



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

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

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FOREWORD

This report was prepared by researchers at the Economic and Social Research Institute (ESRI) for the Department of Health. The report is published as an ESRI Survey and Statistical Series report and should be read in conjunction with the recently published *Projections of national demand and bed capacity requirements for older people's care in Ireland, 2022–2040: Based on the Hippocrates model*. This report analyses demand for long-term residential care and home support services in 2022 at the HSE Health Region level and projects demand and bed capacity requirements to 2040.

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

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

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ABBREVIATIONS

ADL	Activities of daily living
BIU	Business Information Unit (HSE)
CHO	Community Health Organisation
CM	Compression of morbidity
CSO	Central Statistics Office
DE	Dynamic equilibrium
DTOC	Delayed transfers of care
ESRI	Economic and Social Research Institute
HCCI	Home and Community Care Ireland
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
ICPOP	Integrated Care Programme for Older People
iHCP	Intensive Home Care Package
LHO	Local health office
LTRC	Long-term residential care
NHI	Nursing Homes Ireland
NHSS	Nursing Homes Support Scheme
SYOA	Single year of age
TILDA	The Irish Longitudinal Study on Ageing

Health Regions

DNE	Dublin and North East
DML	Dublin and Midlands
DSE	Dublin and South East
SW	South West
MW	Mid West
WNW	West and North West

EXECUTIVE SUMMARY

INTRODUCTION

This report is part of a new series of reports that uses the Economic and Social Research Institute (ESRI) Hippocrates model to provide up-to-date projections for three service areas (public acute hospitals, general practice and older peoples' services) at both national and regional level. Focusing on older people's services, this report extends the national-level demand and bed capacity analysis published in Walsh and Kakoulidou (2025), by estimating regional activity profiles for 2022 for the six HSE Health Regions, and providing medium-term regional projections of demand and bed capacity requirements to 2040 for long-term residential care (LTRC) and home support for each HSE Health Region.

Building on the existing modelling framework, the specific objectives of this report are to:

- provide regional profiles for LTRC bed capacity and home support hours among older people (aged 65 years and over) for each HSE Health Region; and
- project LTRC bed capacity and home support hour requirements to 2040 for each HSE Health Region.

Hippocrates model projections are influenced by the model of service delivery, data availability and quality, and the policy environment in the base year. Fluctuations in activity rates for older people's services occurred in recent years, especially during the COVID-19 pandemic period. While available national-level data on older people's services are limited, as discussed in Walsh and Kakoulidou (2025), available data at the HSE Health Region level are even more limited. Consequently, the findings in this report should be interpreted with caution. It is anticipated that as the HSE Health Regions become more embedded into the health system over time, better data will be available, allowing more refined analyses to be undertaken.

METHODS

The projections of demand and capacity (short stay and long stay beds and home support hours) requirements included in this report use the Hippocrates model, the ESRI's macro-simulation healthcare projection model. In these analyses, LTRC bed capacity and home support hour requirements are modelled from a 2022 base for each HSE Health Region.

The starting point for Hippocrates is to estimate short stay and long stay bed rates and home support hour activity rates in 2022 in each HSE Health Region from

analysis of current use of services by age and sex. A number of survey-based and administrative data sources are used to compile baseline activity profiles. Population projections by age and sex to 2040 are provided by the ESRI's regional demographic model. LTRC bed rates and home support hour requirements are projected by multiplying these rates by the projected population in each HSE Health Region. Baseline estimates of beds and hours are projected; these estimates are based on a range of assumptions, including the size and structure of the population, healthy ageing, potential policy changes such as reducing waiting lists and delayed transfers of care (DTC) in public acute hospitals, and expansion of the home support service. Projection results are presented across four projection scenarios – status quo, low pressure, high pressure and progress. Importantly, the report does not forecast demand or capacity for each HSE Health Region; rather it provides projections of requirements based on clear assumptions in relation to the evolution of key drivers of demand and capacity.

FINDINGS

Between 2022 and 2040, the population aged 65 years and over is projected to increase across all Health Regions, with increases ranging from 53 per cent in the West and North West (WNW) to 76 per cent in the Dublin and Midlands region (DML). The proportion of the population aged 65 and over is projected to grow at a similar rate across regions, by between 6 and 7 percentage points. In this context, Tables ES.1 and ES.2 present the projected additional short stay and long stay bed capacity and home support hour requirements by 2040, and associated average annual growth rates. The lower and upper range of the projections are presented.

TABLE ES.1 BASE YEAR LTRC BED CAPACITY AND PROJECTED REQUIREMENTS BY HSE HEALTH REGION, 2022–2040

	2022	Projected additional requirements across scenarios (min–max)	
		2040	Average annual growth
	N	N	%
Short stay			
DNE	1,024	661–893	2.8–3.5
DML	468	337–444	3.1–3.8
DSE	783	506–676	2.8–3.5
SW	469	307–412	2.8–3.6
MW	311	211–282	2.9–3.6
WNW	689	433–580	2.7–3.5
Long stay			
DNE	6,932	4,243–5,735	2.7–3.4
DML	4,900	3,389–4,451	3.0–3.7
DSE	6,329	3,889–5,201	2.7–3.4
SW	4,351	2,743–3,676	2.8–3.5
MW	2,465	1,662–2,197	2.9–3.6
WNW	4,603	2,773–3,715	2.7–3.3

Notes DNE: Dublin and North East; DML: Dublin and Midlands; DSE: Dublin and South East; SW: South West; MW: Mid West; WNW: West and North West.

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

TABLE ES.2 BASE YEAR HOME SUPPORT HOURS AND PROJECTED REQUIREMENTS BY HSE HEALTH REGION, 2022–2040

	2022	Projected additional requirements across scenarios (min–max)	
		2040	Average annual growth
	N (millions)	N (millions)	%
Home support			
DNE	6.7	4.0–5.6	2.6–3.4
DML	5.0	3.3–4.7	2.9–3.8
DSE	5.4	3.1–4.5	2.6–3.4
SW	4.1	2.4–3.5	2.6–3.5
MW	2.6	1.6–2.3	2.7–3.6
WNW	5.5	2.9–4.2	2.4–3.2

Notes DNE: Dublin and North East; DML: Dublin and Midlands; DSE: Dublin and South East; SW: South West; MW: Mid West; WNW: West and North West.

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

Baseline analysis did identify variation in per capita (population aged 65+) supply in short stay beds, long stay beds, and home support hours across HSE Health Regions. Sensitivity analysis estimated the additional beds and home support hours that would be required if all HSE Health Regions were to have the same per capita level of supply as the HSE Health Region with the highest per capita numbers in 2040.

DISCUSSION

This analysis projects significant increases in demand and capacity requirements for short stay and long stay care, as well as home support services, by 2040 across all HSE Health Regions. The analysis shows that it is the large projected increase in the older population that is the main driver of projected requirements in all HSE Health Regions, and that healthy ageing and new care models can moderate, though not offset, the impact on the demand and capacity requirements driven by this population ageing effect. The lack of available, regional-level data on older people's services presents a major challenge for effective capacity planning. As more comprehensive data become available, especially for key services such as the Integrated Care Programme for Older People (ICPOP) teams, day centre care and community-based older people's services, the projections in this report should be reviewed and updated accordingly.

CHAPTER 1

Introduction

1.1 OVERVIEW

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

This report is part of a series of reports that uses the ESRI Hippocrates model to provide up-to-date projections for three service areas (public acute hospitals, general practice and older peoples' services) at both national and regional level. Focusing on older people's services, this report extends the national-level demand and bed capacity analysis published in Walsh and Kakoulidou (2025), by estimating regional activity profiles for 2022 for the six HSE Health Regions and providing medium-term regional projections of demand and bed capacity requirements to 2040 for LTRC and home support for each of the Health Regions.

While the national-level analysis provides projections of the overall potential demand and capacity requirements for LTRC and home support in Ireland, regional-level analysis is important in the context of planning, equity and efficiency in the healthcare system. Responsibility for managing and delivering health and social care is increasingly being devolved to the newly established six HSE Health Regions. Population health, size and age structure all vary regionally in Ireland, and national-level analyses may mask such differences. By examining older people's services, this report can also identify any regional inequalities in supply that may exist.

Within this research, the six HSE Health Regions are HSE Dublin and North East (DNE), HSE Dublin and Midlands (DML), HSE Dublin and South East (DSE), HSE South West (SW), HSE Mid West (MW), HSE West and North West (WNW). The new HSE Health Regions take over from Community Health Organisations (CHOs) and Hospital Groups. Previously there were nine CHOs that were developed to manage and deliver primary- and community-based care in Ireland. CHOs were subdivided into 32 local health offices (LHO) that managed and delivered care at a more local level. In addition, there were seven hospital groups that were developed to deliver public acute hospital care regionally. CHOs and Hospital Groups were non-coterminous, making the delivery of integrated care pathways more difficult. HSE Health Regions effectively merge CHOs and Hospital Groups together, while LHOs remain and are mapped on to the new HSE Health Region structures. [Figure A.1](#)

shows the geographical distribution of the six Health Regions. Table A.1 shows the allocation of LHOs and CHOs to each HSE Health Region.

The projection analysis in this report is undertaken at the level of HSE Health Regions. This analysis incorporates new population projections from the ESRI regional demographic model developed by Bergin and Egan (2024), and an extended range of demand, capacity and policy assumptions for older people's services. An overview of the main assumptions for these new population scenarios is presented in Table B.1 (in Appendix B of this report), and a more detailed discussion can be found in Brick and Kakoulidou (2025).

Much of the background, context, and methodology for the analysis can be found in the accompanying national capacity analyses by Walsh and Kakoulidou (2025). However, this report also provides a short overview of both the LTRC and home support sectors, in Sections 1.3 and 1.4. In addition, it provides some context to provision of LTRC and home support at the regional level, building upon some recent analyses of regional variations in these services in Ireland (Walsh et al., 2019; Walsh et al., 2020; Smith et al., 2021).

We acknowledge that uncertainty exists with all projection analyses, and we account for uncertainty by including a range of assumptions across our projection scenarios within the analyses. As recent policy changes, such as the establishment of the Integrated Care Programme for Older People (ICPOP) or the proposed establishment of a statutory home support scheme, become more embedded in the system, activity profiles may change. Therefore, projection analyses should be regularly reviewed in light of any important changes that may occur.

Similarly, while variations in baseline demand and capacity per capita may exist in 2022 across the HSE Health Regions, it is difficult to identify the key factors that underpin any such variation. Therefore, in this report, while we highlight variation that may exist, we do not attempt to explain any variation found. However, we do undertake sensitivity analysis, which involves estimating the additional supply that would be required in each HSE Health Region if all of them were to have the same per capita level of supply as the HSE Health Region with the highest projected per capita supply requirements in 2040. This provides stakeholders with an understanding of the extent of additional resources that may be required to equalise supply across HSE Health Regions.

The authors acknowledge that while LTRC and home support together comprise the largest share of expenditure on older people's services by the HSE, there are other key services such as day centre care and ICPPOP team-provided care, as well as informal care, that are not examined in this report or the national report. It is hoped that future Hippocrates modelling projects will include ICPPOP and other older people's services, as well as informal care demand projections.

1.2 OBJECTIVES

The main objectives of this report are:

- to provide baseline demand profiles for each Health Region, covering LTRC recipients (both short stay and long stay), bed capacity, and home support recipients and hours among older people aged 65 years and over; and
- to project short stay and long stay bed capacity and home support hour requirements for each HSE Health Region to 2040.

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

1.3 LONG-TERM RESIDENTIAL CARE – REGIONAL ANALYSES

LTRC is mainly provided to older people who have personal or nursing care needs that impact their activities of daily living (ADL) and which make it difficult to live independently at home. As discussed in the accompanying national capacity review by Walsh and Kakoulidou (2025), activity included in this regional projection analyses comprises both longer and shorter stays within LTRC facilities.

Most people in residential care (e.g., a nursing home) are long-stay residents who will spend the rest of their lives in such a setting. The majority of long stay care is provided by the Nursing Homes Support Scheme (NHSS – ‘Fair Deal’), which was established by the Nursing Home Support Scheme Act, 2009. The NHSS provides a statutory basis for the State to fund the residential care of people assessed to require such care. Approximately 70 per cent of all LTRC expenditure in 2019 was financed via the NHSS (Walsh et al., 2021) and almost all LTRC homes in Ireland provide care to at least some of their residents under the NHSS (Walsh and Connolly, 2024). While the State provides the majority of NHSS funding, a co-payment based on an income and assets means test is payable by the resident, and NHSS residents contribute 80 per cent of their income and 7.5 per cent of the value of their assets towards the cost of their care. The first €36,000 of assets for an individual are not counted in the financial assessment.¹

A small proportion of residential care is short stay in nature, provided to help with convalescence, rehabilitation or recuperation following a public acute hospital stay. In 2015, the Transitional Care Fund was established to fund short-term residential care to ease transition to the NHSS by providing beds in LTRC centres for up to ten weeks. Following the onset of the COVID-19 pandemic, this fund was

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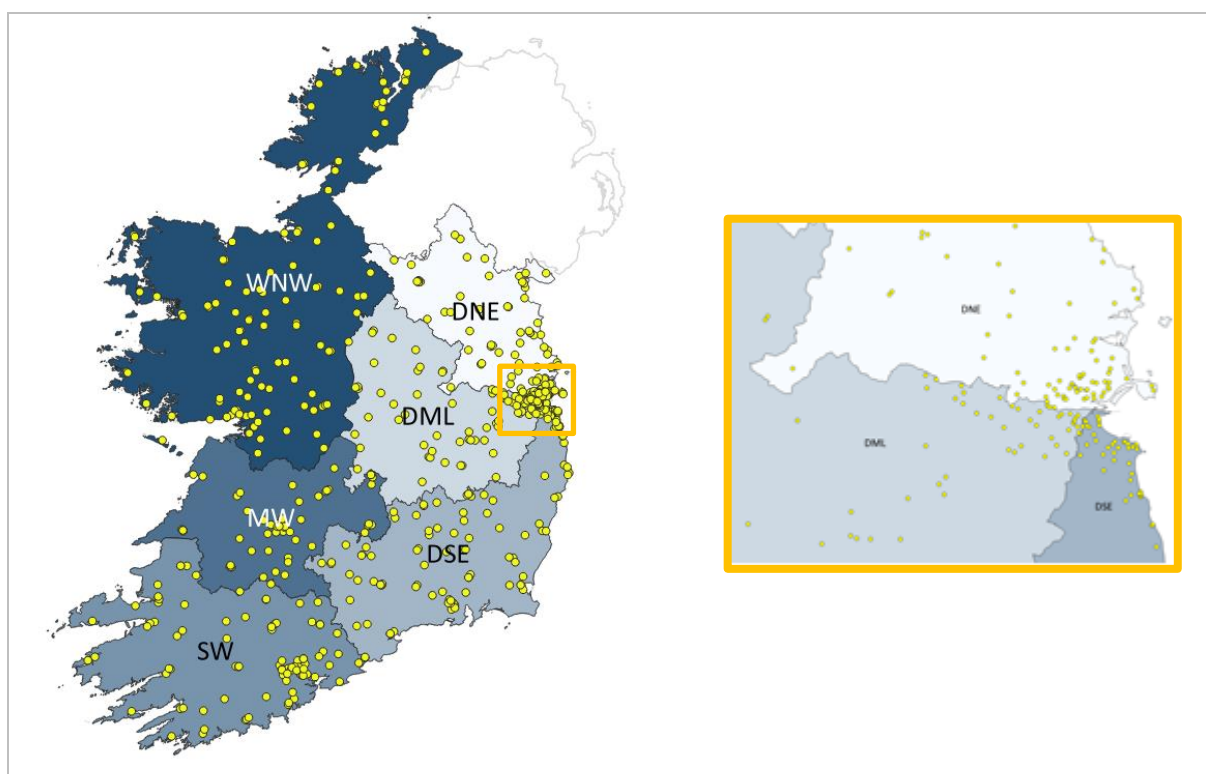
Other income and asset caps are applied to certain residents including farmers and business owners. See <https://www.citizensinformation.ie/en/health/health-services/health-services-for-older-people/fair-deal-scheme/>.

expanded to cover surge capacity (e.g., free up beds in acute hospitals), and to provide LTRC for those awaiting a new home support package or housing adaption.

