

Analysis of Irish Home Care Market

Irish Private Home Care Association
(IPHCA)

February 2009



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Executive summary

The Irish Private Home Care Association (IPHCA) engaged PA Consulting Group (PA) to undertake a rapid, fact-based analysis of the Irish home care market. The analysis was based on publicly available data and literature. This Executive Summary highlights the key messages from the analysis.

Ireland's home care market is new but substantial in value (€340.27M) and set to grow significantly

Ireland is following a global trend of shifting the focus of care from the acute sector to the individual's home for demographic, financial and policy reasons. The Irish home care market is relatively new but substantial with an estimated value of €340.27million. Our analysis indicates that based on population growth alone, the number of home care recipients may increase from 57,581 to 96,250 by 2021. This potential future demand heightens the importance of getting the conditions right for a regulated, healthy, competitive market so that the required capacity is available and cost effective.

This review identified two necessary changes to the market to ensure the required capacity is provided in a cost effective and safe manner:

- Greater transparency of cost of home care provision is required to inform purchasing decisions and identify opportunity for savings
- The market must be regulated to safeguard home care customers.

Whilst there is poor cost transparency in the home care market, analysis of the available data indicates a significant cost differential between providers:

- Whilst the HSE and non-profit figures provided here are approximate as they are limited by data availability, they indicate that there is a noteworthy cost differential between providers that should be examined.
- Detailed analysis of available data suggests that the true cost per hour of HSE and non-profit care (€29.44) is 29% more expensive than the private sector (€21). Higher staff costs are the primary factor driving higher costs in the public and non-profit sectors.
- The non-profit sector charges the HSE their marginal cost (€18.50), rather than total cost (€29.44), per hour for provision of home care under the home care package scheme. They do not recover their overhead costs. This suggests that these overhead costs must be covered in other ways, such as Section 39 grant funding, or client contributions. Either way, this subsidisation of the non-profit sector from other sources distorts the cost of care in the market.

The cost differential indicated by this analysis suggests the HSE, as the largest purchaser, could yield significant benefit from introducing competition in the market

- If all HSE-funded home care were outsourced to the private sector (including that provided by the HSE and the non-profit sector under the Home Care Package scheme) €79.83M could potentially be realised¹
- For example, if the delivery of the home help scheme were outsourced to the private sector, savings of €60.49M could potentially be realised²
- Switching 20% of the home help scheme hours delivered internally by the HSE to the private sector could realise savings of €9.42M³
- The current context of pressure to realise savings whilst meeting rising demand for home care highlight the need for the approach to market to be reconsidered.

Introducing competition, realising savings and most importantly, safeguarding quality requires change to current market conditions:

- Increasing demand and financial constraints will place considerable pressure on the market, heightening the importance of regulation and quality guidelines.
- The absence of quality standards creates unacceptable risk to home care customers. High profile adverse incidents in residential care have led to regulation of the sector, catering for c.5% of the population over 65. Home care services cater for c.12.5% of this population group, but there are no standards or regulation, despite the development of draft National Quality Guidelines for Home Care Support Services by the HSE.
- The current approach to procurement is not transparent, limits competition and value for the HSE and may hinder further growth of the market. The absence of a national framework for procurement limits access to new entrants and reduces competition. The largest section of the market - the home help scheme - is closed to private providers.

¹ Based on the non-profit sector share of the market (as discussed in Chapter 3); the HSE delivered share of the HCP budget (excluding respite and cash grants) estimated to be 36% / €43.68M and an estimate of the proportion of this budget spent on home help derived from the Evaluation of Home Care Packages finding that 41.6% of HCPs involved home help services.

² Based on 29% of the €211M budget

³ Based on 29% of the €162.47 proportion of the home help scheme allocated to internal delivery by the HSE

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1 Introduction

The Irish Private Home Care Association (IPHCA) engaged PA Consulting Group (PA) to undertake a rapid, fact-based analysis of the Irish home care market.

Note that this analysis was based on publicly available data and literature.

This report contains the findings of that analysis. It outlines the key characteristics of the market including the:

- Current and future demand for home care
- Profile of the current home care market:
 - The role of the consumer (public and private)
 - The range, type and cost of providers (including subsidisation and grant aid)
 - Barriers to entry (including policy and regulation)
 - Competition and choice.
- Implications for future direction and priorities for the Irish home care market.

For the purposes of this report, home care (often referred to as domiciliary care) is defined as home help or personal care provided in a person's home. Home help refers to tasks such as housework, meal preparation and social support (companionship, grocery shopping).

Personal care involves tasks such as bathing, toileting and incontinence, assisting with mobility and feeding. A fuller definition is provided at Appendix A.



2 Current and Future Demand for Home Care

Key messages:

- Home care is increasingly a dominant feature of care provision in health systems internationally
- Ireland is following this global trend of shifting the focus of care from the acute sector to the individual's home for demographic, financial and policy reasons
- Provision of home care services is a relatively new but substantial and growing market in Ireland, with an estimated value of €340.27million
- Our analysis indicates that based on population growth alone, the number of home care recipients may increase from 57,581 to 96,250 by 2021
- This potential future demand heightens the importance of getting the conditions right for a regulated, healthy, competitive market so that the required capacity is available and cost effective.

2.1 The shift towards home care is a global trend

Home care is increasingly a dominant feature of care provision in health systems internationally. This convergence of trends can be explained by a number of universal developments:

- A changing and ageing population that wishes to live as independently as possible in their own home for as long as possible, rather than in residential or acute facilities. This ageing population also increases the number of ongoing degenerative or chronic diseases, which suit a different organisation of health care delivery than acute conditions. The optimal management of these types of conditions requires multidisciplinary teamwork and care close to or at home.
- The perception that home care is a cost-effective substitute for both acute care and care in long-term care facilities have increased its appeal, in the context of fiscal pressures since the early 90's combined with the spiralling cost of healthcare.

- Evidence of the benefits of home care is starting to emerge. For example, PA's recent Evaluation of Home Care Packages⁴ found that they are supporting an elderly, dependent group to live at home, and preventing inappropriate admission to residential care.

Most Western health systems are in various stages of reform, and shifting the balance of care from the acute to community sectors is a key enabling trend. It is clear that the approach to home care delivery and the home care market evolve as health system reform is delivered as illustrated in table 1 below.

This table shows that home care is typically initially driven by a need to reduce pressure on the acute and/or residential care sector and over time shifts towards broader preventative and re-ablement objectives. Further, over time the delivery changes from health service or local authority managed to self-directed care driven by customer empowerment and choice. The market grows and consolidates to provide capacity and respond to the demand and preferences of customers. It is useful to bear these international trends in mind when considering the Irish market.

Table 1: Evolution of approach to home care delivery through healthcare reform

	Early stages	Reform Delivery	Mature
Objectives of home care	Reduce reliance on acute	Maintain elderly at home	Broad maintenance and preventative role
Funding and administration	Managed by health service	Managed by health service with significant involvement of eg local councils	Cross-departmental and multi-agency working
Referral	Referral mainly from acute	Referral mainly from primary	Self-referral supported
Access and entitlements	Targeted on most critical	Wide access, preventative	Consumer choice
Home care market	Limited independent sector role	Cottage industry, high turnover	Consolidated, fewer providers
Range of services included	Limited, targeted at high volume reasons for avoiding acute stays	Broader range of services shaped by consumer feedback and preventative role	Menu of services agreed between providers and consumer

Delivery differences taken into account, at the highest level, home care services may be grouped into these three categories:

- **Maintenance and preventive care:** Typically non-complex support, such as home help (defined below) which helps to preserve independent living

⁴ Evaluation of Home Care Packages, PA Consulting Group 2009

- **Short-term home care:** Often provided as a substitute or adjunct to hospital services and can involve complex care and multi-disciplinary input. The strong international trend is now to focus on re-ablement in short-term home care provision.
- **Longer term home care for people with ongoing care requirements:** Often viewed as a substitute for residential care, or a mechanism to delay admission.

