The Business Case for the Outsourcing of Home Care Provision and a More Efficient Use of Fair Deal Funds

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A Report by EPS Consulting for Home and Community Care Ireland

March 2013

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List of Abbreviations

ACTS	**Aged Care Assessment Teams**
CACP	**Community Aged Care Packages**
CARDI	**Centre for Ageing Research and Development in Ireland**
DCA	**Domiciliary Care Allowance**
D/PER	**Department of Public Expenditure and Reform**
EHCP	**Enhanced Home Care Package**
HCCI	**Home and Community Care Ireland**
HCP	**Home Care Package**
HIQA	**Health Information and Quality Authority**
HSE	**Health Service Executive**
ISAE	**International Standard on Assurance Engagements**
LHO	**Local Health Office**
NESF	**National Economic and Social Forum**
NHI	**Nursing Homes Ireland**
NHSS	**Nursing Home Support Scheme**
RFT	**Request for Tenders**
TUPE	**Transfer of Undertakings and Protection of Employees**

Foreword by HCCI co-chairmen, Michael Harty and Bryan Meldrum

In commissioning this report from EPS Consulting, HCCI has been primarily aware of the difficult economic times we live in and the absolute need to ensure that scarce resources are spent in the most efficient and effective manner possible. Secondly, in the absence of regulation, the report considers how we can best improve the quality of home care provision in the state.

The report highlights that the current practice of the HSE and heavily subsidised 'not-for profit' organisations providing home care services to older people and disabled is unsustainable and has already reached a level that the Exchequer cannot afford. It also questions the wisdom of ring fencing budgets for one type of care over another rather than "letting the money follow the patient" in line with Government policy. The issues the home care sector now faces will only multiply in coming years because of the demographic time bomb we are sitting on. The demographic trends point to an older, more dependant society, and this lends a tremendous urgency to the need to address these problems and put in place long term affordable solutions.

Against this background, the report provides evidence-based research to support the case for a phased outsourcing of home care service provision in Ireland in line with the Minister for Health and HSE calls for increased efficiencies and innovative models of care.

The findings are important, not least that some €2 billion could be saved over the period to 2021, for patients, providers and the general taxpayer.

The new delivery model which has been informed by emerging best practice in other jurisdictions will offer patients what they want: quality care at home, choice of provider, a more affordable service and the opportunity to stay at home for much longer.

HCCI's overall view is that the Government needs to regulate and supervise the provision of home care but that does not mean the HSE has to be involved in the actual delivery of that care.

The HSE has already outsourced home care by way of a competitive tendering process. The early results have indicated that there is much more untapped potential and the HCCI is now pressing for a much wider range of services to be tendered.

We go as far as to propose that older people would be far better off financially and medically if they were not forced into a Fair Deal arrangement because they have the option of getting a very similar level of care at home.

We acknowledge that some operational issues need to be discussed in more detail and to this end we are committed to engaging with the HSE in particular in a positive and collaborative manner.

The report should be viewed as a first step in defining how increased investment in and professionalisation of home care delivery can provide cost effective patient centric services for high and low acuity care needs – helping to alleviate pressure on acute hospital beds, provide support care management of chronic diseases and play an essential role in re-ablement.

We hope that this report will inform Government policy on home and residential care and will serve as a basis for informed discussion between all stakeholders.

Executive Summary

Overview

This report is a response to the Department of Health's challenge: *that change should be implemented at scale and pace and more care should be delivered in the community*.

A key finding indicates that the outsourcing of home help services and home care packages and the extension of enhanced home care packages to low and medium dependent people availing of the Fair Deal scheme could save the HSE some €117m in 2014 rising to some €373m by 2021. **Over the eight year period to 2021 the cumulative savings could be in the region of €2 billion.**

Savings accrue from the fact that professional private service operators can deliver higher standards of care some 30 per cent lower than the cost of direct provision by HSE staff and the organisations that are heavily subsidised under Section 39 of the Health Act 2004 (**Section 39 organisations**). In addition, as these non-core services are outsourced on a phased basis, some of the HSE's employees in the Older People Care Group could be redeployed to front line and core healthcare provision with a net increase in employment levels overall.

Most importantly, older people and the disabled will get what they want; better professional care at the highest possible standards in their own home.

This evidence-based submission makes the business case for a complete overhaul of the manner in which home care services are delivered. It also explains how to turn a policy aspiration into practical reality. If the key tenets of this outsourcing proposition were accepted substantial savings could begin to flow from 2014.

The core recommendation (as part of a phased approach) is that the HSE should tender forthwith for the full outsourcing of the entire home care package (**HCP**) service and that portion of home help services provided by Section 39 organisations.

Introduction

With a rapidly expanding population over 65, changing health and social care needs and expectations and a wide recognition that acute care services are not the best place to support older people, the contribution of home based services should be at the heart of the debate on the reform of the health services.

