



ESRI
RESEARCH SERIES

Number 238, October 2026



**AN INSTITIÚID
UM THAIGHDE
EACNAMAÍOCHTA
AGUS SÓISIALTA**
ESRI ECONOMIC & SOCIAL
RESEARCH INSTITUTE

Family care in Ireland: Carers, recipients and projections of need

ELLEN McHUGH, BRENDAN WALSH, FRANK WOLFE AND
SHEELAH CONNOLLY

Family care in Ireland: Carers, recipients and projections of need

Ellen McHugh

Brendan Walsh

Frank Wolfe

Sheelah Connolly

October 2026

ESRI Research Series

Number 238

Available to download from www.esri.ie

<https://doi.org/10.26504/rs238>

© 2026 The Economic and Social Research Institute

Whitaker Square, Sir John Rogerson's Quay, Dublin 2.



This Open Access work is licensed under a Creative Commons Attribution 4.0 International License (<https://creativecommons.org/licenses/by/4.0/>), which permits unrestricted use, distribution and reproduction in any medium, provided the original work is properly credited.

About the ESRI

The Economic and Social Research Institute (ESRI) advances evidence-based policymaking that supports economic sustainability and social progress in Ireland. ESRI researchers apply the highest standards of academic excellence to challenges facing policymakers, focusing on ten areas of critical importance to 21st century Ireland.

The Institute was founded in 1960 by a group of senior civil servants led by Dr T.K. Whitaker, who identified the need for independent and in-depth research analysis. Since then, the Institute has remained committed to independent research and its work is free of any expressed ideology or political position. The Institute publishes all research reaching the appropriate academic standard, irrespective of its findings or who funds the research.

The ESRI is a company limited by guarantee, answerable to its members and governed by a Council, comprising up to 14 representatives drawn from a cross-section of ESRI members from academia, civil services, state agencies, businesses and civil society. Funding for the ESRI comes from research programmes supported by government departments and agencies, public bodies, competitive research programmes, membership fees, and an annual grant-in-aid from the Department of Public Expenditure, Infrastructure, Public Service Reform and Digitalisation.

Further information is available at www.esri.ie.

The authors

Ellen McHugh was a Research Assistant at the Economic and Social Research Institute (ESRI) at the time of working on this report. Brendan Walsh is a Senior Research Officer at the ESRI and an Adjunct Associate Professor at Trinity College Dublin (TCD). Frank Wolfe is a Research Analyst at the ESRI. Sheelah Connolly is an Associate Research Professor at the ESRI and an Adjunct Associate Professor at TCD.

Acknowledgements

Financial support for this research was provided by the Department of Health. The authors thank members of the Department of Health/ESRI Research Programme Steering Group and the Department of Health Working Group for their input and direction in completing this analysis. The authors are also grateful to personnel at The Irish Longitudinal Study on Ageing (TILDA) for facilitating access to the TILDA dataset. The authors also acknowledge the significant contribution of Anne Nolan of the ESRI and three anonymous reviewers.

This report has been accepted for publication by the Institute, which does not itself take institutional policy positions. All ESRI Research Series reports are peer reviewed prior to publication. The author(s) are solely responsible for the content and the views expressed.

Table of contents

Executive summary	vii
Chapter 1 Introduction	1
Chapter 2 An overview of family care in Ireland	4
2.1 Introduction	4
2.2 Numbers of family carers and recipients in Ireland	6
2.2.1 Number of carers.....	6
2.2.2 Number of care recipients.....	9
2.3 Characteristics of family carers and care recipients in Ireland	9
2.3.1 Characteristics of family carers	9
2.3.2 Characteristics of care recipients	13
2.4 Impact of care provision on the physical and mental well-being of family carers	13
2.5 Government policy on family care.....	14
2.6 Government support for family carers.....	15
2.7 The future of family care.....	17
Chapter 3 Data and Methods	19
3.1 Introduction	19
3.2 Data sources.....	19
3.2.1 The Healthy Ireland Survey	20
3.2.2 Census Longitudinal Dataset.....	21
3.2.3 The Irish Longitudinal Study on Ageing (TILDA)	22
3.3 Methods – baseline family care provision and receipt.....	25
3.3.1 Family care provision	25
3.3.2 Family care need and receipt	27
3.4 Methods – projections	29
3.4.1 Hippocrates	29
3.4.2 Assumptions	31
3.4.3 Decomposition analysis.....	36
Chapter 4 Findings: Characteristics of family carers and care recipients	37
4.1 Introduction	37
4.2 Family carers	37
4.3 Care recipients.....	42
4.4 Baseline estimates of family care receipt	45
Chapter 5 Findings: Projections	48
5.1 Introduction	48
5.2 Projections of family care need.....	48
5.3 Projections of family care need: Decomposition analysis	51

Chapter 6	Discussion	53
6.1	Summary of findings	53
6.2	Limitations	54
6.3	Meeting projected care needs	56
6.3.1	<i>Family Care</i>	56
6.3.2	<i>Formal care</i>	62
6.4	Conclusions.....	63
References		64

List of tables

Table 2.1	Questions on the provision of care in a sample of Irish surveys	8
Table 2.2	Age distribution of care recipients, 2025.....	13
Table 3.1	Datasets used in the analysis	19
Table 3.2	Questions used to profile care recipients using TILDA data	24
Table 3.3	Variables used in the analysis describing carers in the Healthy Ireland Survey and the Census Longitudinal Dataset	26
Table 3.4	Variables used in the analysis describing care recipients in TILDA.....	28
Table 3.5	Summary of main assumptions for population scenarios	31
Table 3.6	Projection scenario assumptions.....	35
Table 4.1	Family care provision across socio-demographic groups (aged 15+), Healthy Ireland Survey Waves 8 and 9	38
Table 4.2	Family care provision across socio-demographic groups (aged 15+), 2022 sample of the Census Longitudinal Dataset.....	40
Table 4.3	Family care provision across socio-demographic groups (aged <15), 2022 sample of the Census Longitudinal Dataset.....	42
Table 4.4	Family care receipt across socio-demographic groups (aged 50+ living in community), TILDA Wave 5	43
Table 4.5	Percentage reporting they have a difficulty with ADLs/IADLs and in receipt of care, TILDA Waves 3, 4 and 5, males	45
Table 4.6	Percentage reporting they have a difficulty with ADLs/IADLs and in receipt of care, TILDA Waves 3, 4 and 5, females	46
Table 5.1	Projections of family care demand, 2022–2040	49

List of figures

Figure 2.1	Percentage of population providing care, by county (2022)	11
Figure 2.2	Percentage of family carers by weekly hours of care provided (2022).....	12
Figure 3.1	Hippocrates model – diagrammatic representation of family care projections, 2022–2040.....	30
Figure 3.2	Total population – low, central and high population growth scenarios	32
Figure 3.3	Central scenario – population age pyramids for 2022 and 2040 (% of population)	33
Figure 4.1	Percentage aged 50 and over reporting difficulties with ADLs/IADLs but not receiving help, TILDA Waves 3, 4 and 5	47
Figure 5.1	Projections of family care need based on current receipt of care, 2022–2040	49
Figure 5.2	Projections of family care need based on a reported difficulty with an ADL/IADL, 2022–2040	50
Figure 5.3	Need for care (based on current receipt of care) – decomposition of growth (central scenario), 2022–2040	51
Figure 5.4	Need for care (based on difficulties with ADLs/IADLs) – decomposition of growth (central scenario), 2022–2040	52

Abbreviations

ADL	Activities of daily living
CAPI	Computer-aided personal interview
HSE	Health Service Executive
IADL	Instrumental activities of daily living
TILDA	The Irish Longitudinal Study on Ageing
UK	United Kingdom
WHO	World Health Organization

Executive summary

Introduction

The growing and ageing population in Ireland will result in a significant increase in the need for a range of health and social care services in the coming years. Services used predominantly by older people, in particular long-term care, are projected to experience the largest increases. In Ireland, family carers are an integral component of the long-term care system, providing the majority of such care and facilitating many people to remain within their own home and community as they age. Despite the clear reliance on family care in Ireland, relatively little is known about current receipt of such care or potential future needs.

There are two main objectives of this report: (i) to profile carers and recipients of family care in Ireland and (ii) to project future care needs, given the growing and ageing population.

Methods

Two datasets – the Healthy Ireland Survey and the Census Longitudinal Dataset – were used to profile family carers in Ireland.

The Irish Longitudinal Study on Ageing (TILDA) includes several questions on the provision and receipt of care among those aged 50 and over, and was used to profile the characteristics of care recipients. It was also used to create two baseline metrics of need for care that formed the basis of the projection analysis. The two metrics were the proportion of age and sex groupings reporting:

- (i) difficulties with activities of daily living (ADLs) and instrumental activities of daily living (IADL);
- (ii) difficulties with ADLs and IADLs and receiving family care.

The projections of need for care were based on the ESRI's healthcare projection tool, the Hippocrates model. The Hippocrates model projects the future demand for a particular service or sector based on the use of the service in a base year, while incorporating assumptions on how demand may change in the future. In this analysis the base year is 2022, and the projection period is 2023–2040.

Both sets of baseline estimates (those with difficulty with an ADL/IADL and those with difficulty with an ADL/IADL and in receipt of family care)

were projected based on assumptions on the size and age structure of the population and healthy ageing.

Findings

Females and those aged 45–64 were the most likely to report providing family care. However, older carers were found to provide more hours of care. People who reported that their current situation in regard to work was that they were looking after the family or home were more likely to report providing care than other groupings, and to provide more intense levels of care.

Analysis using the TILDA dataset showed that a higher proportion of females reported receiving family care, and unsurprisingly, receipt of care increased with age. A significant proportion of those aged 50 and over who reported difficulties with ADLs and IADLs did not receive any care, with this proportion tending to be higher for younger (older) people and for males. While some of those with difficulties with ADLs and IADLs may not need care, it is likely that for some, the absence of care represents an unmet need.

In 2022, an estimated 123,802 people aged 50 and over reported difficulties with ADLs/IADLs and received care. The number of people needing care is projected to increase by between 49 and 58 per cent between 2022 and 2040. If all those with difficulties with ADLs/IADLs were to receive care in 2040, then the projected increase in the number of people requiring care would be in the region of 123 per cent. The ageing population is the main driver of projected growth, followed by population growth. Healthy ageing has the potential to offset some of the projected increases.

Discussion

The growing and ageing population is projected to contribute to a significant increase in the number of people with care needs in the coming years. A key question for policymakers is how this additional need for care can be met and whether it will come from family or formal (paid professionals) sources, or most likely a combination of both.

Family care is a central component of long-term care in Ireland, and from a policy perspective is likely to continue as such in the future. Policy interventions in this regard should aim at ensuring there is sufficient support (both financial and otherwise) available so that the

type and intensity of care provided is a meaningful choice for family carers and is appropriate for the needs of the care recipient. Further policies which support flexible working arrangements will be important in this context. Given the extent of the increased need for family care projected in this report, it is likely that some of the additional need will require an increase in formal services.

Chapter 1

Introduction

With Ireland's population both growing and ageing, recent reports show that demand for a range of health and social care services will rise sharply in the coming years (Brick et al., 2025; Connolly et al., 2025; Walsh and Kakoulidou, 2025). Services used predominantly by older people, in particular long-term care, are projected to experience the largest increases in demand (Walsh and Kakoulidou, 2025). Long-term care includes a broad range of personal, social and healthcare services to assist people who have functional or cognitive limitations in their ability to perform self-care and other activities (Zimmerman and Sloane, 2007) and is delivered in various settings, including the home, community, and residential facilities. Older people in Ireland have a strong preference to keep living in their own homes and communities as they age (Fox et al., 2017). The Sláintecare reform proposals reiterated the need to prioritise this preference and recommended the introduction of a Statutory Home Support Scheme (Houses of the Oireachtas Committee on the Future of Healthcare, 2017).

The National Carers' Strategy defined a carer as 'someone who is providing an ongoing significant level of care to a person who is in need of that care in the home due to illness or disability or frailty' (Department of Health, 2012, p.8). In the coming years, the ageing population and the move towards increased delivery of care in the community will likely increase the need for care for those with care needs from family and other people important to them (Cattaneo et al., 2025). Such care is generally unpaid, unregulated, and mostly provided by family and friends (Rocard and Llena-Nozal, 2022), with carers providing emotional support, assistance with activities of daily living¹ (ADL) and instrumental activities of daily living² (IADLs), as well as managing healthcare and medication regimens alongside the care recipient (Mouchaers et al., 2023). Several terms are used to describe care provided in the home by family, neighbours and friends (rather than paid professionals), including informal care, family care and unpaid care, with little agreement about which term is the most appropriate (Care Alliance Ireland, 2022). In this report, the terms

¹ Activities of daily living (ADLs) are basic self-care activities that people need to do on a daily basis including bathing, dressing, toileting, feeding and mobility.

² Instrumental activities of daily living (IADLs) are more complex activities that are needed to manage daily life within a community and include preparing meals, managing finances, shopping and communication.

2 | Family care in Ireland: Carers, recipients and projections of need

‘carer’ and ‘family carer’ are used interchangeably to encompass informal, family and unpaid carers. It is understood that a family carer (as the term is used in this report) does not necessarily need to be a relative of the person being cared for (Care Alliance Ireland, 2022); this broader understanding of family care appears appropriate given the current reality of family life (Levine et al., 2010).

In the 2022 Census, almost 300,000 people (6 per cent of the population) reported providing regular unpaid help or support to a family member, neighbour or friend with a long-term illness, health issue, or an issue related to old age or disability (Central Statistics Office, 2023a). While somewhat difficult to quantify, the value of care to the Irish state was previously estimated to be in the region of €2.1 billion to €5.5 billion (Hanly and Sheerin, 2017). However, that valuation was based on estimates of care hours from 2011, and given recent increases in the number of carers and an increase in prices over the last decade, the value now is likely to be significantly higher.

Across 30 European countries, the proportion of the population aged 65 and older providing care in Ireland is mid-range, with similar proportions to Belgium, Italy and Sweden (The Eurocare Team, 2024); however, the proportion providing intense care (defined as 20+ hours per week) is relatively high. The extensive role of family carers in Ireland is recognised by policymakers. The Health Service Executive (HSE), for example, notes that formal home support services are not intended, nor would there be sufficient funding, to replace family care; rather, the aim is to support family carers (HSE, 2018). In Ireland, the model of family care as the primary source of long-term care also applies to younger people and younger adults with additional care needs; however, for data reasons this report focuses predominantly on family care for older people.

Despite the clear reliance on family care, relatively little is known about current receipt of such care or potential future needs. Further, relatively little is known about the characteristics of carers or care recipients. This report aims to fill these gaps.

There are two main objectives of this report: (i) to profile carers and recipients of family care in Ireland and (ii) to project future care needs, given the growing and ageing population.

The rest of this report is structured as follows:

- Chapter 2 provides an overview of family care in Ireland.
- Chapter 3 describes the data and methods used in the analysis.
- Chapter 4 shows the characteristics of family carers and recipients of care.
- Chapter 5 includes projections of the need for family care to 2040.
- Chapter 6 concludes, providing a summary of the findings, identifying the limitations of the analysis and discussing how the projected care needs could be met.

Chapter 2

An overview of family care in Ireland

2.1 Introduction

In Ireland, there has traditionally been an emphasis on the family as providers of care (Timonen and Doyle, 2008). While a range of care is provided within the family setting, family care – the focus of this report – generally relates to unpaid care provided to an individual with an illness, health condition, disability, frailty or age-related support needs.

Family carers are a diverse group along several domains, including the hours and type of care provided, the length of time spent caring, their relationship to the care recipient, and the carer's own demographic, socio-economic and health circumstances. Carers undertake a variety of tasks, including (but not limited to) personal care, housekeeping, transportation, financial management, emotional support, coordinating and attending healthcare appointments, managing and providing healthcare at home, and assisting with decision-making (Alam et al., 2020; Schulz et al., 2020). Time commitments can range from a few hours to 120+ hours per week, depending on the care recipient's needs, the relationship between the carer and care recipient (including living arrangements), the ages of the carer and care recipient, and the availability of other formal³ and informal care services. A care recipient often receives care from more than one person, which requires communication and coordination among carers and the person receiving care.

Despite being an integral part of the wider Irish health and social care system – and therefore Irish society as a whole – family care, historically, received little attention or support. Due in part to the development and campaigning of various carers' advocacy and representative groups, attempts have been made to improve the circumstances of carers in more recent years. The National Carers' Strategy was published in 2012 (Department of Health, 2012) and noted that carers should be recognised and respected as key care partners, supported to maintain their own health and well-being, empowered to care with confidence, and have their health and

³In this context, 'formal services' refers to structured, professional and paid health services generally provided by trained individuals and organisations.

preferences considered within care plans. The strategy outlined 42 actions for policymakers to empower and help carers in the areas of income supports, respite care, training and education, and inclusion in care plans. However, these actions were only partly operationalised and annual reporting on achievements from the strategy stopped in 2018.

More broadly, in 2024 a referendum was held to amend the Irish Constitution by deleting language regarding a mother's duties in the home and replacing it with a gender-neutral article acknowledging that care provided by family members supports the common good. A 'Yes' vote was supported by all government and most opposition parties, along with numerous civil society organisations. However, the referendum was defeated, with 73.9 per cent voting against it, in part due to concerns that the wording of the amendment was vague and placed too much responsibility on families rather than legally obligating the state to provide adequate care supports. Also in 2024, a Commission on Care for Older People was established to examine the provision of health and social care services and supports for older people and to make recommendation to the government for their strategic development, with the first report from the Commission expected to be published in Autumn 2026.

Despite carers being an integral part of the care system in Ireland, there is a lack of information on caring. In recent years there have been attempts to provide more information on carers' lives. Questions on care provision (and to a lesser extent, care receipt) are now included in some large-scale surveys, including the Census of Population, the Healthy Ireland Survey and the Irish Longitudinal Study on Ageing (TILDA).

This chapter provides a brief overview of family care in Ireland, detailing the number and characteristics of carers and care recipients, the impact of caring on the physical and mental well-being of carers, current government policy on family care, and the future of family care.

2.2 Numbers of family carers and recipients in Ireland

This section provides a brief overview of data sources and data on family carers and care recipients.

2.2.1 Number of carers

There is no definite estimate of the number of carers in Ireland.

Different sources provide different estimates due to the definition of ‘carer’ used, the sample population (e.g. the total population, those in receipt of the Carer’s Allowance/Benefit, carers of people with particular health conditions), the method of data collection and the time frame. The use of survey data to identify carers is useful in potentially identifying those who would not otherwise be identified; however, it is dependent on people identifying themselves as a carer and reporting accordingly, and this may not always happen in practice (Care Alliance Ireland, 2022).

Table 2.1 shows some of the large-scale Irish surveys that include a question on the provision of care. A question on care was first added to the Census of Population in 2002 and has been included in subsequent censuses in 2006, 2011, 2016 and 2022. The wording of the question, however, changed over time (Table 2.1). The 2022 Census widened the definition of care by (i) referencing ‘neighbour’ as a potential recipient of care and (ii) including the word ‘support’ in addition to personal help. The number of people reporting providing care in the Census increased from 195,263 in 2016 to 299,128 in 2022; given the population increase over the same period, this represents a rise from 4 per cent of the population in 2016 to 6 per cent in 2022. The inclusion of the words ‘neighbour’ and ‘support’ in the 2022 question is likely to explain at least part of this increase (Care Alliance Ireland, 2022).

