is required if the system had the capacity to tailor services to needs in a more personalised way. This problem is not unique to Ireland[156] but it is still a problem in terms of using scarce resources efficiently and in line with agreed policies.

2.5 Reducing Health Inequalities

There are substantial inequalities in health across the Irish population, with particular implications for older people, as measured by morbidity and mortality. Morbidity (such as the likelihood of feeling healthy or having an illness) and mortality (such as how long one can expect to live) are each affected by education, employment, income and related variables. This 'social gradient' gives rise to health inequalities. For example, three quarters of professionals in Ireland report having very good health, compared to less than half unskilled workers[157]. Similarly, professionals live over six years longer than unskilled workers[158]. A recent review of evidence on life expectancy on the island of Ireland concluded that: "Despite important data limitations, socio-economic inequalities in DFLE [disability-free life expectancy] and HLE [healthy life expectancy] appear to be greater than socio-economic inequalities in LE [life expectancy]."[159] Given the remarkable increase in life expectancy at 65 in Ireland during the first decade of this century (3 years), the impact of social class on life expectancy (6 years) is doubly remarkable and confirms that "Our socio–economic status is a stronger determinant of how we age than our chronological age."[160]

These social class differentials are also pronounced among older people in terms of the average number of difficulties experienced with activities of daily living (ADL)[161] and instrumental activities of daily living (IADL)[162]; difficulties are more than three times higher among those with a primary education only (6.9), as compared to those with a third-level education (2.1)[163].

Over the lifecycle, the social gradient in health outcomes is determined and sustained by the social determinants of health, defined as "the conditions in which people are born, grow, live, work, and age, and the inequities in power, money, and resources that give rise to them"[164]; these are associated with differences in life-style, particularly smoking, diet and physical activity[165] which in turn affect the ageing process[166]. How Irish society addresses these inequalities – within the entire population but also among older people – is an important issue which requires a focus on all determinants of health and well-being and not just ageing. Specifically, it requires a focus that includes but not confined to health services since "health care is just one determinant of population health. Other inputs to health, such as social protection, good employment, and early years care, should not be forgotten but they have been"[167]. This suggests that the approach being proposed by the social enterprise is consistent with evidence on the need for both a population-centred and a person-centred approach to the unequal impacts of ageing[168].

Our socio–economic status is a stronger determinant of how we age than our chronological age

2.6 Developing Long-term Care Sector

The supply of long-term care for older people in Ireland, as in many EU countries, relies heavily on the 'informal sector', which effectively means it is provided by relatives (mainly partners and adult children). The HSE's 2013 National Service Plan indicates that approximately 20% of the population aged 65+ receive a paid service such as HCPS, HHS or Day care. This implies that anything up to eight out of ten older people in Ireland rely on unpaid care. TILDA data indicates that around 5% of older people living at home receive some type of paid 'formal' care (such as home help, personal assistant or meals-on-wheels)[169], with higher rates for those with specific ADL and IADL needs[170].

There are a number of reasons why this model of informal unpaid provision may not continue indefinitely – particularly associated with declining fertility and increased female labour force participation[171] – while the correspondingly demand for paid care is likely to grow[172]. One of the immediate consequences of a growth in paid care is a corresponding growth in cost, both public and private. The EU Commission has estimated that the effect of an annual 1% increase in the proportion of dependent elderly who receive paid care over a 50-year period till 2060 would imply increasing public expenditure on long-term care across EU-27 from 1.8% of GDP in 2010 to 2.6% in 2060[173]. The study found that in Ireland the effect would be much greater, and would lead to a tripling of public spending from 1.1% of GDP to 3.4% in 2060[174].

Separate projections were undertaken to estimate the impact of likely increases in the cost of formal long-term care – currently a low-wage sector in most EU countries – and the effect for Ireland would be to increase public spending from 1.1% of GDP to 3.3% in 2060[175]. Given that these projections are expressed as percentages of GDP, their full implications depend on the actual size of GDP – in Ireland as in EU-27 – and the underlying rate of economic growth. Moreover, under all scenarios considered in both the OECD[176] and EU[177] projections, public spending on long-term care in Ireland is projected to at least double by 2050.

Other issues to be addressed in the long-term care sector include the regulation of private home-care providers and the use of technology to improve the quality and effectiveness of care. In the case of regulation, this is acknowledged to be an issue in Ireland[178] as in many other countries[179]. In the case of technology, there is a widespread (albeit untested) assumption that ICT technologies have the potential to support more people to live at home through telecare[180] and telehealth[181]. However, as a recent study of the home care sector in 31 European countries observed, "use of this type of care is still in its infancy in Europe"[182], though supported by the EU Commission through the European Innovation Partnership on Active and Healthy Ageing[183].

Separate projections were undertaken to estimate the impact of likely increases in the cost of formal long-term care ..... the effect for Ireland would be to increase public spending from 1.1% of GDP to 3.3% in 2060

There is little doubt that the evolution of long-term care will see increases in the amount and share of paid care for older people. However, this will complement rather than replace informal care, since family members are likely to remain an important source of care if only because they are still the preferred source of care. That is why supporting family carers is an important part of the response to ageing, as proposed by the social enterprise, and has been described as a "three-win arrangement", because it benefits carers, those being cared for, and the government who may otherwise have to pay the higher costs of formal care[184].

The implications of these 'supply-side' scenarios – including the evolution of the long-stay care sector, which currently absorbs most of the expenditure on long-term care – need to be considered in the context of aligning systems for resource allocation with the goals of national policy for older people. As with the other challenges considered, the need to shift the balance of resources towards supporting older people to live at home, with the support of family and friends, is indicated as a clear priority.

2.7 Summary

This chapter examined some of the challenges which Ireland faces in terms of providing services for older people: aligning resources to policies, aligning services to people's needs and preferences, improving health system efficiency, reducing health inequalities and developing the long-term care sector. From the perspective of the proposed social enterprise, these challenges are also opportunities, and the proposed entity has the potential to support more people to live at home, in line with national policy as well as people's needs and preferences. In addition, it has the potential to work collaboratively with hospital groups to reduce delayed discharges, which are an expensive source of inefficiency in the health system. The proposal also has the potential to develop the long-term care sector by improving the qualifications and qualities of staff who work directly with older people. In its current form, this is a proposal to establish a social enterprise and, as such, its potential can only be realised if it is supported to develop to the next stage through a detailed business plan, with the aim of becoming a self-sustaining social enterprise for older people.

Footnotes

119 Expert Group on Resource Allocation and Financing in the Health Sector, 2010; Staines, et al, 2010a; 2010b; Brick, Nolan, O'Reilly and Smith, 2010a; 2010b; 2010c; 2012.

120 "Internationally, the concept of population health need is being used to allocate health-care resources, in contrast to traditional methods driven by historic allocations to existing providers and facilities. In Ireland, resources are allocated largely on an historic funding basis, notwithstanding recent attempts to move to a more rational allocation of resources for some services (e.g. services for older persons)" (Brick, Nolan, O'Reilly and Smith, 2010c:66).

121 "What was driving improvements in health systems prior to the crisis? One word sums it up: 'more'. We were hiring more doctors, more nurses, to do more expensive diagnostics using MRI and CT scans, to dispense more pharmaceuticals, to deliver more spectacular new surgical interventions, and paying higher prices in the process. And this all required more money. A lot more – health spending per person in Europe went up around three times more quickly than income per person in the decade prior to the crisis. There is nothing wrong in principle with spending more on health - people may well be happy to prioritise health over other ways of spending money. However, as the resource-tap was left wide open for health, there was less of a move towards ensuring that money was spent efficiently and affordable. Then circumstances changed and public spending on health collapsed from around 4.5 percent real growth per year up to 2009 to 1 percent declines each year since then. When the tap was switched off, and health systems could no longer rely on 'more' and in some cases had to do with 'less', health systems too often cut the obvious rather than make the important structural changes to make health care efficient and affordable over the longer term. ... . This failure to transform our health systems has often been because there has been far too much focus on what we spend on health today and not enough on how much we will spend on health tomorrow, and the day after. ... . The worst example of this has been in spending on prevention. Work by the OECD and many others has provided evidence that overwhelmingly shows that careful investment in tackling obesity, harmful use of alcohol and a range of preventive activities is a hugely better way of spending money that dealing with the consequences once they appear. Yet when we look at spending on different areas of health, which one has seen the biggest cuts in spending in Europe? Prevention. In both 2010 and 2011, spending on prevention fell." (Leterme, 2013, OECD Deputy Secretary General).

122 Staines, et al, 2010a:62.

123 OECD, 2008:13.

124 Department of Taoiseach, 2011:24.

125 Department of Public Expenditure and Reform, 2012:74-75.

126 In England, place death is the main KPI to assess the outcome of its End of Life Care Strategy (Department of Health, 2008). The numerators for this KPI are: deaths at home (defined as the person's home address and not a communal establishment); deaths in care home (defined as NHS or private nursing home, private or Local Authority residential home or specialist nursing home); and deaths in hospital (defined as NHS or non-NHS acute or community hospitals / units but not psychiatric hospitals). The denominator for this KPI is all deaths from all causes registered in a year (National End of life care Intelligence Network, 2011). Progress on this KPI is tracked on a quarterly basis using mortality data from the Office for National Statistics, equivalent of the Central Statistics Office in Ireland. The End of Life Care Strategy in England recognises that place of death is not the only relevant outcome indicator and does not replace KPIs for the structure and process of care. For that reason, the strategy team is developing two additional KPIs: (i) number of hospital admissions of 8 days or more which end in death; and (ii) number of emergency admissions in the final year of life.

127 In Scotland, the end of life strategy – called Living and Dying Well (Scottish Government, 2008; 2011a; 2011b) – is being implemented as part of the Government's wider Healthcare Quality Strategy (Scottish Government, 2010). One of the Key Performance Indicators for the strategy is the percentage of last six months of life spent at home or in a community setting; or the inverse of this which the percentage of last six months of life spent in acute hospital. The numerator for this KPI is: 'Total bed days spent in an acute hospital setting in the 6 months before death for those people who died within a specified year'. The denominator for this KPI is: "Total number of bed days that an individual could have spent in an acute hospital setting in the last 6 months of life (187.5 days)." By comparison with England, the Scottish KPI is a more composite measure that combines place with the time spent in that place during the last six months. England has a somewhat more static measure of place – where the death occurred - but this is complemented by measures of both hospital admissions and emergency admissions. In practice, the choice of KPI is determined not just by its appropriateness to the outcome but also by the availability of data to measure it on a regular basis. Similar considerations will also apply if this KPI is adopted in Ireland.

128 TNS Opinion & Social, 2007:95-97.

129 Weafer and Associates, 2004. This was a national survey of 1,000 adults carried out in 2004 which showed that 67% preferred to die at home; 10% preferred to die in hospital; 10% preferred to die in hospice; 5% preferred to die in long-stay; and the remaining 8% were a combination of 'other' and 'don't know'.

130 A similar survey was carried out in England in 2003 and found, compared to Ireland, a weaker preference for dying at home (56%) but a stronger preference for dying in a hospice (24%) (Higginson, 2003). A 2010 update of the English survey found that the preference for dying at home strengthened (63%) but so also did the preference for dying in a hospice (29%) (Gomes, et al, 2011). This led the authors to make the following recommendation: 'Maximum impact to meet preferences for place of death is derived from focusing future investment and service developments in extending and improving care at home and in hospices both at national and local levels.' (ibid.:21).

131 A recent study of preferences for place of death in seven European countries found that 'at least two-thirds of people prefer a home death in all but one country studied' (Gnomes, et al, 2012).

132 A systematic literature review of research on place of death for patients with non-malignant conditions (Murtagh, et al,2012) noted that 'most cancer patients (50-70%) prefer a home death' (ibid.:19) while, for those with non-malignant conditions, 'preference for home death is 42-48%' (ibid.:216).

133 As part of the National Audit of End-of-Life Care 2008/9, a survey of 2,358 ward staff and 1,858 hospital staff revealed a much higher preference to die at home among both ward staff (81%) and hospital staff (77%); correspondingly, the proportion preferring to die in hospital (6%) was smaller than in the national population (10%) (McKeown, Haase and Twomey, 2010c). This is consistent with the results of a survey of 1,899 ICU doctors, nurses and patients in six European countries, who were asked where they would rather be if they had a terminal illness with only a short time to live; the results showed that more doctors and nurses would prefer to be at home or in a hospice and more patients and families preferred to be in an ICU (Sprung, Carmel, Sjokvist, et al., 2007). The same study also revealed that physicians provide more extensive treatment to seriously ill patients than they would choose for themselves, possibly indicating a public demand for life-prolonging interventions that may have little prospect of success.

134 A recent review observed that 'previous studies have shown that patients nearing the end of life often do not receive the care they prefer. .... In some regions of the United States, and in some hospitals, patients with short life expectancies receive relatively high levels of comfort-focused, palliative services and are less likely to die in a hospital or in a hospital's intensive care unit. In other places, such patients are more likely to spend their last days in the hospital, often in intensive care units, receiving uncomfortable treatments - such as using a breathing tube connected to a ventilator - that are unlikely to prolong or enhance the quality of life. In some cases intense care may be driven by patient preferences, but commonly it is not.' (Morden, Chang, Jacobson, Berke, Bynum, Murray and Goodman, 2012:786; see also Tolle, et al, 1999).

135 In the National Audit of End-of-Life Care, nearly a quarter of patients are described as being suitable to die at home by nurses (22%), doctors (22%) and relatives (24%) (McKeown, Haase, Pratschke, Twomey, Donovan and Engling, 2010:125). This is somewhat similar to another study in Ireland where doctors and nurses assessed that 18% of patients who died in a hospice or hospital could have died at home (Tiernan, Connor, Kearney and Siorain, 2002).

136 A systematic review of research on place of death for patients with non-malignant conditions found that three broad sets of factors to explain variations in place of death between and within countries: personal and socio-demographic factors such as living alone; disease-related factors such as symptoms, functional impairment, disease trajectory and disease burden; and environmental factors such as healthcare provision and policy, patient's social supports, and wider factors such as societal expectations (Murtagh, et al, 2012).

137 This is based on a US study of variations in end-of-life care for Medicare beneficiaries with severe chronic illness (Goodman, Esty, Fisher and Chang, 2011). The authors of this study offer the following explanation for the observed association between hospital resources and deaths in hospital: 'This phenomenon, which we have labeled supply-sensitive care, results from uncertainty about how best to treat patients with chronic diseases and the tendency of clinicians to use the resources available to them (e.g., hospital beds, ICU beds, physician FTEs), whether the capacity is low or high. For example, when a patient's chronic condition worsens, it sometimes seems easier and safer to clinicians to treat the patient in the hospital, even though it may be reasonable to start outpatient treatment and monitor the patient's condition in clinic or by phone. If more hospital beds are available in an area, local care patterns unconsciously adapt to this higher capacity, and patients are more likely to be admitted. Similarly, research has shown that when ICU beds are readily available, more patients who are less severely ill will be admitted, and they will stay longer. Yet greater use of the hospital or ICU as a site of care does not lead to better outcomes on average. Although it is possible that some of the differences across hospitals may be explained by differences in patients' preferences for care, studies show that regional variation in patient preferences overall explains very little of the variation in the intensity of end-of-life care.' (Goodman, Esty, Fisher and Chang, 2011:3).

138 A study of hospital deaths in six European countries suggested the following explanation: "Our research in Europe seems to indicate that availability of hospital beds plays only a minor role in explaining European country differences. Availability of alternatives to hospital for older people (i.e., number of care home beds) explained differences between countries to a larger extent. The relatively low availability of care home beds in Wales and Flanders, compared with the Netherlands, could to a considerable extent explain the higher probability of hospital deaths in those places. However, the case of Sweden, with a low number of hospital beds and a high number of care home beds but a high probability of hospital death illustrates that this factor cannot fully explain country variation. Possibly other factors such as cross-national differences in reimbursement policies and possibilities for complex home care may play a role, but this cannot be confirmed by our data." (Cohen, Bilsen, Addington-Hall, Lofmark, Miccinesi, Kaasa, Onwuteaka-Philipsen and Deliens, 2008:707-708).

139 This study focused specifically on why the state of Oregon has one of the lowest proportions of deaths in hospital (Tolle, et al, 1999:681 and 684): "Throughout the United States, use and availability of acute care hospital beds have been confirmed to be the principal determining factors in location of death. Within that constraint, however, the availability of other resources and services both facilitates the process of arranging for patients to die outside the hospital and improves satisfaction with the quality of terminal care. ... . It is hard to know which came first: restrictions on in-hospital bed availability that drove the creation of alternative resources or the availability of these resources and services that led to decreased demand for in-hospital beds and, in turn, encouraged planners and administrators to shrink the in-hospital bed supply. Dying out of the hospital may be more feasible in Oregon than in some other states. Oregon has an extensive network of services to support dying patients and their families at home and in nursing homes. Wishing to die in a setting that is not institutional and having that wish become a reality require not only advance planning but also appropriate resources. Unless strong community resources are available to support patients and their families, as in Oregon, hospital admission at the end of life may be the patient's only realistic alternative. We acknowledge that in states with large inner-city cores of poverty, out-of-hospital care and other support for dying patients can be far more challenging to provide".

140 This factor has been used as part of the explanation for the much lower proportion of cancer deaths in hospital in Netherlands compared to its other European neighbours: "The Netherlands is known to value candor, which stimulates open communication between patient and physician, as does the relationship between Dutch people and their general practitioners. Dutch government policies are clearly directed at care at home, or at least outside hospitals, with well-organized possibilities for home care and nursing home care, and comprehensive palliative care in the Netherlands has always been strongly focused on the home and the family. Many other countries have developed palliative care predominantly in hospitals and also give a less powerful gate-keeping role to primary care." (Cohen, Houttekier, Addington-Hall, Bilsen, 2010:5; see also Alonso-Babarro, et al, 2011:1165).

141 Wennberg, 2010; See also: www.dartmouthatlas.org.

142 RightCare, 2011:17.

143 Krumholz, 2013:152.

144 HSE, 2013b.

145 The Expert Group on Resource Allocation and Financing in the Health Sector (2010; also Brick, Nolan, O'Reilly, and Smith, 2010a; 2010b; 2010c) examined the issue of delayed discharges in Irish hospitals in 2009. It found that there were over 820 delayed discharges in Irish acute public hospitals in 2009, higher than the equivalent number in 2008 (696 delayed discharges); this resulted in 144,565 bed days lost in 2009, 35 per cent less than in 2008 (223,704 bed days). (Brick, Nolan, O'Reilly and Smith, 2010a:263) According to the authors 'If these bed days had been available, an estimated additional 24,000 inpatients could have been treated in 2009 (assuming an average length of stay of 6 days, which was approximately equal to the inpatient average length of stay in 2008)' (ibid.).

146 See HSE, 2012a:37; 2013a:42.

147 The Expert Group on Resource Allocation and Financing in the Health Sector, 2010; also Brick, Nolan, O'Reilly, and Smith, 2010a; 2010b; 2010c.

148 Department of Health, 2013:9.

149 Department of Health, 2013:10. The proposed structure for implementing this would involve separate entities for price-setting and commissioning: "it is proposed that the price-setting function should be independent of the purchasing function even within the interim system. This is considered important in terms of the integrity of the process and ensuring support and buy-in from the hospital system. It is, therefore, suggested that the price-setting function would be absorbed into a National Information and Pricing Office with multi-stakeholder oversight and strong clinical representation, while the purchasing function would be built up from within the HSE prior to creating an independent statutory commissioner." (Department of Health, 2013:44).

150 Department of Health, 2013:65.

151 HSE, 2011.

152 Levels of dependency were measured on the Barthel Scoring Tool and the results of the audit showed that only 20% of those deemed eligible were in the maximum dependency category of 0-4 on the Barthel Score (HSE, 2011:11). The most common diagnosis among those assessed as eligible was dementia (28%) but only 17% in this category were assessed as being maximum dependency (HSE, 2011:12). As the report observes: "Even taking Dementia/Confusion/

Alzheimers into account as diagnosis, there is still a significant number in the medium to lower dependency areas that have been approved for long term care. This is something that needs to be looked at more closely." (ibid.).

153 A minority (28%) were known to be in receipt of a Home Care package prior to application (HSE, 2011:10). More significantly, less than a fifth (18%) of applicants were known to have been considered for a Home Care Package; the remainder are evenly divided between those who were definitely not considered and those where it is not known to have been considered (ibid.). As the report observes: 'as HCP [Home Care Package] is a key component of provision of services for Older Persons, it is a recommendation that this area is examined in more depth.' (ibid.)