The starting point for this discourse is the reality that home care services are struggling due to budget cuts; services are falling behind the needs of older people; there is an uneven quality of service delivery; and there is an artificial division of what is seen as separate services for older people.

A wide range of different services are delivered and the catch-all title of home care covers many different activities, both formal and informal, with different purposes and very different results. The HSE, Section 39 organisations, carers and professional private providers assist some 248,000 older people or those with disabilities. A further 22,761 avail of the Fair Deal scheme.

There will be a 54 per cent increase in the number of people over 65 over the period 2011 to 2025. In short, in excess of 320,000 additional Irish citizens are entering the zone where sooner or later home care support services will be part of their daily lives.

Strategic Context

Government policy is supportive of reforming the way in which primary care is provided.

Future Health - The Strategic Framework for Reform of the Health Service 2012-2015, makes several points, as follows, that are consistent with the practical ideas set out in this submission.[1]

- A core principle is equal access to care based on need, not income.
- The system should be responsive to patient needs, providing timely, proactive, continuous care which takes account of individuals' needs and preferences.
- Incentives should be aligned throughout the health system to support the efficient use of resources and the elimination of waste and to drive continuous performance management and coordination across different providers.

Government has acknowledged that the impending challenges include, insofar as home care is concerned: inequitable access to care, lack of integration in the delivery of care, and the absence of rigorously monitored quality based reporting. It is also accepted that the current hospital-centric model of care cannot deliver the quality of care required at a price which the country can afford. In the context of future demographic trends and patients' rising expectations the Department of Health acknowledges that profound questions about the long-term sustainability of the health system (and within it home care) need to be addressed.

The focus is on primary care; an essential prerequisite to developing a new integrated model of care that treats patients at the lowest level of complexity that is safe, timely, efficient *and as close to home as possible* (our emphasis). The Government has further stated that the proposed reform in social care will help older people and people with disabilities to live in their homes for as long as possible rather than go into long-term residential care.

Furthermore, the new delivery model will be based on enabling integrated care which in the context of home care involves enhanced guarantees, including an entitlement to an agreed care plan, a named case manager responsible for coordinating care and a personal health budget where appropriate.

In short, this outsourcing proposition for what is a non-core service is 'fit for purpose' when assessed in the context of the Department of Health's reforming agenda.

The Evidence

The delivery of home care in many other jurisdictions has been reviewed in detail; benchmarks and best practice examples support the business case. There are a number of countries responding to the universal problem of an ageing population and the commensurate growing need for home care. Reforms underway share some common features including: high quality care which meets

[1] Department of Health, *Future Health - The Strategic Framework for Reform of the Health Service 2012-2015, November 2012.*

increasingly diversified and individual needs; the efficient and effective delivery of cost containment; a stronger user-orientation in the provision of care; and an optimal balance between formal and informal sources of care. [2]

Unlike in many other countries, Ireland does not have a formal home care policy. The sector remains unregulated in terms of the quality of service provision and the lack of clear eligibility and implementation guidelines (at least until 2011) has resulted in uneven provision and hence glaring inequality of access to services and serious fraud and mismanagement of resources. Funding for care services for older people remains disproportionately channelled into residential care (the Fair Deal scheme has statutory backing) rather than home care and there is no legal obligation on the Government to provide home care services.[3]

The reforms underway in the UK are perhaps the most apposite. While the market is characterised by a wide range of providers and business models, there has been a significant shift away from the delivery of services by public bodies towards an outsourcing model for these non-core services. Some 90 per cent of total contact hours are now provided by private service providers mostly through outsourcing arrangements by means of framework agreements. [4]

The Business Case

What is proposed here – the outsourcing of the HSE funded home care packages and Section 39 home service provision as part of a wider and phased approach to the outsourcing of all home care services funded by the Exchequer – is consistent with Government policy on the reform of healthcare and public sector reform generally and is capable of being delivered as part of the National Clinical Programme for Older People.

The business case builds on an assessment of the disparate services provided to older people and the disabled. These include home help (provided exclusively by HSE paid employees and the Section 39 organisations – in Dublin and Wicklow mainly), home care packages (provided by a mix of HSE, Section 39 organisations and private providers), social welfare supported schemes (including the Carers' Allowance), the Fair Deal and informal care.

Having regard to the Public Spending Code,[5] the constraints that need to be addressed have been identified. A detailed SWOT analysis was carried out which, in turn, informed the evaluation of six options. The full outsourcing of the HCP scheme (with a €130m budget in 2012) and home help services provided by Section 39 organisations (to a value of some €58m) emerged as the preferred option. A risk assessment of the preferred option was then completed with proposed mitigation

[2] Rostgaard et al, Reforming Home Care in Aging Societies, Special Issue, *Health and Social Care in the Community*, Wiley-Blackwell, Volume 20, Number 2, May 2012. Nine countries, including Ireland, contributed as part of LIVINDHOME, a collaborative research project on reforms in European home care for older and disabled people: http:/www.sfi.dk/LIVINDHOME.