This approach of examining short stay and long stay residential care is in line with previous analyses using the Hippocrates model (Wren et al., 2017; Walsh et al., 2021). As discussed in the national capacity report, the reliance on LTRC care settings such as private nursing homes, for short stay care, especially rehabilitative care, instead of better delayed discharge planning and/or home-based rehabilitation, may be impacting people's healthcare outcomes and preferences on where best to receive such care (HSE, 2024). In this report, in line with the national capacity report, we examine short stay and long stay care beds separately.

In this analysis on short stay and long stay care, we examine the activity in the 577 LTRC homes that were providing short stay and/or long stay LTRC in Ireland in December 2022. We have categorised each LTRC home by geographic location (their county and Health Region). Figure 1.1 presents the geographic distribution of the LTRC homes included in this report by HSE Health Region.

FIGURE 1.1 MAP OF LTRC HOMES IN IRELAND, 2022



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

Notes: Map denotes location of LTRC homes included in analysis by HSE Health Region.

When projecting LTRC capacity regionally in Ireland, it is important to understand the context of LTRC provision. LTRC providers can be partitioned into three groups according to ownership:

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

While the vast majority of LTRC in Ireland is publicly funded (Walsh et al., 2021), mainly via the NHSS, in 2022, 80 per cent of all LTRC was provided by the private and voluntary sector (Walsh and Kakoulidou, 2025). The percentage of LTRC provided by the private sector has been increasing over time (Mercille, 2024; Walsh and Connolly, 2024). There is also evidence that the percentage of LTRC beds provided in private LTRC homes, and by larger providers, also differs significantly regionally (Walsh and Connolly, 2024).

While we do not project short stay and long stay beds within public and voluntary/private LTRC homes separately, the ownership context of the sector is important to understand when interpreting the projection results, and when using evidence from this report to design policies to extend capacity in the sector. Results presented in Appendix C present the percentage of all LTRC beds delivered privately within each HSE Health Region.

1.4 HOME SUPPORT – REGIONAL ANALYSES

Home support (home care) refers to health, personal and domestic care services provided to people in their own homes by a professional carer. Home support aims to provide the personal ADL supports that allow people to continue to live in their own homes with a degree of independence. As discussed in the accompanying national capacity review (Walsh and Kakoulidou, 2025), in relation to activity, this projection analyses only includes support provided by professional carers (formal home support). However, it is important to acknowledge that the majority of supports provided to people in their own homes in Ireland are provided by family carers (Hanly and Sheerin, 2017; McGarrigle et al., 2022); the formal home support services have been developed to complement and support rather than replace family carers.

As with LTRC, the context of home support provision is important to understand. Home support services are either provided through the HSE’s ‘public’ home support service scheme, or by carers hired privately by the recipient or family members (‘private’ home support) (Walsh and Lyons, 2021). Home support hours are delivered either by directly employed HSE carers or by voluntary, not-for-profit and for-profit providers, the latter of which usually operate through regional franchise structures. There is no definitive list of home support providers in Ireland. The national analyses estimated that over 70 per cent of home support is provided

by the private sector (Walsh and Kakoulidou, 2025). The percentage of private provision has been growing significantly over time (Mercille and O'Neill, 2020).

The composition of the private LTRC sector is also changing, with larger operators now dominating provision (Mercille and O'Neill, 2020). Results presented in Appendix D present the proportion of all home support provided privately within each HSE Health Region.

1.5 STRUCTURE OF THE REPORT

The report is structured as follows.

- Chapter 2 describes the Hippocrates modelling methodology, the methods and data of the analysis as they apply to the HSE Health Regions, and the projection scenarios incorporated.
- Chapter 3 presents baseline findings for LTRC (short stay and long stay) at the HSE Health Region level.
- Chapter 4 presents baseline findings for home support at the HSE Health Region level.
- Chapter 5 presents projection analyses for LTRC to 2040 at the HSE Health Region level.
- Chapter 6 presents projection analyses for home support to 2040 at the HSE Health Region level.
- Chapter 7 concludes and discusses findings.

CHAPTER 2

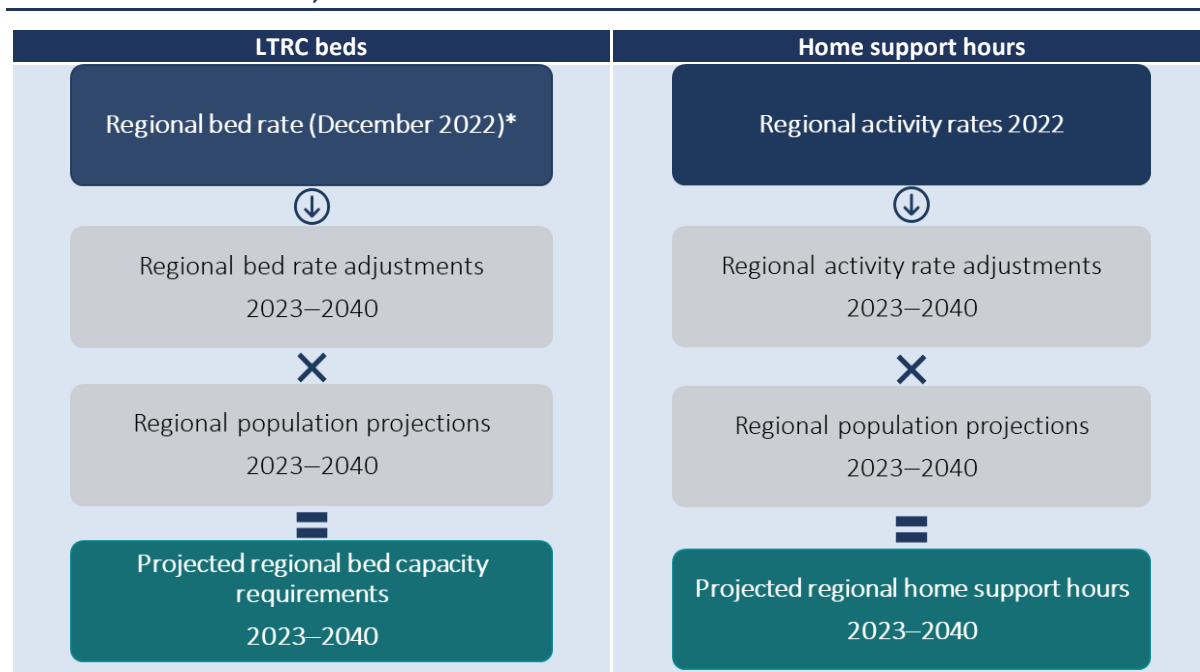
Hippocrates regional projection methods and data

2.1 INTRODUCTION

This chapter describes the regional Hippocrates projection methodology, and provides an overview of the data and methods used to estimate baseline activity profiles. It outlines the data and methods used to generate the baseline regional utilisation profiles for older peoples' services, highlighting any changes compared to the national analysis in Walsh and Kakoulidou (2025). The chapter also provides a short description of the assumptions used to project baseline demand, with a more detailed description of these assumptions provided in the accompanying national capacity report (Walsh and Kakoulidou, 2025).

2.2 REGIONAL PROJECTION METHODOLOGY

Figure 2.1 presents a diagrammatic representation of the steps involved in applying Hippocrates to project regional long-term residential care (LTRC) bed capacity requirements and home support hours requirements. The first step in developing projections in Hippocrates is to develop 2022 age- and sex-specific LTRC bed and home support hour rates at the HSE Health Region level. Rates are then adjusted based on a range of evidence-based assumptions, which have been developed and enhanced over the lifetime of the model. Adjusted rates are multiplied by regional population projections to provide estimates of demand and capacity requirements in a projection year. Sections 2.3 and 2.4 outline the steps involved in calculating baseline profiles for both services.

FIGURE 2.1 HIPPOCRATES MODEL – DIAGRAMMATIC REPRESENTATION OF LTRC AND HOME SUPPORT PROJECTIONS, 2022–2040

Notes: *Bed rates based upon age and sex profile of residents (December 2022).

Source: Authors' representation of the Hippocrates model.

2.3 DEVELOP REGIONAL ACTIVITY RATE PROFILES FOR 2022

2.3.1 Long-term residential care

Data: As no comprehensive dataset capturing all LTRC residents or beds exists, we use a combination of HSE administrative data on LTRC residents and LTRC beds, Health Information and Quality Authority (HIQA) bed register data, and survey information published by Nursing Homes Ireland (NHI) (BDO and Nursing Homes Ireland, 2022; 2024) on beds, residents and occupancy rates. Together, these data sources allow us to also determine the number of residents by short stay and long stay bed status. The data used to estimate a national profile are also used to estimate regional baseline profiles in this report. A detailed discussion of these data is available in the accompanying national report (Walsh and Kakoulidou, 2025). Table 2.1 summarises the data sources used to calculate the baseline activity rates LTRC at the HSE Health Region level.

TABLE 2.1 SUMMARY OF LONG-TERM RESIDENTIAL CARE DATA SOURCES FOR REGIONAL BASELINE ACTIVITY

	Data	Details	Regional breakdown
LTRC residents	NHSS residents ¹	Data available by single year of age (SYOA) and sex in December 2022. Applies only to long stay (NHSS) residents.	LHO and HSE Health Region
LTRC beds	HIQA Bed Register ²	Beds in public, voluntary and private LTRC homes in December 2022. No partition by short stay/long stay status. Data on location of LTRC homes (e.g., name, address, registered provider).	LHO and HSE Health Region
	HSE Bed Register ³	Beds in public LTRC homes in February 2023. Beds available partitioned by short stay/long stay status. Data on location of LTRC homes (e.g., name, address).	LHO and HSE Health Region
	NHI surveys ⁴	NHI surveys based upon data collected from voluntary and private LTRC homes in 2018 and 2022 (BDO and Nursing Homes Ireland, 2022; 2024). Surveys used to provide data to partition beds into short stay and long stay beds, and estimate privately purchased LTRC care.	Not at level of HSE Health Region
Waiting list	NHSS waiting list ⁵	Data available by single year of age (SYOA) and sex of people on waiting list for the NHSS in December 2022.	LHO and HSE Health Region
	Delayed transfers of care (DTOC) ⁶	Data available on DTOCs categorised as waiting for a LTRC bed by SYOA and sex.	Not at level of HSE Health Region

Sources: ¹ NHSS office HSE.

² HIQA.

³ National Service for Older People Office HSE.

⁴ NHI website.

⁵ NHSS office HSE.

⁶ Business Information Unit (BIU) HSE.

Resident data: In order to develop baseline age- and sex-specific bed rates, we utilise detailed demographic information on Nursing Homes Support Scheme (NHSS) recipients. The HSE provided information on the number of NHSS recipients by single year of age (SYOA) and sex as of 31 December 2022 (covering the same time period as the bed data included in the analysis). As the NHSS data are available at the HSE Health Region level (based upon their home address), separate age and sex profiles are available for each HSE Health Region. Figure C.1 shows consistency, with only small differences in age profiles observed across HSE Health Regions. HSE Health Region-specific age and sex profiles of NHSS residents are applied to all short stay and long stay beds, since comparable demographic data are not available for non-NHSS long stay or short stay residents. This approach of applying the NHSS age and sex profile to all LTRC beds is consistent with previous projection analyses (Wren et al., 2017; Walsh et al., 2021) and the national capacity analysis

(Walsh and Kakoulidou, 2025). In line with previous Hippocrates analyses, we present baseline profiles as bed rates at a point in time – 31 December 2022.²

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

- Using the bed data described above, we calculate the number of LTRC beds in the system in each HSE Health Region in December 2022 based upon the address of each LTRC home. We partition these beds into short stay and long stay categories.
- The age- and sex-specific distribution of NHSS residents in each HSE Health Region is applied to short stay and long stay beds to provide us with a calculation of beds per age and sex group in the population.
- A bed rate is calculated by dividing the number of beds in each age and sex group by the population in each group within each HSE Health Region. Regional bed rates were estimated by dividing the number of HSE Health Region residents in each age and sex group by the population in each respective group in 2022.

2.3.2 Home support

Similar to LTRC, there exists no comprehensive dataset on home support recipients or the number of hours provided to them. In order to examine publicly funded and privately purchased home support, we mainly use a combination of HSE administrative data and data from The Irish Longitudinal Study on Ageing (TILDA) that captures information on public and private home support recipients and home support hours used. A detailed discussion of these data is available in the accompanying national report (Walsh and Kakoulidou, 2025). Table 2.2 summarises the data sources used to calculate the regional baseline activity rates for home support.

² HIQA (HIQA, 2023) and the HSE (HSE, 2022a) also routinely use December as their reporting period for each year.

TABLE 2.2 SUMMARY OF HOME SUPPORT DATA SOURCES FOR REGIONAL BASELINE ACTIVITY

	Data	Details	Regional breakdown
Home support hours and recipients	HSE home support data ¹	Data available on total number of HSE home support service recipients and hours provided in 2022. Data on age and sex of recipients not available.	Local health office (LHO) and HSE Health Region
	TILDA waves 2–4 ²	Used to provide data on use of publicly funded and privately purchased home support recipient numbers and hours (see Walsh and Kakoulidou (2025) for more detailed description). Data on age group and sex of recipients/respondents available.	Not at level of HSE Health Region
	Home and Community Care Ireland (HCCI)	Data on the number of privately purchased home support hours per package (used to inform Walsh et al. (2021) previously).	Not at level of HSE Health Region
Waiting list	HSE home support service waiting list ³	Data on people on waiting list for the HSE home support service in December 2022. Information of reason for wait (new package or additional hours) also available. No data on SYOA or sex available.	LHO and HSE Health Region
	Delayed transfers of care (DTOC) ⁴	Data available on DTOCs categorised as waiting for home support by SYOA and sex.	Not at level of HSE Health Region

Sources: ¹ HSE.

