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Projections of national demand and bed capacity requirements for older people's care in Ireland, 2022–2040: Based on the Hippocrates model

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FOREWORD

This report was prepared by researchers at the Economic and Social Research Institute (ESRI) for the Department of Health. The report is published as an ESRI Research Series report and is one of three reports that update projections of demand and capacity using the Hippocrates model. This report analyses home support hours demand and long-term residential care (LTRC) bed use in 2022, and projects home support hour demand and LTRC bed capacity requirements to 2040.

The Hippocrates model was developed at the ESRI under the Department of Health/ESRI Research Programme in Healthcare Reform. The Hippocrates model is a tool that can: inform health and social service planning in Ireland; inform financial planning for the healthcare system; inform planning for capacity, services and staffing; identify future demand pressures; and provide a framework in which to analyse the effects of potential system changes and reforms. The latest project was overseen by the Department of Health with input from the Health Service Executive (HSE).

The ESRI is responsible for the quality of this research, which has undergone peer review prior to publication. This report was prepared by Dr Brendan Walsh and Dr Theano Kakoulidou, and reflects their expertise and views. The views expressed in this report are not necessarily those of other ESRI researchers, the Minister for Health, the Department of Health or organisations represented on the ESRI/ Department of Health Research Programme Steering Group.

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ABBREVIATIONS AND ACRONYMS

ADL	Activities of daily living
BIU	Business information Unit
CFS	Clinical Frailty Scale
CHN	Community Healthcare Network
CM	Compression of morbidity
CSO	Central Statistics Office
DE	Dynamic equilibrium
DTOC	Delayed transfer of care
ECC	Enhanced community care
ESRI	Economic and Social Research Institute
GP	General practitioner
HIQA	Health Information and Quality Authority
HPSC	Health Protection and Surveillance Centre
HSE	Health Service Executive
IADL	Instrumental activities of daily living
ICPOP	Integrated Care Programme for Older People
IHCP	Intensive Home Care Package
LOS	Length of stay
LTRC	Long-term residential care
NHI	Nursing Homes Ireland
NHSS	Nursing Home Support Scheme
OR	Occupancy rate
SYOA	Single year of age
TAPS	Temporary Assistance Payment Scheme
TCD	Trinity College Dublin
TILDA	The Irish Longitudinal Study on Ageing
TIPS	Temporary Inflation Payment Scheme

EXECUTIVE SUMMARY

INTRODUCTION

Life expectancy rates have increased substantially in Ireland in recent years, driven mainly by reductions in mortality rates at older ages. Accordingly, Ireland has seen large increases in its older population, and along with this increasing demand for health and social care services, particularly those aimed at the older population such as long-term residential care (LTRC) and home support. Due to the projected increase in the older population in the future, planning health and social care capacity is vital to ensure the health system is in a position to meet the care needs of this segment of the population.

Over the past ten years, as part of the Department of Health/Economic and Social Research Institute (ESRI) Research Programme in Healthcare Reform, the ESRI developed the Hippocrates projection model. Previous analyses have applied Hippocrates to provide medium-term projections of healthcare demand, bed capacity, expenditure and workforce requirements. This recent work, commissioned under the programme, has used the model to provide up-to-date projections for three service areas – public acute hospitals, general practice and older people's services to 2040.

Analyses in this report use the Hippocrates model to update baseline estimates of home support hours and LTRC beds in 2022, and to project demand and capacity for these services to 2040. Building on the existing Hippocrates modelling framework, the broad objectives of this report are to:

- provide updated baseline profiles for LTRC bed capacity and home support hours among older people (aged 65 years and over) incorporating new population estimates based on Census 2022; and
- project LTRC bed capacity and home support hour requirements to 2040.

Hippocrates projections are influenced by the model of service delivery, data availability and quality, and the policy environment in the base year. Despite fluctuations in activity rates in recent years, during the COVID-19 pandemic period especially, previously published Hippocrates projections for LTRC and home support based on 2015 and 2019 data have proved to be a reliable guide to actual activity levels in 2022. However, it is acknowledged that projections should be regularly reviewed given ongoing changes in the data environment, service delivery models, including capacity expansion, and the introduction of the Health Service Executive (HSE) Health Regions.

Methods

The projections of demand and capacity (short stay and long stay beds and home support hours) requirements included in this report use the ESRI's macro-simulation healthcare projection model, the Hippocrates model. The Hippocrates model is a component-based model that projects from a bottom-up service or sectoral perspective. In these analyses, LTRC bed capacity and home support hour requirements are modelled from a 2022 base.

The starting point for Hippocrates is to estimate short stay and long stay bed rates and home support hour activity rates in 2022 from analysis of current use of services by age and sex. A number of survey-based and administrative data sources are used to compile baseline activity profiles. Population projections by single year of age (SYOA) and sex to 2040 are provided by the ESRI's regional demographic model. LTRC bed rates and home support hour rates are projected by multiplying rates by the projected population. Baseline estimates of beds and hours are projected based on a range of assumptions including the size and structure of the population, healthy ageing, potential policy changes such as reducing delayed transfers of care (DTOC) in public acute hospitals, and expanding the home support service. Projection results are presented across four projection scenarios – status quo, low pressure, high pressure and progress.

Importantly, the report does not forecast demand or capacity; rather it provides projections of requirements based on clear assumptions in relation to the evolution of key drivers of demand and capacity.

FINDINGS

The population of Ireland aged 65 years and over is projected to increase from 0.78 million to over 1.3 million between 2022 and 2040, with the overall proportion of the population aged 65 and over projected to increase from 15 per cent to 21 per cent. In this context, Tables ES.1 and ES.2 present the projected additional short stay and long stay bed capacity and home support hour requirements by 2040, and associated average annual growth rates. The lower and upper range of the projections are presented.

Table ES.1 shows that short stay bed capacity requirements are projected to increase from 3,745 beds in 2022 to between 6,431 beds and 7,265 beds by 2040, equivalent to average annual growth of 3.0 to 3.7 per cent. Long stay bed capacity requirements are projected to increase from 29,579 beds in 2022 to between 47,588 beds and 53,266 beds by 2040, equivalent to average annual growth of 2.7 to 3.3 per cent.

TABLE ES.1 Base year LTRC capacity and projected requirements, 2040

	2022	Projected requirements across scenarios (min–max)	
		2040	Average annual growth
	N	N	%
Short stay			
Beds	3,745	6,431–7,265	3.0–3.7
Long stay			
Beds	29,579	47,588–53,266	2.7–3.3

Sources: ESRI population data, HSE administrative data, NHI surveys, and HIQA bed register data; authors' calculations.

Table ES.2 shows that home support hour requirements are projected to increase from 28.7 million hours annually in 2022 to between 44.9 million and 54.9 million hours by 2040, equivalent to average annual growth of 2.5 to 3.7 per cent.

TABLE ES.2 Base year home support hours and projected requirements, 2040

	2022	Projected requirements across scenarios (min–max)	
		2040	Average annual growth
	N (millions)	N (millions)	%
Home support			
Hours	28.7	44.9–54.9	2.5–3.7

Sources: ESRI population data, HSE administrative data and TILDA data; authors' calculations.

DISCUSSION

This analysis projects significant increases in demand and capacity requirements for short stay and long stay care, as well as home support services, by 2040. The analysis shows that it is the large projected increase in the older population that is the main driver of projected requirements. Healthy ageing and new care models can moderate, but not offset, the impact on the demand and capacity requirements driven by this population ageing effect. Consequently, policies will inevitably be required to develop effective financing, workforce and infrastructure planning to help deliver the additional LTRC and home support to the older population.

While the model of provision is not examined explicitly in this report, it is important to acknowledge that the majority of LTRC and home support services are provided by the private sector. This report does not consider the role of private care providers when estimating LTRC bed capacity and home support hour requirements. However, the current context of care provision needs to be acknowledged by policymakers when using results from these analyses to inform capacity, workforce and infrastructure planning, as policies needed to develop public (HSE) capacity, workforce and infrastructure may differ from policies needed to encourage more private investment and provision.

Future analyses will seek to examine other services (including rehabilitative care, day centre care, and the Integrated Care Programme For Older People (ICPOP)) in

more detail; this will provide a more comprehensive understanding of older people's care capacity requirements in Ireland.

CHAPTER 1

Introduction

1.1 OVERVIEW

This report provides analyses of projections of demand and capacity requirements for publicly and privately funded long-term residential care (LTRC) and home support from 2022 to 2040 in Ireland.[1] Projection analyses presented in the report have been generated using the Hippocrates projection model, a model developed at the Economic and Social Research Institute (ESRI) in a programme of research funded by the Department of Health.

Recently published, related analyses have used the Hippocrates model to project demand and capacity for public acute hospital care (Brick et al., 2025) and general practice (Connolly et al., 2025) in Ireland. This report updates the Hippocrates model to project capacity requirements for the two key older people's services in Ireland: LTRC and home support. Analyses conducted as part of this study, and presented in this report, estimate national baseline utilisation profiles for 2022, for publicly and privately financed LTRC as well as for publicly and privately funded home support among the population aged 65 years and over. The analyses then provide medium-term projections of home support hour demand, and short stay and long stay bed capacity requirements to 2040. These projections incorporate new population projections developed using the ESRI's regional demographic model (Bergin and Egan, 2024), and an extended range of demand, capacity and policy assumptions for older people's services.

The analyses in this report were conducted as the health and social care system emerged from the COVID-19 pandemic. Evidence presented here shows there was a reduction in the number of LTRC residents during the COVID-19 period, but subsequent increases have followed a pre-COVID-19 period trend, and the trend projected in previous Hippocrates analyses (Wren et al., 2017). Based upon examination of previous projections with actual outcomes, the Hippocrates model has been found to work well in projecting demand for older people's services in the medium term. However, we acknowledge that uncertainty exists with all projection analyses, and we account for uncertainty by including a range of assumptions, projections scenarios and sensitivity checks within the analyses. Activity profiles may change as recent policy changes, such as the establishment of the Integrated Care Programme for Older People (ICPOP), become more embedded in the system, and with the implementation of any future policy

[1] The year 2040 is the end year for the analysis to align with Project Ireland 2040, the Government's long-term development strategy. Project Ireland 2040 incorporates both the National Planning Framework and the National Development Plan. See https://www.gov.ie/en/department-of-public-expenditure-ndp-delivery-and-reform/campaigns/project-ireland-2040/.

changes, such as the potential establishment of a statutory home support scheme. Therefore, projection analyses should be regularly reviewed in light of important changes.

Importantly, the report does not forecast demand or capacity; rather it provides projections of LTRC bed capacity and home support hour requirements based on clear assumptions in relation to the evolution of key drivers of demand and capacity.

1.2 OBJECTIVES

The main objectives of this report are to:

- calculate 2022 baseline LTRC (short stay and long stay) bed profiles and baseline home support hour demand profiles among older people (aged 65 years and over), incorporating new population estimates based on Census 2022; and
- project LTRC bed capacity and home support hour requirements nationally to 2040.

1.3 STRUCTURE OF THE REPORT

The report is structured as follows.

- Chapter 2 provides an overview of older people's services in Ireland with particular focus on LTRC and home support.
- Chapter 3 describes the Hippocrates modelling methodology, the data to inform baseline analyses and the projection scenarios incorporated.
- Chapter 4 presents baseline findings for short stay and long stay care in LTRC homes, and includes and highlights the role of the private sector in LTRC provision in Ireland.
- Chapter 5 presents baseline findings for home support, and highlights the role of the private sector in home support provision in Ireland.
- Chapter 6 presents projection analyses for short stay and long stay beds to 2040.
- Chapter 7 presents projection analyses for home support hours to 2040.
- Chapter 8 concludes, summarises findings and presents policy implications from the analyses.

CHAPTER 2

Older people's care in Ireland

2.1 INTRODUCTION

This chapter provides an overview of older people's services in Ireland. It defines the two services examined in this report: long-term residential care (LTRC) and home support. The chapter outlines the differing eligibility criteria and financing mechanisms for these services. Finally, LTRC and home support are discussed within the wider policy landscape, and policy changes implemented since the onset of the COVID-19 pandemic in Ireland are described.

2.2 BACKGROUND

2.2.1 Health and social care and older populations

Life expectancy rates have increased (Duffy et al., 2022) and mortality rates have reduced substantially in Ireland (Eighan et al., 2020) in recent years, driven mainly by improvements in mortality rates at older ages. Accordingly, Ireland has seen large increases in its older population in recent years. A large proportion of all health and social care in Ireland is delivered to older people (Keegan et al., 2020; Walsh et al., 2021). For services provided in the acute hospital system (e.g. emergency department) and community-based care (e.g. public health nursing), utilisation rates have increased significantly across the age distribution (Wren et al., 2017; Keegan et al., 2020) and over half of all inpatient bed days are used by those aged 65 years and over (Walsh and Brick, 2023). In this context, the Commission on Care for Older People was established in 2024 to examine the provision of health and social care services and supports for older people, and to make recommendations to improve health and social care for older adults in Ireland.

The vast majority of long-term care and social care services are provided to the older population. Long-term care provides a mixture of health and supportive services to meet the health, frailty and personal care needs of older people. In 2023, over €2.5 billion of the Health Service Executive's (HSE) current expenditure budget was spent on all services provided through older people's services, mainly LTRC and home support.[2] This expenditure on older people's services accounted for 10.9 per cent of the total HSE current expenditure budget.

A complex mix of public and private funding and provision characterises the long-term care sector in Ireland. Previous analyses show that both the LTRC and home support sectors are largely publicly funded (Walsh and Lyons, 2021). However,

[2] See https://www.hse.ie/eng/services/publications/performancereports/performance-profile-december-2023.pdf.

privately purchased care remains an important component of long-term care, especially for home support where between one-fifth (Institute of Public Health in Ireland, 2018) and one-quarter (Walsh and Lyons, 2021) of total hours are bought privately. Many people who privately purchase this care highlight the waiting times for public home support as a reason for doing so, while others essentially use privately purchased care to 'top-up' their existing public home support service (Institute of Public Health in Ireland, 2018). This continued reliance on private purchasing complicates capacity planning, affordability and equity; our analysis therefore aims to capture it, in line with earlier studies that employ the Economic and Social Research Institute's (ESRI) Hippocrates model (Walsh et al., 2021).

Despite the predominance of public financing, LTRC and home support services rely heavily on private-sector providers. The majority of publicly funded care is now delivered by private firms, a market increasingly dominated by a small number of international, private-equity-backed companies (Mercille and O'Neill, 2020; Mercille, 2024; Walsh and Connolly, 2024). Consequently, our baseline analysis (Chapters 4 and 5) presents estimates of the percentage of long-term care provided by the private sector to help policymakers determine future capacity requirements.

LTRC and home support together comprise the largest source of expenditure on older people's services by the HSE. Other important services, including day centre care, respite care and 'meals on wheels' are also funded via the older people's services budget, and are often provided as part of wider care packages with home support. However, data on the utilisation of these other services are poor, which means we cannot include them in the analyses presented in this report. In addition, new care programmes for older people have emerged in recent years. As part of a wider focus on new enhanced community care (ECC) programmes developed by the HSE, the Integrated Care Programme for Older Persons (ICPOP) has been established specifically to allow for integration of health and social care for the older population. ICPOP services are delivered via specialist multidisciplinary teams that support a population of approximately 150,000.[3] ICPOP teams typically include a geriatrician (based out of a public acute hospital), community nurses, as well as health and social care professionals such as speech and language therapists, occupational therapists and physiotherapists. The ICPOP teams can also include a 'community connector'[4] to further help promote social connectedness for care recipients. While eligibility for many public health and social care services is dependent upon possessing a medical card, services provided via ICPOP are available to individuals regardless of medical card status. Access to ICPOP teams can be made via referral from a general practitioner (GP) or a consultant geriatrician. Currently, ICPOP prioritises older people with more severe frailty, with 65 per cent of ICPOP recipients (Government of Ireland, 2024) having a Clinical

3 Equating approximately to each ICPOP covering two community healthcare networks.

4 This role is played by ALONE and other charitable organisations.

Frailty Scale (CFS) score of between five and nine (Rockwood et al., 2005; Rockwood and Theou, 2020). ICPOP teams represent a new and increasingly important component of older people's health and social care. However, similar to the services outlined above, a lack of detailed utilisation data means they cannot be included in this analysis. It is hoped that future Hippocrates modelling projects will include ICPOP and other older people's services. This report focuses on LTRC and home support, which are defined and discussed in the sections that follow.

2.3 LONG-TERM RESIDENTIAL CARE

2.3.1 Definition

LTRC has long formed a central component of the care of older people in Ireland. It is mainly provided to older people who have personal or nursing care needs that impact their activities of daily living (ADL) to the extent that it is difficult for them to live independently at home.

As with previous reports using the Hippocrates model (Wren et al., 2017; Walsh et al., 2021) and analyses examining residential care for older people in Ireland (Walsh and Connolly, 2024), we define LTRC as both short stay and long stay care provided outside of acute hospital settings and within residential care facilities such as nursing homes. Short stay and long stay beds can be distinguished by the length of stay (LOS) of residents, but also the intended purpose of the care provided. Short stay beds are intended for temporary needs. Short stay beds are typically used for: post-acute step-down care (also termed intermediate or community care beds) for patients transitioning from acute hospitals but not yet ready to return home; rehabilitative care for patients recovering from surgery; and transitional care for people awaiting a long stay bed via the Nursing Homes Support Scheme (NHSS). There are no defined LOS cut offs for short stay beds; the Transitional Care Fund, for example, provides funding for up to ten weeks.

Long stay beds, by contrast, are intended for individuals with ongoing, often permanent, care needs that cannot be met at home. These beds support people who require assistance with ADL on a continuous basis, and care typically includes medical oversight and personal care. These beds are generally located in nursing homes. In Ireland, long stay care is most commonly funded through the NHSS. The average LOS for the NHSS is three years (Collins, 2019). The majority of long stay residents will spend the remainder of their lives in an LTRC home.

Short stay and long stay beds also tend to face differing monitoring and regulatory oversight. Every LTRC home that only (or predominantly) provides long stay care must register with the Health Information and Quality Authority (HIQA) as a designated centre of care, and designated facilities providing such care are subject

to HIQA regulatory oversight.[5] However, residential facilities that are designated as short stay are not required to be registered as a designated centre, and therefore are not subject to HIQA monitoring or regulatory oversight (HIQA, 2017). Many of these facilities were previously categorised as nursing homes or district hospitals.

2.3.2 LTRC provision structures

LTRC providers can be partitioned into three groups according to ownership:

- public provision mainly provided in HSE owned and operated LTRC homes;
- voluntary (or private 'not-for-profit') providers of care who tend to be charitable or religious organisations; and
- private 'for-profit' providers.

Currently, the majority of LTRC (approximately 80 per cent, see Chapter 4) is provided by the private sector. Moreover, this percentage is growing over time (Mercille, 2024). The composition of the private LTRC sector is also changing, with larger operators of multiple LTRC homes now dominating provision, leading to a reduction in independently owned and operated LTRC in recent years (Walsh and Connolly, 2024).

2.3.3 LTRC financing and eligibility

In 2023, over 5 per cent of the total HSE health and social care budget was spent on LTRC, mostly via the NHSS (HSE, 2023). Previous analyses using the Hippocrates model estimated that, in 2019, total public and private expenditure on LTRC was almost €2 billion, and the sector provided care to an estimated 32,000 people, 94 per cent of whom were aged 65 years and over (Walsh et al., 2021). The majority of LTRC expenditure was provided by the State, though resident co-payments do form part of the NHSS, while private financing of LTRC also occurs.

Nursing Home Support Scheme

Financing of LTRC in Ireland is dominated by the NHSS. The scheme, commonly known as 'Fair Deal', was established by the Nursing Home Support Scheme Act, 2009. This scheme provides a statutory basis for the State to fund/subsidise the residential care of people assessed to require such care. Approximately 70 per cent of all LTRC expenditure in 2019 was financed via the NHSS. Almost all LTRC homes in Ireland provide care to at least some of their residents under the NHSS (Walsh and Connolly, 2024).

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5 If residential services are provided to older people, on either a short-term or long-term basis, in a facility that meets the definition of a designated centre, then they are required to register with HIQA and are subject to regulation (HIQA, 2017).