154 HSE, 2011:17. This result is consistent with the results of the 2011 survey of long-stay units in Ireland which found that 12.8% of residents were low dependency, 22.3% were medium dependency, 28.2% were medium dependency and 36.7 were maximum dependency (Department of Health, 2012c:18). Dependency levels were defined as follows. Low Dependency: Persons who need some support in the community and the more independent residents in residential accommodation who require little nursing care. They are usually independently mobile but may use a walking stick and have difficulty managing stairs. Medium Dependency: Person whose independence is impaired to the extent that he or she requires residential care because the appropriate support and nursing care required by the person cannot be provided by the community. Mobility is impaired to the extent that the person requires supervision or a walking aid. High Dependency: Independence is impaired to the extent that the person requires residential care but is not bed bound. The person may have a combination of physical and mental disabilities, may be confused at times and be incontinent. He/she may require a walking aid and physical assistance to walk. Maximum Dependency: People whose independence is impaired to the extent that he/she requires nursing care. The person is likely to be bed bound, requires assistance with all aspects of physical care and may be ambulant but confused, disturbed and incontinent. (Department of Health, 2012c:17).

155 HSE, 2013b:4. SAT is based in part on the InterRAI suite of assessment tools (www.interrai.org) plus a carer assessment and will be part of an computerised system called SATIS (Standardised Assessment Tool Information System).

156 The results of research at The Dartmouth Institute for Health Policy and Clinical Practice, which produces The Dartmouth Atlas of Health Care merit reflection in this context even though they are based on a different health system (US) and have a particular focus on mainly older patients (Medicare beneficiaries). Its website poses and answers the following question: "The Atlas is often cited as a source for the estimate that 30% of the nation's spending is unnecessary -- what is the evidence? The Dartmouth approach was to ask how much might be saved if all regions could safely reduce care to the level observed in low-spending regions with equal quality; we find estimates ranging from 20-30%, but view these as an underestimate given the potential savings even in low cost regions. At least three other groups have come to 30% waste estimates: the New England Healthcare Institute, McKinsey, and Thomson Reuters." (www.dartmouthatlas.org).

157 Central Statistics Office, 2011, Part 2, Table 29.

158 Khan, 2013:13.

159 The review concluded: "With an ageing population across the island of Ireland, it is important to understand the impact of chronic conditions as well as physical and mental health problems on our health as we grow older. It is a great success story that life expectancy is increasing, but measures such as DFLE and HLE must also be brought into the policy debate in order to reflect broader life course influences and quality of life in later years. Greater harmonisation of the approach to data gathering methodology will lead to more reliable data on health inequalities, enabling a more targeted approach to healthy ageing." (Balanda, Fahy, Abdalla and Barron, 2013:23.

160 Central Statistics Office, 2010a.

161 "ADL are the basic tasks of everyday life that pertain to personal care, such as eating, bathing, dressing, toileting, and moving about" (Kamiya, Murphy, Savva and Timonen, 2012:1).

162 "IADL are activities performed by a person in order to live independently in a community setting, such as housekeeping, preparing meals, shopping, using the telephone, taking medications correctly and managing money" (Kamiya, Murphy, Savva and Timonen, 2012:1).

163 Kamiya, Murphy, Savva and Timonen, 2012:8. Note that the term 'older' as used in TILDA refers to those aged 50+.

164 Marmot, 2013.

165 The National Institute for Health and Clinical Excellence (2012) has commented that: "Smoking is currently the main reason for the gap in life expectancy between rich and poor; and tobacco use is the single greatest cause of preventable deaths in England. Furthermore, with rising levels of obesity, physical activity remains essential for maintaining good health, with research suggesting inactivity could soon have the same impact on health as smoking."

166 "The need for long-term care is not arising from ageing itself; it is a consequence of frailty, causing individuals to be dependent on others. The prevalence levels of dependency have been shown to be an important determinant of long-term care expenditure. As in the field of health care, there is an on-going debate on the future developments of disability, defined as some form of functional impairment of the individual. Nevertheless, what determines the demand for long-term care and therefore expenditure is not only the measure of disability, but also the extent to which this disability transfers into dependency, and therefore requires some kind of long-term care provision." (European Commission, 2012a:196-197).

167 Marmot, 2013.

168 This approach has been described as the emerging paradigm of medicine in the 21st century: "In the 21st century, clinicians have a responsibility to the population they serve, to the patients they never see, as well as to the patients who have consulted or been referred. Individual clinicians, while still focused on the needs of the individual in front of them when in the consultation, also make decisions about the allocation and use of resources to maximise value for all the people in the population they serve. ... The new responsibilities for the clinician practising population medicine not only include maximising value by getting the right outcomes for the right patients in the right place with the least use of resources, but also ensuring the prevention of inequity related to age or gender or race or social class. The clinician practising population medicine will develop population-based systems that cut across the traditional boundaries of primary, secondary, or tertiary care even if this is to the short-term disadvantage of their employing organisation. ... What is emerging is a new paradigm: better value through population and personalised medicine." (Muir Gray, 2013).

169 "3.5% of older people received home help services in the past year, while 1% of the population had the help of a state provided personal care attendant and around 1% received meals on wheels." (Normand, Kamiya, Timonen and Whelan, 2011:215).

170 "For those with combined IADL and ADL limitations, 12% did not receive any help, 33% were primarily helped by a spouse, 31% by children, 3% by other relatives, and 20% by non-family members." (Normand, Kamiya, Timonen and Whelan, 2011:216). In a subsequent report it is stated that "only 10.5% (n=107) of all carers received payment for the care they provided" (Kamiya, Murphy, Sava and Timonen, 2012:18)

171 "In addition to the expected growing demand and financial constraints in the home-care sector, the availability of home-care workers is another possible challenge. Home care is labour intensive and the question is whether sufficient qualified staff will be available if the ratio between the working age population and the elderly population changes as mentioned above. Scarcity also applies to informal carers, such as spouses, children, other relatives and volunteers. In many countries informal care is becoming scarcer as a result of growing mobility, urbanization and women's increasing participation in the labour market, the latter traditionally providing the lion's share of informal care. Conversely, the current economic crisis could have a softening effect on the workforce problem in the care sector. In times of economic stagnation and growing unemployment, working in the care sector can be perceived as a relatively safe haven." (Genet, Boerma, Kroneman, Hutchinson and Saltman, 2012:3-5).

172 "Pressure is likely to emerge in the future for policy changes to increase formal care provision, especially as the future availability of informal care is likely to diminish rather than increase. Even informal care is now seen as having a potential side-effect on public expenditure, in that it calls for more support (such as respite care for instance) in order to avoid its major adverse impact on labour participation and carers' health. Note also that the private market for LTC is still under-developed in most Member States and is most often not a real alternative yet." (EU Commission, 2012:210-211).

173 EU Commission, 2012:211.

174 EU Commission, 2012:212.

175 EU Commission, 2012:212.

176 Colombo and Mercier, 2011: Table 1, p.5.

177 EU Commission, 2012:195-246.

178 "In Ireland, there is said to be a lack of regulation over this private sector (even that part paid through public sources) and quality assurance appears not to have been addressed so far. This facilitates more flexibility with regard to qualifications, training and monitoring of the quality of work. As a consequence, care workers in the private sector have fewer social rights than their colleagues in the public and non-profit-making sectors." (Genet, Boerma, Kroneman, Hutchinson and Saltman, 2012:38).

179 "Several country experts interviewed for this study mentioned the lack of regulation on the private sector as one of their main concerns. Hence, future governments will likely be concerned with regulating privately owned home-care providers and less involved in actual provision and needs assessment." (Genet, Boerma, Kroneman, Hutchinson and Saltman, 2012:51).

180 "Telecare is used for the monitoring of changes in an individual's condition or lifestyle, including emergencies, in order to manage the risks of independent living. Examples include movement sensors, falls sensors, and bed/chair occupancy sensors. These technologies are generally provided to patients with social care needs". (Hendy, Barlow and Chrysanthaki, 2011:21-22).

181 "Telehealth is the remote exchange of data between a patient and health care professional to assist in the diagnosis and management of a health care condition. Examples include blood pressure monitoring and blood glucose monitoring. These technologies are generally provided to patients with long-term health conditions such as diabetes". (Hendy, Barlow and Chrysanthaki, 2011:22).

182 Genet, Boerma, Kroneman, Hutchinson and Saltman, 2012:100. See also Hendy, Barlow and Chrysanthaki, 2011.

183 European Commission, 2012b.

184 "Supporting family carers is a three-win arrangement, for carers (who provide care out of love or duty), for the 'carees' (who prefer to be cared for by family and friends) and for governments (who would otherwise face higher costs for formal care services and need all available support for their dependent populations). But currently only two in seven people in Europe are satisfied with the public support available to those caring for dependent older relatives. Family carers experience problems accessing support, such as a lack of information, costs related to access or use of support, waiting lists for supportive services, bureaucracy, a lack of transport, or even a caree's negative attitude. Some family carers do not see themselves as a group for whom services are available, or may feel stigmatised by the term, and thus may be hard to target. In addition, while support for carers is in demand, for some major support mechanisms – including financial payments and employment-related measures – there is little evidence of (cost)-effectiveness. ... . Supporting family carers needs to become a key aspect of any LTC system, and may well require a mix of measures such as cash benefits, flexible leave options for working family carers and other support forms, such as information, training, respite services and peer support. However, a crucial outstanding question is how to do this effectively, when there is still a dearth of evidence on cost-effectiveness." (Tjadens and Colombo, 2011:16)

3

The Concept of a Social Enterprise for Older People

3.1 Introduction

It is proposed to set up a social enterprise – defined as a business with a social purpose – to provide services for older people, supporting them to live at home. These services will include, but are not confined to personal care, health care, practical care and house care. The services will be individualised to meet the needs and preferences of each person and will integrate with the recipient's existing networks of support and care, both formal and informal. In this chapter, we outline the ideas and principles that will guide the social enterprise in the design and delivery of its services and consider the most appropriate structure for the business. We begin by outlining the vision that will guide the social enterprise (Section 3.2) and then set out the principles that will underpin it: individualisation (Section 3.3), integration (section 3.4), innovation (Section 3.5) and institutional learning (Section 3.6). The organisational structure for the social enterprise takes account of the need for economies of scale to achieve cost effectiveness (Section 3.7). We conclude with a summary of findings (Section 3.8).

3

The Concept of a Social Enterprise for Older People

3.2 Vision for Proposed Social Enterprise

The proposed social enterprise will be a 'public interest trust'[185] and constituted as a 'charitable trust' under the Charities Act 2009[186]. In that sense, it will have a different legal status to a public body[187] or a private body[188]. It is a social enterprise in the sense that it will trade commercially but has a social rather than a private purpose and its surplus is re-invested in this social purpose[189].

The social enterprise is informed by the same vision for older people that informs national policy, as described above (Section 1.4). Based on this vision, the social enterprise will act as a catalyst in the communities where it works to create support and care to enable older people to live at home, consistent with their expressed needs and wishes, and using all available resources in the local area. This means that the social enterprise will tender to become a HSE-approved provider of community services for older people (HCPS, HHS and Day Care), but will also seek other sources of revenue, as discussed in Chapter Four below, to develop supports for older people beyond those currently funded under the existing HSE budget. Examples of these additional supports, whose purpose is to build community capital in social care, include: community navigators to advise and support on accessing services; greater use of assistive technology; time banks; befriending service; organising volunteers; care and repair for home and garden; group-purchasing schemes to reduce the cost of heating or respite breaks. This makes the proposed social enterprise different to other providers of services for older people, where the offering is largely confined to HSE-funded schemes. This approach has economic and social benefits, as demonstrated by a recent evaluation of similar initiatives in England (involving time banks, befriending services, community navigators) which found that "there could be sizeable savings to the public purse when investing in community capital-building initiatives at relatively low cost"[190].

> The social enterprise will act as a catalyst in the communities where it works to create support and care to enable older people to live at home, consistent with their expressed needs and wishes, and using all available resources in the local area

Box 3.1
CareBright: Exemplar of a Social Enterprise for Older People

About Us

CareBright was formed from understanding the need for professional and supportive care in our community. CareBright is a long established non-profit Irish homecare provider. Our focus is caring for and supporting people to live independently in their own homes. CareBright has been providing services for older people in Munster since 1998 in the form of Home Care Grants, Home Help Services, Chiropody, and Subsidised Hours in the home, while also being a homecare provider providing care for clients in a private capacity.

Homecare Provider

We have a team of approximately 250 carers managed and supported by a team of six Care Managers who are all qualified nurses with many years' experience. As a homecare provider, our Care Managers work closely with carers, clients, families, Public Health and Community Nurses, Physiotherapists, Occupational Therapists, GP and other members of the Multi-Disciplinary Team to ensure person-centred care is delivered in the home. All staff are Garda Vetted and trained at FETAC level.

Providing care in our community

Our care agency was formed not only to provide care in our community but also to provide employment to those who deliver care, ensuring our community and the people who live within it, benefit from our services. Our values have not changed, we deliver excellence in care while ensuring employment in our community. Our motivation is the delivery of quality care in the home.

Homecare

CareBright provides home care support services that allow you or your loved one to remain living an independent life at home. We will assist with the daily activities of living in a caring and sensitive manner. Our care at home service is available 24 hours a day, all year round this includes weekends and bank holidays. We are flexible in our approach to care at home; we can provide services ranging from 1 hour to 24-hour care.

24-Hour Home Care

The CareBright 24-hour care support system allows either you or a loved one to remain living independently at home in a safe comfortable environment. Our live-in care is provided by carers that are Fetac Level 5 Accredited, Garda Vetted, reference-checked and fully insured. Our carers will remain in the home for the scheduled time (including overnight care) and will require their own bedroom; this will ensure privacy for everyone. We provide carers that will work in rotation for your required needs.

Respite

CareBright can provide long-term or short-term care for clients allowing family members to take a much-needed respite break. Throughout this service we are dedicated to meeting the needs of both the client and the family carer.

Palliative Care

Palliative Care is a practice used to enhance the quality of life for people living with life-limiting illness. This can be a difficult time for the patient and their loved ones. CareBright offers support, using a team approach to address the needs of the patient and their family, and where possible will enhance the quality of their life.

Dementia Care

Dementia impacts on daily activities and social relationships and usually runs a progressive course. At CareBright our Care Managers have experience of caring for clients with dementia. We are committed to providing a therapeutic approach to care; delivered through a dementia specific care plan, enhanced by our dedicated team of carers.

Post Disability Care

CareBright is committed to empowering people with either a physical or sensory disability to live independently in their own home. Our Care Manager will meet with you to assess your needs and devise a care plan that will suit your requirements.

Post-Operative Care

The Convalescent and Post-Operative Rehabilitative Care Programme assists individuals with recuperation and recovery after surgery or serious illness. As each individual's medical condition is different, the length of service can vary from one week to a more long-term service. The service will assist and support you for your required time whilst recovering from illness and surgery.

Chiropody Services

CareBright Chiropody Clinics have been in operation since 2004. We are a service provider on behalf of the HSE for chiropody care to persons over 66 and have established a good reputation amongst the local community and medical practitioners including GPs and other clinicians. CareBright currently employ six highly qualified Chiropodists who provide chiropody treatment. All of whom are members of the Irish Chiropodists and Podiatrists Association. The Chiropodists are involved in Continual Professional Development programme to ensure best practice for all our clients. Suffering from foot problems need not be an issue as professional help is available.

Source: www.carebright.ie

An illustration of the type of social enterprise envisaged is presented in Box 3.1. This is CareBright, a business employing about 250 carers and serving over 400 older people at home. Originally founded in 1998 by Ballyhoura Development, a local development company, it has evolved over 15 years to become a significant provider of services for older people in Limerick, Tipperary and Cork; Ballyhoura Development also set up Ballyhoura Rural Services in 2010 to tackle rural and social isolation within the catchment area.

The social enterprise will build on four principles that are widely recognised as constituting the essence of quality in all public services, with particular reference to health and social services. These principles, which are expanded in subsequent sections, are:

- Individualisation of support and care according to the needs and preferences of the older person so that each person's autonomy and integrity are fully respected
- 'Intelligent', integrated networks of support and care in defined geographical areas; these networks will have the capacity to respond with competence and care to the changing needs of each person over the life-cycle of ageing
- Innovation with regard to the type and use of material, financial, infrastructural, and human resources – including the design of housing, transport and social supports – particularly with regard to maintaining the independence and quality of life of the older person
- Institutional arrangements for learning and oversight to ensure accountability in the best use of resources, ensuring the best possible experience and outcome for each person, and the transfer of learning throughout

3.3 Individualisation

The principle of individualisation builds on the understanding that each person is capable of expressing his/her needs and preferences and, in practice as well as in principle, this should shape the response provided by each service. In that sense, the principle of individualisation embodies a person-centred and needs-led approach to service provision rather than a service-led approach. This perspective is at the heart of public service reform across all sectors[191], and the principle of individualised supports is at a somewhat more advanced stage of implementation in services for people with intellectual disabilities in line with current national disability policies and strategies[192]. The principle of 'person-centred care and support' constitutes the first of eight national healthcare standards which are used by the Health Information and Quality Authority (HIQA) to monitor service providers in terms of the quality and safety of health and personal social care services in Ireland[193].

Individualisation is informing not just how services are designed and delivered but is also shaping how they are funded. In the case of services for older people, and other vulnerable groups such as people with disabilities and mental health difficulties, the possible funding implications are spelt out in the health strategy as follows: (i) funding may be allocated directly to one or more service providers chosen by individuals to provide them with services or supports; (ii) funding may be allocated to service brokers nominated by individuals to manage their budgets, or choose supports based on an agreed plan, following assessment of need; or (iii) funding may be allocated directly to individual service users where they opt to manage their budgets themselves[194]. Funding for the Home Care Package Scheme is in line with the first of these approaches since there are four approved providers in each LHO area from which the older person may choose. Currently there is no provision for 'personalised budgets', where an older person who is assessed as having a need and eligible for support receives a grant to purchase services[195].

Addressing this challenge requires a thorough understanding of the needs and preferences of older people and their families, as well as understanding how the flow of services within the system currently operates

It is recognised that implementing the principle of individualisation remains a challenge for many public services. Addressing this challenge requires a thorough understanding of the needs and preferences of older people and their families, as well as understanding how the flow of services within the system currently operates, so that blockages are removed and each person receives the package of support and care that is required – "the right care is delivered in the right place"[196]. In order to develop this understanding, a separate analysis of TILDA was undertaken to clarify the determinants of well-being and need among older people, so that services can be aligned and supportive of the processes which keep people well in their own home (see Section 1.6 above).

This analysis also maps the geographical distribution of well-being and need in different parts of the country, facilitating analysis of how services – and the resources used to fund them – are matched to needs in each area. In this way, the analysis is intended to improve knowledge on how to target resources effectively, in line with national health policy[197], while also helping to ensure that services are planned and delivered to meet population-level and area-level needs. Building information systems such as this not only facilitates better management of services and resources; they also allow geographical variation in outcomes – such as comparing areas with and without the proposed social enterprise - to be compared thereby increasing national capacity for learning and innovation[198].

3.4 Integration of Services through Intelligent Networks

The principle of integration refers to the way different service providers are coordinated with each other as part of a network in order to deliver a seamless service tailored to the needs and preferences each person. Integration is widely regarded as an area of weakness in many health and social services – including Ireland[199], England[200], Europe[201] and the OECD[202] generally – and has the effect of making it more difficult than is necessary for people to make smooth transitions from one part of the system to another as their needs require.

The framework for reform of the health service lays particular emphasis on integration and provides a clear description of what it involves: "Understanding integrated care means looking at processes and outcomes of care rather than at structural and organisation issues. Achieving integrated care means that services must be planned and delivered with the patient's needs and wishes as the organising principle. It is preferable that the term integrated care rather than 'integration' be used so that it is clear that the focus is where it should be i.e. on patients and families and the services they need rather than on funding systems, organisation or professionals. Each of these will be important levers in enabling and facilitating integrated care – but they in themselves are not the objectives."[203]

Achieving integrated care means that services must be planned and delivered with the patient's needs and wishes as the organising principle

Building on this understanding, the reform of health and social care in Ireland offers important opportunities for the proposed social enterprise to become part of an 'intelligent network' in each local area, providing integrated care for older people. It will work collaboratively with other providers such as hospital groups, small hospitals and nursing homes as well as private home care providers. As explained in more detail in Chapters Four and Five below, the proposed social enterprise could be part of the solution to delayed discharges and unnecessary admissions to Emergency Departments; more generally, it could have a role in facilitating smoother transitions for older people between different care settings.