² TILDA.

³ HSE.

⁴ Business Information Unit (BIU) HSE.

Recipient data: We use a combination of HSE administrative data at the HSE Health Region level and The Irish Longitudinal Study on Ageing (TILDA) data on public and private home support recipients, and home support hours used. Administrative data from the HSE provided the number of home support and Intensive Home Care Package (IHCP) recipients in each HSE Health Region in 2022.

As the HSE data do not capture the age or sex of recipients, we use data from TILDA waves 2–4 to provide an age and sex distribution of home support recipients. As TILDA data do not allow for regional age and sex profiles to be estimated, we adopt a national profile for each HSE Health Region. In TILDA surveys, the respondents were asked whether they had received any of the following from the State in the previous 12 months:

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

In addition, the TILDA survey captures information on private home support; respondents were asked whether they had paid any individual or private company to provide home help or personal care in the previous 12 months. We use responses to this question (by SYOA and sex) to estimate private home support recipient rates. Again, these data were not available at the HSE Health Region level, and the national profile was adopted for all HSE Health Regions.

Home support hours data: Administrative data from the HSE provided HSE home support hours at the HSE Health Region level and intensive Home Care Packages (iHCPs) at the national level in 2022. These data allowed us to estimate an average home support package (dividing hours by recipients) at an annual and weekly level for each HSE Health Region. Data from TILDA waves 2–4 were also used to provide an age and sex distribution of home support recipient hours. For private home support, we combined information on privately purchased home support in TILDA with information provided by Home and Community Care Ireland (HCCI). This is in line with previous Hippocrates model analyses (Walsh et al., 2021) that provide the average number of hours provided in a private home package.

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

- The total number of hours provided in 2022 through the HSE home support service and IHCP schemes are combined to calculate the total number of public home support hours provided in 2022 for each HSE Health Region.
- The age- and sex-specific distribution estimated using TILDA data is applied to *public home support* hours to provide an estimate of the activity profile in the population.
- TILDA data are used to estimate the number of recipients utilising *privately purchased home support* by age and sex for each HSE Health Region, and these recipients are apportioned an average weekly package of private home support.³
- Public and private hours are combined for each age and sex group in each HSE Health Region, and a home support hour activity rate is then calculated by dividing the number of hours in each age and sex group by the population in each group in each HSE Health Region.

2.4 ADJUSTMENT OF ACTIVITY RATES, 2023–2040

Once baseline activity rates have been established for 2022 for LTRC and home support, a series of assumptions are applied in the projection scenarios, which adjust activity rates across the projection horizon. This follows the approach used

³

The average weekly package is grossed to a yearly package by multiplying by 52 weeks, in line with Walsh et al. (2021) and Walsh and Kakoulidou (2025).

in previous Hippocrates based output and other health and social care projection exercises (Charlesworth and Johnson, 2018; Lorenzoni et al., 2019; Walsh et al., 2021; Rachet-Jacquet et al., 2023), and in the national capacity analysis (Walsh and Kakoulidou, 2025).

2.4.1 Long-term residential care

For LTRC, we project short stay and long stay beds separately. While the majority of LTRC is provided to those aged 65 years and over, we also include the small number of younger residents using LTRC in our baseline analysis. In this projection analysis we consider the following assumptions.

Population growth and ageing

Three population projection scenarios are incorporated into the latest version of the Hippocrates model. The data and methods used to develop these updated ESRI population projections, based on the Central Statistics Office (CSO) Census of Population 2022, are described in detail in Bergin and Egan (2024). In summary, the scenarios are based on assumptions around the three key drivers of population change: mortality, migration and fertility. A detailed description is available in Brick et al. (2025) with a summary of the main assumptions provided in Appendix B of this report. While the three population scenarios are defined at a national level, their application to the regional level depends on regional factors. For example, for international migration, the national-level assumption is distributed across counties according to their historic averages, as migrants tend to live in larger population centres such as Dublin.⁴ However, in general, migration assumptions have less of an impact on the older population, who are the main users of older people's services.

As observed at the national level, the oldest age groups are projected to see the largest relative increase in growth between 2022 and 2040 across all HSE Health Regions. Table 2.3 illustrates the projected population growth in each HSE Health Region between 2022 and 2040 in the central population scenario. Overall, much larger relative increases are projected for the population aged 65 years and over and 85 years and over, compared to the younger population. The largest projected increases are seen in Dublin and Midlands in the 65+ age group (138 per cent increase) and the Mid West in the 85+ age group (158 per cent). Figure B.1 also shows the age structure of the population will change in each HSE Health Region. In all HSE Health Regions, the proportion of the population aged 65 year and over is projected to increase by between 5.4 (WNW) and 6.3 (DSE) percentage points

⁴

For mortality, which has the greatest impact on the older population, an age- and sex-specific profile of mortality rates is developed for the projection horizon, and these rates are applied at a county level, and aggregated to the HSE Health Region level. This means that any variation in mortality at a regional level will be driven by differences in the age structure of that region. As a result, the same assumptions apply across regions but will give different results – depending on county age and sex profile (Bergin and García-Rodríguez, 2020; Bergin and Egan, 2024).

over the period (in the central scenario). The proportion aged 85 years and over is projected to more than double in all HSE Health Regions. These demographic changes, especially for the 85+ age group who are significant users of LTRC and home support, will have significant implications for future demand for older people's services, as we show in later chapters.

TABLE 2.3 PROJECTED POPULATION INCREASE 2022–2040 BY HSE HEALTH REGION (CENTRAL SCENARIO)

	DNE	DML	DSE	SW	MW	WNW
0–64	11%	12%	7%	9%	7%	6%
65+	75%	76%	66%	62%	59%	53%
85+	137%	152%	138%	145%	158%	135%

Source: Bergin and Egan (2024).

Healthy ageing

The same healthy ageing assumptions are used as described in the national report (Walsh and Kakoulidou, 2025). These assumptions are based on an approach adopted from the European Commission (European Commission, 2014; 2017; 2023) and previously applied in Hippocrates outputs (Wren et al., 2017; Keegan et al., 2020; Walsh et al., 2021; Keegan et al., 2022). The assumptions make adjustments to account for the fact that, as life expectancy increases, not all additional life years may be spent in bad health (see Section 3.3.5 in Wren et al. (2017)). To simulate these effects, we shift age- and sex-specific home support activity rates (or LTRC bed rate) curves to the right in proportion to projected changes in life expectancy.

There is literature showing some improvements in disability, frailty and difficulties with activities of daily living (ADL) rates among older people as life expectancy increases (Crimmins et al., 2009; Kreft and Doblhammer, 2016; Qian et al., 2023); this is discussed in more detail in the national capacity report. Therefore, in this analysis, we focus on the relatively more optimistic healthy ageing assumptions for the LTRC projection analysis, those of dynamic equilibrium and compression of morbidity, with dynamic equilibrium serving as our 'as is' assumption used in the status quo scenario. This conforms with previous outputs using the Hippocrates model (Wren et al., 2017; Keegan et al., 2020; Keegan et al., 2022). Healthy ageing assumptions are applied equally to each HSE Health Region.

Waiting lists and unmet demand

The same unmet demand methods are used as described in the national report. To estimate the unmet demand for LTRC, we use the numbers on the NHSS waiting list at the end of December 2022 in each HSE Health Region and DTOCs awaiting short stay or long stay care provided by the HSE. A complication of these data is that some people on the NHSS waiting list are in short stay beds and therefore already captured in the short stay demand. For this reason, we remove those beds

being funded via the Transitional Care Fund that are already captured in the short stay bed analysis from the NHSS waiting list when estimating unmet need for long stay care.

In addition, we use data on DTOCs awaiting short stay or long stay care. We estimate the number of days DTOCs are waiting in hospital after being deemed medically fit for discharge, and divide this number by 365*90 per cent to estimate the additional beds that would be required to meet this demand (assuming average occupancy rates within the sector).⁵ While information on the acute public hospital where the patient is registered as a DTOC is available, no information is available on either the home address of the patient or the LTRC facility to which they may be admitted. Therefore, we distribute unmet need from DTOCs proportionally to each HSE Health Region based upon the distribution of bed capacity across HSE Health Regions.

Expansion of home support

As discussed in detail in the national report, we assume a reduction in the rate of admission from home support services to LTRC – from approximately 8 per cent per annum (Aspell et al., 2019) to 6 per cent. This two percentage point reduction is assumed for all HSE Health Regions, and the age and sex profile of NHSS residents in each HSE Health Region is applied to those substituting towards home support. In the projection analyses, we assume that that reduction in the rate of admission from home support services to LTRC – from 8 per cent to 6 per cent per annum – occurs gradually between 2026 and 2029. These adjustments are made consistently across all HSE Health Regions.

Summary

Table 2.4 provides a summary of the assumptions included in the four projection scenarios presented in this report, and the scenarios follow those included in the national capacity analysis. The ‘status quo’ scenario applies the central population projection assumption and a relatively optimistic healthy ageing (dynamic equilibrium) assumption. The ‘low pressure’ scenario also applies the central population projection assumption and a more optimistic healthy ageing assumption (compression of morbidity). Under the ‘high pressure’ scenario, a higher projected population growth assumption is applied, as is a reduction in waiting lists and unmet demand. Finally, the ‘progress scenario’ applies a central population assumption, reduction of waiting lists and unmet demand, optimistic healthy ageing effects (compression of morbidity) and a policy change assumption of lower demand for LTRC due to the expansion of home support. All scenarios assume a 90 per cent occupancy rate.

⁵

For example, we divide the total number of bed days for this group by 365 to estimate an additional resident. An occupancy rate of 90 per cent is once again assumed to estimate bed requirements.

TABLE 2.4 SUMMARY OF LONG-TERM RESIDENTIAL CARE PROJECTION SCENARIOS

	2040			
	Status quo	Low pressure	High pressure	Progress
Demand assumptions				
1. Population growth and age structure	Central	Central	High	Central
2. Waiting lists and unmet demand	No	No	Yes	Yes
3. Healthy ageing	DE	CM	DE	CM
4. Expansion of home support	No	No	No	Yes
Bed capacity assumptions				
5. Occupancy rate	90%	90%	90%	90%

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

For short stay and long stay care, we present the projected additional bed requirements, total percentage growth from 2021 to 2040, and a decomposition of growth for the status quo and progress scenarios. National-level projections from Walsh and Kakoulidou (2025) are also included for reference. Due to the five-year age group structure of the regional population projections and the regional specificity of some data, regional aggregates may differ slightly from national totals – typically by less than 0.3 per cent.

Sensitivity analysis

In the sensitivity analysis, we project bed rates for each HSE Health Region based upon the baseline bed rate profiles in each region. While differences in supply per capita exist, it is difficult to determine if such differences are due to models of care that have evolved differently across regions, or simply due to lack of supply of care. These baseline profiles, once projected, effectively reinforce any differences in supply that exist. In an attempt to address these regional differences, we estimated an additional projection scenario whereby the population-adjusted number of short stay and long stay beds in each HSE Health Region in 2040 was estimated based on the per capita number of beds in the HSE Health Region with the highest number of short and long stay beds.

2.4.2 Home support

For home support, the majority of hours are provided to those aged 65 years and over. We also include the small number of younger recipients in our baseline analysis. In this analysis we consider the following assumptions.

Population growth and ageing

Assumptions are the same as outlined for LTRC above.

Waiting lists and unmet demand

To estimate the unmet demand for public home support, we use the numbers on the waiting lists at the end of December 2022 for each HSE Health Region provided by the HSE. These data disaggregate those waiting by whether they are waiting for a new home support package, or additional hours. However, the waiting list data are not disaggregated by age or sex. Therefore, the age and sex distribution of current public home support recipients in each HSE Health Region is applied. We allocate an average home support package for those awaiting a new home support package. For those awaiting additional hours, we assume a 20 per cent increase in hours over and above their current home support package.⁶

In addition, we use data on DTOCs awaiting home support. We estimate the number of days DTOCs are waiting in hospital after being deemed medically fit for discharge, and divide this number by 365*90 per cent to estimate the additional beds that would be required to meet this demand (assuming average occupancy rates within the sector). While information on the acute public hospital where the patient is registered as a DTOC is available, it is not possible to establish the address of the LTRC facility to which they were admitted. Therefore, we distribute unmet need from DTOCs proportionally to each HSE Health Region based upon the distribution of bed capacity across HSE Health Regions.

Healthy ageing

Assumptions are the same as outlined for LTRC above.

Expansion of home support

Assumptions are the same as outlined for LTRC above. In the projection analyses, we allocate an extended home support package of 21 hours per week to the estimated number of individuals who would require home support if admission into LTRC from home support reduced from 8 per cent to 6 per cent per annum.⁷ Again, these adjustments are made consistently across all HSE Health Regions.

Summary

Table 2.5 provides a summary of the assumptions included in the four projection scenarios for home support presented in this report; these scenarios are equivalent to those outlined for LTRC above.

⁶ These allocations were based upon similar assumptions on unmet demand made in previous research (Walsh and Lyons, 2021), and following extensive discussions with the Department of Health and the HSE.

⁷ These allocations were based upon similar assumptions on unmet demand made in previous research, and following extensive discussions with the Department of Health and the HSE. They are the equivalent of an iHCP.

TABLE 2.5 SUMMARY OF HOME SUPPORT PROJECTION SCENARIOS

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

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

For home support we present the projected additional home support hour requirements, total percentage growth from 2022 to 2040, and a decomposition of growth for the status quo and progress scenarios. National-level projections from Walsh and Kakoulidou (2025) are also included for reference. Due to the five-year age group structure of the regional population projections and the regional specificity of some data, regional aggregates may differ slightly from national totals – typically by less than 1 per cent.

Sensitivity analysis

In this sensitivity analysis, we project home support hour rates for each HSE Health Region based upon the baseline home support hour profiles in each region. Similar to LTRC, while differences in supply per capita exist, it is difficult to determine if such differences are due to models of care that have evolved differently across regions, or are simply due to a lack of supply of care. These baseline profiles, once projected, effectively reinforce any differences in supply that exist. Therefore, we estimate another scenario that estimates the additional hours that would be required in each HSE Health Region to ensure all HSE Health Regions has the same per capita hours supply (per population aged 65+) as the HSE Health Region with the largest relative supply.

CHAPTER 3

Findings – Regional long-term residential care bed capacity profiles, 2022

3.1 INTRODUCTION

This chapter presents baseline demand profiles for short stay and long stay care in 2022 by HSE Health Region. It should be noted that while utilisation rates for long-term residential care (LTRC) vary across HSE Health Regions, it is difficult to explain why this might be the case. Some possible reasons for differences in rates are listed below to provide a guide, but this is not an exhaustive list.

- Population structures differ by HSE Health Region (see Chapter 2), and higher bed rates may reflect an older population within a HSE Health Region.
- The structure of health and social care services in some HSE Health Regions may place a greater focus on LTRC over home support and community-based services.
- Some HSE Health Regions may simply have greater supply of LTRC, especially privately provided LTRC.
- Inconsistent data, especially for short stay beds and patients, is an issue and may require national profiles to be used for each HSE Health Region.
- In LTRC, the place of someone's home address may differ to the location of the LTRC home they use. For example, despite Kildare being the youngest county in the country (i.e., it has the lowest proportion of people aged 65 and 85 years), it has the largest number of LTRC homes beds per capita. LTRC homes in Kildare likely cater to LTRC residents from a number of HSE Health Regions (Walsh and Connolly, 2024).

