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ESRI ECONOMIC & SOCIAL RESEARCH INSTITUTE

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF ABBREVIATIONS

AROP	At-risk-of-poverty rate
CSO	Central Statistics Office
HCCI	Home and Community Care Ireland
HRB	Health Research Board
HSE	Health Service Executive
iHCP	Intensive Home Care Package
LTRC	Long-term residential care
NHSS	Nursing Homes Support Scheme ('Fair Deal')
NHS	National Health Service (UK)
TILDA	The Irish Longitudinal Study on Ageing
SAT	Single Assessment Tool
PCRS	Primary Care Reimbursement Service
PRSI	Pay-related social insurance
SILC	Survey of Income and Living Conditions
SWITCH	Simulating Welfare, Income Tax, Childcare and Health policies
USC	Universal social charge

EXECUTIVE SUMMARY

A new statutory scheme for the provision of home support services is currently being developed by the Department of Health. Research has shown that access to home support services varies across the country. The new scheme aims to tackle this issue to ensure equitable access to home support services nationwide and is part of wider reform of Ireland's health and social care systems as envisaged in the *Sláintecare* report and Department of Health action plans.

Publicly funded home support services in Ireland are currently provided free of charge for recipients, unlike long-term residential or nursing home care, which involves a contribution from residents. In 2019, the HSE's Older Persons' Services provided care to 53,000 people at a cost of €440 million. It is anticipated that demand for home support services may increase under the new scheme, for example if unmet demand is met or if the new scheme results in more people being able to remain in their own home, substituting away from long-term residential care. Any increased demand would result in an increased cost, which may also rise as the population ages. This report examines the possible introduction of co-payments for home support services. We focus on the likely Exchequer impact of a range of different funding scenarios along with the distributional, poverty and inequality impacts of such charges. Due to data limitations, and the fact that the majority of home support services are provided to older age groups, we focus on those aged 65 years and over. Regarding co-payments we examine the impact of flat-rate charges for users, regardless of means, as well as co-payments for home support recipients above a variety of income levels. The tapering of payments is also examined to ensure that individuals just over a specific income threshold would see co-payments gradually increasing as their income rises. We also consider the capping of co-payments so that those needing a high number of home support hours would not potentially face very high costs.

Under the scenarios examined, recipient contributions could provide up to 19 per cent of the total cost of home support services for those over 65. While demand for the scheme is likely to increase if it addresses unmet needs for care, the introduction of co-payments may drive down demand; therefore, the impact on demand is uncertain and these results are based on current home support usage. Unsurprising, a flat-rate charge of €5 per home support hour for all home support recipients would be regressive as such a charge fails to take into account an individual's income and charges low-income home support recipients the same as those in receipt of higher incomes. The vast majority of the co-payment options examined are, however, progressive, taking more from those on higher incomes. In fact, most of the schemes examined result in no charges for the lowest two income quintiles and a progressive pattern for the remaining three income

quintiles. The capping of payments, which would place a cap on the amount an individual is expected to contribute, would ensure that those with a higher need for home support would not potentially face extremely high charges. Some scenarios examined would result in the poverty rate among older people increasing by 1.4 per cent, specifically a flat-rate hourly payment of €5 or those with means above the medical card limit facing the full €26.60 hourly cost of home support. The remaining scenarios examined result in only a very small (around 0.2 per cent) increase in poverty among older people, reflecting the progressive distributional pattern found for these scenarios. Overall, inequality impacts are minimal.

These findings are based on the assumption that the value of a person's home is not taken into account in the means test. If the value of a person's primary residence is included in the definition of means for the scheme, the results are likely to differ substantially: such a move would generate significantly more for the Exchequer towards the cost of home support but would result in regressive distributional impacts under all the scenarios examined and most scenarios would lead to large increases in the poverty rate among older people, reflecting the fact that individuals may be 'asset rich' but 'cash poor'.

Finally, a data system capturing home support needs and usage, along with a person's means, will be required if co-payments are to be introduced. Better centralised administrative information on home support usage could also be used to enable us to more precisely model the impact of potential co-payments and allow us to expand the analysis to younger age groups in receipt of home support.

CHAPTER 1
Introduction

The Health Service Executive (HSE) funds home support hours for those needing assistance with everyday tasks across a number of different schemes that encompass disability services and services for older people. The current schemes that exist for older people are need dependent and are provided free of charge. The 2017 *Sláintecare* report (Houses of the Oireachtas Committee on the Future of Healthcare, 2017) proposed a new statutory home support scheme and reference to such a revised scheme was also included in the 2020 'Programme for Government' (Department of the Taoiseach, 2020). In July 2020, the Covid-19 Nursing Homes Expert Panel (Frazer et al., 2021) also emphasised the need to place home support on a statutory footing and recommended that home support services be expanded and prioritised.

The Department of Health is currently developing a new statutory scheme for the financing and regulation of home support services. Professional home support has been an important aspect of health and social care in Ireland since the 1970 Health Act but there has never been a statutory scheme in place. This differs from the support for those entering long-term residential care (LTRC), with the Nursing Homes Support Scheme (NHSS or 'Fair Deal') having provided a statutory basis for the financing of LTRC since 2009. The aim of the statutory home support scheme will be to allow people to continue to live independently at home for as long as possible. As discussed in Smith et al. (2019), access to the home support services currently provided by the HSE's Older Persons Services varies across the country. The new scheme will seek to address this issue and provide equitable access to home support services based on a person's assessed care needs regardless of where they reside. It is intended that the new scheme will integrate effectively with other health and social care services, such as primary care, community-based therapy services and the NHSS. This work is integral to the broader reform of Ireland's health and social care system, as envisaged in the *Sláintecare* report and recent implementation and action plans published by the Department of Health. The *Sláintecare Implementation Strategy and Action Plan 2021–2023* (Government of Ireland, 2021) commits to the implementation of a statutory home support scheme starting in 2022 and to its continued implementation in 2023. Work is ongoing in the Department of Health on the development of a reformed model of service delivery for home support, the regulation of home support providers, and the development of a funding model for the proposed new scheme. This report aims to inform the latter component of this work.

It is anticipated that demand for home support services may increase under the new scheme, which will result in increased expenditure on home support. Walsh and Lyons (2020) outline the various mechanisms in which increased demand may

occur. For example, the new scheme may result in a substitution away from LTRC, an increase in use among people with support needs who are currently being cared for by unpaid family carers and a reduction in unmet demand (e.g. waiting lists) for currently existing supports. This increase in demand for home support due to a statutory scheme also needs to be understood in the context of demographic changes in Ireland: even without such a scheme, demand for home support services are projected to increase substantially due to the ageing of the population (Walsh et al., 2021).

This report follows on from work by Walsh and Lyons (2021) and Walsh et al. (2021), which examined the current and potential demand for the new statutory home support scheme for older people (aged 65 and over). It seeks to complement that work by providing information on the Exchequer and distributional impact of a range of financing models for the new scheme. Currently, public home support services are provided free of charge for recipients. However, within a new scheme where demand, and thereby expenditure, is likely to increase substantially, one way to increase funding available for the scheme would be to introduce user co-payments for some or all recipients. This would put the home support scheme in a similar footing to the NHSS, whereby residents funded through that scheme pay for some of the cost of the care they receive. Therefore, in this report, we examine the extent to which co-payments may reduce some of the overall expenditure on the scheme. Using SWITCH (Simulating Welfare, Income Tax, Childcare and Health policy), the ESRI tax-benefit model, we examine some potential co-payment options to estimate how these out-of-pocket payments would affect the Exchequer cost of the new statutory home support scheme. As co-payments will affect people across the income distribution in different ways, we also examine the distributional impact of the options examined, along with potential impacts on poverty and inequality.

This report concentrates on the expenditure aspect of a new scheme for the older population. We acknowledge that other aspects are of key importance in the development of a successful home support scheme. Factors such as availability of the home support workforce to provide the necessary care, regulatory requirements of the sector, and the capacity of such a scheme to provide recipients with high quality care that meets their individual needs will all be key to its success. Furthermore, home support is a key component of care for many children, as well as and younger adults. Though beyond the scope of this study, it is vitally important that further research is conducted to inform all of these areas.

The report continues as follows. Chapter 2 discusses current home support provision in Ireland. Chapter 3 describes the data and methodology used and Chapter 4 presents the findings of the research, detailing the Exchequer,

distributional, poverty and inequality impacts of alternative funding options. Chapter 5 concludes.

CHAPTER 2

Home support services

Home support structures differ considerably across countries. Home support in Ireland follows a family-based structure, in this way differing from Nordic and other northern European countries where professional home support plays a larger role (Ilinca et al., 2015; Hanly and Sheerin, 2017; Kiersey and Coleman, 2017). Here, families are, by a distance, the main providers of care to people, including for those who receive professional home support.

The Health Service Executive (HSE) provides home support and personal assistance to children and adults needing care through a number of schemes. The HSE Home Support Service,[1] provided by the HSE's Older Persons Services, is available to people aged 65 and over who may need support to continue to live at home as well as, in exceptional cases, to 'people younger than 65 who may need support' due, for example, to 'early onset dementia or a disability'.[2] The scheme mainly provides support for those who need assistance with everyday tasks. The disability services within the HSE's Social Care Division provide home support hours for people under 65. Following Walsh and Lyons (2021), due to data limitations, we limit the analysis in this report to home support for older people as there is no reliable source of survey data capturing usage of home support for younger age groups.

A recent Health Research Board (HRB) review examined different approaches to regulating and financing professional home support in Germany, the Netherlands, Scotland and Sweden (Kiersey and Coleman, 2017). The report highlighted differences across countries in terms of financing, noting that Germany and the Netherlands have well established long-term care insurance schemes that facilitate home support financing. Both countries also have co-payments mechanisms for home support, with this meeting 13 per cent of the cost of home support in Germany and ten per cent in the Netherlands. In both countries, the amount of co-payments paid by the individual is means tested. In Scotland and Sweden, the State is the primary source of funding for home support (Kiersey and Coleman, 2017). Local authorities in Scotland are responsible for dispersion of both funds and supply. In Sweden, while co-payments do exist, they constitute less than five per cent of home support expenditure. A monthly cap of less than €200 is in place for recipients and co-payments are linked to recipient income and the number of support hours received (Kiersey and Coleman, 2017). One key finding of this HRB review was that need, as opposed to the ability to pay, was an underlying feature

1 This formerly consisted of the Home Help Service and the Home Care Package Scheme.
2 HSE, 'Home Support Service for Older People', see https://www.hse.ie/eng/home-support-services.

of home support in each country. Each country had formal needs assessment criteria for eligibility to aid equitable distribution of services. While co-payments existed to some degree in each country, they were minimal and were linked to income and ability to pay, and the State was significantly the main funder of home support. This is similar to the situation in Denmark, which was an early adopter of care for older people being centred on home support. Like other Nordic countries, all citizens are eligible for home support, with no co-payments within the public model. The Danish system has also evolved to better integrate services and accommodate other services that take care of home recipient needs, such as home adaptation. In England, where healthcare is provided free at the point of access via the National Health Service (NHS), co-payments for home support and private purchasing of home support are common, and the sector is predominantly based upon private provision of care (Glendinning, 2012), which is at odds with the model of healthcare provided through the NHS.

Home support in Ireland, funded through the HSE's Older Persons Services, consists of two services – the Home Support Service and the intensive Home Care Package (iHCP).[3] The former generally covers non-personal and personal care such as cleaning, cooking, shopping, bathing and dressing. Many people who receive home support through this scheme also receive more medical and therapy-based care from community therapists and public health nurses, for example, in combination with their support package. The iHCP is a newer, more targeted scheme. It provides a more intensive care package for people with high needs and can often confer a significant number of weekly hours on a recipient. In 2019, the dominant Home Support Service provided care to around 53,000 people, at a cost of €440 million, while there were only 235 iHCP recipients.[4] In addition, many people purchase home support privately as a substitute for, or complement to, the public home support schemes (Carter et al., 2020).

Home support is provided by a range of bodies – the HSE itself, along with the voluntary sector and private providers. Private providers are funded both by the HSE through the provision of publicly funded home support and by individuals who purchase home support privately. HSE-funded services (provided either by the voluntary sector, private providers or the HSE directly) are currently free of charge but access to them varies by region, depending on local supply levels (Smith et al., 2019). Access to support is impacted by geographic location and unmet demand for care reflects socioeconomic inequalities. Smith et al. (2019) found wide differences in the supply of public home support across counties. As of September

[3] We provide a brief summary of the current Home Support Service in this section; for more detailed information on the schemes and their evolution over time, see Walsh and Lyons (2021).

[4] See https://www.hse.ie/eng/services/publications/national-service-plan-2020.pdf.

2021, 5,326 people were on a waiting list for home support from Older Person's Services. Privalko et al. (2019) found evidence of unmet need among both those currently receiving professional care hours and those not currently receiving hours. They also found a link between social class and usage of professional home support – of those containing a household member with a need for assistance, 34 per cent of high social class households reported receiving professional home support compared to 18 per cent of those in the middle social class and 21 per cent of those in the lowest social class,[5] suggesting that those in the higher social class may be financially better able to secure home support hours privately through the market. This is underpinned by findings from Walsh and Lyons (2021) that show while public home support rates are much higher in lower income and educational attainment groups, private home support rates can often be higher in higher income and educational attainment groups.

There is evidence from Ireland, and internationally, that older people in need of support services have a clear preference to stay in their own home for as long as possible (Costa-Font et al., 2009; Fried et al., 2000; Donnelly et al., 2016; Walsh et al., 2020). Where appropriate care is available, home support has clear benefits for the health of recipients. Recent survival analyses research points to life expectancy being higher for those who remain in their own homes compared to those who enter residential care settings (the main substitute for many people), even after controlling for health states and functional ability (Brent, 2021). In Ireland, availability of home support has been shown to enable people within hospital settings to return home quicker (Walsh et al., 2021). However, the evidence is ambiguous when it comes to home support reducing health and social care resource use and costs more generally. Evidence from countries such as the US (Huckfeldt et al., 2014), England (Fernandez and Forder, 2008), Switzerland (Gonçalves and Weaver, 2017) and Spain (Costa-Font et al., 2018) shows that home support may not reduce other health and social care service usage and, subsequently, expenditure. This is partly due to many home support recipients being high users of health and social care services (Walsh and Lyons, 2021). The arising need to understand the expenditure implications of a new statutory home support scheme and to identify options available to policymakers forms the rationale for this research.

[5] 'High social class' is composed of managerial and professional occupations (manager, doctor, solicitor, teacher, nurse); 'middle social class' is composed of technical, white collar occupations (clerical workers, lab technician) as well as farming and non-farming self-employed; 'lowest social class' consists of those who were never employed, the skilled/semi-skilled/un-skilled manual and routine non-manual occupations (e.g., shop assistant, taxi driver, carpenter, labourer, cleaner).