3.5 Innovation

The agenda for public sector reform lays particular emphasis on innovation in term of 'maximising new and innovative service delivery channels' and 'leading, organising and working in new ways'[204]. This is echoed in the HSE's 2013 National Service Plan which emphasises the need for innovative approaches to integrating care for older people: "In order to meet increasing population need and deliver sustainable services within available resources, innovative models of care are required to further advance the development of equitable integrated care for older people across community-based services, intermediate care options and quality long term residential care services (supported by a robust and well-funded scheme – presently the NHSS)."[205]

The social enterprise is proposed as a contribution to innovation in services for older people, by virtue of being a new provider in the field, offering a response to the needs of older people which draws upon existing budget headings for older people (HCPS, HHS, etc), and using a social enterprise model which draws resources from a diversity of revenue streams as detailed in Chapter Five below. In particular, the proposed social enterprise is committed to developing innovative responses to the needs of older people which could include the following: community navigators to advise and support on accessing services; re-visioning traditional services such as meals-on-wheels, day centres and respite; micro-working systems to manage paid, bartered and donated time; organising volunteers; transport; greater use of assistive technology; group-purchasing schemes to reduce the cost of heating or respite breaks; befriending service; telephone contact and support services; urgent adaptations to a person's home to enable return from hospital; care and repair for home and garden; advice and assistance with financial and legal matters; emergency response in situations where home-based supports are threatened or the family is unable to cope; advance planning when the end of life is known to be approaching. This innovative approach has the aim of making better use of existing public resources for older people but also finding new revenue streams, such as corporate and community contributions, which could finance a wider range of services while also creating employment.

3.6 Institutional Learning, Accountability and Oversight

The process of public sector reform is still in its early stages in Ireland and, as first steps in reform of the health service illustrates, it involves a complex set of interdependent reforms. One of these is the 'purchaser/provider split' which may lead to a 'market' of purchasers and providers for services. This reform, although an enabling condition for the emergence of providers like the proposed social enterprise, involves more than simply 'out-sourcing' or 'contracting-out' services that were formerly provided by State agencies, and raises a number of difficult issues. A key lesson from international experience of public sector reform is that a move to decentralised, results-driven and in some cases, out-sourced public services, is unlikely to work if the State

does not create adequate systems of funding, accountability and oversight that bring coherence between purchasers, providers, regulators, and service users.

In previous attempts to create a 'market' for publicly-funded health services, public authorities have played a key role in monitoring service providers and seeking to avoid the emergence of monopolies. In most cases, however, such authorities have proven to be relatively ineffective and highly expensive, failing to achieve their original reform objectives of greater efficiency, value for money and improved outcomes.[206] For example, the introduction of an 'internal market' for health care in the UK proved to be anything but a cost-saving innovation, as spending accelerated rapidly following this reform[207]. Perhaps for this reason, and due to Ireland's small population, market-based reforms have generally been treated with scepticism in this country. For example, Jerry O'Dwyer, former Secretary-General at the Department of Health and Children, stated at the end of the 1990s: "It is reasonable to assume that changes in structures will not be driven by any particular ideology and that the market model will not be adopted. It is much more likely that changes in structures will be evolutionary, based on experience and evidence, responding to an agenda which is primarily dominated by the requirements of health strategy, formulated in accordance with overall government policies".[208] Freeman and Moran summarise international trends in health policy, and further reinforce this perspective: "Competition ... perhaps the signal term in the international discourse of reform, may well turn out to have been one of the more transient. In the UK, where it was promoted most vigorously, and in Sweden, competition has turned relatively quickly into collaboration between larger units with more clearly defined functions of planning and providing care."[209]

The issue of public sector reform has also been considered by the National Economic and Social Council, particularly from the perspective on the changing role of the developmental welfare state. Drawing on experiences of contracting-out public services in countries such as New Zealand, Australia and the UK[210] it suggests ways in which the State, as 'policy centre', could facilitate institutional learning: "[it] must not only insist that frontline providers engage in serious monitoring of outcomes and processes, but combine this with a more supportive stance. The enhanced and modified role of the policy centre would include establishing and convening a forum through which the examples of the most successful could be explored and emulated as per the top-runner method; it would see the centre leading the consideration of alternative institutional models of provision such as social enterprises that could act as a stimulus for wider change in a given policy area."[211]

The issue of public sector reform, and effective ways to achieve it, are outside the scope of this report although this forms part of the context in which the proposed social enterprise will operate. As part of that context, our analysis has already drawn attention to the need for services for older people to be more closely aligned to the 'naturally occurring' processes which promote personal well-being (see Section 1.6 above). It has also drawn attention to delayed discharges as evidence of inefficiency in the health system requiring greater collaboration between hospital and community providers, possibly including the proposed social enterprise (Section 2.4). A further implication is that the proposed social enterprise will require its own organisational arrangements to support continuous quality improvement mainly driven by responsiveness to local needs. This means having systems for monitoring and reviewing performance, drawing on measurements of outcomes using key performance indicators (KPIs) but also facilitating reflective practice as an integral part of the work so that the fundamental importance of the face-to-face interactions between provider and service user remains the central focus. This also involves giving priority to the experience of service users and the outcomes that are achieved in terms of well-being.

A move to decentralised, results-driven and in some cases, out-sourced public services, is unlikely to work if the State does not create adequate systems of funding, accountability and oversight that bring coherence between purchasers, providers, regulators, and service users

3.7 Organisational Structure and Cost Effectiveness

In assessing the national business case for the proposed social enterprise, the issue of cost is central, quite apart from the more complex question of whether community-based care is more cost-effective than institutional care[212]. It is widely recognised that wages in the social care sector – not just eldercare but childcare as well – are low, which significantly reduces the scope for reducing costs. A review of this issue by the National Economic and Social Council concluded that "addressing costs while improving quality is not a straight-forward process"[213]. It added that: "the limited evidence suggests that some quality approaches can reduce the cost of provision, for example, cutting out waste, changing the way services are provided to make them more efficient and effective (such as more care at home, or changes in staff skill-mix), and taking a person-centred approach. The challenge is to organise work systems and practices in such a way that staff resources can deliver the optimal quality service within the financial resources available, and that associated regulation, standards and quality improvement initiatives support this approach."[214]

Across business organisations generally, the most frequently-used methods to reduce cost are economies of scale and the use of technology. Economies of scale are used increasingly in the home care sector by larger private and voluntary providers, both in England and Ireland, so that they have the necessary human and financial resources to compete on cost and quality. In Ireland, for example, half of the approved providers of HCPS are private companies operating under franchise.

An example of this business model in the social enterprise sector has been developed by the Fledglings childcare provider in Ireland[215]. Fledglings may be an appropriate organisational model for the proposed social enterprise, at least from an efficiency perspective. With this structure, the national organisation facilitates development of local trusts and carries the overhead costs associated with various processes such as: preparing business plans, tenders and funding applications; developing quality assurance procedures; staff training and development; payroll; publicity and advocacy. IT systems are an essential part of this infrastructure and provide leverage to support the emergence of local social enterprises that might otherwise be difficult, if not impossible. This approach would also overcome the obstacle of 'tendering capacity', which many social enterprises (and small enterprises generally) encounter in public procurement[216].

Building organisational infrastructure to achieve economies of scale is not simple or cheap. That is why the National Economic and Social Council has suggested that public funding might "support providers in putting IT systems in place, to promote optimum use of data, timetabling of staff, staff monitoring, automatic billing, etc., as not all providers may be in a position to support the investment that this requires, and it has been shown that it can reduce costs for both providers and commissioners of home care. It will also be important to ensure that contracting on a national rather than local scale continues under the HSE's successor, as this economy of scale can allow better negotiation on prices and reduce the need for local health service offices to 'reinvent the wheel'"[217].

The challenge of providing quality services which are also value-for-money appears substantial but it applies to all services, not just those for older people, where human interaction is a central component. It applies therefore to health, education, hospitality and the arts, which are labour-intensive and, by comparison with capital-intensive sectors like manufacturing and food production, are less amenable to productivity improvements[218]. At the heart of this challenge is the fact that the quality of a human service depends on its being tailored to each person's needs, delivered on time and sensitively, and connected to other elements of care on which the person may depend. Quality services in this sense are relatively costly because the main input is staff time and, although there is scope for improving productivity, there is little or no scope for reducing wages, particularly in the home-care sector for older people, much less competing with private companies on cost. In that sense, the national business case for the proposed social enterprise does not rest on reducing costs but on offering quality[219] and value-for-money[220]. This is based on the assumption that these services will inevitably cost more over time but will still remain affordable because of productivity gains in other sectors of the economy, and there remains a general willingness in society to pay for services which enhance education, health and personal well-being[221].

At the heart of this challenge is the fact that the quality of a human service depends on its being tailored to each person's needs, delivered on time and sensitively, and connected to other elements of care on which the person may depend

Recognising that a service is only as good as its staff, the proposed social enterprise aims to recruit and retain highly qualified and motivated staff but will also include experienced staff who are less formally qualified, providing them with in-house training and mentoring to ensure they have capacity to deliver a quality service[222]. This approach has the potential to yield improvements in the health and well-being of older people – and improve standards in the voluntary and community sector generally - which can be justified in terms of cost effectiveness, and will be attractive to high-achieving professionals who see social care as a rewarding career path.

3.8 Summary

This chapter outlined the vision and principles that will guide the proposed social enterprise and its collective response to ageing. Its four principles summarised by the words – individualisation, integration, innovation, and institutional learning – represent the vision and hallmark towards which it aspires. A core challenge for the social enterprise – which it shares with all services where human interaction is a central component such as health, education, hospitality, and the arts - is providing quality services which are also value-for-money. These services are relatively costly because the main input is staff time and, although there is scope for improving productivity, there is little or no scope for reducing wages, particularly in the home-care sector for older people. In that sense, the national business case for the proposed social enterprise does not rest on reducing costs but on offering quality and value-for-money. This approach has the potential to yield improvements in the health and well-being of older people which can be justified in terms of cost effectiveness, while also being attractive to high-achieving professionals who see social care as a rewarding career path.

Footnotes

185 It might be noted that the term 'trust' has become increasingly common as part of the evolving welfare state – hospital trusts and housing trusts are examples – and is different from the traditional legal concept of trust where 'property' is held in trust by 'trustees' on behalf of 'beneficiaries'. Commenting on the term as used in England, one lawyer has observed: "What confuses matters is the frequent use of the word 'trust' in these contexts [hospital and housing trusts] as a rhetorical device aimed at mollifying the citizenry into believing that the bodies corporate are indeed 'trustworthy'. However, most of these entities are bodies corporate which own their own property and which do not have any vested beneficiaries for whom any property could be held on a trust, properly so-called. At the time of writing all that can be said is that in the decades to come it is likely that such structures will continue to be used and that their proper legal analysis will remain opaque. ... the potential for a public interest trust, with its own fiduciary principles, is to support social welfare initiatives like housing action trusts and NHS trusts both to enable them to operate effectively and also to enable users of their services to effect some control over them. In this way, law becomes a means of democratic control – lending a voice to ordinary citizens." (Hudson, 2012).

186 The Charities Act 2009 defines a 'charitable trust' as a trust: (a) established for a charitable purpose only; and (b) established under a deed of trust that requires the trustees of the trust to apply all of the property (both real and personal) of the trust in furtherance of that purpose except for moneys expended in the management of the trust (Section 2). A 'charitable purpose' is defined as: (a) the prevention or relief of poverty or economic hardship; (b) the advancement of education; (c) the advancement of religion; (d) any other purpose that is of benefit to the community (Section 3).

187 For example, it will be different from the hospital trusts which are proposed for the Irish health service (Department of Health, 2013b). From 2014, Ireland's 49 acute hospitals will be re-configured into six hospital groups which, in time, will become hospital trusts. The report setting out the composition and structure of these hospital groups does not discuss their legal status but notes that "Individual hospital groups can only develop into trusts once it is proven by the group that it is viable and capable of providing the relevant services to its population." (Department of Health, 2013b:108).

188 Private trusts such as partnerships are quite common. "In private law contexts of partnership the partners owe fiduciary duties one to another. In relation to private sector trusts and companies, the trustees and directors owe fiduciary duties to the beneficiaries and the companies (or potentially the shareholders) respectively." (Hudson, 2012).

189 The defining features of a social enterprise are clarified in the Forfás report on social enterprise in Ireland: "Social enterprises differ from traditional charities as they earn some income from trading and so are not reliant solely on fundraising or grants, although it is recognised that some charities do engage in traded activities. The social purpose and the re-investment of the surplus in the social objective should be the delineating factor between social enterprises and conventional enterprises. Where a social enterprise is trading and uses a business model to deliver a social good or service it can be deemed to be operating within the commercial sphere." (Forfás, 2013:10).

190 "Our findings suggest that there could be savings to the public purse when investing in relatively low-cost community capital-building initiatives. Each initiative we looked at generated net economic benefits in quite short time periods. Our findings are therefore consistent with, although used different methods from, some other studies in the United Kingdom." (Knapp, Bauer, Perkins, and Snell, 2013:327).

191 Depending on the sector, person-centred services are also referred to as child-centred, pupil-centred, learner-centred, patient-centred, client-centred, customer-centred, family-centred. Illustrations of this perspective can be found in of strategic statements across the public sector:

- "Provide a service which holds the individual care recipient at its centre" (Department of Health, 2012a:37)
- "Service users must be at the centre of decision-making at an individual level in terms of the services available to them" (Vision for Change, 2006:24)
- "The Review proposes a fundamental change in approach to the governance, funding and focus of the Disability Services Programme, with the migration from an approach that is predominantly centred on group- based service delivery towards a model of person- centred and individually chosen supports" (Department of Health, 2012d:xvii)
- "DYCA will be child- and youth-centred, with children, young people and families at the heart of its work" (Department of Children and Youth Affairs, 2011:6)
- "The recommendations are focused on putting the child at the centre of policy and services" (Task Force on Child and Family Support Agency, 2012:iii).
- "The department's role is to support the educational success of each learner" (Department of Education and Skills, 2011:3).

192 This principle is embodied in reports such as the following: Value for Money and Policy Review of Disability Services (Department of Health, 2012d); Time to Move On from Congregated Settings (Working Group on Congregated Settings, 2011); New Directions Review of Adult Day Services (National Working Group to Review HSE Funded Adult Day Services, 2012); and National Housing Strategy for People with a Disability 2011-2016 (Department of the Environment, Community & Local Government, 2011).

193 There are nine standards on the theme of person-centred care and support: Standard 1.1 The planning, design and delivery of services are informed by service users' identified needs and preferences. Standard 1.2 Service users have equitable access to healthcare services based on their assessed needs. Standard 1.3 Service users experience healthcare which respects their diversity and protects their rights. Standard 1.4 Service users are enabled to participate in making informed decisions about their care. Standard 1.5 Service users' informed consent to care and treatment is obtained in accordance with legislation and best available evidence. Standard 1.6 Service users' dignity, privacy and autonomy are respected and promoted. Standard 1.7 Service providers promote a culture of kindness, consideration and respect. Standard 1.8 Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process. Standard 1.9 Service users are supported in maintaining and improving their own health and wellbeing. (Health Information and quality Authority, 2012a; 2012b).

194 Department of Health, 2013b:39.

195 It is reported that in the UK, 'take-up is still low' where there are 'personalised budgets and direct payments allowing individuals to employ their own home carer' (national Economic and Social Council, 2012a:43-44).

196 Department of Taoiseach, 2011:32 and 38. The challenge of delivering the right care at the right time requires a form of systems thinking which has been used successfully in manufacturing (notably Toyota Motor company) but also applied successfully in some local authorities in Britain (Zokaei, Elias, O'Donovan, Samuel, Evans and Goodfellow, 2010). A key feature of systems thinking in these public sector settings is "its emphasis on effectiveness thinking as opposed to efficiency thinking. All of the authorities studied were thus refocused into concentrating on delivering against the central purpose of their service and were able to redesign their system in accordance with systems principles. In all three cases the systems thinking intervention involved conscientious study of the demand in a 'longer than usual' process which proved to be very valuable for the redesign. Becoming intimately familiar with the customers and demand is at the heart of the approach. Another feature of the approach was that workers themselves were responsible for the redesign of the system in which they worked – a powerful way of creating the engagement of the workers." (ibid.:57)

197 "In order to maximise our health system's ability to deliver a truly integrated care system, it is vital to measure the distribution of healthcare needs throughout the population. Resources will need to be targeted on the basis of formal needs assessment at the population level to ensure the greatest possible impact in terms of health outcomes for a given level of resources" (Department of Health, 2012a:18).

198 This development is in keeping with a growing body of research on organisational and regional variation in health care resources, utilisation, and outcomes. (see for example Wennberg International Collaborative, 2010; 2011). Many countries including Ireland are developing health atlases to map variations in health services, including variations in outcomes as a way of studying 'unwarranted variation'. Unwarranted variation has been defined as: 'Variation in the utilization of health care services that cannot be explained by variation in patient illness or patient preferences' (Wennberg, 2010; See also: www.dartmouthatlas.org). By contrast, some variation is warranted when different populations have different levels of need (RightCare, 2011:17). Significant improvements in health services, including greater value from the use of healthcare resources, can be obtained by mapping and then reducing unwarranted variations in health services.

199 A recent review of health services in Ireland observed that: "there appears to be considerable scope for enhancing efficiency of delivery in Ireland through improved coordination and integration of existing hospital, primary and community services." (Thomson, Jowett and Mladovsky, 2012:102).

200 The Department of Health in the UK has observed that "fragmented care is a concern for many people in health and social care, especially for those who have multiple, chronic conditions and long-term needs who need care from a myriad of NHS and social care services." (Department of Health UK, 2012:5). Others describe the lack of integration in the NHS as follows: "Public experience of NHS services is marked by praise for the specific experiences of treatment but problems with the overall experience of service. Whilst most staff and leaders in the NHS recognise the severe problems caused by the organisation of care into episodes of care, there are few models of integrated care that have emerged which have sufficient integrative power to challenge the organisational distinction of episodic care. This is partly because those arguing for integration do so usually within the episodic paradigm but also because they want to develop a new model of integration without disrupting the old model of episodic care." (Corrigan and Laitner, 2012:4).

201 A study of home care in 31 European countries found that: "In many countries, concerns were raised about the lack of integration between home health care and home social care. Generally, this lack of integration in the delivery of health and social services is also associated with a lack of integration in the needs assessment and monitoring of the quality of services. In almost all countries it is common practice that different types of home care are provided by different organizations or teams. Often, home-care coordination takes place voluntarily and this, by its very nature, puts services at risk. As we have shown, formal coordination between home care and hospital care is stronger than coordination between home care and nursing home/residential care. In some places there are weak links between home health care and home social care. However, there are good examples of integrated care across Europe and these can be drawn on as possible models for developing systems." (Genet, Boerma, Kroneman, Hutchinson and Saltman, 2012:101-102).

202 "Another important area is better co-ordination of care pathways and along the care continuum. In several OECD countries, long-term care is fragmented across care episodes, providers, settings and services. Many OECD countries have set up co-ordination tasks or assigned responsibilities to guide users through the care process. These range from: single point of access to information (e.g., Canada); the allocation of care co-ordination responsibilities to providers (e.g., Australia, France, Sweden) or to care managers (e.g., Japan, Germany, Denmark, the United Kingdom); dedicated governance structures for care co-ordination (e.g., Belgium, the French Caisse nationale de solidarité pour l'autonomie, Japan); the integration of health and care to facilitate care co-ordination (e.g., examples in the United States, Canada and Sweden). Despite these mechanisms, problems of care co-ordination remain. The co-ordination of care within LTC systems and across health and long-term care deserves considerable policy attention in the future. An overall vision of health and long-term care could lead to gains in management." (Colombo, Llena-Nozal, Mercier and Tjadens, 2011, Summary and Conclusions, p.35).

203 Department of Health, 2012a:16.

204 Department of Public Expenditure and Reform, 2011:3.

205 HSE, 2013a:57.

206 Evans, 1998.

207 Reflecting on the UK experience of markets for publicly-funded services, the Professor of Government at University of Manchester noted that "According to one expert about one third of public expenditure on services – or about £80 billion per year – is now outsourced to the mainly private sector "public services industry". But is this evidence-based policy, or just ideological obsession? ... . One of the problems with the rhetoric of competition and outsourcing is that it systematically subsumes two assumptions together: one, that competition is good; and two, that private sector provision is better than public. ... . First, these two policy aims might actually conflict with one another – in practice outsourcing to private suppliers has often led to de facto monopoly provision with no real competition after an initial flurry. The barriers to entry are so high that genuine competition fades away. ... . Second, the assumptions about private sector provision being more efficient are dubious at best. One important strand of research in recent years has been into "public service motivation" ... . What most of this research shows is that public organisations have an advantage over private sector ones because of their intrinsic public service ethos which creates higher levels of commitment ... . So one policy option that would be worth exploring would be to limit public service "markets" to "public interest" organisations (broadly defined). This could provide some (limited) competition while at the same time avoiding the downsides of private sector provision." (Talbot, 2013).