2.2 Ireland is following this global trend

Home care provision in Ireland has increased dramatically since the Health Act (1970), which made the provision of home nursing mandatory and empowered the new health boards to make available a 'Home Help Service' and to engage with voluntary bodies to facilitate service provision. Home care in Ireland is now viewed as central to meeting current and future health need and achieving system reform for reasons similar to other countries:

- **Demand is increasing through demographic changes:** The Irish population is growing and ageing. It is projected that this demographic change will lead to an increase of 60% in demand for healthcare.⁵
- **The current Irish use of acute hospital beds is unsustainable:** The acute bed utilisation survey in 2007 identified that 13% of acute admissions 39% of acute inpatients could be treated in an alternative setting.⁶ Healthcare funding will decrease in 2010, and the HSE is under sustained pressure to reduce inappropriate use of expensive acute beds. Home based care was identified as the third most frequent alternative to admission and occupancy of an acute bed, and increased provision of such services was a key recommendation of the study.
- **Government policy** states that community and home-based care should be developed to maintain older people in their own communities for as long as possible and to support the important role of the family and the informal carer. Home care is central to realising this policy ambition through the re-configuration of the health service, bringing health and social care close to home, strengthening the capacity of community health services.

Ireland is therefore following the global trend of shifting the focus of care from the acute sector to the individual's home and this has created demand for home care services.

⁵ Acute Hospital Bed Capacity Review, PA Consulting Group, 2007

⁶ HSE Acute Hospital Bed Utilisation Review, PA Consulting Group 2007

2.3 These changes have led to the emergence of a new healthcare market in Ireland

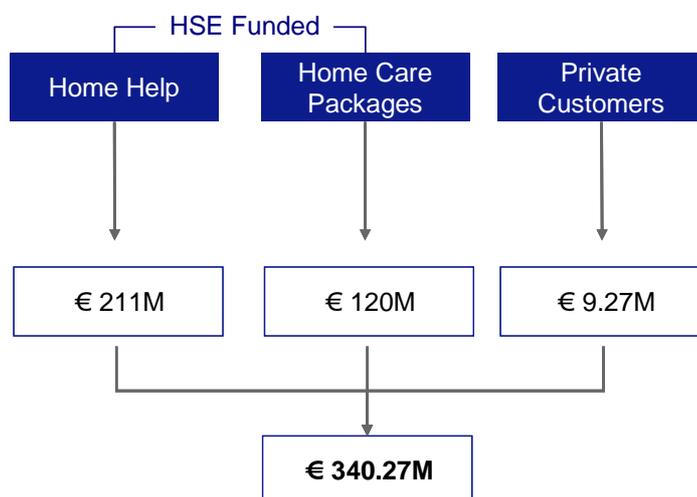
2.3.1 Size of the formal home care market

The net effect of these demographic and policy changes, is that there has been considerable expansion of home care in recent years and this will need to continue. Figure 1 below shows that the total approximate value of the current formal home care market is €340.27M and that:

- **The publicly funded home care market in Ireland is worth approximately €331 million.** This is channelled through the Home Help scheme (€211M) whereby services are delivered by the HSE and non-profit organisations, and the Home Care Package scheme (€120M⁷) which is delivered by the HSE, non-profit and private providers.
- **We estimate the value of the market funded by self-payers to be €9.27M.** There is little reliable nationally available information on the revenues of private operators; however this estimate is based on a survey of 25 private providers undertaken by PA for as part of the Evaluation of Home Care Packages. The analysis supporting this estimate is provided at Appendix B.

Data regarding Home Help service budget and hours delivered prior to the establishment of the HSE is limited, however it is clear from the available data that expansion has been rapid⁸. In many locations, the number of home help hours provided has doubled since 2001.

Figure 1: Estimated total value of the Irish home care market



⁷ The Home Care Package budget allocation was increased to €130M in Budget December 2009. The analysis in this report is based on the previous allocation of €120M.

⁸ Roisin Shortall Parliamentary Question, 32019-06 Home Help Services, 11th September 2006; HSE Annual Report 2007; HSE Annual Report 2008

This €340.27M worth of home care services is provided by three formal sectors:

- **The Health Service Executive:** The HSE is the largest provider of home care, through direct employees. The majority of this service is home help but the HSE also provides more intensive nursing and multi-disciplinary home care as part of the Home Care Package scheme.
- **Non-profit sector:** Most of these providers evolved from the religious and voluntary organisations that were the first providers of home care. This sector includes large-scale providers such as Rehabcare, the Irish Wheelchair Association and the Alzheimer Society of Ireland, and small-scale local providers.
- **Private sector:** Care services provided by private companies.

These providers are discussed in more detail in Chapter 3. There are also two *informal* sectors of home care provision. These are not the focus of our analysis but are important given their influence on capacity and demand for formal care.

- **Informal care:** This support is typically provided by partners / family members. It is difficult to confirm the size of this sector. The 2006 Census figures suggest that c. 161,000 people identify themselves as carers.⁹ Based on available data from the Department of Social and Family Affairs for 2007, there are approximately 35,000 full-time carers in Ireland¹⁰. In addition, 37,303 people received Respite Care Grants. The Carer's Association estimate that informal carers provide over €2.1 billion worth of care per year¹¹.
- **The 'grey' market:** A proportion of home care is paid, informal care, also known as the 'grey market'. These providers are usually untrained, unscreened, unsupervised and without insurance, but provide more affordable care and typically hired through personal recommendation. There is no available data or research on the size of this informal market sector.

2.4 Demand for home care will continue to grow

It is clear that the Irish home care market has grown quickly and is now substantial - estimated at a third of a billion euro. In this section we examine the factors that may drive future growth and estimate their impact on demand.

⁹ Central Statistics Officer, Census 2006

¹⁰ 33,067 in receipt of Carer's Allowance and a further 2,080 are in receipt of Carer's Benefit

¹¹ Pre-Budget Submission to the Government of Ireland Budget 2008, Carer's Association

- **Population ageing is the key factor that will drive demand for home care:** The Central Statistics Office (CSO) predicts that the number of older people living in Ireland will increase from approximately 462,000 to 770,000 by 2021 as shown in Table 2. This represents an increase of 66.7% in just over a decade.

Table 2: Population projections 2006 - 2021¹²

	0-14	15-24	25-44	45-64	65+	Total
2006	865,000	638,000	1,343,000	924,000	462,000	4,233,000
2011	957,000	590,000	1,552,000	1,050,000	536,000	4,686,000
2016	1,050,000	587,000	1,647,000	1,165,000	646,000	5,095,000
2021	1,116,000	624,000	1,639,000	1,303,000	770,000	5,451,000

- **Increase in healthy life expectancy is not expected to keep pace with improvements in total life expectancy.** In future the total number of people with dependencies and potentially in need of care will be higher. In particular, disability in later life arises as a result of heart disease and stroke, sensory problems, (vision and hearing) arthritis, incontinence, dementia and depression, so trends in these diseases and conditions can be used to estimate future numbers of people with home care needs.
- **We estimate the ageing population could increase demand from 57,581 to 92,400 recipients by 2021.** Based on current provision, 12.5% of the population over 65 in receipt of home help and this population cohort is expected to increase by 52 %. This means that due on population growth alone, the number of recipients would increase from about 57,581 to 96,250 between 2009 and 2021.

Table 3: Future demand for home care

Home Care	Demand 2009	Estimated Demand, 2021
Average monthly number of home help recipients	57,581 (54,500 via the Home Help scheme ¹³ , plus an additional 3,081 via the Home Care Package scheme ¹⁴)	96,250
Users per 100 population above 65 years (2006 CSO Census Data)	12.5	12.5

¹² Central Statistics Office, Regional Population Projections: 2006-2026

¹³ HSE Service Plan 2009, confirmed in Roisin Shortall Parliamentary Question 19995/09 21st August, 2009

¹⁴ 3,081 is an estimate of the HCP recipients receiving home help funded as part of their HCP, but not as part of the mainstream Home Help scheme. This is based on the local data collected as part of the Evaluation of Home Care Packages, 2009.