CHAPTER 3

Data and methodology

3.1 THE SWITCH MODEL

This analysis uses SWITCH (Simulating Welfare, Income Tax, Childcare and Health policies), the ESRI's tax and benefit microsimulation model.[6] SWITCH is run on data from the 2017 Survey of Income and Living Conditions (SILC), the primary source of representative information on household incomes collected annually by the Central Statistics Office (CSO).[7] Income information such as earnings, occupational pensions and social welfare receipt are taken from administrative sources (Revenue and the Department of Social Welfare) for the majority of SILC respondents. The data are used in the model and adjusted to be representative of the 2021 population in terms of income levels, for example by adjusting incomes upwards in line with income inflation between 2017 and 2021. Given that it is anticipated that the scheme will be rolled after the COVID-19 pandemic has subsided, we retain the pre-pandemic employment structure: we do not include COVID-19-related job and income losses.[8] The SWITCH model is also used in a variety of government departments to analyse the cost and distributional impacts of actual and potential policy changes. Our analysis focuses on a variety of outcomes – the Exchequer impact of various funding options, the distributional impact of co-payments along with the impact on poverty among older people and overall inequality.

3.2 HOME SUPPORT USAGE

In this report, we focus on the population aged 65 years and over, as per Walsh and Lyons (2021). While national statistics on the provision of home support by age group are not available, home support is generally, though not exclusively, provided to those aged 65 years and over (Wren et al., 2017). Walsh and Lyons (2021) estimate that at least 90 per cent of those in receipt of home support funded by the HSE's Older Persons Services are aged 65 years and over. Numerous studies using HSE and TILDA (The Irish Longitudinal Study on Ageing) data have found the median age of these home support recipients to be approximately 83 years (Aspell et al., 2019; Walsh and Lyons, 2021; Walsh et al., 2021). We therefore

6 SWITCH stands for 'simulating welfare, income tax, childcare and health benefits'.

7 For more information on SILC, see https://www.cso.ie/en/aboutus/takingpartinasurvey/surveysofhouseholdsindividuals/surveyonincomelivingconditions/.

8 This is also more realistic given that our focus is on the over 65 population whose incomes were more shielded from the pandemic as the majority of this group are retired.

are confident we will capture the vast majority of home support recipients in our analysis. Another reason for focusing on this age group is the fact that individual-level survey data exist that capture home support usage among over 65s (see more below). There is currently no individual-level data source capturing home support usage among younger age groups that would allow us to include them in our analysis. If individual-level administrative data capturing home support use across all age groups were to become available, it may be possible to integrate these data into the SWITCH model and to extend this work in the future.

As discussed in Walsh and Lyons (2021), it is intended that the services provided through the new home support scheme will be accessible to all those aged 18 and over based on their assessed care needs. These needs will primarily be assessed using the InterRAI Single Assessment Tool (SAT), which will use information on health, wellbeing and the social support of the person needing care. It is intended to develop a system of care bands, which will be used to place an individual in a care band in line with their assessed need. Given that this tool is yet to be rolled out nationally, and that the detailed health information needed by the tool is not available in the SILC data that underpin the SWITCH model, in assessing care need we instead rely on current public home support hours usage.[9] While our main focus is on providing evidence for a publicly funded home support scheme, there may be substitutability between publicly and privately funded home support hours. Therefore, we are also interested in estimating privately funded home support hours to allow us to analyse home support more generally and different home support usage scenarios discussed in the next sub-section.

SILC 2017, whose focus is on incomes, does not include any data on the use of home support. TILDA data do contain detailed information on home support usage among those over 50. Specifically, that study captures whether people receive publicly funded ('public') home support or privately funded ('private') home support, and the number of hours of public home support that they receive. A special module of SILC, carried out in 2016, provides information on home support use but does not contain detailed information on precise hours used or differentiate between publicly and privately funded hours (for a more detailed analysis of this module, see Privalko et al., 2019). We therefore use statistical matching, a commonly used technique for integrating variables from two data sources related to the same target population.[10]

9 Current support hours are based on home support usage in advance of the new scheme being implemented. Current usage is imputed from TILDA Waves 2–4 and SILC 2017 as described in more detail in this section.

10 See Kuypers et al. (2017) for an example of imputing wealth information into EUROMOD, the European Commission's tax-benefit microsimulation model.

We use three regressions to impute the following variables:

- usage of any kind of home support (public or private);
- selection into private home support; and
- the number of hours of public home support utilised by those availing of public home support.

We identify those in TILDA in receipt of public home support, and the number of hours used per day, from the following questionnaire question:

> *"On the days when [you/he/she] received help from the Home Care Package, for about how many hours per day did [you/he/she] receive help?"*

We also identify those utilising private home support in TILDA – there is no information about the number of private hours used − from the following question:

> *"In the last 12 months, did [you/name] pay any individual or private company to provide home help or personal care?"*

This is very comparable to the information obtained in the SILC 2016 module, although in SILC, aggregate usage of home support, both private and public, is revealed by the following questions:

> *"Is there anyone usually resident in the household that usually needs help due to long-term physical or mental ill-health, infirmity or because of old age?"*
>
> *"Does the person (or persons) concerned usually receive any home care services provided by professional health or care workers?"*
>
> *"For how many hours per week are such home care services usually provided by professional health or care workers?"*

For the first imputation, usage of any kind of home support, we impute usage in SILC 2017 using home support usage available from the special, one-off module available from SILC 2016. SILC also has detailed geographical information, in the form of eight NUTS3 regions, which ensures our imputations will match average realised demand levels across the country.[11]

We impute realised demand for any type of home support as the public or private breakdown is not specified in SILC − although 85 per cent of households availing of home support paid no user fee (in 2016–2017), indicating that public provision is the dominant mode of delivery. This compares favourably with Walsh and Lyons

[11] NUTS stands for 'nomenclature of territorial units for statistics'.

(2021) who estimated that 82 per cent of home support recipients receive public only, or public and private, home support (in 2019).

Equation 1 shows how we derive estimated values for home support usage in SILC 2016. $Home\ support$ is a binary variable, with '1' indicating household j avails of home support in order to aid a household member who suffers from old-age-related decline in physical or mental capacities. This is regressed onto a series of fixed effects in the NUTS3 region, age of the oldest household member (55 to 60, 60 to 65, etc.), household size (one to five plus) and a measure of limitations in daily activities (none, mild, severe). The latter variable is used as a proxy for d-ADL (difficulties with activities of daily living) a key determinant of home support need. We use these estimated regression coefficients to predict the probability that individuals availed of home support in SILC 2017–2020.[12] Once we have predicted these probabilities, we rank them in centiles based on their likelihood of home support (1 being the lowest likelihood and 99 being the highest). We then calibrate the portion availing of home support in five-year age bands to match the observed portion in the age band availing of care from Waves 2 to 4 of TILDA. For example, if 40 per cent of individuals aged 85 years and over avail of home support in TILDA, we impose that those in the top 40 per cent of predicted probabilities among the 85+ group in SILC 2017 avail of home support. Age distribution in Waves 2 to 4 of TILDA has been shown by Walsh and Lyons (2021) to compare favourably with administrative data from the HSE and Aspell et al. (2019), increasing our confidence in this approach. In this way, the imputations from regressions act as a ranking mechanism and the estimated population levels from TILDA are used as a calibration tool.

1. $Home\ Support_j = f(Region_j, Age_i, Size_j, Limitations_i)$

After binary usage of home support has been established, as shown in Equation 2, we then predict selection into private home support usage by regression methods from TILDA Waves 2–4, as TILDA contains separate information on public and private home support use. For home support recipients, we regress a dummy variable for those availing of private home support on: a quadratic in age; a quadratic of age interacted with gender; marital status; a fixed effect for being limited in daily activities (none, mild, severe); a fixed effect in educational attainment (primary or less, completed second-level education, and tertiary); a dummy variable for whether an individual was admitted to hospital as an in-patient in the past 12 months;[13] and a trend in household income quintile.[14] We include

12 We estimate regressions for those aged 55 years and over, but in the analysis we only focus on those aged 65 years and over, as this represents the majority of those in receipt of home support.

13 As home support packages are common post-hospital discharge.

14 Calculated based on household, equivalised income.

this income control to help capture the social inequalities that exist in access to care, as found by Privalko et al. (2019) and Walsh and Lyons (2021). After estimating these regression coefficients, we then estimate the predicted values in SILC 2017. Once again, we use the observed portion of a five-year banded age cohort availing of private home support from TILDA to calibrate the portion of individuals in SILC we assign to private home support. As before, the predicted values imputed in SILC 2017 are used to rank individuals in a given cohort most likely to be availing of private home support.

2. $Private\ Home\ Support_i = f(\ AgeSquared_i, Gender_i, AgeSquared_i * Gender_i, Limitations_i,\ Married\ _i, PHI_i,\ Educ_i, Hospital_i, IncomeQuintile)$

$$if\ Home\ Support_i = 1$$

Our next step is to assign individuals to public home support. As individuals can avail of both private and public home support simultaneously, the portion of a given age cohort availing of home support will be less than the sum of those in private and public home support when considered separately. As shown in Equation 3, we allow for an intersection of private and public home support by randomly assigning those modelled as in home support after imputation via Regression 1 to avail of public home support. We do so by assigning a random uniform variable with a range of 0 to 1 to those imputed as availing of home support. If this random variable is less than the share of an age cohort availing of public home support based on TILDA data, we model said individual as availing of home support. In this way, we use observed home support usage in TILDA to calibrate the imputed values in SILC 2017. Those modelled as being in receipt of public home support then have their daily hours of home support predicted based on the coefficients of Equation 3, which we carry out in TILDA for those availing of public care. This regression is very similar to that outlined in Equation 2 except for the exclusion of a trend in income quintile, as income is likely a more relevant factor for private demand rather than public hours.

3. $Public\ Home\ Support\ Hours_i = f(\ AgeSquared_i, Gender_i, AgeSquared_i * Gender_i, Limitations_i, Married\ _i, PHI_i,\ Educ_i, Hospital_i)$

$$if\ Public\ Home\ Support_i = 1$$

At this point we have pseudodata on those in home support, both public and private, and the daily hours used of public home support. These data closely match those in TILDA, Aspell et al. (2019) and Walsh and Lyons (2020) in terms of age/sex distribution. To annualise the usage of public home support, we then multiply the daily predicted hour of public home support by 13.68 – the average number of days per month people reported availing of home support in TILDA. This monthly figure is then multiplied by 12 to reach a per annum aggregate.

Table 3.1 summarises how the imputation of home support usage into SWITCH compares with actual usage in TILDA. In both surveys, home support usage is low among those under 65, at just over one per cent in TILDA and less than one per cent in SWITCH, which reinforces our decision to focus only on those aged 65 and older in our analysis. Estimates of home support usage tend to be lower in SWITCH for the 66-70 age cohort, at one per cent, compared to 3.3 per cent in TILDA. The same goes for those aged 71-75 years, where SWITCH estimates that 2.5 per cent of the cohort avail of home support compared to the 4.7 per cent in TILDA. Given the low overall usage of care in the 66-75 age group, these differences are small in absolute terms. For the oldest cohorts, where home support demand will likely be strongest, and current usage is more common, home support usage rates are very comparable, with close to ten per cent of those aged 76-80, in both SWITCH and TILDA, availing of care. The home support coverage among those aged 81-85 years is also very comparable – 18 per cent in TILDA and 21.3 per cent in SWITCH, while SWITCH is slightly higher for those aged over 85, at 50 per cent compared to 42 per cent in TILDA. Overall, the home support usage patterns are similar across age groups, with most of the differences across age groups being attributed to usage of exclusively private home support. These tend to be lower in SWITCH up to the 71-75 age category, while for those aged 75 years and over, SWITCH finds a higher portion of private-only home support usage.

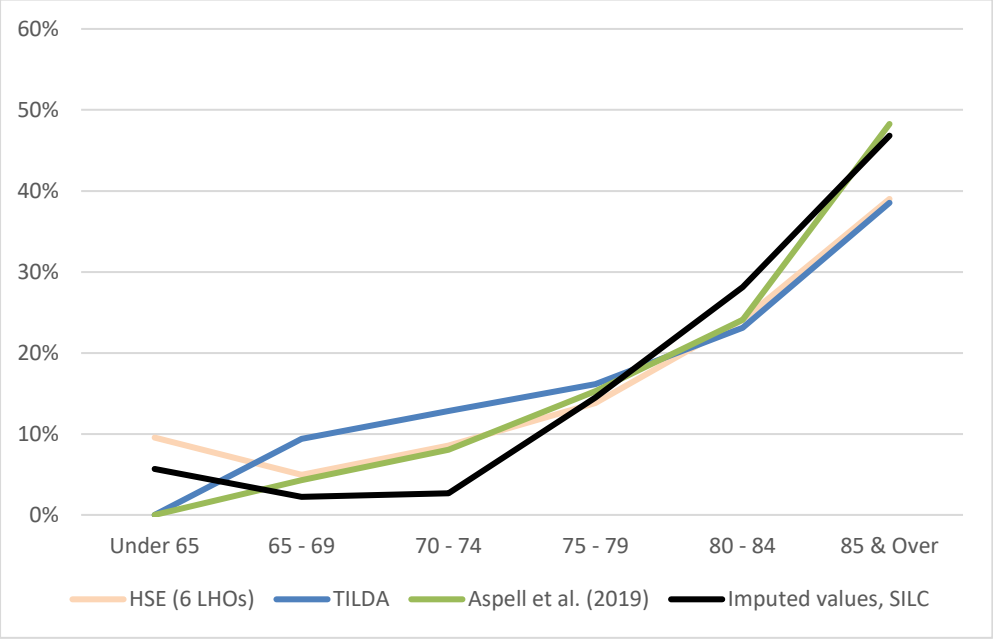
TABLE 3.1 PORTION OF AGE COHORTS AVAILING OF HOME SUPPORT, PUBLIC AND PRIVATE CARE

	TILDA, Waves 2–4				SWITCH, imputed values			
Age	Any (%)	Public (%)	Private (%)	Dual users (%)	Any (%)	Public (%)	Private (%)	Dual users (%)
55-60	1.1	0.6	0.8	0.3	0.7	0.5	0.6	0.4
61-65	1.3	1.1	0.5	0.3	0.8	0.6	0.2	<0.1
66-70	3.3	2.4	1.9	1.1	1.0	0.7	0.4	0.1
71-75	4.7	3.1	2.5	0.9	2.5	1.6	1.1	0.1
76-80	9.7	7.8	4.7	2.9	10.0	9.4	6.1	5.5
81-85	18.0	15.2	7.6	4.8	21.3	19.9	12.5	11.1
>85	42.0	36.4	19.5	13.9	50.8	44.3	30.7	24.2

Source: Own calculations using TILDA Waves 2–4 and SILC 2017.
Note: Survey weights applied.

As an additional robustness check, Figure 3.1 shows the proportion of different age groups estimated to be in receipt of public home support, based on the imputation process just described (see the series in black) and various other sources. It shows that our imputation of the proportion of each age group that receives home support hours compares favourably to other sources, particularly in the older (75+) age groups, where higher proportions receive home support. Some of the variation across the sources may also relate to the data being collected at varying time periods.

FIGURE 3.1 PERCENTAGE OF HOME SUPPORT RECIPIENTS BY AGE GROUP: AGES 65+



Source: TILDA Waves 2-4: Walsh and Lyons (2021); HSE (6 LHOs): HSE Social Care Division; Aspell et al. (2019); imputed values, SILC: Own estimates.
Note: Survey weights applied.