The Healthy Ireland Survey was first conducted in 2015 and has been undertaken annually (except in 2020) since then. A question on care provision has been included in all waves. The question in the Healthy Ireland Survey from 2015 to 2024 is the same question as in the earlier (pre-2022) Census of Population (Table 2.1); in the 2025 Healthy Ireland Survey, the question was updated to reflect the question used in the 2022 Census of Population.

The Irish Health Survey was undertaken by the Central Statistics Office (CSO) in 2019 and 2024, with both waves including a question on care provision. However, the wording of the question differs slightly across the two waves and also differs from the question used in the Census of

Population and the Healthy Ireland Survey. In particular, the Irish Health Survey references the provision of care at least once per week.

In all three surveys, the proportion of respondents reporting that they provide care has increased over time. However, there are differences across the three surveys in the proportion reporting they provide care. For example, in the 2022 Census of Population 6 per cent reported providing care, while for the same year, 10 per cent of respondents to the Healthy Ireland Survey reported providing care. Comparing across similar time points, estimates of provision of care tend to be highest in the Irish Health Survey and lowest in the Census of Population. There are a number of potential reasons for the differences across the surveys including the different wording of the questions, the differing methods of data collection (the Census is a self-completed form, the Healthy Ireland Survey is telephone-based, while the Irish Health Survey is generally completed online), the response rate, and the general focus of the survey (the Census is wide ranging while both the Healthy Ireland Survey and the Irish Health Survey are more narrowly focused on health and the use of health services).

In addition to the aforementioned nationally representative surveys, TILDA and the Growing Up in Ireland study include questions on the provision of care for older people and younger people respectively (McGarrigle et al., 2022; Russell and Smyth, 2024; McGarrigle, 2025). Analysis from TILDA showed that 3 per cent of men and 5 per cent of women aged 60 and over reported providing care for a family member or friend in the last month (McGarrigle, 2025), while analysis from the Growing Up in Ireland study found that one in ten 17-year-olds reported providing care for a parent (Russell and Smyth, 2024).

Table 2.1 Questions on the provision of care in a sample of Irish surveys

Survey	Years	Definition/question	Inclusions/exclusions	% reporting provision of care
Census of Population	2002 2006 2011 2016 2022	2002/2006/2011/2016: ‘... provide[s] regular, unpaid personal help for a friend or family member with a long-term illness, health problem or disability (including problems which are due to old age). Personal help includes help with basic tasks such as feeding and dressing.’ 2022: ‘...provide[s] regular unpaid personal help or support to a family member, neighbour or friend with a long-term illness, health issue, an issue related to old age or disability.’	Nationally representative self-complete questionnaire. Approximately 96% response rate. Census 2006 did not ask the question to those aged less than 15.	2002: 5% 2006: 5% 2011: 4% 2016: 4% 2022: 6%
Healthy Ireland Survey	2015 2016 2017 2018 2019 2021 2022 2023 2024 2025	2015–2024: ‘Do you provide regular unpaid personal help for a friend or family member with a long-term illness, health problem, or disability? Include problems which are due to old age. Personal help includes help with basic tasks such as feeding or dressing.’ 2025: ‘Do you provide regular unpaid personal help or support to a family member, neighbour or friend with a long-term illness, health issue, an issue related to old age or disability?’	Nationally representative sample of those living in the community aged 15 and older, with a target response rate of 60%. Response rates in more recent waves have fallen below 60%. 2015–2019 interviews were face-to-face with residential addresses identified from the Ordnance Survey Ireland GeoDirectory. Since 2021, interviews have been telephone-based using a mobile number random digit dialling sampling frame.	2015: 9% 2016: 10% 2017: 9% 2018: 8% 2019: 9% 2021: 9% 2022: 10% 2023: 12% 2024: 14% 2025: 14%
Irish Health Survey	2019 2024	2019: ‘Are you providing care or assistance at least once a week to one or more people suffering from any chronic condition or infirmity due to old age (exclude professional activities)?’ 2024: ‘Do you provide care or assistance to one or more persons suffering from some age problem, chronic health condition or infirmity, at least once a week? Note: Exclude any care you provide as part of your profession.’	Nationally representative survey of those living in the community aged 15 and older. The response rate for the 2024 survey was 21%. The survey is self-completed online and the sampling frame is the Census of Population.	2019: 13% 2024: 18%*

Source: Census of Population data; Healthy Ireland Survey (Ipsos B&A, 2025); Irish Health Survey.

Note: *For the Irish Health Survey, in the final column the 2024 figure applies to those aged 18+, while the 2019 figure applies to those aged 15+.

2.2.2 Number of care recipients

While several surveys have included a question on the provision of care, there have been fewer attempts to quantify the proportion of the population in receipt of family care. This is a significant limitation in understanding and quantifying the extent of care in Ireland, as research from the United Kingdom (UK) has shown that there can be discrepancies between carers' and care recipients' reports, both in terms of whether care has been provided and the number of hours of care (Urwin et al., 2021). It is also possible that carers and care recipients have different perspectives on what constitutes care.

The Irish Health Survey is one of the few national surveys including a question on family care receipt. The 2024 survey included the following question:

*In the past 12 months, have you received any unpaid care or assistance from a family member (within or outside your household), partner, friend or neighbour because of a long-standing health problem or old age, at least once a week?
Note: Please include any help or assistance with personal care and household activities, as well as companionship and emotional support.*

Data from the Irish Health Survey for 2024 show that 10 per cent of respondents aged 18 and over received care or assistance from a family member, while 0.9 per cent received care or assistance from a non-family member (non-professional).⁴

2.3 Characteristics of family carers and care recipients in Ireland

2.3.1 Characteristics of family carers

Age and sex

Consistent with other countries, women and those in the middle-aged groups in Ireland are more likely to report providing care (Murphy and Walsh, 2015; Verbakel et al., 2017; McGarrigle and Kenny, 2020). Data from the 2022 Census, for example, show that 61 per cent of carers were female and 64 per cent of carers were aged between 40 and 64 (Central Statistics Office, 2023a). This is consistent with the documented 'gender care gap' in Europe, wherein the majority of unpaid care is performed by females. This is seen both in the

⁴ Estimates come from tabulations at data.cso.ie.

prevalence of care (most unpaid carers are female) and also in the intensity of care (female carers, on average, provide more hours of care than males) (Gimenez-Nadal and Molina, 2020).

Employment

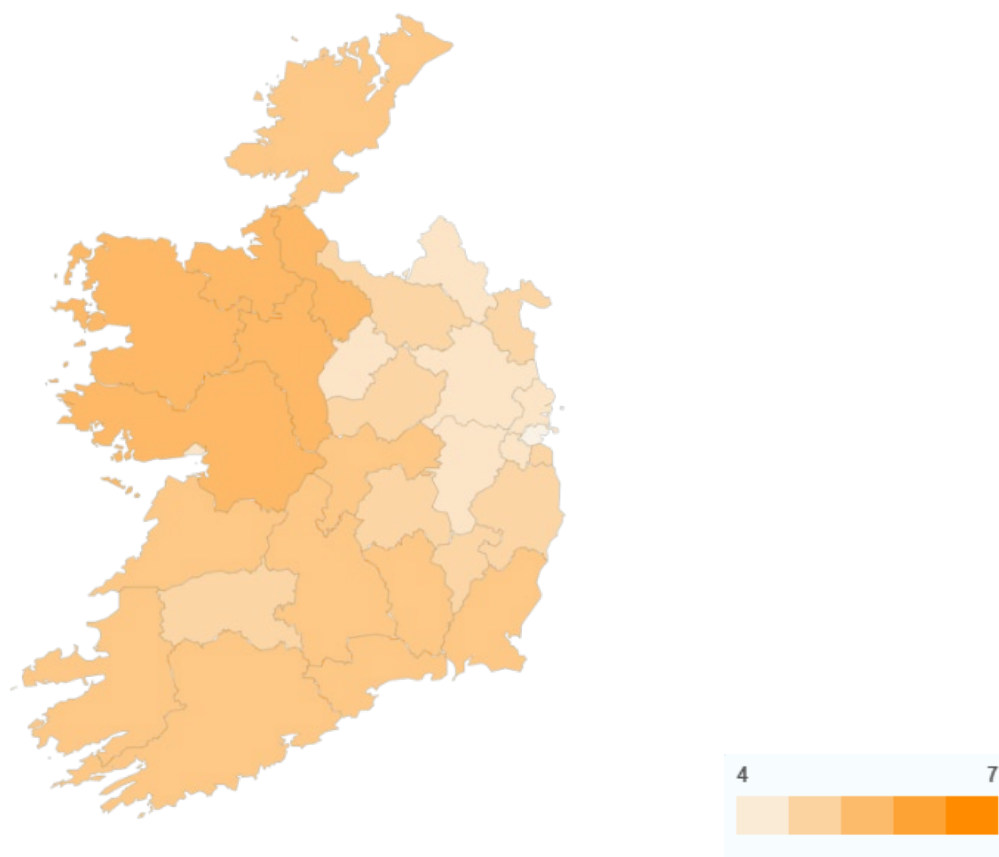
There has been an increase in the proportion of carers in paid employment in recent years. In 2022, among carers aged 15 and older, 57 per cent were in paid employment relative to 51 per cent in 2016 and 49 per cent in 2011. Further, there has been a decrease over time in the proportion of carers unemployed (10 per cent in 2011 and 4 per cent in 2022) and looking after the home/family (20 per cent in 2011 and 16 per cent in 2022) (Central Statistics Office, 2023a). A number of changes could have contributed to these trends. In Budget 2020, the maximum number of hours that carers in receipt of the Carer's Allowance, the Carer's Benefit or the Carer's Support Grant could engage in employment, education or training increased from 15 to 18.5 hours per week, which may have encouraged carers to participate in paid employment.⁵ The change could also be related to the change in the wording of the question between 2016 and 2022. For example, people in paid employment and providing a relatively small number of hours of care to their neighbour may not have reported themselves as providing care under the 2016 wording but may have identified as a carer using the 2022 wording. Alternatively, improving economic conditions and the reduction in unemployment in the intercensal years may also have contributed to a higher proportion of carers being in employment in 2022 relative to 2011.

County

Census data show that the proportion of the population who provided care varied across counties, ranging from 5 per cent in Dublin City to 7 per cent in Mayo (Central Statistics Office, 2023a). Other counties with relatively high proportions of family carers included Galway, Leitrim and Sligo (Figure 2.1). The higher proportion of the population providing care along the west coast may be related to the higher need for care given the relatively older age profile of the population in these areas (Brick and Kakoulidou, 2025).

⁵ Social Welfare Schemes – Wednesday, 6 May 2026 – Parliamentary Questions (34th Dáil) – Houses of the Oireachtas.⁶ Numbers add up to more than 100 per cent as some carers provided care to more than one person.

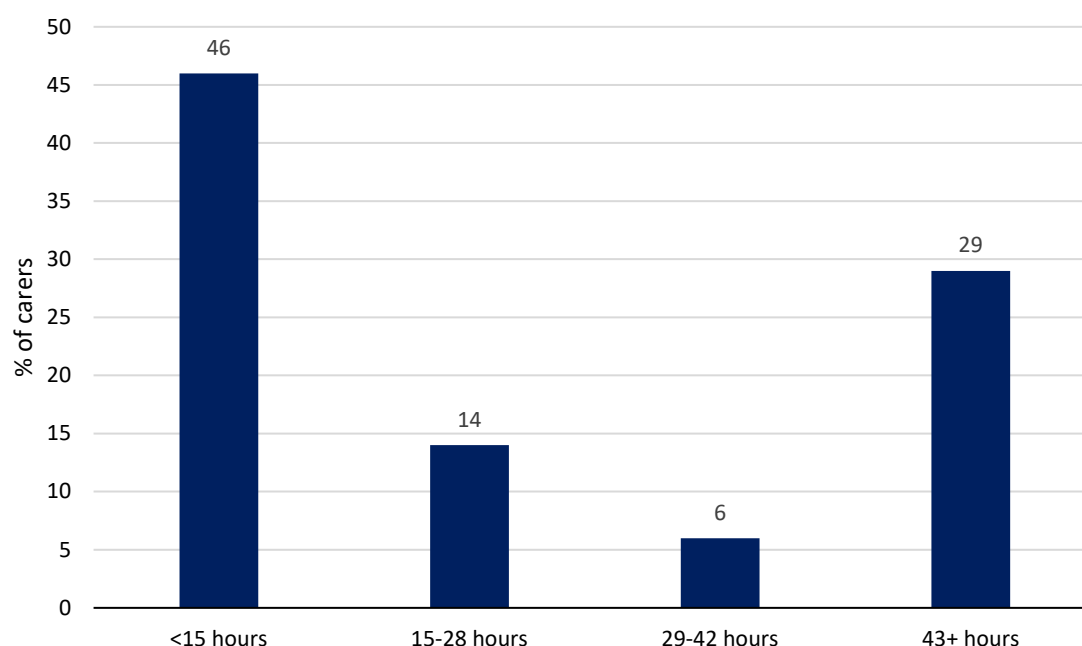
Figure 2.1 Percentage of population providing care, by county (2022)



Source: Central Statistics Office (2023a).

Hours of care

Data from the 2022 Census of Population show that of the 6 per cent of the population providing care, 46 per cent reported providing up to 14 hours of unpaid help per week, 14 per cent reported providing between 15 and 28 hours per week, 6 per cent reported providing between 29 and 42 hours per week, while 29 per cent reported providing 43 hours or more per week (Central Statistics Office, 2023a) (Figure 2.2). Five per cent did not state the number of hours of care provided.

Figure 2.2 Percentage of family carers by weekly hours of care provided (2022)

Note: Five per cent of carers did not report hours of care provided.

Source: Central Statistics Office (2023a).

There have been some changes over time in the number of hours of care provided. For example, a slightly higher percentage of respondents to the 2022 Census reported providing up to 14 hours per week relative to 2016 (46 per cent in 2022 and 43 per cent in 2016), while a higher percentage also reported providing more than 43 hours per week (29 per cent in 2022 and 21 per cent in 2016) (Central Statistics Office, 2023a).

Data from the 2025 Healthy Ireland Survey (for those aged 15 and over) show that 82 per cent of carers provided care for one person, with the remaining 18 per cent providing care for multiple people (Ipsos B&A, 2025).

Relationship between carer and care recipient

In terms of the relationship between the carer and care recipient, data from the 2025 Healthy Ireland Survey show that 49 per cent of carers provided care to a parent or parent-in-law, 16 per cent to a child, 11 per cent to a spouse/partner, 21 per cent to another relative and 9 per cent to a friend (Ipsos B&A, 2025).⁶

⁶ Numbers add up to more than 100 per cent as some carers provided care to more than one person.

2.3.2 Characteristics of care recipients

Due to the lack of questions on care receipt within survey-based data, compared with carers there is less information available on the characteristics of care recipients in Ireland.

Table 2.2 shows the age distribution of care recipients in 2025, as reported by carers in the Healthy Ireland Survey. Approximately 78 per cent of care recipients were aged 50 and older, while 13 per cent were aged less than 20.

Table 2.2 Age distribution of care recipients, 2025

Age group	% of care recipients
<10	6
11–20	7
21–30	4
31–40	2
41–50	4
51–60	6
61–70	11
71–80	26
81+	35

Source: Ipsos B&A (2025).

Analysis of data from TILDA for those aged 50 and over showed that receipt of help with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) was more common among females, those living outside of Dublin and those with lower levels of education (McGarrigle and Kenny, 2020).

2.4 Impact of care provision on the physical and mental well-being of family carers

A large body of international research has examined the impact of care provision on the health and well-being of family carers (Schulz and Beach, 1999; Beach et al., 2000; O'Reilly et al., 2008; Roth et al., 2015; Bom et al., 2019), with mixed findings. While there is a view that caring is a chronically stressful experience that can negatively impact the mental and physical health of the carer, this may not always be the case. Positive aspects of caring have been identified, and several studies have found that caring is not necessarily stressful, nor does it always harm the physical and mental health of the carer (Roth et al., 2015). For some carers, there are both positive and negative impacts of

care provision (Lawton et al., 1991). In practice, the existence and extent of the negative impact of caring on the carer is likely to differ depending on a range of factors, including the characteristics of the carer and care recipient, the relationship between the carer and care recipient, the amount and type of care provided, the length of the caring role, and the existence of formal and informal support and services (Cohen et al., 2017; Cook et al., 2018; Verbakel et al., 2018; Bom et al., 2019).

In Ireland, there is no nationally representative longitudinal study which captures how transitions into and out of care provision impact the physical and mental health of carers. However, TILDA provides evidence on the physical and mental health status of carers aged 50 and older. Using TILDA data, McGarrigle (2025) found that the impact of caring varied by intensity. While those providing less than 50 hours of care per week were relatively similar to non-carers, those providing more than 50 hours per week reported poorer quality of life, greater depressive symptoms and higher perceived stress compared to non-carers, even after controlling for a range of demographic and socio-economic covariates (McGarrigle, 2025).

2.5 Government policy on family care

The 2012 National Carers' Strategy (Department of Health, 2012) recognised the contribution of family carers in Ireland, in particular in supporting people to live independently in their own home and community for as long as possible. The strategy identified four goals:

- (i) To recognise the value and contribution of carers and promote their inclusion in decisions relating to the person that they are caring for.
- (ii) To support carers to manage their physical, mental and emotional health and well-being.
- (iii) To support carers to care with confidence through the provision of adequate information, training, services and supports.
- (iv) To empower carers to participate as fully as possible in economic and social life.

A total of 42 recommendations were published under these four goals. However, many of these recommendations have not been fully

developed, and the Strategy's ambition to improve the lives of carers was somewhat limited by the constraints on public spending at the time, in light of the global financial crisis (O'Sullivan, 2019). While there have been developments in relation to family care in Ireland in recent years (see Section 2.6 for more detail), the 2012 Strategy remains as government policy in the area.

2.6 Government support for family carers

Currently, there are four main cash benefit schemes to support carers – the Carer's Allowance, the Carer's Benefit, the Domiciliary Care Allowance and the Carer's Support Grant. The combined spending on these payments was estimated to be approximately €1.9 billion in 2025 (Minister For Social Protection, 2025). These benefit schemes differ in terms of eligibility and support.

- The Carer's Allowance is a means-tested benefit for those providing full-time care. In 2025 there were 107,142 recipients of the Carer's Allowance, of whom 22 per cent were aged 65 or older (Department of Social Protection, 2026). The estimated expenditure on the scheme was €1.24 billion in 2025 (Minister For Social Protection, 2025). At the time of writing (September 2026), the maximum weekly rates for the Carer's Allowance are typically €270 per week for carers under age 66 and €308 per week for carers aged 66 and over. The rate can increase by up to 50 per cent for those caring for two or more people. A Half-Rate Carer's Allowance is payable to individuals who meet the full-time care criteria but are already receiving another primary social welfare payment, allowing them to retain their main payment while receiving a half-rate carer's payment.
- The Carer's Benefit is a PRSI-based payment for individuals who reduce their work hours or leave employment to care for someone requiring full-time care. Those in receipt of the Carer's Allowance or Benefit are automatically eligible for a GP visit card. At the time of writing (September 2026), the maximum weekly rate for the Carer's Benefit is €271 for a person caring for one individual; the rate increases to €406.50 a week for those caring for two or more people. In 2025 there were 5,413 recipients of the Carer's Benefit (Department of Social Protection, 2026).
- The Domiciliary Care Allowance is a monthly non-means-tested payment for children under 16 with severe disabilities requiring substantial care. At the time of writing (September 2026), the

Domiciliary Care Allowance was €380 per month. In 2025 there were 63,124 recipients of the Domiciliary Care Allowance (Department of Social Protection, 2026).