This is a conservative estimate, as other factors are likely to further increase demand:

- **The population over 75 will increase more dramatically than the population over 65, and this 'older elderly' group are more intensive users of home care:** The projections from the CSO indicate that this population group may increase from 162,158 to 414,300 in 2026. The Evaluation of Home Care Packages found that the majority (77%) of recipients were over 75 years of age, indicating that this group are more likely to require home care .
- **The availability of informal care may not keep pace with increases in care needs** in the future. Increased formal care may be required to complement or substitute informal care.
- **This estimation of future demand is projected based on current provision, which may not be sufficient.** As the current provision reflects the services that are available in the health system today, this does not necessarily give the *desired* future solution.
- **Further reform of the HSE model of care would increase demand for home care:** For example, shifting 15% of care from the acute sector to the community means the community will need to manage the equivalent of about 250,000 patient episodes in 2020. The hospital bed review found that of the patients unnecessarily admitted to hospital, 14% could have been receiving home care services. Assuming this applies to the 250,000 avoided patient episodes means that 35,000 acute patient episodes can be avoided by providing home care services.

This potential future demand heightens the importance of getting the conditions right for a responsive market so that the required capacity is available and cost effective.



3 Profile and comparison of providers

Key messages:

- The HSE is estimated to have the largest share of the market (€237.95), followed by non-profit providers (€79.15) and private providers (€23.17).
- There is lack of transparency of the true cost of home care provision:
 - Analysis of true cost per hour of provision undertaken using readily available data indicates the HSE and non-profit sector to be 29% more expensive (€29.44) than the private sector (€21).
 - There is further complexity caused by the absence of management information on how Section 39 Grant funding is used by non-profit organisations, and whether it supports delivery of Home Care Packages as well as Home Help.
 - Non-profit providers can also request financial contributions from customers as part of the Home Help scheme, but this is not permitted under the Home Care Package scheme.
- There is an equal lack of information regarding the services delivered, in particular the quality of services:
 - The type of care delivered by provider varies, with the private sector the most flexible in terms of service
 - There is no minimum requirement for vetting and training of staff, and the research suggests it varies by provider
 - Many providers have not introduced monitoring of time spent on client site, a practice proven in the UK to increase client contact time by up to 12% and realise savings of 5 - 8%
 - In the absence of guidelines and monitoring, there is no visibility of the quality of care delivered.

3.1 Share of the formal home care market by provider

In this section we quantify the share of the market held by the three providers (HSE, non-profit and private providers).

- **The HSE is the largest provider of home care services.** There were 5,276 WTEs employed by the HSE and its subsidiaries as "home helps" at the end of 2007.¹⁵
- **The private sector has grown rapidly.** The minority of private providers operate on an agency model, whereby the carer is considered an independent contractor. In most cases, carers are full employees. There are now approximately 128¹⁶ private providers operating in Ireland.
- **The past decade has seen the professionalisation of the non-profit sector:** The earliest home care services were delivered by religious and voluntary organisations. Increasing financial support from the state, primarily through 'Section 39 grants'¹⁷, now means that workers in this sector are approximating public sector workers. It is now considered more appropriate to refer to this sector as 'non-profit' rather than 'voluntary'.¹⁸ There are approximately 41 non-profit providers in receipt of Section 39 grants¹⁹. These grants are paid monthly (in advance of services delivered) to non-profit providers.

From the Workhouse to the Home: Evolution of care policy for older people in Ireland

Timonen, Doyle,

IJSSP, Vol. 28 No.3/4, 2008

"...many non-profit organisations that now compete with the emerging private sector seem to be evolving into limited companies with more professional boards and management structures"

Home care is funded by both the HSE and by private customers. HSE funding is channelled through the Home Help scheme and the Home Care Packages scheme. Care may be delivered by:

- Direct care provision, by HSE employed staff
- Outsourcing of care delivery to both the non-profit sector and the private sector
- Provision of 'cash grants' to enable individuals to purchase home care services from the private sector.
- Customers and families also contract services directly from the private sector. Figure 2 below shows our estimate of how the market is shared amongst the three formal providers: the HSE, the non-profit sector and the private sector.

¹⁵ Add reference to Personnel Census

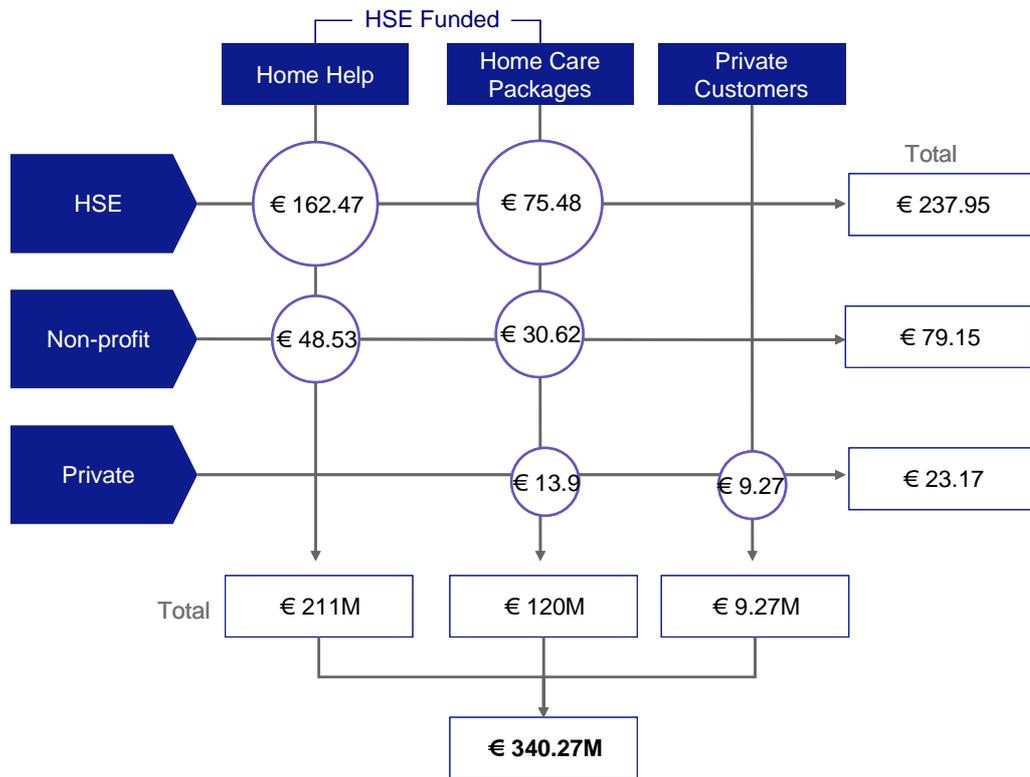
¹⁶ Based on latest information available to the Irish Private Home Care Association

¹⁷ Under Section 39 of the Health Act, 2004, the HSE can provide funding to voluntary organisations for health and related purposes.

¹⁸ From the workhouse to the home: evolution of care policy for older people in Ireland, Virpri Timonen and Martha Doyle, IJSSP 2009, 28, 3/4.

¹⁹ Roisin Shortall Parliamentary Question 19995/09 21st August, 2009

Figure 2: Share of the market by provider



3.2 Comparing providers - price of service

The HSE procures services for home care packages on an hourly basis. In this section, we explore the price charged per hour by provider, based on the best, readily available data.

3.2.1 Private sector cost per hour

The average private sector cost per hour charged to the HSE is €21. This is based on data from 26 private providers²⁰ and is verified by the Irish Private Home Care Association. This hourly cost is the total cost to the HSE for an hour of service, that is, there are no additional costs or financial supports paid to private sector providers.

3.2.2 HSE cost per hour

The price per hour for HSE home care services is not readily available. We have derived a cost per hour from an analysis of available data. The detail of the analysis is provided in full at Appendix C. This analysis highlights some key points:

²⁰ PA Consulting Group, Home Care Provider Questionnaire, 2009

- The detailed, 'bottom-up' calculation of cost per hour derived is initially from HSE workforce costs. This indicates the cost of an additional home help hour is €18.53 on a pure wages basis. When approximate additional workforce overhead charges are added (for example sick pay - a full list is provided at Appendix C), the average cost per hour rises to €23.55.
- Data from Budget 2008 provides a high-level 'sense-check' of this calculation. In this budget, €4.6m was allocated for an additional 200,000 hours of home help²¹. This suggests a marginal cost of €23 per additional hour of home help.
- This is not the true, full cost per hour however, as it only reflects staff costs and not the other overhead costs absorbed by the HSE. Adding overhead costs such as administration, supervision, travel and training costs, uniforms and the running cost of premises further increases the cost per hour. The true HSE overhead cost is not available. Based on available research we have assumed an overhead percentage of 25%.²²
- This calculation leads to a HSE full cost per hour of €29.44.