In Table 3.2, we document how usage of imputed daily public home support hours compare in TILDA and SWITCH. Up to the 90th percentile of home support recipients, SWITCH and TILDA are very comparable, with a mean usage of 1.96 hours in TILDA compared to 1.66 hours for those aged 65 years and over in SWITCH. At the 90th percentile, the TILDA and SWITCH values begin to diverge for those aged 65 years and over − at five in TILDA and 2.6 in SWITCH. The gap widens at the 99th percentile, with TILDA at 20 hours and SWITCH at 3.3 hours. This highlights that SWITCH can match the distribution of public home support hours well, up the top five to ten per cent of users. It suggests that the imputation of public home support hours for very high users is problematic, implying that while the variables controlled for in Equation 3 do a good job in estimating public home support hours for the majority, they do not fully capture the hours used by those with very high demand/needs.

Overall, we estimate that, in 2017, 15.3 million public hours are used by those aged 65 years and over – this compares to 16.3 million estimated to have been provided by the HSE in 2017.[15] This ratio of 94 per cent compares favourably given that SILC captures the private household population at a point in time and annualises their home support hours, while the HSE figures capture total receipt of home support hours over a full year. Those aged 65 and over living in LTRC homes will not be captured in SILC (as it is a survey of private households only); this partly explains the discrepancy, as eight per cent of those receiving home support are admitted to a LTRC in a 12-month period (see Aspell et al., 2019)

[15] See https://www.hse.ie/eng/services/publications/serviceplans/national-service-plan-2018.pdf.

TABLE 3.2 DISTRIBUTION OF PUBLIC DAILY HOME SUPPORT HOURS

	TILDA	SWITCH, >=55	SWITCH, >=65
Minimum	0.25	0.68	0.675
p5	1	0.9	0.9
p10	1	0.98	0.97
p25	1	1.35	1.35
Median	1	1.7	1.66
Mean	1.96	1.91	1.72
p75	2	2.16	2.03
p90	3	2.74	2.55
p95	5	4.44	2.7
p99	20	6.06	3.34
Max	24	6.1	4.47
Annual total		**18,101,405**	**15,310,724**

Source: TILDA Waves 2-4 and own calculations using SWITCH.
Note: Survey weights applied.

As discussed in Walsh and Lyons (2021), the establishment of a statutory home support scheme may well affect demand for public home support hours. There are a number of reasons as to why demand might increase. Firstly, there is currently an unmet need for public home support hours, as evidenced by waiting lists. Privalko et al. (2019) found unmet need for home support hours both among people not receiving home support and those already in receipt of hours, which suggests that even those people currently receiving hours may require more. This is also demonstrated by the fact that 13 per cent of those on a waiting list for public home support hours are already receiving them and awaiting additional hours. As discussed in Chapter 2, geographical and financial constraints also have a role to play. Privalko et al. (2019) highlight that, within Europe, the majority of people who report a need for assistance report not receiving professional home support. In Ireland, only 24 per cent of those reporting a need for help in the household received professional home support, which likely indicates a strong reliance on unpaid family carers. The new scheme may relieve some of the pressures on family carers by increasing the number of professional home support hours that recipients receive.

The introduction of the harmonised InterRAI SAT for assessing the care needs of older people may ensure a more efficient allocation of home support resources based on need and that is not dependent on location, for example (see Walsh and Lyons, 2021). Those currently using private hours may partly or fully switch these hours to public ones, thereby increasing demand for publicly provided hours. The new scheme may also result in some substitution for long-term residential care,

another potential factor leading to an increase in demand.[16] For some, the introduction of co-payments may actually reduce demand if people are required to contribute to the cost of such hours themselves, particularly if the full hourly cost of care is charged. It is therefore very difficult to anticipate how demand for home support hours will evolve.

3.3 HOURS SCENARIOS

Due to these uncertainties surrounding behavioural responses to the new scheme, we propose two simple extensions to our analysis based on public home support usage. These additional scenarios will examine the issue of private hours usage and unmet needs for support hours. The scenarios are as follows.

A. We examine in the main body of the report a **baseline scenario** assuming current usage of publicly funded home support services.

B. Extension 1: We expand the baseline scenario to one whereby all those using private home support hours now switch these hours to a publicly funded scheme.

C. Extension 2: In addition to (B) above, we expand usage in line with unmet need.

For Scenario B, while the TILDA data provide information on the usage of public home support hours and the average hours used, TILDA only provides information on whether private home support hours are availed of, not the number of hours used. Therefore, we assign an average annual usage of 287.5 private hours for all individuals estimated to be using private home support (after imputation from Equation 2). This figure is taken from Walsh and Lyons (2021) based on estimates from Home and Community Care Ireland (HCCI) − the representative organisation for private home care organisations.[17] While this will miss variation in hours across private home support users, a lack of data prevents us from examining private home support use in more detail.

For Scenario C, unmet need and substitution effects are harder to quantify. While Privalko et al. (2019) examine the issue of unmet need and find unmet need among both those currently receiving professional care hours and those not currently receiving hours, people are not asked to quantify how many hours would be needed to satisfy their need for professional home support hours. Given these constraints, we use information from the HSE National Service Plan (HSE, 2021), which planned for an annual increase of five million in total home support hours for those aged 65 and over. This would equate to a 15 per cent increase in home

16 As the SILC data underlying the SWITCH model are based on a representative private household sample of the population, those already in a LTRC are not captured in the data. It is therefore not possible to examine this issue.

17 The HCCI states that the agencies it represents provided 2.3 million home support hours to their 8,000 private home support clients in 2018. This equates to 287.5 hours per annum to each client.

support hours between 2020 and 2021. According to the HSE (see Carer Alliance Ireland, 2018), the gap between clinically assessed need and actual home care provision is also estimated at 15 per cent. While significant numbers are on a waiting list to receive publicly funded home support hours (5,436 in December 2019 (Walsh and Lyons, 2021); 5,326 in September 2021), there is no means of identifying who needs hours but is not getting them via the SILC data. We therefore assume that this 15 per cent increase will go to current recipients and simply increase estimated public home support hours by 15 per cent for all. Exchequer results for Scenarios B and C are presented in Appendix 2.

It is anticipated that the scheme may include caps on hours awarded in recognition of the fact that residential care may be a more appropriate setting for those individuals with very intensive care needs. In looking at Scenarios A, B and C, we cap home support hours at 60 hours per week. This figure is based on the equivalent cost of residential care.[18] While it would also be desirable to look at the impact of a higher 168-hour cap (essentially 24/7 care) – the current maximum number of hours provided through the current Intensive Home Care Package – no individuals in our data are estimated to use more than 60 hours per week. This is a reflection of the issue highlighted in Table 3.2, namely that the imputation of public home support hours in SWITCH performs well for the majority but does not accurately capture the hours used by those at the very top of the distribution. Therefore, we cannot model the impact of a cap beyond 60 hours per week.

Due to the lack of data, we do not examine in detail scenarios leading to an increase in demand for home support that may occur in regards to the new statutory scheme, such as people who receive care from family members substituting towards professional carers, and individuals provided with an iHCP using that instead of LTRC. While Walsh and Lyons (2021) highlighted that these substitution effects could increase demand within a statutory scheme, at the time of analyses, there were insufficient data to model in detail such effects in this report. However, the analysis of unmet need (see Appendix 2) will help give some idea of the impact of a rise in demand.

3.4 FUNDING SCENARIOS

As mentioned, publicly funded home support services are currently free of charge. However, the funding model for the new scheme has yet to be determined. In order to enhance the evidence base for the development of the optimal funding

[18] According to the Office of the Comptroller and Auditor General (2020), the average weekly charge for public nursing homes was €1,564 in 2018. Dividing this cost by an hourly cost of home support of €26.60 per hour gives a figure of 58.8 hours, rounded for simplicity to 60 hours.

model for the new scheme, we examine a range of options for this, including full Exchequer funding and the provision by the State of varying degrees of financial support to service users.[19]

The potential scenarios are listed below. In scenarios where co-payments will be charged for those whose income is above a certain level (Scenario 3 onwards), assessable income/means are calculated as per the calculation for medical cards and GP visit cards.[20] All income limits are increased for couples in line with the ratios applied in the means test for medical cards and GP visit cards.

We examine the following funding options.

1) Full Exchequer funding of home support services.

2) A flat €5 per hour of home support co-payment for all.[21]

3) Exchequer funding of home support hours for those whose assessable income is below the relevant medical card limit,[22] full cost of home support hours for those above this level.

   (3.1) Will assume a €5 charge per hour above this limit.

   (3.2) Will assume the full €26.60[23] charge per hour above this limit.

4) Exchequer funding of home support hours for those whose assessable income is below the GP visit card limit,[24] full cost of home support hours for those above this level.

   4.1) Will assume a €5 charge per hour above this limit.

   4.2) Will assume the full €26.60 charge per hour above this limit.

5) Exchequer funding of home support services on a graduated means-tested basis.
   5.1) Full cost covered if means are below €377.40 (current minimum wage), payments of €26.60 per hour above this point tapered at a 50 per cent rate – i.e. for every one euro above the income limit, public funding of home support will be withdrawn by 50 cent and replaced with a 50 cent user co-payment.

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19 These funding scenarios have been outlined to us by the Department of Health.

20 See Appendix 1 for a full description of assessable means calculations.

21 This €5 is based on evidence regarding willingness to pay from Walsh et al. (2020), showing the public would be willing to pay €77.48 for 15 hours of home support and €116.65 for 20 hours.

22 In all means-tested scenarios, the maximum income limit is increased for couples in line with the relevant ratio applied in the means tests for medical cards and GP visit cards.

23 The current, average hourly cost of home support provision.

24 GP visit cards are not means tested for the over 70s, which means that no income limits currently exist. We therefore calculate an equivalent limit for those over 70 by adding 65 per cent to the medical card income limit for those over 70, as the income limit for GP visit cards for those under 70 is 65 per cent higher than that for the medical card.

5.2) Full cost covered if means are below €455.10 (current living wage), payments of €26.60 per hour above this point tapered at a 50 per cent taper rate.

5.3) Full cost covered if means are below €972.36 (current average hourly wage of €26.28[25] *37 hours per week), co-payments of €26.60 per hour above this point tapered at a 50 per cent taper rate.

5.4) Full cost covered if means are below €377.40 (current minimum wage), payments of €26.60 per hour above this point tapered at a 25 per cent taper rate.[26]

5.5) Full cost covered if means are below €455.10 (current living wage), payments of €26.60 per hour above this point tapered at a 25 per cent taper rate.

5.6) Full cost covered if means are below €972.36 (current average hourly wage of €26.28[27] X 37 hours per week), payments of €26.60 per hour above this point tapered at a 25 per cent taper rate.

6) Exchequer funding of home support services on a graduated means-tested basis (75 per cent taper rate)[28] for those with incomes above the notional minimum wage (6.1) or living wage (6.2), with an annual cap on the amount that each individual is required to contribute to the cost of their care.[29] The annual cap will be based on the following:

- The maximum amount payable for home support for someone whose means are between €377 and €655 will be €3,000 per annum or ten per cent of the annual equivalent of the applicant's notional net weekly income, whichever is less;
- The maximum amount payable for home support for someone whose means are between €655 and €868 will be €4,500 per annum or ten per cent of the annual equivalent of the applicant's notional net weekly income, whichever is less;
- The maximum amount payable for home support for someone whose means are above €868 will be €9,000 per annum or ten per cent of the annual equivalent of the applicant's notional net weekly income, whichever is less.

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25 Based on the seasonally adjusted Q1 2021 figure, available at https://www.cso.ie/en/statistics/earnings/earningsandlabourcosts/.

26 For every one euro above the income limit, public funding of home support will be withdrawn by 25 cent and replaced with a 25 cent user co-payment.

27 Based on the seasonally adjusted Q1 2021 figure, available at https://www.cso.ie/en/statistics/earnings/earningsandlabourcosts/.

28 For every one euro above the income limit, public funding of home support will be withdrawn by 75 cent and replaced with a 75 cent user co-payment.

29 As a robustness check, we also conduct simulations of scenarios 6.1 and 6.2 using a 50 per cent taper rate, so that home support service services are withdrawn less aggressively. This lower taper rate increases the cost of provision by €3 million in 6.1 and €1 million in 6.2. These are very small percentage increases in cost and have a negligible impact on inequality, poverty and the distributional impact of the scheme. The results are also similar when we allow the value of principal private residences to be accounted for in our definition of means.

7) Exchequer funding of home support services on a means-tested basis, guaranteeing that no individual's disposable income is reduced to less than the equivalent of the living wage, €455.10 per week.

Table 3.3 summarises the funding scenarios for ease of reading throughout the text.

TABLE 3.3 SUMMARY OF FUNDING SCENARIOS

Scenario	Short name
1	Zero co-payments
2	€5 p.h. co-payment, flat rate
3.1	€5 p.h. co-payment, means>MC limit
3.2	€26.60 p.h. payment (i.e. full cost), means>MC limit
4.1	€5 p.h. co-payment, means>GPC limit
4.2	€26.60 p.h. payment (i.e. full cost), means>GPC limit
5.1	Co-payment > Minimum wage, 50% taper
5.2	Co-payment > Living wage, 50% taper
5.3	Co-payment > Average wage, 50% taper
5.4	Co-payment > Minimum wage, 25% taper
5.5	Co-payment > Living wage, 25% taper
5.6	Co-payment > Average wage, 25% taper
6.1	Co-payment > Minimum wage, 75% taper, caps
6.2	Co-payment > Living wage, 75% taper, caps
7	Co-payment, means > Living wage

Notes: p.h indicates per hour. MC denotes medical card, GPC denotes GP visit card.

3.5 SENSITIVITY ANALYSIS – TAX RELIEF AND PRIMARY RESIDENCES

Under the funding scenarios examined in the main body of the report, we assume no tax relief is given on any co-payments made by users of home support hours. Those paying for private hours under the current system are allowed tax relief on these costs at the person's marginal rate of tax, so either 20 per cent or 40 per cent depending on their tax liability. Medical costs incurred by taxpayers currently benefit from a standardised 20 per cent tax relief on such costs. We therefore perform some sensitivity analysis in Appendix 3, whereby we examine the Exchequer impact of a standard 20 per cent rate of tax relief on co-payments for home support. Standardising the rate of tax relief at 20 per cent ensures that all those paying for home support would receive relief – for example, those on higher incomes whose marginal rate of tax is 40 per cent would not receive a higher rate of relief than those paying the standard rate of tax, or indeed those whose incomes are too low to incur a tax liability.

The funding scenarios that involve means testing of freely provided home support (Scenarios 3.1 on) follow the definition of means for the assessment of medical cards and GP visit cards. One notable asset exclusion from this is the individual's family home: the value of a person's principal primary residence is not included in

the means assessment for medical cards and GP visit cards. However, recognising that in many cases, a person's private residence is their most valuable asset, and cognisant of the fiscal context within which the new home support scheme is being developed, we also examine the Exchequer impact of the funding options with principal residences included in the assessment of assets. This would be in line with the financial assessment currently in use for the NHSS, which does take account of an individual's principal residence in the financial assessment (specifically it is included at a rate of 7.5 per cent per year for the first three years of a person's time in nursing home care, capping the contribution to 22.5 per cent of the property value). Therefore, we also examine the Exchequer impact of the various funding scenarios if the value of a person's principal primary residence were to be included as an asset in the assessment of means.[30] These results are shown in Appendix 3.

[30] As per non-primary residence properties and other capital assets (such as savings) under the means assessment for the medical card and the GP visit card, we add the value of a person's primary residence to their other assets and calculate a weekly 'notional interest' amount whereby the first €36,000 of assets are ignored (double that amount for couples), with the next €10,000 assessed at €1 per €1,000; the next €10,000 at €2 per €1,000 and the balance assessed at €4 per €1,000.