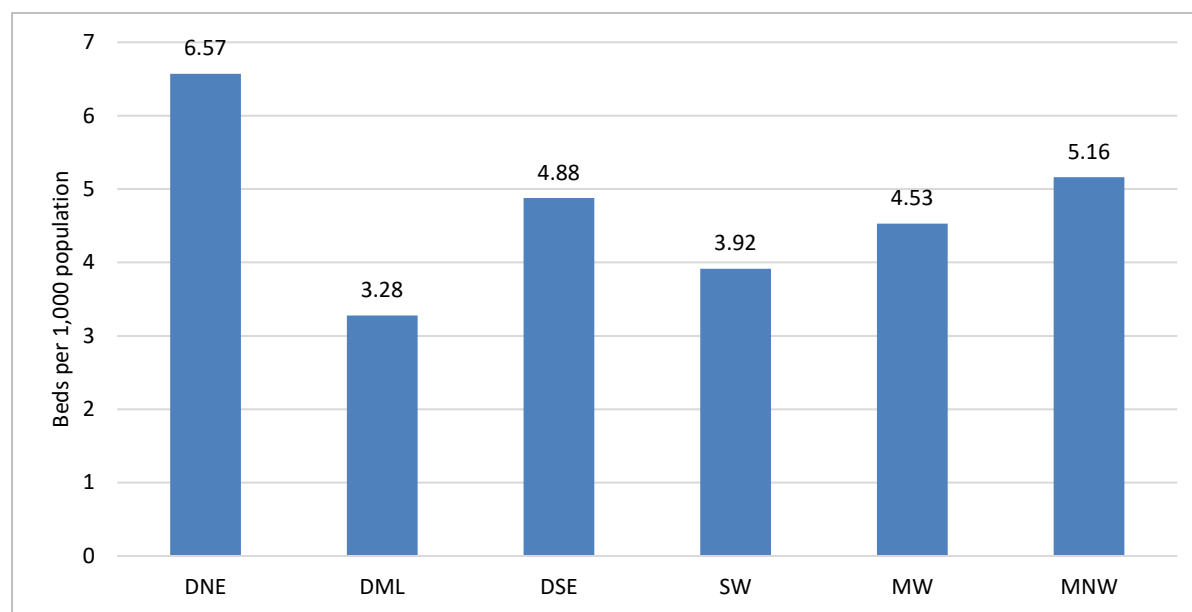
In this chapter we present age-specific short stay and long stay beds by HSE Health Region, in line with the results presented in the national report (Walsh and Kakoulidou, 2025). More results on total beds and beds provided in public and voluntary/private LTRC homes are presented in Appendix C.

3.2 SHORT STAY BEDS

Figure 3.2 illustrates the number of short stay beds per 1,000 population aged 65 years and over in HSE Health Regions in December 2022. This figure illustrates the variation in supply across HSE Health Regions in our 2022 baseline year. Large variation in short stay bed supply is observed. There were 6.57 short stay beds per 1,000 population aged 65 years and over in Dublin and North East, compared to

3.28 short stay beds per 1,000 population aged 65 years and over in Dublin and Midlands.⁸

FIGURE 3.2 SHORT STAY BEDS PER 1,000 POPULATION AGED 65+ BY HSE HEALTH REGION, 2022



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

Notes: Includes beds used by residents aged <65. Population aged 65+ denominator reflects the population who use the vast majority of short term care.

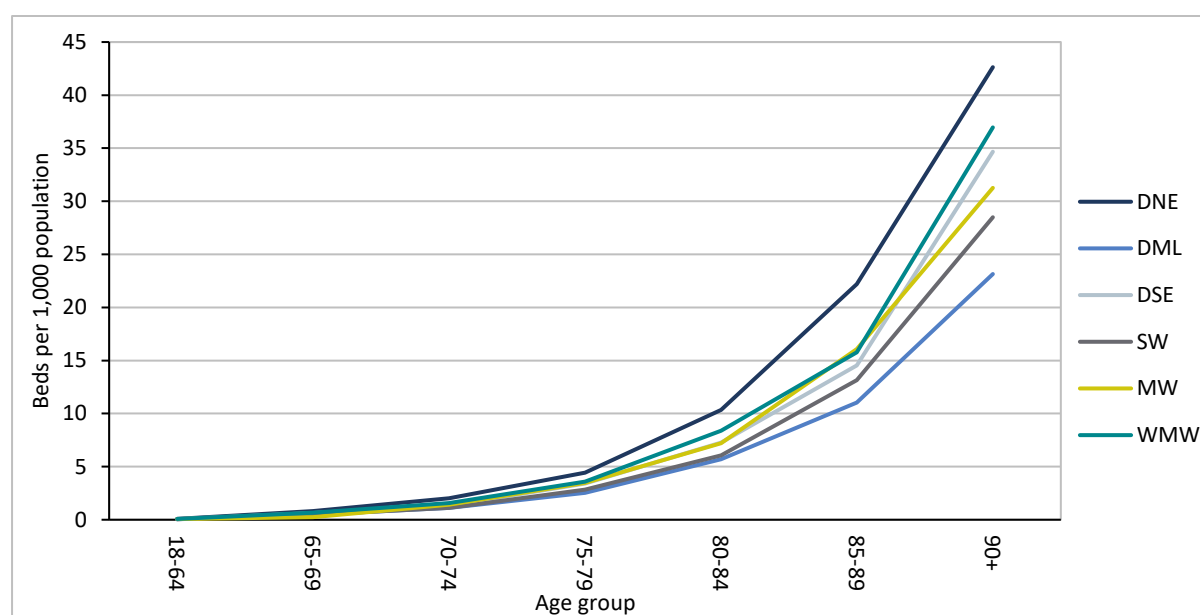
The total number of short stay beds within each HSE Health Region are presented in Figure C.2.

The total number of short stay beds in public and voluntary/private LTRC homes within each HSE Health Region are presented in Figure C.3.

The number of short stay beds per population aged 65+ in public and voluntary/private LTRC homes within each HSE Health Region are presented in Figure C.4.

The percentage of short stay beds in public and voluntary/private LTRC homes within each HSE Health Region are presented in Figure C.5.

Figure 3.3 illustrates age-specific short stay beds per 1,000 population and over in HSE Health Regions in December 2022. Similar age distributions are observed across HSE Health Regions, and rates increase with age. Age-specific bed rate variations across HSE Health Regions are mainly due to the variation in supply across HSE Health Regions, rather than any observed differences in age distribution across regions.

FIGURE 3.3 AGE-SPECIFIC SHORT STAY BED RATES PER 1,000 POPULATION BY HSE HEALTH REGION, 2022

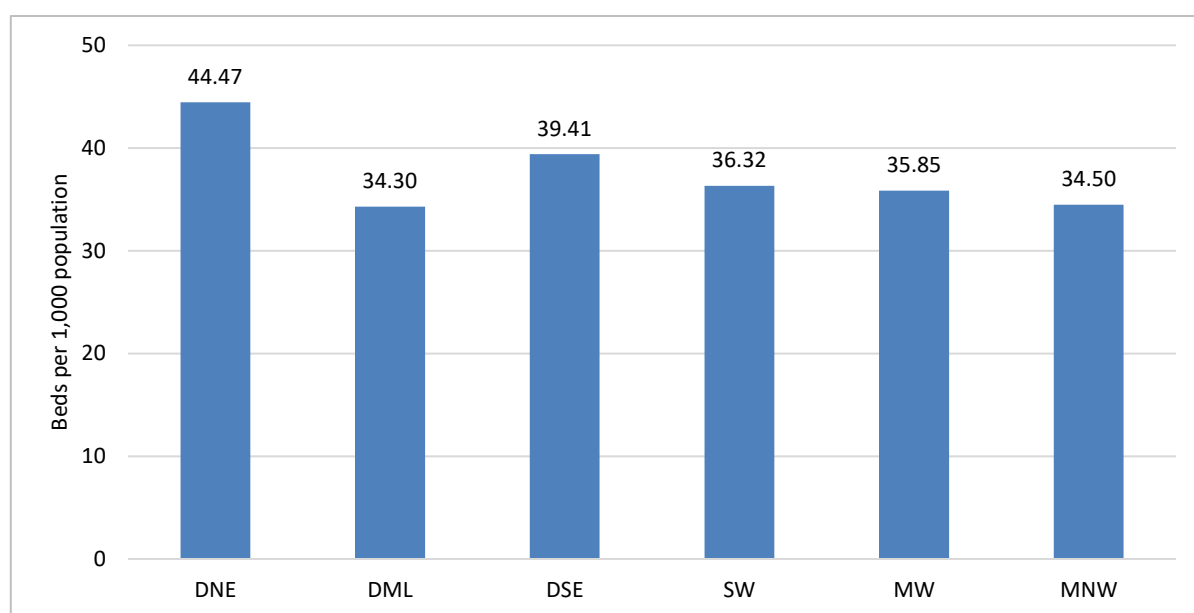
Sources: ESRI population data, HSE administrative data, NHI survey data, and HIQA bed register data; authors' calculations.

3.3 LONG STAY BEDS

Figure 3.4 illustrates the number of long stay beds per 1,000 population aged 65 years and over in HSE Health Regions in December 2022. Variation in long stay bed supply is observed, though the relative differences are not as large as those observed for short stay beds. There were 44.47 long stay beds per 1,000 population aged 65 years and over in Dublin and North East compared to 34.30 long stay beds per 1,000 population aged 65 years and over in Dublin and Midlands.⁹

⁹

Figure C.6 illustrates the number of long stay beds in HSE Health Regions. Figures C.7 and C.8 also illustrate the number of these beds delivered public and by voluntary/private LTRC homes.

FIGURE 3.4 LONG STAY BEDS PER 1,000 POPULATION AGED 65+ BY HSE HEALTH REGION, 2022

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

Notes: Includes beds used by residents aged <65. Population aged 65+ denominator reflects the population who use the vast majority of long term care.

The total number of long stay beds in each HSE Health Region are presented in Figure C.6.

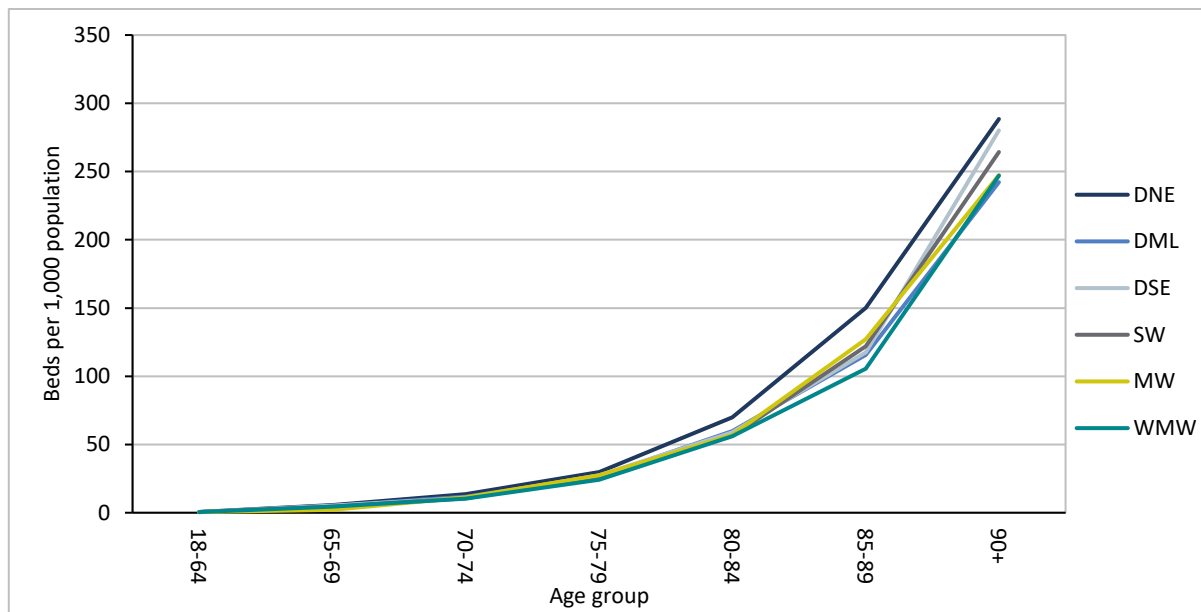
The total number of long stay beds in public and voluntary/private LTRC homes in each HSE Health Region are presented in Figure C.7.

The number of long stay beds per population aged 65+ in public and voluntary/private LTRC homes in each HSE Health Region are presented in Figure C.8.

The percentage of long stay beds in public and voluntary/private LTRC homes in each HSE Health Region are presented in Figure C.9.

Figure 3.5 illustrates age-specific long stay beds per 1,000 population aged 65 years and over in HSE Health Regions in December 2022. Similar age distributions were observed across HSE Health Region, with rates increasing with age. Variations in age-specific bed rates across HSE Health Regions are much smaller than observed for short stay beds, which is reflective of smaller variation in capacity across regions, as well as little observed differences in age distribution across regions.

FIGURE 3.5 AGE-SPECIFIC LONG STAY BED RATES PER 1,000 POPULATION BY HSE HEALTH REGION, 2022



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

CHAPTER 4

Findings – Regional home support hour profiles, 2022

4.1 INTRODUCTION

This chapter presents baseline demand profiles for public and private home support in 2022 by HSE Health Region. As with long-term residential care (LTRC), it is important to note that while utilisation rates for home support vary across HSE Health Regions, it can be difficult to explain why this might be the case. Some possible reasons for differences in rates are listed below; these are provided only as a guide and do not constitute an exhaustive list of reasons.

- As with LTRC, population structures differ by HSE Health Region; higher utilisation may reflect an older population within a HSE Health Region, and the structure of health and social care services in some HSE Health Regions may place a greater focus on home support over LTRC.
- Some HSE Health Regions may simply have greater supply of home support provision, specifically private provision.
- HSE home support service waiting lists may be longer in some HSE Health Regions.
- Family and informal care may be stronger in some HSE Health Regions, resulting in lower demand for formal home support.
- Inconsistent data capture, especially for private home support, is an issue, one that required the use of national age and sex profiles for each HSE Health Region; this may explain some differences.