3.2.3 Non-profit cost per hour for home care packages

The average price per hour charged by non-profit providers based on an analysis of seven non-profit providers is €18.50. This cost raises some important questions:

- The HSE and the non-profit sector are both unionised and pay the same staff rates. Analysis of these rates indicates that the non-profit provider cost per hour only reflects their staff costs - rather than the total cost of care.
- This analysis of staff cost per hour indicates that the non-profit sector is essentially charging the HSE for its staff costs, but not its total cost of service provision.
- Deriving the total cost of per hour requires calculation of overhead costs. Assuming the non-profit sector overheads are the same as the HSE (whereas in reality they may be higher, as the HSE has greater economies of scale) would indicate the same cost per hour of €29.44.

²¹ http://www.hse.ie/eng/services/Publications/corporate/Addendum_to_National_Service_Plan_2008.pdf

²² Please see Appendix C for the details underpinning this assumption

Table 4: Hourly rates for home care services by sector

Provider	Cost per Hour	
	Marginal cost	Full cost
HSE	€23.55	€29.44
Non-Profit Organisations ²³	€18.50	€29.44
Private sector ²⁴	€21	€21

3.2.4 Analysis of cost per hour

This data indicates that:

- The hourly rate charged by non-profits (€18.50) is approximately 85% of that of private providers (€21).
- Analysis of true cost per hour of provision indicates the HSE and non-profit sector to be 29% more expensive (€29.44) than the private sector (€21). This is in line with the experience in the UK, where the Commission for Social Care Inspection found that 'The unit cost of councils' in-house provision has always been higher [than the independent sector].²⁵
- There is poor cost transparency in the home care market. Detailed analysis of available data indicates that the trust cost per hour of HSE and non-profit care (€29.44) is 29% more expensive than the private sector (€21). Higher staff costs are the primary factor driving higher costs in the public and non-profit sectors.
- The non-profit sector charges the HSE their marginal cost (€18.50), rather than total cost (€29.44), per hour for provision of home care under the home care package scheme. They do not recover their overhead costs. This suggests that these overhead costs must be covered in other ways, such as Section 39 grant funding, or client contributions. Either way, this subsidisation of the non-profit sector from other sources distorts the cost of care in the market.

This analysis underlines the benefits to the HSE (as main buyer) of introducing competition in the market.

- For example, if the delivery of the home help scheme were outsourced to the private sector, savings of €60.49M could potentially be realised²⁶

²³ HSE, Price List for Home Care Package

²⁴ PA Consulting Group, Home Care Provider Questionnaire, 2009

²⁵ Commission for Social Care Inspection, Time to Care: An Overview of Home Care Services for Older People, 2006

²⁶ Based on 29% of the €211M budget

- Switching 20% of the home help scheme hours delivered internally by the HSE to the private sector could realise savings of €9.42M²⁷
- If all HSE-funded home care were outsourced to the private sector (including that provided by the HSE and the non-profit sector under the Home Care Package scheme) €79.83M could potentially be realised²⁸

3.2.5 Value delivered

This data is not sufficient however to accurately compare the value delivered by each sector:

- **The HSE does not quantify or monitor the cost of its in-house provision of home care.** There is no readily available cost per hour data available for the largest home care provider in the State. This places the HSE at a significant disadvantage when deciding whether to outsource home care services or invest in-house. This lack of transparency reduces the ability to measure and ensure value for money is being delivered.
- **Home Help recipients may be asked to contribute towards the cost of their provision by non-profit organisations:** Research has shown that many non-profit organisations ask for contribution that can amount to as much as half of the costs of delivering the services²⁹. Contributions can only be requested as part of the home help service, as there is no legal basis for co-payment for the Home Care Package scheme. Some organisations in the non-profit sector therefore receive payment from recipients in addition to their hourly rate. Private providers do not.

PQ Number: 19141/09 Deputy Joan Burton DATE: 21st August, 2009	Details of the charges (if any) levied by [non-profit] organisations on recipients of care
	<ul style="list-style-type: none"> • 'The majority of the [non-profit organisations] do not levy charges on recipients of care however, in some cases voluntary contributions are sought towards service provision ranging from €10-€20 per month, €5 per hour, €5 per household per week, 50 cent per service user for travel costs, and in a number of cases, charges are levied based on individual financial assessments by the Home Help organisation.'

- **A further complexity is the provision of Section 39 Grant aid to the non-profit sector to deliver services as part of the Home Help scheme:** Due to limitations in HSE management information, it is unclear how many home help hours are delivered as

²⁷ Based on 29% of the €162.47 proportion of the home help scheme allocated to internal delivery by the HSE

²⁸ Based on the non-profit sector share of the market (as discussed in Chapter 3); the HSE delivered share of the HCP budget (excluding respite and cash grants) estimated to be 36% / €43.68M and an estimate of the proportion of this budget spent on home help derived from the Evaluation of Home Care Packages finding that 41.6% of HCPs involved home help services.

²⁹ Worlds apart? Public, private and non-profit sector providers of domiciliary care for older persons in Ireland
Virpi Timonen, Martha Doyle, 6 October 2006

part of the Home Help scheme and how many as part of the Home Care Package scheme. This data may be available locally, but it is not collated nationally. It is therefore unclear the extent to which Section 39 funding supports the Home Help scheme or whether it more broadly supports all home care services provided by non-profit organisations. The new HSE Governance Framework for Non-statutory agencies seeks to remedy this lack of transparency:

HSE Governance Framework for Non-statutory Agencies	<p>As part of a HSE wide initiative to improve governance arrangements for the funding of Non-Statutory Agencies, a national framework has been developed which will ensure a consistent approach.</p> <p>This Framework ³⁰seeks to provide a level of governance, which will link funding provided to a quantum of service, and provides for these services to be linked to quality standards, with continuous monitoring to ensure equity, efficiency and effective use of available resources.</p> <p>A critical element of the Framework is the use of standard documentation to formalise the funding arrangements. This documentation is available for download under the following headings.</p>
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- **It is unclear what costs are reflected in the price per provider.** The recent home care outsourcing guidance for councils in England details the cost and service elements of home care provision that must be taken into account when comparing provider price. In addition to care staff, it requires costs such as facilities, administrative and managerial staff, cost of training etc to be articulated and considered together with service and quality data (see table 5 below). This data is not available for all providers. Based on stakeholder consultation and research, differences include:
 - HSE provide support to some non-profit organisations through provision of office accommodation, reducing overhead costs
 - In some instances, staff (e.g. Home Help Organisers) in non-profit organisations are employed by the HSE³¹

³⁰ Section 38 / 39 Health Act, 2004 HSE Governance Framework for Non-statutory Agencies Guide to Standard Control Process and Forms Version 1 July 2009

³¹ Worlds apart? Public, private and non-profit sector providers of domiciliary care for older persons in Ireland
Virpi Timonen, Martha Doyle, 6 October 2006

- Private sector care workers are typically required to have completed training before their employment commences.

Price is only one of the elements to be considered when comparing services to inform procurement decisions.

Table 5: Data required to inform public sector outsourcing of home care

What data would be required to inform the outsourcing decision: Putting People First: Internal versus External (services) Toolkit. Department of Health	<ul style="list-style-type: none"> • The nature of service delivered by providers (in-house or external) to ensure a like-for-like basis for comparison • The quality and performance of each provider in order to determine if there are any difference worthy of a premium • Detailed information concerning the activities and associated costs of in-house services, including how indirect costs and central overheads are allocated • Pricing details for external provider.
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3.3 Comparing providers - service delivered

Review of the available literature shows some differences between the three sectors of formal care provision.