- The Carer's Support Grant is an annual payment to carers in receipt of the Carer's Allowance, the Carer's Benefit or the Domiciliary Care Allowance. At the time of writing (September 2026), the Carer's Support Grant was €2,000 per person being cared for.

Reflecting commitments made in the 2025 Programme for Government (Department of the Taoiseach, 2025), a number of increases were announced in Budget 2026 to both the rates of payment and the income limits/disregards for the cash benefits for carers. The 2025 Programme for Government also discussed the phasing out of the means test for the Carer's Allowance, and an examination of the introduction of a pay-related Carer's Benefit for individuals who have to give up work suddenly to provide full-time care to a loved one (Department of the Taoiseach, 2025). Another recent development is an attempt to better reconcile caring and work responsibilities. This has included the introduction of the Long-Term Carers Contributions scheme, giving access to the State Pension (Contributory) to individuals who were family carers for 20 or more years, and the Work Life Balance and Miscellaneous Provisions Act, which affords employees who are in employment the right to five unpaid (care) leave days per year (World Health Organization, 2024).

However, there are limitations to the support provided to family carers. The World Health Organization (WHO), for example, notes that social protection schemes for carers in Ireland are fragmented from other long-term care services and benefits (World Health Organization, 2024). Family Carers Ireland have noted that while there have been several positive moves to support carers, more is needed, including measures to deal with the cost-of-living and housing crises, as well as more respite and day care services for those in need (Family Carers Ireland, 2024). This was reiterated in a recent report using TILDA data, which noted that more state-provided home care hours, respite services and financial support are necessary to support carers in sustaining their role (McGarrigle, 2025).

2.7 The future of family care

In 2022, approximately 15 per cent of the population was aged 65 and older; this is projected to increase to 21 per cent by 2040 (Bergin and Egan, 2024). The ageing of the population, along with population growth, will result in a significant increase in the demand for a range of health and social care services in the coming years (Brick et al., 2025; Connolly et al., 2025; Walsh and Kakoulidou, 2025), with demand for long-term care projected to experience some of the largest increases (Walsh and Kakoulidou, 2025). Given the importance of family care as a component of long-term care, it is expected that the need for family care will also increase significantly.

As the need for family care increases over time, the availability of family carers may decrease (or at least not keep pace with growing need). This is due to a range of demographic and socio-economic factors, including an increase in the older population relative to those of working age, decreasing family size and higher employment rates for women (Courtin et al., 2014). In addition to the number of older people in the population increasing, the share of the population aged 15 to 64 is projected to fall from 65 per cent to 63 per cent between 2022 and 2040, while the share of children will decrease from 20 per cent to 16 per cent (Bergin and Egan, 2024). In relation to family size, data from Census 2022 show that the average number of children per family decreased from 1.82 in 1996 to 1.34 in 2022 (Central Statistics Office, 2023b), and declining fertility rates could further decrease this number in the future. Hanly and Sheerin (2017) discuss the potential tension between increased female labour market participation, which could increase the availability of formal care providers (working in hospitals, long-term residential care facilities, community settings) but decrease the availability of family care.

Another factor that may influence the availability of family carers is the population's health status. While life expectancy has increased over time in Ireland, increases in healthy life expectancy⁷ have stalled in the period since the onset of the Covid-19 pandemic in 2020.⁸ The provision of family care is dependent on the carer having a level of physical and mental health that facilitates the provision of care.

⁷ Healthy life expectancy at birth measures the number of years that a person at birth is expected to live in a healthy condition, and combines information on mortality and morbidity.

⁸ Healthy Life Years Mental and Physical Health Well-being Information Hub – Central Statistics Office.

Deterioration in health status could have implications for the provision of family care as well as the need for such care.

This report will add to the available evidence on family carers by examining the characteristics of carers and care recipients in Ireland, quantifying the receipt of family care and projecting future need for care.

Chapter 3

Data and methods

3.1 Introduction

This chapter details the data and methods used to (i) profile family carers and care recipients in Ireland, and (ii) project future needs for care.

3.2 Data sources

Three main data sources were used in this analysis – the Healthy Ireland Survey, the Census Longitudinal Dataset and the Irish Longitudinal Study on Ageing (TILDA). Table 3.1 details the relevant datasets and metrics.

Table 3.1 Datasets used in the analysis

Dataset	Metric	Note
Healthy Ireland Survey	Characteristics of family carers	Waves 8 (2022) and 9 (2023) of the survey were used to describe the demographic and socio-economic characteristics of family carers aged 15 and over by hours of care provided.
Census Longitudinal Dataset	Characteristics of family carers	Data from Census 2022 (Census Longitudinal Dataset sample) was used to describe the demographic and socio-economic characteristics of all family carers (aged 0–14 and 15 and over, separately) by hours of care provided.
The Irish Longitudinal Study on Ageing (TILDA)	Characteristics of care recipients	Wave 5 (2018) of TILDA was used to describe the demographic, socio-economic and health characteristics of care recipients aged 50 and over by hours of care received.
	Prevalence of care receipt by age and sex (aged 50 and over)	Waves 3 (2014), 4 (2016) and 5 (2018) were used to estimate, for the population aged 50 and over, (i) the proportion of age- and sex-specific groups reporting difficulties with ADL/IADL and (ii) the proportion of age- and sex-specific groups reporting difficulties with ADL/IADL who receive family care.

Source: Authors' summary

3.2.1 The Healthy Ireland Survey

The Healthy Ireland Survey is an annual, nationally representative, cross-sectional survey first undertaken in 2015. Interviews are conducted with a representative sample of the population aged 15 and older living in Ireland (Ipsos MRBI, 2015; Ipsos B&A, 2023). The sample size is approximately 7,500 people per wave. To date, 10 waves of the survey have been completed in the following years: 2015 (Wave 1), 2016 (Wave 2), 2017 (Wave 3), 2018 (Wave 4), 2019 (Wave 5), 2021 (Wave 7), 2022 (Wave 8), 2023 (Wave 9), 2024 (Wave 10) and 2025 (Wave 11). Wave 6 of the survey, which was due to take place in 2020, was cancelled due to the Covid-19 pandemic and associated restrictions. The first five waves were completed using face-to-face interviews, while the subsequent waves were completed via the telephone. In each wave of the survey, the final sample is weighted by sex, age, education, working status and region to maximise its representation of the general population.

The Healthy Ireland Survey includes a range of health-related topics and has been previously used to undertake several health-related research studies (Barlow et al., 2022; Masterson and Phillips, 2023; McHugh and Connolly, 2025), including estimating general practitioner and general practice nurse consultation rates (Connolly et al., 2025). The Healthy Ireland Survey is approved by the Research Ethics Committee of the Royal College of Physicians of Ireland.

In this analysis, the Healthy Ireland Survey was used to profile family carers in Ireland. As noted in Chapter 2, all waves of the Healthy Ireland Survey have included a question on the provision of care; in keeping with the change in the question in the 2022 Census of Population, the question on the provision of care in the Healthy Ireland Survey changed in Wave 11 (see Table 2.1). For this analysis, Waves 8 (2022) and 9 (2023) of the survey were used. Wave 8 had a response rate of 40 per cent (percentage of known eligible telephone numbers that were contacted and fully completed a survey interview) (Ipsos, 2022), while Wave 9 had a response rate of 45 per cent (Ipsos B&A, 2023).

Wave 11 (2025) included several additional questions on carers; however, neither Wave 10 nor Wave 11 data were available to the research team at the time of completing the analysis.

Waves 8 and 9 included the following question in relation to the provision of care:

Do you provide regular unpaid personal help for a friend or family member with a long-term illness, health problem, or disability? Include problems which are due to old age. Personal help includes help with basic tasks such as feeding or dressing.

Those who responded that they did provide care were asked how many hours of care they provided per week. The demographic, socio-economic and health characteristics of care providers are presented by care intensity.

3.2.2 Census Longitudinal Dataset

The Census Longitudinal Dataset is a 10 per cent sample of people selected from the 2016 and 2022 Irish censuses. The sample includes usual residents in Ireland who were born on one of 37 randomly chosen dates.⁹ The same dates were used to select people from the 2016 and 2022 censuses. People in the sample who were present in both the 2016 and 2022 censuses have had their census data linked over time. People who were born after the 2016 census, who died before the 2022 census or who migrated do not have a link across the two censuses but are included in the dataset for the year in which they were present.

In this analysis, the 2022 sample was also used to profile family carers in Ireland. While the Census Longitudinal Dataset includes fewer health-related variables relative to the Healthy Ireland Survey, in this context it has the advantage of including all of the population (including those aged less than 15) and includes a wider range of demographic and socio-economic variables than the Healthy Ireland Survey. Where possible, consistent variable categories were used across the Healthy Ireland Survey and the Census Longitudinal Dataset analyses. To note, as discussed in Chapter 2, the question on care provision included in the 2022 and 2023 waves of the Healthy Ireland Survey differs slightly from that included in the 2022 Census.

The 2022 Census included the following question in relation to the provision of care:

Do you provide regular unpaid personal help or support to a family member, neighbour or friend with a long-term illness, health issue, an issue related to old age or disability?

⁹ Research Microdata Files (RMFs) register - CSO - Central Statistics Office.

Those who responded that they did provide care were asked how many hours of care they provided per week.

The demographic, socio-economic and health characteristics of carers were examined by care intensity. This was done separately for those aged 15 and older (to allow consistency with the Healthy Ireland Survey analysis) and those aged less than 15. Given the relatively small number of carers aged less than 15, it was not possible to examine caring intensity for this group.

3.2.3 The Irish Longitudinal Study on Ageing (TILDA)

TILDA is a nationally representative sample of community-dwelling individuals aged 50 and over in Ireland, and includes an extensive set of variables on the health and socio-economic circumstances of participants. The sampling procedure and the study design have been described in detail in Kearney et al. (2011). In short, the RANSAM¹⁰ sampling system was used to randomly identify households, and all household residents aged 50 and over and their spouse/partner (of any age) were invited to participate in the study. The household response rate was 62 per cent, leading to a final Wave 1 sample of 8,172 adults aged 50 and older who completed an in-home interview between October 2009 and February 2011. Data collection involved an in-home computer-aided personal interview (CAPI), a self-completion questionnaire completed and returned by participants, and a comprehensive health assessment carried out by research nurses in a dedicated health centre, or if required, a modified assessment carried out in the participant's own home. Further data collection has taken place every two years since Wave 1 data collection (currently seven waves of data), with an additional collection during the Covid-19 pandemic (Ward et al., 2021). TILDA has previously been used to estimate utilisation of healthcare services among older people in Ireland (Nolan, 2014).

TILDA received ethical approval from the Trinity College Research Ethics Committee. Data are weighted to correct for selection bias, with weights calculated by comparing the distributions of individual characteristics (age category, sex and educational attainment) within the sample to those derived from the Quarterly National Household Survey.

¹⁰ RANSAM is a computer-based system for drawing random samples from the electoral register (Whelan, 1979).

TILDA includes several questions on the provision and receipt of care. In this analysis, in keeping with the literature (Hu et al., 2024), TILDA was used to profile the characteristics of care recipients and to create baseline estimates of the proportion of the population reporting

- (i) difficulties with activities of daily living (ADLs) and instrumental activities of daily living (IADL) and
- (ii) difficulties with activities of daily living (ADLs) and instrumental activities of daily living (IADL) and receiving family care.

TILDA questions about the receipt of care are filtered through the question on difficulties with ADLs and IADLs, i.e. only those who report difficulties with ADLs/IADLs are asked if they receive help from a friend, family member, etc. This potentially underestimates the extent of receipt of care, as some individuals may receive help but not report difficulties with ADLs/IADLs. However, the use of ADLs and IADLs to measure care need in this way is common in the literature: Hu et al. (2024), for example, used questions on ADLs/IADLs in the English Longitudinal Study of Ageing to create a functional disability variable, which they treated as representative of the need for care. Table 3.2 shows the TILDA questions which were used to identify care recipients for this analysis.

Table 3.2 Questions used to profile care recipients using TILDA data

Question	Inclusion/ exclusion criteria	Use in analysis
<i>Activities of daily living</i> Please look at card FL2. Because of a health or memory problem, do you have difficulty doing any of the activities on this card? Again, exclude any difficulties you expect to last less than three months. 1. Dressing, including putting on shoes and socks 2. Walking across a room 3. Bathing or showering 4. Eating, such as cutting up your food 5. Getting in or out of bed 6. Using the toilet, including getting up or down 7. None of these 8. Don't know 9. Refused to answer	All respondents	In some of the projection analyses, future need for family care is based on a reported difficulty with an ADL/IADL, regardless of whether the person currently receives such help
<i>Instrumental activities of daily living</i> Please look at card FL3. Because of a health or memory problem, do you have difficulty doing any of the activities on this card? Again, exclude any difficulties that you expect to last less than three months. 1. Preparing a hot meal 2. Doing household chores (laundry, cleaning) 3. Shopping for groceries 4. Making telephone calls 5. Taking medications 6. Managing your money, including paying bills 7. None of these 8. Refused to answer	All respondents	In some of the projection analyses, future need for family care is based on a reported difficulty with an ADL/IADL, regardless of whether the person currently receives such help
Does anyone help [you/him/her] with... 1. Dressing, including putting on shoes and socks 2. Walking across a room 3. Bathing or showering 4. Eating, such as cutting up your food 5. Getting in or out of bed 6. Using the toilet, including getting up or down	Asked for each activity (identified in the previous two questions) for which a respondent reports a difficulty	Respondent assumed to receive care if they report that someone helps them with at least one activity
Does anyone help [you/him/her] with... 1. Preparing a hot meal, doing household chores (laundry, cleaning), shopping for groceries 2. Making telephone calls 3. Taking medications 4. Managing your money	Asked for each activity (identified in the previous two questions) for which a respondent reports a difficulty	Respondent assumed to receive care if they report that someone helps them with at least one activity

Source: TILDA, Waves 3–5.

While a question on the provision of care is included in TILDA, it is not included in this analysis as the number reporting that they provide care is relatively small. For example, in Wave 5 only 3 per cent of respondents (approximately 140 respondents) reported providing care, meaning that there is limited scope for subgroup analysis to be undertaken for this report.

3.3 Methods – baseline family care provision and receipt

3.3.1 Family care provision

Using data (separately) from both the Healthy Ireland Survey and the Census Longitudinal Dataset, the prevalence of family care provision was described both for the study population as a whole and for several subgroups (Table 3.3). Carers were grouped according to the amount of care provided: less than 15 hours per week, 15–28 hours per week, and 29+ hours per week. Individuals with missing data across the included variables were dropped from the analysis. There were 14,730 observations in the pooled Waves 8 and 9 Healthy Ireland Survey analysis. In the Census Longitudinal Dataset, there were 406,533 observations aged 15 and over and 98,502 observations aged less than 15.

Table 3.3 Variables used in the analysis describing carers in the Healthy Ireland Survey and the Census Longitudinal Dataset

Variable	Healthy Ireland Survey	Census Longitudinal Dataset
Sex	Male; Female	Male; Female
Age group	15–24; 25–34; 35–44; 45–54; 55–64; 65–74; 75–84; 85+	<15; 15–24; 25–34; 35–44; 45–54; 55–64; 65–74; 75–84; 85+
Marital status	Single and never married; Married or civil partnership; Separated/divorced/widowed	Single and never married; Married or civil partnership; Separated/divorced/widowed
Chief earner	Chief earner; Not chief earner	–
Highest level of education	Less than Leaving Certificate; Leaving Certificate; Degree or higher	Secondary or lower; Technical/vocational or higher certificate; Bachelor's degree/professional qualification; Postgraduate diploma or higher
Employment status	Working for payment or profit; Looking for first regular job; Unemployed; Actively looking for work after voluntary interruption; Student or pupil; Looking after home or family; Retired from employment; Unable to work due to permanent sickness or disability; Other	Working; Unemployed; Student or pupil; Retired; Other, incl. looking after home and permanent sickness/disability
Country of birth	Republic of Ireland; Outside of Republic of Ireland	Republic of Ireland; Outside of Republic of Ireland
Region	Dublin; Rest of Leinster; Munster; Connaught/Ulster	–
Medical card status	No card; GP visit card; Medical card	–
Self-reported health status	Very good/good/fair health; Bad/very bad health	Very good/good/fair health; Bad/very bad health
Deprivation	–	Very/extremely disadvantaged; Disadvantaged; Marginally below average; Marginally above average; Affluent; Very/extremely affluent
Housing tenure		Owner occupancy; Rented (including free rent); Communal establishment

Note: The deprivation variable captures the relative deprivation level of the respondents' location and is based on the HP Deprivation Index.

Source: Healthy Ireland Survey (Waves 8 and 9); Census Longitudinal Dataset 2022.

3.3.2 Family care need and receipt

As detailed in Section 3.2.3, TILDA questions on the receipt of care are first filtered through the question on having difficulties with ADLs and IADLs, i.e. only those who report difficulties with ADLs/IADLs are asked if they receive care. If an individual reports that they receive care, they are subsequently asked who provides this care (e.g. spouse, daughter, neighbour, etc.) and whether the care was paid for. For many respondents, those who stated that care was paid for also stated that such care was provided by a family member. Therefore, in this analysis we assume paid care in this context relates to receipt of the Carer's Allowance/Benefit or informal payments made to the carer by the care recipient rather than care provided by a paid professional. Given the difficulty in detangling 'paid' care provided by a family member and 'paid' care provided by a professional, in this analysis all of those who responded that they receive help with ADLs/IADLs are assumed to receive some form of family care. This likely leads to a slight overestimate of the number of people receiving family care. However, other factors contribute to an underestimate of receipt of family care. For example, care recipients aged less than 50 are not included in the analysis, though data from the Healthy Ireland Survey in 2025 suggests that 23 per cent of care recipients were aged less than 50 (Table 2.2). Further, as the question on care receipt is only asked of those who report a difficulty with an ADL/IADL, estimates may exclude a small number of people who receive care but do not report a difficulty. Finally, the wording of the TILDA question specifies that respondents should exclude reporting difficulties that they expect to last less than three months. Respondents who (rightly or wrongly) expect their needs to change over time, therefore, may exclude themselves from further analysis, despite having some care needs.

Weighted data from Wave 5 (2018) of TILDA were used to describe the demographic, socio-economic and health characteristics of care recipients (Table 3.4) by the number of hours of care received per week (<15, 15–28, 29+). After responses with missing variables were dropped, the sample size in Wave 5 was 4,584.

Table 3.4 Variables used in the analysis describing care recipients in TILDA

Variable	Categories
Sex	Male; Female
Age group	50–64; 65–69; 70–74; 75–79; 80–84; 85+
Marital status	Single, never married; Married or civil partnership; Separated or divorced; Widowed
Highest level of education	Primary/none; Secondary; Third-level/higher
Location of household	Dublin City or county; Another town or city; A rural area
Housing tenure	Owned outright; Owned with mortgage; Owned under tenant purchase agreement; Rented from local authority; Occupied rent free
Employment status	Employed; Retired; Other
Self-rated physical health	Excellent/very good/good; Fair/poor
Long-term illness	No long-term illness; Long-term illness; Limiting long-term illness
Serious cognitive impairment	None; Alzheimer's, dementia or serious memory impairment
Fall in the last year/ since last interview	Yes; No
Receives home support (home help, personal care, home care)	Yes; No
Number of GP visits in last 12 months	None; 1–4; 5–9; 10+
Receives public health or community nurse care	Yes; No
Receives day centre services	Yes; No

Source: TILDA, Wave 5.