CHAPTER 4
Results

We focus here on the results under our baseline Scenario A: assuming current usage of publicly funded home support hours. Given the uncertainty surrounding how the new scheme will change private hours used and tackle unmet need, and the issues discussed in estimating these in the first place, two alternative scenarios are presented in Appendix 2. There, we assess the Exchequer impact under Scenario B (assuming all privately funded hours become public) and Scenario C (assuming all privately funded hours become public and all users of public hours receive a 15 per cent increase in hours to meet unmet needs).

4.1 DISTRIBUTION OF PUBLIC HOME SUPPORT HOURS

We begin by showing the cost and distribution of the current, entirely publicly funded, home support scheme: Scenario A. This can help provide some initial information on the feasibility of co-payments, assuming that those in higher income quintiles may be more easily able to afford co-payments;[31] research has shown that lower-income groups tend to consume more of their income (see CSO, 2017a, 2017b; Coffey et al., 2020) and therefore may be more likely to face affordability issues if faced with co-payments for home support. As shown in Table 4.1, just over 54,000 individuals aged 65 and over are estimated in our data to use home support hours.[32] Half of them are found in the second income quintile.[33] Only seven per cent of home support recipients are in the bottom income quintile. The rest are spread throughout the income distribution, with 16–17 per cent in Quintiles 3 and 4 with the remaining nine per cent found in the highest income quintile. This distribution of home support recipients reflects the overall distribution of those aged 65 and over, shown in the last column in Table 4.1 – this age group is most commonly found in Quintile 2, followed by Quintiles 3 and 4. They are less likely to be found in either the highest or lowest income quintile.

31 Annual income quintile cut-offs in equivalised income are €13,677 for Quintile 2, €17,720 for Quintile 3, €25,522 for Quintile 4 and €32,170 for the highest income quintile.

32 Reassuringly, this is very close to the 52,853 reported by the HSE as at December 2020.

33 The current maximum rates of the state contributory and non-contributory pensions are €248.30 and €237 per week respectively, with a €10 supplement for those aged over 80. These are significantly higher than the main rates of benefit payments received by those of working age – for example, the maximum rate for both Jobseekers Benefit and Disability Allowance is €203 per week.

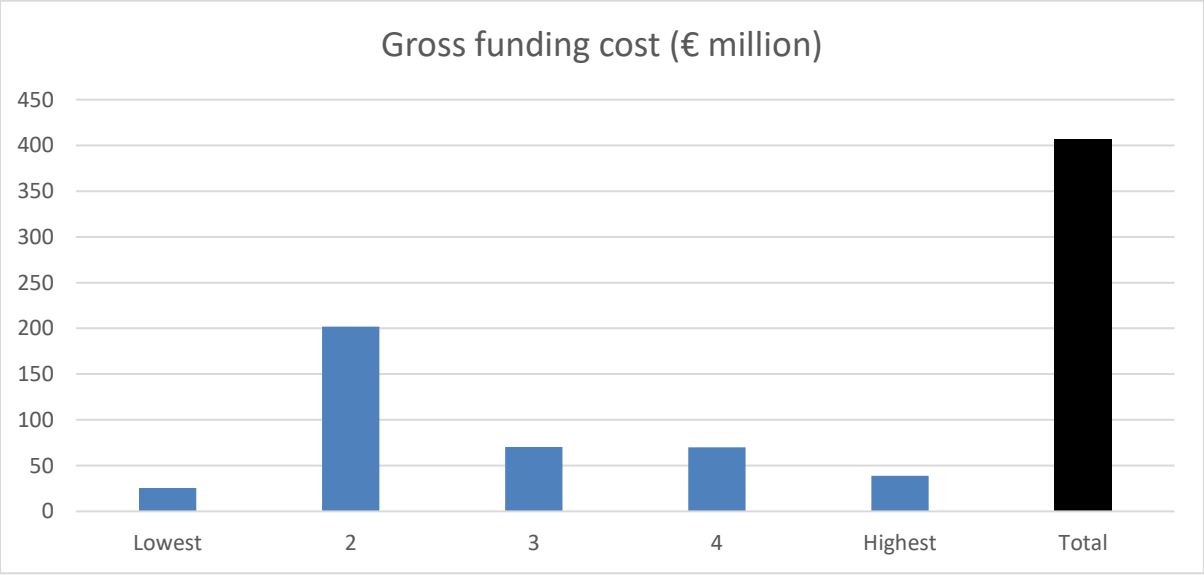
TABLE 4.1 CURRENT DISTRIBUTION OF HOME SUPPORT HOURS (65+)

Quintile	No. using public home support hours	No. public home support hours used (millions)	Distribution of 65+ (%)
Lowest	3,549	1.0	10.5
2	27,828	7.6	35.9
3	9,231	2.7	21.5
4	8,825	2.6	19.2
Highest	4,893	1.5	12.9
Total	54,327	15.30	100.0

Source: Own calculations for those aged 65 and over using SWITCH.
Note: Quintiles are based on the total population and are calculated based on equivalised, disposable income.

Based on the average hourly cost of home support of €26.60, Figure 4.1 shows the current distribution of home support funding of just over €400 million. In line with the distribution of home support recipients, the second quintile receives half of the total funding, followed by Quintiles 3 and 4. Quintile 1 receives the lowest proportion of funding followed by the highest income quintile.

FIGURE 4.1 DISTRIBUTION OF HOME SUPPORT FUNDING, SCENARIO 1



Source: Own calculations for those aged 65+ using SWITCH.
Notes: Quintiles are based on the total population and are calculated based on equivalised, disposable income.

4.2 EXCHEQUER IMPACTS

We begin by examining the Exchequer impact of the various funding scenarios (see Table 4.2). As mentioned above, the full expenditure on home support for those aged 65 and over is estimated to be €407 million per annum and this €407 million is applied to all scenarios. In the future, the total expenditure is likely to increase,

and we therefore compare scenarios based upon the percentage of total expenditure borne by home support recipients.

In Scenario 1, all expenditure is being borne by the Exchequer, as zero co-payments apply. Across the other scenarios, there are large variations in the percentage of expenditure borne by recipients, with the largest percentage of expenditure borne by home support recipients found in Scenario 2, where a €5 flat rate per home support hour for all recipients is modelled. The lowest percentage is modelled in Scenario 4.1 (*€5 p.h. co-payment, means>GP visit card limit*) covering 0.2 per cent of the total cost. As anticipated, the percentage of expenditure borne by recipients is lower the higher the income cut-off for full state support. The amount of tapering modelled (i.e. the rate at which state support gets withdrawn) generally has little effect on results. Therefore, the income cut-off point is significantly more important in determining how much co-payments will generate for the Exchequer (as it effectively determines how many people are fully exempted from co-payments) than is the rate at which state support gets withdrawn for people above this income cut-off.

An important caveat in respect of these findings is the fact that they don't take account of elasticity of demand, as no reliable estimates exist. In other words, in response to being charged for home support hours, particularly if the full €26.60 hourly cost of care is charged, recipients of home support hours may reduce the hours they use or stop availing of the service entirely. This would obviously have implications for the welfare of those needing home support and would affect the Exchequer costs shown below. Previous work on health and social care has found that cost is a driver of utilisation. Research by Ma and Nolan (2017) found that when older people lost a medical card, thereby increasing the cost of visiting a GP (to approximately €50 per visit), it resulted in 0.9–1.3 fewer GP visits in the following year. There is also some international evidence on home support use and co-payments. Evidence from France estimates a price elasticity of -0.4 (Roquebert and Tenand, 2017). In other words, the study found that a ten per cent increase in the hourly co-payment cost of home support reduced home support consumed by four per cent. However, evidence from the Netherlands finds a much smaller elasticity of demand of -0.14; in that study, a ten per cent increase in co-payment costs reduced home support consumed by 1.4 per cent (Non, 2017).

While we cannot explicitly estimate the likely impact of co-payments on demand, due to a lack of data, scenarios where co-payments are especially high may result in some dampening of demand and thereby Exchequer costs. However, any dampening may be small. Approximately one-quarter of home support recipients currently purchase some private home support. While, even in the current scheme where private purchases of home support exist, existing waiting lists show that demand outstrips supply.

TABLE 4.2 EXCHEQUER COST OF FUNDING SCENARIOS

Funding scenario		Exchequer cost €m p.a.	Co-payment €m p.a.	Co-payment as % of total cost
1	Zero co-payments	407.1	-	-
2	€5 p.h. co-payment, flat rate	330.5	76.5	19%
3.1	€5 p.h. co-payment, means>MC limit	396.0	11.1	3%
3.2	€26.60 p.h. payment (i.e. full cost), means>MC limit	348.0	59.0	15%
4.1	€5 p.h. co-payment, means>GPC limit	406.1	0.9	0.2%
4.2	€26.60 p.h. payment (i.e. full cost), means>GPC limit	402.2	4.9	1%
5.1	Co-payment > Minimum wage, 50% taper	349.3	57.7	14%
5.2	Co-payment > Living wage, 50% taper	362.2	44.8	11%
5.3	Co-payment > Average wage, 50% taper	402.9	4.2	1%
5.4	Co-payment > Minimum wage, 25% taper	359.7	47.3	12%
5.5	Co-payment > Living wage, 25% taper	371.0	36.1	9%
5.6	Co-payment > Average wage, 25% taper	403.2	3.9	1%
6.1	Co-payment > Minimum wage, 75% taper, caps	358.7	48.3	12%
6.2	Co-payment > Living wage, 75% taper, caps	369.9	37.1	9%
7	Co-payment, means>Living wage	371.1	35.9	9%

Source: Own calculations for those aged 65+ using SWITCH.

Notes: Results based on Scenario A of home support hours use i.e. estimated current usage of public home support. Home support hours eligible for funding are capped at 60 hours per week.
The funding scenarios are as follows:
1=Full Exchequer funding; 2=€5 flat rate hourly contribution; 3.1/3.2=Exchequer funded if means<medical card limit (€5/€26.60 co-payment otherwise); 4.1/4.2=Exchequer funded if means<GP visit card limit (€5/€26.60 co-payment otherwise); 5.1=graduated means test if means>minimum wage (50% taper rate); 5.2=graduated means test if means>living wage (50% taper rate); 5.3=graduated means test if means>average wage (50% taper rate); 5.4=graduated means test if means>minimum wage (25% taper rate); 5.5=graduated means test if means>living wage (25% taper rate); 5.6=graduated means test if means>average wage (25% taper rate); 6.1=graduated means test if means>minimum wage (75% taper rate); annual caps; 6.2=graduated means test if means>living wage (75% taper rate); annual caps; 7=disposable income after co-payments not to fall below the living wage.
Tax relief is not included here, means exclude the value of a person's primary residence.

4.3 DISTRIBUTIONAL IMPACT

In addition to differing Exchequer impacts, the scenarios modelled will also have varying distributional impacts. In looking at the distributional impact of the potential co-payment structures, we focus on the change in disposable income of an individual due to the co-payment faced. We do not include the value of the (currently free) home support hours received in the individual's disposable income. While non-cash benefits can have substantial impacts on the distribution of economic welfare (see Callan and Keane, 2009), including the value of public health services used would mean that those in poor health and availing of home support hours would appear better off than their healthier counterparts with the same cash income. While there is a benefit in tracking where public resources are spent, as is done in Figure 4.1, it is not appropriate in terms of measuring welfare.

It is worth bearing in mind that different co-payment structures will have differing impacts. Having costs incurred by the individual above a certain point and an absence of tapering (as is the case in Scenarios 3.1, 3.2, 4.1 and 4.2) creates cliff edges – as an individual goes €1 over the relevant income limit, they face a much sharper reduction in income as they now incur either a €5 co-payment or the full €26.60 hourly cost of home support. This issue is evident in the hypothetical case shown in Appendix 2. Likewise, the flat-rate €5 co-payment examined under Scenario 2 will take more in percentage terms from those on low incomes than those higher up the income distribution. Introducing such cliff edges is likely to be seen as undesirable within the scheme by recipients.

For these reasons, we examine the distributional impact of the various co-payment options. People are first grouped into an income quintile based on household, equivalised income i.e. ranked from the one-fifth of the population with the lowest equivalised income to the highest. Figure 4.2 shows the average percentage change in disposable income for those aged 65 and over by income quintile under our baseline analysis i.e. assuming no behavioural change in hours used, no tax relief and principal residence value excluded from assets. While it would also be desirable to examine the percentage change of those affected only – those aged 65 and over receiving home support hours – small sample sizes once the data are broken down into income quintiles prevents us from doing so. Results are presented in ascending order of the overall average reduction in income (ranked from the scheme with the lowest total co-payments to the highest) and are relative to the current situation of full Exchequer funding of home support.

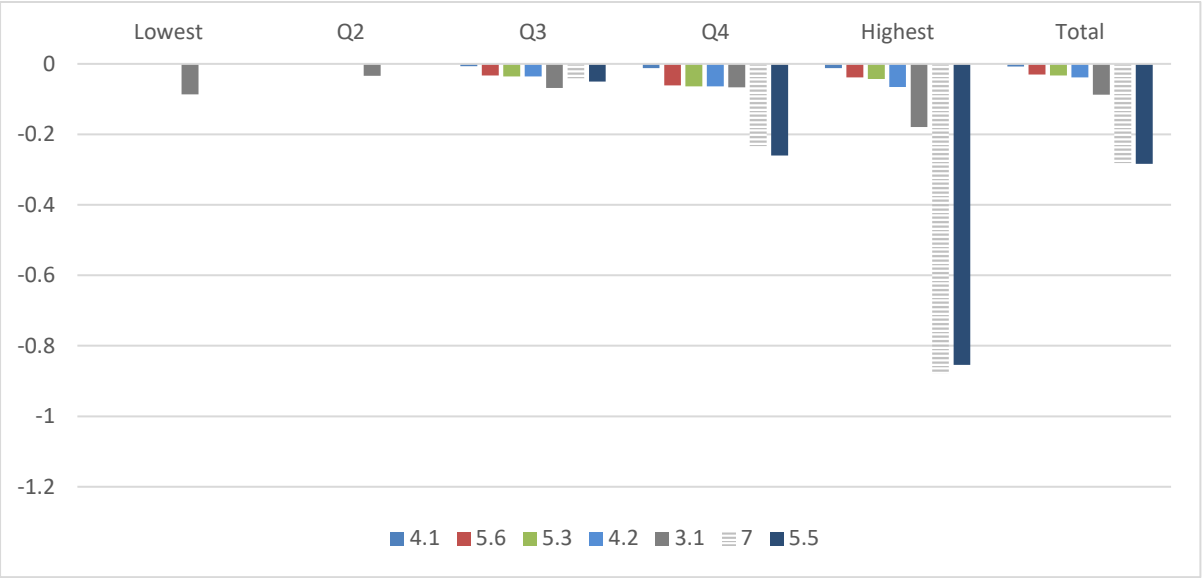
The majority of the co-payment options examined are progressive – taking more in percentage terms from those in higher income quintiles – despite the fact that usage of home support is more concentrated in the lower part of the income distribution (particularly Quintile 2, as shown in Figure 4.1). Of the 14 co-payment scenarios, only three involve a reduction in income for the lowest two income quintiles: 2 (*€5 p.h. co-payment, flat rate*); 3.1 (*€5 p.h. co-payment, means > MC*