208 O'Dwyer, 1998:38.

209 Freeman & Moran, 2000:55.

210 Paun and Harris, 2012; Gash and Panchamia, 2011.

211 National Economic and Social Council, 2012c:67.

212 "At the moment, there is little firm evidence that care closer to home is cheaper than hospital-based care (although there may be some quality benefits). It would be useful if an authoritative study were undertaken to show how the benefits – including the reduction of costs in acute hospitals – could be derived. This would need to recognise that changes in the way care is delivered should be system-wide" (Harvey, Liddell and McMahon, 2009: 42). One study on the impact and costs of The Marie Curie 'Delivering Choice Programme' in Lincolnshire, England found that "the project in Lincolnshire has significantly increased the proportion of deaths at home and decreased the proportion of deaths in hospital, while keeping the overall combined cost of acute and community care stable for patients receiving palliative care in the last eight weeks of life ... As such, we can conclude that the findings presented here demonstrate that the programme has successfully achieved its objective while not incurring any additional costs on the health care system or indeed incurring any significant overall shifts in costs between the acute and community sectors"' (Addicott and Dewar, 2008: 33). Since then, another review has found that in England, community care is cheaper than acute care, adding that these findings "will only be valuable as a set of working assumptions until such point as they are superseded by more robust findings." (National End of Life Care Programme, 2012:20). A Cochrane review of the effectiveness and cost-effectiveness of home palliative care also found that "evidence on cost effectiveness is inconclusive" (Gomes, Calanzani, Curiale, McCrone, Higginson, 2013:2)

213 National Economic and Social Council, 2012a:8.

214 National Economic and Social Council, 2012a:8.

215 "Fledglings is a not-for-profit, social, franchise-based organisation providing high quality, early years education. ... The Fledglings

initiative was born in 2007. Trained early years educators (many of whom were trained by Fledglings) are supported in setting-up new Fledgling services which operate in a similar fashion to a franchise. ... Each of the eight operational Fledglings services is self-funded and breaks-even from its establishment. Its income is made up of fees paid by parents and the subventions and ECCE contributions made from the State. Some philanthropic funding has been won for additional elements such as parental supports. ... Each centre also pays a franchise fee of 5% of turnover towards central costs. At the target level of franchise operations for 2016 the central costs of the organisation would be met by franchise fees from the 20 Centres." (Forfás, 2013:49; see also www.ancosan.com)

216 One of the recommendations in the Forfás report on social enterprise in Ireland is that the National Procurement Service "consider how best to develop tendering skills as part of capacity building programmes of social enterprises" (Forfás, 2013:6 and 25). Note that Forfás, established in 1994, is Ireland's policy advisory board for enterprise, trade, science, technology and innovation.

217 National Economic and Social Council, 2012a:57.

218 This has been referred to as 'Baumol's disease' which is based on the hypothesis that, as wage levels rise across all sectors of the economy, productivity improvements in services-producing sectors are unlikely to match those in goods-producing sectors, with the result that the relative cost of services gradually rises by comparison with the cost of goods (Baumol, 1967).

219 There is no universally accepted definition of 'quality' in healthcare. However, the following definition, from the US Institute of Medicine, is often used: "[quality is] the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." (Institute of Medicine, 1990:244; see also Health Foundation, 2013:7). The Institute of Medicine has identified six dimensions of healthcare quality: safe; effective; patient-centred; timely; efficient; equitable.

220 Value for money involves more than simply comparing prices; it involves assessing price relative to value, also called value-based pricing. "Outside the area of health policy, value-based pricing happens when a price is set reflecting the value to the customer. ... . In the health sector, the "value-based" terminology blossomed in the 2000's. ... . In a broad sense, "valued-based" means that activities of the health sector should be oriented, organised or funded so that the ultimate objective is to maximise health benefits for patients and the society as a whole. Although this does not sound as if it should be a novelty (has not improving health always been the objective of health systems?), it is, in the sense that it proposes to link payments for pharmaceuticals or health care services to evidence-based assessments of value for patients, their relatives and the society as a whole. But as the increasingly ubiquitous use of the term "value" suggests, "value-based pricing" for pharmaceuticals can also be seen as part of a wider movement in health systems involving health technology assessment, quality of care measurement and pay-for-performance payments for health professionals and institutions. All these policies aim to change resource allocation decisions on the basis of the respective values of health care interventions." (Paris and Belloni, 2013:12).

221 This perspective has been articulated by William Baumol (2012) whose name is associated with 'Baumol's disease' (Baumol, 1967). He argues that human services such as health, education, hospitality, and the arts are already absorbing an increasing share of society's wealth, mainly because the relative cost of goods such as food, cars, computers, etc. continue to fall. It is true that productivity gains are possible in the provision of services but a public policy that is based solely on 'out-sourcing' services from public to private sector runs the risk of reducing the quality and affordability of these services. Baumol writes that 'the true threat' to affordable human services is 'foolish public policy': 'It is clear that if improvements to health care and education are hindered by the illusion that we cannot afford them, we will all be forced to suffer from self-inflicted wounds. The very definition of rising productivity ensures that the future offers us a cornucopia of desirable services and abundant products. The main threat to this happy prospect is the illusion that society cannot afford them, with resulting political developments – such as calls for reduced governmental revenues with demands that budgets always be in balance – that deny these benefits to our descendants.' (ibid:181-182).

222 The concept of staff capacity refers to the knowledge, skills and competence required to practice in an area of work. In this understanding, staff capacity involves having appropriate knowledge (based on what is known and the limits of what is known in that field), using appropriate skills (such as having the tools required for the task and knowing how and when to use them), and acting with competence (notably the capacity to act in different roles and contexts, with insight to self and others, and learning continuously from experience). This understanding of staff capacity is informed by the framework used by FETAC (Further Education and Training Awards Council) and HETAC (Higher Education and Training Awards Council) to validate its education and training courses. Since 2012, a new body called "Quality and Qualifications Ireland" (QQI) has taken over this responsibility by integrating within itself, FETAC and HETAC along with NQAI (National Qualifications Authority of Ireland) and IUQB (Irish Universities Quality Board) (www.qqi.ie).

4

Estimating Demand for Services for Older People

4.1 Introduction

The purpose of this chapter is to establish the level of need and demand for services for older people, including likely demand in the future. As explained in the Introduction, the term 'demand' as used here has both a wide and a narrow meaning. In its widest sense, demand is synonymous with need, both met as well as unmet, irrespective of whether it is met formally through payment or entitlement, or informally through the care of family and friends. In its narrow sense, demand refers to services that people are able and willing to pay for or have an entitlement to receive. We begin by using demand in its narrow sense in order to establish the number of older people who currently receive a service (Section 4.2) and, on that basis, estimate the likely future demand (Section 4.3). We also assess the demand which arises from delayed discharges from hospital (Section 4.4). Turning to demand in the broader sense we assess the level of unmet need which arises when older people are known to have needs but receive no service (Section 4.5). Specifically, we assess unmet demand from the following sources: dementia (Section 4.6), disability (Section 4.7), social isolation and loneliness (Section 4.8) and carer needs (Section 4.9. The chapter concludes with a summary of current and likely future demand for services for older people, some of which could be addressed by the proposed social enterprise (Section 4.10).

4

Estimating Demand for Services for Older People

4.2 Current Demand for Services for Older People

Current demand for services for older people, based on the HSE's 2013 National Service Plan, is summarised in Table 4.1. This shows that approximately 20% of the population aged 65+ is in receipt of a service, equivalent to 105,093 persons. The majority of these receive community-based services (78%), notably HCPS, HHS and Day care. A minority (4.3%) are in residential care but, as already observed, these account for 72% of the HSE budget for services for older people.

As indicated above (Section 1.4), the purchaser/provider split is well advanced in services for older people, with about half of all services commissioned from private providers (49%), over a third delivered directly by the HSE (37%), and the remainder provided by the not-for-profit sector (14%). This suggests that there is scope to increase the share of voluntary provision through the type of social enterprise that is proposed; this could involve reducing direct provision or outsourcing to private providers, or a combination of both.

A minority (4.3%) are in residential care but... these account for 72% of the HSE budget for services for older people

4.3 Future Demand for Services for Older People

Future demand for services for older people is determined by two core sets of projections: (i) the population aged 65+ and (ii) the utilisation rate of services by the population aged 65+. Both sets of projections, in turn, build on wider assumptions about the future. For example, the projected population aged 65+ depends on the demographic components of births, deaths and migration while the utilisation rate depends on the projected level of need associated with disability, age, gender, other personal circumstances (such as income, living alone, loneliness, remoteness, etc), availability of services, eligibility for services as well as informal care provided by family and other carers.

For the purposes of assessing the national business case for the social enterprise, we estimate projected future demand for services for older people based on: (i) CSO population projections 2016-2046[223] and (ii) HSE utilisation rates in 2013 for residential long-term care (NHSS) and community long-term care (HCPS & HHS)[224], assuming these rates will remain constant until 2026.

As noted earlier (Section 2.2), demographic projections for Ireland indicate that the population aged 65+ is expected to grow, both in absolute terms and as a proportion of the population, creating pressures on the health and social care system which are beyond its current capacity to withstand. Tables 3.2a and 3.2b summarises the population aged 65+ and 85+ in 2011, with 5-year-interval projections from 2016 to 2046, based on CSO population projections for this period[225]. The CSO projections are based on six different

Table 4.1
Clients of HSE Services for Older People, 2013

Budget Heading	Clients		(iii) % Pop 65+
	N	%	
1. NHSS: Nursing Home Support Scheme (i)	22,761	22	4.3
2. OP Services of which (i):		78	
2.1 HCPS: Home Care Packages Scheme(ii)	10,870		2.0
2.2 HHS: Home Help Scheme (ii)	50,002		9.3
2.3 Day Care + Other (ii)	21,460		4.0
Total	105,093	100	19.6

Sources: (i) Health Services Executive, 2013a:57; (ii) The budget is estimated based on data in EPS Consulting, 2013:9; the number of clients is based on Health Services Executive, 2013a:60; (iii) Central Statistics Office, 2012a. Notes: There may be some double-counting of clients since some Day Care clients may also be in receipt of HCPS and HHS.

Table 4.2a
CSO Population Projections, 2016-2046: Population Aged 65+

Year	Total Pop (000)	Pop 65+ (000)	Change in Pop 65+ (000)	% Change Pop 65+	Pop 65+ as % of Total Pop	Inverse Dependency Ratio*
2011	4,574.9	531.6			11.6	5.8
2016	4,669.0	623.8	92.2	17.4	13.4	4.8
2021	4,778.0	729.3	105.5	16.9	15.3	4.1
2026	4,852.1	849.6	120.3	16.5	17.5	3.6
2031	4,893.7	982.4	132.8	15.6	20.1	3.1
2036	4,932.3	1,118.4	136.0	13.8	22.7	2.7
2041	4,970.8	1,257.9	139.5	12.5	25.3	2.3
2046	4,997.4	1,392.2	134.3	10.7	27.9	2.0
2011-2046 change	422.5	860.6	860.6	161.9	-	-
Average annual change	12.07 (0.26%)	24.5	-	4.6%	-	-

* The inverse dependency ratio which is the number of people aged 15-64 for each person aged 65+.

Table 4.2b
CSO Population Projections, 2016-2046: Population Aged 85+

Year	Pop 65+ (000)	Pop 85+	Change Pop 85+ (000)	% Change Pop 85+	Pop 85+ as % of Total Pop (000)
2011	531.6	58.2			1.3
2016	623.8	69.9	11.6	19.9	1.5
2021	729.3	84.8	15.0	21.5	1.8
2026	849.6	103.6	18.8	22.1	2.1
2031	982.4	134.7	31.0	29.9	2.8
2036	1,118.4	176.2	41.6	30.9	3.6
2041	1,257.9	216.8	40.5	23.0	4.4
2046	1,392.2	259.7	42.9	19.8	5.2
2011-2046 change	860.6		201.4	346.2	-
Average annual change	24.5	-	5.8	9.9%	-

Sources for Tables 4.2a and 4.2b: CSO Population and Labour Force Projections 2016-2046. Note that this table is based on one of the six scenarios projected by the CSO (referred to as M3F2) and involves the assumption of low fertility (F2) and continued negative migration (M3).

Table 4.3
Projected Changes to HSE Services for Older People, 2013-2026

Services for Older People	2013	2016	2021	2026
Population 65+ (000) (2011 figure)	531.6*	623.8	729.3	849.6
Increase since 2011 + (000) (N)	-	92.2	197.7	318.0
Increase since 2011 (%)	-	17.3	37.2	59.8
NHSS at 4.3% of 65+ + (000)	22.9	26.8	31.4	36.5
Increase in NHSS clients since 2013 + (000) (N)	-	4.0	8.5	13.7
Increase in NHSS clients since 2013 (%)	-	17.3	37.2	59.8
Increase in NHSS budget since 2013 (€m)	998.0	173.1	371.2	597.0
Projected NHSS budget (€m)	998.0	1,171.1	1,369.2	1,595.0
HCPS at 2.0% of 65+ + (000)	10.6	12.5	14.6	17.0
Increase in HCPS clients since 2013 + (000) (N)	-	1.8	4.0	6.4
Increase in HCPS clients since 2013 (%)	-	17.3	37.2	59.8
Increase in HCPS budget (€m)	130.0	22.5	48.3	77.8
	130.0	152.5	178.3	207.8
HHS at 9.3% of 65+ + (000)	49.4	58.0	67.8	79.0
Increase in HHS clients since 2013 + (000) (N)	-	8.6	18.4	29.6
Increase in HHS clients since 2013 (%)	-	17.3	37.2	59.8
Increase in HHS budget (€m)	190.0	33.0	70.7	113.7
Projected HHS budget (€m)	190.0	223.0	260.7	407.3
Day Care at 4.0% of 65+ + (000)	21.3	25.0	29.2	34.0
Increase in Day Care clients since 2013 + (000) (N)	-	3.7	7.9	12.7
Increase in Day Care clients since 2013 (%)	-	17.3	37.2	59.8
Increase Day Care budget (€m)	72.0	12.5	26.8	43.1
Projected Day Care budget (€m)	72.0	84.5	98.8	115.1
Total clients + (000) (N)	104.2	122.3	142.9	166.5
Total budget (€m)	**1,390.0**	**1,631.1**	**1,906.9**	**2,325.1**

Sources: CSO Population and Labour Force Projections 2016-2046; HSE National Service Plan, 2013:57-61. *2011 Census of Population

scenarios (high and low fertility; high and low positive net migration, continued negative migration). Given that uncertainty surrounds each scenario, we adopt the forecast of least population increase – described by the CSO as 'the most pessimistic scenario (M3F2)'[226]– based on low fertility (F2) and continued negative migration (M3). The purpose of adopting this scenario is simply to illustrate the minimum likely future requirements for services for older people. Even if future population exceeds this lowest possible estimate, services for older people must at least meet this minimum basic level of demand, if current levels of service provision are to be maintained.

As shown in Tables 4.2a and 4.2b, the population aged 65+ is projected to grow at an annual average of 5% over the next 35 years compared to about 10% for the population aged 85+; this is much higher than the 0.25% annual growth rate for the entire population. This means that the population aged 65+ is expected to grow by 24,500 each year between 2011 and 2046, with annual increases of 5,800 in the population aged 85+. This is a radical shift in the demographic structure of the population, amounting to a total increase of 860,700 older people between 2011 and 2046. The growth rate in the population aged 65+ is relatively constant over most of this period until 2036, but quickens in the decade to 2046. As indicated, these growth patterns are even more pronounced for the population aged 85+[227], though somewhat less rapid compared to other OECD[228] and EU[229] countries. In summary, CSO projections indicate a substantial ageing of the Irish population. Given that other OECD-EU countries are experiencing even more substantial population ageing, it has been observed that across the EU "the shape of the population pyramid gradually changes, increasingly resembling a pillar"[230].

It is also important to note that utilisation is not the same as either need or demand, unless it is based on a robust needs assessment, coupled with availability and eligibility for those who need them. This is a recognised area of weakness in current services for older people[231] which is being rectified by HSE through the introduction of SATIS (Standardised Assessment Tool Information System) which will "considerably improve the rigour of decisions made regarding provision of resources under the Nursing Home Support Scheme (NHSS), the Home Care Package Scheme (HCPS) and Home Help Services"[232]. In light of this, current utilisation rates may not be an entirely accurate guide to future utilisation rates.

From the perspective of the social enterprise, this implies that hospital groups may enter into contractual arrangements with other providers to deliver primary and continuing care to their patients

Based on these assumptions, however, Table 4.3 shows that over the next 13 years (2013-2026), the number of people in residential long-term care is likely to grow by 13,772 which is equivalent to an average of about 1,000 new clients each year, resulting in an increase in the NHSS budget of €604 million during this period. Similar increases, based on the same conservative population projections and unchanged utilisation rates, are projected for community-based services. Overall, the number of people using services for older people will increase from 105,093 in 2013 to 166,522 in 2026 (not taking account of some double counting that may arise from people using two of these services such as HHS and Day Care). The budget to support these services will increase from €1.4 billion in 2013 to €2.2 billion in 2026, an increase of 60%, or about 5% per annum.

These projections are similar to a more elaborate projection study of long-term care demand in Ireland[233], albeit based mainly on 2006 data. Our projected demand for NHSS is quite similar[234], but projected demand for HCPS & HHS is higher due to the higher service utilisation rates which we have used[235]. From the perspective of the national business case for the social enterprise, our estimates clearly indicate that a substantial opportunity exists to contribute to meeting the growing demand for services for older people, both within the existing budgetary framework of HCPS and HHS, but also through more innovative configurations of services, including the use of NHSS for a wider range of services to support older people to live at home.

4.4
Demand Arising from Reducing Delayed Discharges in Acute Hospitals

We have seen in Chapter Two that the system of support and care for older people in Ireland is not as efficient as it could be. One example of this is where patients remain in hospital after their treatment has finished, usually referred to as 'delayed discharge'. Delayed discharges, which are formally defined as: "patients who have completed the acute phase of their care and are medically fit for discharge"[236], could be a significant source of demand for the proposed social enterprise – and other providers of social care – by working collaboratively with hospital groups. This would involve developing and implementing care plans for patients who cannot be discharged and offering more seamless and safe transitions between hospital, home, convalescent home or nursing home, given that these patients are likely to need more intensive and sustained support compared to the average service user in the community. This type of 're-ablement service' is used in England[237] and has been shown to improve quality of life by comparison with conventional home care services[238]. Although it is not cheaper[239], it has wider systemic benefits in terms reducing the number of people on waiting lists who need access to acute hospital beds.

As indicated, the reconfiguration of Ireland's hospital system into six hospital groups is part of a more ambitious systemic reform of the health service which, to be effective, will require improved linkages with primary care, including services for older people. The report setting out the transition to six hospital groups makes numerous references to the expectation that "up to 95% of care can, in future, be delivered in the community"[240]. From the perspective of the social enterprise, this implies that hospital groups may enter into contractual arrangements with other providers to deliver primary and continuing care to their patients. This is a source of effective demand for the social enterprise and essential to the integration of primary, continuing and hospital care: "The integration between primary care and hospital care is vital in the implementation of hospital groups. Groups should be managed so that they enable and encourage this movement, working in close synergy with their colleagues in primary care as well as within and between hospital groups. How they are managed and run must acknowledge the direction of travel for healthcare across the developed world, where in the future most healthcare

will be delivered outside traditional hospital settings. Hospital group management will have to be familiar with and responsive to the frameworks being put in place to address social care needs, and the experience of implementing Fair Deal[241] should be built upon. Good relationships with social care providers are clearly essential. Arrangements for cross financing between hospital groups and social care providers, if required, will need to be clarified by the Department of Health to ensure a transparent business-like relationship, with sensitive well-targeted service provision. It is essential that hospital group operational policies are such that hospitals can work in close synergy with the social care providers, recognising and responding appropriately to the individual care plans that will guide the provision of services to patients in this area. The response of hospital groups to these requirements will be a component of the evaluation of the performance of hospital groups as part of the process of seeking trust status."[242]

Table 4.4 summarises the number of 'days lost' through delayed discharges in Ireland's acute hospitals in 2012. This shows that the number of hospital days involved is substantial (243,673), as is the overall cost (€343m). Under existing funding arrangements, hospitals do not have a clear financial incentive to reduce or eliminate delayed discharges, but this will change under the new system of hospital financing. In the new system, to be implemented from 2014[243], hospitals will be paid for each episode of care on the basis of 'best practice prices' so that "hospitals are actually paid for the care they deliver rather than receiving a historically determined block grant"[244] and "money can follow the patient out of hospital settings where appropriate and towards the provision of safe, timely treatment in primary care"[245]. One of the consequences of this is that hospital groups will have a clear incentive to reduce or eliminate delayed discharges by funding and/or facilitating less costly alternative arrangements for the provision of care.