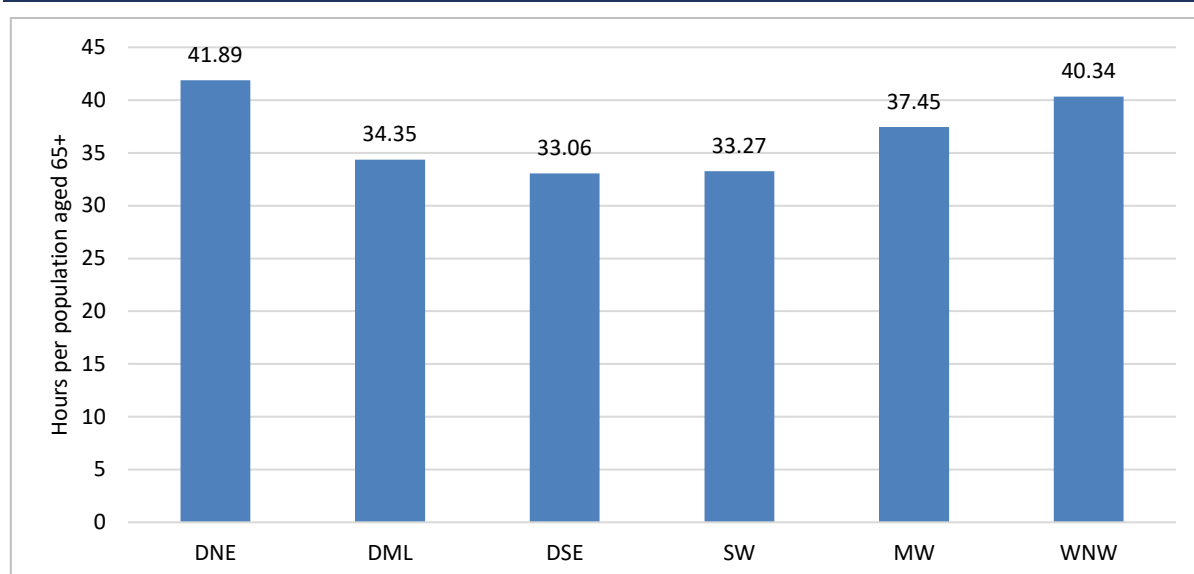
In this chapter we present results as age-specific hours by HSE Health Region in line with the results presented in the national report (Walsh and Kakoulidou, 2025). Additional results on total hours and hours provided by HSE or private providers are presented in Appendix D.

4.2 HOME SUPPORT HOURS

Figure 4.1 illustrates the number of home support hours per population aged 65 years and over in HSE Health Regions in December 2022. There were 33.06 home support hours per population aged 65 years and over in Dublin and South East, compared to 41.89 hours per population aged 65 years and over in Dublin and North East.¹⁰

¹⁰

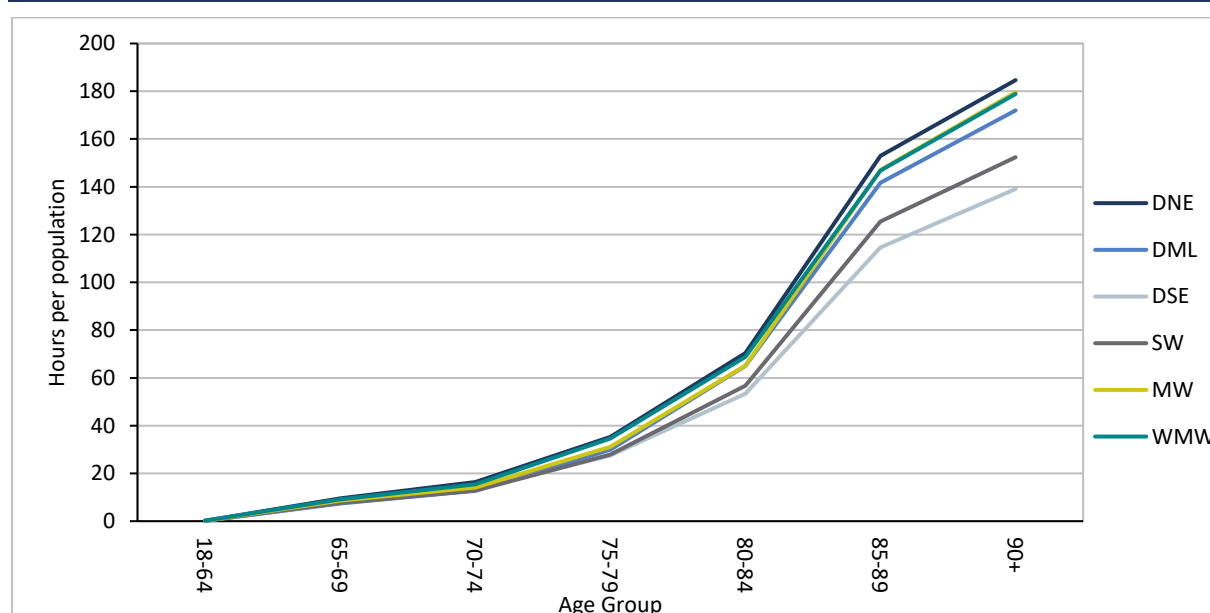
Figure B.1 illustrates the number of home support in HSE Health Regions in December 2022. Figures B.2 and B.3 illustrate the number of these hours delivered by the HSE and by voluntary/private providers.

FIGURE 4.1 HOME SUPPORT HOURS PER POPULATION AGED 65+ BY HSE HEALTH REGION, 2022

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

Notes: Includes home support hours used by recipients aged <65. Population aged 65+ denominator reflects the population who use the vast majority of home support services.

Figure 4.2 illustrates age-specific home support hours per population aged 65 years and over in HSE Health Regions in December 2022. Similar age distributions were observed across HSE Health Region, with rates increasing with age. Variations in age-specific activity rates across HSE Health Regions are reflective of variation in hours provided across regions, as well as little observed differences in age distribution across regions.

FIGURE 4.2 AGE-SPECIFIC HOME SUPPORT HOUR RATES PER POPULATION AGED 65+ BY HSE HEALTH REGION, 2022

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

CHAPTER 5

Projections – Regional long-term residential care beds

5.1 INTRODUCTION

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

5.2 REGIONAL BED CAPACITY PROJECTIONS

Table 5.1 presents the projected increase in short stay and long stay bed capacity requirements between 2022 and 2040 for the status quo, low pressure, high pressure and progress scenarios for all HSE Health Regions. For short stay beds, similar percentage increases are projected across all HSE Health Regions, ranging from 2.7 per cent to 3.8 per cent when presented as average annual increases. These projected increases equate to 211–282 beds in the Mid West Health Region, and to 661–893 beds in the Dublin and North East Health Region.

For long stay beds, again similar percentage increases are projected across all HSE Health Regions, ranging from 2.7 per cent to 3.7 per cent when presented as average annual increases. These projected increases equate to 1,662–2,197 beds in the Mid West Health Region and 4,243–5,735 beds in the Dublin and North East Health Region.

TABLE 5.1 LONG-TERM RESIDENTIAL CARE BED PROJECTIONS BY HSE HEALTH REGION, 2022–2040

	2022	Projected additional requirements 2040				Average annual growth 2022–2040			
		Status quo	Low	High	Progress	Status quo	Low	High	Progress
	N Beds	N Beds				%			
Short stay									
DNE	1,024	797	661	893	669	3.2	2.8	3.5	2.8
DML	468	398	337	444	337	3.5	3.1	3.8	3.1
DSE	783	608	506	676	511	3.2	2.8	3.5	2.8
SW	469	371	307	412	310	3.3	2.8	3.6	2.9
MW	311	254	211	282	214	3.4	2.9	3.6	2.9
WNW	689	521	433	580	437	3.2	2.7	3.5	2.8
National	3,745	2,949	2,456	3,287	2,479	3.3	2.8	3.6	2.9
Long stay									
DNE	6,932	5,391	4,474	5,735	4,243	3.2	2.8	3.4	2.7
DML	4,900	4,169	3,526	4,451	3,389	3.5	3.1	3.7	3.0
DSE	6,329	4,912	4,093	5,201	3,889	3.2	2.8	3.4	2.7
SW	4,351	3,440	2,849	3,676	2,743	3.3	2.8	3.5	2.8
MW	2,465	2,009	1,672	2,197	1,662	3.4	2.9	3.6	2.9
WNW	4,603	3,484	2,891	3,715	2,773	3.2	2.7	3.3	2.7
National	29,579	23,406	19,505	24,975	18,700	3.3%	2.9%	3.5%	2.8%

Notes: Bed estimates presented are subject to rounding to the nearest whole number.

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

Table 5.2 presents the decomposition analysis of short stay and long stay beds across HSE Health Regions. It illustrates the drivers of growth in short stay and long stay bed requirements in the status quo and progress scenarios. A similar structure of the key drivers of capacity requirements is observed for both short stay and long stay bed capacity, and across HSE Health Regions.

Similar to the national report, the population age structure is by far the biggest driver for projected bed capacity for short stay and long stay beds in each Health Region. For short stay beds, population ageing accounts for 85 per cent of short stay bed projections in Dublin and North East, and 93 per cent in the Mid West Health Region. While population growth also increases projections, these projected increases are offset in the status quo scenario when the healthy ageing assumption of dynamic equilibrium is applied, which reduces short stay bed requirements by between 28 per cent (West and North West) and 31 per cent (Dublin and Midlands). In the progress scenario, additional healthy ageing (compression of morbidity) would also offset projected increases by approximately 7 per cent in all Health Regions. The policy options, which include removal of waiting lists and expansion of home support, essentially offset each other and are found to have little additional effect on projections in the progress scenario.

For long stay beds, the effects of each assumption factor are similar to the effects found for short stay care; this is because very similar age and sex profiles are found among those in short stay and long stay care, across each HSE Health Region. Once more, population ageing accounts for between 85 per cent (Dublin and North East) and 93 per cent (Mid West) of short stay bed projections. Population growth also

increases projections. Healthy ageing (dynamic equilibrium) reduces long stay bed requirements by between 28 per cent (West and North West) and 31 per cent (Dublin and Midlands) under the status quo scenario, with additional healthy ageing (compression of morbidity) reducing projected requirements by between 7 and 8 per cent in the progress scenario. The policy options, which include removal of waiting lists and expansion of home support, are found to have a small additional effect on reducing projections in Dublin and North East, Dublin and Midlands and Dublin and South East Health Regions.

TABLE 5.2 DECOMPOSITION OF LONG-TERM RESIDENTIAL CARE BED PROJECTIONS, 2022–2040

	2022	Decomposition			2040 Status quo	Decomposition		2040 Progress
		Pop growth	Pop age structure	Healthy ageing (DE)		Healthy ageing (CM)	Policy options	
	N beds	%			N beds	%		N beds
Short stay								
DNE	1,024	22	85	-29	1,821	-7	0	1,693
DML	468	24	92	-31	867	-7	0	805
DSE	783	19	87	-29	1,391	-7	0	1,295
SW	469	20	89	-29	840	-7	0	779
MW	311	19	93	-30	565	-7	0	525
WNW	689	18	86	-28	1,210	-7	0	1,126
National	3,745				6,894			6,494
Long stay								
DNE	6,932	22	85	-29	12,323	-7	-2	11,175
DML	4,900	24	92	-31	9,069	-7	-2	8,288
DSE	6,329	19	87	-29	11,241	-7	-2	10,218
SW	4,351	20	89	-29	7,791	-8	-1	7,094
MW	2,465	19	93	-30	4,473	-8	-0	4,127
WNW	4,603	18	86	-28	8,087	-7	-1	7,376
National	29,579				52,331			47,588

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

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

Table 5.3 presents results from the sensitivity analysis that estimates the additional beds that would be required in each HSE Health Region if per capita (per population aged 65+) bed supply in each HSE Health Region was to match the region with the highest relative level of projected requirements in 2040.

For short stay beds, projected supply per capita varies significantly across HSE Health Regions and largely reflects differing levels of supply in the baseline. The table shows that the Dublin and North East region has the highest level of projected supply requirements in 2040. An additional 820 beds (on top of those projected in Table 5.1) would be needed in Dublin and Midlands in order to meet the per capita supply in Dublin and North East. Smaller increases would be required in other HSE Health Regions.

For long stay beds, projected supply per capita supply vary significantly across HSE Health Regions and largely reflect differing levels of supply in the baseline. The table shows that the Dublin and North East region again has the highest level of projected supply requirements in 2040. An additional 2,338 beds (on top of those projected in Table 5.1) would be needed in Dublin and Midlands in order to meet the per capita supply in Dublin and North East. Smaller increases would be required in other HSE Health Regions.

TABLE 5.3 LTTC BED PROJECTIONS BASED ON PER CAPITA SUPPLY BY HSE HEALTH REGION, 2040

	Projected bed requirements 2040 (Status quo)	Beds per 1,000 pop Aged 65+	Additional beds to meet highest supply HSE Health Region 2040
Short stay			
DNE	1,821	6.69	0
DML	866	3.43	820
DSE	1,391	5.22	390
SW	840	4.32	459
MW	565	5.18	164
WNW	1,210	5.92	155
Long stay			
DNE	12,323	45.24	0
DML	9,069	35.97	2,338
DSE	11,241	42.19	813
SW	7,791	40.10	1,000
MW	4,474	41.01	462
WNW	8,087	39.60	1,153

Notes: Estimates are based upon the status quo projection scenario.

Bed estimates presented are subject to rounding to the nearest whole number.

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

CHAPTER 6

Projections – Regional home support hours

6.1 INTRODUCTION

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

6.2 REGIONAL HOME SUPPORT HOURS PROJECTIONS

Table 6.1 presents the projected increase in home support hour requirements between 2022 and 2040 for the status quo, low pressure, high pressure and progress scenarios, for all HSE Health Regions. Similar percentage increases are projected across all HSE Health Regions, ranging from 2.4 per cent (low pressure scenario) to 3.8 per cent (high pressure scenario) across HSE Health Regions. Presented in terms of additional requirements, we project additional hours required range from between 1.6 million to 2.3 million hours in the Mid West to between 4 million and 5.6 million hours in Dublin and North East.

TABLE 6.1 HOME SUPPORT HOURS PROJECTIONS BY HSE HEALTH REGION, 2022–2040

	2022	Projected additional requirements 2040				Average annual growth 2022–2040			
		Status quo	Low	High	Progress	Status quo	Low	High	Progress
	N hours (millions)	N hours (millions)				%			
DNE	6.7	4.9	4.0	5.6	4.9	3.1	2.6	3.4	3.1
DML	5.0	4.1	3.3	4.7	4.3	3.3	2.9	3.8	3.5
DSE	5.4	3.8	3.1	4.5	4.1	3.0	2.6	3.4	3.2
SW	4.1	3.0	2.4	3.5	3.1	3.1	2.6	3.5	3.2
MW	2.6	2.0	1.6	2.3	2.1	3.2	2.7	3.6	3.3
WNW	5.5	3.6	2.9	4.2	3.7	2.9	2.4	3.2	2.9
National	28.7	20.6	16.2	26.2	21.5	3.1	2.6	3.5	3.2

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

Table 6.2 presents the decomposition analysis of home support hours across HSE Health Regions. It illustrates the drivers of growth in the status quo and progress scenarios. A similar structure of the key drivers of capacity requirements is observed across HSE Health Regions.