[3] Timonen, V., Doyle, M. And O'Dwyer, C., Expanded, but not regulated: ambiguity in home care policy in Ireland, in *Health and Social Care in the Community*, Wiley-Blackwell, Volume 20, Number 2, May 2012.

[4] *Where the heart is.....a review of the older people's home care market in England*, IPC Market Analysis Centre, Oxford Brookes University, October 2012.

[5] *Public Spending Code*, Department of Public Expenditure, July 2012. The Code brings together in one place details of the obligations that those responsible for spending public money (in this case the Department of Health) are obliged to adhere to as well as guidance material on how to comply with the obligations outlined.

measures identified. Finally, a comparison was made between the current scheme and the proposed outsourced scheme.

Economic and Financial Appraisal

The current and future demand for home care services, both domiciliary and residential, reveals some startling trends driven by Ireland's demographics. In summary, compared to 2006, there will be 148,608 more people over 75 in Ireland by 2021 with the population in this cohort numbering 353,986. The number of people who will be over 65 by 2021 will rise to some 792,067. The increase over the fifteen years from 2006 to 2021 is 319,141; a 40 per cent increase.[6] There will be some 1.3 million people over 65 by 2045; an increase of 142 per cent on 2011 Census figures. [7] Projections for older peoples' dependency rate reveal a sharp rise of some eight percentage points from 16.1 per cent in 2006 to 24.5 per cent in 2021.[8]

Applying the current take-up rate of 8.8 per cent, a reasonable assumption could be made that 75,000 people may seek to avail of home help services by 2021 (up from a current (2012) rate of 48,000) and that 14,250 HCPs may be required; up from 10,942 units of care currently.[9] The projected rate of increase in demand over nine years is 21.6 per cent for home help services and 33 per cent for HCPs. Another critical assumption is that around a third of people with low to medium dependency who avail of the Fair Deal scheme could be encouraged to stay at home with the assistance of enhanced home care.

Projected Demand for Home Care Services

	Forecast 2013	Forecast 2021
Home help	50,000	75,000
of which, 65+	44,000	69,700
HCP	10,870	14,250
of which, 65+	10,200	13,400
Fair Deal	7,600	9,200
TOTAL	68,470	98,450

Source: EPS Consulting estimates based on HSE Service Plan (2013)

This suggests that almost 30,000 additional older people may need home help and home care services in the short term. This is a substantial increase (44 per cent) in the quantum of current

[6] Morgenroth, E. 2009, *The Impact of Demographic Change on Demand for and Delivery of Health Services in Ireland 2006-2021.* Report 2: Demographic Projections for the period until 2021, Dublin, Economic and Social Research Institute, Table 5.3. The base year of 2006 was chosen because of the availability of detailed demographic, disability and utilisation data for that year.
[7] *Health in Ireland: Key Trends 2012,* Department of Health, December 2012.
[8] Barry, U., *Elderly Care in Ireland – Provisions and Providers*, UCD School of Social Justice Working Papers Series, April 2010.
[9] Reply to a Parliamentary Question from the Minister for Health, 31 December 2012.

delivery levels. As the HSE does not have resources to provide this increased level of service options must be explored about the delivery of home care services for both older people and the disabled.

The following table sets out the demand for and the costs of the current services.

Current Demand and Current Costs

	Current Demand	Current Costs
Home Help- HSE	35,000	€137m
Home Help – Section 39	15,000	€58m
Home Help – Private	No current provision	0
HCP- Private/Section 39	10,870	€130m
HCP for Fair Deal	2,500	€127m
Total	63,370	€452m

Source: EPS Consulting based on HSE data

The key drivers are quality standards and cost. It has been determined that the cost of care provided by the HSE and the heavily subsidised Section 39 organisations is some 30 per cent more expensive than the corresponding levels of care provided by professional private operators.[10] Applying this level of cost differential to future demand (and assuming no inflation) and on the basis that all services (other than a small portion of home help) are outsources from 2014, results in potential annual saving in the range of €117m in 2014 rising to €373m by 2021 as the following tables illustrates. Part 5 below sets out the assumptions made in detail.

Potential Savings in 2014 and 2021

	Projected Savings in 2014	Forecast Demand 2021	Projected cost with outsourcing	Projected savings in 2021
Home help – HSE	0	10,000	€39m	0
Home Help – Successful Providers	€18m	65,000	€178m	€76m
HCP – Successful Providers	€30m	14,250	€131m	€41m
Fair Deal - Assigned to Successful Providers	€69m	9,200	€211m	€256m
Total	€117m	98,450	€559m	€373m

Source: EPS Consulting estimates based on CARDI population forecasts (2012)

[10] *Analysis of Irish Home Care Market*, a report for the Irish Private Home Care Association, PA Consulting Group, February 2009. Based on the current costs of delivery in Section 39 organisations, and allowing for a decrease in HSE gross salaries, industry sources have confirmed that this cost differential is still valid.