Worlds apart? Public, private and non-profit sector providers of domiciliary care for older persons in Ireland	<ul style="list-style-type: none"> • 'the non-profit sector specialises in providing domestic help during the daytime ...the public sector focussed on personal care (also during day-time), the private sector is carving a niche in more flexible, night-time, round the clock but also companionship-type services.
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- **The type of care delivered varies by provider but there are some signs of convergence:** The HSE typically focuses on the provision of personal care. The non-profit sector would traditionally have focussed on the provision of domestic help, although in recent times has diversified into personal care. The private sector offers a combination of personal and domestic help. The HCP Evaluation found that for HCP recipients, the services provided are increasingly in the realm of personal care, even when badged as 'home help'.
- **The private sector offers greatest flexibility of service:** The general pattern is towards greater variability and flexibility in the private sector, in contract to the considerably more

closely delineated tasks and working time confined to the 'office hours' in the public sector and to a lesser extent in the non-profit sector.³²

- **In the absence of guidelines and monitoring, there is no visibility of the quality of care delivered:** In theory the quality dimension of each provider should be addressed via a regulatory inspection framework supported by quality standards. Unlike residential care, there is however no regulatory framework for home care, no standards articulated by the HSE and no complaints process. Providers cannot therefore be compared by the quality of service they provide to customers.
- **Lack of regulation means that employer training requirements are diverse.** In the HSE and the private sector, job applicants typically must have completed relevant training before their application is considered. In the non-profit sector, applicants are expected to have some prior experience of formal or informal care work. In the absence of standards and monitoring, the experience and qualification of home care staff varies. Whilst there are costs associated with developing and implementing regulation (which in many healthcare settings are at least in part off-set by licensing arrangements), there are costs associated with the current lack of regulation.
 - Risk of abuse or system failure due to unsuitably qualified, vetted or monitored care givers
 - Reduced confidence in the health system (and the home care market specifically)
- **There is no minimum requirement for vetting of staff:** Practices regarding qualifications, training requirements, reference and security checks vary widely in the non-profit and private sectors. Whilst the requirements in the HSE are clear, there is no available data on timely completion of pre-employment background checks. The HSE elder abuse monitoring data shows that most alleged victims of abuse are elderly females living in their own homes³³ - the largest recipient group for home care. At a time when safeguarding of the vulnerable and elderly is an established priority in other countries, this clearly creates risk for care delivery to a vulnerable group.

Worlds apart? Public, private and non-profit sector providers of domiciliary care for older persons in Ireland

Virpi Timonen, Martha Doyle, 6 October 2006

Practices regarding qualifications, training requirements, reference and security checks vary widely in the nonprofit and private sectors. While all the private agency care managers interviewed insisted that carers are required to have certain minimum training qualifications, the extent to which this is enforced was found to be dubious in some instances. Background and reference checks are not thorough in all cases. The non-

³² Worlds apart? Public, private and non-profit sector providers of domiciliary care for older persons in Ireland Timonen, Doyle Journal of Aging Studies 21 (2007) 255 - 265

³³ Elder Abuse Service Development in 2008, HSE, 2009



- Monitoring and time spent at client site:** One of the key quality issues with home care services is the erosion of client-facing time due to staff time pressures, insufficient travel time allowances and excessive case loads. Studies in the UK have shown that introduction of electronic monitoring with no other service changes can deliver a 12% increase in client contact time. This clearly suggests that in the absence of such monitoring, customers are less likely to receive the full service time allocated to them. The DH has confirmed this is a 'national trend', with very few authorities who are not introducing some form of electronic call monitoring. Stakeholder consultation suggests greater - but not complete - usage of electronic monitoring in the private sector.

<p>Cash Study: Benefits of monitoring</p> <p>The usage of Electronic Monitoring in the delivery of Homecare</p> <p>Nathan Downing (Care Services Efficiency Delivery)</p> <p>www.dhcarenetworks.org.uk/csed Making your business case a reality</p>	<p>The English Department of Health now actively promotes the usage of Electronic Monitoring in the delivery and contracting of Homecare by Local Authorities. The benefits it has been shown to deliver include:</p> <ul style="list-style-type: none"> • Authorities have delivered a 12% increase on client contact time. This is because electronic monitoring systems reduce the 'leakage' of hours • Authorities are achieving 5-8% savings on independent sector Homecare spend • Greater efficiencies through the use of technology –electronic reconciliation of commissioned v actuals, automation of invoices, billing, payroll • Quality assurance of providers –measuring providers against call duration, punctuality, continuity of carer and sharing these indicators with users.
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4 The strength of home care buyers in the Irish market

Key messages:

- The similarity of provider offerings and relatively low cost of switching from one provider to another should make home care a buyer's market. The strength of home care buyers in the Irish home care market is limited by a number of factors, primarily the approach to procurement and lack of information on providers, their true cost and quality.
- The fragmented, locally driven approach to procurement combined with poor clarity of true service cost and value by provider significantly reduces the HSE's power as primary buyer in the home care market.
- Customers receiving home care paid for the HSE are disempowered by limited information, lack of a complaints process and absence of a formal choice policy.
- For self-payers, the market can be difficult to negotiate and choice of provider hampered by lack of information on relative cost and quality.
- For all buyers, the absence of provider regulation and care quality standards create uncertainty and reduce informed choice.

4.1 The HSE

The characteristics of the two HSE funded home care schemes have important implications for the market. The key features of these schemes are outlined below.

Figure 3: Description of the publicly funded home care schemes

Scheme	Home Care Services	Status	Budget 2009	Provider	Recipients 2009
Home Help	Home help hours	HSE is not legally obliged to provide these services Recipients may be asked to contribute financially, even if they hold a medical card.	€211M	HSE (77%) Non-profit sector (23%) (funded via Section 39 of the Health Act	54,500 at any one time

				2004)	
Home Care Packages	Multi-disciplinary but home help / personal care a significant element	HCPs are provided on an 'administrative' or 'non-statutory' basis by the HSE. This means that individuals do not have an automatic right to HCPs; rather, the decision to allocate a Home Care Package is based on an assessment of individual needs by the HSE, and the availability of healthcare resources.	€120M ³⁴	HSE (c.62.9%) ³⁵ Other providers: Non-profit sector (25.5%) Private sector (11.5%)	8,700 at any one time

Whilst the HSE is main purchaser of home care services in Ireland, a number of important factors limit its power as a buyer:

- **There is no national procurement framework**, therefore purchasing is locally driven by LHOs. A local approach to procurement reduces the HSE's power as a buyer of high-volume care services. It also limits the ability of the market to respond as providers have poor visibility of opportunities in the market. The HSE is not exploiting its collective buying power. A national approach to competitive tendering would increase the HSE's ability to improve cost and value of home care services.
- **LHOS typically contract on an individual client basis**, whereas block contracting (for higher volumes of clients, or entire services) for this service seems to offer benefits for both commissioner and supplier. It offers the commissioner predictability of supply and an opportunity to manage the market by signalling future needs. It offers providers greater predictability of demand, allowing them to undertake recruitment, training, financial management and marketing with lower risk. Audit Commission case studies³⁶ in England have shown that this stability can reduce costs on both sides and support continued service improvement.
- **From the client perspective, the current approach to contracting can lead to multiple providers:** For example, mainstream Home Help is provided by the HSE or non-profit providers, and additional home care support as part of a Home Care Package

³⁴ The Home Care Package budget allocation was increased to €130M in Budget December 2009. The analysis in this report is based on the previous allocation of €120M.

³⁵ Note re: respite etc

³⁶ Add reference to Audit Commission home care site / Norwich

may be provided by the private sector. This reduces continuity of care and can be disruptive.