Similar to the national report, the population age structure is by far the biggest driver for projected home support hour requirements in each Health Region, accounting for 80 per cent of home support hour projections in West and North West, and 94 per cent in Dublin and Midlands. While population growth also increases projections, these projected increases are offset in the status quo

scenario when the healthy ageing assumption of dynamic equilibrium is applied, which reduces home support hour requirements by between 29 per cent (West and North West) and 34 per cent (Dublin and Midlands). In the progress scenario, additional healthy ageing (compression of morbidity) would additionally offset projected increases by approximately 8 per cent in all Health Regions. The policy options, which include removal of waiting lists and expansion of home support, essentially together would increase projected home support hour requirements by between 8 per cent (Dublin and North East) and 11 per cent (Dublin and Midlands).

TABLE 6.2 DECOMPOSITION OF HOME SUPPORT HOUR PROJECTIONS, 2022–2040

	2022	Decomposition			2040 Status quo	Decomposition		2040 Progress
		Pop growth	Pop age Structure	Healthy ageing (DE)		Healthy ageing (CM)	Policy options	
	N hours	%			N hours	%		N hours
Home support hours								
DNE	6.7	20	86	-32	11.6	-8	8	11.6
DML	5.0	21	94	-34	9.1	-8	10	9.2
DSE	5.4	17	84	-30	9.3	-8	11	9.6
SW	4.1	17	86	-31	7.0	-8	10	7.2
MW	2.6	16	92	-31	4.6	-8	9	4.7
WNW	5.5	15	80	-29	9.1	-8	9	9.2
National	28.7				49.3			50.2

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

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

Table 6.3 presents results from the sensitivity analysis, which estimates the additional home support hours that would be required in each HSE Health Region if per capita (per population aged 65+) hours in each HSE Health Region was to match the region with the highest relative level of projected requirements in 2040. Projected home support supply per capita varies across HSE Health Regions. Table 6.3 shows that West and North West has the highest level of projected supply requirements in 2040. An additional 2.7 million hours (on top of those projected in Table 6.1) would be needed in Dublin and South East in order to meet the higher per capita supply. Smaller increases would be required in other HSE Health Regions.

TABLE 6.3 HOME SUPPORT HOUR PROJECTIONS BASED ON PER CAPITA SUPPLY BY HSE HEALTH REGION, 2040

	Projected hour (million) requirements 2040 (Status quo)	Hours per pop Aged 65+	Additional hours (million) to meet highest supply HSE Health Region 2040
Home support			
DNE	11.6	42.50	0.6
DML	9.1	36.03	2.2
DSE	9.3	34.81	2.7
SW	7.0	36.18	1.7
MW	4.6	42.55	0.2
WNW	9.1	44.78	-

Notes: Estimates are based upon the status quo projection scenario.

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

CHAPTER 7

Summary and discussion

7.1 INTRODUCTION

This report projects long-term residential care (LTRC) and home support demand and capacity requirements across HSE Health Regions to 2040. The report builds upon previous applications of the Hippocrates model for older people's care (Wren et al., 2017; Walsh et al., 2021), and the recent national older people's care capacity review (Walsh and Kakoulidou, 2025). This chapter provides a brief overview of the results, discusses the sensitivity of the findings to alternative assumptions, outlines some limitations and opportunities for further analysis, and draws out implications for policy.

7.2 SUMMARY FINDINGS

7.2.1 Long-term residential care

This report projects large increases in short stay and long stay bed capacity requirements between 2022 and 2040 across all projection scenarios for all HSE Health Regions. For short stay beds, similar relative increases are projected across all Health Regions, ranging from 2.7 per cent to 3.8 per cent when presented as average annual increases. These projected increases equate to 211–282 additional beds in the Mid West Health Region, and 661–893 additional beds in the Dublin and North East Health Region. For long stay beds, again similar percentage increases are projected across all Health Regions, ranging from 2.7 per cent to 3.7 per cent when presented as average annual increases. These projected increases equate to 1,662–2,197 additional beds in the Mid West Health Region, and 4,243–5,735 additional beds in the Dublin and North East Health Region.

Similar to the national report, the population age structure is by far the biggest driver for projected bed capacity for short stay and long stay beds in each Health Region. Our decomposition analysis shows that for short stay and long stay beds, population ageing accounts for 85 per cent of short stay bed projections in Dublin and North East, and 93 per cent in the Mid West. Healthy ageing assumptions mitigate some of the projected increases, though fail to offset the large projected increases driven by the population ageing effect. Within our progress scenario, unmet demand assumptions effectively reduce any potential reductions that may arise from expansion of home support.

7.2.2 Home support

This report projects large increases in home support hours requirements between 2022 and 2040 across all projection scenarios for all HSE Health Regions. Similar

percentage increases are projected across all HSE Health Regions, ranging from 2.4 per cent (low pressure scenario) to 3.8 per cent (high pressure scenario) across HSE Health Regions. Presented in terms of additional requirements, we project that additional hours required range from 1.6–2.3 million hours in the Mid West to 4–5.6 million hours in Dublin and North East.

Similar to the national report, and to the LTRC analysis, the population age structure is by far the biggest driver for home support hour requirements. Population ageing accounts for 80 per cent of home support hour projections in West and North West, and 94 per cent in Dublin and Midlands. Healthy ageing assumptions did mitigate some of the projected increases. Unmet demand assumptions and the expansion of home support assumptions would increase requirements by approximately 10 per cent across all HSE Health Regions.

7.3 POLICY IMPLICATIONS

Between 2022 and 2040, the population aged 65 years and over is projected to increase by between 53 per cent (West and North West) and 76 per cent (Dublin and Midlands) across HSE Health Regions. The population aged 85 years and over – high users of older people's care services – will see even larger percentage increases. A growing and ageing population across all HSE Health Regions will increase demand for home support and LTRC significantly in the coming years. As highlighted in the accompanying national capacity review report (Walsh and Kakoulidou, 2025), the substantial impact of the projected increases in the older population will offset a large proportion of potential moderations in home support and LTRC requirements that may arise out of healthy ageing or model of care changes. There is a need to develop effective financing, workforce and infrastructure planning to help deliver the additional long-term care and capacity at the national and regional levels.

Analyses presented in the appendices to this report show that the vast majority of LTRC and home support is provided by the private sector, with HSE Health Regions – such as Dublin and North East, Dublin and Midlands, and Dublin and South East in particular – having very large rates of private provision of care. Regional policymakers need to take this into account when interpreting results from these analyses. If current levels of reliance on private providers continue into the future, meeting projected LTRC bed and home support hours requirements will depend on significant increases in private provision across all HSE Health Regions. This will require policies that continue to attract providers to join and remain in the long-term care market, as well as policies that help ensure provision is located in an equitable manner across regions in Ireland, and that care recipients receive the required services within a more integrated care environment.

We show that variation in supply is observed across HSE Health Regions. This finding – of variations in the supply of LTRC beds and home support hours per capita across the HSE Health Regions – is consistent with other work, which has found significant differences at the county level (Smith et al., 2021; Walsh and Connolly, 2024). Sensitivity analyses highlight that additional beds that would be required, over and above those already projected, to ensure each HSE Health Region had the same supply per capita as the highest supplied HSE Health Region. However, the authors acknowledge that each HSE Health Region will have its own factors that impact on the demand and delivery of long-term care services within their respective region. Region-specific responses will be required to deliver sufficient long-term care services within each region.

Similar to the national level analysis, the extent of the analysis that could be undertaken on LTRC and home support at the HSE Health Region level was severely curtailed by a lack of data. At the regional level, there is a lack of information on privately purchased LTRC and home support and short stay care. At both a regional and national level, there is a lack of information on LTRC and home support recipients' dependency levels and care needs. Such data are needed for better capacity planning across the system. These limitations and data gaps are detailed in a forthcoming report that examines current gaps in health and social care data in Ireland, which need to be addressed in order to carry out Hippocrates model analysis (Connolly et al., forthcoming).

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

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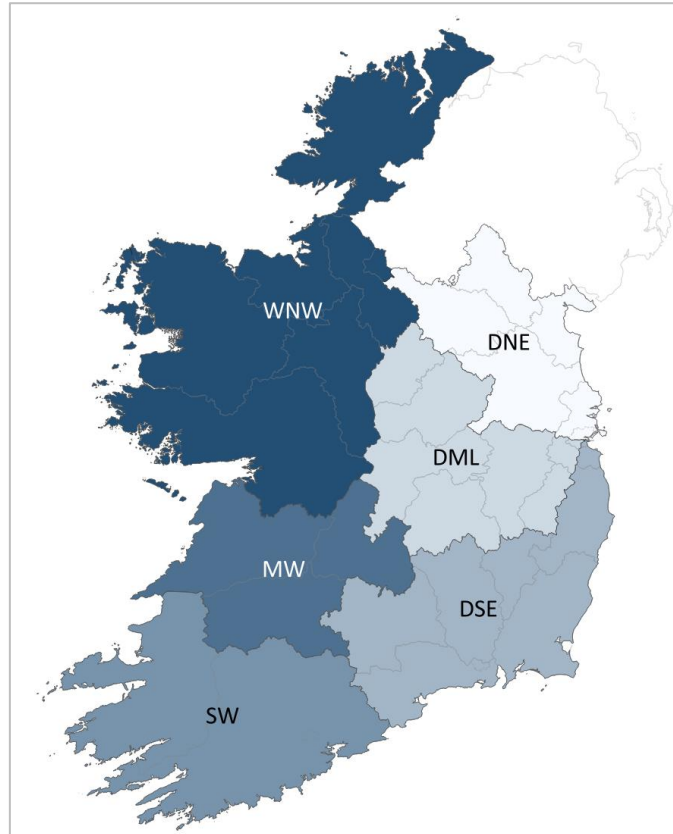
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APPENDIX A

HSE Health Regions

FIGURE A.1 GEOGRAPHICAL DISTRIBUTION OF THE SIX HSE HEALTH REGIONS



Notes: Authors' representation of the six HSE Health Regions. DNE: Dublin and North East; DML: Dublin and Midlands; DSE: Dublin and South East; SW: South West; MW: Mid West; WNW: West and North West.

Source: CSO SAPMAPs (2022).

TABLE A.1 ALLOCATION OF LHOS AND CHOS TO HSE HEALTH REGIONS

Health region	LHO	CHO
Dublin and North East (DNE)	Cavan/Monaghan	CHO 1
	Meath	CHO 8
	Louth	CHO 8
	Dublin North	CHO 9
	Dublin North Central	CHO 9
	Dublin North West	CHO 9
Dublin and Midlands (DML)	Dublin West	CHO 7
	Dublin South City	CHO 7
	Dublin South West	CHO 7
	Kildare/West Wicklow	CHO 7
	Laois/Offaly	CHO 8
	Longford/Westmeath	CHO 8
Dublin and South East (DSE)	Wexford	CHO 5
	Carlow/Kilkenny	CHO 5
	Waterford	CHO 5
	South Tipperary	CHO 5
	Dublin and South East	CHO 6
	Dun Laoghaire	CHO 6
	Wicklow	CHO 6
South West (SW)	Kerry	CHO 4
	North Cork	CHO 4
	North Lee	CHO 4
	South Lee	CHO 4
	West Cork	CHO 4
Mid West (MW)	Limerick	CHO 3
	Clare	CHO 3
	North Tipperary/East Limerick	CHO 3
West and North West (WNW)	Donegal	CHO 1
	Galway	CHO 2
	Sligo/Leitrim/West Cavan	CHO 1
	Mayo	CHO 2
	Roscommon	CHO 2

Notes: CHO 1 includes Cavan, Donegal, Leitrim, Monaghan, Sligo; CHO 2 includes Galway, Mayo and Roscommon; CHO 3 includes Limerick, Clare, North Tipperary; CHO 4 includes Cork and Kerry; CHO 5 includes Kilkenny, Carlow, Tipperary South, Waterford, Wexford; CHO 6 includes Dublin and South East, Dublin South, Wicklow; CHO 7 includes Dublin South, Kildare and West Wicklow; CHO 8 includes Meath, Louth, Longford, Westmeath, Offaly, Laois; CHO 9 includes Dublin North City & County.

Sources: Introducing HSE health regions; Community Healthcare Organisations in Ireland | The AT Network.

APPENDIX B

Population assumptions

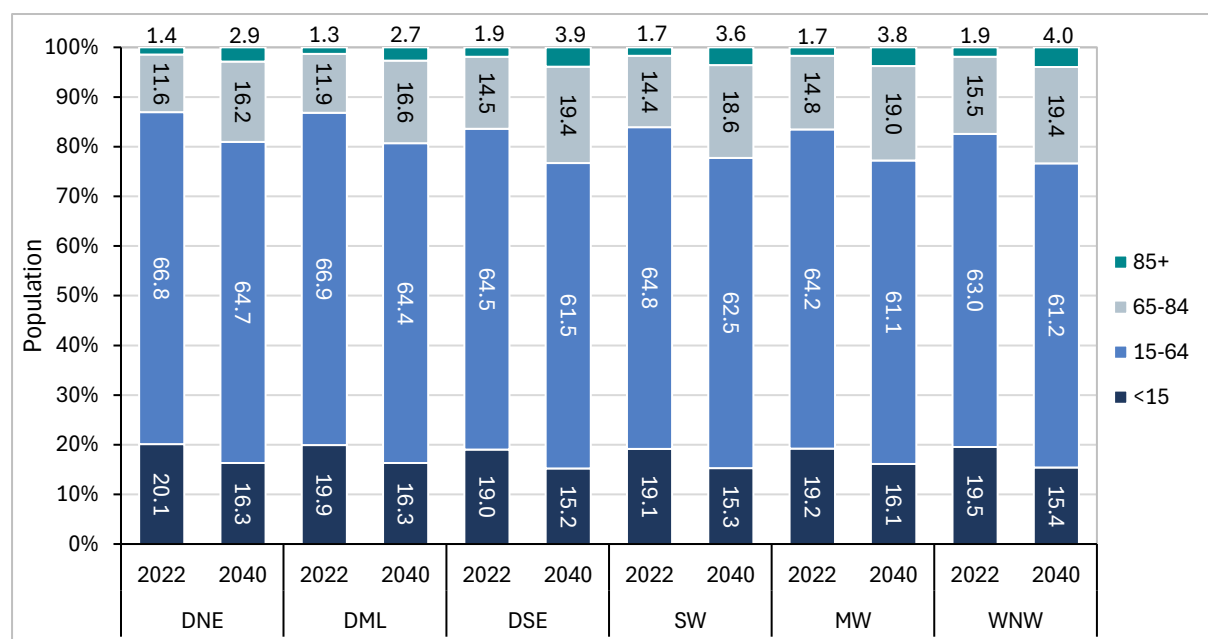
TABLE B.1 SUMMARY OF MAIN ASSUMPTIONS FOR POPULATION SCENARIOS

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

Note: p.a.=per annum.

Source: Bergin and Egan (2024).

FIGURE B.1 AGE-SPECIFIC POPULATION DISTRIBUTION, 2022 AND 2040 (CENTRAL SCENARIO)



Sources: Generated by the authors, from Bergin and Egan (2024).