A sensitivity analysis (see Table 20) using a 15 per cent cost differential between public and private providers also shows a high level of savings.

HSE home help staff, the vast majority of whom are on zero hours employment contracts, will secure employment opportunities with approved private operators as the demand for home care rises. The HSE will have the option of redeploying some of its personnel in its Older People Care Group (including over 500 administrators and managers) to frontline and core healthcare services.

The most obvious benefit arising from the proposed outsourcing model is that the quality of care will be more consistent, more measurable and more amenable to continuous improvement. The second benefit is financial in terms of direct Exchequer savings. Patients will have better choice, more potential providers to pick from, and a care package more tailored to their unique needs.

Hidden benefits include the innovation that private providers will bring to care service delivery and the better use of technology. Costs will be kept competitive while maintaining high standards. Another such benefit is that with the projected increase in home care provision as the population ages, the private sector providers will be better resourced, better skilled and better equipped to deliver more clinical-type home care further removing pressure on the acute hospital sector.

Implementation

With a new public sector outsourcing proposition, implementation issues would need to be teased out. However, as the provision of enhanced HCP has already been tendered and is the subject of a framework agreement most operational issues have already been addressed by the HSE. Weaknesses with the current arrangement have been signalled by HCCI and the Section 39 organisations to the HSE and are being considered in a collaborative manner. This outsourcing proposition proposes to leverage the lessons learned from the HCP tender.

In line with best practice, HCCI wishes on the basis of this submission to engage with the Departments of Public Expenditure and Reform and Health, and the HSE to explore all the operational issues that need to be included in the competitive tender to outsource HCP provision and home help services provided by the Section 39 organisations in the first instance and to explore the other short-term options set out, in particular offering HCPs to low and medium dependent people within the Fair Deal scheme.

Conclusions

The UK Department of Health believes the single most important factor in the successful outsourcing of home care provision is to articulate a clear vision for what is to be commissioned. This submission provides such a vision. The Department also stresses the importance of setting down the characteristics of the services to be outsourced and setting relevant contract performance measures. Again, this submission addresses these issues. [11]

Policy towards care of older people in Ireland has largely been based on the assumption that family-based or community-based care is the preferred option and the role of public provision should only

[11] Department of Health, *Care Services Efficiency Delivery Homecare Re-ablement Toolkit*, March 2011.

arise where carers are not available. [12] Given the demographic trends evident from the recent Census, such a model is no longer sustainable.

The time has come for a reform of home care delivery in Ireland.

As a first step the entire HCP scheme and home help services provided by Section 39 organisations should be opened forthwith to competitive tender. Once the quality standards are firmly embedded, all home help services should be outsourced from 2014. The next logical step would see low and medium dependency patients in expensive Fair Deal beds being looked after at home. The outsourcing of this service could be considered once the HCP tender is awarded.

The significant savings generated could be used to provide more HCP services or to be applied to core front line services such as primary care.

The bottom line is that the proposed outsourcing programme will go a very long way to giving elderly patients and the disabled what they want; care at home.

This is a dynamic agenda as private home care providers are pro-actively expanding the services they can offer. Home care teams now include nurses, physiotherapists, and occupational therapists to enable 'acute' home care to be delivered at home. Intermediate care teams provide a short term rehabilitation service following illness or accident. Home care re-ablement is being piloted. In addition, private providers are making greater use of technology to support home care management.

[12] op cit. Barry (2010).

PART 1

Introduction

Overview

This report makes the business case, argues the rationale (strategic, operational and financial) and identifies the benefits for the outsourcing of the HSE funded home care package (**HCP**) scheme in Ireland as part of a wider and phased approach to the outsourcing of all home care services funded by the Exchequer. At the outset the main objectives and benefits of the proposition are explained. The advantages are both financial in terms of potential savings but also qualitative as higher standards of care and well-being are a pre-requisite for any outsourcing solution.

Trends in outsourcing in Ireland are examined as are trends globally, including in England where the outsourcing of home care is a proven business model. The argument is made that this proposal (not least because it affects non-core services only) is entirely consistent with and supportive of the Government's policy on outsourcing. The phased outsourcing of the HCP scheme is also consistent with and indeed supportive of the HSE's policy on the provision of high quality home care services reflecting the wishes of elderly and disabled people to remain at home.

The current arrangements – the 'as is' level of service provision – are set out in **Part 2** as are the key metrics, including the costs of service delivery. HCP is but one element of the care and social services provided to older people and the disabled. Hence other schemes such as home help services, carers' allowances and benefits, the domiciliary carers' allowance, tax credits and the resources spent on the Fair Deal (low and medium dependency cases only) are all provided as the overall budget for these disparate but common services is some €1.56 billion per annum. The provision of the Exchequer subsidies not-for-profit organisations (under Section 39 of the Health Act 2004) which then compete with private providers in the home care market is addressed.