Unlike primary and community care, eligibility for the NHSS or publicly funded short stay care is not linked to possession of a medical card.[6] Rather, eligibility is based upon assessment of needs. The NHSS includes a systematic care assessment, along with a financial assessment for those with a defined care need, as part of its application process. This assessment is carried out prior to entering into an LTRC home. Additionally, the assessment can also happen prior to or during the course of any residential care being provided via the Transitional Care Fund. A co-payment based on an income and assets means test is payable by the resident (or their family). Eligible NHSS applicants must contribute 80 per cent of their income and 7.5 per cent of the value of any assets towards the cost of their care. The State pays the balance, which equates to three-quarters of the cost of their care (Collins, 2019). The first €36,000 of assets for an individual are not counted in the financial assessment.[7] Current funding through the NHSS does not recognise dependency levels, or the presence of certain illnesses such as dementia. Rather, the funding allocation for residential stays in the NHSS is based upon the LTRC centres that provide the care. Various studies have highlighted variations in NHSS funding between public and non-public LTRC homes and across counties in Ireland (Walsh and Connolly, 2024).

Other funding mechanisms

A number of other, albeit smaller, state-provided funding sources exist for LTRC:

- Legacy funding: A small number of LTRC residents are funded though schemes that existed prior to the introduction of the NHSS. The numbers funded via these legacy schemes are small, and have reduced over time. In the analyses we combine NHSS and legacy funded residents as one long stay group.

- Transitional Care Fund: The Transitional Care Fund was established in 2015 as a short-term funding scheme to ease the transition to the NHSS by providing beds in LTRC centres for up to ten weeks.[8] Through this funding, the State covers the cost of the residents' stay, with no co-payments required. All LTRC homes eligible for the NHSS are eligible to receive residents supported by this fund, and the rates of payment for a bed per week are equivalent to the rates agreed under the NHSS. Following the onset of the COVID-19 pandemic, this fund was expanded to cover surge capacity (e.g. free up beds in acute hospitals), and to provide LTRC for those awaiting a new home support package or housing adaption.

  In the analysis, as the fund is predominantly used to provide care for those wating for the NHSS, activity is included in the baseline as a short stay activity. However, while many of those receiving care are technically on a waiting list for

6 Almost two-thirds of the population aged 65 years and over hold a medical card (Mattsson et al., 2022).

7 Other income and asset caps are applied to certain residents including farmers and business owners. See https://www.citizensinformation.ie/en/health/health-services/health-services-for-older-people/fair-deal-scheme/.

8 Between 2022 and 2024, the wait time for NHSS funding approval was consistently approximately four weeks. See https://www.hse.ie/eng/services/publications/performancereports/performance-profile-october-to-december-2022.pdf.

the NHSS, we do not count them in our unmet demand assumptions – in order to avoid duplication.

- Intermediate, step-down and community care: In addition to short stay care provided in private LTRC homes, the HSE and Section 38 facilities also provide short stay or intermediate care within LTRC facilities, mainly community nursing units.

2.3.4 LTRC policy changes

LTRC, in Ireland and internationally, has faced significant changes and challenges in recent years due to population ageing and, particularly, the onset of the COVID-19 pandemic in early 2020. Internationally (Comas-Herrera et al., 2021) and in Ireland (HIQA and HPSC, 2022), the LTRC sector was severely impacted by the COVID-19 pandemic in terms of infections and deaths, as well as provision and workforce constraints. Between March 2020 and March 2021, there were over 8,500 confirmed COVID-19 infections and more than 2,100 deaths attributable to COVID-19 among LTRC residents in Ireland (Walsh et al., 2023).

LTRC providers also experienced significantly higher costs as a result of COVID-19; this was caused by admissions and occupancy rates (ORs) declining (Frazer et al., 2021). In supplementary analyses shown in Appendix A, using data on NHSS residents, we highlight the large reduction in LTRC resident numbers that occurred during the pandemic period. In addition, costs increased as LTRC homes were required to adapt spaces for COVID-19-specific areas, improve cleaning and infection controls, and hire agency staff due to staffing absences from COVID-19 infection (Frazer et al., 2021). To aid LTRC providers, the State provided significant funding and resources to the sector, and established the Temporary Assistance Payment Scheme (TAPS) to offer financial support to non-public LTRC homes (Walsh and Connolly, 2024). TAPS was introduced in April 2020, and provided a significant €132 million to LTRC homes through to December 2021 (Walsh and Connolly, 2024).[9] LTRC homes could avail of TAPS for a number of different reasons including for cleaning and infection control and additional staffing.

In November 2022, the Temporary Inflation Payment Scheme (TIPS) was announced to provide financial assistance to voluntary and private LTRC homes to help them with the costs of energy inflation experienced since 2022. TIPS is similar to TAPS and is administered by the National Treatment Purchase Fund. However, the TIPS budget was relatively small and in the first year only €10 million was allocated through this scheme.[10]

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9 TAPS continued in a more limited capacity into 2022.

10 See https://www.gov.ie/en/press-release/0ecc0-ministers-for-health-announce-10-million-new-scheme-to-support-private-and-voluntary-nursing-homes-with-costs-of-energy-inflation/#:~:text=Minister%20for%20Health%2C%20Stephen%20Donnelly,from%20July%20to%20December%202022.

2.4 HOME SUPPORT

Home support (or home care) refers to health, personal and domestic care services provided to people in their own homes by a professional carer (often termed formal home support). The aim of home support is to provide personal care and assistance to support people with their ADLs (the key tasks involved in caring for oneself such as mobility, nutrition, toileting) and/or their instrumental activities of daily living (IADLs) (the key tasks that allow for independent living such as cleaning, shopping and food preparation) (HIQA, 2024). However, it is important to acknowledge that the majority of supports provided to people in their own homes in Ireland are provided by family carers (Hanly and Sheerin, 2017; McGarrigle et al., 2022).

Home support services are either provided through the HSE's 'public' home support service scheme, or by professional carers hired privately by the recipient or family members ('private' home support). Recipients can access both public and private home support together (Walsh and Lyons, 2021). A typical home support visit in Ireland lasts 30–60-minutes (or is broken up into two 30 minute visits). They are provided on a daily basis by a health care support assistant (formerly known as a 'home help'). In 2022, the average public home support package per week was just under eight hours.

The State began funding and providing home support following the 1970 Health Act, which established the initial such support: the Home Help Scheme. This mainly provided domestic supports such as help with basic household tasks, such as cleaning and cooking, and getting up in the morning. In 2006, a second scheme, the Home Care Package Scheme, was established to provide more comprehensive home care packages. It was mainly aimed at older people who needed support in place to enable them to safely return to living at home following a stay in an acute hospital. Home care packages were often provided by multidisciplinary teams that included carers, nurses, and health and social care professionals. More recently, the Intensive Home Care Package (IHCP) scheme was established to provide very intensive packages of care to a small number of people with high levels of dependency, including people with cognitive impairment and dementia (Keogh et al., 2018). In 2018, the home help and home care package schemes were merged into the Home Support Service Scheme (HSE, 2018), which we examine in the analysis. We also examine the IHCP scheme, though the scale of this scheme remains small.

2.4.1 Home support provision structures

Similar to LTRC, home support provision can be partitioned into hours provided by directly employed HSE carers (health care support assistants, formerly known as 'home helps'), voluntary (or private not-for-profit) providers of care, and private for-profit providers, who are typically organised through a regional franchise

structure. Currently, the majority of home support hours, approximately 71 per cent (see Chapter 5), is provided by the private sector. The percentage of private provision has been growing significantly over time (Mercille and O'Neill, 2020). The composition of the private LTRC sector is also changing, with larger operators now dominating provision (Mercille and O'Neill, 2020).

2.4.2 Home support financing and eligibility

Similar to LTRC, eligibility for home support is not linked to the possession of a medical card, but rather is based upon assessment of needs. Care assessments are carried out by public health nurses or community-based health and social care professionals. A single assessment tool, interRAI, is being rolled out to allow for more systematic assessment of care needs to be carried out for the HSE Home Support Service Scheme. However, rollout of the tool has been slow due in part to limitations in Ireland's health information systems (HIQA, 2022), and as of 2024, interRAI has only been used to determine care needs in less than one-quarter of HSE home support service assessments (HSE, 2025).

While the NHSS includes a co-payment component, all care provided through the HSE Home Support Service Scheme is free of co-payments for recipients. There have been discussions and analyses on adopting a co-payment structure for home support in Ireland. Research has highlighted that introduction of a flat co-payment per home support hour would be regressive (Keane et al., 2022). Attempts to introduce more progressive funding systems that cap payments or payments for hours above a certain level are more progressive, but would capture only a small percentage of overall costs (Keane et al., 2022). Additionally, a study undertaken by the World Health Organization and the European Observatory on Health Systems and Policies found that introducing co-payments for home support would not significantly reduce demand (Durvy et al., 2023).

2.4.3 Home support policy changes

Unlike LTRC, where a statutory NHSS exists, no statutory scheme exists for home support in Ireland. The Sláintecare report called for the introduction of a statutory home support scheme (Houses of the Oireachtas Committee on the Future of Healthcare, 2017), and the 2025 Programme for Government includes provisions for such a scheme.[11] Research has estimated that the introduction of a statutory home support scheme could increase demand for home support significantly (Walsh and Lyons, 2021). However, at the time of writing no decision has been made on the introduction of such a statutory scheme. As highlighted in Walsh and Lyons (2021), a statutory scheme may offer the opportunity to provide a more intensive package of home support to allow some individuals who are currently in

11 *Programme for Government 2025: Securing Ireland's Future*, https://assets.gov.ie/static/documents/programme-for-government-securing-irelands-future.pdf.

LTRC to remain at home for longer. In this analysis, we include a projection assumption in the 'progress' scenario that models the potential impact of such a substitution towards home support and away from LTRC.

While there is no evidence that home support recipients were as impacted by COVID-19 as residential care residents, the COVID-19 period did change the perception of home support; following it there has been a greater emphasis on supporting older people in their own homes (Ní Shé et al., 2020). For example, the Expert Panel on Nursing Homes outlined the preference for home support to be emphasised, so that older people can be enabled to live independent lives at home (Frazer et al., 2021). The panel also highlighted the need for home support standards to be improved.

CHAPTER 3

Hippocrates projection methods and data

3.1 INTRODUCTION

This chapter provides an overview of the Hippocrates projection methodology used in this report. An accompanying report (Brick et al., 2025) examining projections of public acute hospital capacity offers more detail on the background and evidence that informs the development of the Hippocrates projection modelling framework for these capacity analyses. Detailed discussion on the development of the Hippocrates model, the use of similar models in other countries, and potential alternative models can be found in previous Hippocrates reports and academic papers (Wren et al., 2017; Keegan et al., 2018; Keegan et al., 2020; Keegan et al., 2021; Keegan et al., 2022).

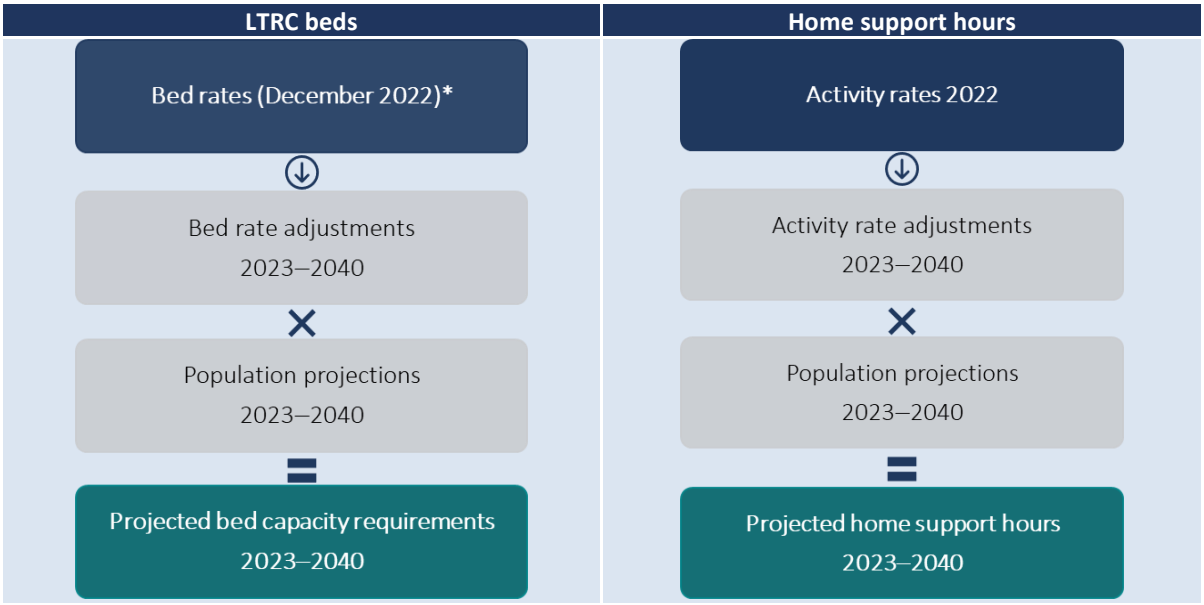
This chapter also provides an overview of the data and methods used to generate the capacity rate and activity rate profiles for long-term residential care (LTRC) beds and home support hours in Ireland in the base year, 2022. In addition, we describe how capacity and activity rates are adjusted to account for assumptions related to population growth and ageing, healthy ageing, reducing unmet demand and potential expansion of the Health Service Executive's (HSE) Home Support Service.

3.2 PROJECTION METHODOLOGY

A significant benefit of the Hippocrates model is its flexibility in providing projections when the data available are not optimal and differ across services. The two services under consideration in this report, LTRC and home support, require two slightly different approaches. For LTRC, short stay and long stay beds are the key capacity metric; we therefore develop age- and sex- adjusted bed rates in the base year, and project this metric to 2040. For home support, there is no equivalent measure of capacity, so we use home support hours as our key metric, develop an age- and sex-adjusted home support hour activity rate in the base year, and project this metric to 2040.

Figure 3.1 presents a diagrammatic representation of steps involved in applying Hippocrates to project LTRC bed capacity and home support hour requirements to 2040. The first step in developing projections in Hippocrates is to develop 2022 age- and sex-specific LTRC bed and home support hour rates. Rates are then adjusted based on a range of evidence-based assumptions, which have been developed and enhanced over the lifetime of the model. Adjusted rates are multiplied by population projections to provide estimates of demand and capacity requirements in a projection year. Section 3.3 outlines the steps involved in calculating baseline profiles for both services.

FIGURE 3.1 Hippocrates model – Diagrammatic representation of LTRC and home support projections, 2022–2040



Notes: *Bed rates based upon age and sex profile of residents (December 2022).
Source: Authors' representation of the Hippocrates model.

3.3 DEVELOPMENT OF BASE YEAR PROFILES FOR 2022

3.3.1 LTRC beds

There is no resident-level dataset capturing all LTRC residents receiving care in Ireland, or data on residents' sociodemographic characteristics, length of stay (LOS), or personal and healthcare needs. In addition, no comprehensive dataset exists that captures all short stay and long stay beds available nationally. These issues have been encountered in previous Hippocrates analyses (Wren et al., 2017; Walsh et al., 2021). Previous Hippocrates analyses used data from the Health Information and Quality Authority (HIQA) and the HSE on beds and bed categories in December 2015 (Wren et al., 2017) and December 2019 (Walsh et al., 2021) in combination with information on occupancy rates (ORs) from the HSE and Nursing Homes Ireland (NHI) to estimate the number of LTRC residents in Ireland in 2015 and 2019. Age and sex profiles were estimated by applying information on the number of Nursing Homes Support Scheme (NHSS) residents at each age for males and females to project LTRC resident demand (Wren et al., 2017) and expenditure (Walsh et al., 2021). Therefore, similar to the approach adopted in previous Hippocrates analyses, we combine data available on LTRC residents and LTRC beds at a point in time – 31 December 2022.[12] As this analysis is focusing on LTRC beds as the key sector capacity metric, we present baseline profiles as bed rates in December 2022. This approach of using data on beds at a point in time as the basis to undertake projection analyses has also been used in other national projection analyses of LTRC beds such as the 2018 Department of Health Capacity Review (Department of Health and PA Consulting, 2018). A similar approach has been used

[12] Both HIQA (HIQA, 2023) and the HSE (HSE, 2022a) also routinely use December as their reporting period for each year.

internationally in an analysis of LTRC bed requirements in Canada (Financial Accountability Office of Ontario, 2019).

Bed data

The HIQA bed register was the first source of data used to estimate baseline bed capacity. All public, voluntary and private LTRC homes that provide long stay care to older people must register with HIQA. The HIQA bed register captures the list of registered operators and other information important for this analysis, specifically the number of beds in each LTRC facility. We use the HIQA bed register data for December 2022 in this analysis.

We also include a list of public LTRC homes captured in the HSE bed register in December 2022. The HSE bed register separates beds into short stay and long stay beds, which the HIQA bed register does not. Most public LTRC homes are captured in both bed registers. In such instances, we included only data from the HSE bed register for these LTRC homes to avoid duplication of LTRC homes and bed data.[13] The combination of the HIQA and HSE bed register data allows this analysis to capture all LTRC beds registered with HIQA to provide care to older people and all public LTRC homes operating in the system.

As the HIQA bed register does not partition beds in voluntary and private LTRC homes into short stay and long stay beds, we used information from surveys conducted for NHI in 2018 and 2022 that captured information on the percentage of beds used for short stay care. We used this information to disaggregate LTRC beds in voluntary and private LTRC homes into short stay or long stay beds.

Resident data: In order to develop baseline age- and sex-specific bed rates, we utilise detailed demographic information on Nursing Home Support Scheme (NHSS) recipients. The HSE provided information on the number of NHSS recipients by single year of age (SYOA) and sex as of 31 December 2022 (covering the same time period as the bed data included in the analysis). Age and sex profiles of NHSS residents (who constitute almost three-quarters of LTRC residents) are applied to all short stay and long stay beds, since comparable demographic data are not available for non-NHSS long stay or short stay residents. This approach of applying the NHSS age and sex profile to all LTRC beds is consistent with previous projection analyses (Wren et al., 2017; Walsh et al., 2021).

A limitation of this analysis is the lack of resident data across the 2022 period; however, there is no evidence that the resident data for December 2022 is not

[13] In addition, one large LTRC home with over 200 short stay beds, privately operated but which predominantly provides publicly funded short stay care, was also included in the baseline analysis and categorised as a public LTRC home in the analysis. The National Rehabilitation Hospital specialises in rehabilitative care, and is not included in the analyses. These inclusion and exclusion decisions are consistent with previous Hippocrates analyses (Wren et al., 2017; Walsh et al., 2021).

reflective of the residents residing in short stay and long stay beds throughout 2022. Annually, HIQA asks for all registered LTRC homes to submit information on the number of residents residing in their LTRC homes on three dates throughout the year, and evidence from 2022 finds relatively a similar number of residents across the year (HIQA, 2023).

Methods: We estimate a baseline bed rate, utilising residents' age and sex profiles, and use this to project LTRC bed capacity requirements to 2040.

- Using the bed data described above, we calculate the number of LTRC beds in the system in December 2022 and partition these beds into short stay and long stay categories.
- The age- and sex-specific distribution of NHSS residents is applied to short stay and long stay beds to provide us with a calculation of beds per age and sex group in the population, consistent with previous research (Wren et al., 2017; Walsh et al., 2021).
- A bed rate is calculated by dividing the number of beds in each age and sex group by the population in each group.

3.3.2 Home support hours

Similar to LTRC, there exists no comprehensive dataset on home support recipients or the number of hours provided to them. These issues have been also encountered in previous Hippocrates analyses (Wren et al., 2017; Walsh et al., 2021). Therefore, similar to the approach adopted in previous Hippocrates analyses, we combine HSE administrative data with survey-based data from The Irish Longitudinal Study on Ageing (TILDA). As there is no defined capacity metric for home support, we present baseline profiles as home support hours rates in 2022. The analysis includes both publicly funded and privately purchased home support.