Addressing delayed discharges is an essential part of improving hospital efficiency, but can only be achieved in collaboration with providers such as the proposed social enterprise. This will require the type of innovation envisaged by proposals for public sector reform and highlighted in the HSE's 2013 National Service Plan: "In order to meet increasing population need and deliver sustainable services within available resources, innovative models of care are required to further advance the development of equitable integrated care for older people across community-based services, intermediate care options and quality long term residential care services (supported by a robust and well-funded scheme - presently the NHSS)."[246]

Table 4.4
Number and Cost of Delayed Discharges from Acute Hospitals, 2012

Delayed Discharges (DDs)	Dublin Academic Teaching Hospitals*	Other Acute Hospitals	All Acute Hospitals
Total Days Lost (i)	130,643	113,030	243,673
Cost per Day (ii)	1,917	825	-
Total Cost (€million)	250.4	93.2	343.7
Total Cost (%)	73	27	100
% DDs aged 65+ (i)	86	87	87

Sources: (i) HSE, Business Intelligence Unit, Personal Communication, July 2013. Note that the number of delayed discharges is not the same as the number of patients (ii) PA Consulting Group, 2007:155.
*Dublin Academic Teaching Hospitals (DATHs) Group comprises: Tallaght Hospital, James's Hospital, Beaumont Hospital, Mater Hospital and Vincent's Hospital.

4.5 Unmet Demand

Unmet demand arises where an underlying need is not satisfied because the care is not available or accessible. More specifically, unmet demand occurs where service availability is 'resource-limited' rather than 'demand-led'. Resource-limited services, as we use the term, are provided up to the budgeted allocation of resources, and include all current services for older people (NHSS, HCPS, HHS, Day Care). By contrast, demand-led services are provided even if the budgeted allocation of resources is exceeded, such as GP services for Medical Card holders. Demand-led services, which are more the norm in health services in other EU countries, particularly for home care services[247] are destined to increase with the introduction of Universal Health Insurance in 2016 and the extension of Medical Cards to the entire population[248], creating new cost containment challenges[249].

Given that services for older people, as currently organised, are resource-determined, there is likely to be a growing level of unmet need for services for older people. This arises because rising demand associated with population ageing is not matched by a corresponding increase in services. For example, the 2013 HSE budget (€13.4billion) is 22% less (€3.3 billion) than in 2008[250], with corresponding reductions in services and increases in waiting times for these services.

Table 4.5
Projected Prevalence of Dementia in Ireland, 2011-2046

Year	Population Total (000) (i)	Population 65+ (000) (i)	Dementia @ 8.2% of pop 65+ (000) (ii)
2011	4,588.3	531.6	43.6
2016	4,669.0	623.8	51.2
2021	4,778.0	729.3	59.8
2026	4,852.1	849.6	69.7
2031	4,893.7	982.4	80.6
2036	4,932.3	1,118.4	91.7
2041	4,970.8	1,257.9	103.1
2046	4,997.4	1,392.2	114.2
actual change 2011-2046	409.2	856.8	70.3
% change 2011-2046	8.9	160.0	160.0
% annual change 2011-46	0.3	4.6	4.6

Sources: (i) CSO Population and Labour Force Projections 2016-2046. Note that this table is based on one of the six scenarios projected by the CSO (referred to as M3F2) and involves the assumption of low fertility (F2) and continued negative migration (M3). (ii) Cahill, O'Shea and Pierce, 2012:32, Table 2.4. This is based on European (EuroCoDe) age-specific and gender-specific prevalence rates for dementia.

This is a general indicator of unmet demand. In the remainder of this chapter we examine some indicators of unmet demand arising from: (i) dementia; (ii) disability; (iii) reduced quality of life; and (iv) carers. This analysis is designed to illustrate the possible scope of unmet demand and, although estimates of its scale are provided, we are not currently in a position to provide a definitive assessment of unmet need.

4.6 Dementia and Unmet Demand for Services

The programme for government (2011-2016) contains a commitment to develop a national dementia strategy by 2013[251]. In preparation for this, a comprehensive review of research has been carried out[252] as well as a public consultation[253]. Given that the risk of dementia increases exponentially with age, and given that the population is ageing, dementia is set to become a 'worldwide epidemic'[254], unless a cure is found. The overall prevalence of dementia amongst those aged 65+ in Ireland, based on European rates, is 8.2%[255], with a pronounced age and gender gradient as illustrated in Figure 2.3 (presented in an earlier chapter).

Applying this overall prevalence of dementia to the current and projected population aged 65+ in Ireland, Table 4.5 indicates that the number of persons with dementia is likely to more than double (160%) over the next 35 years (2011-2046), equivalent to an annual increase of about 5%. This is lower than earlier estimates, which were based on more optimistic demographic assumptions[256] and, in any case, the estimates in Table 4.6 are only intended to underline the substantial service requirement which are likely to arise from dementia over the next three decades[257].

The majority of people with dementia (63%) live in the community and are cared for by family and friends, with most of the remainder (34%) in long-stay residential care[258]. Compared with other caring roles, it is generally recognised that caring for a person with dementia places much greater demands and strain on family members, depending on the symptoms (which can include repeated questioning, agitation, wandering, paranoia, hallucinations, delusions, sleep disturbance and resistance to care).

Compared with other caring roles, it is generally recognised that caring for a person with dementia places much greater demands and strain on family members, depending on the symptoms (which can include repeated questioning, agitation, wandering, paranoia, hallucinations, delusions, sleep disturbance and resistance to care)

Funding systems for older people in Ireland, and for dementia in particular, tend to favour residential over community care. A recent review noted that: "In the absence of the required level of community support, people with dementia will be placed in long-term care prematurely. The absence of entitlement to home care services has been identified as a potential barrier to living at home and the main reason why some people with dementia can no longer live in the community... The demand for statutory provision seems

to be the only way to ensure that additional resources will be allocated to home care in light of competing demands, but it will be costly requiring additional resources or the redeployment of existing budgets."[259] Moreover, even within the realm of long-stay provision, there are relatively few alternatives to the nursing home model for older people with dementia[260].

It has been estimated that the annual cost per person of dementia in Ireland is €40,500, nearly half of which is borne by family and friends (48%)[261]. By comparison with other diseases, dementia is associated with 'a relatively high economic burden'[262]. At the same time, the annual cost of dementia is less than the annual minimum cost of long-stay care (€45,000-50,000) and, as the recent review suggests, "spending on one person with dementia in the community can reach €50,000 per annum before institutional funding thresholds are reached"[263].

The development of community-based services requires the necessary skills (occupational therapists, social workers, physiotherapists, speech and language therapists) and facilities (day care centres), working to an agreed case management system to support the person and family. A 'dementia champion' is also recommended to assist and support people in their journey through the disease trajectory[264].

The social enterprise which is proposed will contribute to the development of community-based services for persons with dementia and their families. This is already the direction of developments in the field of health service reform and is likely to be a central focus of the forthcoming dementia strategy. The recent review of research which was prepared to support development of the strategy pointed decisively in this direction: "In simple language, we are not doing enough for people with dementia living at home in the community. It seems to be administratively and politically easier to fund buildings and new health technologies than it is to support the development of personal services for older people with dementia. That must change if we want genuine transformation in the way we look after people with dementia in this country. ... New investment in community-based facilities and services will yield significant returns. For example, day care and respite facilities are highly valued by those that have access to them currently, but there are not enough of them, and even where they do exist not all of them provide dementia–specific care in appropriately designed buildings. ... Funding through the residential NHSS should not be released for any applicant unless it has been shown that a similar allocation could not be used to support home care alternatives for that person. Furthermore, given what could be achieved through interventionist case management, integrated delivery and innovative psychosocial programmes, all of which can be delivered at relatively low cost, the development of a world class community-based care is not an unrealistic goal. This is what we should be aiming for in the medium-term of three years. As part of this process, local communities should be mobilised to provide moral and practical support for people with dementia and their carers living at home."[265]

> Living alone has been found in the TILDA analysis to exercise a significant influence on whether a person receives formal care which suggests that isolation and loneliness may be areas of need for some older people

4.7 Disability and Unmet Demand

An indicator of unmet demand is the proportion of persons with a disability who are not receiving care, either formal or informal. In the TILDA survey, disability is defined on the basis of reported difficulties in carrying out activities of daily living (ADL) or instrumental activities of daily living (IADL)[266]. ADL refers to basic tasks of everyday life pertaining to personal care, such as eating, bathing, dressing, toileting, and moving about, sometimes defined as "activities which people perform habitually and universally"[267]. IADL refers to activities performed by a person in order to live independently in a community setting, such as managing money, shopping, using the telephone, housekeeping, preparing meals and taking medications correctly.

Based on this definition, Table 4.6 summarises evidence from TILDA showing that 13% of the population aged 50+ have a disability (ADL and/or IADL) which is significantly less that the corresponding figure in the 2011 census (27%), although the latter is based on a wider definition of disability[268]. Table 3.9 also shows that more than a tenth (12%) of those who have both ADL and IADL difficulties do not receive help from any source, formal or informal. This led the authors to comment that "these people constitute a potentially very vulnerable group"[269]. As with all forms of ADL and IADL, disability increases with age, is higher among those living alone and much higher among those who are widowed as well as those with low education[270]. If this rate of unmet need (12%) is applied to the population aged 65+ (531,600) who have both ADL and IADL (4.2%), it suggests that 2,679 older people may have an unmet need for care.

Table 4.6
Prevalence of Disability and Their Carers, Persons Aged 50+ in Ireland, 2009-2011

Primary Carer of Persons 50+	No Disability %	ADL only %	IADL only %	ADL+IADL %
% disability	87.1	4.8	3.9	4.2
No one / no help	95.3	83.0	26.0	12.0
Spouse		13.0	28.0	33.0
Child		3.5	26.0	31.0
Other relative		0.0	5.0	3.0
Non-Family (Paid+Unpaid)	4.7*	0.5	14.0	20.0
Total	100.0	100.0	100.0	100.0

Source: TILDA: The Irish longitudinal Study of Ageing (Barrett, Savva, Timonen and Kenny, 2011:216-217; Kamiya, Murphy, Savva and Timonen, 2012:4; also Wren, Normand, O'Reilly, Cruise, Connolly and Murphy, 2012:63).
Notes:
(i) 'The category "non-family members" includes both informal carers such as neighbours and friends and formal carers such as those paid privately, those paid by the state and those provided by non-profit bodies.' (Barrett, Savva, Timonen and Kenny, 2011: 217).
(ii) 'The vast majority of all carers (89.5%) were identified as unpaid informal carers. Only 10.5% (n=107) of all carers received payment for the care provided. A range of publicly funded financial supports are available to informal carers through the Department of Social Protection. These financial supports are available to carers providing care to individuals of all ages.' (Kamiya, Murphy, Savva and Timonen, 2012:18).

4.8 Social Isolation, Loneliness and Unmet Demand

Unmet demand can also arise where people experience reduced quality of life due to social isolation and loneliness. The relationship between objective indicators of social isolation (such as living alone) and subjective indicators such as loneliness or feeling unsupported is not straightforward. Results from TILDA indicate that "60% of people who are 'objectively' socially isolated state that they never feel isolated"[271]. At the same time, evidence from TILDA indicates that a minority of those in receipt of formal home care (5%), while not having difficulties with either ADL or IADL, have other characteristics which trigger a need for care such as poorer health[272], loneliness[273] or living alone[274]. Living alone has been found in the TILDA analysis to exercise a significant influence on whether a person receives formal care which suggests that isolation and loneliness may be areas of need for some older people[275].

> Addressing social isolation involves cultivating, wherever possible, the person's naturally occurring social relations as well as community-based interventions, since these are likely to be more effective than the kindness and befriending of professionals

The prevalence of loneliness in the Irish population is not reported in the TILDA reports. If the prevalence is estimated to be around 5% – this being at the lower end of loneli ness

Table 4.7
Estimated Number of Persons Experiencing Social Isolation and Loneliness in Ireland, 2011

Year	Population (000)
Population 65+ (i)	535.4
Population 65+ Living in communal establishments (i)	31.1
Population 65+ Living in Private households (i)	504.3
Population 65+ experiencing loneliness @ 5% of total (ii)	25.2

Sources: (i) Central Statistics Office, 2012a. Census 2011 Results: Profile 8 Older and Younger; (ii) Windle, Francis and Coomber, 2011; Local Government Association, 2013.

Table 4.8
Estimated Number of Carers of Persons Aged 65+ With Caregiver Strain in Ireland, 2009

Year	Population (000)
Population 65+ (i)	535.4
Population 65+ Living in communal establishments (i)	31.1
Population 65+ Living in Private households (i)	504.3
Population 65+ who have carers @ 20% of total[287] (ii)	100.8
% carers experiencing caregiver strain @ 27% of all carers (iii)	27.2

Sources: (i) Central Statistics Office, 2012a. Census 2011 Results: Profile 8 Older and Younger; (ii) TILDA (Barrett, Savva, Timonen and Kenny, 2011:216-217; Kamiya, Murphy, Savva and Timonen, 2012:4). (iii) Central Statistics Office, 2010b. Quarterly National Household Survey: Carers, Quarter 3 2009.

prevalence among persons aged 65+ in England (5%-16%)[276] – and applied to the population aged 65+ living in private households, as in Table 4.7, it suggests that 25,000 older people in Ireland may experience loneliness.

Social isolation, of which loneliness is a subjective manifestation[277], is known to have negative consequences for quality of life and mortality. A meta-analytic study of the impact of social relationships (measured using objective as well as subjective indicators) on mortality, based on a synthesis of 148 separate studies, found that "individuals with adequate social relationships have a 50% greater likelihood of survival compared to those with poor or insufficient social relationships. The magnitude of this effect is comparable with quitting smoking and it exceeds many well-known risk factors for mortality (e.g., obesity, physical inactivity)."[278] This suggests that substantial benefits are likely to follow from addressing social isolation and loneliness, particularly where there is a co-occurrence of both its objective aspects (such as living alone) and subjective aspects (feeling lonely).

This is an area of unmet need that could be addressed through the proposed social enterprise, particularly in light of its focus on developing person-centred, community-based supports and services. Addressing social isolation involves cultivating, wherever possible, the person's naturally occurring social relations as well as community-based interventions, since these are likely to be more effective than the kindness and befriending of professionals[279].

4.9 Carer Needs and Unmet Demand

The needs of carers who provide unpaid and 'informal' care for older people are a source of unmet demand. This group, as defined by the CSO[280] and the National Carers Strategy[281], comprises persons who give regular unpaid personal help to a friend or family member with a long-term illness, health problem, disability or with problems due to old age. The TILDA data summarised in Table 3.9 shows that most care for older people is unpaid and informal, provided by the spouse or child of the older person. Only a tenth of all carers (10%) receive payment for the care provided and these are much more likely to be non-family members[282]. In light of the importance of carers to supporting vulnerable older people, and without discounting the intrinsic benefits of caring for carers[283], their own needs also merit consideration. Providing support for carers has been described as a 'three-win arrangement' because it benefits carers, those being cared for, and the government who may otherwise have to pay the higher costs of formal care[284].

In 2009, the CSO carried out a special survey of carers and found that a significant minority of carers (21%) provide care for 57+ hours per week, particularly those assisting a person in the same household, and over a quarter of all carers (27%) were experiencing 'caregiver strain' based on the Caregiver Strain Index[285]. Table 4.8 applies this rate of caregiver strain to the population in private households aged 65+ who have carers (estimated at 20%), to produce an estimate of over 27,000 carers who may have an unmet need for support. This level of need is also an opportunity for the social enterprise to develop supports for carers building on the national carers strategy and the recognition that "helping carers is one of the most effective ways of helping those in receipt of care"[286].

4.10 Summary

This chapter has shown that there is substantial demand for the services which the proposed social enterprise seeks to provide. As a result of population ageing, demand for services for older people is likely to grow in coming years. The two main sources of current demand are existing services for older people and demand arising from the need to reduce delayed hospital discharges. Our analysis also suggests that there may be substantial unmet demand for services arising from dementia, disability, social isolation/loneliness and the needs of carers. From a business perspective, therefore, it is clear that the proposed social enterprise is entering a market where there is a large and growing demand for services for older people, many of which are covered by publicly-funded schemes or have the potential to attract public funding.