The delivery of home care in other jurisdictions is evaluated briefly in **Part 3**. There is reform underway in most of the markets considered. For example, in England a recent (July 2012) White Paper on care and social services has been published with supporting legislation. Australia too has very recently reformed the way it delivers home care services. The key elements of the HCCI proposition are based on this review of best practice.

An assessment of options is informed by a SWOT analysis. One key conclusion of the business case (**Part 4**) is that there are solid reasons on the grounds of cost efficiency and operational effectiveness to outsource the HCP scheme. Six different scenarios are examined with each listing possible advantages and disadvantages. Following this robust assessment the outsourcing of the entire HCP scheme and the home help services delivered by Section 39 organisations emerged as the preferred option. The option of a pilot and/or phased approach is ruled out as the HSE has already outsourced part of the HCP scheme. A risk assessment of the preferred model and the assumptions and constraints under-pinning the outsourcing delivery model follows. The costs associated with this preferred delivery model are then set out. The proposed new service is then described and a comparison with the current level of service delivery is provided.

The economic and financial appraisal in **Part 5** looks at the key metrics and performance indicators that are used to determine a value for money proposition. It also endeavours to assess the HSE's

resources required to manage Service Level Agreements and the opportunity costs of re-assigning HSE staff. This data will help the Department of Health complete its assessment of the proposed outsourcing.

The following section (**Part 6**) looks at the issues to be addressed in relation to the implementation of the proposed approach. Given the importance of quality control, a customer's charter and code of practice and associated legal and regulatory matters are reviewed in detail as are other key elements of the proposal, including affordability, achievability and implementation issues, setting fixed cash limits for what is a demand-led scheme, the need for better accountability and transparency. Other important matters that complete the business case are the governance arrangements that should be put in place; possible TUPE implications; HIQA's buy-in, planning and project management, evaluation and performance monitoring and a recommended procurement strategy.

The main conclusion (**Part 7**) is that more patients will get a higher quality home care service at some 70% of the current cost of delivery.

Table 1 Key Facts and Statistics

- **Some 60,872 people may benefit from HSE home help services or home care packages at a cost of €322m (2013), of which €195m will be spent on home help services.**
- **Section 39 organisation's market share of home help services is approximately 28% to a value of some €58m.**
- **HCCI member's share of the total home care market is some €33m i.e. 10%.**
- **HSE and Section 39 providers are some 30% more expensive than private home care providers.**
- **The home help services budget of €195m is not tendered nor is it available to private providers.**
- **An additional €998m is spent on Fair Deal; with 22,761 long-term residential places supported by HSE.**
- **There is a 25% turnover in Fair Deal nursing homes as average length of stay is 3.5 to 4 years.**
- **Some 34% of all patients in long-term nursing care with low to medium dependency could avail of enhanced home care packages.**
- **Some 4.5% of older people are living in long-term residential care: 40% above the EU average.**
- **Spending on older people and the disabled through HSE provision, Fair Deal, social welfare payments and tax credits is in the region of €1.56 billion per annum.**
- **The number of recipients who could benefit from home care is projected to rise from 63,370 (2014) to 96,450 by 2021.**
- **10,942 people are in receipt of home care packages and around 10.3 million home help hours were provided to 48,000 clients (2012).**
- **HSE provides 5,300 new HCP packages a year i.e. a turnover rate of 50%.**
- **The Department of Social Protection paid €762m in income support to some 51,600 carers (2011).**

Sources: Referenced throughout the report

Definitions

Outsourcing is a key strategic decision for organisations aiming to enable more efficient operation through a focus on core areas, while leveraging capabilities and scale of specialist service providers to effectively operate non-core areas. [13]

Home care is the generic term generally used to cover a range of care and support interventions delivered to a person, including older people, in their own home. It includes support with domestic tasks, shopping, home maintenance, personal care, social activities, and rehabilitation and recovery. Home care services also include self-care activities that a person must perform every day such as bathing, dressing, eating, getting in and out of bed, moving around, using the toilet etc. Its purpose and function varies greatly from place to place, service to service. It can provide early intervention; it can help postpone the need for residential care; it helps people regain mobility following an injury or illness; it can be part of a post-hospital discharge offer. [14]

Home help is another term used to describe home care services.

Home care packages consist of community services and supports provided to an older person or a person with disability, depending on their individual assessed care needs, to return home from hospital or residential care or to remain at home. The package may comprise paramedical, nursing, respite and/or home help and/or other services depending on the assessed care needs of the individual applicant. [15]

In practice, there is very little difference between home help and home care. The HSE and Section 39 organisations provide up to five hours of home help support and then call in approved private providers to deliver extra hours. In such a situation both the HSE/Section 39 organisations and the private sector care teams deal with patients. The current framework agreement for enhanced home care packages only covers additional services where direct HSE provision is not feasible. Thus the distinction has more to do with the hours provided to those in need than the tasks performed for their benefit.