Recipient data: We use a combination of HSE administrative data and TILDA data on public and private home support recipients, and home support hours used. Administrative data from the HSE provided the number of home support (and Intensive Home Care Package (IHCP)) recipients nationally in 2022. These data captured the total number of home support recipients.[14]

As the HSE data do not capture the age or sex of recipients, we use data from TILDA waves 2–4 to provide an age and sex distribution of home support recipients. In these surveys, the respondents were asked whether they had received any of the following from the State in the previous 12 months:

[14] An audit carried out in 2023 also provided an age distribution for some recipients.

- Home help (a person employed by the State to help you with household chores such as cleaning and cooking);
- Personal care attendant (a person employed by the State to assist [you/him/her] with bathing, showering, bodily care etc.); and
- Home care package.

In addition, the TILDA survey captures information on private home support; respondents were asked whether they had paid any individual or private company to provide home help or personal care in the previous 12 months. We use responses to this question (by SYOA and sex) to estimate private home support recipient rates.

Home support hours data: Administrative data from the HSE provided the number of hours provided via the HSE home support service and IHCPs nationally in 2022.[15] These data allowed us to estimate an average home support package (dividing hours by recipients) at an annual and weekly level. Data from TILDA waves 2–4 were also used to provide an age and sex distribution of home support recipient hours. For private home support, we combined information on privately purchased home support in TILDA with information provided by Home and Community Care Ireland for previous Hippocrates model analyses (Walsh et al., 2021) that provides the average number of hours provided in a private home package.

Methods: The following approach has been used to develop home support hours activity rates in 2022.

- The total number of hours provided in 2022 through the HSE home support service and IHCP schemes are combined to calculate the total number of public home support hours provided in 2022.
- The age- and sex-specific distribution estimated using TILDA data[16,17] is applied to *public home support* hours to provide an estimate of the activity profile in the population, consistent with previous research (Wren et al., 2017; Walsh et al., 2021).
- TILDA data are used to estimate the number of recipients utilising *privately purchased home support* by age and sex, and these recipients are apportioned an average weekly package of private home support.[18]

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15 An audit carried out in 2023 also provided an age distribution for some recipients.

16 Importantly, as TILDA captures information only from respondents who live at home, estimates were grossed up to the national level using Census 2022 only after the population estimated to be in LTRC homes was removed.

17 Additional analyses presented in Appendix B compare home support recipient rates from this analysis by age to the 2023 HSE audit data (FIGURE B.1), and by age and sex from Aspell et al. (2019) – a study that used granular on data home support use in CHO9 (North Dublin) (FIGURE B.2). Consistent age and sex distributions were observed between the different sources.

18 The average weekly package is grossed to a yearly package by multiplying by 52 weeks, in line with Walsh et al. (2021).

- Public and private hours are combined for each age and sex group, and a home support hour activity rate is then calculated by dividing the number of hours in each age and sex group by the population in each group.

3.4 ADJUSTMENT OF BASE YEAR RATES, 2023–2040

Once base year rates have been established for 2022, for LTRC and home support, a series of assumptions are applied in the projection scenarios, which adjust LTRC bed rates and home support hour rates across the projection horizon. This follows the approach used in previous Hippocrates-based output and other health and social care projection exercises (e.g. Charlesworth and Johnson, 2018; Lorenzoni et al., 2019; Walsh et al., 2021; Rachet-Jacquet et al., 2023).

3.4.1 LTRC assumptions

For LTRC, we project short stay and long stay beds both together and separately. In this projection analysis we consider the following assumptions.

Population growth and ageing

Three population projection scenarios are incorporated into the latest version of the Hippocrates model using estimates provided from the Economic and Social Research Institute (ESRI) regional demographic model (Bergin and Egan, 2024). The ESRI regional demographic model is a cohort component model. It generates population projections under different sets of assumptions around the three key drivers of population change: mortality, migration and fertility. The model projects the population by gender and SYOA at the national and regional level for each year, from a 2022 baseline to 2040. The data and methods used to develop these population scenarios by the ESRI regional demographic model are based upon the Central Statistics Office (CSO) Census of Population 2022. The detailed underlying methods of the ESRI regional demographic model are described in Bergin and Egan (2024).

Table 3.1 provides an overview of the main assumptions for each demographic scenario. The only difference between the three scenarios is the assumption relating to migration. In the central scenario, net migration is projected to average +35,000 per annum up to 2030 and 20,000 per annum thereafter. The low (high) scenario assumes 10,000 less (more) net migration per annum. As migration mainly impacts the working age population, and fertility assumptions impact younger aged groups, different assumptions for migration and fertility will have little impact on LTRC or home support projections in our projection period (2023 to 2040).

The mortality assumption, consistent with a projected increase in life expectancy at birth for males (females) from 81.1 (84.6) in 2022 to 84.2 (87.1) in 2040, and the

fertility assumption, with a constant fertility rate of 1.65, remain the same across scenarios.

TABLE 3.1 Summary of main assumptions for population scenarios

Assumptions	Central	Low	High
Mortality	Life expectancy at birth for males (females) is expected to increase from 81.1 (84.6) in 2022 to 84.2 (87.1) for males (females) in 2040.	No change from central scenario.	No change from central scenario.
Migration	Net immigration to average +35,000 p.a. to 2030 (higher at +45,000 in the short term) and +20,000 p.a. thereafter.	Net immigration to average +25,000 p.a. to 2030 (higher at +35,000 in the short term) and +10,000 p.a. thereafter.	Net immigration to average +45,000 p.a. to 2030 (higher at +55,000 in the short term) and +30,000 p.a. thereafter.
Fertility	Total fertility rate is unchanged at 1.65 over the period.	No change from central scenario.	No change from central scenario.

Note: p.a.=per annum.
Source: Bergin and Egan (2024).

Brick et al. (2025) provide an overview of population changes across each population assumption and age group. However, as discussed above, little variation is projected across scenarios for those aged 65 years and over, as assumptions surrounding fertility and migration will have little to no impact on the population aged 65 years and older over the 2022–2040 projection horizon of this analysis. Similarly, Section 3.4.1 in Brick et al. (2025) shows that for each assumption scenario, the oldest age groups are projected to see the largest relative increase in growth between 2022 and 2040. The population aged 65–84 years is projected to increase by almost 60 per cent, to approximately 1.1 million in 2040. Additionally, the population aged 85 years and over is projected to more than double to between 203,000 and 206,000 people in 2040. These age groups, especially the 85+ age group, are significant users of LTRC and home support.

Healthy ageing

This assumption makes adjustments that account for the fact that as life expectancy increases, not all additional life years may be spent in bad health; see Section 3.3.5 in Wren et al. (2017). To simulate these effects, we shift age- and sex-specific rate curves to the right in proportion to projected life expectancy change. This is based on an approach adapted from the European Commission (European Commission, 2014; 2017; 2023) and previously applied in Hippocrates outputs (Wren et al., 2017; Keegan et al., 2020; Walsh et al., 2021; Keegan et al., 2022).

Previous Hippocrates analyses have applied four different healthy ageing assumptions, which differ in relation to their optimism around healthy ageing. The absence of healthy ageing (*expansion of morbidity*) refers to a scenario where the period of chronic disease or disability at the end of life increases in direct

proportion to gains in life expectancy (Gruenberg, 1977). In contrast, the most optimistic scenario, the *compression of morbidity* theory, assumes that the period of chronic disease or disability at the end of life reduces in future cohorts over time, resulting in a greater proportion of life spent in good health (Fries, 1980; Fries et al., 2011). *Compression of morbidity* takes a very optimistic view and assumes the gain in health status exceeds the gain in life expectancy by 50 per cent, i.e. the associated age-specific activity rate profile shifts back more than one age year. *Dynamic equilibrium* and *moderate healthy ageing* are other positive, but less optimistic, scenarios. *Dynamic equilibrium* takes a less optimistic view than *compression of morbidity*; it assumes that for every one-year increase in life expectancy, the associated age-specific activity rate profile shifts back one age year (Manton, 1982; Manton et al., 2006). The *moderate healthy ageing* assumption models gains in health set at 50 per cent of the gain in life expectancy.

There is a scarcity of evidence on trends on healthy ageing, especially for factors such as activities of daily living (ADL) and instrumental activities of daily living (IADL) in Ireland. While evidence in the literature is mixed, there appears to be decreases or stabilisation in healthy ageing among older people internationally. Evidence from the United States has found that the proportion of people aged 70 years and older experiencing ADL or IADL difficulties has reduced in recent decades (Crimmins et al., 2009). Analysis of long-term care in Germany found a compression in the number of years older people were living with need for long-term care, with the biggest compression seen for severe care (Kreft and Doblhammer, 2016). A recent cross-country analysis from the World Bank found the percentage of older adults with any ADL/IADL limitations was relatively stable across time, though with considerable variation across countries (Qian et al., 2023). Based upon the literature showing some improvements regarding disability, frailty and difficulties with ADL rates among older people as life expectancy increases, we focus on the relatively more optimistic healthy ageing assumptions for the LTRC projection analysis: *dynamic equilibrium* and *compression of morbidity*, with *dynamic equilibrium* serving as our 'as is' assumption used in the status quo scenario. This aligns with previous outputs using the Hippocrates model (Wren et al., 2017; Keegan et al., 2020; Keegan et al., 2022).

For LTRC, we project short stay and long stay beds separately. In addition to demographic change and healthy ageing, in this projection analysis we consider the following assumptions.

Unmet demand: Waiting lists and delayed transfers of care

To account for unmet demand for short stay and long stay care, we combine information from a number of different sources. We then develop adjusted bed rates that include additional beds that would be required to meet this unmet demand, and project these adjusted baseline bed rates in the Hippocrates model.

The waiting list data we include provide a measure of unmet demand, but the data by definition only capture individuals who have applied and been assessed for the service. There is likely to be additional unmet need for care among the older population who are deterred by the eligibility rules and application process. However, the approach undertaken is based upon the data available, and the fact that a similar approach was adopted in previous Hippocrates analyses.

Short stay

Data: No comprehensive dataset capturing people waiting for a short stay bed exists. However, as short stay care is typically used for post-acute care, data are available on public acute hospital patients with an unmet demand for short stay care. Delayed discharges or delayed transfers of care (DTOC) data from public acute hospitals were provided by the Business Information Unit (BIU) in the HSE. The DTOC data include information on public acute hospital patients who have been medically cleared for discharge from hospital. Data captured include the hospital to which the patient was admitted, the age and sex of the patient, the number of days spent in hospital after having been flagged as a DTOC, and the service awaited while remaining in hospital. We include patients as having an unmet demand for short stay care if they transferred to a short stay bed.[19]

Methods:

- Using 2022 data on the numbers of days DTOC patients waited in hospital for short stay care, we estimate the total number of DOTC bed days used by age and sex. Based on this approach, we estimate that over 61,000 hospital bed days were occupied by patients who were medically fit for discharge but awaiting short stay care.

- We convert hospital bed days into an estimate of required short stay beds by dividing the total by the number of days in a year (365). To reflect operational efficiency, we apply a 90 per cent target OR to estimate the number of additional beds required.

  An OR of 90 per cent is applied as this reflects the short stay bed occupancy target outlined in HSE National Service Plans (HSE, 2023), assumptions included in previous health service capacity reviews (Department of Health and PA Consulting, 2018), and is similar to ORs estimated in surveys of LTRC homes conducted by NHI (BDO and NHI, 2022; 2024).[20]

[19] Categories used to determine DTOC for short stay care: 'care transferred for convalescence', 'care transferred to community nursing unit', 'care transferred to intermediate care', 'care transferred to step-down care', 'care transferred to transitional care bed prior to nursing home admission', 'care transferred to designated older persons rehabilitation bed', 'care transferred to other rehab bed' and 'ward of court – care transferred to transitional care bed'. Categories were chosen after discussion with the HSE.

[20] Feedback from LTRC stakeholders also suggested 90 per cent occupancy as an appropriate rate to include in the analysis.

- We calculate an age- and sex-specific unmet demand bed rate by dividing the estimated number of required beds in each demographic group by the corresponding population. This unmet demand rate is then added to the baseline short stay bed rates to produce adjusted bed projections.

Long stay

Data: For long stay care, we combine information from three main datasets and sources: the NHSS waiting list data, the HSE Winter Plan 2022/23 (HSE, 2022b) and the DTOC data. The NHSS waiting list data include individuals who were approved for a long stay bed under the NHSS as of 31 December 2022, but had not yet secured a placement. These data include information on the age and sex of the individual. However, many of these individuals are temporarily occupying short stay beds funded by the Transitional Care Fund. Since these beds are already counted in the short stay baseline, we subtract these individuals from the waiting list totals to avoid double counting. For this adjustment, we also use data from the HSE Winter Plan 2022/23. In addition, we use DTOC data to estimate unmet demand for long stay care. As described above, DTOC data capture public acute hospital patients who have been medically cleared for discharge but are awaiting a long stay bed. We include patients as having an unmet demand for care if they transferred to a long stay bed.[21]

Methods:

- Following the same approach used for short stay beds, we estimate the total number of DTOC bed days used by patients waiting for long stay care, disaggregated by age and sex. We do the same for individuals on the NHSS waiting list and, to avoid double counting, we first subtract short stay beds paid for via the Transitional Care Fund.

- We convert bed days into the number of beds required by dividing the total by the number of days in a year (365). To reflect operational efficiency, we again apply a 90 per cent target OR to estimate the number of additional beds required.

  Similar to short stay, an OR of 90 per cent is applied for long stay beds, as this reflects evidence found in surveys of LTRC homes conducted by the NHI (BDO and NHI, 2022; 2024), as well assumptions included in previous health service capacity reviews (Department of Health and PA Consulting, 2018).

- We calculate age- and sex-specific unmet demand bed rates by combining estimates of beds required using the DTOC and NHSS waiting data, and dividing beds required by the population in each age and sex group. This unmet demand

[21] Categories used to determine DTOC for long stay care: 'care transferred to nursing home (NHSS and Ancillary State Support loan)', 'care transferred to nursing home (NHSS and top up)', 'care transferred to nursing home (NHSS)' and 'care transferred to nursing home (self pay)'. Categories were chosen after discussion with the HSE.

rate is then added to the baseline long stay bed rates to produce adjusted bed projections.

In Appendix C, we present full analyses of the DTOC data for public acute hospital patients waiting for short stay and long stay care.

Expansion of home support

Previous evidence has shown that 8 per cent of home support recipients in Ireland transition into LTRC annually (Aspell et al., 2019). In this assumption, we assume a reduction in this admission rate from 8 per cent to 6 per cent annually – a 25 percentage relative decrease. We assume that the reduction in the admission rate from home support to LTRC occurs gradually between 2026 and 2029.

The age and sex profile of NHSS residents is applied to those assumed to remain receiving home support and have not been admitted into LTRC.[22] We assume this substitution of some care from LTRC to home support applies for both short stay and long stay residents. For long stay care, this does not imply that individuals no longer enter long stay beds, but rather that the rate of admission slows, thereby reducing the average duration of stay in LTRC. For short stay beds, we assume that some step-down care previously provided in a short stay bed is now instead delivered through a home support package. The impact of this scenario is allocated proportionately between short stay and long stay projections, based on the proportion of residents in each category.

3.4.2 Home support assumptions

For home support, we project public and private home support hours collectively. In addition to demographic change and healthy ageing, in this projection analysis we consider the following assumptions.

Population growth and ageing

Assumptions are the same as outlined for LTRC above.

Unmet demand: Waiting lists and delayed transfers of care

To account for unmet demand for home support, we combine information provided by the HSE from a number of different sources. We then develop adjusted home support hour demand rates, which include additional hours that would be required to meet this unmet demand, and project these adjusted baseline rates in the Hippocrates model. This is a similar approach to that adopted in previous Hippocrates analyses. Similar to LTRC, we acknowledge that using waiting list data as a measure for unmet demand may not capture all unmet need for home

[22] LTRC beds are calculated by applying a 90 per cent OR to the estimated number of people not admitted to LTRC through expanded home support hours.

support. These data may not capture people deterred from trying to access home support due to perceived access barriers or long waits for care. ESRI research has highlighted that many people with ADL difficulties, who may have an unmet need for home support, are not captured in current recipient or waiting list data, but rather rely on family carers to receive help and support (Walsh and Lyons, 2021).

Data: We use data provided by the HSE on the numbers on the waiting list for the HSE home support service as the main measure of unmet demand for home support. These data capture the number of people waiting for a new public home support package or additional hours as of their current package at end December 2022. We also use DTOC data to estimate unmet demand for home support for people in public acute hospitals. DTOC data, as described for short stay and long stay care, also capture information on public acute hospital patients who have been medically cleared for discharge from hospital and are awaiting home support.[23]

Methods:

- For individuals on the HSE home support service waiting list, and for individuals awaiting a new package, we apportion an average public home support package. For individuals awaiting additional hours, we apportion a 20 per cent increase in hours.[24]
- Similar to the approach for short stay and long stay outlined above, we estimate the total number of DTOC bed days used, by age and sex, by people waiting for home support. We then apportion an average public home support package to transform bed days into home support hours.[25]
- We estimate age- and sex-specific unmet hours rates by combining estimates of additional hours required using the DTOC and HSE waiting data and dividing hours required by the population in each age and sex group. This is added to the baseline home support hour rates to project unmet need adjusted home support hour rates.

In Appendix C, we present full analyses of the DTOC data for public acute hospital patients waiting for home support.

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23 Categories used to determine DTOC for home support: 'care transferred to transitional care bed to await implementation of home support package', 'home to pre-existing levels of supports', 'home with intensive home care package (>21 hours)' and 'home with new home support package'. Categories were chosen after discussion with the HSE.

24 Based upon discussions with the HSE and Department of Health.

25 An annual average public home support package of 370 hours is applied, which equates to approximately 1 hour per bed day.

Expansion of home support

This assumption assumes that the home support scheme is expanded to substitute some services from LTRC to home support (and joined up community care services). Previous research has found that 8 per cent of home support recipients enter LTRC in a 12-month period (Aspell et al., 2019). In the projection analyses, we assume a reduction in the rate of admission from home support services to LTRC from 8 per cent to 6 per cent per annum, and that this reduction occurs gradually between 2026 and 2029. These individuals who would otherwise have been receiving long stay care are assumed to receive an extended home support package of 21 hours per week to account for the fact that they are likely to have greater need for home support than a typical recipient.[26,27]

3.4.3 Projection scenarios

Table 3.2 provides a summary of the assumptions included in the projection scenarios presented in this report for LTRC. The 'status quo' scenario applies the central population projection and current ORs for LTRC; baseline healthy ageing is assumed (dynamic equilibrium) and no additional demand assumptions are applied. The 'low pressure' scenario also applies the central population projection, but demand evolves in line with more optimistic healthy ageing effects (compression of morbidity). Under the 'high pressure' scenario, demand evolves in line with higher projected population growth and baseline healthy ageing. All scenarios for LTRC incorporate a 90 per cent occupancy, which is similar to the rate observed in 2022. Sensitivity analyses also express results using a 95 percent OR (see Chapter 8).

Finally, we also specify a 'progress' scenario, which presents the potential implications of implementing a range of policy goals. These include the reorientation of long-term care to the home support scheme and community settings. This scenario also includes an optimistic healthy ageing assumption of compression of morbidity.

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26 It should be noted that these assumptions are less optimistic than previous assumptions on the substitution of care from LTRC to home support. In Walsh et al. (2021) it was assumed a home support scheme would be established by 2024, and that admission into LTRC from home support recipients would reduce to 4 per cent, with an intensive home package of 52 hours provided.

27 These allocations were based upon assumptions on unmet demand made in previous research, and following extensive discussions with the Department of Health and the HSE. They are the equivalent of an IHCP.

TABLE 3.2 Summary of LTRC projection scenarios

	Scenarios			
	Status quo	Low pressure	High pressure	Progress
Demand assumptions				
1) Population growth and age structure	Central	Central	High	Central
2) Healthy ageing	DE	CM	DE	CM
3) Unmet demand	No	No	Yes	Yes
4) Expansion of home support	No	No	No	Yes
Bed capacity assumptions				
6) Occupancy rate	90%	90%	90%	90%

Notes: DE=Dynamic equilibrium. CM=Compression of morbidity.