- **Pro-actively minimising the number of providers per client can disadvantage the private sector:** As the private sector cannot tender for the mainstream Home Help service, seeking continuity of care and provider for a HSE customer in provision of additional home care as part of a Home Care Package would reduce the likelihood of engaging the private sector, if the non-profit sector is already supporting that client.
- **There is poor transparency of cost and value.** As discussed in Chapter 3, there is little clarity around price and limited understanding of the differences in price between providers, in particular between the private and the non-profit sector. This reduces the HSE ability to push for efficiencies and higher quality from all its providers.
- **HSE monitoring of home care services delivered is inconsistent across the country:** Locally, the extent to which LHOs monitor the services they and other providers deliver varies. This is national reporting or monitoring requirement. At national level, the HSE does not have sufficient visibility of what volume or quality of services are delivered through provision of Section 39 grants or its other outsourcing arrangements.
- **The HSE has very limited information on the cost of its own service provision.** This reduces its ability to make decisions regarding outsourcing of home care. Further, data that allowed the HSE to identify and reconcile differences in cost between internally provided service and their external equivalents would identify opportunities for HSE efficiency gain. The HSE does not have enough information to gain bargaining leverage.

In theory, the HSE should have considerable leverage over the providers (both private and non-profit). The HSE is in the position to shape the future market and ensure it will be in a position to respond to HSE requirements. In practice, the above factors limit its power as the primary buyer in the market, and limit its effectiveness as a purchaser of services on behalf of home care recipients.

Case study: Public sector buyers using competition to drive down cost in England³⁷

Home care service provision has changed rapidly in the last decade under the demographic pressure of an ageing population. The independent (private and voluntary) sector delivered just 2 per cent of the total hours of care in 1992; in 2005 it delivered more than 73 per cent. This shift has been driven by rapidly expanding demand and the fact that the independent sector has been able to provide the same standards of care at lower cost.

The problems associated with comparing like for like services and variations in recording practice mean it is difficult to make completely accurate cost comparisons of social care provision between sectors. However, home care provided by the independent sector is consistently and significantly less expensive. In its recent Time to Care report, the Commission for Social Care Inspection (CSCI) states:

'The average price for a weekday, daytime hour of home care in the independent sector was £11.45 in 2004. Prices paid by local authorities to the agencies that took part in the UKHCA [United Kingdom Homecare Association] survey in the same year ranged from £5 to £14. The unit cost of councils' in-house provision has always been higher. For 2005-06 councils have reported their unit costs to be in the range of £13-£16.50, with an England average of £14.80.'

Part of this cost differential is likely to be because a disproportionate amount of the home care provided by councils involves more highly dependent users. However, the CSCI analysis suggests that there remains some scope for councils to use competition and contestability to reduce costs without reducing service quality.³⁸

4.2 Customers receiving home care paid for by the HSE

Customers accessing home care (and their families) are usually making life-changing decisions at a time of pressure or stress - from a hospital bed for example - therefore the process needs to be as simple as possible. Typically, this is an elderly and dependent group requiring support with the main activities of daily living (ADLs) (being able to wash, dress,

³⁷ <http://www.audit-commission.gov.uk/localgov/goodpractice/olderpeople/Pages/norfolkhomecare.aspx>

³⁸ Commission for Social Care Inspection, Time to Care: An Overview of Home Care Services for Older People, 2006

feed, toilet, walk and so on). It is important to consider the possible vulnerability of this group in their role as customer / buyer.

Factors that reduce the power of customers receiving home care paid for by the HSE include:

- **The absence of a 'choice' policy:** The global trend of promoting customer 'choice' or provider in healthcare is not a policy commitment in Ireland. Over twenty years ago, into community care, published in 1988, placed a strong emphasis on the importance of establishing services to help people live in their own homes and retain independence, dignity and choice³⁹. Since then choice has been a cornerstone of choice customer empowerment. Piloting of UK - independence, dignity and choice. Personalisation of services Implementing personalisation: selfdirected support and personal budgets [use of resources in adult social care] Choice and control runs through all aspects of the policy – the whole of a transformed social care system needs to focus on enabling people to achieve the outcomes they want.
- **Limitations in the information supplied to customers:** Absence of information on home care reduces individual buying power: For example, the recent evaluation of home care packages found that recipients are not notified that they are in receipt of package.
- **Variation in access:** There are no standard guidelines for access to Home Help or Home Care Package services. There are no formal eligibility criteria. This means that access is based on decision to allocate home care is based on availability of local resources and prioritisation based on need. The national data shows that access to these services varies across the country.
- **Support to recipients of 'Cash Grants' is inconsistent:** In some LHOS, Home Care Package recipients may receive a 'Cash Grant' to purchase home care services. Providing funds directly to the customer individual budgets may result in new ways to provide individuals with 'purchasing power'. This can be a powerful tool to drive market reform and empower customers, however they require information on cost and quality of providers and support to execute their choice. This information is not routinely available.
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Care vouchers

Australian cast study

The introduction of care vouchers was proposed in a review pricing arrangement for aged care in Australia⁴⁰. This system involves a prospective recipient of home care being issued a voucher to spend on home care. This allows the choice of provider to be in the hands of the user and offers more capacity for regulation than a straight cash grant.

³⁹ The Griffiths Report: Community Care, Agenda for Action, London HMSO, 1988

⁴⁰ Department of Health and Ageing, Review of Pricing Arrangements in Residential Aged Care, 2004

Cash benefits in long-term home care

Dutch case study

**Bernard van den Berga,
Wolter H.J. Hassink**

**Health Policy Journal,
Volume 88, Issue 2,
Pages 209-221
(December 2008)**

This paper tests empirically for differences in prices paid between parts of the cash benefit that clients may and not may keep when it is unspent. In The Netherlands, demand-side subsidies were introduced in 1996. Clients receive a cash benefit to purchase the type of home care (housework, personal care, support with mobility, organisational tasks or social support) they need from the care supplier of their choice (private care provider, regular care agency, commercial care agency or paid informal care provider). Furthermore, they negotiate with the care supplier about price and quantity. Our main findings are the following: (1) the component of the cash benefit that a client may not keep when it is unspent has a positive impact on the price of care. (2) In contrast, the components of the cash benefit a client may keep when it is unspent, have no or a negative impact on the price of care. Both results have important implications for designing health policy. If cash benefits are introduced in long-term home care in an attempt to make customers more conscious about prices, it is only successful when customers may keep the unspent part of the cash benefit.

The English Government's vision for social care includes a commitment that every customer approaching social care for care or support after April 2012 will go through a process of self-directed support with a personal budget.

Self-directed support is a fundamental part of social care transformation. Putting People First includes a commitment to make personal budgets the norm for people who are eligible for ongoing social care. This will mean that:

- assessment is led by the person and focuses on the outcomes that they and their family want to achieve;
- the person knows the amount of money that is likely to be available to achieve these outcomes before they decide how to use the money;
- there is advice and support available to help people plan support arrangements that will achieve the agreed outcomes, and to raise concerns about those arrangements should they not work well; and
- support arrangements make the most use of natural support and mainstream services.

4.3 Self-payers

- Self-payers face many of the same issues as customers for whom the HSE pays for home care. This group of customers is currently the smallest in the market but is likely to increase. The current economic climate may reduce the likelihood of further development funding by the HSE in area of home care in the short-term. If HSE provision does not increase home care provision, purchase by private customer may increase to close the capacity gap. For this group of customers:
- **The market can be difficult to negotiate:** For people who pay for their own care or with a cash grant, negotiating the system, finding relevant and appropriate information at the right time, and receiving help to find services, can be a difficult process.
- **This is primarily because information to support self-payer choice is limited:** In the absence of regulation, quality standards and information on services delivered, self-payers do not have the information they need to compare providers and make informed choice about their care. Home care represents a significant investment and comparison shopping should be prevalent. Unless a customer has specialised care needs, the similarity of provider offerings and relatively low cost of switching from one provider to another should make it a buyer's market.

5 The wider market environment

The analysis has shown that the Irish home care market is poised for significant growth in demand over the next decade. It is therefore important to consider whether the broader market environment is conducive to this growth through new entrants and existing providers, and whether the conditions are right for quality service delivery.

This review found that a number of factors facilitate entry to the Irish home care market:

- **Ease of switching provider:** Costs associated with switching providers are low, as most services are procured on a client by client basis so there are no lengthy contracts. As many market entrants are relatively new, there are few established brands to compete with. The nature of the service means that there is limit product differentiation.
- **The technological barriers are currently low,** this may change if there is greater take-up of telehealth or tele-monitoring, where home care is supplemented by devices that track and monitor patient conditions. Currently the vast majority of home care provision is not technologically supported.
- **Absence of regulation:** The absence of regulation and standards governing staff vetting, training, supervision or quality of service delivery makes it easier for start-ups in home care.