[13] O'Shaughnessy, G., Byrne Wallace Solicitors, Managing Outsourcing, *The Public Sector Magasine*, (2012).
[14] *Where the heart is.....a review of the older people's home care market in England*, IPC Market Analysis Centre, Oxford Brooks University, October 2012.
[15] HSE (2011), *Code of Governance: Framework for the Corporate and Financial Governance of the Health Service Executive: Version 4*, Dublin: Health Service Executive.

The Objectives of the Proposal

Home care is a 'non-core' service

The Exchequer will this year fund home help services to the benefit of some 61,000 people. [16] Many more elderly and disabled people receive care from family members and friends; 'informal carers'.

What is at issue is whether patients and the Exchequer are getting value for money.

This submission provides evidence that if this non-core service was outsourced it would generate savings of some €117 million in 2014 rising to €373 million by 2021. The projected level of saving assumes that those in the Fair Deal with low and medium dependencies were provided with an enhanced HCP i.e. some 21 hours a week instead of residential care.

So the real issue is the preferred delivery model that meets the requirements of those who require care.

This model assumes that the HSE continues to exercise control over budgets, service quality and key performance indicators but does not deliver this non-core service through direct provision. In addition, it is essential that the Section 39 organisations compete for this business on a level playing field i.e. reflecting the real cost of delivery without the benefit of State subsidies.

The primary objective of the HCCI proposal is as follows:

- All HCP requirements and the home help services provided by Section 39 organisations be outsourced in 2013 by way of a competitive tender.

Secondary objectives include the following.

- To move on a phased basis to a situation where all home care provision, including home help services, is outsourced from 2014.
- Also in 2014, that a competitive tender is issued in respect of the provision of enhanced HCP for persons with low to medium dependency who would otherwise avail of the Fair Deal scheme.
- To improve the quality and standard of home care.
- To introduce a level playing field between State funded and private sector provision by requiring that the Section 39 organisations tender for all home care services they currently provide with the benefit of State subsidies.
- The HSE withdraws from service provision if the private sector's price/quality proposition is proven and re-deploys the staff affected to core and front line services.

[16] HSE (2013) *National Service Plan 2013*.

- To guarantee the highest levels of service and an independently audited enhanced performance and quality standards should be implemented.
- To deliver better value for money that a single budget for all services for older people be established and that resources are allocated to patients on the basis of their medical situation, personal circumstances and personal preference.

The main benefits of this recommended approach include:

- Improving people's independence.
- A quantifiable financial saving for the Exchequer.
- Increase in the quality of home care provision.
- Giving people choice of what type of care they want.

If this submission was endorsed by Government, and given the capacity of private providers to respond to increased demand, the new delivery model could be in place by the end of 2013.

Strategic fit with the Government/HSE policy on home care

As the following material demonstrates, this proposal is well aligned with existing Government priorities.

1. Views of the Minister for Health [17]

The Minister for Health has remarked that *...no one disputes the fact that high quality home care makes a big difference to older people and their families. It (home care) is a vital element in meeting the preferred wishes of older people and people with disabilities and their families to stay in their homes where at all possible.*

The Minister's guiding principle is to treat the patient at the lowest level of complexity which is safe, timely, efficient and as near to home as possible, and nowhere is closer to home than the home itself. He added, *I acknowledge and salute the invaluable work done by home helps in helping us achieve this goal, that people, older people in particular, remain in their homes for as long as possible with all that means for their well-being*.

In speaking to a Dáil motion on home help and home care, the Minister also stated that services will have to adapt and be more flexible in their use of funding while maintaining at their core the person-centred approach. He noted that it has long been the case that the HSE has worked in partnership with Section 39 organisations and private providers to augment its valuable services to people who need home help at local level where, for whatever reason, the HSE is not in a position to do so itself. This may include situations where there are resource limitations locally or to ensure care in the evenings and at weekends.

The Minister *is seeking new models of working in the public sector to achieve efficiencies and seeking to provide a choice of provider where this is possible*. This must, in the Minister's view, include partnership arrangements with Section 39 organisations and private sectors.

[17] Oireachtas, Dáil Éireann Debate, 17 October 2012.

2. A Strategic Framework for Reform of the Health Service

Future Health - The Strategic Framework for Reform of the Health Service 2012-2015, makes several points, as follows, that are entirely consistent with the practical ideas set out in this submission.[18]

- A core principle is equal access to care based on need, not income.
- The system should be responsive to patient needs, providing timely, proactive, continuous care which takes account of individuals' needs and preferences.
- Incentives should be aligned throughout the health system to support the efficient use of resources and the elimination of waste and drive continuous performance management and coordination across different providers.

