Improving home care sustainability in Ireland

Are user charges a promising option?

Béatrice Durvy, Technical University of Berlin
Ewout van Ginneken, European Observatory on Health Systems and Policies
Jonathan Cylus, European Observatory on Health Systems and Policies
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Acronyms

CCFE  Care Chain Frail Elderly
ECC  Enhanced Community Care
EU  European Union
GDP  gross domestic product
GP  general practitioner
HSE  Health Service Executive
HSS  Home Support Services
ICPOP  Integrated Care Programme for Older Persons
LTC  long-term care
OECD  Organisation for Economic Co-operation and Development
PASH  Population Ageing financial Sustainability gap for Health systems simulator tool
PPP  purchasing power parity
UN  United Nations
WHO  World Health Organization
Home health care can bring multiple benefits for service-users as well as for payers. However, in many countries, the changing age-mix of the population leads to concerns that having more older people will result in increasing demand for home care services and unsustainable growth in expenditures.

In this report we consider three main questions:

- Is population ageing likely to lead to unsustainable growth in home care demand and spending?
- Can growth in home care be addressed with demand-side mechanisms, such as user charges?
- Can growth in home care be addressed with supply-side mechanisms, such as supporting integrated care?

Based on our review, we find that population ageing is unlikely to lead to uncontrollable growth in home care demand and spending. Ireland’s population is indeed ageing but it is doing so at a similar rate to the average in European Union (EU) and Organisation for Economic Co-operation and Development (OECD) countries, and its share of the population over age 65 is and will remain relatively lower than most OECD countries through 2060. Population ageing is likely to contribute only marginally to health spending growth in the next 40 years and revenues for health, which are raised through a diverse mix of taxes, are expected to remain stable as the population ages.

User charges are a common policy tool used to address sustainability concerns. By introducing a ‘price signal’ for service-users, the aim is to reduce demand for unnecessary care and slow health expenditure growth while generating additional revenues for the health system. But do user charges work this way in practice?

- Evidence suggests there is limited potential for user charges to steer health consumption efficiently. Service-users are typically unable to distinguish between high-value and low-value care. This means that both necessary and unnecessary service utilization will be reduced if user charges are put in place.
- Some service-users who do continue to use services will experience financial hardship if required to pay out-of-pocket, while others will forgo care. In both cases, poorer households with limited capacity to pay are most likely to be affected, however those that forgo care are likely to require more costly health services in the future if and when their health deteriorates.
- Ireland already has an effective mechanism to reduce the risk of unnecessary use of home care services through its mandatory Care Needs Assessment, which determines individuals’ home care eligibility based on need.
- It is likely that user charges will only marginally increase revenues while potentially introducing additional administrative costs, thereby questioning the capacity of co-payments to make up any health financing gap.

On the contrary, evidence suggests that increasing the use of home support services is associated with a reduction in more costly care for society and better health for individuals, and that home care is more cost-effective than residential care for almost every level of dependency. This implies that home care services might actually be part of the solution rather than the problem in maintaining sustainability of care services. Addressing home care sustainability through demand-side mechanisms might not be the most effective policy response.

There is scope for supply-side mechanisms, such as better regulation of the provider market or new models of care, to improve sustainability of health financing. In particular, integrating care across different types of provider is a popular and innovative service-user-centred approach to improving and reorganizing care delivery.
Formal home support services for older people in Ireland have been provided since the 1970 Health Act. Initially this included domestic support for daily activities, such as cooking or cleaning, along with some minor health-related tasks. In 2006, a new home support scheme, Home Care Packages, was established and introduced, which consisted of both domestic support and health care services, such as nursing or therapeutic care delivered at home. Since 2018, these two schemes have been merged into the Home Support Services (HSS) scheme, which consists of both domestic support and health care services (Walsh & Lyons, 2021).

Publicly funded home support services are delivered either directly by the Health Service Executive (HSE), or on behalf of the HSE by voluntary service providers, or for-profit companies, and are provided free of charge to any older people – aged 65 and over – in need, based on a preliminary Care Needs Assessment and regardless of the financial situation of the individual (HSE, 2022).

However, demand outstrips supply and there is a lack of equity of access to services. The Care Needs Assessment is performed by HSE staff and consists of a comprehensive evaluation of the individual’s abilities to carry out daily activities, the medical or support services already provided, the service-user’s social environment and preferences, and any other area where the individual might need support (HSE, 2022). In addition to public home support provision, individuals purchase home support directly from private providers with their own funds.