APPENDIX C

Long-term residential care

FIGURE C.1 DISTRIBUTION OF NHSS RESIDENTS BY HSE HEALTH REGION, 2022

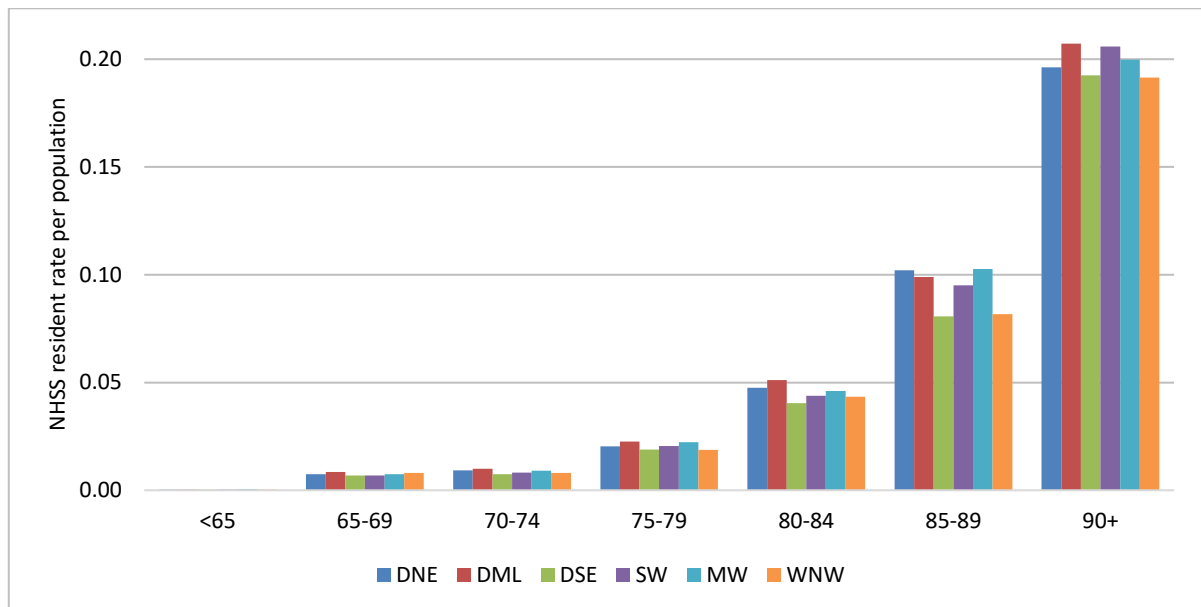
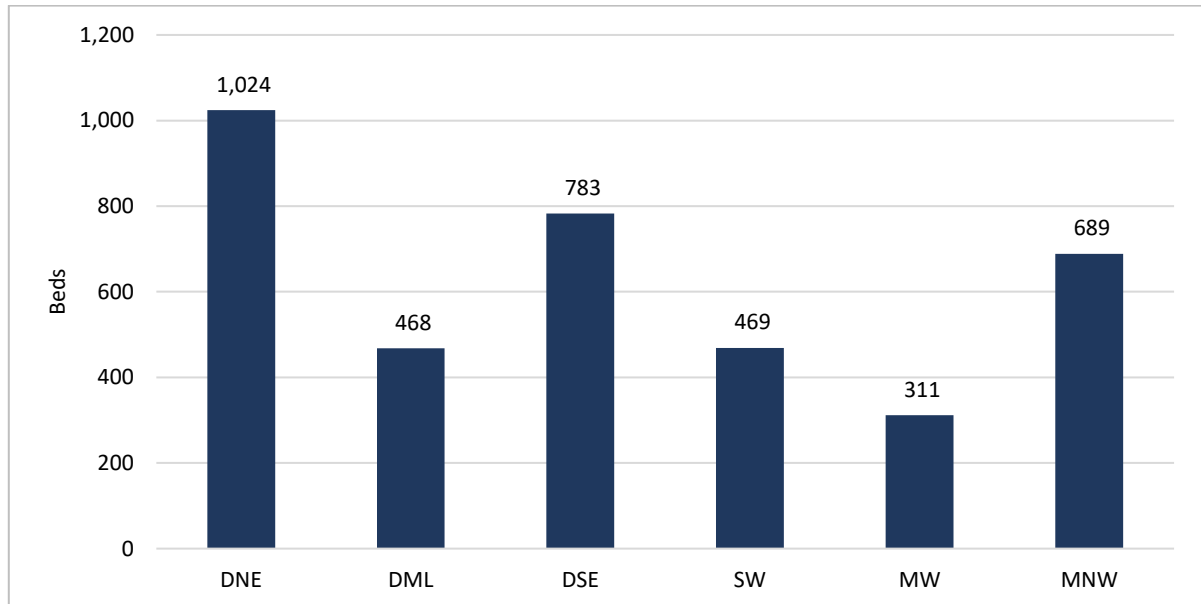
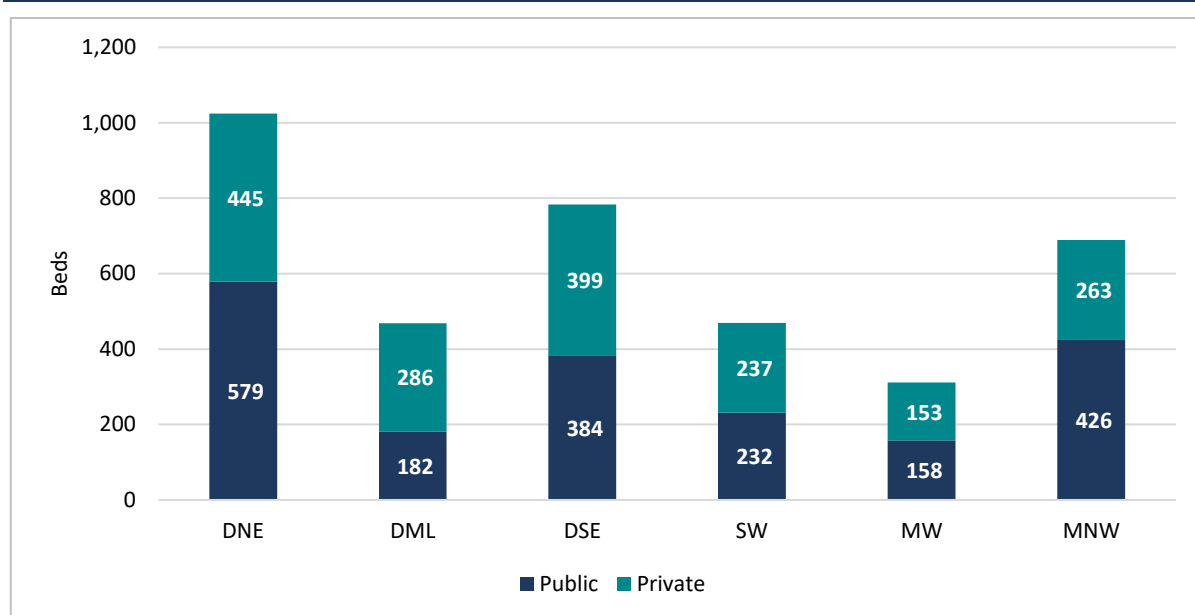


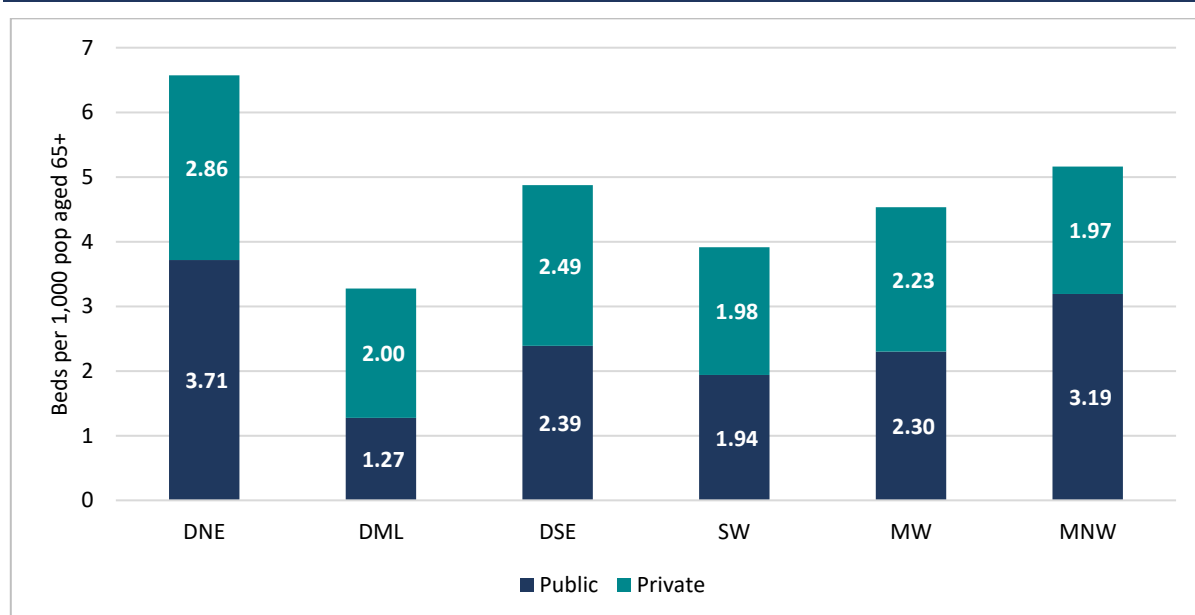
FIGURE C.2 SHORT STAY BEDS BY HSE HEALTH REGION, 2022



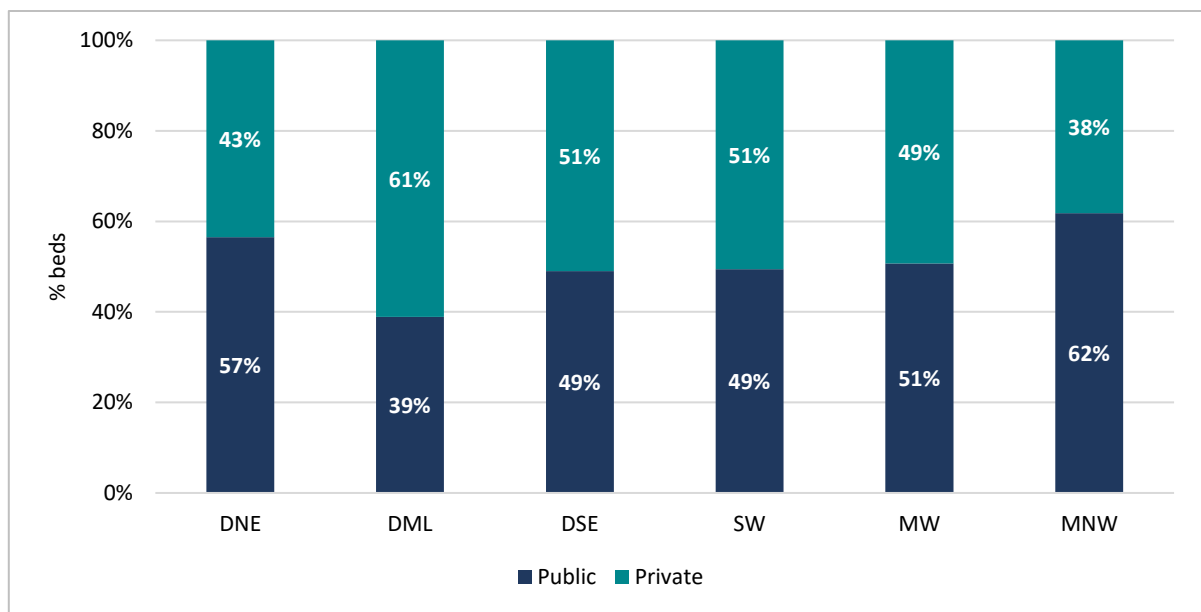
Sources: ESRI population data, HSE administrative data, NHI survey data, and HIQA bed register data; authors' calculations.

FIGURE C.3 SHORT STAY BEDS BY OWNERSHIP AND HSE HEALTH REGION, 2022

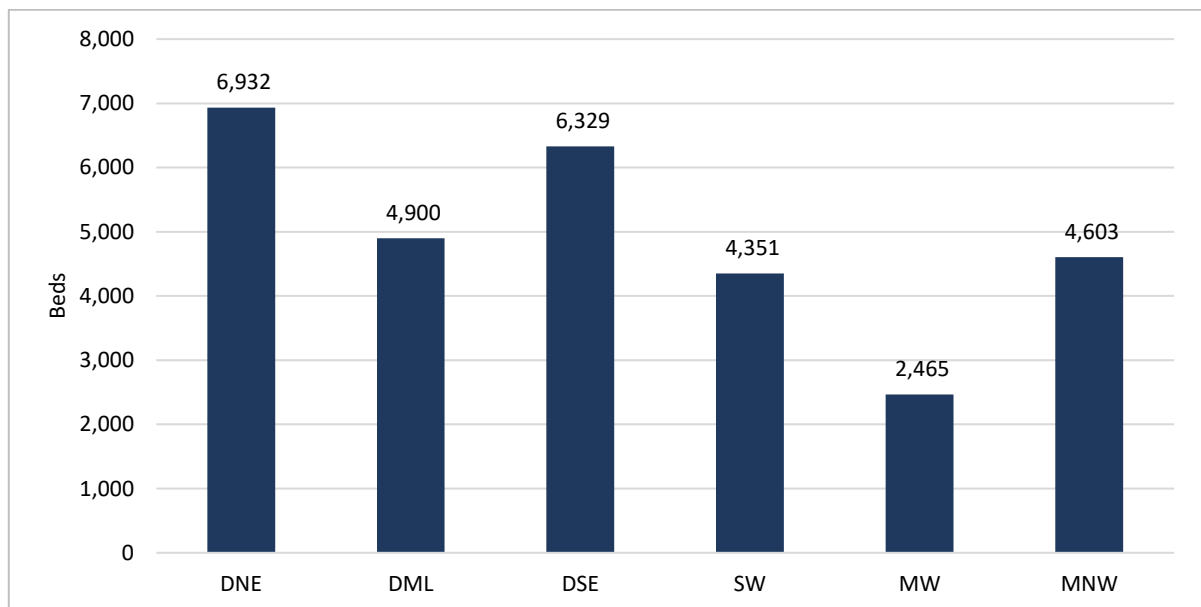
Sources: ESRI population data, HSE administrative data, NHI survey data, and HIQA bed register data; authors' calculations.