Government has acknowledged that the near time challenges include, insofar as home care is concerned, inequitable access to care, lack of integration in the delivery of care, and the absence of rigorously monitored quality based reporting. The current hospital-centric model of care cannot deliver the quality of care required at a price which the country can afford. Add future demographic trends and patients' rising expectations and it is no wonder the Department of Health acknowledges that profound questions about the long-term sustainability of the health system (and within it home care) need to be addressed in the context of real change.

The focus is on primary care; an essential prerequisite to developing a new integrated model of care that treats patients at the lowest level of complexity that is safe, timely, efficient *and as close to home as possible* (our emphasis). The Government has further stated that the proposed reform in social care will help older people and people with disabilities to live in their homes for as long as possible rather than go into long-term residential care.

Furthermore, the new delivery model will be based on enabling integrated care which in the context of home care involves enhanced guarantees, including an entitlement to an agreed care plan, a named case manager responsible for coordinating care and a personal health budget where appropriate.

In short, this outsourcing proposition for what is a non-core service is 'fit for purpose' when assessed in the context of the Department of Health's reforming agenda.

3. HSE Delivery Model

There appears to have been an intensification of care within formal home care, while the proportion of the older population in receipt of such care has reduced. The HSE National Service Plan (2013), as follows, is explicit about this more targeted approach.

> *In order to meet increasing population need and deliver sustainable services, innovative models of care are required to further advance the development of equitable integrated care for older people across community-based services, intermediate care options and quality long term residential care options.*

[18] Department of Health, *Future Health - The Strategic Framework for Reform of the Health Service 2012-2015, November 2012.*

The provision of intermediate type care systems will continue to be developed in 2013, with specific emphasis on the provision of transitional and intermediate type care to address the issue of unnecessary admissions to acute hospitals and the requirements for long stay care.

The priority in 2013 includes the provision of comprehensive home and community supports such as home help and home care packages.

Another priority is to ensure a robust equitable standardised care needs assessment nationally.[19]

In addition, and quite correctly, the HSE wants to stop spending money on basic housekeeping and concentrate instead on higher dependency cases requiring more personal care.

Work is advanced on the phased implementation of a National Care of the Elderly Programme. The programme aims to re-organise the way older patients are managed in the health service. The principles underlying the programme design are quality of care, improved access for patients and cost-effective care. The integration of acute and community services is a key objective as is reducing inappropriate admission to nursing homes.[20] One of the key deliverables is a model for community care for older people.

The external delivery (i.e. outsourcing) of services to older people is expressly recognised by the HSE as part of the solution to enable older people to live independently in their own homes. [21]

However, a view still persists within the HSE that there is an 'obligation' to use internal resources and by extension all outsourcing options cannot be considered regardless of the merits of the case and the high cost of HSE direct provision. This point of view needs to be challenged given the evidence set out in this submission.

4. What Older People Want

Unsurprisingly, the majority of people wish to remain at home in the older years. [22] Equally importantly, they also want choice with regard to the type of care they receive.

The contention is that, without legislation to underpin access to home help services and packages, access is discretionary, unequal and problematic.[23]

The Ombudsman has observed that people do not know where they stand in terms of their entitlements and in terms of the HSE's obligations to provide services.[24]

The National Federation of Pensioners Association has also recommended that community care should be underpinned by clear legislative entitlement.[25]

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[19] HSE, *National Service Plan 2013*. Service Plans at regional level set priorities for older people services and performance activity and indicators.
[20] Briefing Note, Royal College of Physocians of Ireland and the HSE, May 2012.
[21] Public Service Agreement (Croke Park), Health Sector Action Plan 2012, 22 February 2012.
[22] www.olderandbolder.ie
[23] Houses of the Oireachtas, Seanad Eireann (2012), Report on the Rights of Older People.
[24] Health Policy – An Ombudsman's Perspective, address by Emily O'Reilly, Mater University Hospital Conference, September 2011.
[25] Oireachtas Debates, 24 November 2011. The Irish Hospice Foundation also supports this point of view.

Conclusion

The outsourcing of HCP and home help services is:

i) Consistent with Ministerial policy;
ii) Acknowledged as a preferred solution in the Croke Park Agreement; and
iii) Capable of delivering what the HSE is seeking to achieve under the National Clinical Programme for Older People.
iv) Building on the current successful outsourcing of enhanced home care packages as a 'non-core' service.

It is important to emphasise that an enhanced service could be delivered by private home care providers who meet the HSE's required standards without recourse to primary legislation.

PART 2

Current Services

The number of older people aged over 65 is projected to rise from 12% of the population (535,000) to 15% within a decade.[26]

Services for Older Persons - Overview

In 2009, spending by the HSE on services for older persons (excluding internal costs) amounted to €1.2 billion (or approximately 14.6 per cent of total primary, community and continuing care expenditure). It will rise to some €1.39 billion in 2013. These services aim to support older people to remain at home in independence for as long as possible or, where this is not possible, in an appropriate residential setting. A range of services is provided for older people and their families and carers by public, private and Section 39 providers. Expenditure on services for older persons comprises expenditure on residential services and expenditure on community services, although the number of individuals supported in a community setting is larger.