Table 3.3 provides a summary of the assumptions included in the four projection scenarios presented in this report for home support. The 'status quo' scenario applies the central population projection; healthy ageing (dynamic equilibrium) and no additional demand assumptions. The 'low pressure' scenario also applies the central population projection, but demand evolves in line with more optimistic healthy ageing effects (compression of morbidity). Under the 'high pressure' scenario, demand evolves in line with higher projected population growth and dynamic equilibrium healthy ageing.

Finally, we also specify a 'progress' scenario, which presents the potential implications of implementing a key policy goal of expanding the home support scheme. This policy includes the reorientation of long-term care to the home support scheme away from LTRC homes. This scenario also includes an optimistic healthy ageing assumption of compression of morbidity.

TABLE 3.3 Summary of home support projection scenarios

	Scenarios			
	Status quo	Low pressure	High pressure	Progress
Demand assumptions				
1) Population growth and age structure	Central	Central	High	Central
2) Healthy ageing	DE	CM	DE	CM
3) Unmet demand	No	No	Yes	Yes
4) Expansion of home support	No	No	Yes	Yes

Notes: DE=Dynamic equilibrium. CM=Compression of morbidity.

CHAPTER 4

Findings: Long-term residential care bed capacity profiles, 2022

4.1 INTRODUCTION

This chapter examines short stay and long stay bed capacity in Ireland in 2022. The chapter also highlights the breakdown of bed capacity across public and voluntary, and private long-term residential care (LTRC) homes.

4.2 OVERVIEW OF LTRC BED CAPACITY IN 2022

Table 4.1 presents the number of short stay and long stay beds in LTRC homes in Ireland in December 2022. Overall, there were 3,745 short stay beds across public and voluntary and private LTRC homes, representing 11 per cent of all LTRC beds. There were 29,579 long stay beds in Ireland in December 2022, with 84 per cent of all long stay beds located in voluntary and private LTRC homes.

An analysis of LTRC resident profiles is presented in Appendix A. Overall, we estimate that there were over 29,650 residents across short stay and long stay beds in 2022, with the majority (28,394) aged 65 years or older. In December 2022, there were 22,200 Nursing Home Support Scheme (NHSS) residents, representing 75 per cent of all LTRC residents.

TABLE 4.1 Short stay and long stay beds in Ireland, December 2022

Category	N beds
Short stay	
Public LTRC homes	1,961
Voluntary and private LTRC homes	1,784
Total short stay beds	**3,745**
Long stay	
Public LTRC homes	4,814
Voluntary and private LTRC homes	24,765
Total short stay beds	**29,579**
Total LTRC beds	**33,324**

Sources: ESRI population data, HSE administrative data, NHI survey data, and HIQA bed register data; authors' calculations.

The number of LTRC residents in Ireland in 2022 is slightly lower than projected in previous Hippocrates analysis. Wren et al. (2017) used 2015 baseline data to project LTRC resident demand of between 33,000 and 34,000 residents by 2022. Some of the difference is likely due to the impact COVID-19 had on LTRC. Figure A.1 illustrates the number of NHSS-funded residents between 2018 and 2024 using data provided by the Health Service Executive (HSE). A sharp reduction in the

2020–2021 years is observed, during which the COVID-19 pandemic was at its peak. Increases in NHSS residents are observed from 2022, and the rate of increase – approximately 2 per cent per annum – is similar to that of the pre-pandemic 2018–2019 period.[28,29]

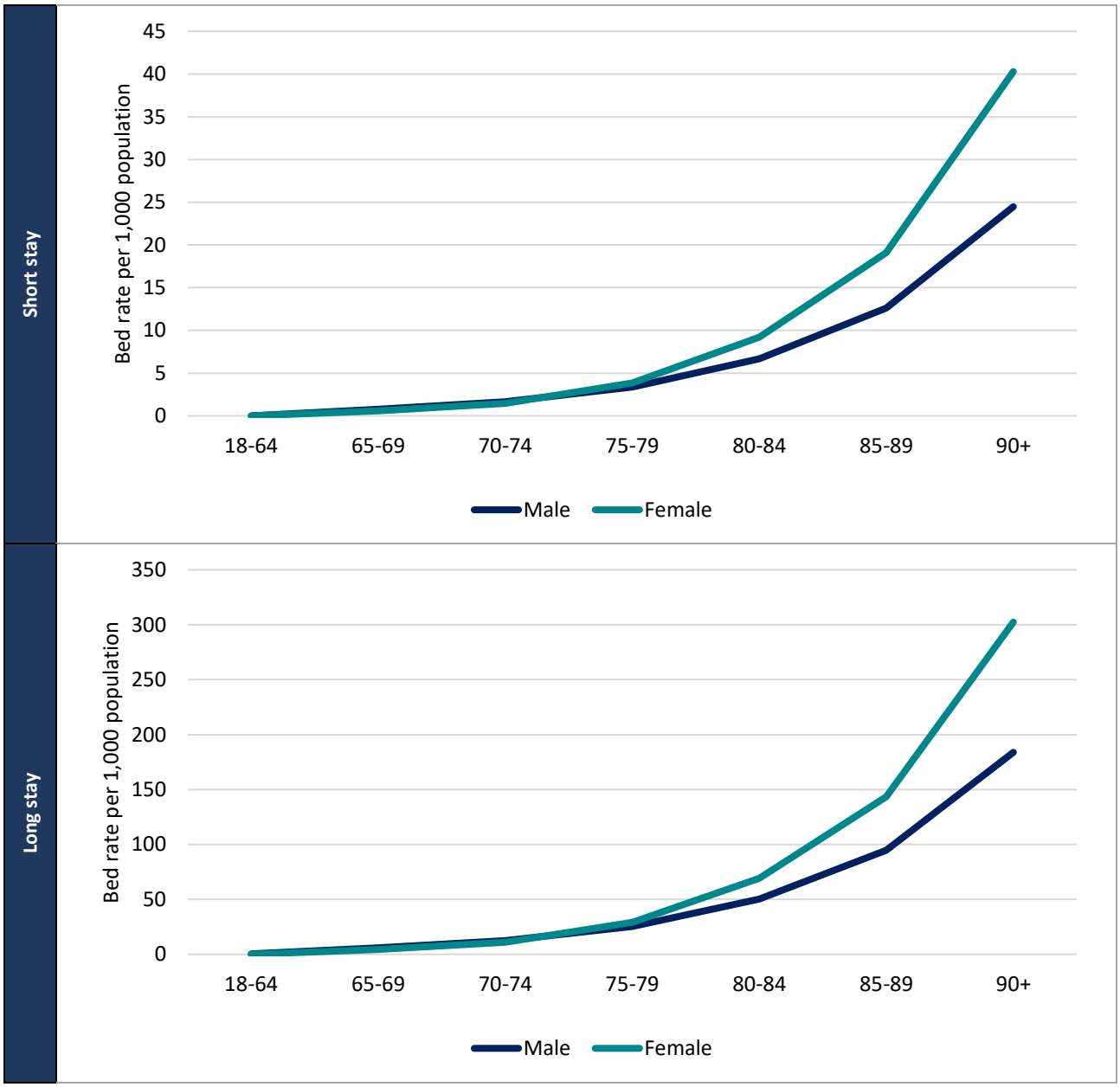
The majority of LTRC in Ireland is provided by voluntary or private providers. Figure A.3 illustrates the percentage of LTRC beds provided in 2022, by public and private status. Across all LTRC beds, 20 per cent were provided in public LTRC homes. The majority, 80 per cent, were provided in voluntary or private LTRC homes, with most of these in for-profit private LTRC homes.

Figure 4.1 shows age-specific short stay and long stay bed rates disaggregated by sex in December 2022. For both short stay and long stay beds, a clear age gradient is observed, with rates much higher in the oldest age groups. Differences between males and females are also evident at older ages. Short stay bed rates were relatively low, especially for the population aged under age 80. However, a sharp increase in bed rates does emerge from 80 years of age.

Long stay bed rates are much higher in general than short stay bed rates, reflective of the fact that almost 90 per cent of LTRC beds are used for long stay care. However, a similar age and sex gradient emerges. While long stay care bed rates remain relatively low at younger ages for males and females, a sharp increase emerges from age 85, especially for females. Long stay bed rates increase to more than 140 per 1,000 population for females in the 85–89 age group, before increasing to 302 per 1,000 for females aged 90 years and over. Some of the differences in bed rates between males and females may be explained by a greater propensity for a female spouse to care for a male spouse at home, reducing the use of long stay care among older males.

28 HSE administrative data show a small increase in the age composition of residents between 2018 and 2024.
29 Data limitations prevent analyses of non-NHSS long stay trends and short stay trends.

FIGURE 4.1 LTRC bed rates, December 2022



Sources: ESRI population data, HSE administrative data, NHI survey data and HIQA bed register data; authors' calculations.

4.3 UNMET DEMAND

Short stay: Detailed analysis of delayed transfers of care (DTOC) data on public acute hospital inpatients waiting for short stay beds is provided in Appendix C. This analysis estimates that there were over 61,000 inpatient bed days used by inpatients awaiting short stay care in 2022 (see Table C.1). Assuming a 90 per cent short stay bed occupancy rate (OR), this equates to an additional requirement for 169 short stay beds nationally in 2022.

Long stay: Analysis of NHSS waiting list data shows that, in December 2022, there were 653 people awaiting an NHSS bed. The age distribution of those awaiting a

bed follows the age distribution of NHSS residents more generally. As discussed above, some of these people were also receiving short stay care via the Transitional Care Fund; the analyses find that 452 people awaiting a NHSS bed were receiving short stay care via the fund, and were thereby captured in baseline short stay resident estimates.

Analyses in Appendix C show that there were a number of DTOC in public acute hospitals awaiting long stay care in 2022. This analysis estimates that there were over 92,000 inpatient bed days used by inpatients awaiting long stay care. Assuming a 90 per cent long stay bed OR, this equates to an additional requirement for 253 long stay beds nationally in 2022.

4.4 SUMMARY

This chapter presents findings for baseline bed rates and unmet demand for short stay and long stay LTRC in 2022. The chapter also highlights that the vast majority of LTRC beds are provided by the private sector. This is an important aspect of the system to consider when planning for LTRC capacity, and we provider greater discussion on this topic in Chapter 8.

CHAPTER 5

Findings: Home support hour profiles, 2022

5.1 INTRODUCTION

This chapter examines utilisation of, and unmet demand for, public and private home support in Ireland in 2022. The chapter also provides trends in home support using estimates from previous projection analyses.

5.2 OVERVIEW OF HOME SUPPORT CARE IN 2022

Table 5.1 presents baseline estimates for home support recipients and home support hours provided in Ireland in 2022. Across the Health Service Executive (HSE), public home support scheme and the Intensive Home Care Package (IHCP) scheme, there were over 56,000 recipients who received just over 21 million home support hours. In addition, we estimate that there were over 13,000 recipients of private home support. Over 7.6 million home support hours were privately purchased in 2022, representing 26 per cent of all home support hours provided. Overall, over 28.7 million home support hours were provided in Ireland in 2022 to almost 70,000 recipients. Examining the population aged 65 years and older specifically, we estimate that approximately 8.8 per cent of the population aged 65 years and over were in receipt of home support in 2022.

TABLE 5.1 Home support recipients and hours, 2022

Category	N recipients	N hours
Publicly funded home support	56,162	20,792,772
IHCP	235	225,096
Privately financed home support[a]	13,411	7,670,581
Total recipients	**69,808**	**28,688,449**

Notes a Recipients who receive public and private home support counted in publicly funded home support recipient estimate. Private home support hours include hours for all private recipients.

Sources: ESRI population data, HSE administrative data and TILDA data; authors' calculations.

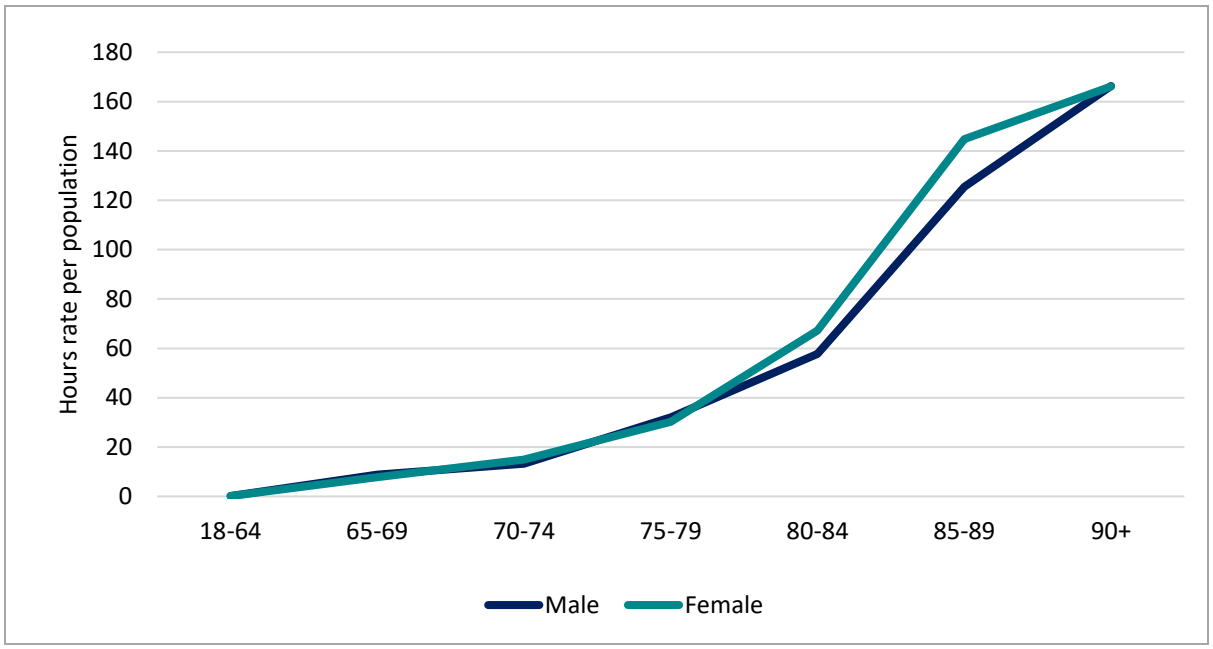
Like long-term residential care (LTRC), the majority of home support hours are provided by voluntary and private providers. Figure B.6 illustrates the percentage of home support hours provided by the HSE (public) and voluntary and private home support agencies in 2022.[30] Overall, 71 per cent of all home support hours in Ireland are now provided by voluntary and private home support agencies (the

[30] As of June 2024, there are 102 individual companies (many of whom are franchises within a small number of companies) providing public home support in Ireland and are registered via the Home Support Authorisation Framework; see https://www.hse.ie/eng/about/personalpq/pq/2024-pq-responses/march-2024/pq-11805-24-richard-boyd-barrett.pdf.

majority being for-profit private agencies), with 29 per cent provided by HSE-employed carers.[31]

Figure 5.1 shows the home support hours utilisation rate (hours per population aged 65+) by age and sex in 2022. A clear age gradient is observed, but few differences between males and females are evident, even at older ages. Home support hour rates increase to more than 140 hours per annum per capita for females in the 85–89 age group, before increasing to 166 hours per annum per capita for females in the 90+ age group.

FIGURE 5.1 Home support hours rate, 2022



Sources: ESRI population data, HSE administrative data and TILDA data; authors' calculations.

Analysis of home support recipients was also undertaken, with results presented in Appendix B. The recipient rates estimated follow a similar pattern to those observed for home support hours in the figures above. Home support recipient numbers are similar for males and females at younger ages, but at older ages, there are more female recipients than males. This is reflected in the median age of recipient. The median age of a male recipient is 83 years. The median age of a female recipient is 85 years.[32]

5.3 UNMET DEMAND

There is a high level of unmet demand for home support in Ireland. Figure B.7 illustrates the numbers waiting for public home support in December 2022. Overall, there were 6,673 people on the public home support waiting list. Of these,

31 Just over three-fifths (61%) of all publicly funded HSE home support service hours were provided by voluntary and private home support providers in 2022.

32 This reflects similar median age estimates reported in Aspell et al. (2019).

3,795 (57%) were waiting for a new home support package and 2,878 (43%) were waiting for additional hours to be added to their current home support package. The number on the waiting list is high when compared to the just over 56,000 people receiving public home support in December 2022.

Detailed analysis of delayed transfers of care (DTOC) data on public acute hospital inpatients waiting for home support is provided in Appendix C. This analysis estimates that there were almost 45,000 inpatient bed days (equivalent to approximately 123 acute inpatient beds based upon an assumed 90 per cent occupancy rate (OR)) used by inpatients awaiting home support.

5.4 SUMMARY

This chapter presents findings for baseline activity rates and unmet demand for home support in 2022. The chapter also highlights an important context: that the financing of the sector is dominated by the HSE Home Support Service. Similar to LTRC, however, the majority of this public home support is provided by private providers. These are important aspects of the home support system to consider when planning for provision in the future.

CHAPTER 6

Projections – Long-term residential care beds

6.1 INTRODUCTION

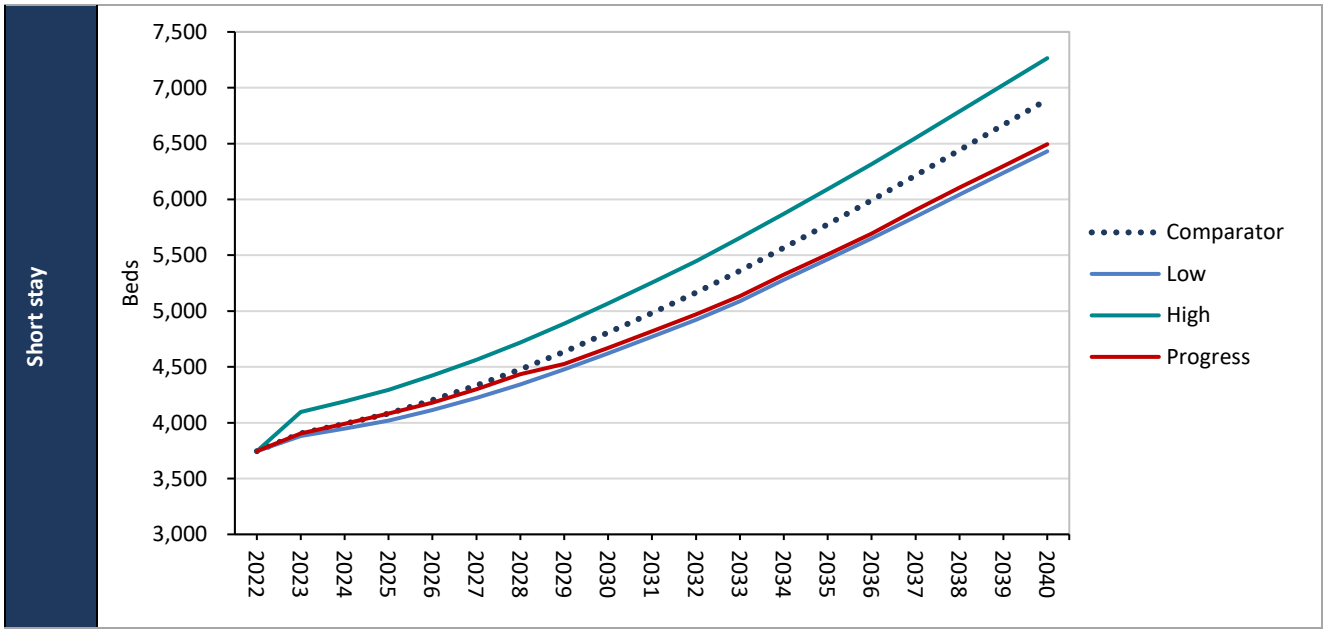
This chapter presents findings for projected long-term residential care (LTRC) bed capacity in Ireland to 2040. Projections include both publicly funded and privately financed short stay and long stay beds. The projection scenarios incorporate assumptions that place varying pressures on LTRC services to 2040, which are reflective of model of care changes, potential expansion of short stay capacity and demand increases.