Footnotes

223 Central Statistics Office, 2013.
224 HSE, 2013a:57-60.
225 Central Statistics Office, 2013.
226 Central Statistics Office, 2013:33. Note however that there is almost no difference in the size of the projected population aged 65+ under any of the scenarios up to 2016; by 2021 the difference between the highest and lowest estimates of population aged 65+ is about 5,000; by 2031 the difference between the highest and lowest estimates of population aged 65+ is about 20,000; by 2041 the difference between the highest and lowest estimates of population aged 65+ is about 40,000 (Central Statistics Office, 2013:Tables L and P, pp27 and 32).
227 For example, between 2006 and 2011, the proportion of those aged 85+ in Ireland grew twice as fast as those aged 65+ (Department of Health, 2012c:5).
228 OECD forecasts that the percentage of those aged 80 and over is likely to more than double from 4% in 2010 to nearly 10% in 2050 in OECD countries (Colombo and Mercier, 2011:3).
229 EU Commission, 2012:26.
230 EU Commission, 2012:26.
231 This was highlighted in an audit of assessments for the Nursing Home Support Scheme using the Common Summary Assessment Report (HSE, 2011). The findings of that audit revealed that a substantial proportion of those deemed eligible for NHSS – and therefore eligible for admission to a nursing home - did not have the highest levels of dependency and only a minority (18%) were known to have been considered for a Home Care Package As the report concludes: "the audit has certainly highlighted two potentially serious issues i.e. the approval of persons for long term care although they are not falling into the maximum dependency category and secondly the availability of Home Care Packages and how these are being used to support people and prevent them requiring long term care." (HSE, 2011:17).
232 HSE, 2013b:4. SAT is based in part on the InterRAI suite of assessment tools (www.interrai.org) plus a carer assessment and will be part of an computerised system called SATIS (Standardised Assessment Tool Information System).
233 Wren, Normand, O'Reilly, Cruise, Connolly and Murphy, 2012.
234 The Wren et al study estimates that the annual average increase in residential long-term care between 2016 and 2021 will be in the range 1,103-1,054, compared to our estimate of 1,059 over a longer period, 2013-2026 (Wren, et al, 2012:104, Table 8.6).
235 The Wren et al study estimates that the annual average increase in formal home care (HCPS & HHS) between 2016 and 2021, based on utilisation rates in the range 8.9% to 10.5%, will be in the range 2,122-2,508, compared to our estimate of 2,702 over a longer period, 2013-2026 (Wren, et al, 2012:108, Table 8.9).
236 HSE, 2013b.
237 "English adult social care departments are developing short-term, specialist home care re-ablement services. Re-ablement is a particular approach within home care; it supports users in developing confidence and relearning self-care skills, thereby increasing their independence. Providing equipment for use at home is an important part of re-ablement. Many re-ablement services started as selective schemes, primarily for people discharged home from hospital or recovering from an illness or accident. However, the approach is increasingly being extended to most people eligible for adult social care and referred for home care support. Re-ablement is usually offered for up to six weeks; after this, some people may require no further support while others will be referred for conventional home care." (Glendinning, et al, 2010:viii-ix).
238 "Re-ablement had positive impacts on users' health-related quality of life and social care-related quality of life up to ten months after re-ablement, again in comparison with users of conventional home care services." (Glendinning, et al, 2010:viii)..
239 "Taking total healthcare, social care and re-ablement costs together, there was no statistically significant difference in the costs of all the services used by the re-ablement and comparison group over the 12 month study period." (Glendinning, et al, 2010:viii).
240 Department of Health, 2013b:13; also pages 2, 9, 39. Four categories of hospital are distinguished based on type of activity. Model 1 hospitals are community hospitals and are not part of any hospital group. Model 2 provides the majority of acute hospital activity. Model 3 provide 24/7 acute surgery, acute medicine, and critical care. Model 4 is similar to Model 3 but also provides tertiary care and, in certain locations, supra-regional care. Models 2-4 must operate within a hospital group. (See also Department of Health, 2013c:8-9).
241 The Nursing Homes Support Scheme, 'A Fair Deal' began on 27th October 2009. The purpose of the Scheme is to provide financial support for people assessed as needing long-term nursing home care. The scheme is founded on the core principles that long-term care should be affordable and that a person should receive the same level of State support whether they choose a public, voluntary or private nursing home. Since 27th October 2009, the Nursing Homes Support Scheme is the single funded means of accessing long-term nursing home care for all new entrants.
242 Department of Health, 2013b:11.
243 Department of Health, 2013:9.
244 Department of Health, 2013:10. The proposed structure for implementing this would involve separate entities for price-setting and commissioning: "it is proposed that the price-setting function should be independent of the purchasing function even within the interim system. This is considered important in terms of the integrity of the process and ensuring support and buy-in from the hospital system. It is, therefore, suggested that the price-setting function would be absorbed into a National Information and Pricing Office with multi-stakeholder oversight and strong clinical representation, while the purchasing function would be built up from within the HSE prior to creating an independent statutory commissioner." (Department of Health, 2013:44).
245 Department of Health, 2013:65.
246 HSE, 2013a:57.
247 "One of the resounding weaknesses of Irish home care services compared with those developed and delivered in other countries (such as the UK, Norway, Sweden, Denmark, France and Australia) is that these services are not underpinned by legislation and are not provided on a statutory basis. Accordingly, there is no onus on LHOs to provide services to people in need. On the demand side, lack of knowledge and confusion about entitlements to services combine to exacerbate supply-side inadequacies leading to significant gaps in home care service provision to people in need. There are also gross inequities across the country in relation to service availability with considerable variation in the type and amount of home care services available" (Cahill, O'Shea and Pierce, 2012:82).
248 The extension of Medical Cards to everyone under Universal Health Insurance is a significant policy change and "will lead to substantially increased demand for GP services. Since around half of those over 50 currently have medical cards, the change in entitlement would lead to more than one million additional visits to primary care by those over 50 years. There might also be some increase in hospital outpatient visits, admissions and longer lengths of stay." (McNamara, Normand and Whelan, 2013:18). This assessment is based on analysis of the TILDA data: "Our result shows that people over 50 years of age with medical cards have an additional two GP visits annually compared to those without medical cards. People in these age groups typically visit the GP 3.9 times annually. Those with medical cards are much more likely to have an overnight stay in hospital and to have an outpatient visit (around 0.4 visits per year), and those admitted to hospital have a longer length of stay (approximately 0.7 extra nights per year)." (ibid.) This study also found that usage of Home Help Service was six time more likely for those with a Medical Card after controlling for health need (ibid.).
249 In the Netherlands, for example, where there is an entitlement to home care for those who qualify, there are "tensions between guaranteeing access to good quality home care while at the same time controlling costs in a universal system such as the Netherlands. Although home care in the Netherlands was initially promoted as a less costly alternative to institutional care, in recent years a cost-containment discourse has dominated in home care itself, stimulating new debates about where overall responsibility for long-term care risks lies, levels of resources and regulation of the home care system." (Rostgaard, Timonen and Glendinning, C., 2012:226).
250 HSE, 2013a:3.
251 Department of Taoiseach, 2011:38.
252 Cahill, O'Shea and Pierce, 2012.
253 Department of Health, 2012f.
254 Cahill, O'Shea and Pierce, 2012:28.
255 Cahill, O'Shea and Pierce, 2012:32, Table 2.4.
256 Cahill, O'Shea and Pierce, 2012:28-44.
257 If it is assumed that dementia affects not just the person but up to four other family members, then over 200,000 people in Ireland are affected by dementia (Cahill, O'Shea and Pierce, 2012:64).
258 Cahill, O'Shea and Pierce, 2012:81-82.
259 Cahill, O'Shea and Pierce, 2012:77.
260 "In Ireland, few alternatives to the nursing home model of care exist, for older people with dementia who are unable to remain in their own homes. In this regard, the Irish situation contrasts strongly with that in the US, UK, Australia, and other European countries where a range of alternate models to nursing home care including (i) housing with care; (ii) sheltered housing; (iii) hostels; and (iv) specialist care units are now fully integrated components of the long-term care landscape for people with a dementia." (Cahill, O'Shea and Pierce, 2012:106).
261 Cahill, O'Shea and Pierce, 2012:58, Table 3.14.
262 Cahill, O'Shea and Pierce, 2012:60.
263 Cahill, O'Shea and Pierce, 2012:90.
264 Cahill, O'Shea and Pierce, 2012:77.
265 Cahill, O'Shea and Pierce, 2012:129.
266 TILDA uses ADL and IADL to measure disability because it is "in line with geriatric literature, where disability is defined as people reporting one or more ADL or/and IADL limitations." (Kamiya, Murphy, Savva and Timonen, 2012:2, footnote 6). This is different to the definition in the Disability Act (2005) which defines disability as "...a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the Irish State or to participate in social or cultural life in the Irish State by reason of an enduring physical, sensory, mental health or intellectual impairment".
267 Barrett, Savva, Timonen and Kenny, 2011:216.
268 According to the CSO, "Data on disability was derived from answers to questions 16 and 17 of the census questionnaire. Question 16 was a seven-part question that asked about the existence of the following long lasting conditions: (a) blindness or a serious vision impairment, (b) deafness or a severe hearing impairment, (c) a difficulty with basic physical activities such as walking, climbing stairs, reaching, lifting or carrying, (d) an intellectual disability (e) a difficulty with learning, remembering or concentrating, (f) a psychological or emotional condition and (g) a difficulty with pain, breathing or any other chronic illness or condition. If a person answered YES to any of the parts of Q16, they were then asked to answer Question 17. This question was a four-part question that asked whether an individual had a difficulty doing any of the following activities: (a) dressing, bathing or getting around inside the home (self-care disability); (b) going outside the home alone to shop or visit a doctor's surgery (going outside the home disability); (c) working at a job or business or attending school or college (employment disability) and (d) participating in other activities, such as leisure or using transport. Individuals were classified as having a disability if they answered YES to any part of the above two questions, including, in particular, if they ticked YES to any of the parts of Q17 even though they may not have ticked YES to any of the parts of Q16." (Central Statistics Office, 2012b:82).
269 Barrett, Savva, Timonen and Kenny, 2011:204.
270 Kamiya, Murphy, Savva and Timonen, 2012:6-9, Tables 2-5.
271 Barrett, Savva, Timonen and Kenny, 2011:61. In a study of returned migrants, based on TILDA data, the authors found that "social isolation is a significant feature of the lives of both male and female return migrants and that the degree of social isolation is typically stronger for people who spent longer away and who have returned more recently. We did not find evidence of higher degrees of loneliness among the returned migrants. ... From a broader social perspective, the presence of large numbers of return migrants in countries such as Ireland and Mexico leads to concerns of social isolation among these people with the potential consequences for health, both physical and mental, and care needs." (Barrett and Mosca, 2013:22).
272 Persons in receipt of formal home care who did not have ADL or IADL had "lower levels of education, higher levels of medical card utilisation, their health status was lower and they were significantly more likely to have had a health system contact in the previous 12 months." (Wren, Normand, O'Reilly, Cruise, Connolly and Murphy, 2012:63).
273 Among those in receipt of formal home care who did not have ADL or IADL "almost a fifth experienced loneliness." (Wren, Normand, O'Reilly, Cruise, Connolly and Murphy, 2012:63).
274 The authors' comment on this finding is worth noting: "Living alone compared to living with a spouse or partner was a strong determinant of formal home care utilisation, independent of need characteristics in this study. The content of care provided to those living alone requires investigation to determine how much of the care provided is for social or supervisory reasons to monitor risk. Where the predominant need is for social interaction the use of community based resources may be an appropriate alternative to more expensive formal home-based care. If home care continues to be targeted at those who live alone regardless of need level, this has the potential to disadvantage older people who live with a spouse or others, yet experience a high level of unmet need despite the presence of others." (Wren, Normand, O'Reilly, Cruise, Connolly and Murphy, 2012:63).
275 "The key determinants of formal home care utilisation were IADL disability, older age and living alone." (Wren, Normand, O'Reilly, Cruise, Connolly and Murphy, 2012:62).
276 "Across the present population aged 65 and over, between 5 and 16 per cent report loneliness" (Windle, Francis and Coomber, 2011:2). "Research over decades has found a fairly constant proportion (six-13 per cent) of older people feeling lonely often or always." (Local Government Association, 2013:6).
277 "Although social isolation is sometimes equated with loneliness, loneliness and social isolation are separate concepts and do not necessarily co-occur. Social isolation refers to the absence of relationships, and is related to objective characteristics. Loneliness is the feeling of missing intimate relationships or missing a wider network, which is conceptualised as an individual's subjective evaluation of their degree of social participation or isolation. ... In TILDA, loneliness is assessed using a modified version of the University of California-Los Angeles Loneliness Scale. We selected four negatively-worded questions (e.g., How often do you feel left out?) and one positively-worded question (How often do you feel in tune with the people around you?), each with a three-point response scale of hardly ever or never; some of the time; or often. The responses to the five items are summed, with higher scores signifying greater loneliness. The average score for older adults is 2, on a scale from 0 (not lonely) to 10 (extremely lonely)." (Barrett, Savva, Timonen and Kenny, 2011:61).
278 Holt-Lunstead, Smith and Layton, 2010:14.
279 "Our analyses suggest that received support is less predictive of mortality than social integration. Therefore, facilitating patient use of naturally occurring social relations and community-based interventions may be more successful than providing social support through hired personnel, except in cases in which patient social relations appear to be detrimental or absent. Multifaceted community-based interventions may have a number of advantages because such interventions are socially grounded and include a broad cross-section of the public. Public policy initiatives need not

be limited to those deemed 'high risk' or those who have already developed a health condition but could potentially include low- and moderate-risk individuals earlier in the risk trajectory" (Holt-Lunstead, Smith and Layton, 2010:14).

280 Central Statistics Office, 2012b.

281 Department of Health, 2012e:8.

282 "Only 10.5% (n=107) of all carers received payment for the care they provided. Paid carers were predominantly non-relatives (87%) and female (93%)." (Kamiya, Murphy, Savva and Timonen, 2012:22; also Barrett, Savva, Timonen and Kenny, 2011:217).

283 "Research into intergenerational relations has highlighted the opportunities caregiving for an ageing parent offers adult children to 'give back' to loved ones. This more positive view of caregiving has also been confirmed in an Australian study where caregivers viewed with pride their accomplishments in looking after loved ones. A recent US cancer survey reported greater personal strength and opening of new possibilities for those providing care for someone with a life-threatening illness." (Burns, Abernethy, Dal Grande and Currow, 2013:6).

284 "Supporting family carers is a three-win arrangement, for carers (who provide care out of love or duty), for the 'carees' (who prefer to be cared for by family and friends) and for governments (who would otherwise face higher costs for formal care services and need all available support for their dependent populations). But currently only two in seven people in Europe are satisfied with the public support available to those caring for dependent older relatives. Family carers experience problems accessing support, such as a lack of information, costs related to access or use of support, waiting lists for supportive services, bureaucracy, a lack of transport, or even a caree's negative attitude. Some family carers do not see themselves as a group for whom services are available, or may feel stigmatised by the term, and thus may be hard to target. In addition, while support for carers is in demand, for some major support mechanisms – including financial payments and employment-related measures – there is little evidence of (cost)-effectiveness. ... Supporting family carers needs to become a key aspect of any LTC system, and may well require a mix of measures such as cash benefits, flexible leave options for working family carers and other support forms, such as information, training, respite services and peer support. However, a crucial outstanding question is how to do this effectively, when there is still a dearth of evidence on cost-effectiveness." (Tjadens and Colombo, 2011:16)

285 "Carers were asked questions on the Caregiver Strain Index which is intended to measure the burden and stress of caring in a home context. It includes questions on topics such as whether the carer's sleep is disturbed, whether any adjustments in personal, family life or work have had to be made and whether aspects of caring are upsetting. A score of 7 out of a total of 13 is considered to be the threshold for indicating carer strain." (Central Statistics Office, 2010b:21; see also Tables 3.4 and 4.3).

286 Department of Health, 2012e:6.

287 This is a guess-estimate since the TILDA data on 'primary carers' is based on those older people who have ADL or IADL; therefore it excludes older people who do not have ADL or IADL but may still have a carer because of other conditions such as dementia, isolation and loneliness, or generally poor physical or mental health.

5

Estimating Sources of Revenue for the Social Enterprise

5.1 Introduction

This chapter sets out the main revenue sources that could support the social enterprise as a viable business providing services to older people. These revenue sources are potential rather than actual and, at implementation stage, the revenue streams which are actualised may differ somewhat from one part of the country to another.

5

Estimating Sources of Revenue for the Social Enterprise

Forfás, in its review of social enterprise in Ireland, identified an extensive array of funding sources which are potentially available to social enterprises and small businesses[288], including:

(i) employment supports (such as the Community Employment Programme, Community Services Programme, and other employment initiatives such as JobBridge National Internship Scheme and Tús Community Workplace Initiative);

(ii) public procurement (contracts to deliver services in areas of health, housing, transport, energy);

(iii) repayable and equity finance (such as loans from the Social Finance Foundation and Triodos Bank);

(iv) miscellaneous sources (philanthropy, traded income, National Lottery, Dormant Accounts, credit unions, social impact bonds);

(v) EU sources (funds from ESF and ERDF for community-led local development such as LEADER, Local Community and Development Programme).

The proposed social enterprise could conceivably generate revenue from all these funding sources, although its viability as a sustainable business is likely to depend on just one source: public procurement. In order to reach the point of sustainability, the enterprise will require start-up capital, and this is undoubtedly a pressing necessity. For this reason, the main focus of this chapter is on identifying and quantifying the scale of resources that are available through public procurement of services for older people. Additional sources of funding may play a supporting role, but only if the proposed social enterprise succeeds in securing public service contracts and can source start-up capital to sustain it to the point where it can compete for these.

We begin by focusing on the two main revenue sources which are available through public procurement: the HSE budget for older people's services (Section 5.2) and collaboration with hospital groups to reduce delayed discharges (Section 5.3). We briefly review other potential funding streams (Section 5.4) before concluding with a summary assessment (Section 5.5).

Table 5.1
HSE Services for Older People: Budget Projections 2013-2026

	(i) Clients 2013	(ii) % Pop 65+	(iii) 2013 (€m)	(iv) 2016 (€m)	(v) 2021 (€m)	(vi) 2026 (€m)
1.NHSS: Nursing Home Support Scheme	22,761	4.3	998	1,176	1,375	1,602
2. OP Services	-	-	392	453	530	617
2.1 HCPS: Home Care Packages Scheme	10,870	2.0	130	149	174	203
2.2 HPS: Home Help Scheme	50,002	9.3	190	220	258	300
2.3 Day Care + Other	21,460	4.0	72	84	98	114
Total	-	-	1,390	1,629	1,905	2,219

Sources and assumptions:
(i) Health Services Executive, 2013a:57-61; HSE, 2013b:8. (ii) Central Statistics Office, 2012a.
(iii) Health Services Executive, 2013a:57-61; HSE, 2013b:8.
(iv) (v) (vi) CSO population projection (F2MS) - Central Statistics Office, 2013 - and existing utilisation rates.

5.2 Revenue from Public Procurement of Services for Older People

The HSE budget for services for older people, 2013-2026, is summarised in Table 5.1. It comprises the existing 2013 budget (column iii) along with projections for 2016 (column iv), 2021 (column v), and 2026 (column vi). The projections are based on CSO population forecasts – the most conservative possible in order to illustrate the likely minimum budgetary requirements over the period – which are then applied to existing utilisation rates of services for older people. Utilisation rates are expressed as a percentage of the population aged 65+ for each of the four main schemes for older people: NHSS (4.3%), HCPS (2.0%), HHS (9.3%) and Day Care (4.0%). The projections reveal that the budget for services for older people will increase between 2013 and 2026 (€829 million), equivalent to an annual increase of €64 million. In percentage terms, this represents an increase of 60% over 13 years, equivalent to nearly 5% per annum. The scale of the challenge which this represents is evident from the fact that the ESRI's medium-term (2013-2020) projected rate of growth in Ireland's GNP, under the most optimistic 'recovery scenario', will be "around 3.5 per cent a year in the second half of the decade"[289]. Moreover, this is against a backdrop of 10% fall national income between 2007 and 2012[290].

The challenge of maintaining the budget for services for older people will be substantial not just because of competing demands from other aspects of population ageing – notably pensions and acute hospital services – but because of challenges arising from the need to provide additional school and pre-school places as well as providing income support and training for people who are unemployed, since the unemployment rate is not expected to fall below 10% until after 2016 under the most optimistic 'recovery scenario'. In addition, even if the budget is maintained, the focus of public sector reform on quality and value for money remain of foremost concern. That is why the review of NHSS is of particular significance since this absorbs 72% of the budget for services for older people while, on average, meeting the needs of just 22% of all service users. The programme of government is committed to a review of Fair Deal and to the possibility of using this budget more flexibly: "The Fair Deal system of financing nursing home care will be reviewed with a view to developing a secure and equitable system of financing for community and long-term care which supports older people to stay in their own homes."[291]

The scope for reform of the NHSS budget could be substantial given evidence that previous assessments of need may have under-estimated the capacity of older people to live at home while also under-estimating the formal and informal supports that are (or could be) available to them[292]. This is likely to be rectified through the Single Assessment Tool, and could result in a lower rate of utilisation of residential services; even a reduction in utilisation from 4.3% to 4.0% could generate substantial additional funds for re-allocation to community-based services. At the same time, it is worth recalling that the advantages of community-based services over residential services – in those cases where the person is capable of living at home – seem to lie primarily in terms of quality of life and meeting client preferences rather than costs. As we saw in the previous section, the evidence on the relative costs of residential and community-based services is weak and inconclusive.

The scope for reform of the NHSS budget could be substantial given evidence that previous assessments of need may have under-estimated the capacity of older people to live at home while also under-estimating the formal and informal supports that are (or could be) available to them

It is clear that the existing and future HSE budget for services for older people (especially HCPS, HHS and Day Care) will be a major source of revenue for the social enterprise, which will enable it to supply home-based and community-based services to older people. The design and implementation of these schemes has been developed over a number of years and the procurement process (for HCPS in particular) has a strong focus on both quality and value for money. The social enterprise has a clear interest in tendering for the delivery of these schemes as part of its core business. However, it also has an interest in developing innovative responses to the needs of older people which are not encompassed by these schemes, such as those described above (Section 3.5).

This type of innovation, which could have the effect of reducing demand for and utilisation of mainstream services, may be envisaged by the wider agenda of public sector reform which refers to "maximising new and innovative service delivery channels"[293] as well as "leading, organising and working in new ways"[294]. However, innovations cannot take place without revenue, and it may therefore be worthwhile proposing the establishment of an "innovation fund" as part of the budget for services for older people. This fund could be in the region of 0.1% to 1% of the HSE's annual budget for services for older people – which corresponds to the range between €1.39m and €13.9m – and treated as an investment in R&D. Such a fund might be part of the answer to the question posed by the National Economic and Social council: "If one takes as an example the field of care for older people, is there a better way of delivering services? … But what if the total amount of money available for different kinds of care for older people, within a distinct geographical area, was available for tender to social enterprises? … Facilitating alternative models of care could prove to be a stimulus for innovation … It might prove to be a crucial feature of the expansive notion of a 'performance dialogue' that is concerned with the overall functioning of a policy area and the best use of resources therein."[295].

Table 5.2
Cost of Delayed Discharges from Acute Hospitals, 2012

Delayed Discharges (DDs)	Dublin Academic Teaching Hospitals*	Other Acute Hospitals	All Acute Hospitals
Total Days Lost (i)	130,643	113,030	243,673
Average Cost per Day (ii)	1,917	825	-
Total Cost (€million)	250.4	93.2	343.7
Total Cost (%)	73	27	100
% DDs aged 65+ (i)	86	87	87

Sources: (i) HSE, Business Intelligence Unit, Personal Communication, July 2013. Note that the number of delayed discharges is not the same as the number of patients (ii) PA Consulting Group, 2007:155.
*Dublin Academic Teaching Hospitals (DATHs) Group comprises: Tallaght Hospital, James's Hospital, Beaumont Hospital, Mater Hospital and Vincent's Hospital.

Table 5.3
Number and Cost of Delayed Discharges in Each Hospital Group, 2012

Hospital Group (i)	Model 4 Hospital (i)	Days Lost (ii)	Estimated Cost (€m) (iii)
Dublin North East	Beaumont Hospital	31,933	61.2
Dublin Midlands	James's Hospital	36,126	69.3
	Tallaght Hospital	13,266	25.4
Dublin East	Mater Hospital	28,465	54.6
	Vincent's Hospital	20,853	40.0
South / South West	Cork University Hospital	10,345	19.8
	Waterford Regional Hospital	8,518	7.0
West / North West	Galway University Hospital	1,377	2.6
Mid-West	Limerick Regional Hospital	3,728	3.1
Total days lost		154,611	283.0
% all days lost		63%	82%
% aged 65+		87%	

Sources: (i) Department of Health, 2013b:19 (ii) HSE Business Intelligence Unit, Personal Communication, July 2013. Note that number of delayed discharges is not the same as number of patients (iii) Estimate based on hospital cost in PA Consulting Group, 2007:155; see Table 3.5 above

5.3
Revenue from Collaboration with Hospital Groups to Reduce Delayed Discharges

The re-organisation of Ireland's 49 acute hospitals into six hospital groups is part of a more systemic reform of the health service, including public sector reform more generally. Central to health service reform is the conviction that "up to 95% of care can, in future, be delivered in the community"[296]. The achievement of this objective will require much closer integration of primary care and hospital care, including "arrangements for cross financing between hospital groups and social care providers"[297].