Home care brings multiple benefits for service-users as well as payers. For individuals, home care supports service-users’ desire to remain at home; enhances psychological and social well-being; maximizes autonomy and independence; promotes confidence and dignity; empowers service-users by improving their knowledge and self-care abilities; slows the deterioration of functional abilities; and maintains or improves health through the same quality of care as in a hospital or residential care (Kane, 1999; Ellenbecker et al., 2008; Institute of Public Health in Ireland, 2018). Home care services improve health status, contribute to maintaining autonomy by mitigating functional mobility limitations, and support service-users’ well-being by reducing psychological negative feelings (Liu & Zai, 2022). From a payer perspective, an advantage of home care is that it can substitute for services that would otherwise be delivered in more costly settings (O’Sullivan & Volicer, 1997; Chappell et al., 2004; Meirmans, 2018). Recent research finds that an increase in long-term care (LTC) spending, including home care, is associated with a general decrease in health care expenditure, mainly driven by a slowdown in service-user and medicine expenditure growth (Costa-Font & Vilaplana-Prieto, 2022).

Yet, as the population ages, there are concerns in Ireland about rising demand for HSS and fears that this might result in uncontrollable expenditures.

At the request of the Home Support Reform Unit from the Department of Health in Ireland, the European Observatory on Health Systems and Policies is undertaking a rapid review on Home Support Services sustainability in Ireland. The aim of the exercise is to consider:

- if population ageing is likely to lead to unsustainable growth in home care demand and spending
- the extent to which it can be addressed with demand-side mechanisms, such as user charges
- the extent to which it can be addressed with supply-side mechanisms such as supporting integrated care.
In this section, we provide an overview of demographics in Ireland and consider the role of population ageing as a driver of health care spending. We then discuss how population ageing is likely to affect home care demand and spending.

The share of older people in Ireland is low compared to other OECD countries

In 2021, the population aged 65 and over comprised 14.8% of the total population in Ireland. This is lower than the average in OECD countries (17.7%) and EU member states (21.0%) (OECD, 2022a). Although Ireland will remain comparatively younger than most other high-income countries in the coming decades, the United Nations (UN) estimates that the population over age 65 will grow to account for almost 27% of the total population in Ireland by 2060 (Population Division of the Department of Economic and Social Affairs of the UN Secretariat, 2022).

Ireland spent more on health per capita than most OECD and EU countries in 2019, although growth rates in recent years are comparable with other high-income countries

In 2019, health expenditures in Ireland were US$ 5083 per capita (adjusted for purchasing power), which is higher than the average OECD country, estimated at US$ 4087 per capita (Figure 1). The annual growth in per capita health spending before the pandemic (2015–2019) was very similar between Ireland and the average in OECD countries, at respectively 2.6% and 2.7% annual growth per capita (OECD, 2021).

Figure 1 Health expenditure per capita, 2019 (or nearest year)

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Population ageing in Ireland will contribute marginally to future health spending growth, although the diverse mix of taxes used to finance health care suggests revenues for health will remain stable

A key question is how population ageing is likely to affect demand for and spending on health services overall, as well as the government’s ability to pay for health care. While we do not have the ability to model home care spending specifically, the European Observatory, together with the World Health Organization (WHO) Kobe Centre, developed the Population Ageing financial Sustainability gap for Health systems (or alternatively, the PASH) Simulator tool, which enables us to explore broad health system financing sustainability in the context of population ageing (Cylus et al., 2022; European Observatory on Health Systems and Policies, 2022).

The PASH simulator can be found here: https://eurohealthobservatory.who.int/themes/observatory-programmes/health-and-economy/population-ageing-financial-sustainability-gap-for-health-systems-simulator

Assuming per person health spending by age in Ireland roughly follows the same pattern as the average EU country, and assuming no policy change in Ireland in the future, health expenditure per person is forecast to increase by 26.6% in total between 2020 and 2060 as a result of the changing age-mix. Health revenue per person is forecast to increase by 3.5% over the same time period. Based on 2018 domestic general government health spending levels in Ireland as a starting point, population ageing on its own would be expected to result in a health financing gap (i.e. the difference between revenues and expenditures) of US$ 1012 per person in 2018 purchasing power parity (PPP), or 1.2% of gross domestic product (GDP) (European Observatory on Health Systems and Policies, 2022). While this gap is notable, these findings are similar to projections for EU countries on average, as Williams et al. (2019) project that population ageing will be responsible for an increase in the health expenditure share of GDP in the average EU country of 1.3 percentage points between 2020 and 2060. Importantly, this increase is expected to occur slowly as the additional growth in average annual per person spending will peak at 0.6% between 2020 and 2025, to then steadily decline to 0.07% in 2060 (Williams et al., 2019). This underscores that factors other than ageing, including new medical technologies and price growth, are much more important drivers of health spending than demographics.