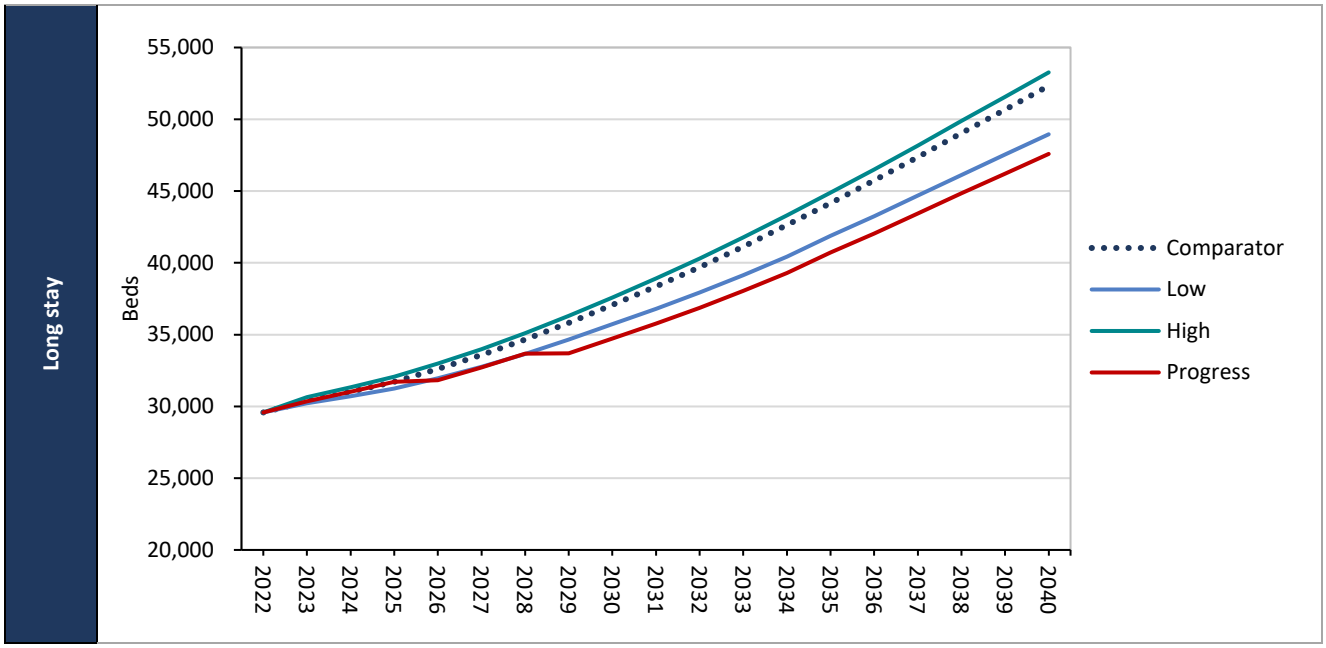
6.2 LTRC BED CAPACITY PROJECTIONS

Figure 6.1 presents the projected increase in short stay and long stay LTRC bed capacity requirements between 2022 and 2040 for the status quo, low pressure, high pressure and progress scenarios.

Across the scenarios, large increases in short stay and long stay bed capacity requirements are projected. The largest increases are projected for the high pressure scenario, with the lowest projected in the low pressure and progress scenarios due to positive healthy ageing (compression of morbidity) assumptions and assumptions reflecting substitution of some LTRC towards home support.

FIGURE 6.1 LTRC bed projections, 2022–2040





Sources: ESRI population data, HSE administrative data, NHI surveys and HIQA bed register data; authors' calculations.

Table 6.1 presents the projected increase in short stay and long stay bed capacity requirements between 2022 and 2040 for the status quo, low pressure, high pressure and progress scenarios. For short stay beds, we project requirements of between 6,431 and 7,265 beds by 2024. These increases in short stay bed capacity requirements equate to annual average growth rates of between 3 and 3.7 per cent.

For long stay beds, we project requirements of between 47,588 and 52,266 beds by 2040. These increases in long stay bed capacity requirements equate to annual average growth rates of between 2.7 and 3.3 per cent.

It is important to note that the largest increases in beds under the progress scenario for both short stay and long stay beds are estimated for the later years across the horizon period, with smaller increases projected until 2030, especially if home support is expanded.

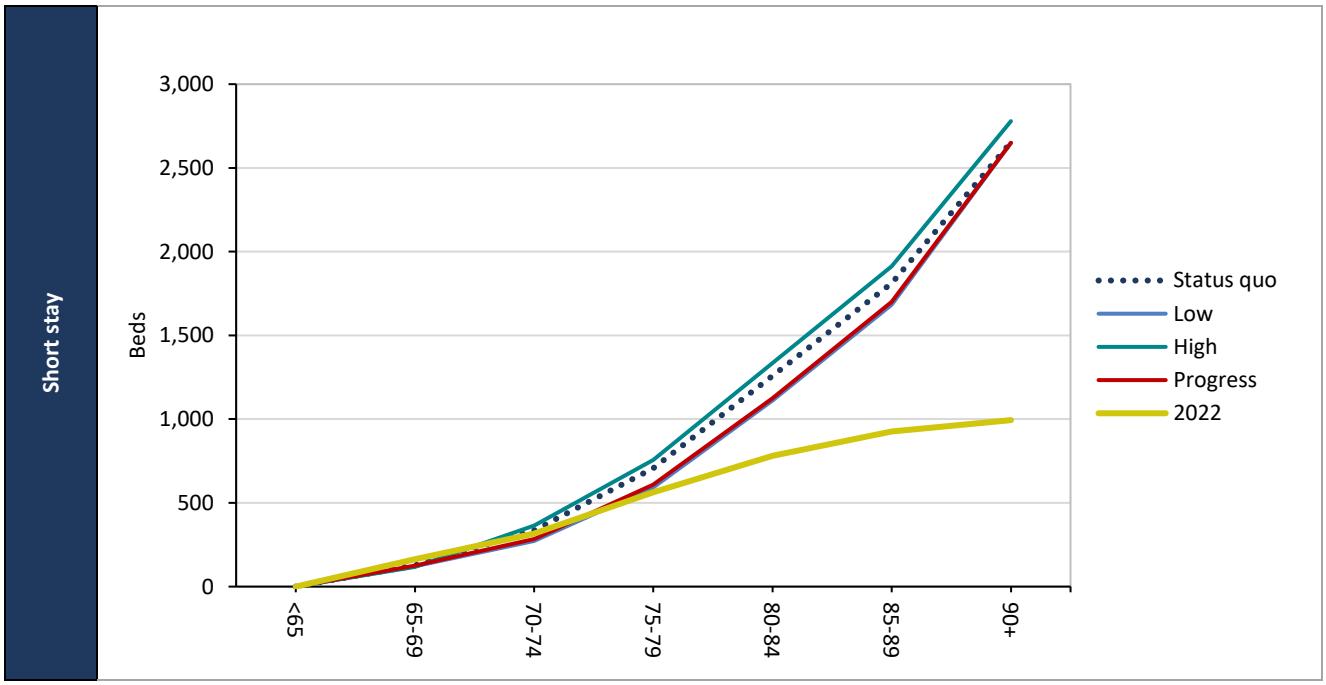
TABLE 6.1 LTRC bed projections, 2022–2040

Scenarios	2022	Projected requirements 2040	Total growth 2022–2040	Average annual growth 2022–2040
	N beds	N beds	%	%
Short stay				
Status quo	3,745	6,894	84%	3.4%
Low pressure		6,431	72%	3.0%
High pressure		7,265	94%	3.7%
Progress		6,494	73%	3.1%
Long stay				
Status quo	29,579	52,331	77%	3.2%
Low pressure		48,955	66%	2.8%
High pressure		53,266	80%	3.3%
Progress		47,588	61%	2.7%

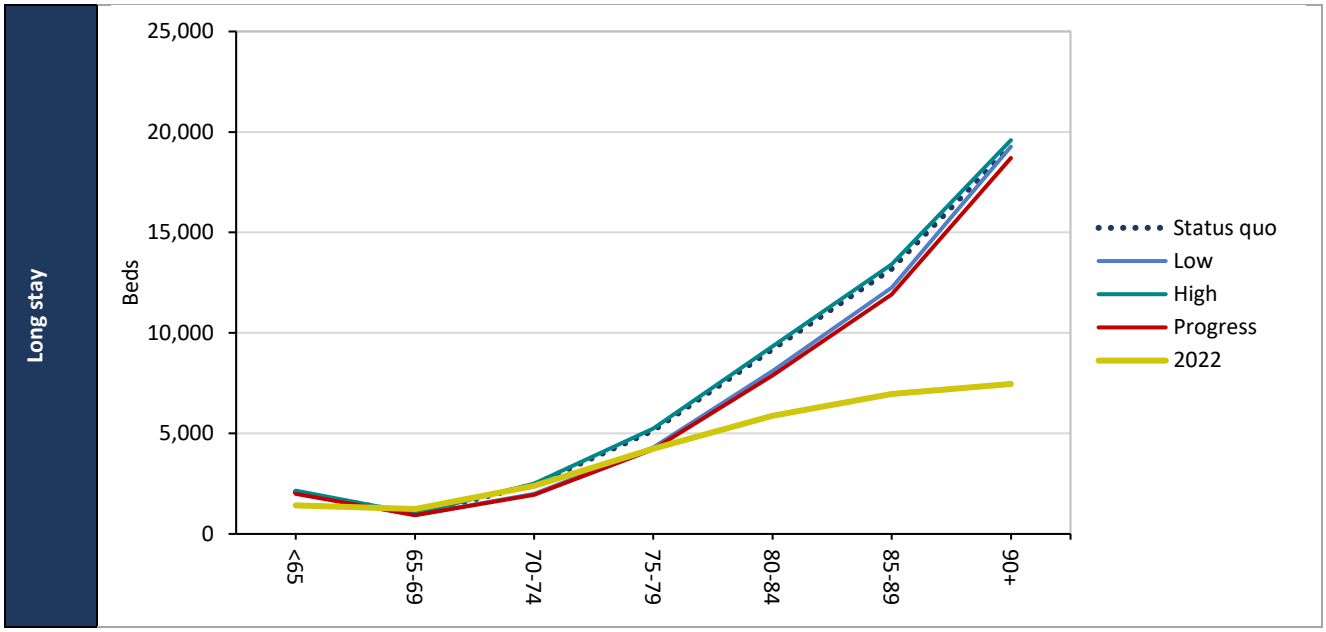
Sources: ESRI population data, HSE administrative data, NHI surveys and HIQA bed register data; authors' calculations.

Figure 6.2 presents the age-specific projected short stay and long stay bed requirements in 2022 and for each projection scenario in 2040. There is a pronounced difference in projected bed requirements by age, with much higher short stay and long stay beds projected to be required in the older age groups. Substantial increases are projected for the population aged 80 years and over.[33]

FIGURE 6.2 Age-based LTRC bed projections, 2022–2040



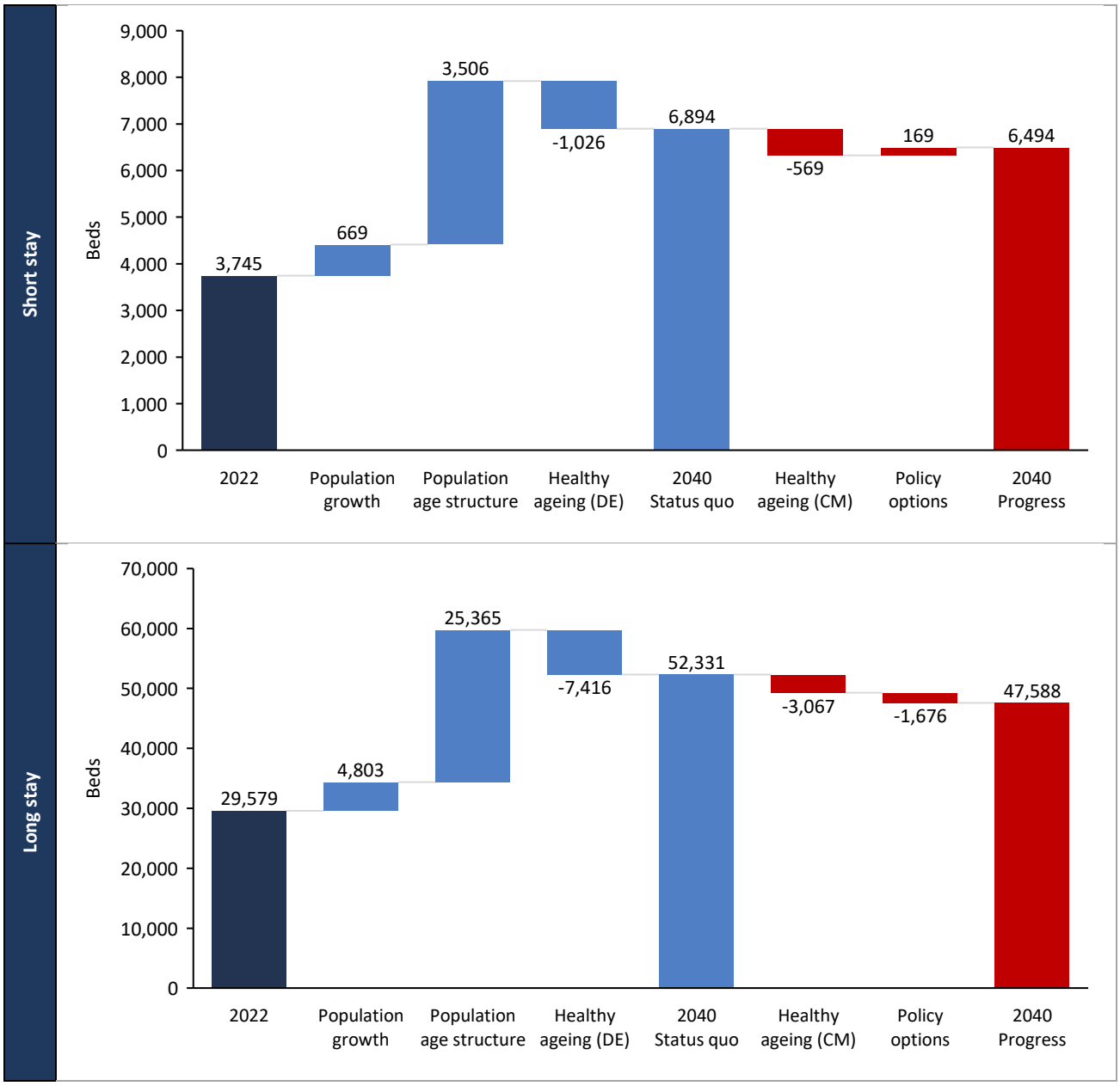
[33] While not presented, larger increases in bed capacity are projected for females at older ages.



Sources: ESRI population data, HSE administrative data, NHI surveys and HIQA bed register data; authors' calculations.

Figure 6.3 presents the decomposition analysis of short stay and long stay beds. It illustrates the drivers of growth in total LTRC bed requirements in the status quo and progress scenarios. A similar structure of the key drivers of capacity requirements is observed for both short stay and long stay bed capacity. Population age structure is by far the biggest driver for projected bed capacity. Interpreting the estimates and percentage changes, population ageing accounts for 87 per cent of short stay and 84 per cent of long stay bed capacity requirement growth in the status quo scenario. This is offset in the progress scenario through combining it with the healthy ageing assumption, which reduces bed requirements by between 20 per cent (short stay) and 25 per cent (long stay). In the progress scenario we see a small increase for short stay and a 17 per cent decrease for long stay in the projected bed requirements compared to the status quo scenario. The slight increase for short stay is driven by the large number of those delayed transfers of care (DTOCs) in the baseline prevailing over any reductions from expanded home support (this is observed more clearly in sensitivity analyses presented in Table 8.1). For long stay care, the observed reduction in beds required in the progress scenario is driven by a mixture of additional healthy ageing and the expansion of home support, which slows the admission into long stay beds in particular.

FIGURE 6.3 Decomposition of LTRC bed projections, 2022–2040



Notes: DE=Dynamic equilibrium. CM=Compression of morbidity.
Bed requirement reductions from compression of morbidity healthy ageing are in addition to those from dynamic equilibrium healthy ageing included in status quo scenario.
Policy options include expansion of home support and reduction in unmet demand.

Sources: ESRI population data, HSE administrative data, NHI surveys and HIQA bed register data; authors' calculations.

6.3 SUMMARY

This chapter presents projections of short stay and long stay LTRC beds to 2040 across four projection scenarios: status quo, low pressure, high pressure and progress. Increases in short stay bed requirements between 2022 and 2040 are projected to increase by between 72 per cent and 94 per cent. Converted to average annual increases, this equates to between 3 per cent and 3.7 per cent per annum. Increases in long stay bed requirements between 2022 and 2040 are projected to increase by between 61 per cent and 80 per cent. Converted to

average annual increases, this equates to between 2.7 per cent and 3.3 per cent per annum.

Decomposition analyses show that the population age structure is the key driver of LTRC bed capacity projections. We find that the largest increases in bed requirements are due to increases in the population aged 80 years and over. Within the projection analyses, we estimate that the median age of LTRC residents is projected to increase from 85 years in 2022 to 88 years in 2040. This results in population ageing being a key driver of increased demand for LTRC services. This result is supported by the decomposition analysis, which shows that population ageing (population increases at older ages) is the key driver of LTRC bed requirements.

CHAPTER 7

Projections – Home support hours

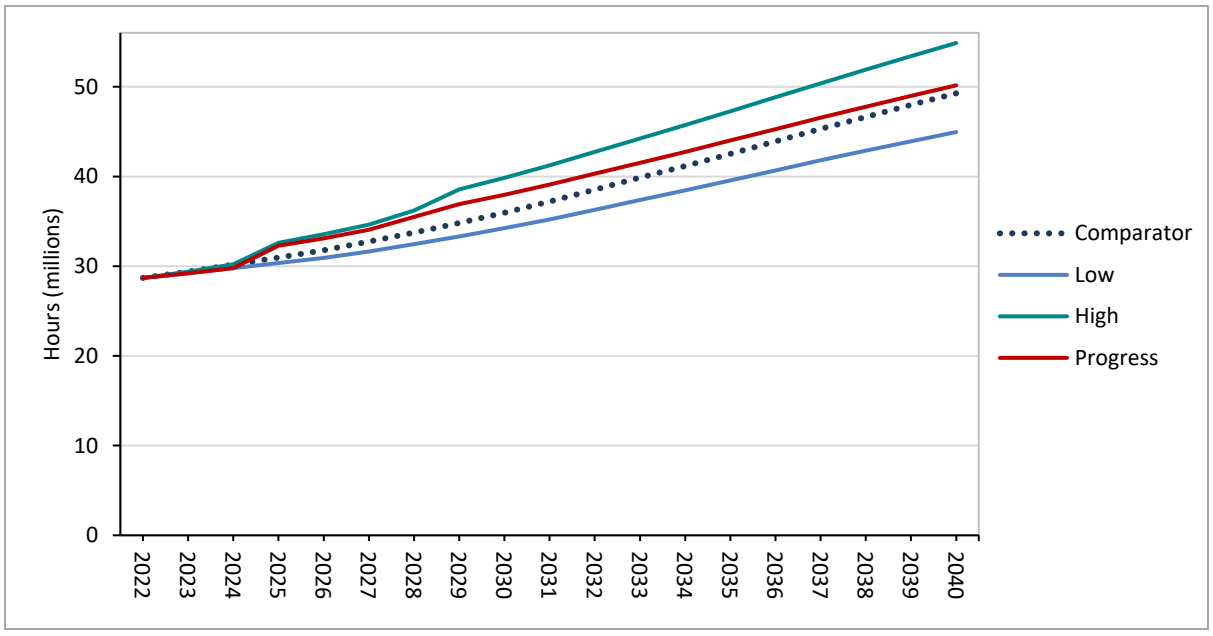
7.1 INTRODUCTION

This chapter presents findings for projected home support hours (used as a proxy for capacity) in Ireland to 2040. Projections include both publicly funded and privately purchased home support hours. The projection scenarios incorporate assumptions that place varying pressures on home support services to 2040, which are reflective of model of care changes and demand increases.