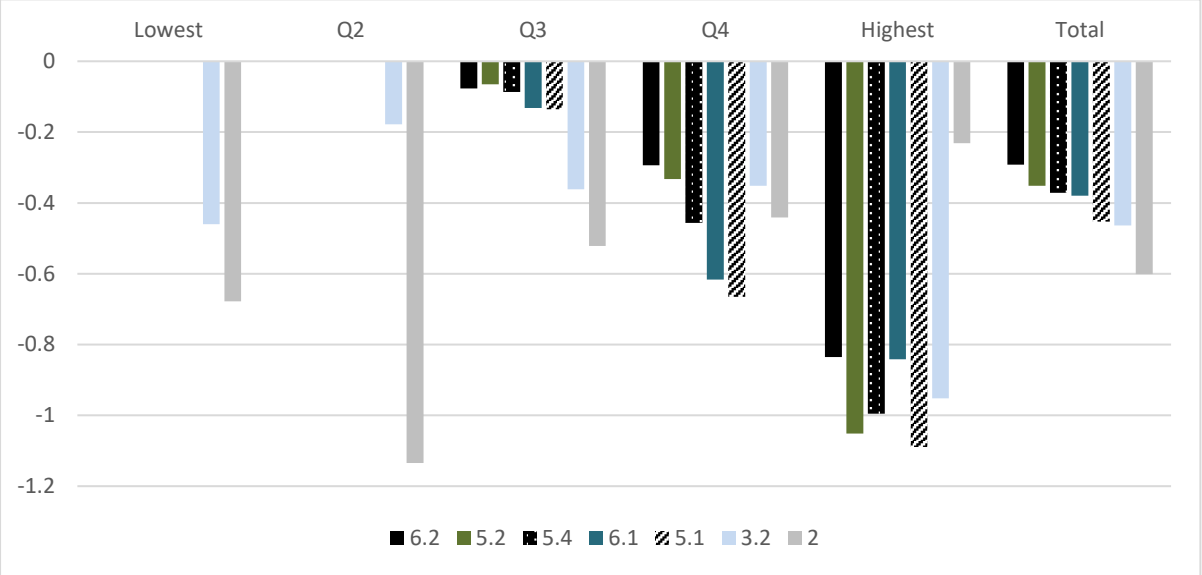
limit) and 3.2 (*€26.60 p.h. payment (i.e. full cost), means > MC limit*). While it generates the most revenue for the Exchequer, the most obviously regressive scheme is Scenario 2 (*€5 p.h. co-payment, flat rate*) whereby the largest percentage loss is in Quintile 2, followed by Quintile 1, and the smallest loss is in the highest income quintile. Despite the fact that home support usage is lower in Quintile 1 than in Quintiles 3–5 (see Table 4.1), a flat rate charge would take more in percentage terms from Quintile 1 than the higher income quintiles. This reflects the fact that incomes in this quintile are the lowest and supports the idea that a flat rate charge is likely to cause affordability issues for lower-income groups. Scenarios 3.1 and 3.2 (*€5/€26.60 p.h. co-payment, means>MC limit)* also take more from the lowest income quintile than Quintiles 2–4. Scenarios 4.1 (*€5 p.h. co-payment, means>GPC limit*) and 4.2 (*€26.60 p.h. payment (i.e. full cost), means>GPC limit*) follow a progressive pattern, with the bottom two income quintiles experiencing no reduction in income and the loss in Quintile 3 lower than that of Quintiles 4 and 5.

Scenarios 5.1 to 5.6 involve an income limit (be that minimum, living or average wage) below which no co-payment is made and a taper rate where individuals would gradually start contributing to their own home support costs as their income rises. As anticipated, this type of co-payment structure is broadly progressive, generally taking more in percentage terms from those on higher incomes and less (or nothing) from those on lower incomes. As shown in Appendix 2, this type of co-payment structure also helps avoid the cliff edge that would be experienced by those just over the income limit for the medical card or GP visit card in Scenarios 3.1, 3.2, 4.1 and 4.2, where no tapering exists. It could, however, result in large total costs for some higher-income people using a large number of home support hours. This is important to bear in mind given that we report the average change in income by quintile among all those aged 65 and over and, due to small sample sizes, are unable to show the average income reduction for those actually paying for home support.

Scenarios 6.1 (*Co-payment > Minimum wage, 75% taper, caps*) and 6.2 (*Co-payment > Living wage, 75% taper, caps*) also involve an income limit with increasing liability for home support costs above this limit (i.e. a 75% taper rate) but they place a means-related cap on the maximum home support costs an individual can face and are strongly progressive. Such caps would help avoid certain individuals with high home support usage (particularly higher-income individuals) facing extremely large co-payments. Scenario 7, which ensures that an individual's disposable income after home support costs does not fall below the living wage, so essentially also capping costs, is also progressive. In these three scenarios, the bottom two income quintiles face no co-payments for home support, with the percentage reduction in income related to co-payments rising as we go up the income distribution.

FIGURE 4.2 PERCENTAGE CHANGE IN DISPOSABLE INCOME OF THOSE >65 DUE TO CO-PAYMENTS





Source: Own calculations for those aged 65+ using SWITCH.

Notes: Quintiles are based on the total population and are calculated based on equivalised, disposable income.
Results based on Scenario A of home support hours used i.e. estimated current usage of public home support. Home support hours eligible for funding are capped at 60 hours per week.
The funding scenarios are as follows:
1=Full Exchequer funding; 2=€5 flat rate hourly contribution; 3.1/3.2=Exchequer funded if means<medical card limit (€5/€26.60 co-payment otherwise); 4.1/4.2=Exchequer funded if means<GP visit card limit (€5/€26.60 co-payment otherwise); 5.1=graduated means test if means>minimum wage (50% taper rate);5.2=graduated means test if means>living wage (50% taper rate); 5.3=graduated means test if means>average wage (50% taper rate); 5.4=graduated means test if means>minimum wage (25% taper rate); 5.5=graduated means test if means>living wage (25% taper rate); 5.6=graduated means test if means>average wage (25% taper rate); 6.1=graduated means test if means>minimum wage (75% taper rate); annual caps;6.2=graduated means test if means>living wage (75% taper rate); annual caps; 7=disposable income after co-payments not to fall below the living wage.
Tax relief is not included here, means exclude the value of a person's primary residence.

4.4 POVERTY AND INEQUALITY

The at-risk-of-poverty (AROP) rate measures the proportion of the population with an income at, or below, 60 per cent of the median income in the country. While

the AROP rate for older people (65+) in Ireland is substantially below that of younger age groups (see CSO, 2020), there may be concerns that co-payments for home support, which will be mainly borne by those aged 65 and over given that they are the age group making most use of home support services, may lead to an increase in poverty rates among older people. To examine this issue, we deduct co-payments from income to see the effect on the AROP rate and compare this to the AROP rate under Scenario 1 (no co-payments). Overall, we see that none of the potential co-payment scenarios have a very large impact on the over-65 poverty rate (Table 4.3). Relative to funding Scenario 1 (the current system of zero co-payments), the largest increase in poverty is a 1.4 per cent rise in poverty among older people under Scenarios 2 (*€5 p.h. co-payment, flat rate*) and 3.2 (*€26.60 p.h. payment (i.e. full cost), means>MC limit*). The other scenarios where state support for home support is fully provided to those below certain income limits or tapered/capped in some way all have a negligible effect on poverty for this group. This ties in with the findings in the previous section showing that these types of co-payment options tend to have little or no effect on the lowest income quintiles – hence they send very few people under the poverty line. It is worth stressing, however, that we cannot show results for those with very high co-payments/reductions in income due to sample size issues. The capping of total home support payments (Scenarios 6.1, 6.2 and 7) can help avoid extremely large co-payments arising. In general, however, all scenarios that potentially charge individuals the full €26.60 hourly costs of home support have the potential to lead to high costs for those above certain income levels, as illustrated in the hypothetical case in Appendix 2.

TABLE 4.3 AT-RISK-OF-POVERTY RATES FOR OLDER PEOPLE

Funding scenario		AROP rate	% change due to co-payments
1	Zero co-payments	6.63	–
2	€5 p.h. co-payment, flat rate	6.73	1.4%
3.1	€5 p.h. co-payment, means>MC limit	6.66	0.4%
3.2	€26.60 p.h. payment (i.e. full cost), means>MC limit	6.73	1.4%
4.1	€5 p.h. co-payment, means>GPC limit	6.63	0.0%
4.2	€26.60 p.h. payment (i.e. full cost), means>GPC limit	6.65	0.2%
5.1	Co-payment > Minimum wage, 50% taper	6.65	0.2%
5.2	Co-payment > Living wage, 50% taper	6.65	0.2%
5.3	Co-payment > Average wage, 50% taper	6.65	0.2%
5.4	Co-payment > Minimum wage, 25% taper	6.65	0.2%
5.5	Co-payment > Living wage, 25% taper	6.65	0.2%
5.6	Co-payment > Average wage, 25% taper	6.65	0.2%
6.1	Co-payment > Minimum wage, 75% taper, caps	6.65	0.2%
6.2	Co-payment > Living wage, 75% taper, caps	6.65	0.2%
7	Co-payment, means>Living wage	6.63	0.0%

Source: Own calculations for 2021 for those aged 65+ using SWITCH.
Notes: Results based on Scenario A of home support hours use i.e. estimated current usage of public home support. Home support hours eligible for funding are capped at 60 hours per week.
The funding scenarios are as follows:
1=full Exchequer funding; 2=€5 flat rate hourly contribution; 3.1/3.2=Exchequer funded if means<medical card limit (€5/€26.60 co-payment otherwise); 4.1/4.2=Exchequer funded if means<GP visit card limit (€5/€26.60 co-payment otherwise); 5.1=graduated means test if means>minimum wage (50% taper rate); 5.2=graduated means test if means>living wage (50% taper rate); 5.3=graduated means test if means>average wage (50% taper rate); 5.4=graduated means test if means>minimum wage (25% taper rate); 5.5=graduated means test if means>living wage (25% taper rate); 5.6=graduated means test if means>average wage (25% taper rate); 6.1=graduated means test if means>minimum wage (75% taper rate); annual caps; 6.2=graduated means test if means>living wage (75% taper rate); annual caps; 7=disposable income after co-payments not to fall below the living wage.
Tax relief is not included here, means exclude the value of a person's primary residence.

Finally, Table 4.4 shows a commonly used measure of inequality – the Gini coefficient – under each scenario. The higher the value of the Gini coefficient, the higher the level of income inequality. We can see that, similarly to the analysis of poverty rates once primary residence values are excluded, none of the co-payment options has any sizeable impact on inequality, with only very small changes seen under any of the 14 scenarios examined.

TABLE 4.4 GINI COEFFICIENT

Funding scenario		Gini
1	Zero co-payments	29.4
2	€5 p.h. co-payment, flat rate	29.4
3.1	€5 p.h. co-payment, means>MC limit	29.4
3.2	€26.60 p.h. payment (i.e. full cost), means>MC limit	29.3
4.1	€5 p.h. co-payment, means>GPC limit	29.4
4.2	€26.60 p.h. payment (i.e. full cost), means>GPC limit	29.4
5.1	Co-payment > Minimum wage, 50% taper	29.3
5.2	Co-payment > Living wage, 50% taper	29.3
5.3	Co-payment > Average wage, 50% taper	29.4
5.4	Co-payment > Min wage, 25% taper	29.3
5.5	Co-payment > Living wage, 25% taper	29.3
5.6	Co-payment > Average wage, 25% taper	29.4
6.1	Co-payment > Minimum wage, 75% taper, caps	29.3
6.2	Co-payment > Living wage, 75% taper, caps	29.3
7	Co-payment, means>Living wage	29.3

Source: Own calculations for 2021 using SWITCH.

Notes: Results based on Scenario A of home support hours use i.e. estimated current usage of public home support. Home support hours eligible for funding are capped at 60 hours per week.
The funding scenarios are as follows:
1=Full Exchequer funding; 2=€5 flat rate hourly contribution; 3.1/3.2=Exchequer funded if means<medical card limit (€5/€26.60 co-payment otherwise); 4.1/4.2=exchequer funded if means<GP visit card limit (€5/€26.60 co-payment otherwise);5.1=graduated means test if means>minimum wage (50% taper rate); 5.2=graduated means test if means>living wage (50% taper rate); 5.3=graduated means test if means>average wage (50% taper rate); 5.4=graduated means test if means>minimum wage (25% taper rate); 5.5=graduated means test if means>living wage (25% taper rate); 5.6=graduated means test if means>average wage (25% taper rate); 6.1=graduated means test if means>minimum wage (75% taper rate); annual caps; 6.2=graduated means test if means>living wage (75% taper rate); annual caps; 7=disposable income after co-payments not to fall below the living wage.
Tax relief is not included here, means exclude the value of a person's primary residence.

CHAPTER 5

Conclusions

To date, home support services in Ireland have been free of user contributions. We understand that a new statutory scheme for the financing and regulation of home support services is being designed. This could involve co-payments towards care, as is the case with the Nursing Homes Support Scheme (NHSS).

In this report, we have examined 14 alternative funding options for those aged 65 and over. While it would be useful to examine co-payment options for all home support recipients, regardless of age, data limitations prevented us from doing so. Numerous studies using Health Service Executive (HSE) and TILDA (The Irish Longitudinal Study on Ageing) data have found the median age of home support recipients to be approximately 83 years (Aspell et al., 2019; Walsh and Lyons, 2021; Walsh et al., 2021). We are therefore confident we have captured the vast majority of home support recipients in our analysis. Detailed, individual-level administrative data on home support usage among all age groups could be considered in the future if it were to become available. While overall our imputation of private and public home support use compares well to external statistics, we also acknowledge that imputed use of home support, particularly private home support for those over 75, is higher when imputed in SILC compared to that found in the TILDA data, although it does match well to the findings of Aspinall at al. (2019). Our imputed values of public home support usage also estimate a lower number of high home support hour recipients than TILDA would suggest. Additional administrative information (for example, linking information on publicly funded home support hours to Survey on Income and Living Conditions (SILC) respondents and information on tax relief received for private home support hours) could improve further the precision of our analysis if such information was to become available in the future.

The co-payment options can be broadly categorised into two main types – options with a flat rate element (Scenarios 2, 3.1, 3.2, 4.1 and 4.2) and options with graduated co-payments in line with income with those below a certain limit receiving full state support for their home care costs (Scenarios 5.1, 5.2, 5.3, 6.1, 6.2, 6.3 and 7). We estimate that the potential funding options examined, excluding any behavioural responses, could raise between 0.2 and 19 per cent of the total cost of the home support scheme for those aged 65 and over. We have briefly looked at Exchequer impacts of some potential demand increases. If unmet needs are addressed by the new scheme, or if the new scheme causes a shift in usage of private home support hours towards publicly provided hours, costs of the scheme could rise significantly. More detailed analysis of these issues is not possible given the lack of data on private home support hours and the hours required to address unmet needs for care. A very important caveat is the assumption in this analysis that there is no behavioural change in the usage of

home support if recipients of home support face co-payments for care. Recipients may reduce the hours they use or stop availing of the service entirely. This would obviously have implications for the welfare of those needing home support. There may also be further behavioural changes that impact upon home support usage; for example, a reduction in hours used due to the scheme impacting upon the caring decisions of unpaid carers, usually relatives. However, the scheme would need to be piloted or monitored in order to quantify such potential changes.