Overall, per person revenues for health are expected to be stable as the population ages. This is due to the fact that, in Ireland, domestic general government health expenditures are financed by a diverse mix of tax sources, each of which is affected differently by changes in age demographics; as a result, health revenues are largely impervious to population ageing (European Observatory on Health Systems and Policies, 2022). This comparative diversity in revenue sources for health can be seen by looking at analysis based on data from the OECD Global Revenue Statistics database and the WHO Global Health Expenditure database (Figure 2). For example, in 2018, many countries, including Slovenia, Poland, Germany and Estonia, relied heavily on social contributions to finance health care. Social contributions (which in Figure 2 also includes payroll taxes) are susceptible to population ageing because they are predominantly paid by those in the labour force and so, as populations age and the size of the labour force declines, so too do tax revenues. In Ireland, the health system is financed from the general budget, which is funded by a diverse mix of taxes that overall is not significantly affected by changes in the population age-structure according to analysis using the PASH simulator.
Home care spending per person in Ireland has grown since 2011

According to OECD data, home-based curative and rehabilitative care spending increased in Ireland from US$ 133 per capita PPP in 2011 to US$ 175 per capita PPP in 2020, an average annual growth rate of 3.1%. Home-based LTC spending increased more rapidly from US$ 301 per capita PPP in 2011 to US$ 490 per capita PPP in 2020, contributing to the average annual growth of total spending on home care per person of 4.9% (Figure 3).

Figure 2 Where the money comes from for publicly financed health care, selected countries, 2018

Home-based curative and rehabilitative care
Home-based long term care
All home-based care

Note: PPP – purchasing power parity.
Source: OECD, 2022f.

Figure 3 Home care spending in US$ per capita PPP per year in Ireland from 2011 to 2020

Note: PPP – purchasing power parity.
Source: OECD, 2022f.
Ireland spends more than most OECD countries on home care

Ireland spends more on home-based curative and rehabilitative care, and on home LTC care than most OECD countries (Figures 4 and 5). Generally, home-based care is primarily paid for by governments, with 83% of home-based curative and rehabilitative care paid by governments on average and 94% paid by governments for home-based LTC on average (OECD, 2022f). In Ireland, the vast majority of home care is also paid by the government. Just 0.8% of home LTC was paid for out-of-pocket, more than in the Netherlands and Lithuania but less than in all other OECD countries with data available.

Figure 4 Home-based curative and rehabilitative care spending in US$ per capita PPP per OECD country with available data (2020)

Note: PPP – purchasing power parity.
Source: OECD, 2022f.
In summary, Ireland’s population is ageing at a similar rate to other EU and OECD countries although the share of older people is and will remain comparatively low in the coming decades. Ireland spends more per person on health care than other high-income countries. Revenues for health are raised through a diverse mix of sources that is likely to remain stable as the population ages. Population ageing is likely to contribute only marginally to health spending growth in the coming decades, but nevertheless, based on current financing models, there is likely to be a financing gap as age demographics change. Home care in Ireland is comprehensive with both domestic support and health care services, and is provided free of charge for any eligible service-user following a Care Needs Assessment, regardless of income. Ireland’s home care spending increased over the past decade to be among the highest of the OECD countries.
Publicly funded home support services in Ireland are provided free of charge for every eligible older person following a Care Needs Assessment. However, demand currently outstrips supply and there is a lack of equity of access to HSS. In this section, we consider the theoretical rationale for user charges. We then discuss lessons based on empirical evidence and the experiences of other countries.

What is the theoretical rationale for user charges?

User charges are out-of-pocket payments at the point of use for covered health products or services. While in European countries these are most commonly used for prescription products, they can also be applied to services. User charges exist in various forms, the two main ones being fixed co-payments, which is when the user pays a fixed fee per product or service; and percentage-based co-payments or co-insurance, which is when the user pays a share of the price per product or service. In some countries, once a user reaches a predetermined maximum level of out-of-pocket spending, no further payments are required.

The main arguments in favour of applying user charges are to reduce unnecessary health care consumption, as well as to generate revenues for the health system. As user charges are a small share of total home care spending in most OECD countries with data available (as we will see below in Figure 7), we focus our attention on the potential for user charges to reduce unnecessary use of services and slow expenditure growth.