7.2 FINDINGS – HOME SUPPORT HOUR PROJECTIONS

Figure 7.1 presents the projected increase in home support hours (public and private) between 2022 and 2040 for the status quo, low pressure, high pressure and progress scenarios. Between 2022 and 2040, the home support hours requirements are projected to increase from 28.7 million hours to between 44.9 million and 54.9 million hours per annum. The largest increase is projected for the high pressure scenario, with assumed higher population growth, a dynamic equilibrium healthy ageing assumption and increased demand for home support driven by a substitution of some care away from long-term residential care (LTRC). Under the progress scenario, 50.1 million hours are projected in 2040, assuming a more optimistic healthy ageing assumption (compression of morbidity).

FIGURE 7.1 Home support hours projections, 2022–2040



Sources: ESRI population data, HSE administrative data and TILDA data; authors' calculations.

Table 7.1 presents the projected increase in home support hours (public and private) between 2022 and 2040 for the status quo, low pressure, high pressure and progress scenarios, as total and annual average percentage increases, as well as the additional home support hours projected annually.

A 91 per cent increase is projected across the projection horizon within the high pressure scenario, followed by a 75 per cent increase within the progress scenario. These increases equate to 1.5 million and 1.2 million additional home support hours required annually, or 3.7 per cent and 2.5 per cent increases. This compares to the 1.1 million hours that are estimated to have been added annually (mainly by the public home support scheme) between 2019 and 2022.

TABLE 7.1 Home support hours projections, 2022–2040

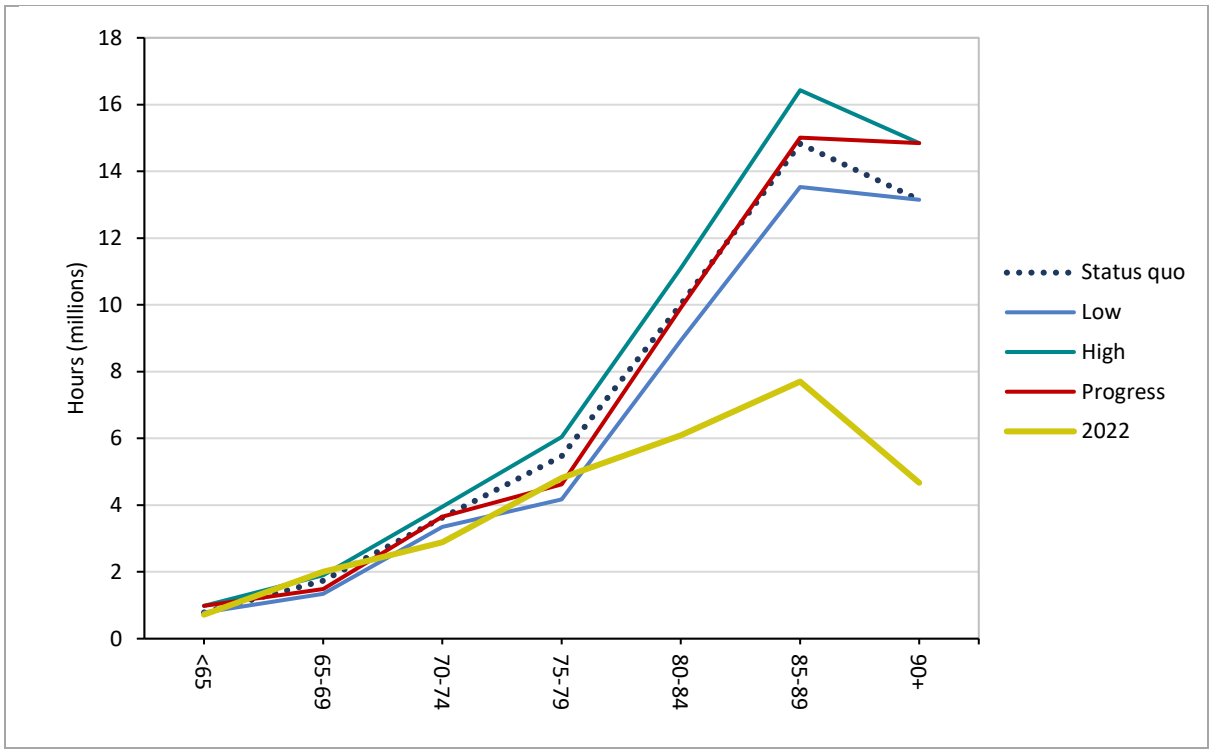
Scenarios	2022	Projected requirements 2040	Total growth 2022–2040	Average annual growth 2022–2040
	N hours (millions)	N hours (millions)	%	%
Home support				
Status quo	28.7	49.3	72%	3.1%
Low pressure		44.9	57%	2.5%
High pressure		54.9	91%	3.7%
Progress		50.2	75%	3.2%

Sources: ESRI population data, HSE administrative data and TILDA data; authors' calculations.

Figure 7.2 presents the age-specific projected home support hours (public and private) in 2022, and for each scenario in 2040. There is a pronounced difference in projected home support hour increase by age, with much higher home support projected to be required in the older age group. While home support hour requirements are projected to be higher in 2040 for age groups <65 and 75–79 years, substantial increases are projected for the population aged 80 years and over.[34]

[34] While not presented, a similar pattern is observed for both males and females.

FIGURE 7.2 Age-based home support hours projections, 2022–2040

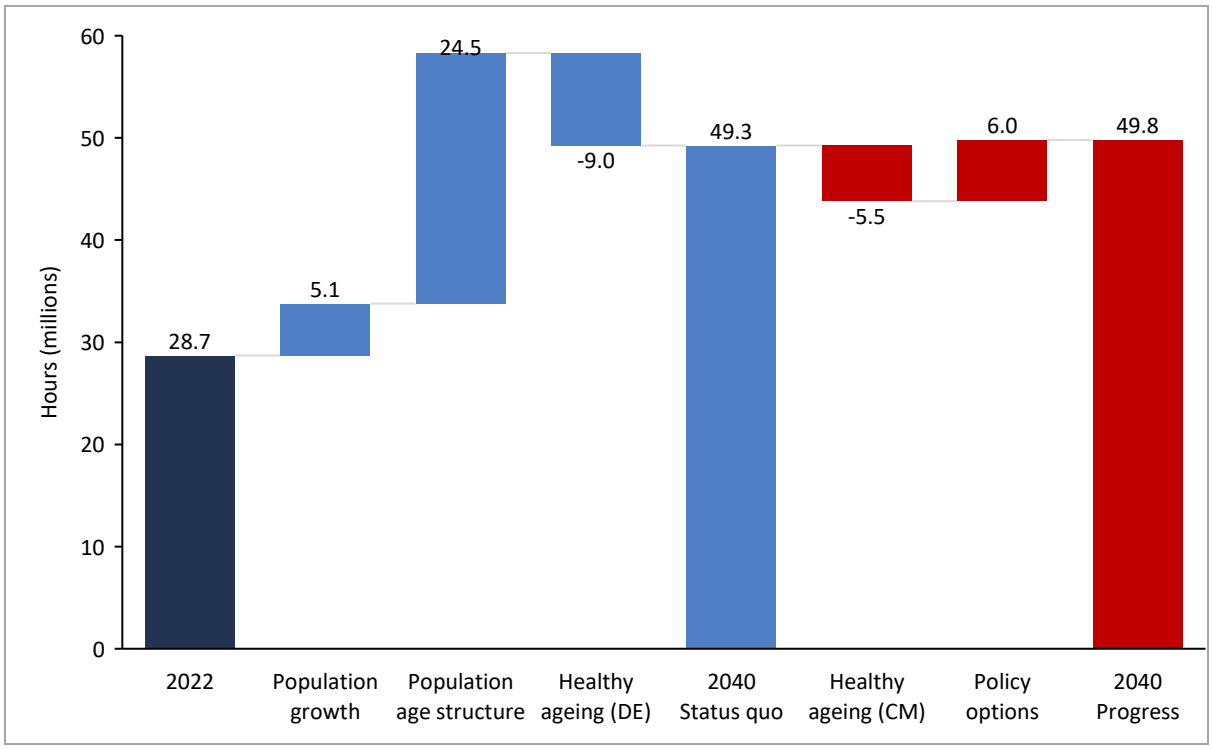


Sources: ESRI population data, HSE administrative data and TILDA data; authors' calculations.

Figure 7.3 presents the decomposition analysis of home support hours. It illustrates the drivers of growth in total home support hour requirements in the status quo and progress scenarios.

Population age structure is by far the biggest driver of projected hours. Population ageing accounts for 83 per cent of growth in the status quo scenario. This is offset in the progress scenario through a combination of the healthy ageing assumption, which reduces projected home support hours by over 30 per cent.

FIGURE 7.3 Decomposition of home support hour projections, 2022–2040



Notes: DE=Dynamic equilibrium. CM=Compression of morbidity.
Hours demanded reductions from compression of morbidity healthy ageing are in addition to those from dynamic equilibrium healthy ageing included in status quo scenario.
Policy options include expansion of home support and reduction in unmet demand.

Sources: ESRI population data, HSE administrative data and TILDA data; authors' calculations.

7.3 SUMMARY

This chapter presents projections of publicly funded and privately purchased home support hours to 2040 for four scenarios: status quo, low pressure, high pressure and progress scenarios. Increases in home support hours between 2022 and 2040 are projected at between 57 per cent and 91 per cent. Converted to average annual increases, this equates to between 2.5 per cent and 3.7 per cent per annum.

The results show very large increases in projected requirements for home support. A key reason why large home support hour increases are projected is that home support is used predominantly by older people. The median age of home support recipients in 2022 was 83 years for males and 85 years for females, while the median age is projected to increase to 85 years for males and 87 years for females in 2040. This results in population ageing being a key driver of increasing demand for home support services. This result is supported by the decomposition analysis, which shows that population ageing (population increases at older ages) is the key driver of home support hours.

Projection results show that potential policy options include expanding public home support to remove the waiting lists for care, and that slow down in the flow of

admissions into LTRC could see demand for home support increase by 6 million hours in 2040.

CHAPTER 8

Summary and conclusion

8.1 INTRODUCTION

This report projects long-term residential care (LTRC) and home support capacity requirements in Ireland to 2040. The report builds upon previous application of the Hippocrates model for older people's care (Wren et al., 2017; Walsh et al., 2021), and more recent capacity analyses for public acute hospital care (Brick and Kakoulidou, 2025) and general practice care (Connolly et al, 2025). This chapter provides a brief overview of the results, discusses the sensitivity of the findings to alternative assumptions, outlines some limitations and opportunities for further analysis, and draws out implications for policy.

8.2 OVERVIEW OF RESULTS

8.2.1 LTRC

This report finds that in 2022, there were an estimated 33,324 LTRC beds providing short stay and long stay residential care in Ireland. The baseline analysis found that in 2022, long stay beds outnumbered short stay beds (which encompass intermediate care, post-acute rehabilitation care and transitional care), with 11 per cent of LTRC beds estimated to be providing care on a short-term basis. Similarly, the baseline analysis shows that 80 per cent of all LTRC was provided in voluntary and private LTRC homes.

Based upon scenarios that vary assumptions on population growth, healthy ageing, and the expansion of alternative services (e.g. home support), we find that LTRC bed capacity requirements are projected to be substantial. Short stay bed capacity requirements are projected to increase by between 72 per cent and 94 per cent between 2022 and 2040. When expressed in average annual increases, these equate to increases of between 3 per cent and 3.7 per cent average annual growth. Long stay bed capacity requirements are projected to increase by between 61 per cent and 80 per cent between 2022 and 2040. When expressed in average annual increases, these equate to between 2.7 per cent and 3.3 per cent average annual growth. The increasing size of the older population is the largest driver of the projected increases in short stay and long stay bed capacity requirement.

While increasing LTRC occupancy rates (ORs) and expanding the ability of home support to substitute some care away from LTRC may help partly offset some bed capacity requirements, it is clear that large increases in capacity are required in the sector. This is mainly due to the projected large future increases in the older population in Ireland.

8.2.2 Home support

This report finds that in 2022, there were almost 70,000 people in receipt of publicly funded or privately financed home support in Ireland. These recipients were provided with almost 28.7 million home support hours in 2022.

The vast majority of home support recipients were aged 65 years and over, and in 2022, 8.8 per cent of the population aged 65 years and older were home support recipients.[35] The baseline analysis found that the vast majority (71%) of home support (including publicly funded support) was provided by voluntary and private home support providers. Even within the publicly funded home support scheme, 61 per cent of hours were provided by voluntary and private home support providers.

Based upon scenarios that vary according to population growth, healthy ageing, and the expansion of the home support services to reduce unmet demand and reduce admissions into LTRC, we find that home support hours required are projected to increase by between 57 per cent and 91 per cent between 2022 and 2040. These projected increases equate to between 2.5 per cent and 3.7 per cent average annual growth (or 0.9 million to 1.2 million additional hours required annually).

Overall, population growth (population ageing) at older ages is the main key driver of the projected increase in hours requirements. While positive healthy ageing could reduce demand somewhat, the results clearly show that substantial increases in home support hours are required to meet future demands for this in Ireland. Expanding the home support service would also increase hours required to be provided.

8.3 SENSITIVITY ANALYSIS

The uncertainty arising from any projection exercise means that it is important to undertake analysis to test the sensitivity of projections to demand assumptions. To illustrate the impact of varying individual assumptions, we run multiple separate analyses to see the impact on LTRC bed capacity requirements and home support hours requirements.

8.3.1 LTRC

Table 8.1 illustrates the sensitivity of our LTRC bed projections to changes in the population, healthy ageing assumptions, unmet demand, the expansion of home support and in increase in ORs. The high population assumption increases short

[35] Therefore, 12.6 per cent of the population aged 65 years and older (or more than 1 in 8) were LTRC and/or home support users.

stay and long stay bed requirements by 0.7 per cent and 0.8 per cent respectively, with a corresponding reduction under the low population assumption. The low levels of sensitivity are due to population assumption differences mainly impacting the working age population via migration, with fewer differences among the older age group.

The optimistic compression of morbidity assumption has a very strong impact, reducing LTRC short stay and long stay bed requirements by 6.7 per cent (463 beds) and 6.5 per cent (3,376 beds) respectively in 2040. Unmet demand has a large impact on short stay beds especially, due to the high number of patients in public acute hospitals awaiting a discharge to a short stay bed. However, in the analyses, unmet demand has a smaller effect on long stay care; this is because many people awaiting long stay beds, for example via the Nursing Home Support Scheme (NHSS), are in receipt of transitional care. The expansion of home support would further reduce short stay bed requirements by 3.7 per cent and long stay bed requirements by 2.6 per cent in 2040, or approximately 1,625 LTRC beds in total. Increasing bed ORs to 95 per cent, thereby increasing resident flow and efficiency, would further reduce short stay and long stay bed requirements by 5.3 per cent in 2040, or approximately 363 and 2,754 beds respectively.

TABLE 8.1 Sensitivity analysis – Effect on projected LTRC bed requirements of varying key assumptions

	Beds	% difference from status quo
Short stay beds		
Status quo scenario 2040	**6,894**	
Effect of changing one assumption on 2040 bed requirements		
Population growth and ageing		
High population	46	0.7
Low population	-46	-0.7
Healthy ageing – Compression of morbidity*	-463	-6.7
Unmet demand	323	4.7
Expansion of home support	-258	-3.7
Occupancy rate 95%	-363	-5.3
Long stay beds		
Status quo scenario 2040	**52,331**	
Effect of changing one assumption on 2040 LTRC beds		
Population growth and ageing		
High population	418	0.8
Low population	-418	-0.8
Healthy ageing – Compression of morbidity*	-3,376	-6.5
Unmet demand	513	1.0
Expansion of home support	-1,367	-2.6
Occupancy rate 95%	-2,754	-5.3

Notes: * Compared to dynamic equilibrium.
Sources: ESRI population data, HSE administrative data, NHI surveys and HIQA bed register data; authors' calculations.

8.3.2 Home support

Table 8.2 illustrates the sensitivity of our home support hours projections if we vary our population, healthy ageing assumptions, unmet demand and the expansion of home support. Home support hour requirements across population assumptions are similar, with the high population assumption increasing home support hour requirements by 0.7 per cent, and a corresponding reduction under the low population assumption.

The optimistic compression of morbidity assumption has a very strong impact, reducing home support hours requirements by 8.8 per cent in 2040, or approximately 4.3 million hours per annum. Due to the large number of people awaiting home support, meeting the unmet demand would increase requirements by 2.9 million hours, a 5.9 per cent increase compared to the status quo. The expansion of home support would further increase hours requirements by 4.7 per cent in 2040, or approximately 2.3 million hours.

TABLE 8.2 Sensitivity analysis – Effect on projected home support hour requirements of varying key assumptions

	Hours (millions)	% difference from status quo
Home support hours		
Status quo scenario 2040	**49.3**	
Effect of changing one assumption on 2040 bed requirements		
Population growth and ageing		
High population	0.3	0.7
Low population	-0.3	-0.7
Healthy ageing – Compression of morbidity*	-4.3	-8.8
Unmet demand	2.9	5.9
Expansion of home support	2.3	4.7

Notes: * Compared to dynamic equilibrium.
Sources: ESRI population data, HSE administrative data and TILDA data; authors' calculations.

8.4 LIMITATIONS AND FURTHER ANALYSES

The projection estimates included in this report are intended as medium-term projections, and reflect data availability and policy objectives at the time of analysis. There are a number of limitations to the analysis, and there are opportunities to undertake further analyses to enhance these projection analyses.

For LTRC, there remains no census on all LTRC residents or beds in Ireland. By combining the Health Information and Quality Authority (HIQA) bed register and Health Service Executive (HSE) bed register data, this analysis captures all LTRC beds operating in the system. However, we acknowledge that existing data limitations meant we could not further categorise short stay beds into the specific type of care

typically provided (e.g. rehabilitative, transitional care) or develop separate age- and sex-specific profiles for short stay beds and privately purchased LTRC beds.

In the analyses, we project short stay and long stay beds separately as these beds differ in terms of residents' care needs, regulatory oversight and requirements, funding and resourcing. In addition, short stay beds often group together a number of bed categories such as rehabilitation, convalescence and transitional care. These data limitations severely curtail the extent to which we can provide specific evidence to inform policy on short stay care for rehabilitation or other purposes as information regarding specific categories of short stay care provided is not available. The next phase of the Department of Health/Economic and Social Research Institute (ESRI) Research Programme will undertake supplemental analysis that focuses on projections of short stay bed requirements including rehabilitative care beds.

Chapters 2 and 3 of this report outline some important data limitations that impacted this analysis. In combination with this research, two forthcoming research reports will outline in greater detail key health information and data limitations that impede research into long-term care in Ireland (McHugh and Walsh, forthcoming; Connolly et al., forthcoming). The data limitations limit the extent to which this research can provide a detailed analysis of LTRC and home support services, in particular short stay care in LTRC homes. The lack of detailed administrative data on home support recipients required the use of survey-based data to allow us to estimate baseline home support activity profiles. These data gaps limit the type and extent of analysis that can be undertaken with the Hippocrates model. For example, the lack of data on important services provided as part of Integrated Care Programme for Older Persons (ICPOP) prevents examination of this programme in this report. It is hoped that data will become available on the ICPOP and similar programmes as they are extended and become embedded in the model of care for older people in Ireland. Other important services include day centre care, respite care and 'meals on wheels', which are also provided via the older people's services budget, and often provided as part of wider care packages that include home support. However, data on the utilisation of these other services are poor, preventing us from examining these services here. Future analyses will endeavour to estimate baseline profiles for these services.

A number of policies have been introduced to aid healthy ageing among older people; these policies may impact demand for older people's services, but the lack of data makes it difficult to examine them in this analysis. The Healthy and Positive Ageing Initiative, for example, is a collaborative initiative between the Department of Health, the HSE and local authorities (i.e. Age Friendly Ireland). Launched in 2014, it aims to promote and sustain evidence-based policy in ageing. In addition, the Healthy Age Friendly Homes Programme, a joint initiative between the Department of Health and Age Friendly Ireland, was established to support older people in living

in their homes and communities. Between May 2021 and December 2023, approximately 2,900 referrals were made to the programme.[36] A range of other community-based services also exist in relation to transportation, home adaption, social prescribing and respite, all designed to improve healthy ageing among older people, and potentially impact use of older people's services. However, thus far, there exists limited data for evaluating the impact of these policies, and the extent to which they have reduced demand for LTRC and home support. Future analyses of older people's services will endeavour to examine this wider suite of initiatives.