The potential for cost savings arising from closer integration of acute and primary care are substantial. A glimpse at this potential can be seen in the estimated cost of delayed discharges from acute hospitals, as summarised in Table 5.2. This is based on HSE data for 2012 on delayed discharges – defined as a patient who has completed acute care and is medically fit for discharge. Table 5.2 shows that the estimated cost of delayed discharges to the health system is substantial (€343m), with nearly three quarters of these costs (73%) in the Dublin Academic Teaching Hospitals (DATHs). The vast majority of these patients are aged 65+ (87%). The 'opportunity cost' of delayed discharges is substantial because it is an 'opportunity lost' to treat other patients, leading to longer

The financial incentive for hospitals to address the problem of delayed discharges is also a potential source of revenue for the social enterprise. These cross-financing arrangements will require collaboration between the social enterprise and hospital groups in order to provide patients – particularly those aged 65+, with seamless and safe transitions between hospital and either home, nursing home, or other supported accommodation

waiting times. Given that the average length of stay in hospital is about 6 days[298], the effect of delayed discharges is such that an estimated additional 40,612 inpatients could have been treated in 2012 if there were no delayed discharges. This underlines how existing funding arrangements are not sufficiently resource-conscious and, under the new financing arrangements for hospital groups, these unnecessary costs are likely to receive careful scrutiny.

The distribution of delayed discharges in each hospital group and major hospital is summarised in Table 5.3. This shows the key hospital in each of the six groups where there is significant potential to reduce delayed discharges, generating more appropriate care for patients and improving efficiency. The report outlining the six hospital groups envisages "arrangements for cross financing between hospital groups and social care providers … It is essential that hospital group operational policies are such that hospitals can work in close synergy with the social care providers, recognising and responding appropriately to the individual care plans that will guide the provision of services to patients in this area."[299]

The financial incentive for hospitals to address the problem of delayed discharges is also a potential source of revenue for the social enterprise. These cross-financing arrangements will require collaboration between the social enterprise and hospital groups in order to provide patients – particularly those aged 65+, with seamless and safe transitions between hospital and either home, nursing home, or other supported accommodation. This is also the aspiration of the HSE's 2013 National Service Plan, which emphasises the need for innovative approaches to integrating care for older people: "In order to meet increasing population need and deliver sustainable services within available resources, innovative models of care are required to further advance the development of equitable integrated care for older people across community-based services, intermediate care options and quality long term residential care services (supported by a robust and well-funded scheme - presently the NHSS)."[300]

5.4
Revenue from Other Sources

Revenue from public procurement, as described in previous sections, is likely to be the main source of income for the social enterprise. The scale of funding available for tender is substantial and this alone means that there is a sound national business case for the social enterprise. However, the challenge for this enterprise, as for any new business, is to find start-up capital in order to build the business to the point where it has the capacity to successfully tender for public service contracts. As observed in the Forfás report on social enterprise: "Given the nature of its activities (which often require a level of subvention, especially at the start of the company lifecycle), funding and finance is critical to social enterprise, at least to the same extent as it is to SMEs."[301]

Aside from public procurement, the main public sources of funding for social enterprises in Ireland include employment supports, loan and equity finance and other sources such as EU funding. Beginning with employment supports, these could be described as a benefit-in-kind to social enterprises. This applies particularly to the Community Employment Programme and Tús Community Workplace Initiative, since they supply staff at subsidised rates of pay. These

initiatives allow the social enterprise to deliver services which are needed but are funded at commercial rates. The Community Services Programme also supports community businesses to deliver local services and create employment for disadvantaged groups, but this has not been open for new applications since 2012.

Loan and equity capital is available to social enterprises from the Social Finance Foundation[302], Clann Credo[303] and the Triodos Bank[304] to fund the start-up phase. Ulster Bank is also interested in social investment. Other funding sources include the National Lottery and Dormant Accounts. Less certain is philanthropic funding since the two main donors in this sector – Atlantic Philanthropies and One Foundation – are in the process of ceasing funding[305]. However, the Social Innovation Fund recommended in the 2012 report of the Forum on Philanthropy and Fundraising in Ireland may be a source of funding once established[306]. The Irish diaspora may also include potential investors.

Social Impact Bonds, referred to in the programme of government[307], might also be a source of investment. These have been the subject of pilot studies in the UK, but have not been implemented in Ireland. A Social Impact Bond is a particular type of contract between a statutory purchaser of services and a non-for-profit provider, but differs from a conventional service contract in that payment is based on the delivery of improved social outcomes rather an agreed quantum of services. A seminar on social impact bonds was held in Dublin in 2011 and the resulting paper suggested that its applicability may be limited, mainly because of substantial deficits in the knowledge required to specify what outcomes can reasonably be expected, for what level of resources and over what period of time[308].

The EU is also a potential source of revenue for the proposed social enterprise, albeit indirectly. In 2011, the European Commission launched the Social Business Initiative "to support the development of social enterprises" in light of "the capacity of social enterprises and the social economy in general to provide innovative responses to the current economic, social and, in some cases, environmental challenges by developing sustainable, largely non-exportable jobs, social inclusion, improvement of local social services, territorial cohesion, etc."[309]. The EU Social Business Initiative is not a direct source of funding for social enterprises but its 11 'key actions' are designed to improve access to funding, mainly through reform of public procurement, easier access to ESF and ERDF, and a common framework for funding social entrepreneurship called the European Social Entrepreneurship Funds (EuSEF)[310].

The significance of the EU Social Business Initiative for Ireland is spelt out in the Forfás report on social enterprise, which recommends that Ireland should "include 'promoting the social economy and social enterprises' as one of the investment priorities under the Operational Plans for ESF & ERDF 2014 - 2020. This will assist Ireland and Irish social enterprises access and benefit from the other actions being pursued by the Commission"[311]. It seems clear that the EU Social Business Initiative will not address the short-term requirement for start-up capital but, if the Forfás recommendations are implemented, it could be a future source of funding.

5.5 Summary

This chapter examined the main revenue sources that could support the social enterprise as a viable and sustainable business. The main revenue stream for the business is likely to be public procurement of services for older people, since the HSE is already at an advanced stage in terms of implementing the purchaser/provider split. In addition, there are likely to be substantial revenue streams arising from the need to reduce or eliminate delayed discharges from hospital, particularly in the Dublin area. Other sources of funding for social enterprise may be found – such as employment supports – but public procurement is likely to remain the main pillar. At this stage, these revenue sources are potential rather than actual and, at implementation stage, may differ from one part of the country to another. In order to reach the point where the proposed social enterprise can tender for public procurement contracts, start-up capital is required. This is the most pressing necessity since, without it, no further development of the social enterprise is possible. Loan and equity capital may be available to fund the start-up phase, but would reduce the capacity of the social enterprise to tender for services at competitive prices. A non-repayable start-up investment would therefore be preferable, although the most viable current sources of such funding are essentially limited to the National Lottery and Dormant Accounts, which therefore deserve a careful assessment.

The significance of the EU Social Business Initiative for Ireland is spelt out in the Forfás report on social enterprise, which recommends that Ireland should "include 'promoting the social economy and social enterprises' as one of the investment priorities under the Operational Plans for ESF & ERDF 2014 – 2020

Footnotes

288 Forfás, 2013:59-89.
289 FitzGerald and Kearney, 2013:viii.
290 Callan, Nolan, Keane, Savage and Walsh, 2013.
291 Department of Taoiseach, 2011:32.
292 This was highlighted in an audit of assessments for the Nursing Home Support Scheme using the Common Summary Assessment Report (HSE, 2011). The findings of that audit revealed that a substantial proportion of those deemed eligible for NHSS – and therefore eligible for admission to a nursing home - did not have the highest levels of dependency and only a minority (18%) were known to have been considered for a Home Care Package As the report concludes: "the audit has certainly highlighted two potentially serious issues i.e. the approval of persons for long term care although they are not falling into the maximum dependency category and secondly the availability of Home Care Packages and how these are being used to support people and prevent them requiring long term care." (HSE, 2011:17).
293 Department of Public Expenditure and Reform, 2011:3.
294 Department of Public Expenditure and Reform, 2011:3.
295 National Economic and Social Council, 2012c:65.
296 Department of Health, 2013b:13; also pages 2, 9, 39. Four categories of hospital are distinguished based on type of activity. Model 1 hospitals are community hospitals and are not part of any hospital group. Model 2 provides the majority of acute hospital activity. Model 3 provide 24/7 acute surgery, acute medicine, and critical care. Model 4 is similar to Model 3 but also provides tertiary care and, in certain locations, supra-regional care. Models 2-4 must operate within a hospital group. (See also Department of Health, 2013c:8-9).
297 Department of Health, 2013b:11.
298 See HSE, 2012a:37; 2013a:42.
299 Department of Health, 2013b:11.
300 HSE, 2013a:57.
301 Forfás, 2013:26.
302 Details at www.sff.ie
303 Details at www.clanncredo.ie
304 Details at www.triodos.com
305 Forfás has described the evolving environment of philanthropy as follows: "Atlantic Philanthropies announced in July 2012 that it was winding down complete grant-making by the end of 2016 and would cease operations in Ireland by 2020. The One Foundation also announced that it would be ceasing to provide funding within Ireland in 2013. These have been very significant funders both directly and in terms of giving organisations leverage to access other funding. They have been important sources of matching funding as required by EU and State agencies. Philanthropy Ireland has launched a proposal outlining initiatives to increase the amount of philanthropic funding from the current level of €500m to €800m by 2016." (Forfás, 2013:85).
306 "The Forum recommends the creation of a Social Innovation Fund of a significant size (starting at €10m+) to support the establishment and growth of social innovations with the potential for transformative impact on critical social issues facing Ireland, including unemployment and the environment." (Forum on Philanthropy and Fundraising, 2012:6 and 20).
307 "We will establish a new model of financing social interventions – called Social Impact Bonds – that share audited exchequer savings with charitable and voluntary organisations." (Department of Taoiseach, 2011:30).
308 Clann Credo, 2011.
309 European Commission, 2011:2 and 5.
310 European Commission, 2013.
311 Forfás, 2013:27.

6

Summary of Assessment of National Business Case

6.1 Introduction

This chapter summarises our assessment of the national business case for a social enterprise to provide services for older people in Ireland. The proposed social enterprise is informed by the same vision for older people that informs national policy, namely, "to enhance the quality of life of older people, maintain their full potential, support them in their homes and communities"[312] and enable them "to live in their homes for as long as possible rather than go into residential care"[313]. The proposed social enterprise will be a 'public interest trust' and will be constituted as a 'charitable trust' under the Charities Act 2009. It will trade commercially but will have a social rather than a private purpose and its surplus will be re-invested in this social purpose.

6

Summary of Assessment of National Business Case

The social enterprise will act as a catalyst in communities where it works to create supports and care for older people, consistent with people's expressed needs and wishes, and using all resources available in each local area. The social enterprise will tender to become a HSE-approved provider of community services for older people – Home Care Package Scheme (HCPS), Home Help Scheme (HHS) and Day Care – but will also seek other sources of revenue to develop supports for older people beyond those which are currently funded under the existing HSE budget. Examples of these additional supports, whose purpose is to build community capital in social care, include the following: community navigators to advise and support on accessing services; greater use of assistive technology; time banks; a befriending service; organising volunteers; care and repair for home and garden; group-purchasing schemes to reduce the cost of heating or respite breaks. This makes the proposed social enterprise different to other providers of services for older people, which are largely confined to HSE-funded schemes.

The preferred structure for the proposed social enterprise involves a national organisation which will facilitate the development of local trusts, but will carry the overhead costs associated with, for example, preparing business plans, tenders and funding applications; developing quality assurance procedures; staff training and development; payroll; publicity and advocacy. This structure is preferred because the home care sector in Ireland (as elsewhere) is increasingly characterised by larger private and voluntary providers, which have considerable economies of scale and can therefore compete on cost as well as quality. In Ireland, for example, half of the approved providers of HCPS are private companies operating under franchise. An illustration of the proposed business model for a social enterprise can be found in the childcare sector in Ireland, where Fledglings operates as a not-for-profit, social, franchise-based organisation providing high-quality early-years education.

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In the remainder of this chapter, we summarise the main findings of the report. In essence, these findings show that there is a strong national business case for the proposed social enterprise on a number of grounds. First, the proposed social enterprise is aligned with important national priorities such as the need to respond to population ageing, to embrace public sector reform as it affects services for older people, and to create jobs through social enterprises (Section 6.2). Second, the proposed social enterprise is part of the wider response to the challenges which Ireland is currently facing, namely aligning resources to policies; aligning services to people's needs and preferences; improving health system efficiency; reducing health inequalities; and developing the long-term care sector (Section 6.3). Third, there is strong and growing demand for services for older people and therefore a sustainable business case for the proposed social enterprise (Section 6.4). Fourth, there are significant revenue streams, both currently and in the future, to underwrite the viability of the proposed social enterprise (Section 6.5). This report is a milestone in the development of a business idea, but this process is still at an early stage. The next stage requires equity investment to allow development of a business plan which will bring the social enterprise to the point where it can be self-sustaining through public procurement contracts. In our concluding section, we highlight that this is a present and pressing necessity since, without it, further development of the social enterprise is not possible or likely (Section 6.6).

6.2 Alignment of Social Enterprise with National Goals for Reform and Recovery

6.2.1 Responding to Population Ageing

Population ageing typically refers to an increase in the share of population aged 65+ and 85+, due mainly to increased life expectancy. Our analysis shows that the share of population aged 65+ in Ireland has been remarkably stable throughout most of the last century at around 11%. Since the turn of the century, there is a noticeable trend towards population ageing and the CSO's projection is that, over a period of just 35 years, the population aged 65+ will more than double from 11.6% in 2011 to 27.9% in 2046. The share of population aged 85+, though much smaller, will grow even more rapidly from 1.3% in 2011 to 5.2% in 2046. In practical terms, this means that, for the next 35 years, the population aged 65+ is projected to increase by nearly 25,000 every year, including an increase of nearly 6,000 in those aged 85+. This is in keeping with OECD and EU projections which anticipate that Ireland's public spending on long-term care will at least double by 2050. At the same time, the number of people of working age (15-64) for each person aged 65+ has continued to fall since the turn of the century and, over the next 35 years, the number of persons of working age for each person aged 65+ will fall from 5.8 in 2011 to 2.0 in 2046. It is clear that population ageing will create pressure on Ireland's health and social care systems which are beyond its current capacity to withstand. The challenges are considerable – in terms of pensions, healthcare and long-term care – but they are also predictable, and therefore amenable to a rational response. Key elements of that response are already visible, including public sector reform. The proposed social enterprise might also be seen as forming part of the response to population ageing.

Services for older people in Ireland are underpinned by the policy goal of helping people to remain in their home environment for as long as possible and desired, rather than entering long-term residential care. That is also the aim of the proposed social enterprise

6.2.2 Public Sector Reform

Public sector reform, as defined by the Department of Public Expenditure and Reform, involves five major commitments to change: (i) placing customer service at the core of everything we do; (ii) maximising new and innovative service delivery channels; (iii) radically reducing our costs to drive better value for money; (iv) leading, organising and working in new ways; and (v) maintaining a strong focus on implementation and delivery. One of the vehicles for bringing about reform is the 'purchaser/provider split', and this is one of the enabling conditions for the proposed social enterprise, which will aim to demonstrate innovative and cost-effective ways of providing support and care services which facilitate older people to live at home for as long as possible and desired.

6.2.3 Services for Older People

Services for older people in Ireland are underpinned by the policy goal of helping people to remain in their home environment for as long as possible and desired, rather than entering long-term residential care. That is also the aim of the proposed social enterprise. However, resources allocated to services for older people in Ireland are poorly aligned with this policy since the largest share of the HSE budget (72%) is spent on long-stay care under the Nursing Home Support Scheme (NHSS). Although, the purchaser/provider split is well advanced in services for older people, with nearly two-thirds of the HSE budget (63%) being allocated to independent entities (mainly private providers), and services provided by voluntary not-for-profit organisations representing over a tenth (14%) of the budget of services for older people. The proposed social enterprise aims to increase the share of services for older people provided by the not-for-profit sector. Across the OECD, there is substantial variation in the number of long-stay beds per 1,000 population aged 65+, ranging from 17.8 in Italy to 51.8 in Ireland and 72.3 in Sweden. This indicates how much long-stay care provision varies across countries with broadly similar levels of prosperity while also underlining how each country finds a different balance between supporting older people to live at home and in long-stay care. This does not imply that living at home is better, in all cases, to living in a long-stay care since there is almost no data on the well-being of older people in long-stay care to compare with 'equivalent' older persons at home. However it suggests that the policy goal of supporting older people to live at home for as long as possible and they prefer is achievable but more could possibly be learned from those countries which actually achieve it such as Italy, Spain and Denmark.

6.2.4 Job Creation and Social Enterprise

Job creation is one of the biggest challenges facing Irish society. Social enterprise has a part to play in meeting this challenge and the programme of government is committed to "the development of a vibrant and effective social enterprise sector". Forfás has estimated that jobs in the social enterprise sector could at least double from the current 25,000 if Ireland were to achieve the EU average

of 6% of GDP contributed by social enterprises. In order to achieve this goal, Forfás has recommended that Ireland adopt and extend the reforms already proposed by the EU Commission for ERDF and ESF, to give 'investment priority for social enterprises' including 'reserved contracts for social enterprises'. The proposed social enterprise will create viable, high-quality sustainable jobs, and this proposal resonates with local development partnerships whose core function is to address social exclusion and unemployment through local and community development. More globally, the role of social enterprise as a vehicle for employment creation and service provision is increasingly recognised. The Social Business Initiative of the European Commission, launched in 2011, is designed "to support the development of social enterprises"[314] whilst in 2013 social investment was on the agenda of G8 countries, promoted by the UK Presidency which sees social enterprises as an important aspect of public service reform and a way of promoting innovative and responsive solutions to local needs[315].

It is well known that many areas of care, formal as well as informal, are associated with women. Social participation and gender equity are boosted by female labour force participation, which implies some shift of the care burden either from women to men (remaining within the sphere of informal caring) or from unpaid women to paid women/men (thus shifting from informal to formal caring). Public provision of care for older people is important from this perspective because: it can free up women to enter/return to the labour market; it can provide employment for women at all levels of qualification, boosting participation; and it can contribute to reducing social inequalities (and child poverty) by facilitating dual-income earning in poorer, larger families. These are core elements of the strategy for social inclusion, in Ireland[316] and the EU[317].

The proposed social enterprise can contribute to greater social inclusion by increasing female labour force participation rates and facilitating the entry/re-entry of vulnerable social groups to employment (women, people with low qualifications, immigrants, older workers). By providing career paths for both highly qualified workers as well as those who are less qualified, including access to on-the-job training, the social enterprise can sustain labour force participation rates, improve social inclusion, and raise the overall status of social care as a profession. Furthermore, by reducing the care burden which is disproportionately assigned to women, this innovation can further boost female participation, which has been recognised as a key way of reducing child poverty and a step towards achieving greater gender equality.

6.2.5
Service Design and Performance Linked to Evidence on Well-Being

The idea that public policy and services should be 'evidence-based', or at least 'evidence-informed', and 'outcome-focused', is now accepted as the basis for assessing performance and efficacy. It is arguably even more important to ensure that the design of services, and the resources allocated to them, is also based on the best scientific available. Given that the raison d'être of services for older people is to improve their well-being, we undertook a detailed analysis of TILDA to identify the determinants of personal well-being. A key finding of this analysis is that social connections, in the broadest sense, constitute the most significant and substantively important determinants of personal well-being among older people; these mainly involve good quality relationships with partners, children, relatives and friends; an active lifestyle; and having access to transport for daily activities. Overall health is also a highly-significant (albeit somewhat weaker) influence on personal well-being, and is strongly influenced by social class. This implies that social class has an indirect (or distal) rather than direct (or proximal) association with personal well-being. These findings are significant not just from the perspective of the proposed social enterprise, but also for the wider paradigm which informs the provision of services for older people. Existing provision seems to be heavily influenced by an 'illness and disability' model of ageing, whereas the TILDA analysis suggests that a well-being model may be more appropriate and more inclusive of the relevant influences on older people's well-being. Re-orienting services for older people to promote personal well-being and not just reduce illness and disability, will require a clearer articulation of this paradigm and its implications for service design and delivery. This well-being paradigm will inform the proposed social enterprise, whose services will focus on strengthening protective factors and minimising risk factors which directly and indirectly influence personal well-being.