User charges generally lead to reductions in both necessary and unnecessary health care

Reduction of unnecessary consumption is based on the idea that the full coverage of health products or services raises risks of unnecessary utilization of these products or services, thereby reducing allocation efficiency and increasing health expenditures (Arrow, 1963; Gagnon, 2017; Einav & Finkelstein, 2018). This concept is called moral hazard. In theory, the price signal introduced by user charges could discourage individuals from using health care services when not needed.

Some research suggests that the introduction of user charges reduces demand and, at least initially when first put in place, can result in slower health expenditure growth (Gemmill, Thomson & Mossialos, 2008; Chandra, Gruber & McKnight, 2010). However, this reduction in demand often occurs for both high-value care and low-value care (Gemmill, Thomson & Mossialos, 2008; Hernández-Izquierdo et al., 2019), sometimes to nearly the same degree (Lohr et al., 1986), and even for service-users with considerable health needs (Chandra, Flack & Obermeyer, 2021). This is perhaps unsurprising, as health care decisions are often based on asymmetrical information, cognitive biases, and a multitude of actors involved in the decision making (Swartz, 2010).

Home care use patterns are unlikely to dramatically change if user charges are put in place

Some research suggests that demand for many types of health care services is price inelastic to the introduction of user charges, particularly those types of service that are not elective. A recent study from Japan shows that increasing the co-insurance rate from 10% to 20% for home care services for high-income users led to miniscule reductions in service utilization, amounting to just 0.5% lower utilization and saving around US$ 25 per person per month (Sano et al., 2022). Beyond home care, in a review of research on the use of co-payments for prescription charges, Gemmill et al. (2008)
concluded that most service-users were not sensitive to the introduction of out-of-pocket payments on prescription medicines and that user charges only contribute to shifting the cost of health products or services from public funding to out-of-pocket payments (Gemmill, Thomson & Mossialos, 2008). Additionally, a study from Ellis et al. (2017), which analysed the health care demand price elasticity by type of service, found that there was high heterogeneity in demand price elasticity both by service and by user characteristics, yet home visits had one of the lowest price elasticities with an elasticity estimated at −0.01 (Ellis, Martins & Zhu, 2017). This suggests that demand for home care services, in particular, is unlikely to be significantly altered by user charges.

Low-income households are most likely to face financial hardship and unmet needs if user charges are put in place

Demand for home care is unlikely to be significantly reduced by user charges. This means that low-income individuals, many of whom will continue to use some services, are more at risk of experiencing financial hardship or unmet needs. Research from Europe shows that, in the absence of protective policies, poorer households are more likely than wealthy households to be pushed into poverty due to out-of-pocket payments, or to experience catastrophic health spending, a well-established indicator that assesses out-of-pocket health spending in relation to a household’s capacity to pay for health care (Cylus, Thomson & Evetovits, 2018).

For health care in general in Ireland, due to numerous user charge exemptions and the high percentage of households benefiting from free health care, only 0.9% of households were pushed below the poverty line due to out-of-pocket payments in 2016, the most recent year with data available (WHO Global Health Observatory, 2022). Yet, in the same year, while the share of households with catastrophic health spending in Ireland was only 1.2%, 83% of these households were from the poorest quintile (Johnston, Thomas & Burke, 2020), highlighting the higher risk for the poorest households to suffer from catastrophic health spending and emphasizing their vulnerability regarding the introduction of user charges.

Decreasing home care use for some service-users could result in an increase in use of other, more expensive services

As discussed above, user charges contribute to not only reducing demand for unnecessary care but also for necessary care (Lohr et al., 1986; Gemmill, Thomson & Mossialos, 2008; Swartz, 2010; Hernández-Izquierdo et al., 2019). Consequently, user charges may also lead to an increase in the use of other, more expensive services, particularly those that are universal and free at the point of use, such as in service-user hospital care or accident and emergency care, after otherwise manageable health conditions deteriorate (Goldman, Joyce & Zheng, 2007; Chandra, Gruber & McKnight, 2010). The lack of home care arrangements for older people who could be well enough to be discharged may result in prolonged hospital stays (Forder, 2009; Gaughan, Gravelle & Siciliani, 2015). Additionally, reducing access to HSS could increase unmet LTC needs and accelerate the loss of independence, associated with both increased utilization of other health care and higher mortality rates (Pudaric, Sundquist & Johansson, 2003; Gaugler et al., 2005; Sands et al., 2006; Xu et al., 2012; Depalma et al., 2013; He et al., 2015; Lo et al., 2015; Hass et al., 2017).