We have shown that the schemes with flat-rate co-payment elements tend not to be progressive, while those involving means testing and graduated co-payments can be designed in a progressive manner. Schemes that cap fees at a maximum rate would ensure that users of high home support hours do not face very high care costs. Overall, we find minimal impacts on poverty among older people, particularly for options without flat-rate elements. Impacts on inequality are likely to be limited. These results assume that a person's primary residence will not be taken into consideration in any means testing of the scheme. If the value of a person's primary residence is included in the definition of means for the scheme the results are likely to differ substantially – such a move would generate significantly more for the Exchequer towards the cost of home support but would result in regressive distributional impacts under all the scenarios examined and most scenarios would lead to large increases in the poverty rate among older people. These findings reflect the fact that, for many, their primary residence is likely to be their most valuable asset, and that property values are still relatively high for those on lower cash incomes, so that they may be 'asset rich but cash poor'. Many home support recipients may receive care for many years and, by definition, will remain in their home during this time, unlike those entering residential care. This presents practical problems in terms of how they would access the equity in their home to contribute towards their home support cost; moreover, the inclusion of their primary residence may deter people from using the home support scheme, which would have an obvious negative impact on their welfare. Any inclusion of primary residence values would likely necessitate some sort of deferral option as is the case for property tax or the capping and deferral scheme in place under the NHSS, so as not to adversely affect the incomes of those aged 65 and over, particularly those at the bottom end of the income distribution. While the introduction of co-payments may dampen some demand for care, as found in other countries (Non, 2017; Roquebert and Tenand, 2017), the fact that, within the current system, many people purchase private home support and waiting lists exist, the results estimated across our scenarios are unlikely to be greatly impacted.

The lack of adequate administrative data hampered the scope of some of the analyses presented here, and required us to utilise other survey sources (e.g. TILDA). Developing a data system will be required for the statutory home support scheme in order to distribute care effectively across recipients. Integration of the InterRai SAT within this data system will allow for more accurate representation of

individual-level support needs, which in turn will enable services to provide a more tailored response. In addition, the potential financing scenarios outlined in this report would require a data system that captures (or integrates) key information, not just of the care needs of recipients, but also of their means (e.g. income, pension, housing costs, etc.) for the purpose of co-payment calculations. This system will need to be flexible enough to account for changes in home support needs and means. Systems used by the Department of Social Protection for means-tested social welfare benefits, as well as the General Medical Services Scheme, developed by the PCRS, may offer insights into the development of a data system for the home support scheme.

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APPENDIX 1

Medical and GP visit card means calculation

In order to calculate income/means in this report, we follow the guidelines for medical cards and GP visit cards.[34] The income limits for these entitlements differ based on age and a person's living situation. Those aged over 70 are automatically entitled to a GP visit card. Those aged over 70 and whose **gross income** is below the relevant limit qualify for a medical card. The current gross income limit for those aged 70 or over is €550 for a single person, or €1,050 for a couple.

For those aged under 70, means are calculated differently. Income from the following sources is included:

- social welfare payments
- wages (net, i.e. after tax, PRSI and USC)
- occupational pensions
- income from savings and investments
- maintenance payments
- rental income from family home
- property other than the family home
- royalties or payments under a settlement, covenant or from an estate.

The following expenses are allowed against the above income sources:

- housing costs (rent/mortgage payments)
- childcare costs
- travel-to-work costs
- maintenance payments
- net cost of private nursing home care
- mortgage protection premium
- life assurance for mortgage protection.

The qualifying financial threshold is then calculated by adding:

- A basic rate – depending on your age, marital status, living situation and if you have any children
- The amount allocated for each dependant
- The amount for allowable expenses.

[34] See https://www2.hse.ie/services/medical-cards/medical-card-application-process/how-much-you-can-earn-and-still-qualify-for-a-medical-card.html and https://www2.hse.ie/services/medical-cards/medical-card-for-over-70s.html.

The three amounts are added together to give a qualifying financial threshold. This figure is the maximum amount you can earn as your net weekly income in order to qualify for a medical card. The value of a person's family home, i.e. principal primary residence, is not included in the means assessment for a medical card or a GP visit card.

Basic rates

- Single person living alone aged up to 65: €184 for medical card and €304 for GP visit card.
- Single person living alone aged 66 and over: €201.50 for medical card and €333 for GP visit card.
- Single person living with family aged up to 65: €164 for medical card and €271 for GP visit card.
- Single person living with family aged 66 and over: €173.50 for medical card and €286 for GP visit card.
- Married, co-habiting couple/single parent family aged up to 65 with dependents: €266.50 for medical card and €441 for GP visit card.
- Married, co-habiting couple/single parent family aged over 66 with dependents: €298 for medical card and €492 for GP visit card.

Additional rates for dependants

- First two children under 16 financially dependent on applicant: €38 for medical card and €57 for GP visit card.
- Third and subsequent children under 16 financially dependent on applicant: €41 for medical card and €61.50 for GP visit card.
- First two children over 16 financially dependent on applicant: €39 for medical card and €58.50 for GP visit card.
- Third and subsequent children over 16 financially dependent on applicant: €42.50 for medical card and €64 for GP visit card.
- A dependent over 16 who is in full-time third-level education, not grant aided: €78 for medical card and €117 for GP visit card.

Those whose means are above the relevant medical card threshold but for whom all their income comes from social welfare payments qualify for a medical card.

The SWITCH data capture the vast majority of income sources and allowable expenses and replicates the means test as just described. Items such as travel-to-work costs and information on savings are not available in the SWITCH model as they are not captured in the SILC data. For more detail on the items not captured in the model and possible implications, see Keane et al. (2021). Means for the purpose of establishing entitlement to GP visit cards are calculated in the same way but have a higher means limit. As there is no income/means limit for those over 70 for a GP visit card, we instead calculate an equivalent limit for those over

70 by adding 65 per cent to the over 70s medical card income limit, as GP visit card income limits for those under 70 are 65 per cent higher than the medical card income limits.

APPENDIX 2

Hours scenarios

Table A.2.1 adds to the Exchequer results shown in Table 4.2, expanding the hours of home support used under Scenario B (current public hours and assuming all private hours become public) and Scenario C (current public hours, assuming all private hours become public and there is a 15 per cent increase in public hours used to meet unmet demand). While hypothetical, these scenarios provide some information on how co-payments could contribute to the total cost of home support, should large behavioural reactions to the introduction of the new scheme occur.

Under Scenario B, the total cost of home support would increase by two-thirds, from €407.1 million to €681.6 million. Under Scenario C, the total cost of home support would nearly double to €783.8 million per annum.

TABLE A.2.1 EXCHEQUER COST OF FUNDING AND HOURS SCENARIOS, € MILLION PER ANNUM

	Hours scenario B			Hours scenario C		
Funding scenario	Exchequer cost	Co-payment	Co-payment as % of total cost	Exchequer cost	Co-payment	Co-payment as % of total cost
1	681.6	0	0%	783.8	0	0%
2	553.5	128.1	19%	636.5	147.3	19%
3.1	664.6	17.0	2%	764.3	19.5	2%
3.2	591.2	90.3	13%	679.9	103.9	13%
4.1	608.6	72.9	11%	699.9	83.9	11%
4.2	674.4	7.2	1%	775.5	8.3	1%
5.1	600.3	81.2	12%	695.7	88.1	11%
5.2	618.0	63.6	9%	717.6	66.2	8%
5.3	676.2	5.4	1%	777.7	6.1	1%
5.4	630.7	50.9	7%	730.8	53.0	7%
5.5	642.6	39.0	6%	743.1	40.7	5%
5.6	677.3	4.3	1%	779.5	4.3	1%
6.1	631.4	50.2	7%	732.8	51.0	7%
6.2	642.6	39.0	6%	744.0	39.8	5%
7	644.6	37.0	5%	745.9	37.9	5%

Source: Own calculations for those aged 65+ using SWITCH.

Notes: Scenario B is based on estimated current usage of public home support plus all private hours of home support are assumed to become public hours. C expands on B and allows for a 15% increase in public home support usage among those currently receiving publicly funded home support to address unmet needs for care.
The funding scenarios are as follows:
1=Full Exchequer funding; 2=€5 flat rate hourly contribution; 3.1/3.2=Exchequer funded if means<medical card limit (€5/€26.60 co-payment otherwise); 4.1/4.2=Exchequer funded if means<GP visit card limit (€5/€26.60 co-payment otherwise); 5.1=graduated means test if means>minimum wage (50% taper rate); 5.2=graduated means test if means>living wage (50% taper rate); 5.3=graduated means test if means>average wage (50% taper rate); 5.4=graduated means test if means>minimum wage (25% taper rate);5.5=graduated means test if means>living wage (25% taper rate); 5.6=graduated means test if means>average wage (25% taper rate); 6.1=graduated means test if means>minimum wage (75% taper rate); annual caps; 6.2=graduated means test if means>living wage (75% taper rate); annual caps; 7=disposable income after co-payments not to fall below the living wage.
Tax relief is not included here, means exclude the value of a person's primary residence.

APPENDIX 3

Sensitivity analysis – Tax relief and primary residences

EXCHEQUER IMPACTS

Providing 20 per cent standard tax relief has relatively little impact on the amount co-payments for home support would generate for the Exchequer – the most co-payments would be anticipated to generate net of the cost of tax relief would reduce from 19 to 15 per cent of the total home support cost (Scenario 2 – *€5 p.h. co-payment, flat rate*). These results are shown in Table A.3.1, labelled *'Baseline + 20% tax relief'*.

The inclusion of a person's family home in the definition of assets changes the results substantially, as shown in Table A.3.1 (labelled '*Baseline + inclusion of primary residence*'). While under the baseline scenario examined in Table 4.2, co-payments, when charged, accounted for between 0.2 per cent and 19 per cent of the total cost of home support, the inclusion of a person's family home increases this range, which now runs from a low of 11 per cent under Scenario 4.1 (*€5 p.h. co-payment, means>GPC limit*) to a high of 86 per cent under Scenario 5.1 (*Co-payment > Minimum wage, 50% taper*). This reflects the fact that many people's primary residence will be their highest-value asset.[35,36] The inclusion of such an asset, however, may present affordability issues for home support recipients as such an asset is generally illiquid. This is even more of an issue for those availing of home support, as opposed to residential care, as they will remain living in the property. This issue is highlighted further when looking at the distributional and poverty impacts of such an approach.

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35 The value of a person's primary residence is based on the value provided by the owner and as recorded in the SILC data. The majority of households provide an estimate for the value of their property – for those without estimates, the property is valued by applying a premium to the insured value of the property (insured values are generally lower as they exclude the land value). In cases where the insured value is not provided, a hedonic regression is run on those who do provide a property value, the results of which are then used to predict a property value for those who did not provide this information; in other words, the characteristics of the property and its location allow us estimate a property value.

36 For example, a property value of €300,000 and no other assets would equate to a notional income of €1,006 per week for a single person (the first €36,000 value is ignored, the following €10,000 worth is assessed at €1 per thousand (€1*10), the next €10,000 worth is assessed as €2 per thousand (€2*10) and the remainder (€244,000) is assessed as €4 per thousand (4*244). The total (€1*10 + €2*10 + €4*244) is more than four times the current maximum state contributory pension rate of €248.30.

TABLE A.3.1 EXCHEQUER COST OF FUNDING SCENARIOS INCLUDING TAX RELIEF AND VALUES OF PRIMARY RESIDENCES

Funding scenario		Baseline	Baseline + 20% tax relief	Baseline+inclusion of primary residence	Baseline	Baseline + 20% tax relief	Baseline+inclusion of primary residence
		€ million per annum			Co-payment as % of total cost		
1	Zero co-payments	407.1	407.1	407.1			
2	€5 p.h. co-payment, flat rate	330.5	345.8	330.5	19%	15%	19%
3.1	€5 p.h. co-payment, means>MC limit	396.0	398.2	347.8	3%	2%	15%
3.2	€26.60 p.h. payment (i.e. full cost), means>MC limit	348.0	359.8	91.7	15%	12%	77%
4.1	€5 p.h. co-payment, means>GPC limit	406.1	406.3	362.8	0.2%	0.2%	11%
4.2	€26.60 p.h. payment (i.e. full cost), means>GPC limit	402.2	403.1	171.6	1%	1%	58%
5.1	Co-payment > Minimum wage, 50% taper	349.3	360.9	57.3	14%	11%	86%
5.2	Co-payment > Living wage, 50% taper	362.2	371.2	80.8	11%	9%	80%
5.3	Co-payment > Average wage, 50% taper	402.9	403.7	234.5	1%	1%	42%
5.4	Co-payment > Minimum wage, 25% taper	359.7	369.2	91.4	12%	9%	78%
5.5	Co-payment > Living wage, 25% taper	371.0	378.2	113.4	9%	7%	72%
5.6	Co-payment > Average wage, 25% taper	403.2	403.9	260.2	1%	1%	36%
6.1	Co-payment > Minimum wage, 75% taper, caps	358.7	368.4	120.3	12%	9%	70%
6.2	Co-payment > Living wage, 75% taper, caps	369.9	377.3	127.7	9%	7%	69%
7	Co-payment, means > Living wage	371.1	378.3	275.1	9%	7%	32%

Source: Own calculations for those aged 65+ using SWITCH.