FIGURE C.4 SHORT STAY BEDS PER 1,000 POPULATION AGED 65+ BY OWNERSHIP AND HSE HEALTH REGION, 2022

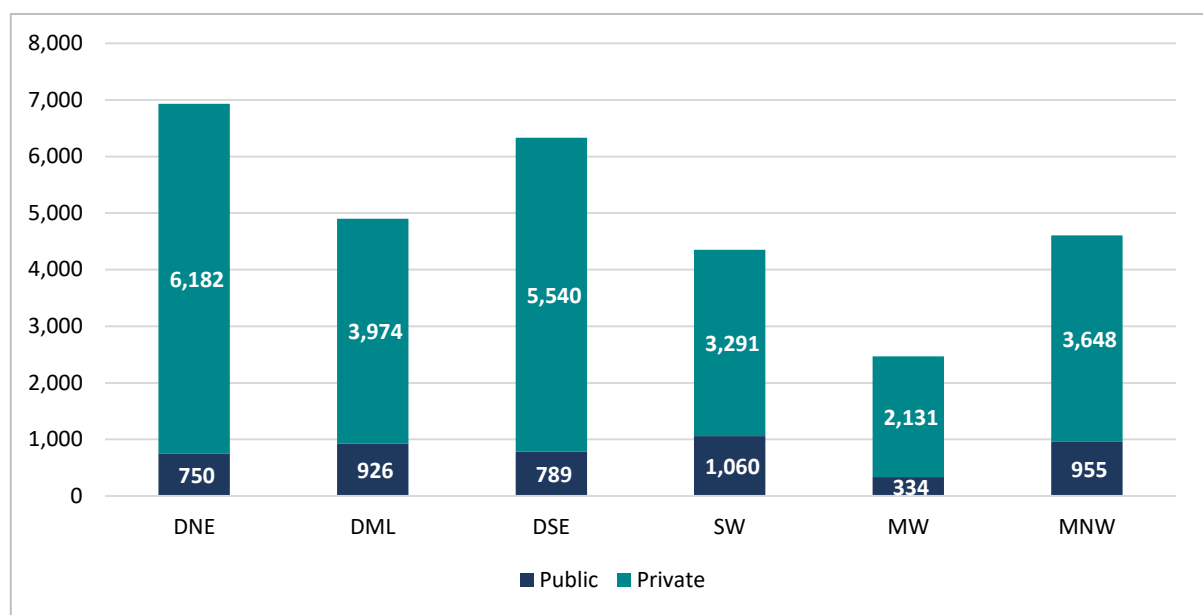
Sources: ESRI population data, HSE administrative data, NHI survey data, and HIQA bed register data; authors' calculations.

FIGURE C.5 PERCENTAGE OF SHORT STAY BEDS BY OWNERSHIP AND HSE HEALTH REGION, 2022

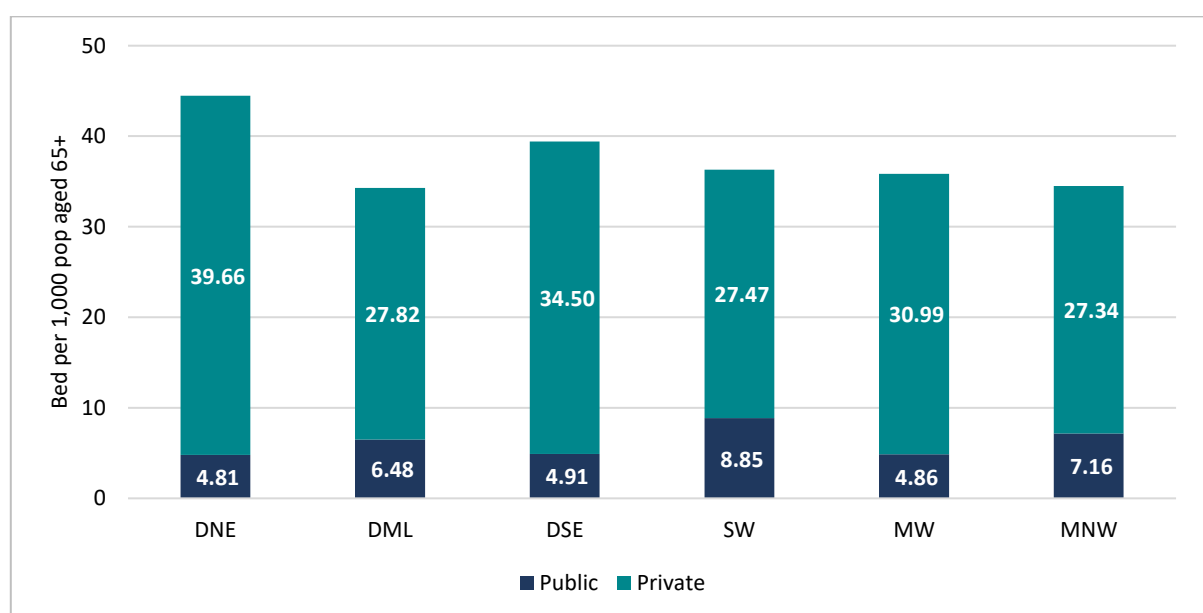
Sources: ESRI population data, HSE administrative data, NHI survey data, and HIQA bed register data; authors' calculations.

FIGURE C.6 LONG STAY BEDS BY HSE HEALTH REGION, 2022

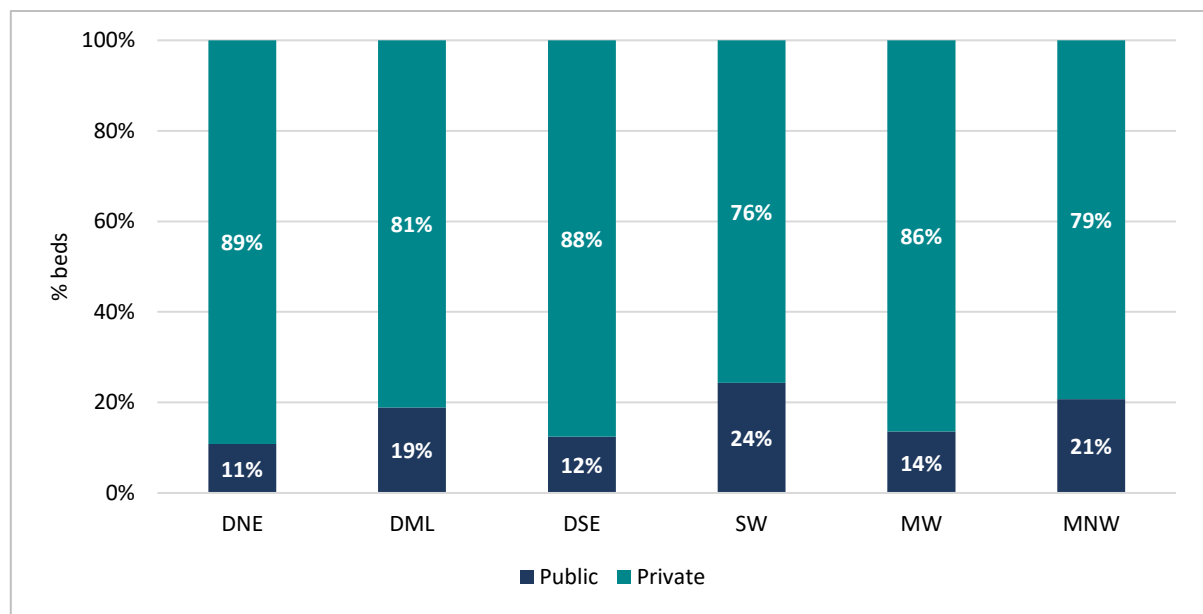
Sources: ESRI population data, HSE administrative data, NHI survey data, and HIQA bed register data; authors' calculations.

FIGURE C.7 LONG STAY BEDS BY OWNERSHIP AND HSE HEALTH REGION, 2022

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

FIGURE C.8 LONG STAY BEDS PER 1,000 POPULATION AGED 65+ BY OWNERSHIP AND HSE HEALTH REGION, 2022

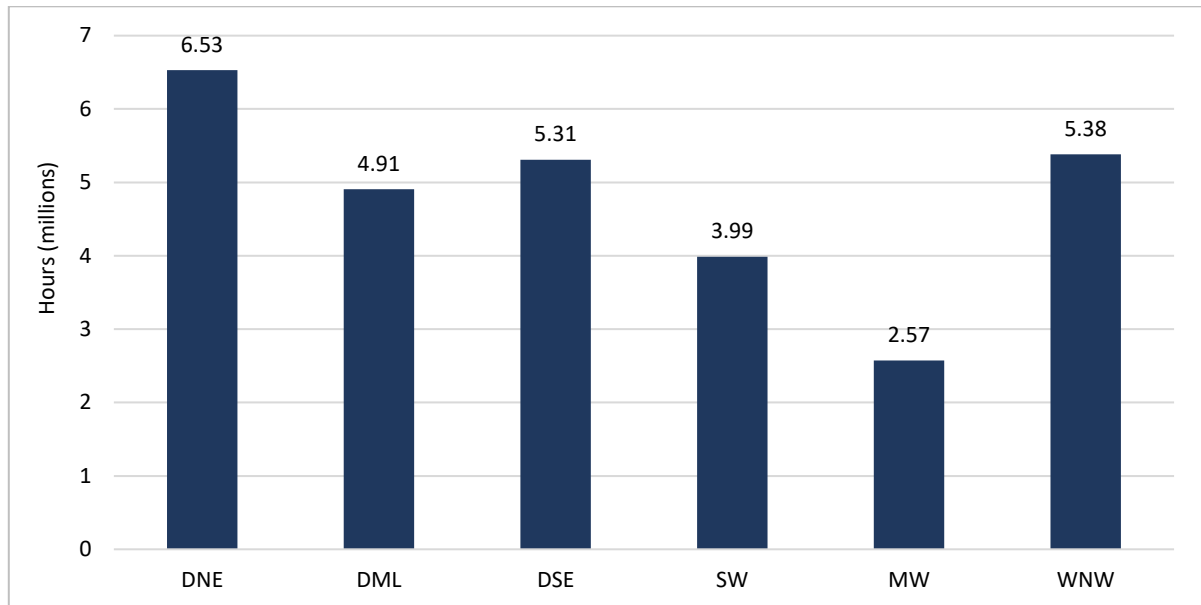
Sources: ESRI population data, HSE administrative data, NHI survey data, and HIQA bed register data; authors' calculations.

FIGURE C.9 PERCENTAGE OF LONG STAY BEDS BY OWNERSHIP AND HSE HEALTH REGION, 2022

APPENDIX D

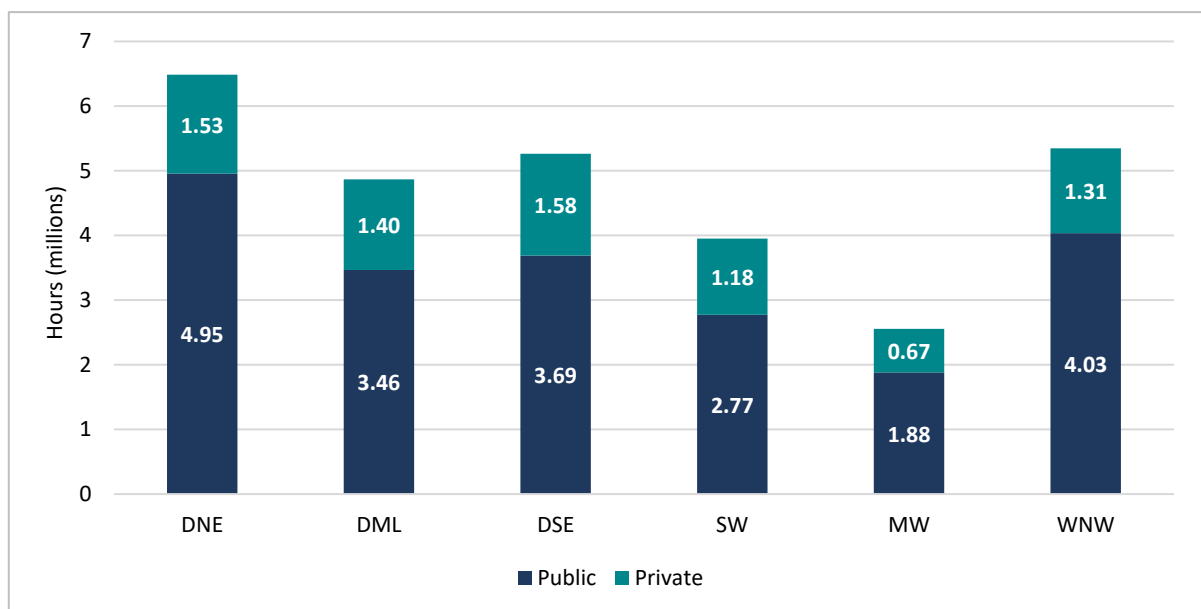
Home support

FIGURE D.1 HOME SUPPORT HOURS BY HSE HEALTH REGION, 2022



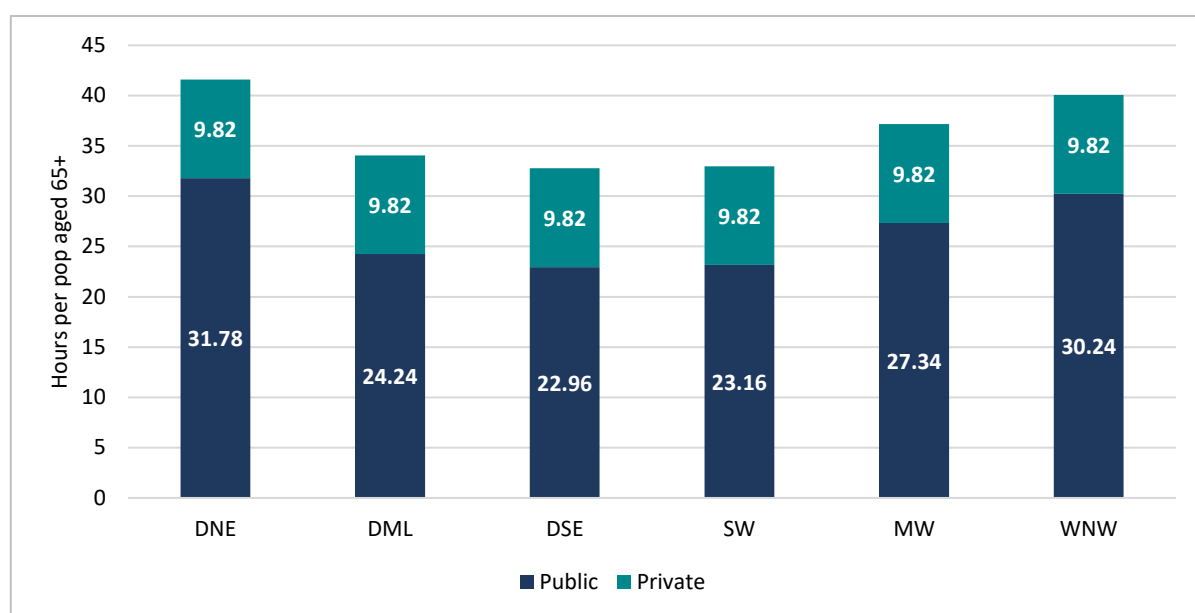
Sources: ESRI population data, HSE administrative data and TILDA data; authors' calculations.

FIGURE D.2 HOME SUPPORT HOURS BY OWNERSHIP AND HSE HEALTH REGION, 2022



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

FIGURE D.3 HOME SUPPORT HOURS PER POPULATION AGED 65+ BY HSE HEALTH REGION, 2022



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



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