Furthermore, looking across OECD countries, although few countries rely heavily on out-of-pocket payments to pay for home care, greater reliance on out-of-pocket payments (i.e. the countries with a higher out-of-pocket payments share) has no strong relationship with public spending growth. This can be seen in Figure 6, which, using the most recently available data, compares each country’s out-of-pocket share of total home care spending on the horizontal access to its public per person spending on home care. If greater reliance on out-of-pocket spending were to slow public expenditure growth (i.e. because people reduce their use of care when faced with paying more at the point of use), we would expect to see a downwards sloping pattern. However, instead, it appears that, based on the line of best fit, regardless of the out-of-pocket share of home care spending, expected growth in public spending per person for home care does not really change. This suggests that implementing user charges in home care may not result in significantly slower public spending growth for home care.
Increasing home care use has many benefits for the wider health system as well as care users

Alternatively, an increase in the use of HSS might decrease use of other, more intensive health services. In their study, Walsh et al. (2020) found that an increase of 10% in HSS provision in Ireland led to a reduction in the length of hospital stay of 0.45 to 1.2 days (Walsh et al., 2020). A systematic review performed in 2019 found similar findings, which suggest that greater use of LTC, including home care services, was associated with a reduction in the average length of hospital stay, a reduction in hospital readmissions and discharge delays, and a reduction in overall health care expenditure (Spiers et al., 2019). By supporting and maximizing the independence of older people, home care prevents the deterioration of health. Home care services can successfully postpone older people’s loss of functional independence (Stuck et al., 2002), and service-users with greater independence are more likely to enjoy good health (Valderrama Gama et al., 2000). Hence, increasing the use of home care services is associated with benefits for society as it reduces the number and length of hospital stays, thereby reducing the provision of costly health care, as well as providing benefits for individuals as it enables greater day-to-day independence, which will result in better health.

Needs assessment already ensures that the people receiving home care are those who need it

The provision of health care free of charge commonly raises concerns regarding the risk of moral hazard. Yet, in the case of Ireland, before being able to access free HSS, individuals must first go through a comprehensive Care Needs Assessment to determine if they need home care services as well as the type of home support required (HSE, 2022) and this preliminary assessment system considerably reduces the risk of unnecessary use. This suggests that growth in home care in recent years may reflect a reduction in unmet need rather than an increase in use of low-value services.
User charges generate few revenues and collecting them comes with additional administrative costs

Internationally comparable data from the OECD suggest that user charges are likely to generate only a small amount of revenues. Only seven OECD countries provide data on the user charge share of total home-based LTC spending (Figure 7), however the user charges portion of home health care spending varies from a low of near 0% of total LTC home care expenditure in Luxembourg and the Netherlands to a high of just 8% in Korea – a country which has a much higher reliance on out-of-pocket spending to finance current health care expenditure in general (~1/3rd of health spending is out-of-pocket) as compared to Ireland (approximately just over 1/10th).

**Figure 7** User charges as a percentage of total home-based LTC spending

Additionally, the recent study from Japan mentioned above found that a substantial increase in the home care co-insurance rate from 10% to 20% for wealthy households saved only US$ 25 per person per month – a very small monetary yield in aggregate when considered across all service users affected by the policy change (Sano et al., 2022). It is possible that poorer households, if faced with similar co-insurance rates, would reduce their utilization (and spending) to a greater degree, however this would likely also result in financial hardship and unmet need.

Some studies argue that the implementation of user charges could introduce an additional administrative cost to collect these user charges – especially if introduced with capping and exemption mechanisms to protect the most vulnerable households – and could eventually outweigh the revenue gain (Dupas, 2012). Administrative cost waste occurs when administrative activities are executed in a more expensive way than required or when they do not add additional value (OECD, 2017). As an example, in the US, the significant reliance on private insurance systems resulted in the development of many complex user charges mechanisms to determine what type of care to insure or reimburse, and for whom. This led to growth in administrative costs for physicians and providers which, according to Evans et al. (1995), resulted in about US$ 100 billions of administrative waste (Evans, Barer & Stoddart, 1995).
Addressing home care sustainability with supply-side mechanisms: integrated care

In this section, we consider the supply side of home support services in Ireland. We briefly present some of the challenges facing the Irish health system and the role of HSS before we examine the concept of integrated care, an innovative person-centred model of care.