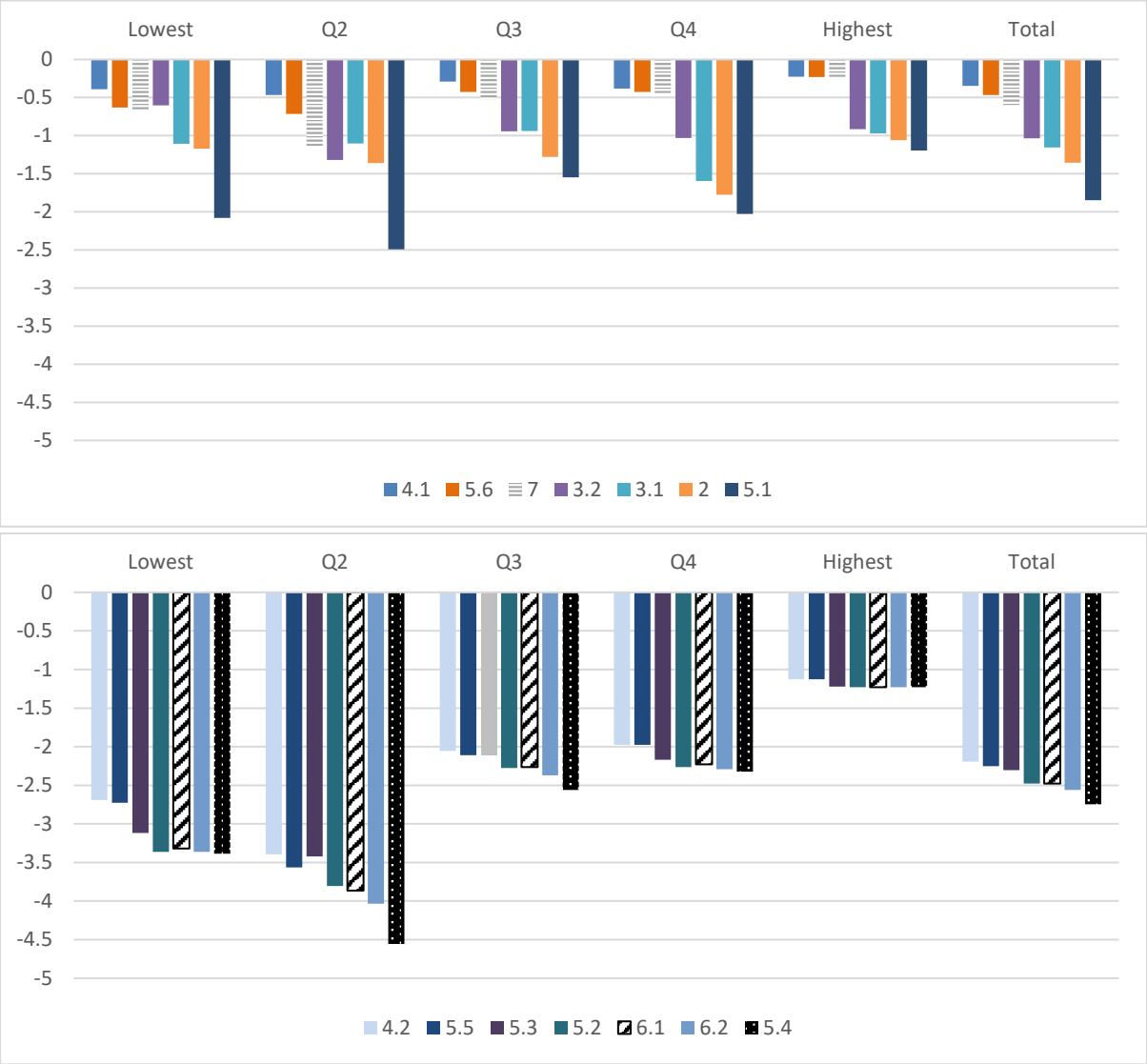
Notes: Results based on Scenario A of home support hours use: estimated current usage of public home support. Home support hours eligible for funding are capped at 60 hours per week.
The funding scenarios are as follows:
1=Full Exchequer funding; 2=€5 flat rate hourly contribution; 3.1/3.2=Exchequer funded if means<medical card limit (€5/€26.60 co-payment otherwise); 4.1/4.2=Exchequer funded if means<GP visit card limit (€5/€26.60 co-payment otherwise); 5.1=graduated means test if means>minimum wage (50% taper rate); 5.2=graduated means test if means>living wage (50% taper rate); 5.3=graduated means test if means>average wage (50% taper rate); 5.4=graduated means test if means>minimum wage (25% taper rate); 5.5=graduated means test if means>living wage (25% taper rate); 5.6=graduated means test if means>average wage (25% taper rate); 6.1=graduated means test if means>minimum wage (75% taper rate); annual caps; 6.2=graduated means test if means>living wage (75% taper rate); annual caps; 7=disposable income after co-payments not to fall below the living wage.
The 'baseline' scenario excludes any tax relief on co-payments, the 'baseline +20% tax relief' scenario allows for a standard (20%) rate of tax relief on all co-payments while the 'baseline + inclusion of primary residence' scenario includes the value of property over 65s are owner-occupier of into their assets but no tax relief on co-payments.

DISTRIBUTIONAL IMPACTS

We do not show the distributional impact of the scenarios assuming standard 20 per cent tax relief, as the pattern is the same as in Figure 4.2, just of a slightly lower magnitude. This reflects the fact that everyone would receive a 20 per cent reduction in co-payments across the income decile.

We have just seen that inclusion of a person's primary residence in the definition of means has a very substantial impact on the total amount of co-payments made; while, on average, co-payments would account for eight per cent of the total cost of home support in Scenario 2 onwards, assuming no tax relief and no inclusion of primary residences in means, this rises to 53 per cent if primary residences are included. The distributional impact of their inclusion is shown below in Figure A.3.1, which indicates the sharper average income losses across all funding scenarios if the value of primary residences is taken into account. If primary residences are excluded, the average overall loss in income among the over 65s for Scenario 2 onwards is 0.26 per cent of income, ranging from .01 per cent in Scenario 4.1 (*€5 p.h. co-payment, means>GPC limit*) to 0.6 per cent in Scenario 2 (*€5 p.h. co-payment, flat rate*). If primary residences are included as an asset, the average income reduction for Scenarios 2 to 7 rises to 1.7 per cent, ranging from 0.3 per cent for Scenario 4.1 (*€5 p.h. co-payment, means>GPC limit*) to 2.7 per cent for Scenario 5.4 (*co-payment > minimum wage, 25% taper*). It is worth bearing in mind these are the average losses among all over 65s; losses among those actually using home support will be substantially higher.

FIGURE A.3.1 PERCENTAGE CHANGE IN DISPOSABLE INCOME OF OLDER PEOPLE DUE TO CO-PAYMENTS, PRIMARY RESIDENCE INCLUDED IN MEANS ASSESSMENT



Source: Own calculations for those aged 65+ using SWITCH.

Notes: Quintiles are based on the total population and are calculated based on equivalised, disposable income. Results based on Scenario A of home support hours use: estimated current usage of public home support. Home support hours eligible for funding are capped at 60 hours per week.

The funding scenarios are as follows:

1=full Exchequer funding; 2=€5 flat rate hourly contribution; 3.1/3.2=Exchequer funded if means<medical card limit (€5/€26.60 co-payment otherwise); 4.1/4.2=Exchequer funded if means<GP visit card limit (€5/€26.60 co-payment otherwise); 5.1=graduated means test if means>minimum wage (50% taper rate); 5.2=graduated means test if means>living wage (50% taper rate); 5.3=graduated means test if means>average wage (50% taper rate); 5.4=graduated means test if means>minimum wage (25% taper rate); 5.5=graduated means test if means>living wage (25% taper rate); 5.6=graduated means test if means>average wage (25% taper rate); 6.1=graduated means test if means>minimum wage (75% taper rate); annual caps; 6.2=graduated means test if means>living wage (75% taper rate); annual caps; 7=disposable income after co-payments not to fall below the living wage.

Tax relief is not included here, 'means' includes the value of a person's primary residence.

Figure 4.2 shows that the lowest income quintile experienced a reduction in income due to co-payments in only three of the 14 scenarios examined if a person's principal residence value is not taken into account. Once principal residence values are taken into account (see Box 1 below for more information on this), the lowest income quintile experiences a reduction in income across all 14 scenarios, reflecting the fact that many may be 'cash poor' but 'asset rich' as the income quintiles are calculated based on cash income. This issue is illustrated in Table A.3.2 below, which shows home ownership rates and average property values by disposable (cash) income quintile among the over 65s group. While those in lower-income quintiles have a lower rate of home ownership than those in higher income quintiles, the rates do not vary hugely and the majority in lower-income groups own their own home – 84 per cent of those aged 65 and over in the lowest income decile own their own home compared to 94 per cent in the middle of the income distribution and 99 per cent at the top.[37] An even stronger driver of our results regarding the inclusion of property values in assessed assets is the average property value by income quintile. While the average property value of those aged 65 and over in the highest income quintile is double that of the lowest income quintile, there is less variation in property values across Quintiles 1 to 4. Therefore, property values can be substantial relative to a person's cash/disposable income and results in the Exchequer and distributional impact shown in Table A.3.1 and Figure A.3.1.

TABLE A.3.2 HOME OWNERSHIP RATES AND AVERAGE PROPERTY VALUES BY QUINTILE (65+)

Quintile	% owning a principal residence	Average property value (€)
Lowest	84	212,818
2	86	189,682
3	94	296,725
4	94	284,417
Highest	99	438,908
Total	91	268,061

Source: Own calculations for those aged 65+ using SWITCH.
Notes: Property values are self-reported by the majority (61%) of respondents in the SILC survey. For those missing a self-reported property value, the insurance value is used, adjusted by the average insured: reported value ratio for those who report both. A small number (8%) are missing the insured value; for these properties, house values are predicted by using a regression of house prices on property effects (bedrooms, property type, damp floors, rot in the property and leaking roof), location effects (population density, noise in area, violence/crime in the area, pollution/grime in the area) and gross income of dwellers in the property.

The flat-rate approach (Scenario 2) remains regressive in nature; in fact, the progressive nature of the majority of funding scenarios when principal residence

[37] It is anticipated that home ownership rates among those over 65 years will fall in future decades as Roantree et al. (2021) find declining home ownership rates among younger cohorts.

values are not included in the means assessment (Figure 4.2) is now erased for all scenarios, with the lower-income groups tending to experience a sharper reduction in income due to home support co-payments than those on higher cash incomes. Even those scenarios with caps on home support payments (Scenarios 6.1, 6.2 and 7) lose their progressive pattern as the location of those concerned in the disposable income distribution (i.e. income quintile) moves further away from their means inclusive of property values.

These results point to affordability issues regarding home support payments if primary residences are taken into account, particularly for lower-income groups. Should it be decided that principal residences are to be included in the means assessment, deferral and/or capping measures could be used to mitigate the losses, particularly for those on lower incomes. A cash income, threshold-based property tax deferral option is currently in place to ensure that the disposable incomes of lower-income groups are protected. The 7.5 per cent (annual) contribution based on the value of a person's primary residence under the Nursing Home Support Scheme can also be deferred and collected from a person's estate upon their death; a similar approach could be applied if the value of a person's home were to be included in the means assessment for home support services. Alternatively, a different notional means assessment could be used for principal residences that would not place such a high weekly notional income amount on people's homes.

POVERTY AND INEQUALITY IMPACTS

Allowing tax relief on home support co-payments has little impact on the poverty and inequality results shown in section 4.4 as the relief applies equally across the income distribution. These results are therefore not shown here for conciseness purposes.

In line with the distributional impact results shown in Figure A.3.1, poverty rates among older people would rise substantially in many of the scenarios examined if primary residence values were taken into consideration (Table A.3.3). Poverty increases would be modest under scenarios with a €5 co-payment rate (2, 3.1 and 4.1), as well as Scenario 7, which ensures people's disposable income remains above the living wage level, which is above the poverty line. They would rise by at least 14.5 per cent under the other scenarios and would increase by more than 50 per cent in Scenario 5.1, sending the at-risk-of-poverty rate among older people to over ten per cent.

TABLE A.3.3 AT-RISK-OF-POVERTY RATES FOR OLDER PEOPLE, PRIMARY RESIDENCE INCLUDED IN MEANS ASSESSMENT

Funding scenario		AROP rate	% change due to co-payments
1	Zero co-payments	6.6	–
2	€5 p.h. co-payment, flat rate	6.7	1.4%
3.1	€5 p.h. co-payment, means>MC limit	6.7	1.4%
3.2	€26.60 p.h. payment (i.e. full cost), means>MC limit	9.8	47.6%
4.1	€5 p.h. co-payment, means>GPC limit	6.6	0.1%
4.2	€26.60 p.h. payment (i.e. full cost), means>GPC limit	8.7	31.1%
5.1	Co-payment > Minimum wage, 50% taper	10.4	56.5%
5.2	Co-payment > Living wage, 50% taper	9.8	47.1%
5.3	Co-payment > Average wage, 50% taper	7.7	16.8%
5.4	Co-payment > Minimum wage, 25% taper	9.7	45.9%
5.5	Co-payment > Living wage, 25% taper	9.6	44.0%
5.6	Co-payment > Average wage, 25% taper	7.6	14.5%
6.1	Co-payment > Minimum wage, 75% taper, caps	9.8	47.7%
6.2	Co-payment > Living wage, 75% taper, caps	9.6	45.2%
7	Co-payment, means > Living wage	6.7	1.0%

Source: Own calculations for 2021 for those aged 65+ using SWITCH.

Notes: Results based on Scenario A of home support hours use: estimated current usage of public home support. Home support hours eligible for funding are capped at 60 hours per week.
The funding scenarios are as follows:
1=Full Exchequer funding; 2=€5 flat rate hourly contribution; 3.1/3.2=Exchequer funded if means<medical card limit (€5/€26.60 co-payment otherwise); 4.1/4.2=Exchequer funded if means<GP visit card limit (€5/€26.60 co-payment otherwise); 5.1=graduated means test if means>minimum wage (50% taper rate); 5.2=graduated means test if means>living wage (50% taper rate);5.3=graduated means test if means>average wage (50% taper rate); 5.4=graduated means test if means>minimum wage (25% taper rate); 5.5=graduated means test if means>living wage (25% taper rate); 5.6=graduated means test if means>average wage (25% taper rate); 6.1=graduated means test if means>minimum wage (75% taper rate); annual caps; 6.2=graduated means test if means>living wage (75% taper rate); annual caps; 7=disposable income after co-payments not to fall below the living wage.
Tax relief is not included here, means include the value of a person's primary residence.

Box 1 outlines how at-risk-of-poverty rate (AROP, or commonly called the 'poverty rate') is calculated and explains the difference between 'income' and 'means'. We provide a simple example of how inclusion of a home support recipient's main residence can significantly impact their means, and by consequence any co-payment charges they may face.

BOX 1 POVERTY RATE CALCULATIONS – INCOME VERSUS MEANS

At-risk-of-poverty rate (AROP) and income

AROP is calculated by adding up all the gross cash income ('income') of a home support recipient's household. This cash income can have various sources, including social welfare, occupational pensions, employment and self-employment income. This cash income is then equivalised to take account of household size. Households are ranked according to their equivalised cash income. The poverty line is then calculated by finding the median (halfway point) income and taking 60 per cent of this median value. All households below this threshold are said to be 'at risk of poverty' or below the poverty line.

Means

The concept of 'means' is similar to that of 'income', but there are differences. For the purposes of this report, means are calculated using the medical card means test. These means are calculated in two ways, depending on the age of the person. For those aged over 70, the means test is straightforward and simply involves adding up the cash income of an individual's household from a variety of sources, such as welfare benefits, occupational pensions and employment income. For those aged under 70, the means test is more complicated. Firstly, all income, from a variety of sources, such as social welfare payments and employment income (see Appendix 1 for more detail), is added up, after which income tax, the universal social charge and PRSI are deducted. Secondly, from this net cash income, households can include allowable expenses such as childcare or rent *against* it to reduce their means. Thirdly, all capital (such as savings) and other assets such as property are taken into account, though primary residences are *not* assessed. The key difference between 'income' and 'means' is therefore inclusion of asset values, such as savings and property. The total value of the assets is not included in means; rather, a 'notional assessment of interest' is calculated. This effectively places a notional value on the income stream that would come from these assets. While people can use the actual interest amount received from savings or the actual rental amount received for a property, this 'notional' interest amount allows for the inclusion of assets such as additional properties that are not rented out.

Example – Primary residence value

In a hypothetical example, let's take two individuals, who live alone in their primary residence (which they own outright) with the same cash income, zero allowable costs and zero savings. When primary residences are not included in the calculation of means, these two individuals would have the same 'means' even if Individual 1 has a home worth €100,000 and Individual 2 has a home worth €300,000. If these two individuals were both using the same number of home support hours they would, therefore, face the exact same co-payments, if any, across all scenarios we modelled in this report. The two individuals would both also have the same equivalised cash income for poverty rate calculation purposes and would fall into the same income quintile as their cash incomes are identical, even though they live in homes of very different values. The inclusion of a person's primary residence in the calculation of means has an impact on their means but not on their position in the income distribution as, again, this is based on cash equivalised income.