For home support, this analysis has once more been required to supplement HSE administrative data with The Irish Longitudinal Study on Ageing (TILDA) data in order to produce an age and sex profile of home support recipients in Ireland. While an audit was carried on a large number of public home support residents in 2023, which captured aggregated age data on recipients, these data were insufficient to be used within this analysis. The lack of information on home support care provided – home support is normally provided by health care support assistants (formerly 'home helps') – makes it difficult to convert home support hour requirements into workforce capacity requirements. Previous policy recommendations from ESRI research have called for the establishment of a long-term care workforce register (Walsh and Lyons, 2021). Such a register would facilitate projects to be made regarding workforce and capacity for home support in Ireland.

8.5 POLICY IMPLICATIONS

A number of key policy implications arise from this research. First, the report shows that the population aged 65 years and over is projected to increase from less than 0.8 million in 2022 to over 1.3 million in 2040. The percentage of the population aged 65 and over in 2022 was 15 per cent, and this is projected to increase to approximately 21 per cent by 2040. While this represents a large increase, across all EU-27 countries, Ireland has the second lowest percentage of its population aged 65 years and over; moreover, despite projected increases in the older population, Ireland is expected to remain among the 'youngest' population in Europe in the future (European Commission, 2020; Eurostat, 2020). This puts Ireland in a potentially more advantageous position from a demographic viewpoint when planning services for older people, in a European context.

The increase in the older population in Ireland reflects recent improvements in life expectancy in this country, and further improvements in life expectancy are projected to occur. However, this analysis shows that this increase in the older population is the key driver of the other outcome of this analysis: the large projected increases in long-term care demand and capacity requirements. The increase in the older population will be a critical factor in the future delivery of health and social care, especially for long-term care services. The analysis shows that the substantial

[36] See https://housingireland.ie/elderly-homes-scheme-moves-ahead-following-pilot-success/.

impact of the projected increases in the older population will offset a large proportion of potential moderations in long-term care requirements that may arise out of healthy ageing effects among older people, or changes to care models. Therefore, there is a clear need for policymakers to develop effective financing, workforce and infrastructure planning to help deliver the additional long-term care and capacity.

The analysis also has important implications for the new model of care recommendations outlined in the Sláintecare report. A key component of the Sláintecare reform proposals is the re-orientation of the model of care towards primary and community settings, including reducing reliance on hospital care and LTRC. The establishment of a statutory home support scheme would mark one important step towards the achievement of this (Houses of the Oireachtas Committee on the Future of Healthcare, 2017). More recent model of care changes that aim to move older people's care from residential facilities towards home- and community-based settings, including an expansion of home support, were called for by the COVID-19 Nursing Homes Expert Panel (Frazer et al., 2021). In addition, the most recent Programme for Government includes details on the establishment of a statutory home support scheme.[37] However, such a scheme has not yet been established. The large projected increase in home support hour requirements estimated in this report further underpins the fact that substantial increases in the caring workforce will be required in the future; these workforce requirements would be even larger were there a statutory scheme in place to help increase substitution from LTRC.

In this report, we partition our LTRC analysis into short stay and long stay care. We find that short stay beds comprised 11 per cent of all LTRC beds in Ireland in 2022. Expanding short stay care, especially for step-down services, could help free up scarce public acute care, where many people are forced to receive rehabilitation, as well as step-down care, due to a lack of capacity in the community and in post-acute facilities. Our delayed transfers of care (DTOC) analyses shows that delayed discharges awaiting short stay or long stay care in 2022 used over 154,000 inpatient bed days. This is the equivalent of approximately 400 inpatient beds providing care for such patients daily. Increasing short stay bed capacity in particular, and improving patient flow into short stay care, could help free up inpatient care beds for those waiting on trollies or on elective waiting lists. However, the reliance on residential care settings for short stay care, especially rehabilitative care, instead of better delayed discharge planning and/or home-based rehabilitation, may be impacting people's healthcare outcomes and preferences on where best to receive such care (HSE, 2024).

[37] *Programme for Government 2025 – Securing Ireland's Future*, https://assets.gov.ie/static/documents/programme-for-government-securing-irelands-future.pdf.

Analyses presented in the appendices to this report show that the vast majority of LTRC and home support is now provided by the private sector. It is vital policymakers take into account this important context when interpreting results from these analyses. If current levels of reliance on private providers continue into the future, meeting projected LTRC bed and home support hours requirements will depend on private provision in these areas. This will require policies that continue to attract providers to join and remain in the long-term care market, as well as policies that help ensure provision is located in an equitable manner across regions in Ireland, and that care recipients receive the required services within a more integrated care environment.

This report will inform work that the ESRI is undertaking in collaboration with the HSE, which seeks to examine future LTRC and home support workforce requirements within the public sector. That research can be used to directly inform capacity and workforce planning for older people's services.

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APPENDICES

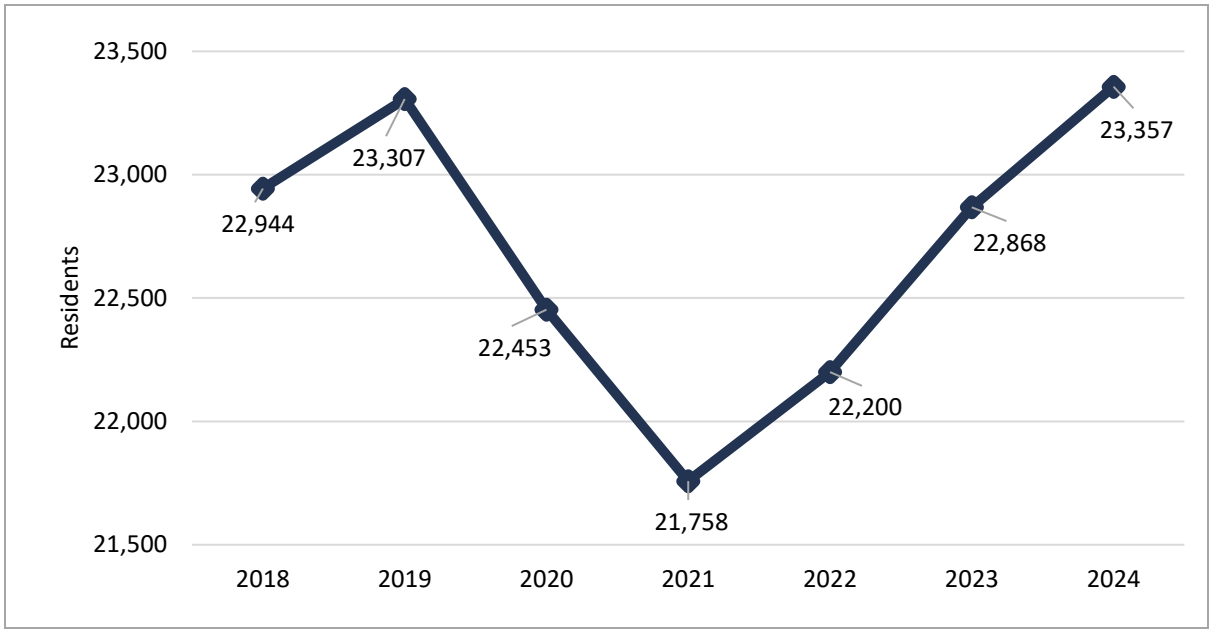
APPENDIX A: LONG-TERM RESIDENTIAL CARE

TABLE A.1 LTRC residents, December 2022

Category	N residents	N residents aged 65+
Long stay		
NHSS-funded	22,200	20,976
Publicly financed legacy schemes	196	164
Privately financed	3,866	3,866
Short stay	3,371	3,371
Total LTRC residents	**29,632**	**28,376**
% population aged 65+ in LTRC		**3.6%**

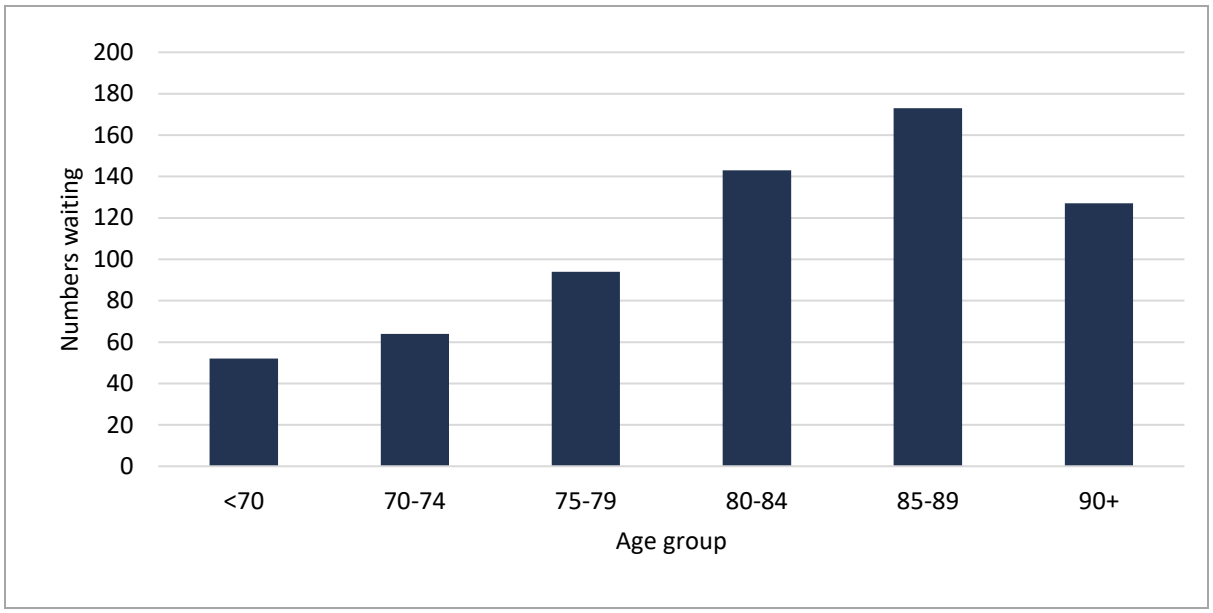
Sources: ESRI population data, HSE administrative data, NHI survey data and HIQA bed register data; authors' calculations.

FIGURE A.1 NHSS-funded residents, 2018–2024



Notes: Based on NHSS residents in December of each year.
Source: HSE administrative data; authors' calculations.

FIGURE A.2 NHSS waiting numbers by age group, December 2022

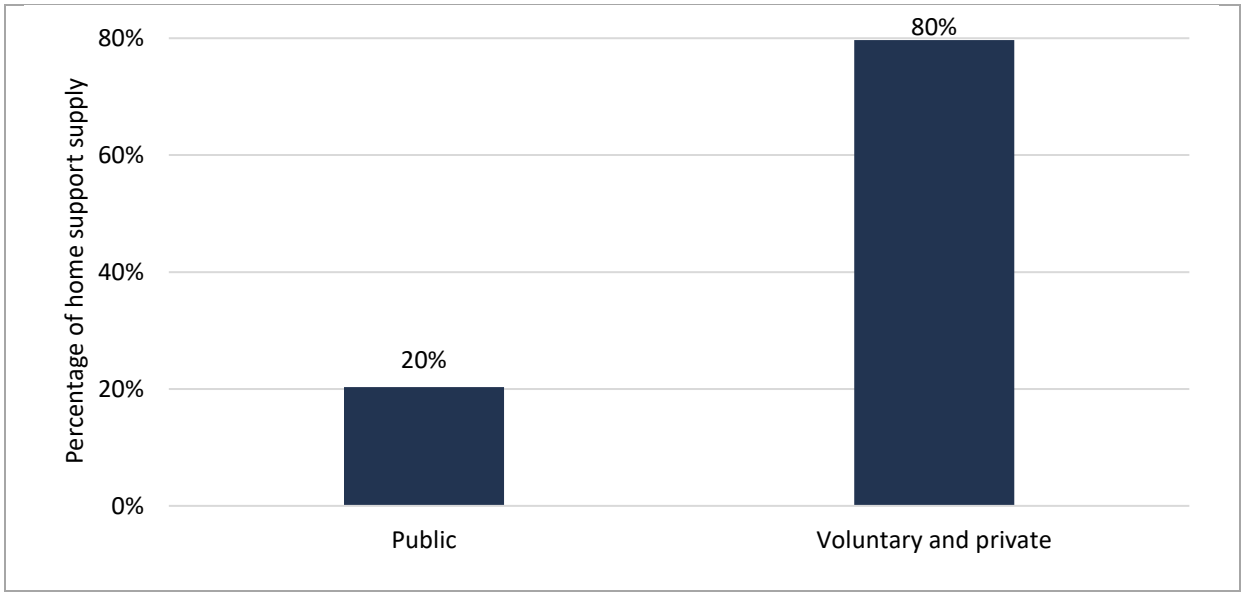


Notes: Age groups 18–64 and 65–69 years merged and age groups 90–94 and 95+ years merged to reflect small numbers of people (<30) in some age groups.

Source: HSE administrative data; authors' calculations.

Data provided by the Health Service Executive (HSE) in their Winter Plan 2022/23 show that, in 2022, an average of 462 individuals receiving short stay care via the Transitional Care Fund were awaiting a Nursing Home Support Scheme (NHSS) bed (HSE, 2022). Those awaiting an NHSS bed represent approximately 60 per cent of all short stay beds provided via the Transitional Care Fund, with the other 40 per cent receiving convalescent care or awaiting a home support package.

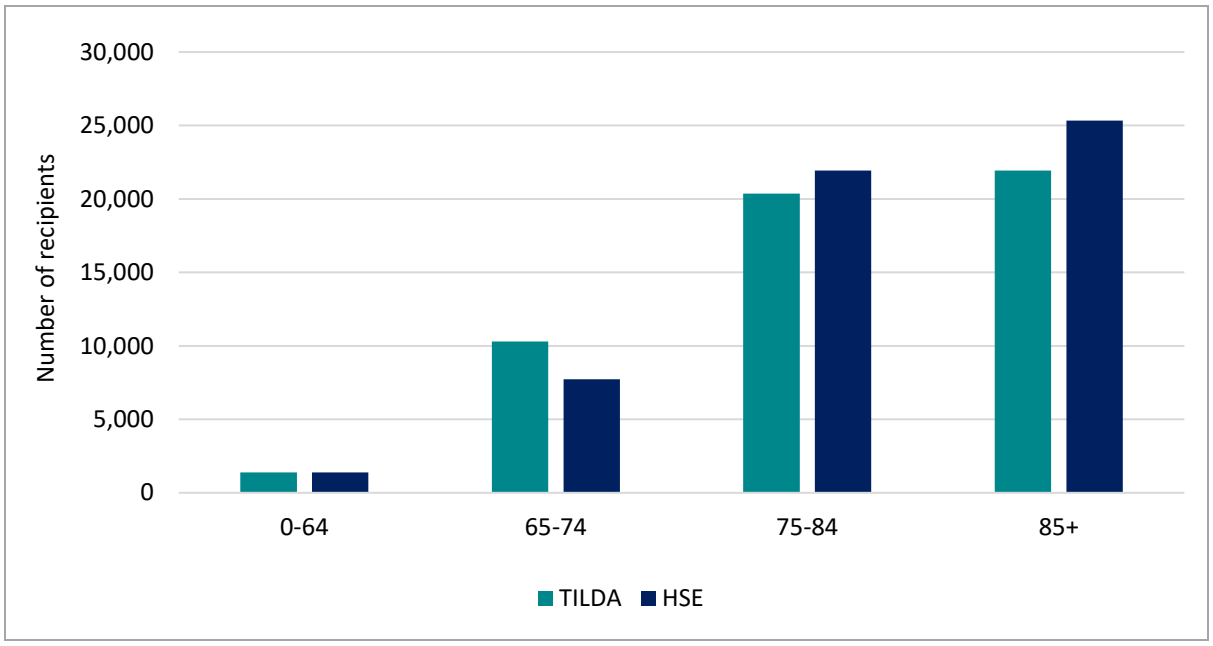
FIGURE A.3 LTRC beds in public and voluntary/private long-term homes, 2022



Sources: HSE administrative data, NHI survey data, and HIQA bed register data; authors' calculations.

APPENDIX B: HOME SUPPORT

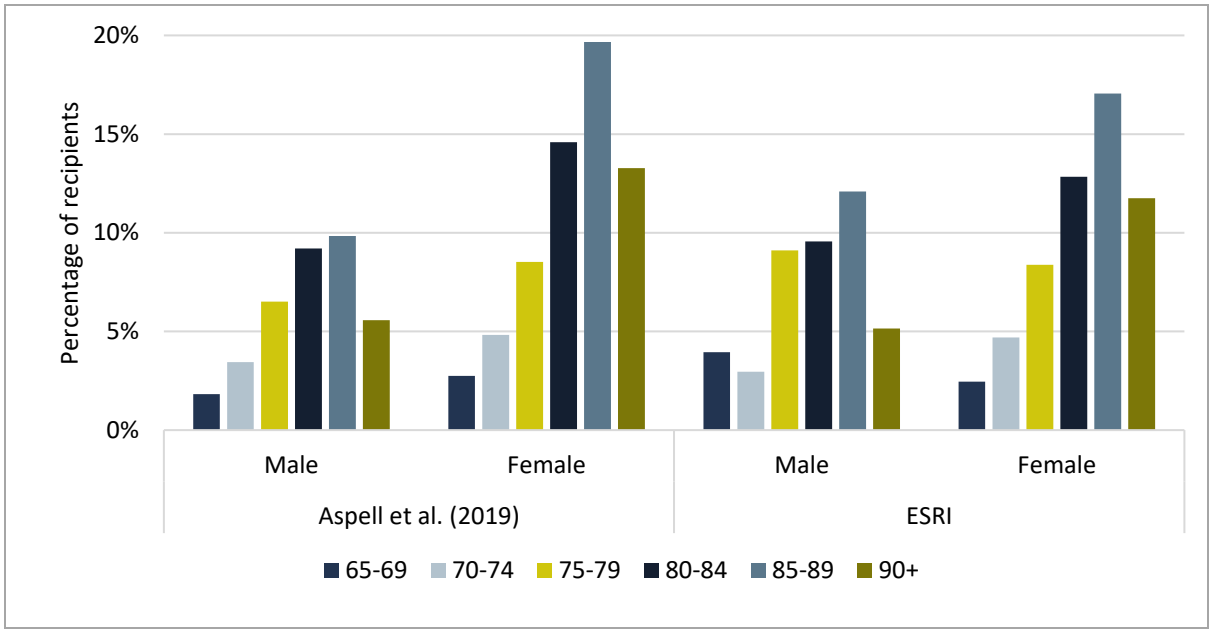
FIGURE B.1 HSE audit (2023) age distribution and TILDA age distribution, 2022



Notes: These recipient numbers are based upon applying recipients for each age group by the 2022 population. HSE audit data did not capture sex, only age groups.