Weighted data from Waves 3, 4, and 5 of TILDA were used to estimate the proportion of age and sex groups reporting difficulties with ADLs/IADLs and the proportion reporting difficulties with ADLs/IADLs who receive help with these difficulties. After excluding those with missing data, there were 15,871 observations.

3.4 Methods – projections

This section details the methods used to project the future need for family care in Ireland. There are a limited number of studies internationally projecting demand for such care. Hu et al. (2022) developed a macro-simulation model to project the demand for family care among older adults in Korea to the year 2067. Similar to the approach taken in this work, that analysis used difficulties with ADLs and IADLs to identify the need for long-term care, with the projections incorporating assumptions on population growth, healthy ageing, marital status and living arrangements, and education. A similar approach was taken for the UK by the same authors (Hu et al., 2024).

The projections of family care demand in this report use the ESRI's healthcare projection tool, the Hippocrates model (Section 3.4.1). While the approach adopted is similar to that previously used to project demand for long-term residential care and home support (Walsh and Kakoulidou, 2025), given limited data on family care in the Irish context, a somewhat more limited analysis was undertaken relative to Walsh and Kakoulidou (2025) and Hu et al. (2022).

3.4.1 Hippocrates model

The Hippocrates model is a component-based healthcare projection model that projects from a bottom-up service or sectoral perspective. A detailed discussion of the model and underlying methods is included in previous reporting that developed and expanded the Hippocrates model (Wren et al., 2017; Brick et al., 2025; Connolly et al., 2025; Walsh and Kakoulidou, 2025).

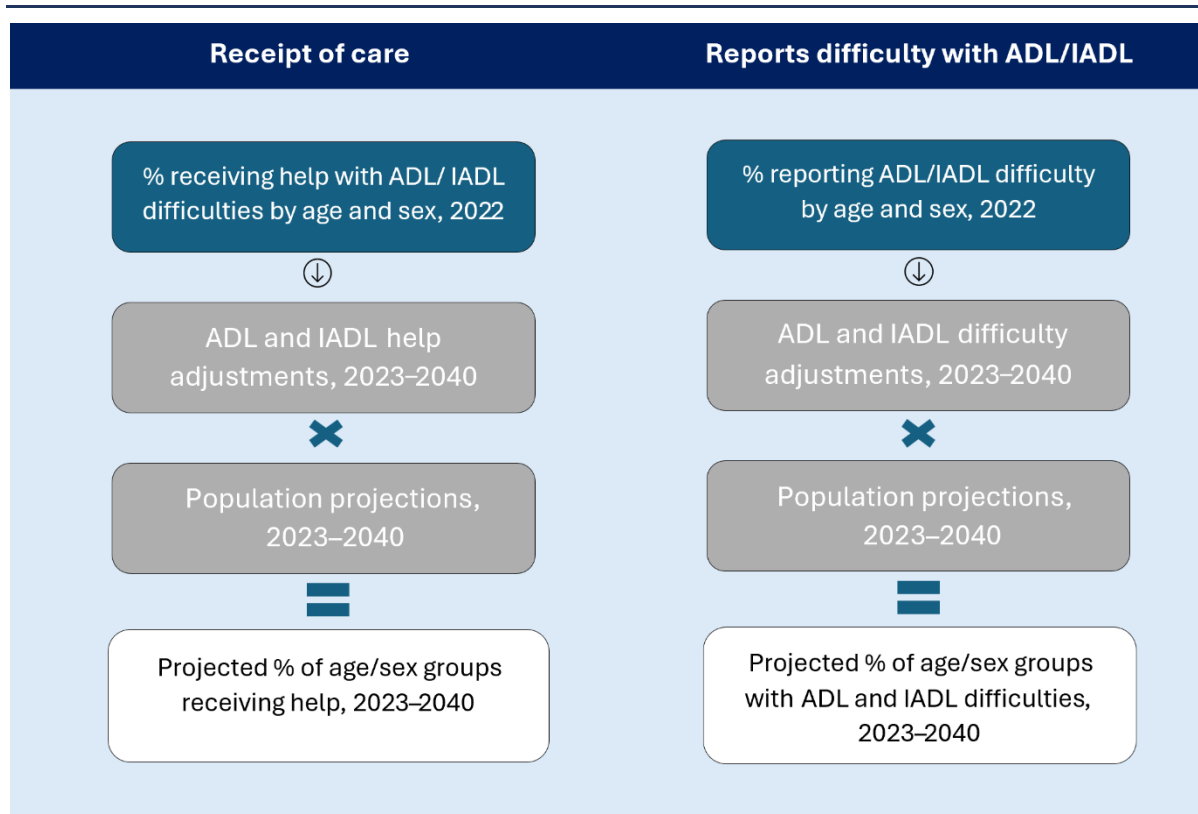
Figure 3.1 provides an overview of the model and describes the steps in the modelling process as applied to the current analysis. The first step is to develop base-year age- and sex-specific care receipt rates. This uses estimates of need for, and receipt of, family care by age and sex from TILDA Waves 3–5 (see Section 3.3.2). The rates from TILDA are then applied to the number of people in each equivalent age and sex group nationally using data from Census 2022. This provides the

estimated number of people in need of, and in receipt of, family care by age and sex in Ireland in 2022.

In the second step, these baseline estimates are then projected based on the size and composition of the population and assumptions on healthy ageing. The base year is 2022, and the projection period is 2023–2040.

In this analysis, two base-year rates are used, resulting in two sets of projections. The first set is based on the current receipt of family care for those who report a difficulty with an ADL/IADL; the second set is broader and includes people who report a difficulty with an ADL/IADL, regardless of whether they receive family care. The second set is based on an assumption that some people may need care (i.e. they have a difficulty with an ADL/IADL) but not receive it. This broader estimate, which includes people who may need care but are not receiving it, will include a larger number of people than the first estimate, resulting in larger projected increases over time.

Figure 3.1 Hippocrates model – diagrammatic representation of family care projections, 2022–2040



Source: Authors' representation of the Hippocrates model.

3.4.2 Assumptions

The two sets of projections of need for family care in this report are based on a range of assumptions on population growth and age structure, and healthy ageing. Each of the population and healthy ageing assumptions is discussed in detail in the following sections.

Population growth and ageing

Based on the 2022 Census of Population, ESRI population projections are used in the analysis. Details on the data and methods used to develop the projections are provided in Bergin and Egan (2024). In the population projections, three projection scenarios are provided – central, low and high (Table 3.5). In each scenario, mortality and fertility are dealt with in the same way; however, migration differs across the scenarios. In the central scenario, net immigration is projected to average 35,000 per annum up to 2030, with particularly high increases in 2025 and 2026 and 20,000 per annum thereafter. The low scenario assumes 10,000 less net immigration per annum, while the high scenario assumes 10,000 more net immigration per annum. For the mortality assumption, life expectancy at birth is expected to increase from 81.1 in 2022 to 84.2 in 2040 for males, and from 84.6 to 87.1 over the same period for females. A constant fertility rate of 1.65 is assumed for each scenario.

Table 3.5 Summary of main assumptions for population scenarios

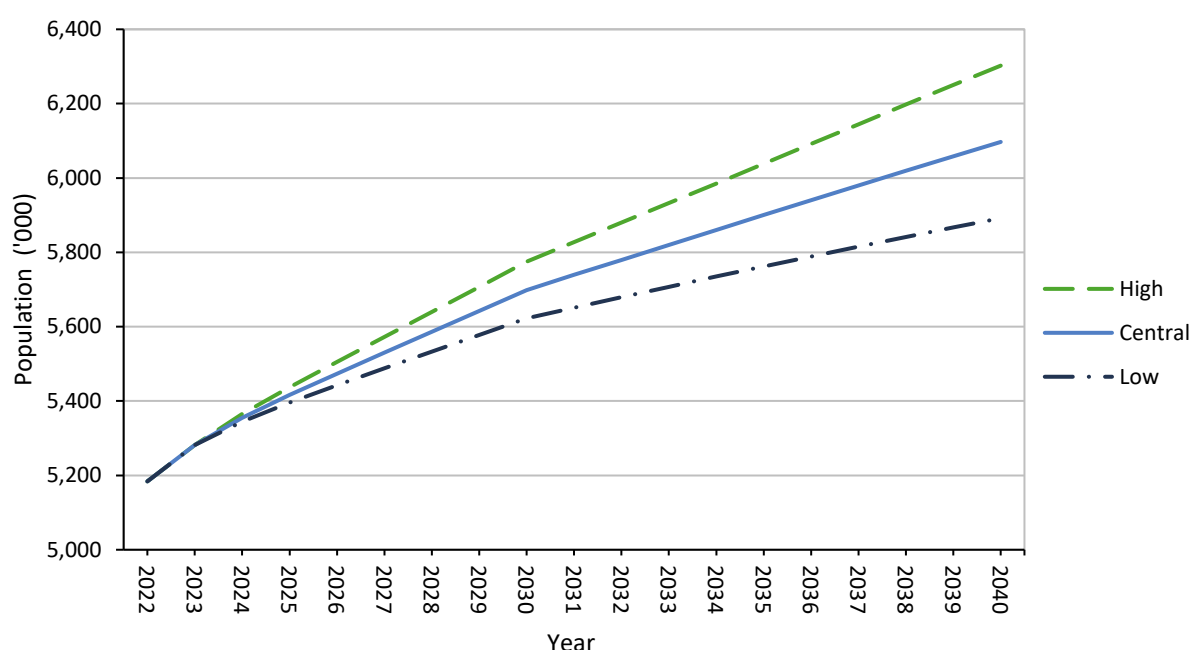
Assumptions	Central	Low	High
Mortality	Life expectancy at birth for males (females) is expected to increase from 81.1 (84.6) in 2022 to 84.2 (87.1) in 2040	No change from central scenario	No change from central scenario
Migration	Net immigration to average +35,000 p.a. to 2030 (higher at 45,000 in 2025/2026) and +20,000 p.a. thereafter	Net immigration to average +25,000 p.a. to 2030 (higher at 35,000 in 2025/2026) and +10,000 p.a. thereafter	Net immigration to average +45,000 p.a. to 2030 (higher at 55,000 in 2025/2026) 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: Adapted from Bergin and Egan (2024).

Figure 3.2 shows the projected population for each year between 2022 and 2040 across the central, low and high population projections. Given the nature of the assumptions applied, the low and high scenarios are equidistant from the central scenario. In the central scenario, the population is expected to increase by 900,000 by 2040, an annual average population growth rate of 0.9 per cent. In the low scenario, the increase by 2040 would be 700,000 with an annual average growth rate of 0.7 per cent, while in the high scenario, an increase of 1.1 million would be expected, reflecting an annual average growth rate of 1.1 per cent.

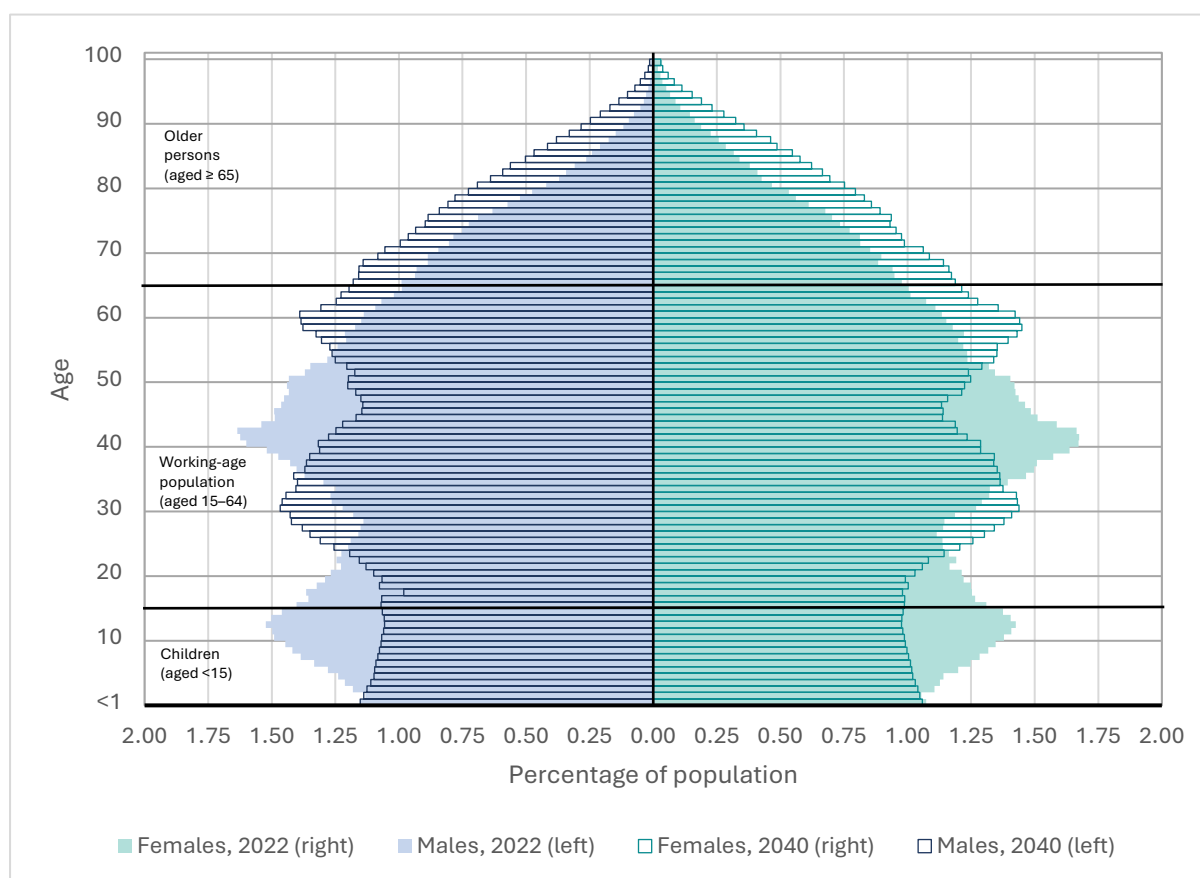
Figure 3.2 Total population – low, central and high population growth scenarios



Source: Bergin and Egan (2024) – additional data provided by the authors.

In addition to the growth in population between 2022 and 2040, there is also projected to be a change in the age structure. Figure 3.3 shows the distribution of the population across age groups for 2022 and 2040 based on the central population projection. Similar patterns are observed for both males and females, with decreases in the proportions of the projected population aged under 25 and for those aged 35–50, and increases in the proportions of those aged 25–34 and over 50 (Brick et al., 2025). The oldest age groups are projected to see the largest relative increase in growth between 2022 and 2040. For example, the population aged 65–84 is projected to increase by almost 60 per cent, while the population aged 85 and over is projected to more than double by 2040 (Walsh and Kakoulidou, 2025).

Figure 3.3 Central scenario – population age pyramids for 2022 and 2040 (% of population)



Source: Bergin and Egan (2024) – additional data provided by the authors.

In this analysis, the central population scenario is applied in the low and central pressure projection scenarios, while the high population scenario is used in the high pressure scenario. Given the relatively high levels of migration to Ireland in recent years, with net migration numbers exceeding those included in the population projections (Potter et al., 2025), the central and high population scenarios are likely the most relevant to current projections.

Healthy ageing

The different healthy ageing assumptions reflect the idea that, as life expectancy increases, the increase in healthy life expectancy may not neatly correspond to the increase in life expectancy (Wren et al., 2017).

Previous Hippocrates analyses have applied four alternative hypotheses about the relationship between increased life expectancy and health, which differ in their optimism around healthy ageing. The *expansion of morbidity* hypothesis assumes that as life expectancy increases, the number of years spent in ill health and disability also

increases (Gruenberg, 1977; Olshansky et al., 1991). Under *compression of morbidity*, both disease-free and disability-free years are assumed to increase more than gains in longevity (Fries, 1980). The *dynamic equilibrium* hypothesis assumes that increasing life expectancy is accompanied by a reduction in disability and the severity of the consequences of chronic diseases, due to advances in medical technology (Manton, 1982). Under this hypothesis, it is assumed that as life expectancy increases, the absolute number of years lived in good health or mild ill health will increase by an amount equivalent to the increased life expectancy (Przywara, 2010). Finally, under the *moderate healthy ageing* hypothesis, used by the European Commission in their reports on ageing (European Commission, 2024), a health profile shift of half the change in age-specific life expectancy is assumed. Further details on the alternative hypotheses and how they have been incorporated into the Hippocrates model are available in Wren et al. (2017).

While a number of studies have examined the relationship between ageing and health, there is little consensus on which theory of healthy ageing is consistent with past trends (European Commission, 2015) and there is a lack of data or evidence on which theory of healthy ageing might apply in the Irish context. Of particular relevance to the current analysis are trends in age-specific difficulties with ADLs/IADLs, as they are often catalysts for requiring care. The evidence in this regard is somewhat mixed. For example, analysis from the United States found that while the average length of expected life with ADL and IADL disability did not change over the period of analysis (1984–2000), there was a decrease in disability-free life expectancy arising from a decrease in disability incidence and an increase in the incidence of recovery (Crimmins et al., 2009). Analysis of long-term care in Germany found a compression in the number of years older people were living with a need for long-term care, with the biggest compression seen for severe care need (Kreft and Doblhammer, 2016). A more recent cross-country analysis from the World Bank found that 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 on the above literature showing some improvements in disability and difficulties with ADLs/IADLs among older people as life expectancy increases, and in keeping with earlier analysis using the Hippocrates model to project long-term care (Wren et al., 2017; Walsh

and Kakoulidou, 2025), relatively optimistic assumptions on healthy ageing are used in the projections of demand for care (Table 3.6).

The alternative healthy ageing effects are modelled by adjusting the percentage of the population requiring care at each age. In effect, the likelihood of requiring care at any given age decreases as the healthy lifespan expands. The extent of this decrease, relative to the increase in life expectancy, depends on which healthy ageing assumption is applied. This follows the methodology adopted by the European Commission (2012; 2015; 2024) and previously applied by Wren et al. (2017) and Walsh and Kakoulidou (2025).¹¹

Projection scenarios

The assumptions on population growth and age structure and healthy ageing are grouped to create three projection scenarios (Table 3.6) – low, central and high. The central scenario includes the central assumption on population growth and the dynamic equilibrium assumption on healthy ageing. The low pressure scenario also includes the central population scenario but a compression of morbidity is assumed, while the high pressure scenario assumes high population growth and a dynamic equilibrium assumption on healthy ageing.

Table 3.6 Projection scenario assumptions

	Scenarios		
	Low pressure	Central	High pressure
Population growth and age structure	Central	Central	High
Healthy ageing	Compression of morbidity	Dynamic equilibrium	Dynamic equilibrium

Source: Authors' assumptions.

¹¹ In keeping with previous reports which used the Hippocrates model to project demand for older people's care (Wren et al., 2017; Walsh and Kakoulidou, 2025), adjustments to activity rates to account for healthy ageing are limited to those aged 65 and over.

3.4.4 Decomposition analysis

Further to the three projection scenarios above, the study also includes a decomposition analysis. The decomposition estimates the proportion of the projected increase in need for family care between 2022 and 2040 which is attributable to the different assumptions (population growth, population ageing and healthy ageing). This illustrates the relative importance of these different drivers of growth in the need for care. Decompositions are provided for both sets of projections (projections of receipt of care and projections of difficulties with ADLs/IADLs).

Chapter 4

Findings: Characteristics of family carers and care recipients

4.1 Introduction

This chapter provides an overview of the demographic, socio-economic and health characteristics of family carers and care recipients in Ireland. For those aged 50 and over, it also provides estimates of the proportion of different age and sex groupings that (i) report difficulties with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in receipt of family care and (ii) report difficulties with ADLs and IADLs regardless of whether they receive care or not. These estimates are the basis for the projections of need for family care detailed in Chapter 5.