The proposed social enterprise will create viable, high-quality sustainable jobs, and this proposal resonates with local development partnerships whose core function is to address social exclusion and unemployment through local and community development

6.2.6
Providing Quality Services and Value for Money

The challenge of providing quality services which are also value-for-money appears substantial but it applies to all services, not just those for older people, where human interaction is a central component. It applies therefore to health, education, hospitality and the arts, which are labour-intensive and, by comparison with capital-intensive sectors like manufacturing and food production, are less amenable to productivity improvements[318]. At the heart of this challenge is the fact that the quality of a human service depends on its being tailored to each person's needs, delivered on time and sensitively, and connected to other elements of care on which the person may depend. Quality services in this sense are relatively costly because the main input is staff time and, although there is scope for improving productivity, there is little or no scope for reducing wages, particularly in the home-care sector for older people, much less competing with private companies on cost. In that sense, the national business case for the proposed social enterprise does not rest on reducing costs but on offering quality and value-for-money. This is based on the assumption that these services will inevitably cost more over time but will still remain affordable because of productivity gains in other sectors of the economy, and there remains a general willingness in society to pay for services which enhance education, health and personal well-being[319]. Recognising that a service is only as good as its staff, the proposed social enterprise aims to recruit and retain highly qualified and motivated staff but will also include less qualified and experienced staff within its workforce, providing them with in-house training and mentoring to ensure they are competent to deliver a quality service. This approach has the potential to yield improvements in the health and well-being of older people which can be justified in terms of cost effectiveness, and will be attractive to high-achieving professionals who see social care as a rewarding career path.

The policy goal of facilitating more older people to live well at home, as proposed by the social enterprise, can only be achieved through significant re-allocations within the existing budget of services for older people

6.3
Responding to Challenges and Opportunities in Services for Older People

Ireland faces a number of challenges in terms of providing services for older people. These challenges will trigger significant changes in all sectors of Irish society. The social enterprise has the potential to form part of the response to these challenges, complementing the initiatives of other agencies and sectors. We briefly summarise these challenges and the potential contribution which the social enterprise could make to addressing them.

6.3.1
Aligning Resources to Policies

The evidence presented in the report illustrates that the goals of public policy for older people are not sufficiently aligned with the corresponding allocation of resources to services. This difficulty is recognised and is the reason why a substantial review is currently being undertaken of NHSS. This challenge of aligning resources to policies is not confined to services for older people and affects all aspects of the health service, since the main influence on resource allocation in Ireland has tended to be precedent rather than policy or the needs of populations or patients. This is underlined by the fact that decisions about the amount of resources allocated to areas, to services, or to agencies has been mainly determined by the previous year's resource allocations. Changing this system is necessary but also a challenge, since it seems easier to change policy than to change systems for allocating resources. As part of public sector reform, significant changes are already being made in this area. However, the policy goal of facilitating more older people to live well at home, as proposed by the social enterprise, can only be achieved through significant re-allocations within the existing budget of services for older people.

6.3.2
Aligning Services to People's Needs and Preferences

In Ireland, as elsewhere, numerous surveys confirm that people prefer to live at home and be supported to live there as long as possible, preferably right to the end. The expectation and preference of the vast majority people across the EU-27 (>75%), based on a Eurobarometer survey, is to live in their own home or the home of a relative "if one becomes dependent and needs regular help and long-term care"[320]. The same survey also showed that the vast majority (>75%) of Irish people share the same set of expectations and preferences. Despite these findings, a gap remains between what people need and prefer and what is provided by the existing system of services and supports. In keeping with national policy, the proposed social enterprise seeks to reduce this gap by supporting people to live at home.

6.3.3
Improving Health System Efficiency

There is clear evidence that the existing system of support and care for older people in Ireland is not as efficient as it could be. The evidence focuses mainly on the inappropriate use of acute hospitals, particularly where patients remain in hospital after their treatment has finished, usually referred to as 'delayed discharges'. In 2012, the number of days lost due to delayed discharges in Ireland's acute hospitals was substantial (243,673)[321], and higher than in 2008 (223,704 bed days) or 2009 (144,565)[322]. A practical consequence of this is that an estimated additional 40,612 inpatients could have been treated in 2012 if there were no delayed discharges. Of particular significance in the context of this proposal is that the vast majority of delayed discharges (87%) are of patients aged 65+. Under the new system of hospital financing, 'Money Follows the Patient'[323], to be implemented from 2014, it is

likely that hospital groups will have a much clearer financial incentive to reduce or eliminate delayed discharges. This will require the development of services to support patients being discharged from hospital. The proposed social enterprise proposes to work with hospital groups to facilitate the safe and speedy discharge of patients who could live at home with support and who would prefer to do so.

6.3.4 Reducing Health Inequalities

There are substantial inequalities in health across the Irish population, with particularly pronounced implications for older people, as measured by morbidity and mortality. Morbidity (such as the likelihood of feeling healthy or having an illness) and mortality (such as how long one can expect to live) have a 'social gradient', illustrated by the fact that three quarters of professional workers in Ireland report having very good health compared to less than half unskilled workers. Similarly and related, professional workers in Ireland live over six years longer compared to unskilled workers. Given the remarkable increase in life expectancy at 65 in Ireland during the first decade of this century (3 years), the impact of social class on life expectancy (6 years) is doubly remarkable The implications of this, as the TILDA analysis suggests, is that 'the most pressing effects of ageing' are not for hospital or residential care, but for 'a range of community-based health and social care services.' This suggests that the approach being proposed by the social enterprise is consistent with evidence on the need for both a population-centred and a person-centred approach to the unequal impacts of ageing.

6.3.5 Developing Long-term Care Sector

The supply of long-term care for older people in Ireland, as in many EU countries, relies heavily on the 'informal sector' which effectively means that it is provided by relatives, mainly partners and adult children. The HSE's 2013 National Service Plan indicates that approximately 20% of the population aged 65+ receive a formal service, mainly HCPS, HHS and Day care. This implies that up to eight out of ten older people in Ireland may rely on informal unpaid care. There are a number of reasons why this model of informal provision is unlikely to continue indefinitely while the correspondingly demand for formal paid care is likely to grow.

One of the immediate consequences of a growth in formal care is a corresponding growth in cost, both public and private. However, formal care will complement rather than replace informal care, since family members are likely to remain an important source of care. That is why supporting family carers is an important part of the response to ageing, as the social enterprise proposes, and has been described as a 'three-win arrangement' because it benefits carers, those being cared for, and the State, which would otherwise have to pay the higher costs of formal care[324]. Other issues to be addressed in the long-term care sector include the regulation of home-care providers and the use of technology to improve the quality and effectiveness of care.

6.4 Estimating Demand for Services for Older People

In order to assess the national business case, it is necessary to establish current and likely future demand for services for older people. The report estimated current and likely future demand for the HSE's services for older people (NHSS, HCPS, HHS, Day Care) as well as demand arising from reducing delayed discharges from hospital. It also estimated unmet need arising from the following sources: dementia; disability; social isolation and loneliness; carer needs. It is clear from the analysis that demand for services for older people is substantial and growing and, from that perspective, the proposed social enterprise represents a sound business idea.

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6.4.1 Current Demand for Services for Older People

Current demand for services for older people, based on the HSE's 2013 National Service Plan, indicates that 20% of the population aged 65+ are in receipt a service, equivalent to 105,093 persons; if NHSS is excluded, there are 82,332 older persons in receipt of a community service, equivalent to about 15% of the population aged 65+. The purchaser/provider split is well advanced in services for older people, with more than half (56%) of the HSE budget for older people being allocated to private providers, mainly through NHSS, HCPS and HHS. More than a third (37%) of the budget is spent on direct provision by the HSE, through NHSS, HCPS, HHS and Day Care. Voluntary provision represents a small part of the overall budget (7%), concentrated mainly in HHS and Day Care. This pattern suggests that there is considerable scope to increase the share of voluntary not-for-profit provision through a social enterprise, particularly if direct HSE provision is reduced.

6.4.2 Future Demand for Services for Older People

Future demand for services for older people was estimated based on two sets of projections: (i) future population aged 65+ based on CSO population projections for 2016-2046[325]; and (ii) future service utilisation which is assumed to continue at 2013 levels for both residential long-term care (NHSS) and community long-term care (HCPS & HHS)[326]. Based on these projections, the report estimates that over the next 13 years (2013-2026), the number of people in residential long-term care is likely to grow by 13,772, equivalent to an average of about 1,000 new residents each year, resulting in an increase in the NHSS budget of €604 million in this period. Similar increases, based on the same population projections and unchanged utilisation rates, are projected for community-based services.

Overall, the number of people using services for older people will increase from 105,093 in 2013 to 166,522 in 2026 (not taking account of some double counting that may arise if people use two services concurrently, such as HHS and Day Care). The budget to support these services will need to increase from €1.4 billion in 2013 to €2.2 billion in 2026, an increase of 60% in this period or about 5% per annum. From the perspective of the proposed social enterprise, these estimates clearly indicate that a substantial opportunity exists to contribute to providing services for older people, within the existing budgetary framework and through more innovative configurations of services, which may include the use of NHSS for a wider range of services to support older people to live at home.

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6.4.3 Demand from Reducing Delayed Discharges in Acute Hospitals

From 2014, Ireland's 49 acute hospitals will be re-configured into six hospital groups which, in time, are destined to become hospital trusts[327]. Given that reform of the hospital system is only part of a more systemic reform of the health service, the linkages between the six hospital groups and the primary care system, including services for older people, is of fundamental importance to the overall success of the reforms. As we showed in this report, it seems clear that demand for the services of the social enterprise – and other providers of social care – is likely to arise from hospital groups, particularly in the Dublin area, where delayed discharges are a particular problem. The savings generated by reducing delayed discharges could be re-deployed to enable social care providers, such as the social enterprise, to deliver safe, supportive and speedy transitions between hospital, home, convalescent home, or nursing home as required, bearing in mind that some patients may need more intensive and sustained support compared to the average service user in the community. This would be consistent with the need for innovation as part of public sector reform, as highlighted in the HSE's 2013 National Service Plan.

6.4.4 Dementia and Unmet Demand

Unmet demand arises when there is an underlying need which is not being met because the care is not available or accessible. The programme for government (2011-2016) contains a commitment to develop a national dementia strategy by 2013[328] and, in preparation for that, a comprehensive review of research has been carried out[329] as well as a public consultation[330]. The overall prevalence of dementia among those aged 65+ in Ireland, based on European rates, is 8.2%[331]. Applying this overall prevalence of dementia to the current and projected population aged 65+ in Ireland indicates that the number of persons with dementia is likely to more than double over the next 35 years (2011-2046), equivalent to an annual increase of about 5%.

If it is assumed that dementia affects not just the person but up to four other family members, then over 200,000 people in Ireland are affected by dementia. The majority of people with dementia (63%) live in the community and are cared for by family and friends with most of the remainder (34%) in long-stay residential care. Compared with other caring roles, it is generally recognised that caring for a person with dementia can place greater demands and strains on family members. The social enterprise which is proposed will contribute to the development of community-based services for persons with dementia and their families. This is already the direction of developments in the field of health service reform and is also likely to be recommended by the dementia strategy.

6.4.5 Disability and Unmet Demand

An indicator of unmet demand is the proportion of persons with a disability who are not receiving care, either formal or informal. The TILDA study shows that more than a tenth (12%) of those who have both ADL and IADL difficulties do not receive any help from any source, formal or informal. This led the authors to comment that 'these people constitute a potentially very vulnerable group'[332]. If this rate of unmet need is applied to the population aged 65+ who have both ADL and IADL, it suggests that 2,679 older people may have an unmet need for care.

6.4.6 Social Isolation, Loneliness and Unmet Demand

Social isolation and loneliness are known to have negative consequences for quality of life and mortality[333]. A meta-analytic study of the impact on mortality of social relationships

an innovation fund – in the region of 0.1% to 1% of HSE's annual budget for services for older people – could stimulate such innovation

(measured using objective as well as subjective indicators), and based on a synthesis of 148 separate studies, found that "individuals with adequate social relationships have a 50% greater likelihood of survival compared to those with poor or insufficient social relationships. The magnitude of this effect is comparable with quitting smoking and it exceeds many well-known risk factors for mortality (e.g., obesity, physical inactivity)."[334] This suggests that substantial benefits are likely to follow from addressing this unmet need, particularly where there is a co-occurrence of its objective aspects (such as living alone) and subjective aspects (feeling lonely).

Based on international evidence, we estimated the minimum prevalence of social isolation and loneliness to be around 5%. Applying this rate to the population aged 65+ living in private households suggests that 25,000 older people in Ireland may experience social isolation and loneliness. This is an area of unmet need that could be addressed by the proposed social enterprise, particularly in light of its focus on developing person-centred, community-based supports and services. Wherever possible, this involves cultivating each person's 'naturally-occurring' social networks of family, friends and neighbours, since these are likely to be more effective and enduring than the kindness and befriending of professionals.

6.4.7
Carer Needs and Unmet Demand

The needs of carers who provide unpaid and 'informal' care for older people are a source of unmet demand for services. This group, as defined by the CSO[335] and the National Carers Strategy[336], comprises persons who give regular unpaid personal help to a friend or family member with a long-term illness, health problem, disability or with problems due to old age. In 2009, the CSO carried out a special survey of carers and found that a significant minority of carers (21%) provide care for 57+ hours per week, particularly those providing care for a person in the same household, and over a quarter of all carers (27%) were experiencing 'caregiver strain' based on the Caregiver Strain Index. Applying this rate of caregiver strain to the population in private households aged 65+ who have carers yields an estimate of over 27,000 carers who may have an unmet need for support. This level of need is thus an opportunity for the social enterprise to develop supports for carers building on the national carers strategy and the recognition that 'helping carers is one of the most effective ways of helping those in receipt of care'.

6.5
Estimating Sources of Revenue for Social Enterprise

The report examined the main revenue sources that could support the social enterprise as a viable and sustainable business. These revenue sources are potential rather than actual and may differ from one part of the country to another. Forfás[337], in its review of social enterprise in Ireland, identified an array of funding sources, including: employment supports; public procurement; repayable and equity finance; miscellaneous sources. The proposed social enterprise could conceivably generate revenue from multiple sources but its viability as a sustainable business is likely to depend on one main source: public procurement. We identified and quantified two main revenue sources which are available through public procurement – the HSE budget for older people's services and collaboration with hospital groups to reduce delayed discharges.

As already indicated, the social enterprise has an interest in developing innovative responses to the needs of older people which are not encompassed by existing public procurement for HCPS, HHS, Day Care. Options being considered include: community navigators to advise and support on accessing services; greater use of assistive technology; time banks; befriending service; organising volunteers; care and repair for home and garden; group-purchasing schemes to reduce the cost of heating or respite breaks. These innovative services, which could have the effect of reducing demand and utilisation of mainstream services, is envisaged by the wider agenda of public sector reform but is unlikely to happen without a revenue stream to fund it. For this reason, an innovation fund – in the region of 0.1% to 1% of HSE's annual budget for services for older people – could stimulate such innovation. In the absence of such a fund, alternative ways of funding such services – which are also of wider relevance to the community as a whole – must be considered, perhaps in partnership with other organisations operating at the local level.

6.5.1
Revenue from Public Procurement of Services for Older People

Over the next 13 years (2013-2026), the HSE budget for services for older people, based on conservative population projections and no change in service utilisation rates, is expected to increase by €829 million, equivalent to an annual increase of €64 million. In percentage terms, this represents an increase of 60% over 13 years, equivalent to nearly 5% per annum. The challenge of maintaining the budget for services for older people will be substantial given that the projected rate of growth in Ireland's GNP, under the most optimistic 'recovery scenario', will be 'around 3.5 per cent a year in the second half of the decade'[338], and against a backdrop of 10% fall in national income between 2007 and 2012[339]. That is why the review of NHSS is of particular significance since it constitutes 72% of the budget for services for older people while, on average, meeting the needs of just 22% of those in receipt of these services. At the same time, the HSE budget for services for older people (especially HCPS, HHS and Day Care) will be a major source of revenue for the social enterprise given that it will tender to deliver these schemes as part of its core business.

6.5.2
Revenue from Collaboration with Hospital Groups to Reduce Delayed Discharges

Reducing delayed discharges from acute hospital is a possible area of collaboration between hospital groups and social care providers, and a potential source of revenue for the social enterprise. The estimated cost of delayed discharges to the Irish health system in 2012 is substantial (€343m), with nearly three quarters of these costs (73%) in the Dublin Academic Teaching Hospitals (DATHs). The vast majority of patients involved in delayed discharges are aged 65+ (87%) which are also the client group of the social enterprise.

The proposal is aligned with the requirements of public sector reform and the need to find more innovative ways of supporting older people to live well at home for as long as possible, where that is preferred

6.5.3
Revenue from Other Sources

A major challenge for the social enterprise, as for any new business, is to find start-up capital in order to build the business to a point where it has the capacity to successfully tender for public service contracts. The option of borrowing start-up capital for the social enterprise is not considered commercially attractive, because future revenues are expected to come through public procurement and the purchaser of services for older people (currently the HSE) will seek tenders at competitive prices which are unlikely to cover the cost of servicing providers' debts. For that reason, a non-repayable start-up investment is the preferred option. The European Commission's Social Business Initiative is designed 'to support the development of social enterprises', but is not a direct source of funding for social enterprises. Its significance for the social enterprise sector in Ireland depends largely on whether the Government makes 'promoting the social economy and social enterprises' one of the investment priorities under the Operational Plans for ESF & ERDF 2014-2020[340].

6.6
Concluding Comments

This report has established that there is a strong national business case for the proposed social enterprise. There is solid and growing demand for services for older people and, despite economic and fiscal challenges facing the country, there are substantial revenue streams to sustain the social enterprise as a viable business. The proposal is aligned with the requirements of public sector reform and the need to find more innovative ways of supporting older people to live well at home for as long as possible, where that is preferred. In addition, the social enterprise will create sustainable and high-quality employment and is likely to generate multiplier effects through its linkages with other service providers in the community and voluntary sector, supporting innovation and learning. In these respects, the proposed social enterprise will contribute to the national priority of recovery and reform.

This report represents a significant step in the evolution of a business concept. Having established the national business case, the next stage requires investment to allow a business plan to be developed. That is an immediate and pressing requirement since, without it, further development of the social enterprise is not possible or likely.

Footnotes

312 Department of Health, 2013a:18.
313 Department of Health, 2013b:ii.
314 European Commission, 2011:2 and 5.
315 Further details at www.gov.uk
316 See notably the programme of government (Department of Taoiseach, 2011).
317 See notably the Europe 2020 Strategy: A strategy for smart, sustainable and inclusive growth (European Commission, 2010).
318 This has been referred to as 'Baumol's disease' which is based on the hypothesis that, as wage levels rise across all sectors of the economy, productivity improvements in services-producing sectors are unlikely to match those in goods-producing sectors, with the result that the relative cost of services gradually rises by comparison with the cost of goods (Baumol, 1967).
319 This perspective has been articulated by William Baumol (2012) whose name is associated with 'Baumol's disease' (Baumol, 1967). He argues that human services such as health, education, hospitality, and the arts are already absorbing an increasing share of society's wealth, mainly because the relative cost of goods such as food, cars, computers, etc. continue to fall. It is true that productivity gains are possible in the provision of services but a public policy that is based solely on 'out-sourcing' services from public to private sector runs the risk of reducing the quality and affordability of these services. Baumol writes that 'the true threat' to affordable human services is 'foolish public policy': 'It is clear that if improvements to health care and education are hindered by the illusion that we cannot afford them, we will all be forced to suffer from self-inflicted wounds. The very definition of rising productivity ensures that the future offers us a cornucopia of desirable services and abundant products. The main threat to this happy prospect is the illusion that society cannot afford them, with resulting political developments – such as calls for reduced governmental revenues with demands that budgets always be in balance – that deny these benefits to our descendants.' (ibid:181-182).
320 TNS Opinion & Social, 2007:95-97.
321 HSE, Business Intelligence Unit, Personal Communication, July 2013.
322 The Expert Group on Resource Allocation and Financing in the Health Sector, 2010; also Brick, Nolan, O'Reilly, and Smith, 2010a; 2010b; 2010c.
323 Department of Health, 2013a.
324 Tjadens and Colombo, 2011:16.
325 Central Statistics Office, 2013.
326 HSE, 2013a:57-60.
327 Department of Health, 2013b.
328 Department of Taoiseach, 2011:38.
329 Cahill, O'Shea and Pierce, 2012.
330 Department of Health, 2012f.
331 Cahill, O'Shea and Pierce, 2012:32, Table 2.4.
332 Barrett, Savva, Timonen and Kenny, 2011:204.
333 Barrett and Mosca, 2013; Kamiya, Doyle, Henretta and Timonen, 2013.
334 Holt-Lunstead, Smith and Layton, 2010:14.
335 Central Statistics Office, 2012b.
336 Department of Health, 2012e:8.
337 Forfás, 2013:59-89.
338 FitzGerald and Kearney, 2013:viii.
339 Callan, Nolan, Keane, Savage and Walsh, 2013.
340 Forfás, 2013:27.

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