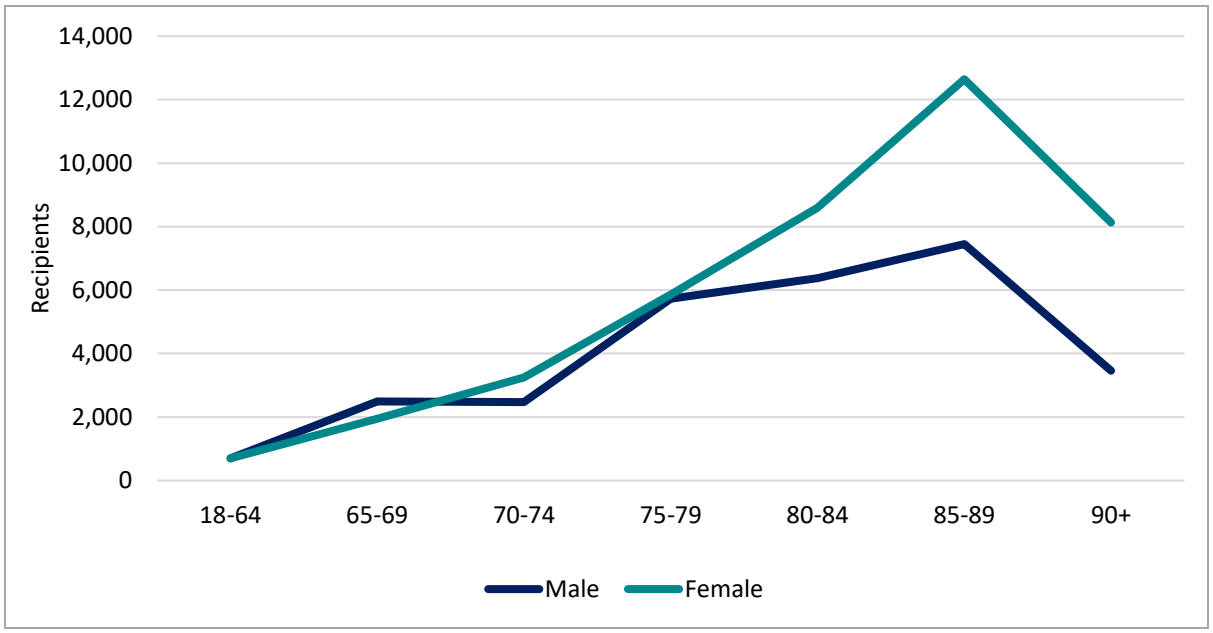
Sources: HSE administrative data and TILDA data; authors' calculations.

FIGURE B.2 Aspell et al. (2019) and ESRI public home support age distributions



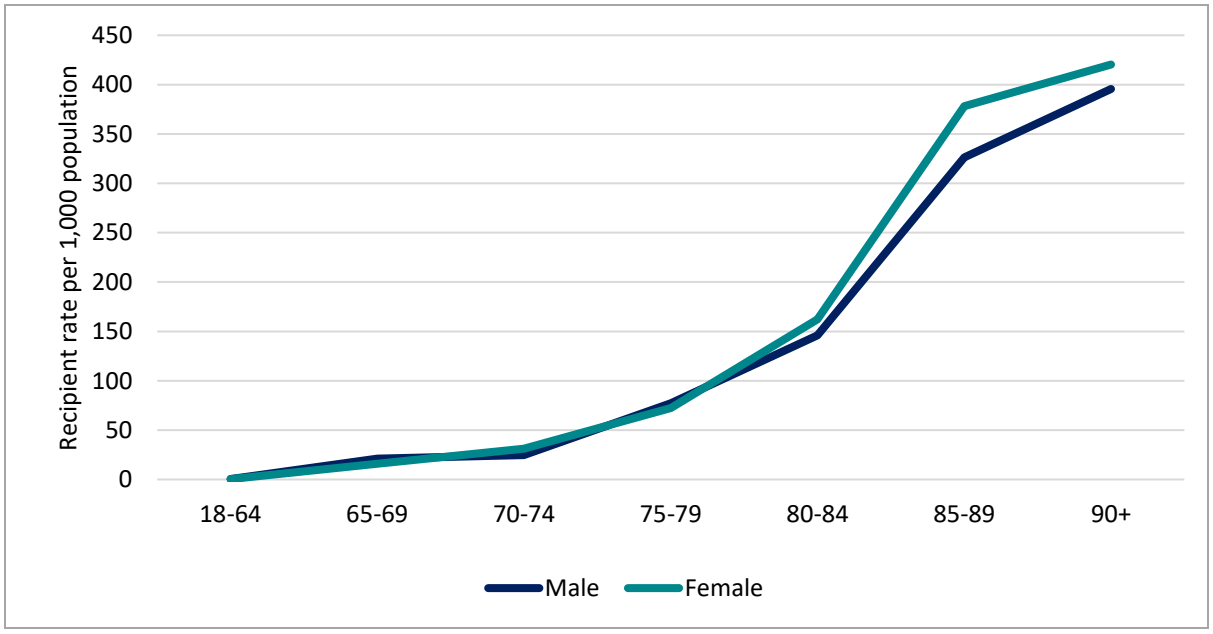
Sources: Aspell et al. (2019), HSE administrative data and TILDA data.

FIGURE B.3 Home support recipients by age group and sex, December 2022



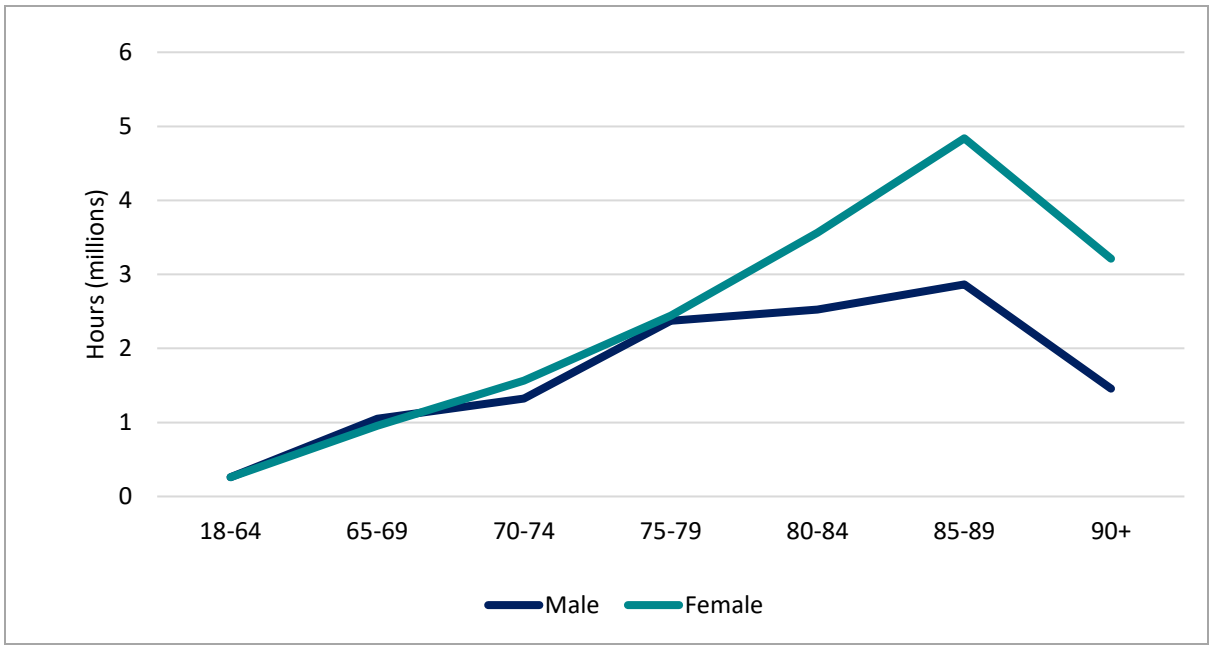
Sources: HSE administrative data and TILDA data; authors' calculations.

FIGURE B.4 Home support recipient rate by age group and sex, December 2022



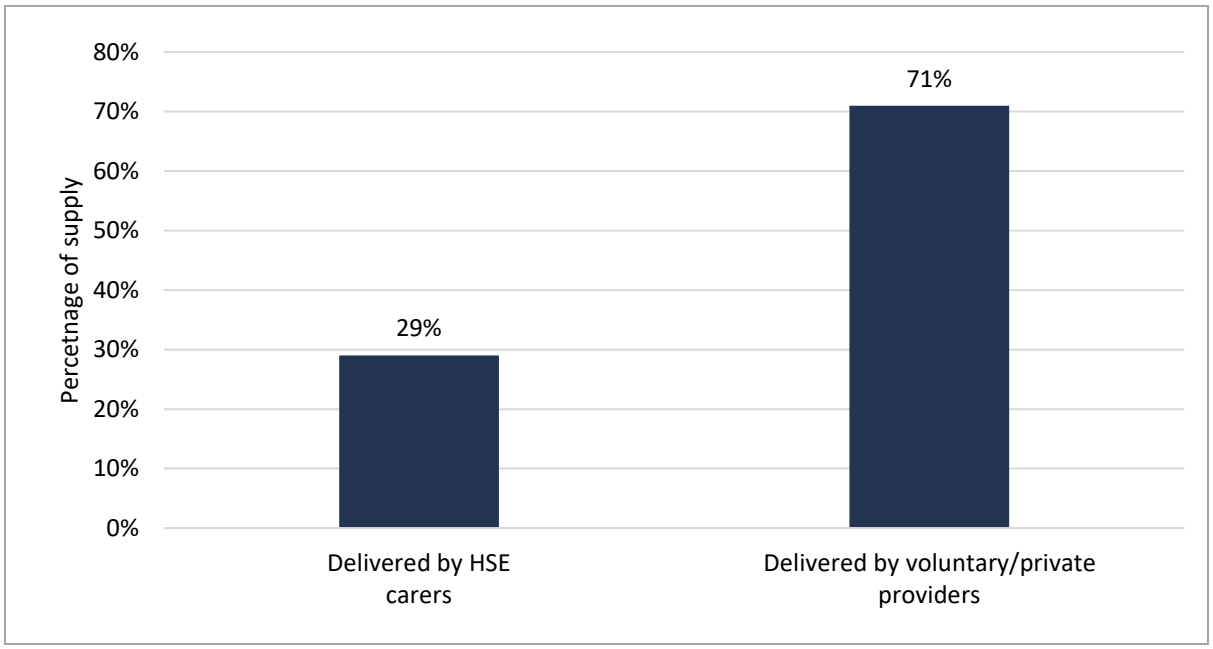
Sources: ESRI population data, HSE administrative data and TILDA data; authors' calculations.

FIGURE B.5 Home support hours by age group, 2022



Sources: ESRI population data, HSE administrative data and TILDA data; authors' calculations.

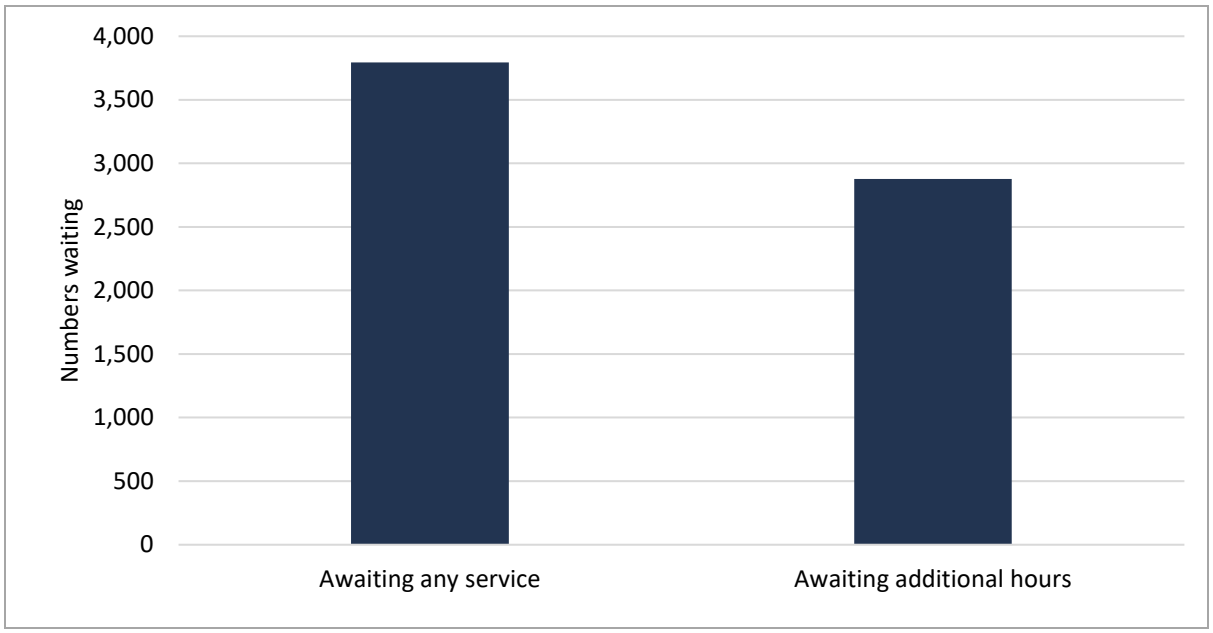
FIGURE B.6 Percentage of all home support hours delivered publicly and privately, 2022



Notes: Hours delivered by HSE employed carers relates only to hours directly provided by publicly funded home support (e.g. HSE home support service).

Source: HSE administrative data; authors' calculations.

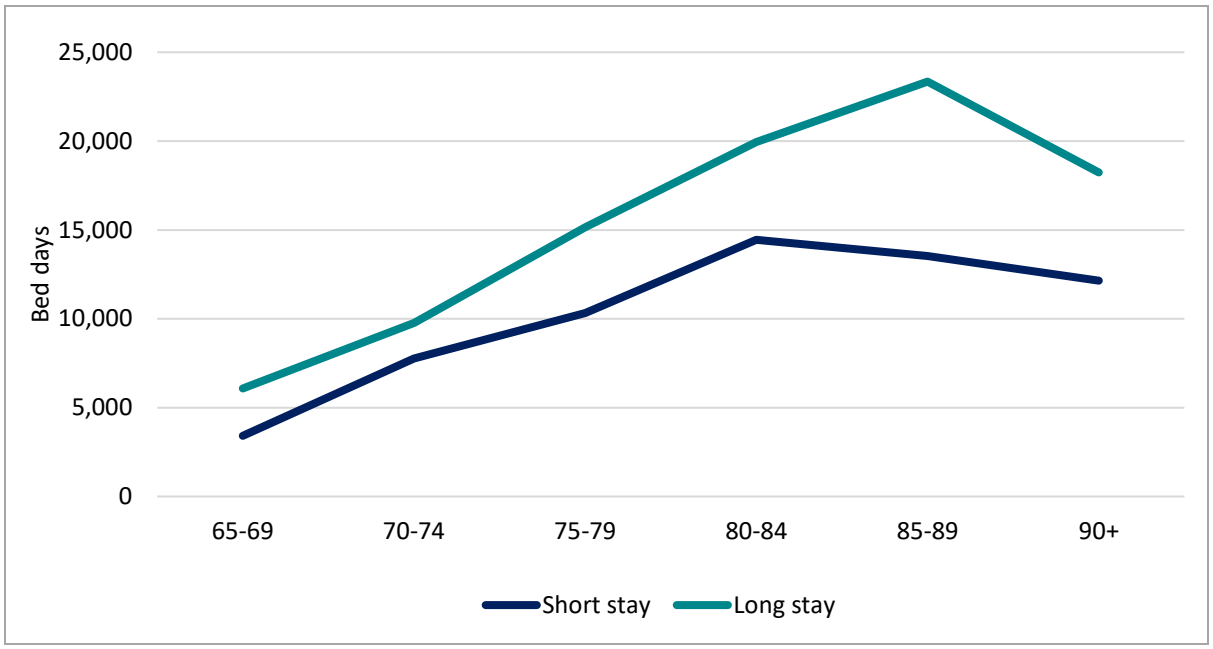
FIGURE B.7 Public home support waiting numbers, December 2022



Source: HSE administrative data; authors' calculations.

APPENDIX C: DELAYED TRANSFERS OF CARE

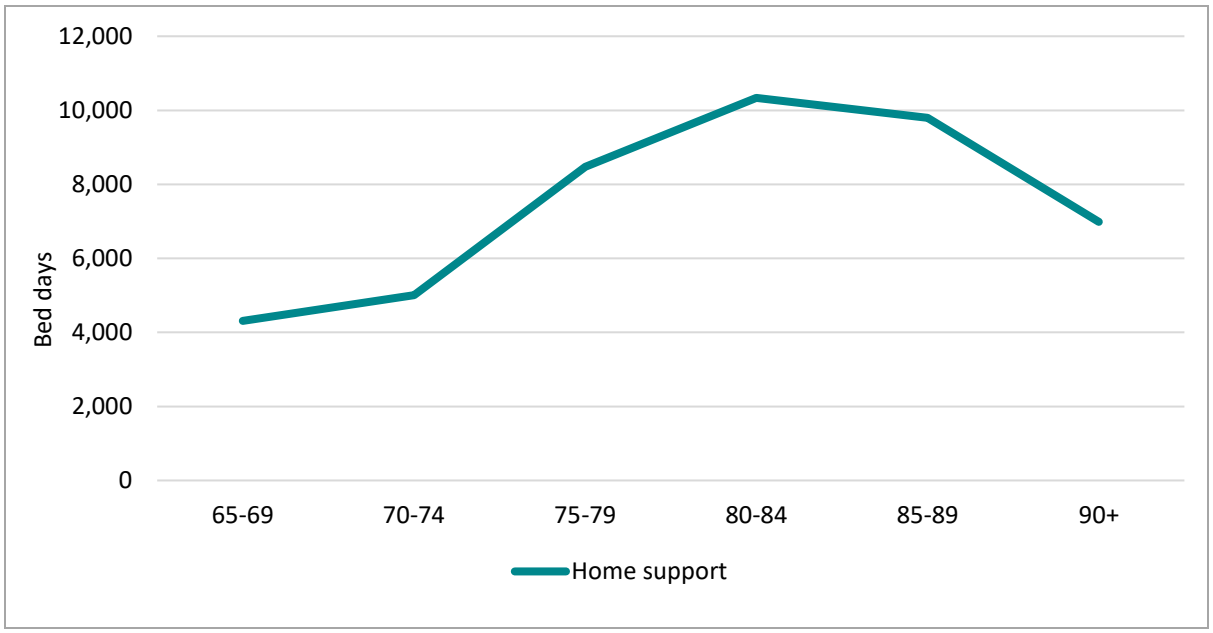
FIGURE C.1 DTOC awaiting short stay and long stay beds by age group, 2022



Notes: Bed days equate to total number of discharges multiplied by length of stay after patient has been medically cleared for discharge.
Short stay care determined as the following: 'care transferred for convalescence', 'care transferred to community nursing unit', 'care transferred to intermediate care', 'care transferred to step-down care', 'care transferred to transitional care bed prior to nursing home admission', 'care transferred to designated older persons rehabilitation bed', 'care transferred to other rehab bed' and 'ward of court – care transferred to transitional care bed'.
Long stay care determined as the following: 'care transferred to nursing home (NHSS and Ancillary State Support loan)', 'care transferred to nursing home (NHSS and top up)', 'care transferred to nursing home (NHSS)' and 'care transferred to nursing home (self pay)'.

Source: HSE BIU DTOC data; authors' calculations.

FIGURE C.2 DTOC awaiting home support by age group, 2022



Notes: Bed days equate to total number of discharges multiplied by length of stay after patient has been medically cleared for discharge.
Home support determined as the following: *'care transferred to transitional care bed to await implementation of home support package', 'care transferred to intellectual disability service', 'discharged with reablement package', 'home to pre-existing levels of supports', 'home with intensive home care package (>21 hours)' and 'home with new home support package'.*

Source: HSE BIU DTOC data; authors' calculations.

TABLE C.1 DTOC bed days and beds, 2022

	Bed days	Beds
LTRC total	154,159	422
Short stay	**(61,623)**	(169)
Long stay	**(92,536)**	(253)
Home support	44,898	123
Total	**199,057**	**545**

Notes: Bed days equate to total number of discharges multiplied by length of stay after patient has been medically cleared for discharge.
Beds calculated after applying 90 per cent OR.
Short stay care determined as the following: 'care transferred for convalescence', 'care transferred to community nursing unit', 'care transferred to intermediate care', 'care transferred to step-down care', 'care transferred to transitional care bed prior to nursing home admission', 'care transferred to designated older persons rehabilitation bed', 'care transferred to other rehab bed' and 'ward of court – care transferred to transitional care bed'.
Long stay care determined as the following: 'care transferred to nursing home (NHSS and Ancillary State Support loan)', 'care transferred to nursing home (NHSS and top up)', 'care transferred to nursing home (NHSS)' and 'care transferred to nursing home (self pay)'.
Home support determined as the following: *'care transferred to transitional care bed to await implementation of home support package', 'care transferred to intellectual disability service', 'discharged with reablement package', 'home to pre-existing levels of supports', 'home with intensive home care package (>21 hours)' and 'home with new home support package'.*

Source: HSE BIU DTOC data; authors' calculations.

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