4.2 Family carers

Table 4.1 shows the percentage of various demographic, socio-economic and health sub-groups reporting the provision of care in Waves 8 (2022) and 9 (2023) (combined) of the Healthy Ireland Survey, categorised by the amount of care provided. In line with earlier research (Verbakel et al., 2017), a gender gap in care provision is seen, with a higher proportion of females found to provide care compared to males. Additionally, care is concentrated in the middle-aged groups: the provision of care was highest in the age groups 45–54 and 55–64. Older carers, however, tended to provide a greater number of hours of care per week: for example, 58 per cent of carers aged 75–84 provided in excess of 29 hours of care per week, relative to 34 per cent of those aged 45–54.

The provision of care tends to differ by marital status and labour market attachment. Those who were married were the most likely to provide care, while the lowest likelihood of care provision was among those who were single/never married. Those who reported that their employment status was ‘looking after the family or home’ had the highest likelihood of providing care (23 per cent); this group were also more likely to report providing intense levels of care, with 58 per cent reporting providing in excess of 29 hours of care per week, relative to a population average of 34 per cent. Twelve per cent of those in employment reported providing care, which was slightly higher than for the unemployed (11 per cent) and retired (8 per cent). Finally, a higher proportion of those born in Ireland (12 per cent) provided care relative

to those born outside Ireland (8 per cent). Relatively few differences were observed across education, region, medical card status and self-reported health groups in the proportion reporting the provision of care.

Table 4.1 Family care provision across socio-demographic groups (aged 15+), Healthy Ireland Survey Waves 8 and 9

Characteristic	Number (% of sub-group providing care)	% of carers, by hours of care provided		
		<15 hours per week	15–28 hours per week	29+ hours per week
Total	14,730 (11%)	49%	13%	34%
Sex				
Male	7,744 (8%)	54%	12%	30%
Female	6,984 (14%)	47%	13%	37%
Age group				
15–24	1,182 (5%)	72%	8%	14%
25–34	2,180 (7%)	59%	15%	23%
35–44	2,859 (12%)	51%	12%	32%
45–54	2,930 (18%)	52%	13%	34%
55–64	2,503 (17%)	44%	14%	36%
65–74	2,013 (9%)	36%	7%	54%
75–84	909 (7%)	23%	17%	58%
85+	154 (6%)	37%	0%	63%
Marital status				
Single and never married	6,090 (8%)	54%	14%	27%
Married or civil partnership	6,889 (14%)	48%	11%	38%
Separated/divorced/widowed	1,750 (9%)	42%	19%	38%
Chief earner				
Not chief earner	3,110 (11%)	52%	12%	32%
Chief earner	11,620 (11%)	48%	13%	35%
Highest level of education				
Less than Leaving Certificate	2,363 (10%)	38%	10%	49%
Leaving Certificate	5,635 (11%)	49%	14%	33%
Degree or higher	6,732 (12%)	59%	13%	24%
Employment status				
Working for payment or profit	9,437 (12%)	56%	13%	27%
Looking for first regular job	46 (8%)	49%	0%	51%
Unemployed	320 (11%)	49%	7%	40%
Actively looking for work after voluntary interruption	60 (10%)	25%	41%	34%
Student or pupil	716 (5%)	72%	5%	18%
Looking after home or family	858 (23%)	24%	16%	58%
Retired from employment	2,717 (8%)	35%	9%	53%
Unable to work due to permanent sickness or disability	503 (11%)	46%	17%	33%
Other	73 (23%)	36%	17%	46%

Characteristic	Number (% of sub-group providing care)	% of carers, by hours of care provided		
		<15 hours per week	15–28 hours per week	29+ hours per week
Country of birth				
Republic of Ireland	11,520 (12%)	50%	13%	34%
Outside of Republic of Ireland	3,210 (8%)	47%	11%	36%
Region				
Dublin	4,562 (10%)	45%	13%	37%
Rest of Leinster	3,977 (11%)	50%	10%	37%
Munster	3,779 (12%)	48%	14%	34%
Connaught/Ulster	2,412 (11%)	56%	13%	26%
Medical card status				
No card	9,832 (11%)	59%	13%	23%
GP visit card	880 (11%)	36%	13%	49%
Medical card	4,018 (11%)	35%	11%	51%
Self-reported health status				
Very good/good/fair health	14,356 (11%)	50%	13%	34%
Bad/very bad health	366 (8%)	35%	7%	50%

Notes: Two people did not report their sex. One person did not report their marital status. Eight people did not report their health status. Numbers do not always sum precisely due to rounding. ~4% of carers did not report weekly hours of care provided: where rows do not add up to 100%, the remainder is accounted for by those who did not report hours of care.

Source: Authors' analysis based on Waves 8 and 9 of the Healthy Ireland Survey.

Table 4.2 shows the percentage of the 2022 sample of the Census Longitudinal Dataset (aged 15+) who reported provision of care across key socio-demographic groups. Results for the amount of care provided are also shown. Where possible, variables and their associated categories were aligned to those used in the Healthy Ireland Survey analysis (Table 4.1).

Among the population aged 15+, a higher percentage of Healthy Ireland Survey respondents reported providing care than respondents in the Census Longitudinal Dataset, and these higher rates were consistent across comparable socio-demographic groups. However, overall somewhat similar patterns were observed, including the role of age and gender in shaping care provision. For example, a higher percentage of females reported providing care relative to males, and the highest proportion of caring is found in the age group 45–54. Further, older carers were more likely to report a higher number of care hours. In terms of employment status, different categories are included in the Census analysis relative to the Healthy Ireland Survey. The high proportion of people in the 'other' category providing care is likely driven by those 'looking after the home' (as observed in the Healthy Ireland Survey).

In relation to deprivation, except for the ‘very/extremely affluent’ group, a similar proportion of people across the different deprivation groups reported providing family care. However, high-intensity caring is more common among respondents from more deprived groups: a higher proportion of those from the more deprived categories reported providing in excess of 29 hours of care per week relative to the more affluent groups.

Table 4.2 Family care provision across socio-demographic groups (aged 15+), 2022 sample of the Census Longitudinal Dataset

Characteristic	Number (% of sub-group providing care)	% of carers, by hours of care provided		
		<15 hours per week	15–28 hours per week	29+ hours per week
Total	406,533 (7%)	46%	14%	36%
Sex				
Male	199,713 (6%)	49%	13%	33%
Female	206,820 (9%)	44%	14%	37%
Age group				
15–24	62,943 (2%)	59%	12%	22%
25–34	61,640 (3%)	43%	13%	36%
35–44	78,004 (7%)	43%	12%	40%
45–54	70,337 (12%)	50%	15%	32%
55–64	57,310 (7%)	49%	15%	32%
65–74	43,093 (6%)	38%	13%	42%
75–84	24,944 (6%)	27%	9%	54%
85+	8,442 (3%)	18%	11%	60%
Marital status				
Single and never married	172,216 (4%)	45%	15%	34%
Married or civil partnership	188,940 (9%)	46%	13%	36%
Separated/divorced/widowed	45,121 (7%)	45%	14%	34%
Highest level of education				
Secondary or lower	180,966 (6%)	36%	14%	42%
Technical/vocational or higher certificate	72,929 (9%)	45%	14%	36%
Bachelor’s degree/professional qualification	82,576 (8%)	54%	13%	30%
Postgraduate diploma or higher	46,446 (9%)	60%	12%	25%
Deprivation				
Very/extremely disadvantaged	15,633 (7%)	27%	15%	48%
Disadvantaged	42,021 (7%)	35%	14%	44%
Marginally below average	119,338 (8%)	42%	14%	37%
Marginally above average	168,569 (7%)	49%	13%	33%
Affluent	56,866 (6%)	56%	12%	28%
Very/extremely affluent	4,076 (4%)	59%	7%	30%
Housing tenure				
Owner occupancy	274,172 (8%)	48%	13%	34%
Rented (including free rent)	110,496 (5%)	37%	14%	41%
Communal establishment	8,384 (3%)	46%	11%	27%

Characteristic	Number (% of sub-group providing care)	% of carers, by hours of care provided			
		<15 hours per week	15–28 hours per week	29+ hours per week	
Employment status					
Working	225,692 (7%)	56%	14%	26%	
Unemployed	20,115 (6%)	40%	17%	34%	
Student or pupil	43,311 (2%)	63%	14%	18%	
Retired	63,389 (6%)	38%	12%	43%	
Other, incl. looking after home and permanent sickness/disability	47,823 (14%)	22%	13%	59%	
Country of birth					
Republic of Ireland	309,916 (8%)	47%	14%	35%	
Outside Republic of Ireland	94,268 (5%)	39%	13%	40%	
Self-reported health status					
Very good/good/fair health	374,284 (8%)	46%	14%	35%	
Bad/very bad health	8,636 (7%)	31%	13%	43%	

Notes: Not all respondents answered all questions; where the numbers for particular variables do not add up to the total (406,533), this is explained by a small number of people not answering that particular question. We do not show ‘not stated’, ‘don’t know’, or ‘refused’ categories in the tables.

~5% of carers did not report weekly hours of care provided: where rows do not add up to 100%, the remainder is accounted for by those who did not report hours of care.

Source: Authors’ calculations using the Census Longitudinal Dataset, 2022.

In Census 2022, a small proportion of those aged under 15 reported providing care (Table 4.3). Given the relatively small numbers included, it was not possible to disaggregate by hours of care. Little difference was observed between younger males and females and those born in and outside of Ireland in the proportions providing care. However, across the deprivation categories a gradient was observed, with a higher percentage of those in the more deprived categories providing care than in the more affluent categories. Further, a higher percentage of those reporting ‘not good health’ provided care relative to those reporting good health. Given the cross-sectional nature of the data, it is not possible to say whether one is causing the other or whether an external factor (e.g. family socio-economic status) is contributing to both.

Table 4.3 Family care provision across socio-demographic groups (aged <15), 2022 sample of the Census Longitudinal Dataset

Characteristic		Number (% providing care)
Total		98,502 (0.5%)
Sex		
	Male	50,749 (0.5%)
	Female	47,753 (0.5%)
Deprivation		
	Very/extremely disadvantaged	3,425 (0.6%)
	Disadvantaged	9,010 (0.5%)
	Marginally below average	28,419 (0.5%)
	Marginally above average	42,076 (0.5%)
	Affluent	14,299 (0.3%)
	Very/extremely affluent	1,273 (0.2%)
Country of birth		
	Republic of Ireland	90,051 (0.5%)
	Outside Republic of Ireland	8,165 (0.4%)
Self-reported health status		
	Good health	93,346 (0.5%)
	Not good health	169 (1.8%)

Source: Authors' analysis of 2022 sample of the Census Longitudinal Dataset.

4.3 Care recipients

Table 4.4 shows the percentage of TILDA Wave 5 respondents reporting receipt of care for difficulties with ADLs/IADLs for various demographic, socio-economic and health groups. Overall, 10 per cent of the sample reported receiving care for difficulties with ADLs/IADLs.¹² Of those reporting receipt of care, 45 per cent reported receiving less than 15 hours of care per week, 20 per cent reported receiving between 15 and 28 hours of care, while 36 per cent reported receiving 29 hours or more of care per week. As discussed in Chapter 3, a small proportion of respondents were in receipt of paid care only.

A higher proportion of females, relative to males, reported receiving care. Unsurprisingly, the proportion of the population in receipt of care increased with age, with 42 per cent of those aged 85 and older in receipt of care for difficulties with ADLs/IADLs. Widowed people were

¹² This 10% is specific to the TILDA sample and does not necessarily align with population-based percentages. This is because of differences between the TILDA sample and the population, including the exclusion of those in residential care from TILDA and a higher proportion of people aged 50–64 in the population relative to the TILDA sample.

most likely to receive care, likely explained by their higher age relative to other marital status groupings. Similarly, the higher proportion of those with a primary or no education in receipt of care is likely explained by the higher average age of this group relative to those who had a third-level qualification. Across the measures of health and healthcare utilisation, those in receipt of care were more likely to report poor health and to have higher utilisation of a range of health and social care services. The receipt of family care and use of formal care services are highly correlated, with 70 per cent of people using formal home support services in receipt of family care compared to only 7 per cent of people not in receipt of formal home support.

Table 4.4 Family care receipt across socio-demographic groups (aged 50+ living in community), TILDA Wave 5

Characteristic	Number (% of sub-group receiving care)	Weekly hours of care (% of care recipients) ¹		
		<15 hours per week	15–28 hours per week	29+ hours per week
Total	4,584 (10%)	45%	20%	36%
Sex				
Male	2,207 (7%)	47%	23%	30%
Female	2,377 (13%)	43%	18%	39%
Age group				
50–64	1,418 (3%)	43%	23%	34%
65–69	914 (4%)	47%	7%	46%
70–74	847 (6%)	54%	11%	35%
75–79	573 (10%)	45%	27%	28%
80–84	358 (20%)	39%	22%	38%
85+	475 (42%)	44%	20%	36%
Marital status				
Single, never married	535 (12%)	66%	22%	11%
Married or civil partnership	2,882 (7%)	36%	19%	45%
Separated or divorced	384 (6%)	66%	24%	10%
Widowed	783 (23%)	44%	19%	37%
Highest level of education				
Primary/none	1,254 (18%)	39%	22%	39%
Secondary	2,080 (8%)	44%	21%	35%
Third-level/higher	1,250 (5%)	69%	5%	26%
Location of household				
Dublin City or county	1,176 (8%)	56%	15%	29%
Another town or city	1,488 (13%)	45%	21%	34%
A rural area	1,920 (9%)	37%	20%	42%
Housing Tenure²				
Owned/occupied rent free	3,145 (10%)	46%	19%	35%
Rented from local authority	232 (13%)	46%	22%	32%
Rented privately	94 (5%)	100%	–	–

Characteristic	Number (% of sub-group receiving care)	Weekly hours of care (% of care recipients) ¹		
		<15 hours per week	15–28 hours per week	29+ hours per week
Employment status				
Employed	1,161 (1%)	89%	0%	11%
Retired	2,479 (12%)	45%	23%	32%
Other	942 (17%)	39%	16%	46%
Self-rated physical health				
Excellent/very good/good	3,643 (5%)	59%	19%	23%
Fair/poor	816 (22%)	46%	21%	33%
Long-term illness				
No long-term illness	2,415 (4%)	55%	13%	32%
Long-term illness	799 (3%)	49%	24%	27%
Limiting long-term illness	1,370 (25%)	41%	21%	38%
Serious cognitive impairment				
None	4,521 (9%)	47%	20%	33%
Alzheimer’s, dementia or serious memory impairment	63 (82%)	20%	15%	65%
Fall in the last year/since last interview ³				
Yes	1,199 (17%)	44%	19%	37%
No	3,378 (8%)	45%	20%	35%
Receives home support (home help, personal care, home care)				
No	4,342 (7%)	51%	20%	29%
Yes	242 (70%)	34%	19%	47%
GP visits in last 12 months				
None	352 (11%)	36%	34%	30%
1–4	2,976 (7%)	48%	21%	31%
5–9	902 (12%)	49%	11%	40%
10+	354 (28%)	34%	22%	44%
Receives public health or community nurse ⁴				
No	4,298 (7%)	50%	17%	33%
Yes	240 (56%)	28%	25%	47%
Receives day centre services ⁴				
No	4,494 (9%)	44%	19%	37%
Yes	44 (61%)	19%	30%	51%

Notes: ¹ One hundred respondents did not provide hours of care received, and are not included in the analysis of hours of care.

² 'Owned/occupied rent free' includes owned outright, owned with mortgage, and owned under tenant purchase agreement, as well as occupied rent free. Three respondents were renters but the form of rent was unknown – these were classed as 'DK/refused', and are not included in the table.

³ Seven respondents did not provide information about falls.

⁴ Forty-six responses did not include information about public health/community nurse receipt, nor day centre services.

Percentages may not add to 100 due to rounding, and total numbers may add to slightly above 4,584 because of rounding after sampling weights were applied.

Source: Authors' analysis of TILDA Wave 5.

4.4 Baseline estimates of family care receipt

Tables 4.5 and 4.6 show the percentage of the (male and female respectively) population aged 50 and over reporting difficulties with ADLs/IADLs and, for those who reported difficulties, the percentage in receipt of family care.

The percentage of the population reporting a difficulty with an ADL/IADL increased with age and was slightly higher among females relative to males. For example, 6 per cent of 50–64-year-old males reported difficulties, compared to 42 per cent of males aged 85 and over; for females, the corresponding percentages are 7 per cent and 55 per cent.

Table 4.5 Percentage reporting they have a difficulty with ADLs/IADLs and in receipt of care, TILDA Waves 3, 4 and 5, males

Age group (n)	No difficulty with ADLs/IADLs	Difficulty with ADLs/IADLs	Difficulty with ADLs/IADLs	
			Receives help with ADLs/IADLs	Does not receive help with ADLs/IADLs
50–64 (2,841)	94.1%	5.9%	1.9%	3.9%
65–69 (1,451)	93.6%	6.4%	3.3%	3.0%
70–74 (1,178)	90.5%	9.5%	4.6%	4.9%
75–79 (753)	86.0%	14.0%	8.9%	5.1%
80–84 (547)	79.7%	20.3%	15.9%	4.4%
85+ (476)	57.7%	42.3%	32.1%	10.0%

Note: The sum of the values in column 4 ('Receives help with ADLs/IADLs') and column 5 ('Does not receive help with ADLs/IADLs') do not always exactly equal the values in column 3 ('Difficulty with ADLs/IADLs') due to rounding.

Source: Authors' analysis based on Waves 3, 4 and 5 of TILDA.

Table 4.6 Percentage reporting they have a difficulty with ADLs/IADLs and in receipt of care, TILDA Waves 3, 4 and 5, females

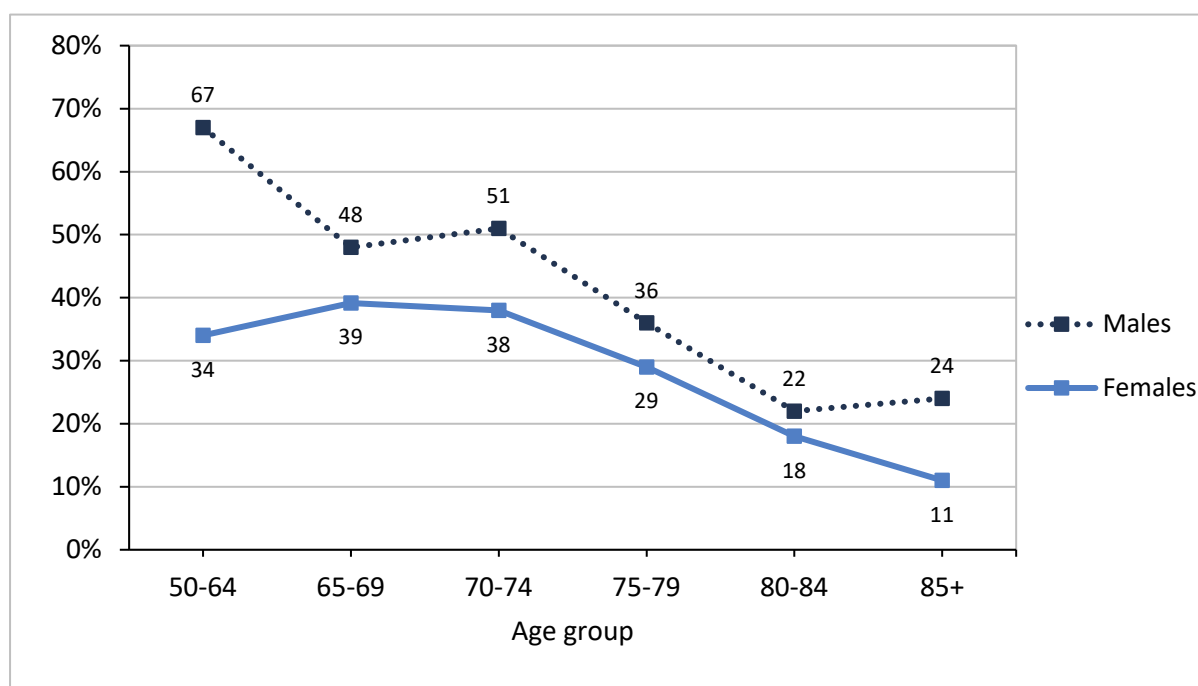
Age group (n)	No difficulty with ADLs/IADLs	Difficulty with ADLs/IADLs	Difficulty with ADLs/IADLs	
			Receives help with ADLs/IADLs	Does not receive help with ADLs/IADLs
50–64 (3,179)	93.4%	6.6%	4.3%	2.3%
65–69 (1,591)	92.5%	7.5%	4.6%	2.9%
70–74 (1,343)	89.1%	10.9%	6.8%	4.1%
75–79 (877)	83.9%	16.1%	11.4%	4.6%
80–84 (760)	71.3%	28.7%	23.4%	5.3%
85+ (877)	44.8%	55.3%	49.3%	5.9%

Note: The sum of the values in column 4 ('Receives help with ADLs/IADLs') and column 5 ('Does not receive help with ADLs/IADLs') do not always exactly equal the values in column 3 ('Difficulty with ADLs/IADLs') due to rounding.