Factors identified that deter entry to the market include:

- **The absence of regulation causes ambiguity and unease amongst potential entrants:** Typically the healthcare sector is highly regulated, which brings validity to providers and gives re-assurance to purchasers. The absence of regulation and monitoring results in ambiguity and a lack of transparency. Whilst this should make it easier for new entrants, the private sector's unease with the absence of regulation is reflected in its active lobbying for the introduction of standards. Without a regulatory framework, new entrants cannot evidence that they are meeting the required quality standards as well as or better than existing providers. This suggests that the absence of regulation is actually a barrier, rather than a facilitator. Regulation would lead to greater market transparency and upwards pressure on service quality.
- **Absence of standards creates unacceptable risk to home care customers:** Regulation has an important role to play in both helping assure standard of quality for people who use services, drive improvement in the quality of services and in doing so also help safeguard people from harm. Even in the absence of formal regulation, consistent standards across the three provider sectors would provide assurance improve quality. Draft National Quality Guidelines for Home Care Support Services developed by an interagency group set up by the EAG (HSE Expert Advisory Group); comprised of the

HSE, voluntary providers, private providers, groups representing older people, and hospital staff. These guidelines cover standards in home care provision (which would apply to home help and home care aspects of HCPs, but not medical care aspects). The nursing home sector, which caters for significantly smaller numbers than home care, is now fully regulated,

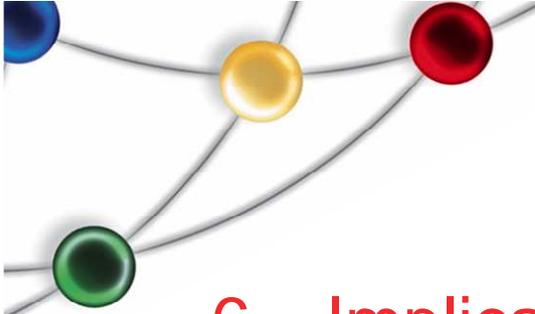
<p>Benefits of regulation</p> <p>The quality and capacity of adult social care services</p> <p>An overview of the adult social care market in England 2008/09</p> <p>CQC</p> <p>December 2009</p>	<p>The percentage of standards that home care agencies met increased from an average of 66% to 88% between 2005 and 2009, with an annual increase of around 6%</p> <p>As with care homes, the greatest improvement has been made in the area of providing information to people who use services (84%), with 36% more agencies meeting this standard in 2009 than in 2005.</p> <p>There has also been significant improvement against the standards for protection (87%), supervision (80%) and service user plans (75%), with around a third more agencies meeting these requirements in 2009 than in 2005. Their best performance is in the areas of privacy and dignity (96%), financial procedures (95%), confidentiality (92%) and autonomy and independence (92%).</p>
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- **Current procurement processes are not transparent:** The absence of a national framework for procurement places heavy emphasis on local relationships and referral in winning business. This can result in a market closed to new entrants and reduces competition.
- **The strong legacy position of the non-profit providers can also reduce competition:** Research suggests that non-profit organisations are preferred providers in some locations, in part due to legacy close working with the HSE.

<p>No Place Like Home</p> <p>Domiciliary Care Service for Older People in Ireland</p> <p>Timonen, Doyle, Prendergast 2006</p>	<p>"Most LHO managers suggested that they would be more comfortable with the home help organisations delivering the [home care] packages as they are 'linked more closely' to the HSE structures."</p>
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- **The largest section of the market - the Home Help scheme - is closed to private providers** Private providers cannot tender to provide services under the mainstream Home Help scheme. The Home Help service is delivered by the HSE and the non-profit sector. This scheme is the largest section of the market but it is not open to tendering by the private sector. This severely reduces competition and in terms of new entrants, restricts the potential share of the market.
 - **The closed nature of the Home Help scheme also has implications for Home Care Package tendering and delivery:** Recipients of Home Care Packages must be in receipt of mainstream services before they can receive a HCP. If this involves home help, then the mainstream element will be provided by the HSE or a non-profit organisation. This may reduce the likelihood of an alternative private provider being selected to deliver the HCP element of the home care. Further, if a private provider is selected, then the customer will have two separate organisations providing their home care.
 - **The current procurement arrangements may hinder further growth of the market:** The largest section of the home care market - the Home Help service - is not open to competitive tendering, tendering is locally driven without a national framework and based on individual contracts rather than commissioned strategically or in blocks: these factors conspire to reduce the attractiveness of the market to new entrants. The experience in other countries is that the major step changes in market capacity and competition were delivered through private sector expansion.
 - **The current market environment may also hinder inward investment in home care.** InterTradeIreland commissioned a study in 2008⁴¹ to undertake on the impact of differences in regulation in Northern Ireland and Ireland on cross-border trade. The study was prompted by the growing recognition across Europe that better regulation can play a key role in improving the competitive position of businesses and therefore fostering faster economic growth. The absence of regulation and transparent procurement processes is likely to deter providers without an existing client base in the State from engaging in the market. New entrants from more mature home care markets could bring new models of care and innovative practices, and increase competition.

⁴¹ Regulatory Barriers to Cross-Border Trade and Business. InterTradeIreland June 2009



6 Implications for the Irish home care market

This analysis of the home care market concludes that there is a strong case for change in how the market operates. The data indicates that the market will need to develop substantial additional capacity in the next decade, which increases the urgency of market reform.

- **Increased demand and financial constraints will place considerable pressure on the market, heightening the importance of regulation and quality standards.**
Providers may be under pressure to deliver more for the less in a constrained economic environment. In this situation, regulation and monitoring that safeguard home care customers is even more vital. In the light of such growth, public policies and regulation are urgently needed to safeguard the rights of the care workforce and to monitor the quality of care delivered by formal domiciliary service providers in Ireland
- **As the primary funder, the HSE will need to actively engage with the market to develop it:** This would include providing a strategic view of future service requirements and commissioning; improving the quality, consistency and availability of data; improving their ability to negotiate effectively with providers and striving to reduce costs of doing business for the HSE and providers. There are also opportunities for greater partnership working not just with providers but also the wider industry (include telehealth, telecare developers and providers), health innovators and academia. The experience of other geographies has shown the importance of the State engagement with the market, and the dividends this approach can bring.
- **The HSE must work with the market to create the right conditions for cost-effective delivery of quality home care:** One key prerequisite for market forces to drive health systems to efficient outcomes is vibrant price and quality competition among providers. Without improvements to home care regulation, procurement processes and transparency of price and quality of provider, the Irish home care market is unlikely to deliver the capacity and quality of home care that both the HSE and the population will require.

Case study:
Engagement with the
market

Audit Commission [add
reference]

The Audit Commission case study shows how Norfolk County Council has improved the value for money of its home care services over the last 15 years in three phases. It shows how the Council: expanded supply by engaging with the market; stabilised supply by introducing new contract arrangements; and reconfigured supply through a process of strategic outsourcing. These changes have led to better targeting, improved service



Appendix A: Definition of home care

Home care can take many forms, and often connects with other services in the community (such as supported housing, health and voluntary sector services). Care workers can support people of all ages and backgrounds; they can work alongside family carers, and either assist them or give them a break. [input from proposal]

The recent Evaluation of Home Care Packages shows that constitutes home care is changing - the dependent nature of recipients is driving a shift from home help to more personal care.