The Irish health system faces staff shortages

While Ireland has one of the highest ratios of nurses per inhabitant among the OECD countries with 14.7 nurses per 1000 inhabitants in 2021 (OECD, 2022c), there are only 31 nursing graduates per 1000 inhabitants, which is far below the OECD average of 45 nursing graduates per 1000 inhabitants (OECD, 2022d), and the country increasingly depends on foreign-trained nurses (OECD & European Observatory on Health Systems and Policies, 2021). Additionally, Ireland’s number of personal care workers in 2021 was below the OECD average, with just over 5 personal care workers for 1000 inhabitants against an average of nearly 8 personal care workers for 1000 inhabitants in OECD countries (OECD, 2022b). Ireland does not have comprehensive and up-to-date data on care staff for HSS. Some findings estimate that there were 5703 HSE carers for HSS in 2019, but there is no information on the number of carers employed by the private sector (Walsh & Lyons, 2021). It can be assumed, however, that HSS will be affected by these shortages as well, as they have to recruit in the same tight labour market as other health providers. Taken together, this underlines a need for system-wide integrated care approaches that are focused on managing service-users in settings outside hospitals, preferably at home. And therefore, also from this perspective, it could be argued that, rather than being a problem, home care might actually be a solution for better utilization of scarce human resources.

Efficient use of home care services could help mitigate pressure on hospital care and residential services

Long waiting times for outpatient and inpatient public hospital care constrain access to services in Ireland (OECD & European Observatory on Health Systems and Policies, 2021; Walsh & Lyons, 2021). Consequently, greater use of HSS could contribute to releasing some pressure both on residential care facilities and public hospitals. Additionally, HSS can be seen as preventive measures, which reduce and delay risks of hospital or residential care facilities admissions. Furthermore, an important consideration in elderly care provision is the level of dependency as it has a significant impact on the allocation of care efficiency. In a Canadian study, Chappell et al. (2004) compared the total cost of home care to the total cost of nursing homes for people aged 65 and over. The same care-level classification was used both for home and residential care, and the dependency levels could be matched with the costs for care, which included both formal costs (home or nursing care) and informal costs (hospital care, physician services and prescribed medicines). The results showed that costs for home care were almost always lower than costs for residential care, but that the degree of expenditure saved with home care varied significantly depending on the level of dependency, and could even be negative for end-of-life care (Chappell et al., 2004; Moran & Halpin, 2021). Additionally, some findings suggest that the increased home care demand has an impact, even if moderate, on reducing residential care admission (Moran & Halpin, 2021).
The markets for home, GP, hospital and nursing care could be better integrated for home care to become truly effective

Hospital-centric health systems are more expensive than community-centric alternatives (Williams et al., 2019). Therefore, the statutory home support scheme seeks to complement other initiatives such as the Enhanced Community Care (ECC) programme to reduce the use of accident and emergency care services and delay the need for residential care. Eliminating any existing conflicting financial incentives between home, GP, hospital and nursing care would be a key first step, to ensure that service-users are treated in the most appropriate setting. Furthermore, home care provision would benefit from an integrated approach in which home care forms an integral part of the services offered to individuals. In this way, the various providers of services are brought together and must seamlessly deliver and coordinate care (also see appendix for selected examples). Indeed, integrated care represents a popular policy approach as it could limit health expenditure growth as well as improve care efficiency, workers’ conditions and service-users’ well-being (Grone & Garcia-Barbero, 2001). Integrated care is the structured effort to provide coordinated, proactive, person-centred, multidisciplinary care by two or more communicating and collaborating care providers that may work at the same organization or different organizations, either within the health care or across the health, social or community care sectors (including informal care) (Leijten et al., 2018).

In practice, integrated care programmes demonstrate promising results

If successful, integrated care should result in a slowdown of hospitalization and long-term institutionalization rates, a reduction in overall health care utilization and costs, a positive impact on the care process, and improvement of health outcomes (Kodner & Kyriacou, 2000; Johri, Beland & Bergman, 2003). Overall, the available evidence demonstrates both the feasibility of implementing integrated care as well as its successes in terms of access, quality, user satisfaction and efficiency (Johri, Beland & Bergman, 2003; MacAdam, 2008; Nolte & Pitchforth, 2014), including in the short term (Looman, Fabbricotti & Huijsman, 2014). On the contrary, the absence of integrated care approaches can lead to fragmented and poorly coordinated care, which results in poorer health and well-being for older people (Glasby, 2017). In the appendix we provide integrated care case studies with a focus on home care. Recognizing that Ireland needs to develop its own solutions, these are meant to provide some inspiration.
This rapid review suggests that investing in home care should be seen as part of the solution to concerns about health financing sustainability in the context of population ageing, rather than as a problem.