Source: Authors' analysis based on Waves 3, 4 and 5 of TILDA.

A significant proportion of those aged 50 and over who report difficulties with ADLs/IADLs do not receive any care (Tables 4.5 and 4.6), with this proportion tending to be higher for younger (older) people and for males. Figure 4.1 shows, for example, that 67 per cent of males aged 50–64 who report a difficulty do not receive any help, compared to 24 per cent of males aged 85 and over; for females, the corresponding figures are 34 per cent and 11 per cent.

Figure 4.1 Percentage aged 50 and over reporting difficulties with ADLs/IADLs but not receiving help, TILDA Waves 3, 4 and 5



Source: Authors' analysis based on Waves 3, 4 and 5 of TILDA.

While it is feasible that some people with a difficulty with an ADL/IADL do not require care, it may also be the case that some of those who report difficulties but are not in receipt of care have an unmet need for such care. The extent of this unmet need is unknown. Consequently, in this analysis two sets of projections of family care are estimated – the first is based on those who report a difficulty with an ADL/IADL and receive family care, while the second is based on those who report a difficulty with an ADL/IADL regardless of whether they are currently in receipt of family care.

Chapter 5

Findings: Projections

5.1 Introduction

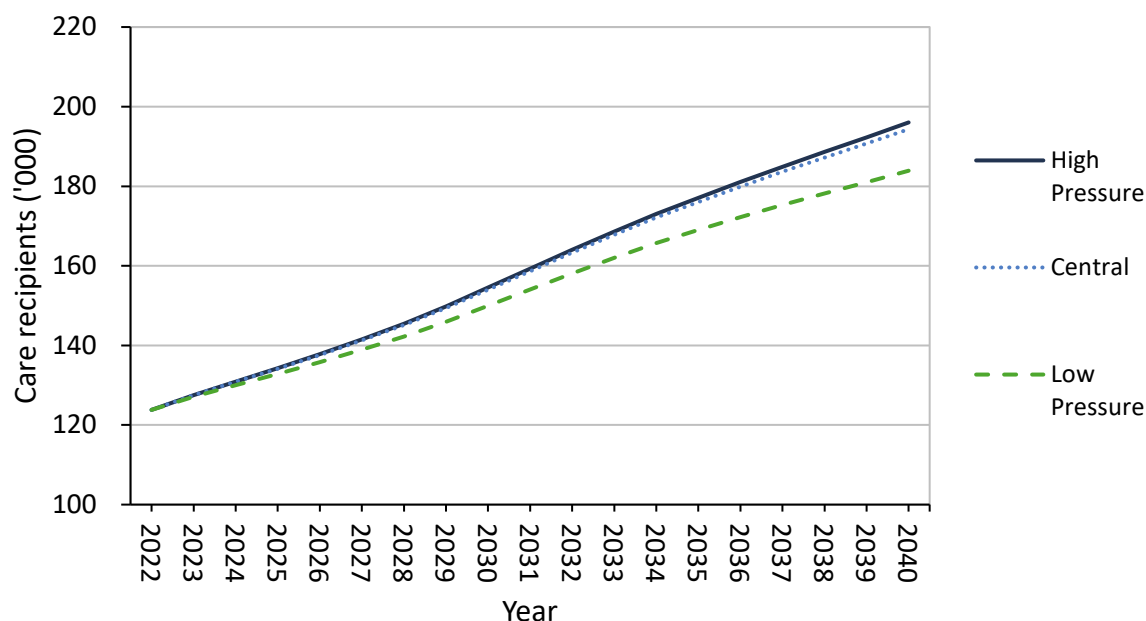
This chapter presents findings for estimated baseline need and receipt of family care in 2022 and the projected need for care in Ireland among those aged 50 and over to 2040. Baseline estimates are derived by applying the age- and sex-specific estimated rates of difficulty with an ADL/IADL and difficulty with an ADL/IADL and in receipt of care, reported in TILDA Waves 3–5 by age and sex, to the 2022 population aged 50 and over. Two sets of projections are provided: (i) based on those who report a difficulty with an ADL/IADL and receive care, and (ii) based on those who report a difficulty with an ADL/IADL regardless of whether they are currently in receipt of care.

5.2 Projections of family care need

Figure 5.1 and Table 5.1 show the projected increase in the number of people aged 50 and over requiring care based on those who are currently in receipt of such care. The projected increases are shown for the three projection scenarios detailed in Table 3.5. The scenarios differ across a range of assumptions, including population growth and age structure, and healthy ageing.

Applying the age- and sex-specific receipt of help rates from TILDA Waves 3–5 to the population in Ireland in 2022, an estimated 123,802 people aged 50 and over with a difficulty with an ADL/IADL were in receipt of care in Ireland in 2022. By 2040, an additional 60,096 to 72,229 people aged 50 and over will require such care, representing a 49 per cent (low pressure scenario) to 58 per cent (high pressure scenario) increase between 2022 and 2040 (Table 5.1).

There is little difference between the central and high scenarios, with a larger difference between the central and low scenarios. Referring to Table 3.6, the difference between the central and high scenarios is due to different assumptions on population growth and age structure, while the difference between the central and low scenarios is due to different assumptions on healthy ageing. This suggests that an optimistic assumption on healthy ageing has the potential to reduce the projected need for care. However, in all scenarios the projected need for care will increase significantly over the projection period.

Figure 5.1 Projections of family care need based on current receipt of care, 2022–2040

Source: Authors' calculations using TILDA data and Bergin and Egan (2024).

Table 5.1 Projections of family care demand, 2022–2040

Scenarios	2022	2040		Total growth 2022–2040	Average annual growth 2022–2040
		Projected additional	Total		
	N	N	N	%	%
Receives care					
Low pressure	123,802	60,096	183,898	49%	2.2%
Central		70,521	194,323	57%	2.5%
High pressure		72,229	196,031	58%	2.6%
Difficulties with ADLs/IADLs					
Low pressure	177,011	86,594	263,605	49%	2.2%
Central		98,966	275,976	56%	2.5%
High pressure		101,323	278,334	57%	2.5%

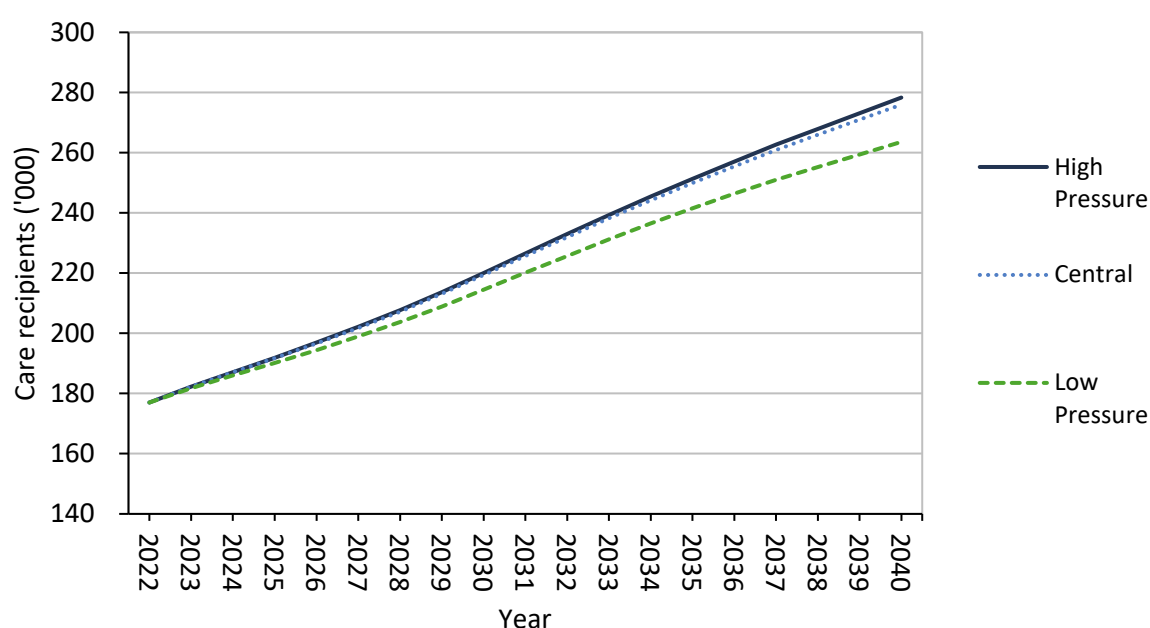
Source: Authors' calculations using TILDA data and Bergin and Egan (2024).

Figure 5.2 and Table 5.1 show the projected increase in the number of people aged 50 and over requiring care based on those who report a difficulty with an ADL/IADL (including those currently in receipt and not in receipt of care).

Applying the age- and sex-specific rates of those reporting a difficulty with an ADL/IADL estimated from TILDA (Table 4.5) to the population in Ireland in 2022, an estimated 177,011 people aged 50 and over reported a difficulty with an ADL/IADL in 2022, of whom 53,209 were not in receipt of care. As discussed in Chapter 4, a significant proportion of those with a difficulty but not in receipt of care likely require some level of care. While there are no data on the proportion of those who require care, in this analysis projections of need for care were undertaken for individuals who reported difficulty with an ADL/IADL, regardless of whether they were currently in receipt of care. By 2040, an additional 86,594 to 101,323 people aged 50 and over will have difficulties with ADLs/IADLs, representing a 49 to 57 per cent increase between 2022 and 2040 (Table 5.1).

If all those with projected difficulties with ADLs/IADLs were to receive family care in 2040, then the projected increase in the number of people requiring care would be in the region of 123 per cent (receipt of care in 2022 = 123,802; projected need in 2040 if all those with a difficulty with an ADL/IADL were to receive care under the central scenario = 275,976).

Figure 5.2 Projections of family care need based on a reported difficulty with an ADL/IADL, 2022–2040



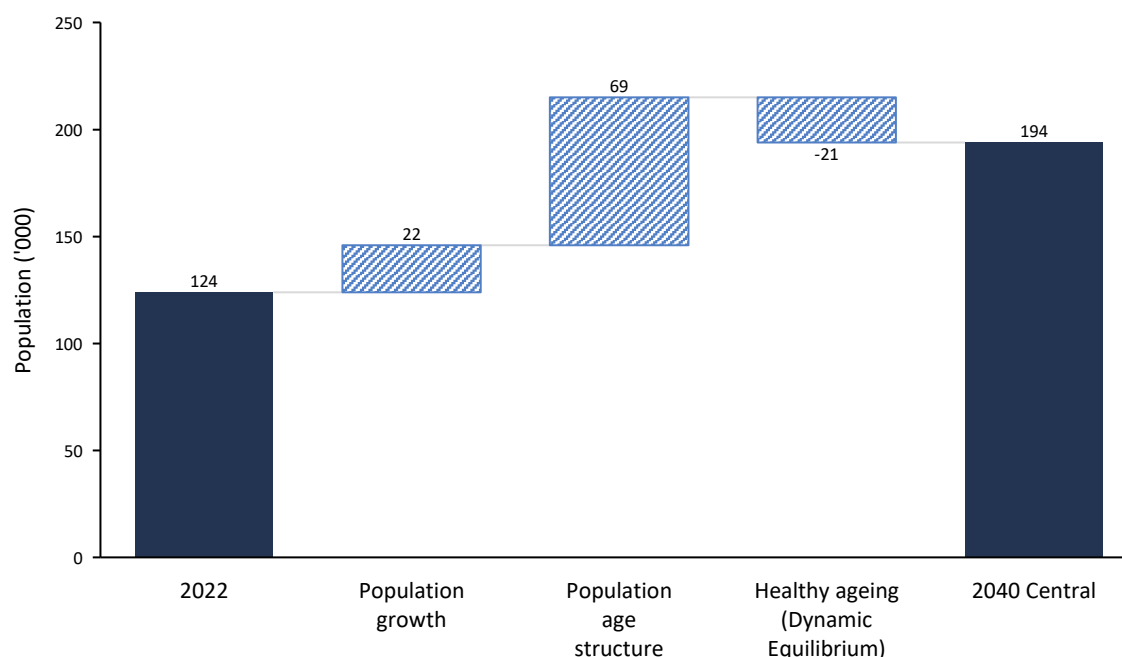
Source: Authors' calculations using TILDA data and Bergin and Egan (2024).

5.3 Projections of family care need: Decomposition analysis

Figures 5.3 and 5.4 show the proportion of the projected increase in need for care between 2022 and 2040 which is attributable to the different assumptions (i.e. population growth, changing age structure and healthy ageing) for the projections based on (i) those with a difficulty with an ADL/IADL in receipt of care (Figure 5.3) and (ii) those with a difficulty with an ADL/IADL regardless of whether they receive care (Figure 5.4).

Based on those currently in receipt of care, relative to 2022, for those aged 50 and over, an additional 70,521 people are projected to require care by 2040 (central scenario). Figure 5.3 shows that the changing population age structure (i.e. ageing population) is the main driver of projected growth, accounting for a 56 per cent increase relative to 2022. Population growth accounts for a further 18 per cent increase between 2022 and 2040. These increases are partly offset by optimistic assumptions on healthy ageing.

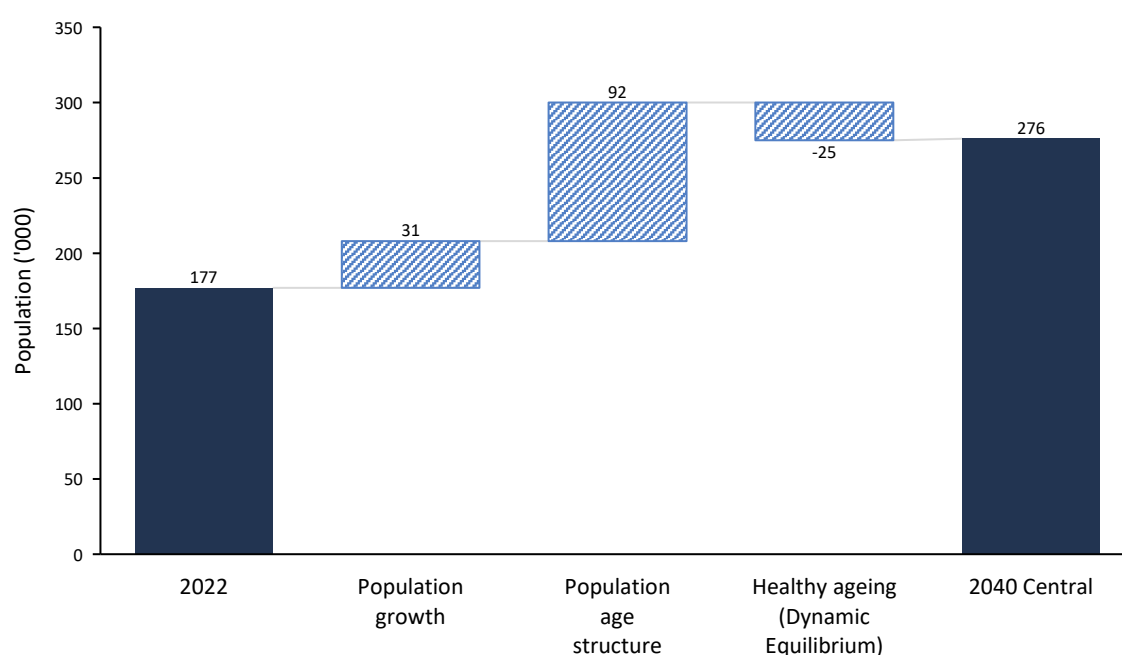
Figure 5.3 Need for care (based on current receipt of care) – decomposition of growth (central scenario), 2022–2040



Source: Authors' calculations using TILDA data and Bergin and Egan (2024).

Based on those who report difficulties with ADLs/IADLs, relative to 2022, for those aged 50 and over, an additional 98,966 people are projected to have difficulties with ADLs/IADLs by 2040 (central scenario). Similar to the projections based on the receipt of care, Figure 5.4 shows that changes to the population age structure are again the main driver of growth in the need for care in the coming years, even when accounting for healthy ageing effects.

Figure 5.4 Need for care (based on difficulties with ADLs/IADLs) – decomposition of growth (central scenario), 2022–2040



Source: Authors' calculations using TILDA data and Bergin and Egan (2024).

Chapter 6

Discussion

6.1 Summary of findings

In the 2022 Census, 299,128 people (or 6 per cent of the population) reported providing regular unpaid personal help or support to a family member, neighbour or friend with a long-term illness, health issue or issue related to old age or disability. Consistent with national and international research, the analysis in this report found that (using self-reported data) females and individuals in middle-aged groups were the most likely to provide care. Older carers, however, tended to provide the highest number of care hours per week, which may reflect the provision of care to a co-residing partner or child. Individuals whose primary activity was looking after the family or home were also more likely than other groups to report being a carer. Given the cross-sectional nature of the analysis, it is not possible to determine whether this group were more likely to become carers due to their role within the home or whether they assumed that role after taking on caring responsibilities. Relatively few differences were observed across regions or socio-economic characteristics (such as education or medical card status) in the likelihood of being a family carer, highlighting the broad, cross-societal nature of family care.

In 2022, an estimated 177,011 people aged 50 and over living in the community reported a difficulty with an activity of daily living (ADL) or instrumental activity of daily living (IADL). Of these, 123,802 (70 per cent) reported receiving family care. Of those in receipt of care, 45 per cent received less than 15 hours of care per week, 20 per cent received between 15 and 28 hours of care, while 36 per cent received 29 hours or more of care per week. A higher proportion of females reported receiving care, while unsurprisingly, the proportion of the population in receipt of care increased with age, with 42 per cent of those aged 85 and older receiving family care.

The growing and ageing population will result in a significant increase in the need for care in the coming years. Between 2022 and 2040, based on the current receipt of family care, the need for care for those aged 50 and over is projected to increase by between 49 and 58 per cent. The lower projection is associated with lower population growth and optimistic assumptions on healthy ageing, while the higher projection is associated with higher population growth and less

optimistic healthy ageing assumptions. If the projections of need are based on those with difficulty with an ADL or IADL rather than the subset of those who received family care in 2022, then the need for care in absolute terms would be even greater.