To highlight the potential impact of including primary residence within the means test, we again take the same individuals from our hypothetical scenario and assume the value of their primary residence is now assessed. The medical card means assessment excludes the first €36,000 of a person's assets in the 'notional assessment of interest'. It then assumes a weekly means of €1 per €1,000 worth of assets for the first €10,000 above the €36,000 level, €2 per €1,000 for the next €10,000 worth of assets and €4 per €1,000 on the balance. If we apply these calculations to the two individuals, Individual 1 would have an additional weekly assessed means value of €206 per week while the Individual 2 would have a weekly assessed means value of €1,006 per week as shown below – almost five times higher. This assessed weekly means value then gets added to the weekly cash incomes of the individual to calculate their total weekly means.

Property value	**€100,000**	**€300,000**
First €36,000	**€0**	**€0**
Next €10,000	**€10**	**€10**
Next €10,000	**€20**	**€20**
Balance	**€176**	**€976**
Total weekly assessment means from primary residence	**€206**	**€1,006**

BOX 1 (CONTD.) POVERTY RATE CALCULATIONS – INCOME VERSUS MEANS

This hypothetical example highlights that the inclusion of a home support recipient's primary residence in the means test will result in significantly different co-payments being charged for home support across the scenarios modelled, even if individuals have the same cash income. It would also result in Individual 2 paying more than Individual 1 despite having the same AROP rate. It is for this reason we see substantial changes in the distributional impact of co-payments under each scenario in Appendix 3, as well as large increases in poverty rates. The introduction of primary residence into means calculations would result in a divergence from the medical card means assessment and may also be likely to produce a significant barrier to many people seeking home support, as these charges would have to be paid from their cash income.

Including the value of a person's primary residence in the definition of means does tend to increase inequality, but only marginally (see Table A.3.4). While some individuals will now face larger income reductions due to co-payments for home support, and thereby face a higher risk of poverty, the aggregate total income loss is not enough to significantly alter the income distribution of the total population reflected by the Gini coefficient.

TABLE A.3.4 GINI COEFFICIENT– PRIMARY RESIDENCE INCLUDED IN MEANS ASSESSMENT

Funding scenario		Gini
1	Zero co-payments	29.4
2	€5 p.h. co-payment, flat rate	29.4
3.1	€5 p.h. co-payment, means>MC limit	29.4
3.2	€26.60 p.h. payment (i.e. full cost), means>MC limit	29.7
4.1	€5 p.h. co-payment, means>GPC limit	29.4
4.2	€26.60 p.h. payment (i.e. full cost), means>GPC limit	29.6
5.1	Co-payment > Minimum wage, 50% taper	29.8
5.2	Co-payment > Living wage, 50% taper	29.7
5.3	Co-payment > Average wage, 50% taper	29.5
5.4	Co-payment > Minimum wage, 25% taper	29.7
5.5	Co-payment > Living wage, 25% taper	29.7
5.6	Co-payment > Average wage, 25% taper	29.4
6.1	Co-payment > Minimum wage, 75% taper, caps	29.6
6.2	Co-payment > Living wage, 75% taper, caps	29.6
7	Co-payment, means > Living wage	29.4

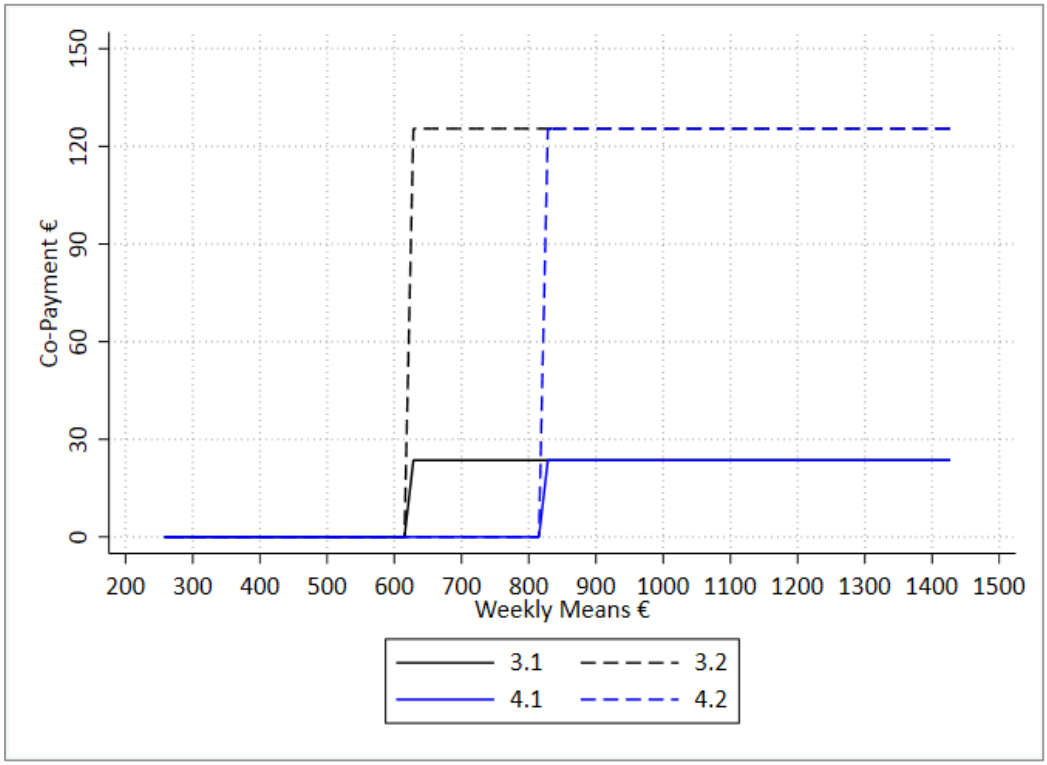
Source: Own calculations for 2021 using SWITCH.

Notes: Results based on Scenario A of home support hours use i.e. estimated current usage of public home support. Home support hours eligible for funding are capped at 60 hours per week.
The funding scenarios are as follows:
1=Full Exchequer funding; 2=€5 flat rate hourly contribution; 3.1/3.2=Exchequer funded if means<medical card limit (€5/€26.60 co-payment otherwise); 4.1/4.2=Exchequer funded if means<GP visit card limit (€5/€26.60 co-payment otherwise); 5.1=graduated means test if means>minimum wage (50% taper rate); 5.2=graduated means test if means>living wage (50% taper rate); 5.3=graduated means test if means>average wage (50% taper rate); 5.4=graduated means test if means>minimum wage (25% taper rate); 5.5=graduated means test if means>living wage (25% taper rate); 5.6=graduated means test if means>average wage (25% taper rate); 6.1=graduated means test if means>minimum wage (75% taper rate); annual caps; 6.2=graduated means test if means>living wage (75% taper rate); annual caps; 7=disposable income after co-payments not to fall below the living wage.
Tax relief is not included here, means include the value of a person's primary residence.

APPENDIX 4

Hypothetical example

FIGURE A.4.1 HYPOTHETICAL EXAMPLE, 1.5 HOUR OF CARE PER DAY AT VARIOUS INCOMES



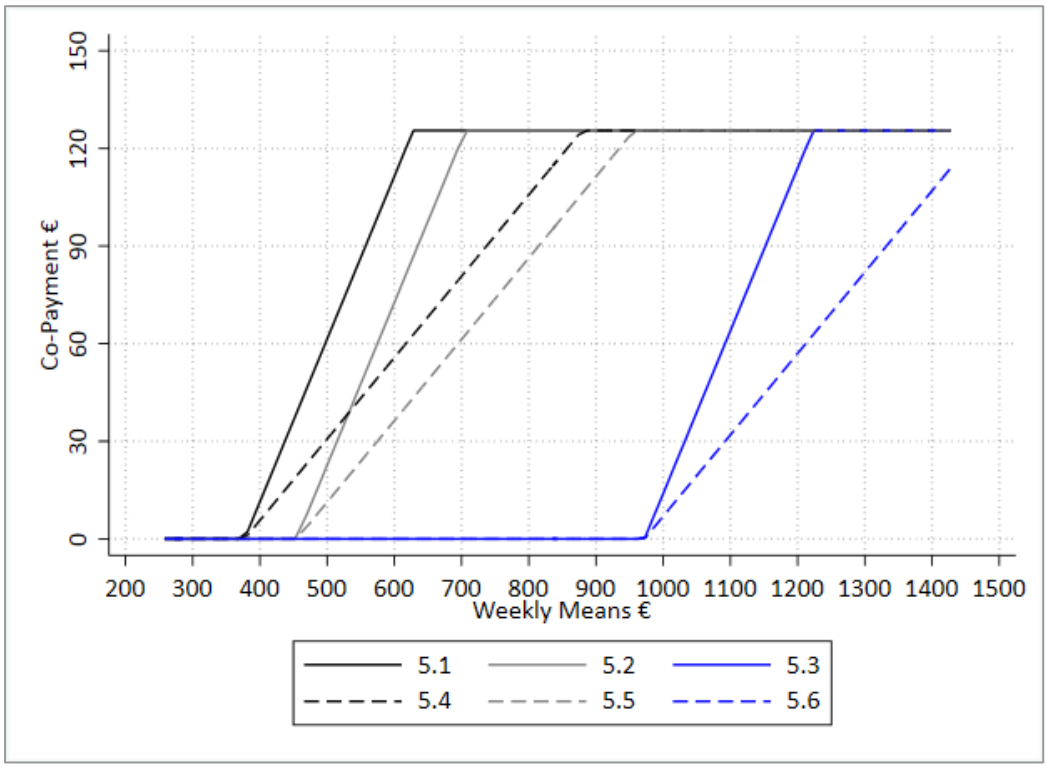
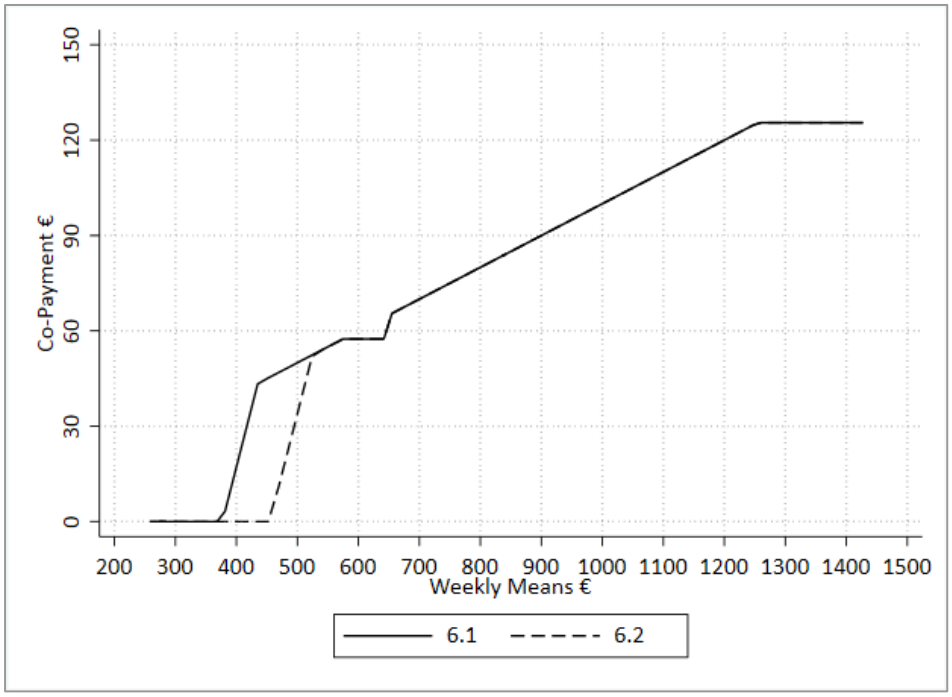
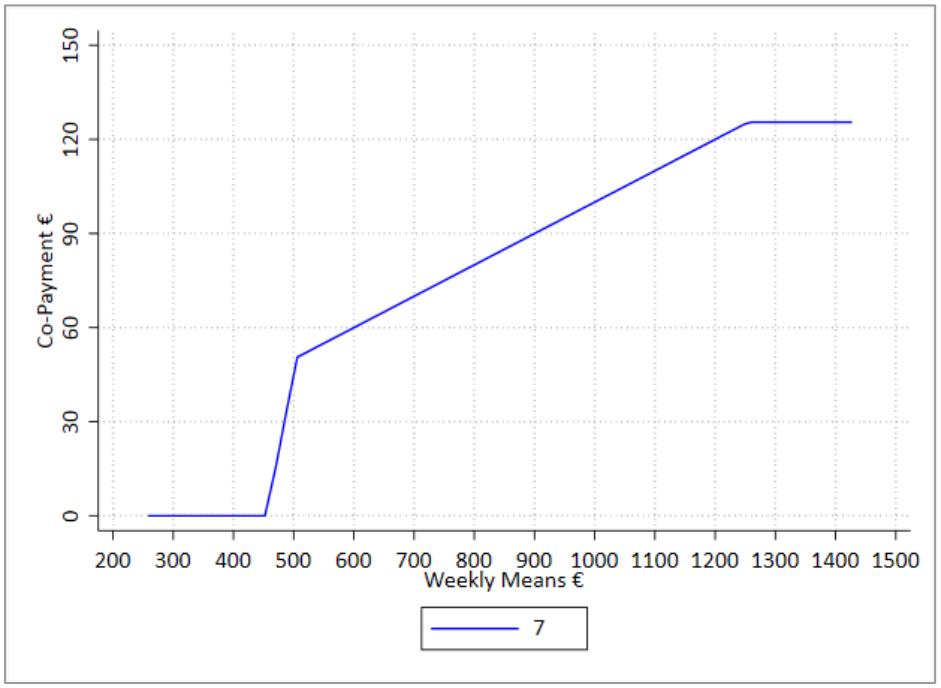


FIGURE A.4.1 (CONTD.) HYPOTHETICAL EXAMPLE, 1.5 HOUR OF CARE PER DAY AT VARIOUS INCOMES





Source: Own calculations using the hypothetical household feature in SWITCH.

Notes: Hours scenario A is assumed for all the workings shown, i.e. current public home support use. In these examples a single pensioner, aged 75, demands 1.5 hour of care per day, this is then scaled by 13.68 – the average number of days per month people reported availing of home support in TILDA – to arrive at average weekly demand per annum. The full weekly cost of care is therefore €126. The size of the private payment for total care is shown on the y-axis and weekly means is shown on the x-axis. Weekly means increase from differing private pension entitlement rates. The funding scenarios are as follows:

1=Full Exchequer funding; 2=€5 flat rate hourly contribution; 3.1/3.2=Exchequer funded if means<medical card limit (€5/€26.60 co-payment otherwise); 4.1/4.2=Exchequer funded if means<GP visit card limit (€5/€26.60 co-payment otherwise); 5.1=Graduated means test if means>minimum wage (50% taper rate); 5.2=graduated means test if means>living wage (50% taper rate); 5.3=graduated means test if means>average wage (50% taper rate); 5.4=graduated means test if means>minimum wage (25% taper rate); 5.5=graduated means test if means>living wage (25% taper rate); 5.6=graduated means test if means>average wage (25% taper rate); 6.1=graduated means test if means>minimum wage (75% taper rate); annual caps; 6.2=graduated means test if means>living wage (75% taper rate); annual caps; 7=disposable income after co-payments not to fall below the living wage.

Tax relief is not included here, means exclude the value of a person's primary residence.

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