Applying user charges to home care is unlikely to be an effective mechanism to reduce spending as service-users are not particularly good at distinguishing between high- and low-value care. User charges will either cause some people to continue using home health services and experience financial hardship as a result, or to forgo needed care, which will put pressures on other parts of the health system. There also seems to be limited scope for generating revenues for the health system through user charges for home care, as out-of-pocket payments are only a small share of home care spending in most high-income countries.

Alternatively, supply-side mechanisms offer a range of options that could both improve the quality and sustainability of home health services. In particular, focusing attention on provider incentives and supporting care integration could be promising options.
References


Casaplus in Germany

Casaplus is a German programme that aims to improve health care services for older multimorbid people. The programme focuses on people aged 55 and over with multiple chronic conditions as well as a high risk of hospital admissions within the next year. The project trains experienced nurses to become case managers using a certified, specialized study university programme for two years. After their training, they act as case managers and coordinate clients’ health and social care by using a sophisticated data support and communication system. Its process involves an initial predictive modelling tool to identify high-risk service-users, followed by an initial assessment of individuals’ health conditions and needs. Thereafter, service-users are categorized into risk levels and receive a matching care plan, tailored to their individual needs. Care plans include nursing, specialist and pharmaceutical home care as well as constant availability of phone support and regular phone monitoring (Struckmann et al., 2016).

Satisfaction measured with client surveys in 2014 was high, with 97% of the beneficiaries satisfied with the programme. From the workers’ perspective, the programme enabled supporting the work of physicians without replacing it, while the reorganization of tasks optimized the integration of care, saving time and costs. Finally, the SELFIE 2020 Working Report indicates that the preventive approach of Casaplus enabled the reduction of avoidable hospital admissions and resulted in annual savings per person when compared to a control group (Struckmann et al., 2016). The programme continues to be offered by several statutory and private health insurance funds throughout Germany.

The Care Chain Frail Elderly (CCFE) in the Netherlands

The Care Chain Frail Elderly (CCFE) implemented in the Netherlands is a community-based programme that targets frail older people with complex care needs. The main goal of the CCFE is to implement integrated person-centred care so that older people can remain in their own homes for as long as possible. It aims to reduce the demand for other care, delay admissions to residential care, and decrease the health care cost per older person (Hoedemakers et al., 2019). The CCFE relies on a multidisciplinary structure for primary care which enables workers from diverse disciplines to coordinate around care groups and tailor their care delivery to the needs of individuals. The two initial phases of the programme are similar to Casaplus, with a proactive case identification tool and a comprehensive care needs assessment. Based on this assessment, individual care plans are discussed and tailored to service-users’ needs during multidisciplinary team meetings. The coordination of care is organized around care groups (a feature of the Dutch system), which are groups of primary care practitioners cooperating to deliver care for service-users with chronic conditions. In this programme, informal carers are also integrated into service-users’ care plans.

Caring for older people with complex care needs in community settings requires health workers to dedicate a substantial amount of time to care coordination and management. The CCFE programme allocates time and funding to do so. While the implementation of such programmes can be challenging, community nurses are well-equipped to coordinate care as they are already collaborating daily with other formal workers as well as service-users and their informal carers. Finally, the integration of care is incentivized by a financing mechanism whereby the programme is funded with bundled payments, a fixed annual budget per person, which providers can share between them as they see fit (Hoedemakers et al., 2019). This bundled-payments mechanism was perceived as an effective financing solution to incentivize the multidisciplinary and multiprovider coordination of care (Hoedemakers et al., 2019). While there is no data available on the impact of this integrated care programme on health care spending, the CCFE successfully manages service-users in their home setting according to their personalized care plan.
Learning networks in Norway

Learning networks are a Norwegian national programme that aims at shifting the care approach from ‘What is the matter?’ to ‘What matters to you?’ by developing coordinated and tailored service-user pathways for any new user of home nursing services or short-term stay in nursing homes (Ervik et al., 2016). It mainly targets frail older people with multimorbidity and can be initiated during hospitalization discharge. Learning networks are implemented at the municipal level with multidisciplinary primary health care teams, which always comprise a general practitioner (GP) and a nurse, and can additionally include other primary care workers, social workers and service-users’ informal carers. The programme consists of functional ability assessments and individual follow-ups based on service-users’ individual goals. Tools such as ‘What matters to you – scheme’ questionnaires and service-user pathway checklists were also developed to support the programme implementation. No financial incentives were included and learning networks are financed via municipalities’ general budgets.