In general, the projected increases in the need for care (which is currently predominantly provided by families) are larger than for community and hospital-based services (Brick et al., 2025; Connolly et al., 2025) and slightly lower than those for other long-term care services, including formal home support (Walsh and Kakoulidou, 2025). The difference between the projected growth in the need for family care and formal home support services is likely explained by the older age profile of those in receipt of formal services and the projected significant increase in the older old population in the coming years. In addition, the formal home support analysis (Walsh and Kakoulidou, 2025) included assumptions on addressing unmet demand and expanding the home support service, which, due to a lack of data, were not possible to model in the projections of family care.

6.2 Limitations

There are a number of limitations to the current analysis.

First, the type and extent of the analysis that could be undertaken were limited by the data available on family care provision and receipt in Ireland at the time of completing the analysis. While many surveys undertaken in Ireland include questions on the provision of care (albeit with differing questions and estimates of the number of carers), there are fewer data on the receipt of care.

The TILDA dataset includes a question on the receipt of care among those aged 50 and over, and was used in the current analysis.

However, the estimated proportion of the population in receipt of care in this analysis is an underestimate of care receipt in Ireland for a number of reasons. First, the dataset includes people aged 50 and over who are living in the community at the time of recruitment to the study; consequently, those aged less than 50 and those not living in the community are excluded. Data from the Healthy Ireland Survey indicate that approximately 78 per cent of community-based care recipients are aged 50 and over; therefore, younger adults who may constitute approximately a quarter of care recipients in Ireland are excluded from the analysis. The lack of data on younger adults and children, many of whom may have intellectual, physical, sensory or mental health disabilities, should be considered when interpreting the

findings, both in terms of the overall number of care recipients and associated projections, as well as differences in the characteristics of care provided to younger and older care recipients. Future research on family care for younger people, using data from the Intellectual Disability Supplement to TILDA and the Growing Up in Ireland Study, for example, is warranted to provide a fuller picture of family care in Ireland. Conversely, the estimate of care receipt in this analysis includes a small number of people who only received ‘paid care’, a proportion of whom are likely to only receive formal, professional services.

Second, while some information on the care recipient is available (e.g. their age, sex and health status), there is limited information available on the type of care needed and received. This will differ considerably across care recipients and is influenced by the demographic, socio-economic and health characteristics of the care recipient, the availability of other formal and informal services, the relationship between the care recipient and the carer, and the location of the care recipient.

Third, in TILDA the question on the receipt of care is only asked of respondents who report difficulties with ADLs/IADLs. Given the self-reported nature of this measure, some individuals may receive care despite not having, or not reporting, such difficulties. As a result, the analysis may underestimate the proportion of the population in receipt of family care. Alternatively, some people who report difficulties with ADLs/IADLs may not need family care. However, further analysis shows that while 70 per cent of TILDA respondents who reported difficulties with ADLs/IADLs also received formal home support, only 7 per cent of respondents who did not report difficulties with ADLs/IADLs received formal home support, suggesting that the measure is capturing a large proportion of people with care needs.

Fourth, the data used in this analysis (including metrics of care provision and receipt, and difficulties with ADLs/IADLs) are based on self-reported survey responses. Self-report survey data have the potential for recall bias (Brusco and Watts, 2015) and stigma. However, given the lack of a centrally held dataset which captures the totality of family care provision and receipt, self-report survey data remain an invaluable source to bridge this data gap.

Fifth, given data availability, it was not possible to fully capture the unmet need for family care in the projections. Unmet need for care could arise in a number of ways, including having a care need but not

receiving any care, or having a care need and receiving some (but not a sufficient amount of) care. Notwithstanding the limitations discussed in the previous paragraph, the set of projections based on those reporting difficulties with ADLs/IADLs largely addresses the source of unmet need associated with having a care need but not receiving any care. However, it does not take into account the unmet need for those who receive some (but not a sufficient amount of) care. Further, it points to a need for care which could come from family or formal sources (see Section 6.3). Consequently, the projections in this analysis may be an underestimate of future care needs.

A sixth limitation relates to uncertainty about how difficulties with ADLs/IADLs may evolve as life expectancy increases. In keeping with earlier analysis (Walsh and Kakoulidou, 2025), the projections in this report are based on two relatively optimistic assumptions regarding healthy ageing. Should more detailed data or evidence on healthy ageing in the Irish context become available, these assumptions should be reassessed and the analysis updated accordingly.

Finally, the projections in this report are based on the current model of long-term care in Ireland. This model has embedded family care as the main source of care and support; publicly provided formal home support services act as a complement (rather than a substitute) for this care. Any change to the current model (including the introduction of the Statutory Home Support Scheme) would have implications for the future need for family care in Ireland.

6.3 Meeting projected care needs

The growing and ageing population is projected to contribute to a significant increase in the number of people with care needs in the coming years. While improvements in health status (were they to occur) could mitigate some of the additional care requirements, they are unlikely to be sufficient to offset the growing care needs. A key question for policymakers, then, is how this additional need for care can be met and whether it will come from family or formal (paid professionals) sources, or a combination of both. In the following sections these two options will be considered in turn.

6.3.1 Family Care

Family care is a central component of long-term care in Ireland and it is not expected that formal services will replace such care in the future. Rather, policy interventions aim at ensuring there is sufficient support

available so that the type and intensity of care provided is a meaningful choice for family carers and is appropriate for the needs of the care recipient. However, in light of the growing need for care, government supports will become increasingly important in the coming years.

Given the limited data available on family care (discussed in Section 6.2), it is not possible to accurately convert the projected need for care estimated in this analysis into the number of family carers required, and such a projection is typically absent from the literature. There is no dataset that captures information on carer–care recipient dyads¹³ and there is no simple one-to-one relationship between carers and care recipients. Some carers provide care for more than one person, and some care recipients receive care from more than one person.

Projecting the future number of family carers is further complicated by the fact that family care depends not only on whether an individual needs care, but also on whether someone within their family or wider social network is available, willing and able to provide that care. These latter factors are likely to be affected by demographic change, household and family composition, labour market participation, geographic proximity to family members, health status and preferences around care provision. In addition, the care system has historically relied on female carers, and while results in this report suggest some convergence between males and females in caring, as female labour force participation continues to increase there may be a reduction in female family carers. Further, the projected need for care in this report relates to the population aged 50 and over. While this group will see the largest increase in size in the coming years, the need for family carers for people aged less than 50 is also likely to increase.

The estimates in this report are projections and not forecasts; as with previous projections using the Hippocrates model, these estimates should be interpreted as such and it should be noted that they are sensitive to the assumptions and scenarios applied. However, given that by 2040 an additional 60,096–72,229 people aged 50 and over will need care (based on current receipt-of-care data), it is likely that a substantial increase in the number of family carers will also be required. While in other projection analyses it is possible to project workforce, as patient/resident-to-staff ratios exist, the number of additional carers required cannot be inferred directly from the number of additional people needing care. The scale of projected growth in

¹³ Dyad means a linked pair consisting of one person providing care and the person receiving that care.

care need indicates that a substantial expansion in family care provision would be required if current patterns of care receipt continue.

This growing demand for family care is coming at a time when the availability of family carers may be reduced. Recent analysis from the Healthy Ireland Survey showed that almost half of carers were caring for a parent or parent-in-law (Ipsos B&A, 2025). This corresponds to the finding that the majority of family care is currently provided by those in the middle-aged groups. There are several reasons why the provision of care among this group may decrease in the coming years.

Demographic change, for example, including a reduction in the absolute number of people aged 40–49 between 2022 and 2040, could reduce the availability of carers. In addition, an increase in female labour market participation, as well as a potential increase in the likelihood of people living further away from their parents (Kalmijn, 2021), may further contribute to a reduction in the provision of care. Population health status could also impact the provision of family care. As noted in Chapter 2, there is much uncertainty over how population health status will evolve; a decline in population health status could reduce the availability of family carers, given the requirement for good physical and mental health to manage the often high demands of care provision.

If family care provision is to remain an integral component of the long-term care system in Ireland, further supports and policies will be required to maximise the potential pool of carers and support those undertaking caring roles. These supports could include an increase in cash (and other) benefits to carers, in particular for those providing a significant number of hours of care per week. Such measures are essential to ensure that carers and their families are not at increased risk of poverty and deprivation arising from their caring role. In some countries, cash benefits are paid to care recipients (generally based on care needs), enabling them to support family carers or even to formally hire them. In Germany, these cash benefits are largely chosen over home care agency services and appear to have generated incentives for family care in terms of an increased number of carers per person receiving care (Colombo et al., 2011). Conceptually, it is assumed that it is easier to identify those with care needs than it is to identify primary carers and that these payments may be more likely to reach carers who may not identify themselves as such. However, there are issues with this form of support: namely, cash benefits paid to the care

recipient may not always be used to pay family carers and may monetise family relationships in a problematic way.

Further, the implementation of the Statutory Home Support Scheme and increased provision of respite services are required to support carers and to provide necessary services (both within and beyond the home) for those who require them. However, some caution is required in relation to the implementation of the Statutory Home Support Scheme and its impact on the need for family care: the scheme could increase the need for family care if formal services allow people to remain in their own home for longer (as an alternative to residential care) than is currently the case; alternatively, it could reduce demand if an expansion of formal support acts as a substitute for some care currently provided by families.

In 2022, 57 per cent of carers aged 15 and over worked outside of the home (Central Statistics Office, 2023a). This percentage has been increasing over time, and given the changing demographic and labour market characteristics, may continue to increase in the coming years. Consequently, consideration is required of how employees (and the self-employed) can be supported to balance employment and caring roles. Initiatives and legislation such as the increase in the number of hours that people may engage in employment or education and retain the Carer's Allowance/Benefit, the Carer's Leave Act, the Long-Term Carers Contributions scheme and the Work Life Balance and Miscellaneous Provisions Act are important provisions in this regard. However, to better support carers who balance employment and care provision, further intervention may be required. Analysis from the UK highlighted the difficulty that many 'working' carers experience in combining the two roles, with half of all working carers reporting that their caring responsibility affected their job and over 80 per cent reporting difficulties in fulfilling their caring responsibilities because of the amount of time they spent on their job (Austin and Heyes, 2020). Employer support, however, was found to make a substantial difference to the ability of working carers to combine both roles. Increased workplace flexibility through, for example, working from home and flexitime, was found to be particularly helpful for those navigating both roles; such policies can also benefit the employer through reduced sick leave and resignations (Austin and Heyes, 2020). Recent analysis from the UK has shown that increased employment flexibility not only increased the provision of family care but also reduced gender disparities in care provision, with more employment

flexibility associated with a significant increase in the likelihood of providing care by males (Costa-Font and Wang, 2026).

In this context, Family Carers Ireland has developed a 'Caring Employers' programme, which is focused on creating an inclusive and supportive workforce for employees who have caring responsibilities. New rights for employees to potentially avail of five days of unpaid carer's leave in the Work-Life Balance and Miscellaneous Provisions Act 2023 were an important step forward in recognising and supporting carers who combine work and caring; however, consideration should be given to the provision of paid carer's leave as exists for some other leave entitlements introduced in the Act. Further, recognising the episodic nature of illness, deterioration or improvement in health conditions, and/or changes in the availability of alternative care over time, consideration should be given to fractionised leave, allowing employed carers to divide care leave over several occurrences (Colombo et al., 2011).

Another potential approach to increasing the pool of family carers is to focus on groups who heretofore may have been less likely to provide care. In this context, the increase in male life expectancy in recent years could increase the availability of spousal and parental carers in the future (Levine et al., 2010), though this is somewhat dependent on how health status evolves along with improvements in life expectancy. In Ireland, like elsewhere, a higher proportion of females provide care and, relative to males, females tend to provide more hours of care (Russell et al., 2019), suggesting there may be potential to increase the provision of care among males. Additional supports, such as easily accessible information on potential services available to carers and the care recipient, as well as basic training, may help empower those who are willing to provide family care but may be less accustomed to a caring role. In this context, in Scotland professionals who may be familiar with carers (and potential carers), including GPs, pharmacists and other professionals, are incentivised to identify carers and refer them to appropriate local supports (Colombo et al., 2011). In Denmark, a national programme to support relatives of people living with long-term diseases was established and includes, for example, weekly interactive training sessions where carers share their experiences and build skills to help them tackle stress and isolation, while looking after their own health (Eurocarers, 2023).

More generally, policies which positively impact population health have the potential to reduce the need for family care while also

potentially increasing the number of people who may be in a position to provide care. While the health system has an integral role to play in maximising population health, other factors also require consideration. As detailed in the HSE's Public Health Strategy, the wider determinants of health (including income, wealth, education, housing and transport) require additional focus as a means of both improving population health and reducing health inequalities (HSE, 2025). Further consideration, too, could be given to other determinants of health, including health behaviours, places and communities (Buck et al., 2018). A healthy population is essential for economic growth (Fumagalli et al., 2024) and maximising the quality of life of the population; it also has the potential to reduce demands on the health and social care system, both by reducing the need for care and potentially increasing the availability of 'healthy' carers.

In 2025, an estimated €1.9 billion was spent on the Carer's Allowance, the Carer's Benefit, the Domiciliary Care Allowance and the Carer's Support Grant (Minister for Social Protection, 2025). However, despite this level of expenditure, a significant proportion of family carers do not receive any financial support. For example, while 300,000 people reported providing regular unpaid help or support to a family member, neighbour or friend with a long-term illness, health issue, or an issue related to old age or disability in the 2022 Census (Central Statistics Office, 2023a), only 94,409 people received the Carer's Allowance and 4,121 received the Carer's Benefit in 2022. However, as detailed in Chapter 2, the numbers in receipt of these benefits had increased to 107,142 and 5,413 by the end of 2025 (Department of Social Protection, 2026).

The expected increase in the number of family carers and the additional initiatives needed to support carers will require increased government expenditure in this area in the coming years. The extent of the increase is dependent on several factors, including the number of family carers, the particular grants and allowances that carers may be eligible for, payment levels, the type and extent of other supports and measures that may be implemented, as well as any other policy changes (including, for example, the removal of the means test for the Carer's Allowance).

While due regard to future expenditure requirements in this area is needed, this must be within the context of the overall budget for long-term care. Adequately supporting and resourcing family care has the potential to offset costs associated with the provision of formal care,

aligns with government policy to support people to remain within their own home and community for as long as practicable, and is in keeping with people's preferences to remain living in their own home as they age (Fox et al., 2017).

6.3.2 Formal care

Previous analysis from the ESRI has considered the growing demand for home support services in Ireland in light of the ageing population (Walsh and Kakoulidou, 2025). Consideration is now required of whether some of the additional home-based care requirements currently provided through family carers will need to be filled from formal sources, further increasing the demand for home support services over and above that projected in Walsh and Kakoulidou (2025). Such an approach could have significant financial implications for the state or individual care recipient, depending on how such care is financed. In 2023, over €720 million was spent on home support for older people by the Health Service Executive (Loughnane, 2024), with the average cost of a home support hour approximately €34.¹⁴ The ageing population will result in a significant increase in the demand for home support in the coming years (Walsh and Kakoulidou, 2025), with an associated increase in expenditure requirements. Given the very significant number of hours of care provided by family carers and the projected increase in the need for care, any move from family care to formal home support would result in significant increases in state expenditure.

Further, given the projected increases in demand for formal long-term care also arising from the ageing population (Walsh and Kakoulidou, 2025), it is unclear where the workforce would come from. Previous research has identified policies which focus on recruitment and retention of the long-term care workforce as essential in addressing potential workforce shortages (Colombo et al., 2011). This includes the identification and recruitment of new employment pools, including men and the long-term unemployed. However, some caution is required in this regard, as it could be that increasing the formal long-term care workforce would result in a decrease in the supply of family care, as some groups outside of the formal labour market are incentivised to enter the labour market (Hanly and Sheerin, 2017).

¹⁴ www.oireachtas.ie/en/debates/debate/dail/2024-06-27/31/

Finally, consideration is required of how family and formal service provision may interact in a time of growing need for care. Given the extent of the projected increases in need for care in the coming years, it is likely that an increase in both family care and formal services will be required. Analysis from the UK has highlighted the need for the right blend of family and formal care to meet growing need and recommended a whole-system approach (Bokhari and Jitendra, 2024), which focuses on working arrangements and the benefits system for family carers, as well as ensuring the availability of affordable formal services. A similar approach is required for Ireland. However, this is not without challenges given the different policies and policy areas involved, including the Department of Social Protection, the Department of Health, and employers'/employment organisations. In this context, Ireland would benefit from a joined-up strategy which recognises how different parts of the system interact and can ensure a sufficient supply of care in the coming years.

6.4 Conclusions

Similar to other aspects of long-term care, the ageing and growing population will significantly increase the need for family care in Ireland in the coming years. At the same time, the availability of family carers may decline due to demographic shifts, smaller family sizes, and higher levels of female participation in the labour market. A central question is how this growing need for care will be met, and whether it will be provided through informal supports (such as family and friends), formal paid services, or a combination of both. If family carers are to remain a core component of Ireland's long-term care system, additional supports and targeted policies will be essential, with these supports varying by the nature and intensity of the caring role.