Home Help		Personal Care	
Light Housework including: Hovering, Dusting, Making Beds, Changing Bedclothes, Mopping, Tidying, Washing Dishes	Clothes Washing including: Drying, Ironing, Putting Away	Bathing or showering	Feeding, if required
	Prescription Collection	Washing and dressing	Managing skin care
	Conversation and companionship	Toileting and incontinence	Assisting with oral care
	Meal Preparation	Assisting with mobility	Prompting and supervision of medication
	Grocery Shopping	Helping to and from bed	

Home Care Packages are packages of care tailored to the needs of individuals whose needs cannot be met by mainstream Primary, Community and Continuing Care (PCCC) services. They could range from some therapy and nursing support for a few weeks after a hospital stay to ongoing, daily visits from a home care assistant to help the client get out of bed, washed and dressed. HCPs can include a variety of services, such as public health nursing, day care, occupational therapy, physiotherapy, home help, home care and respite care, that are shaped around each client's individual needs. HCPs can either be provided through a cash grant, which the recipient can use to purchase the care and support they need or through the organisation of care services by the HSE.

Appendix B: Size of private home care market

B.1 Private providers

The estimated value of the private provider share of the market is based on the following:

- The amount paid for private home care in 2008 as part of home care packages was €13.9m⁴².
- The private sector response to the provider survey undertaken as part of the PA Home Care Packages Evaluation indicates that HSE-funded home care packages account for approximately 60% of the client load of private providers.
- This suggests that the total value of the market to private providers is approximately €23.17m:

60% funded by the HSE via the home care package scheme: €13.9m

40% funded by self-paying private clients: €9.27m.

B.2 Non-profit providers

The estimated value of the non-profit provider share of the market is based on the following:

Share of the Home Help scheme budget allocation

- The HSE projected that non-profit organisations would deliver approximately 23% of Home Help hours in 2009⁴³ (The non-profit sector delivered 2.79m of the total 11.96m home help hours in 2008. The sector delivered 704,786 in the first quarter of 2009. This level of delivery was projected to continue).
- The total Home Help budget allocation is €211m. A 23% share of this budget equates to €48.53m.
- This tallies with the funding provided by the HSE (by way of Section 39, Hepatitis C, Mental Health grant, Autism grant, Training grant or miscellaneous grant aid in 2009, which was €48,523,289. Agencies would not have received funding under each of these headings – the most significant source of funding being Section 39 grants.

⁴² Health Service Executive, PQ Number: 35167/07, 3rd October, 2008

⁴³ Roisin Shortall Parliamentary Question 19995/09 21st August, 2009

Share of the home care package scheme budget allocation

- The PA Consulting Group Evaluation of Home Care Packages included a detailed review of 999 home care package recipient files. Based on these files, approximately 63% of home care packages are delivered by the HSE. The remaining 37% are delivered by the non-profit and private sectors. This equates to €44.52m of the home care package budget allocation.
- The amount paid for private home care in 2008 as part of home care packages was €13.9m⁴⁴. This suggests that the remaining €30.62m was spent on non-profit providers.
- These figures are approximations based on the best available data.

⁴⁴ Health Service Executive, PQ Number: 35167/07, 3rd October, 2008

Appendix C: Cost per hour

C.1 HSE and non-profit marginal cost of home care

HSE Marginal Cost of Home Care								
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Source
Annual Salary	28951.65	29467.51	29993.36	30526.7	31072.53	31669.58	32189.18	http://www.hse.ie/subNav.aspx?pid=payConditions_
Hours	2028	2028	2028	2028	2028	2028	2028	Salary based on 39 hour week
Hourly Rate	14.28	14.53	14.79	15.05	15.32	15.62	15.87	
Employer PSRI	10.75%	1.53	1.56	1.59	1.62	1.65	1.68	1.71
Bank Holiday Pay	3.6%	0.51	0.52	0.53	0.54	0.55	0.56	0.57
Pension Contribution	8.65%	1.23	1.26	1.28	1.30	1.33	1.35	1.37
								Labour Court Ruling - 4.5 weeks pay per year of service = 4.5/52 = 8.65%
Total Marginal Cost	17.56	17.87	18.19	18.51	18.85	19.21	19.52	
Average Rate	18.53							
Does not include Sick pay / premiums / or guaranteed element								
Additional Elements								
Sick Pay	2.8%	0.40	0.41	0.41	0.42	0.43	0.44	http://www.sigtu.ie/health/SupportServices/HomeHelps 7 Days uncertified per year in addition to certified sick leave. Estimate average of 7 days = 7/250 - Well below HSE Average
Guaranteed Income Clause	1.92%	0.27	0.28	0.28	0.29	0.29	0.30	http://www.sigtu.ie/health/SupportServices/HomeHelps 2 - 4 weeks continued pay. Estimate average of 1 week = 1/52 = 1.92%
Premium Payments								
Saturday	7.14%	1.02	1.04	1.06	1.07	1.09	1.11	1.13
Sunday	14.28%	2.04	2.07	2.11	2.15	2.19	2.23	2.27
Bank Holidays	7.20%	1.03	1.05	1.06	1.08	1.10	1.12	1.14
								50% premia Assume an average it amounts to 1/7th of cost. Therefore 1*1/7*50% 100% premia Assume an average it amounts to 1/7th of cost. Therefore 1*1/7*100% 300% premia Assume an average it amounts to 9/250 of cost. Therefore 1*9/250*200%
Total Cost Including allowances	22.32	22.72	23.12	23.53	23.95	24.41	24.81	
Average	23.55							
Does not include allowance for travel								

C.2 Overhead costs

The publicly data available on home care provider overhead costs in Ireland is limited. HSE overhead costs for home care are not publicly available. It is difficult to calculate full overhead costs from the accounts of non-profit providers.

To develop an assumption on overhead costs to inform the calculation of the full cost of care per hour, we have drawn upon detailed analysis recently undertaken by the UK DH on the overhead cost of public home care providers in four English areas. We also analysed the overhead costs of a number of the larger UK private home care providers, to understand the beneficial impacts of economies of scale on overhead costs (which should be relevant to the HSE).

The UK data indicates that:

- Overhead costs for public home care providers averaged 39 per cent of total costs (ranging from 38 per cent to 40 per cent)
- Overhead costs for large private home care providers ranged from 25% to 42%.
- In assuming an overhead percentage for the HSE and the non-profit sector, we have taken the lowest analysed overhead percentage (25%). Based on the available data, this is a conservative estimate.

UK analysis of publicly provided home care overhead costs

The marginal cost essentially reflects staff costs. It therefore is not a true reflection of the total cost of providing the service. Costs such as administration, supervision, travel and training costs, uniforms and the running cost of premises must be considered. A recent detailed analysis⁴⁵ of public sector home care provision in four areas in England found that average overheads (direct and indirect) for the four services accounted for 39 per cent of total costs (ranging from 38 per cent to 40 per cent). Staffing costs for all sites accounted for between 60 per cent and 62 per cent of total costs (average of 61 per cent).

UK DH Care Services Efficiency Delivery	Analysis of home care overhead costs
	<p>There are two types of overheads, direct overheads and indirect overheads. Direct overheads on the re-ablement service include the administrative and supervision costs, travel and training costs, uniforms and the running cost of the buildings. On average, administrative and supervision costs accounted for 22 per cent of total costs (ranging from 16 per cent to 25 per cent). Travel costs were on average ten per cent of total costs (ranging from 3 per cent to 13 per cent of total costs) and other direct overheads accounted for on average two per cent of total costs (ranging from 1 per cent to 3 per cent).</p> <p>Indirect overheads are expenses that do not specifically relate to the service and would continue whether the volume of work in this service increased or decreased. Examples are the finance and human resources function. On average these costs ranged from less than one per cent of total costs to ten per cent of total costs with a mean of four per cent.</p> <p>Average overheads (direct and indirect) for the four services accounted for</p>

⁴⁵ Prospective Longitudinal Study Interim Report – 1 of 2 The Short-term Outcomes and Costs of Re-ablement Services

October 2009 Care Services Efficiency Delivery (CSED) DH Detailed study of four health economies Homecare Re-ablement

Analysis of home care overhead costs

39 per cent of total costs (ranging from 38 per cent to 40 per cent).

Analysis of overhead costs of large private UK home care providers

Analysis of a sample of larger UK private providers showed a broader range of overhead costs, from 25%⁴⁶, to 34%⁴⁷ and 42%⁴⁸.

⁴⁶ Supporta PLC Accounts, 2008

⁴⁷ Claimar Accounts, 2008

⁴⁸ Nestor Accounts, 2009