While such an approach can be time-consuming, and the involvement of many part-time workers in a multidisciplinary team can be challenging for team communication and care continuity, learning networks were well received by the different stakeholders. They allowed service-user-centred care to be provided while keeping sight of the whole health care delivery system. The tools developed for the programme enabled the multidisciplinary teams to receive regular feedback on the developed service-user pathway and to re-evaluate or adapt care delivery as needed. Additionally, this new approach encouraged an increase in systematic training for health care staff, which resulted in improved quality of care. Shifting to a ‘What matters to you?’ approach contributed to empowering service-users by helping them to develop greater consciousness and involvement regarding their care situation and needs. Finally, both doctor and non-doctor medical staff considered that learning networks contributed to better dialogue, helped health workers to gain self-confidence in what can be expected from each other, and raised awareness of polypharmacy (Ervik et al., 2016).

Discharge planning in the US

There is financial pressure for hospitals to discharge service-users as quickly as possible, which leads to a lack of adequate information that will enable community health workers and practitioners to care for their service-users following a hospital stay. Additionally, the interaction of service-users with multiple uncoordinated providers can result in duplication of services and multiple medication prescriptions, increased risks of inappropriate or conflicting care, medication errors, higher care costs, and service-user as well as caregiver distress (Parry et al., 2003). To address this, the Affordable Care Act of 2010 in the US supports the establishment of transitional care programmes which aim to achieve higher-value health care. Transitional care can be defined as any time-limited service that ensures the continuity of care while supporting safe and timely transfer from one care setting to another and preventing the avoidable poor health outcomes of such transitions (Naylor et al., 2011).

Comprehensive discharge planning is one type of transitional care programme. Implemented to ensure the continuity of care between in-service-user hospitalization and community-based care, discharge planning programmes aim at reducing hospital discharge delays, preventing avoidable hospital readmissions, and improving service-users’ well-being and health status (Gonçalves-Bradley et al., 2022).

Systematic reviews indicate that discharge planning contributes to reductions in the length of hospital stay, decreases in all-cause hospital readmissions and increases in service-user satisfaction (Naylor et al., 2011; Gonçalves-Bradley et al., 2022). Some limited evidence also suggests that it may improve caregivers’ and health professionals’ satisfaction as well (Gonçalves-Bradley et al., 2022). Additionally, a more comprehensive approach, which includes individualized post-discharge follow-up to discharge planning programmes, was found to be more effective in reducing hospital readmissions (Naylor et al., 2011). However, no study could draw robust conclusions on the cost-effectiveness of discharge planning (Naylor et al., 2011; Gonçalves-Bradley et al., 2022).
The Integrated Care Programme for Older Persons (ICPOP) as part of the Enhanced Community Care (ECC) Programme in Ireland

Developed in 2019 as part of Sláintecare, the ECC Programme is a suite of strategic reform initiatives which seeks to reduce dependency on the hospital system by delivering increased levels of health care provision in the community setting, with service delivery reoriented towards general practice, primary care and community-based services. The ECC aims to prevent referrals and admissions to acute hospitals where possible, and to facilitate early discharge from acute hospitals where it is safe to do so. The ECC is not a single initiative but rather an overarching heading for a programmatic and integrated approach to the development of the primary and community care sectors.

Integrated Care Programme for Older Persons (ICPOP)

As part of the ECC, the Integrated Care Programme for Older Persons (ICPOP) model aims to shift the delivery of care away from acute hospitals towards a community-based, planned and coordinated care model, which is closely aligned to primary care and acute sector partners. The objective of the programme is to improve the quality of life for older people by providing access to integrated care and support that is planned around their needs and choices. This supports them to live well in their own homes and communities without the need to access acute care settings, in line with the Sláintecare goal of receiving the right care, in the right place and at the right time.

The programme seeks to ensure older people with complex care needs can access care quickly, at or near home, through care pathways specifically designed for older people and targeting frailty, falls and dementia. ICPOP has worked with acute hospitals and their local community older person’s services, including home support services, to develop end-to-end care pathways for older people with complex care needs. Each Community Specialist Team will service a population on average of 150,000 across an average of three Community Health Networks. The teams will be colocated together in ‘hubs’ located in or adjacent to Primary Care Centres, reflecting the shift in focus away from the acute hospital towards general practice, a primary care and community-based service model. As of October 2022, there are 21 viable ICPOP teams in place, out of a target of 30.