References

- Alam, S., Hannon, B., and Zimmermann, C. (2020). Palliative care for family caregivers, *J Clin Oncol*, 38(9), 926–936, <https://doi.org/10.1200/JCO.19.00018>
- Austin, A., and Heyes, J. (2020). *Supporting working carers: How employers and employees can benefit*, Sheffield, England: CIPD, University of Sheffield, www.cipd.org/globalassets/media/comms/news/a1supporting-working-carers-2_tcm18-80339.pdf
- Barlow, P., Mohan, G., and Nolan, A. (2022). Utilisation of healthcare by immigrant adults relative to the host population: Evidence from Ireland, *J Migr Health*, 5, 100076, <https://doi.org/10.1016/j.jmh.2021.100076>
- Beach, S.R., Schulz, R., Yee, J.L., and Jackson, S. (2000). Negative and positive health effects of caring for a disabled spouse: Longitudinal findings from the Caregiver Health Effects Study, *Psychol Aging*, 15(2), 259–271, <https://doi.org/10.1037//0882-7974.15.2.259>
- Bergin, A., and Egan, P. (2024). *Population projections, the flow of new households and structural housing demand*, ESRI Research Series 190, Dublin: Economic and Social Research Institute, <https://doi.org/10.26504/rs190>
- Bokhari, T., and Jitendra, A. (2024). *The future of care needs: A whole systems approach*, York, England: Joseph Rowntree Foundation.
- Bom, J., Bakx, P., Schut, F., and van Doorslaer, E. (2019). The impact of informal caregiving for older adults on the health of various types of caregivers: A systematic review, *Gerontologist*, 59(5), e629–e642, <https://doi.org/10.1093/geront/gny137>
- Brick, A., and Kakoulidou, T. (2025). *Projections of regional demand and bed capacity requirements for public acute hospitals in Ireland, 2023–2040: Based on the Hippocrates model*, ESRI Survey and Statistical Series 132, Dublin: Economic and Social Research Institute, <https://doi.org/10.26504/sustat132>
- Brick, A., Kakoulidou, T., and Humes, H. (2025). *Projections of national demand and bed capacity requirements for public acute hospitals in Ireland, 2023–2040: Based on the Hippocrates model*, ESRI Research Series 213, Dublin: Economic and Social Research Institute, <https://doi.org/10.26504/RS213>
- Brusco, N.K., and Watts, J.J. (2015). Empirical evidence of recall bias for primary health care visits, *BMC Health Serv Res*, 15, 381, <https://doi.org/10.1186/s12913-015-1039-1>
- Buck, D., Baylis, A., Dougall, D., and Robertson, R. (2018). *A vision for population health: Towards a healthier future*, England: The Kings Fund, https://assets.kingsfund.org.uk/f/256914/x/25fa862dd5/vision_for_population_health_2018.pdf

- Care Alliance Ireland (2022). *Defining carers: Update June 2022*, Discussion paper 11, Dublin: Care Alliance Ireland, www.carealliance.ie/userfiles/files/Defining_Carers_2022.pdf
- Cattaneo, A., Vitali, A., Regazzoni, D., and Rizzi, C. (2025). The burden of informal family caregiving in Europe, 2000–2050: A microsimulation modelling study, *Lancet Reg Health Eur*, 53, 101295, <https://doi.org/10.1016/j.lanepe.2025.101295>
- Central Statistics Office (2023a). *Census of Population 2022 profile 4 – disability, health and carers*, Dublin: Central Statistics Office, www.cso.ie/en/releasesandpublications/ep/p-cpp4/censusofpopulation2022profile4-disabilityhealthandcarers/carers/
- Central Statistics Office (2023b). *Census of Population 2022 profile 3 – households, families and childcare*, Dublin: Central Statistics Office, www.cso.ie/en/releasesandpublications/ep/p-cpp3/censusofpopulation2022profile3-householdsfamiliesandchildcare/families/
- Cohen, S.A., Cook, S.K., Sando, T.A., Brown, M.J., and Longo, D.R. (2017). Socioeconomic and demographic disparities in caregiving intensity and quality of life in informal caregivers: A first look at the National Study of Caregiving, *J Gerontol Nurs*, 43(6), 17–24, <https://doi.org/10.3928/00989134-20170224-01>
- Connolly, S., Kakoulidou, T., and McHugh, E. (2025). *Projections of national demand and workforce requirements for general practice in Ireland, 2023–2040: Based on the Hippocrates model*, ESRI Research Series 215, Dublin: Economic and Social Research Institute, <https://doi.org/10.26504/RS215>
- Colombo, F., Llena-Nozal, A., Mercier, J., and Tjadens, F. (2011), *Help wanted? Providing and paying for long-term care*, Paris, France: OECD Publishing, www.oecd.org/content/dam/oecd/en/publications/reports/2011/05/help-wanted_g1g127b2/9789264097759-en.pdf
- Cook, S.K., Snellings, L., and Cohen, S.A. (2018). Socioeconomic and demographic factors modify observed relationship between caregiving intensity and three dimensions of quality of life in informal adult children caregivers, *Health Qual Life Outcomes*, 16(1), 169, <https://doi.org/10.1186/s12955-018-0996-6>
- Costa-Font, J., and Wang, W. (2026). Caring flexibly? Working conditions and the supply of adult care, *Health Economics*, 35(10), 1548–1570, <https://doi.org/10.1002/hec.70133>
- Courtin, E., Jemai, N., and Mossialos, E. (2014). Mapping support policies for informal carers across the European Union, *Health Policy*, 118(1), 84–94, <https://doi.org/10.1016/j.healthpol.2014.07.013>
- Crimmins, E.M., Hayward, M.D., Hagedorn, A., Saito, Y., and Brouard, N. (2009). Change in disability-free life expectancy for Americans 70 years old and older. *Demography*, 46(3), 627–646, <https://doi.org/10.1353/dem.0.0070>

- Department of Health (2012). *The National Carers' Strategy: Recognised, supported, empowered*, Dublin: Government of Ireland, <https://assets.gov.ie/static/documents/national-carers-strategy.pdf>
- Department of Social Protection (2026). *Quarterly statistics on social welfare payments*, Dublin: Department of Social Protection, <https://data.gov.ie/dataset/department-of-social-protection-quarterly-data-age/resource/98de2ece-8dd2-444d-ba96-f3afb1635540>
- Department of the Taoiseach (2025). *Programme for Government 2025 – securing Ireland's future*, Dublin: Government of Ireland, <https://assets.gov.ie/static/documents/programme-for-government-securing-irelands-future.pdf>
- Eurocarers (2023). *Eurocarers country profiles: Denmark*, Retrieved 18 May, 2026, <https://eurocarers.org/country-profiles/denmark/>
- European Commission (2012). *The 2012 ageing report: Economic and budgetary projections for the 27 EU Member States (2010–2060)*, Brussels: European Commission, <https://doi.org/10.2765/19991>
- European Commission (2015). *The 2015 ageing report: Economic and budgetary projections for the 28 EU Member States (2013–2060)*, Brussels: European Commission, <https://doi.org/10.2765/877631>
- European Commission (2024). *The 2024 ageing report: Economic and budgetary projections for the EU Member States (2022–2070)*, Brussels: The European Commission, <https://doi.org/10.2765/022983>
- Family Carers Ireland (2024). *Programme for Government 'Our Shared Future' family carer scorecard 2024*, Dublin: Family Carers Ireland, www.familycarers.ie/media/o2smnb4z/family-carer-scorecard-2024.pdf
- Fox, S., Kenny, L., Day, M.R., O'Connell, C., Finnerty, J., and Timmons, S. (2017). Exploring the housing needs of older people in standard and sheltered social housing, *Gerontol Geriatr Med*, 3, <https://doi.org/10.1177/2333721417702349>
- Fries, J.F. (1980). Aging, natural death, and the compression of morbidity, *N Engl J Med*, 303(3), 130–135, <https://doi.org/10.1056/NEJM198007173030304>
- Fumagalli, E., Pinna Pintor, M., and Suhrcke, M. (2024). The impact of health on economic growth: A narrative literature review, *Health Policy*, 143, 105039, <https://doi.org/10.1016/j.healthpol.2024.105039>
- Gimenez-Nadal, J.I., and Molina, J.A. (2020). *The gender gap in time allocation in Europe*, IZA Discussion Papers, No. 13461, Bonn: Institute of Labor Economics.
- Gruenberg, E.M. (1977). The failures of success, *The Milbank Memorial Fund Quarterly: Health Society*, 55(1), 3–24, <https://doi.org/10.2307/3349592>
- Hanly, P., and Sheerin, C. (2017). Valuing informal care in Ireland: Beyond the Traditional production boundary, *Econ Soc Rev*, 48(3), 28, <https://esr.ie/index.php/esr/article/view/773>

- Houses of the Oireachtas Committee on the Future of Healthcare (2017). *Sláintecare Report*, Dublin: Houses of the Oireachtas, <https://assets.gov.ie/22609/e68786c13e1b4d7daca89b495c506bb8.pdf>
- HSE (2018). *National guidelines & procedures for the standardised implementation of the home support service (HSS guidelines)*, Dublin: Health Service Executive.
- HSE (2025). *The Public Health Strategy 2025–2030*, Dublin: Health Service Executive, <https://about.hse.ie/publications/the-public-health-strategy-2025-2030/>
- Hu, B., Cartagena-Farias, J., Brimblecombe, N., Jadoolal, S., and Wittenberg, R. (2024). Projected costs of informal care for older people in England, *Eur J Health Econ*, 25(6), 1057–1070, <https://doi.org/10.1007/s10198-023-01643-1>
- Hu, B., Shin, P., Han, E.J., and Rhee, Y. (2022). Projecting informal care demand among older Koreans between 2020 and 2067, *Int J Environ Res Public Health*, 19(11), <https://doi.org/10.3390/ijerph19116391>
- Ipsos (2022). *Healthy Ireland Survey 2022: Summary report*, Dublin: Government of Ireland, www.gov.ie/en/healthy-ireland/publications/healthy-ireland-survey-2022/
- Ipsos B&A (2023). *Healthy Ireland Survey 2023: Summary report*, Dublin: Government of Ireland, <https://assets.gov.ie/277357/7ff5c433-4e1f-44ec-9d68-d0decc2ddd7c.pdf>
- Ipsos B&A (2025). *Healthy Ireland Survey 2025: Summary report*, Dublin: Government of Ireland, https://assets.gov.ie/static/documents/2b9f909b/Healthy_Ireland_Summary_Report_2025_Web_07.11.2025.pdf
- Ipsos MRBI (2015). *Healthy Ireland Survey 2015: Summary of Findings*, Dublin: The Stationery Office, <https://assets.gov.ie/static/documents/healthy-ireland-survey-2015-summary-of-findings-6086a75b-19f7-4d0b-b18b-207f064665af.pdf>
- Kalmijn, M. (2021). Long-term trends in intergenerational proximity: Evidence from a grandchild design. *Population, Space and Place*, 27, e2473, <https://doi.org/10.1002/psp.2473>
- Kearney, P.M., Cronin, H., O'Regan, C., Kamiya, Y., Savva, G.M., Whelan, B., and Kenny, R. (2011). Cohort profile: The Irish Longitudinal Study on Ageing, *Int J Epidemiol*, 40(4), 877–884, <https://doi.org/10.1093/ije/dyr116>
- Kreft, D., and Doblhammer, G. (2016). Expansion or compression of long-term care in Germany between 2001 and 2009? A small-area decomposition study based on administrative health data, *Population Health Metrics*, 14(1), 24.
- Lawton, M.P., Moss, M., Kleban, M.H., Glicksman, A., and Rovine, M. (1991). A two-factor model of caregiving appraisal and psychological well-being, *J Gerontol*, 46(4), 181–189, <https://doi.org/10.1093/geronj/46.4.p181>

- Levine, C., Halper, D., Peist, A., and Gould, D.A. (2010). Bridging troubled waters: Family caregivers, transitions, and long-term care, *Health Aff (Millwood)*, 29(1), 116–124, <https://doi.org/10.1377/hlthaff.2009.0520>
- Loughnane, C. (2024). *L&RS General Scheme Briefing Paper: Health (Amendment) (Licensing of Professional Home Support Providers) Bill*, Dublin: Houses of the Oireachtas, https://data.oireachtas.ie/ie/oireachtas/libraryResearch/2025/2025-05-28_general-scheme-briefing-paper-health-amendment-licensing-of-professional-home-support-providers-bill_en.pdf
- Manton, K.G. (1982). Changing concepts of morbidity and mortality in the elderly population, *Milbank Mem Fund Q Health Soc*, 60(2), 183–244, www.ncbi.nlm.nih.gov/pubmed/6919770
- Masterson, A.M., and Phillips, C.M. (2023). Active commuting associations with BMI and self-rated health: A cross-sectional analysis of the Healthy Ireland survey, *J Public Health (Berl.)*, 31, 1867–1874, <https://doi.org/10.1007/s10389-022-01752-w>
- McHugh, E., and Connolly, S. (2025). Remote consultations in general practice in Ireland: Who is missing out? *Telemedicine and e-Health*, 31(4), 468–475, <https://doi.org/10.1089/tmj.2024.0503>
- McGarrigle, C. (2025). ‘Family caring in later life: Prevalence, impact, and the need for policy support’, in O'Connor, D., Hever, A., Kenny, R.A., and Scarlett, S. (eds) *Shaping the future: Longitudinal trends and opportunities for transformation in health and social care in Ireland*, Dublin: TILDA, <https://doi.org/10.38018/TildaRe.2025-01>
- McGarrigle, C., and Kenny, R.A. (2020). *Receipt of care and caring in community-dwelling adults aged 50 years and over in Ireland: The Irish Longitudinal Study on Ageing*, Dublin: Trinity College Dublin, <https://doi.org/10.38018/TildaRe.2020-09>
- McGarrigle, C., Ward, M., De Looze, C., O'Halloran, A., and Kenny, R.A. (2022). Caring in the time of COVID-19, longitudinal trends in well-being and mental health in carers in Ireland: Evidence from the Irish Longitudinal Study on Ageing (TILDA), *Arch Gerontol Geriatr*, 102, 104719, <https://doi.org/10.1016/j.archger.2022.104719>
- Minister For Social Protection (2025). *Parliamentary questions and answers (521-540) - Social Welfare Benefits*. Oireachtas. www.oireachtas.ie/en/debates/question/2025-07-01/section/481/
- Mouchaers, I., Metzelthin, S., van Haastregt, J., Vlaeyen, E., Goderis, G., and Verbeek, H. (2023). Exploring the support and involvement of family caregivers for rehabilitation programs: A qualitative study, *J Multidiscip Healthc*, 16, 2993–3005, <https://doi.org/10.2147/JMDH.S424147>
- Murphy, A., Walsh, E. (2015). An economic analysis of informal care provision in Ireland, *Value in Health*, 18(7), [www.valueinhealthjournal.com/article/S1098-3015\(15\)03864-4/fulltext](http://www.valueinhealthjournal.com/article/S1098-3015(15)03864-4/fulltext)

- Nolan, A. (2014). *Public healthcare eligibility and the utilisation of GP services by older people in Ireland*, TILDA Research Briefs, Dublin: TILDA, https://tilda.tcd.ie/publications/research-briefs/pdf/2014_Research%20Brief_GP%20Utilisation.pdf
- Olshansky, S.J., Rudberg, M.A., Carnes, B.A., Cassel, C.K., and Brody, J.A. (1991). Trading off longer life for worsening health: The expansion of morbidity hypothesis, *J Aging Health*, 3(2), 194–216, <https://doi.org/10.1177/089826439100300205>
- O'Reilly, D., Connolly, S., Rosato, M., and Patterson, C. (2008). Is caring associated with an increased risk of mortality? A longitudinal study, *Soc Sci Med*, 67(8), 1282–1290, <https://doi.org/10.1016/j.socscimed.2008.06.025>
- O'Sullivan, D. (2019). *Mind the care gap: Exposing the health system's vulnerability to the gap between family care provision and anticipated demand*, Dublin: Oireachtas Library & Research Service, Houses of the Oireachtas, https://data.oireachtas.ie/ie/oireachtas/libraryResearch/2019/2019-04-02_spotlight-mind-the-care-gap-exposing-the-health-system-s-vulnerability-to-the-gap-between-family-care-provision-and-anticipated-demand_en.pdf
- Potter, D., Murphy, K., Sheridan, A., and De Barra, Y. (2025). *Annual report on migration and asylum 2023: Ireland*, ESRI Survey and Statistical Series 127, Dublin: Economic and Social Research Institute, <https://doi.org/10.26504/sustat127>
- Przywara, B. (2010). *Projecting future health care expenditure at European level: Drivers, methodology and main results*, Brussels: European Commission, http://ec.europa.eu/economy_finance/publications/economic_paper/2010/pdf/ecp417_en.pdf
- Qian, Y., Chen, S., Lin, Z., Yu, Z., Wang, M., Hou, X., and Chen, X. (2023). *The growing gap of unmet need: Assessing the demand for, and supply of, home-based support for older adults with disabilities in 31 countries*, IZA Discussion Papers No. 16411, IZA Institute of Labor Economics, www.jstor.org/stable/resrep57477
- Rocard, E., and Llena-Nozal, A. (2022). *Supporting informal carers of older people: Policies to leave no carer behind*, OECD Health Working Papers No. 140, Paris: OECD, <https://doi.org/10.1787/0f0c0d52-en>
- Roth, D.L., Fredman, L., and Haley, W.E. (2015). Informal caregiving and its impact on health: A reappraisal from population-based studies, *Gerontologist*, 55(2), 309–319, <https://doi.org/10.1093/geront/gnu177>
- Russell, H., Grotti, R., McGinnity, F., and Privalko, I. (2019). *Caring and unpaid work in Ireland*, Dublin: ESRI and The Irish Human Rights and Equality Commission (IHREC), <https://doi.org/10.26504/bkmnext382>
- Russell, H., and Smyth, E. (2024). *Caregiving among young adults in Ireland*, ESRI Research Series 168, Dublin: Economic and Social Research Institute, <https://doi.org/10.26504/rs168>

- Schulz, R., and Beach, S.R. (1999). Caregiving as a risk factor for mortality: The Caregiver Health Effects Study, *JAMA*, 282(23), 2215–2219, <https://doi.org/10.1001/jama.282.23.2215>
- Schulz, R., Beach, S.R., Czaja, S.J., Martire, L.M., and Monin, J.K. (2020). Family caregiving for older adults, *Annu Rev Psychol*, 71, 635–659, <https://doi.org/10.1146/annurev-psych-010419-050754>
- The Eurocare Team (2024). Later-life caring in Europe, <https://doi.org/10.5281/zenodo.11199206>
- Timonen, V., and Doyle, M. (2008). From the workhouse to the home: Evolution of care policy for older people in Ireland, *International Journal of Sociology and Social Policy*, 28(3/4), 76–89, <https://doi.org/10.1108/01443330810862151>
- Urwin, S., Lau, Y.S., Grande, G., and Sutton, M. (2021). The extent and predictors of discrepancy between provider and recipient reports of informal caregiving, *Soc Sci Med*, 277, 113890, <https://doi.org/10.1016/j.socscimed.2021.113890>
- Verbakel, E., Tamlagsrønning, S., Winstone, L.; Fjær, E.L., and Eikemo, T.A. (2017). Informal care in Europe: findings from the European Social Survey (2014) special module on the social determinants of health, *European Journal of Public Health*, 27, 90–95, <https://doi.org/10.1093/eurpub/ckw229>
- Verbakel, E., Metzelthin, S.F., and Kempen, G. (2018). Caregiving to older adults: Determinants of informal caregivers' subjective well-being and formal and informal support as alleviating conditions, *J Gerontol B Psychol Sci Soc Sci*, 73(6), 1099–1111, <https://doi.org/10.1093/geronb/gbw047>
- Walsh, B., and Kakoulidou, T. (2025). *Projections of national demand and bed capacity requirements for older people's care in Ireland, 2022–2040: Based on the Hippocrates model*, ESRI Research Series 214, Dublin: Economic and Social Research Institute, <https://doi.org/10.26504/RS214>
- Ward, M., Clarke, N., Wang, M., McGarrigle, C., De Looze, C., O'Halloran, A., and Kenny, R. (2021). *Study protocol for TILDA COVID-19 survey. Altered lives in a time of crisis: preparing for recovery from the impact of the COVID-19 pandemic on the lives of older adults* [version 1; peer review: 1 approved], HRB Open Research 4, <https://hrbopenresearch.org/articles/4-51>
- Whelan, B. (1979). RANSAM: A random sample design for Ireland, *Economic and Social Review*, 10(2), 169–174.
- World Health Organization (2024). *State of long-term care in Ireland*, Copenhagen: World Health Organization, www.who.int/europe/publications/i/item/WHO-EURO-2024-10367-50139-75516
- Wren, M.A., Keegan, C., Walsh, B., Bergin, A., Eighan, J., Brick, A., Connolly, S., Watson, D., and Banks, J. (2017). *Projections of demand for healthcare in Ireland, 2015–2030. First report from the Hippocrates Model*, ESRI Research Series 67, Dublin: Economic and Social Research Institute, <https://doi.org/10.26504/rs67>

Zimmerman, S., and Sloane, P.D. (2007). 'Long term care', in Birren, J. (ed.)
Encyclopedia of gerontology, Elsevier,
www.sciencedirect.com/science/article/abs/pii/B0123708702001165



**Economic & Social Research
Institute**

**Whitaker Square
Sir John Rogerson's Quay
Dublin 2**

**Telephone: +353 1 863 2000
Email: admin@esri.ie
Web: www.esri.ie**

**An Institiúid um Thaighde
Eacnamaíochta agus Sóisialta**

**Cearnóg Whitaker
Cé Sir John Rogerson
Baile Átha Cliath 2**

**Teileafón: +353 1 863 2000
Ríomhphost: admin@esri.ie
Suíomh Gréasáin: www.esri.ie**