Historically, the allocation of resources for the provision of services to older persons was directed towards institutions, particularly for the provision of long-term residential care. For community services, resources have been traditionally allocated to institutional-type providers of such services as meals on wheels, home help, etc. The Nursing Homes Support Scheme (**NHSS**) (**'Fair Deal'**) offers an alternative method of resource allocation for residential care services for older people. Before the introduction of the NHSS in October 2009, all resources for services for older persons were allocated on the basis of historic budgets adjusted for incremental spend.

It is not clear that all expenditure under the services for older persons care group area is strictly health care (e.g. meals on wheels). In addition, while the resource allocation mechanisms for the Fair Deal and the HCP scheme are well documented, it is not always clear how resources are allocated for the remaining components of services for older persons. The remainder of expenditure on services for older persons, which are provided either directly by the HSE or in many cases in partnership with non-statutory Section 39 providers, is largely allocated to institutions on an historic block grant basis. [27]

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[26] Wren, M., *et al* (2012) *Towards the Development of a Predictive Model of Long-Care Demand for Northern Ireland and Ireland,* Centre for Ageing Research and Development in Ireland (CARDI), Trinity College Dublin. The CARDI report develops a model of long-term care need and utilisation and its application in Ireland (and Northern Ireland).

[27] Brick, A., *et al*, *Resource Allocation, Financing and Sustainability in Health Care*, Volume 1, a report for the Department of Health and Children, ESRI, July 2011. The remit of the independent group, set up in April 2009, was to report on how current levels of resourcing in health could be better allocated to deliver the objectives of health policy.

Home Help

The home help service was initially developed by Section 39 organisations. The Health Act 1970 (Section 61) empowered health boards to employ home helps directly. The establishment of the health care assistant role in the 1990s was the first publicly financed and publicly-provided, non-medical, home care service in Ireland.

Now home help services are supplied by HSE-employed staff, by community and Section 39 organisations but not by private sector agencies. Individuals apply for home help services through the local public health nurse and an assessment of need is carried out to determine if they are suitable for home help. The home help service has no statutory basis and its patchy provision, combined with the system of state subsidy for residential care, biases utilisation towards residential care.[28] Service users also have no choice in their care provider.

In reality, the HSE provides home help services for all users up to five hours. Private providers who are contracted to deliver additional care to the user (in some 20 per cent of cases) do not take over the work done by HSE staff and as a consequence two teams of people (and their supervisors) visit a user during the week with neither communicating with the other.

As a point of principle, the HSE has decided not to use scarce public resources in the provision of basic housekeeping tasks.

The home help budget is administered in a silo manner from the HCP budget hence the duplication of some services and difficulties with resource allocations towards year-end.

In addition, private providers are prevented from providing home help services.

The level of general satisfaction with home help services is high; a somewhat understandable response as the service is provided free. [29] On the other hand, private providers point out that service is at best adequate compared to what could be provided with better systems, the robust monitoring of quality standards and continuous performance management.

In 2013, some 10.3 million hours of home help service will be provided to 50,000 people.

Home Care Packages

The HCP, which has no legal base, has been operated by the HSE since 2006 in support of Government policy that the use of community and home based care should be maximised and should support the important role of family and informal carers in order to maintain older people at home for as long as possible. These services are flexible, but include additional home help hours, nursing care, physiotherapy, day care services, speech and language therapy, occupational therapy, respite care etc. They might be needed due to illness, disability or after a stay in hospital or following rehabilitation in a nursing home.

HCP is primarily targeted at people with medium to high dependency needs. The scheme is also available to others needing care in the community, such as the disabled. The administration of HCPs is carried out by the Local Health Offices (**LHO**), with funding for HCPs channelled through the

[28] *Quality and Standards in Human Services: Home Care for Older People*, NESC, August 2012.
[29] *Annual Report and Financial Statements* (2011), HSE: 58.

'services for older persons' care group area of Primary, Community and Continuous Care (**PCCC**) funding. [30]

Each HCP is tailored to the needs of the individual and is based on a needs assessment. Services provided included nursing, home care attendants, home helps and various therapies such as physiotherapy and occupational therapy. Unlike the Fair Deal, the HCP scheme is an administrative scheme, i.e. there is no automatic right to the HCP scheme nor to avail of services under it. As guidelines about a standardised national approach to its implementation are not yet fully operational, each LHO implements the scheme differently. While this may allow for flexibility in delivery, it also leads to inconsistencies, inequities and duplication of work. The National Economic and Social Forum (**NESF**) found that there were variations by LHO in eligibility criteria, methods of assessment, the financial value of a HCP and what type of organisation delivers the care (HSE, commercial agencies, voluntary organisations, etc.). In particular, double or triple assessments of needs and means are often carried out. For example, assessments of the care needs of an older person were often carried out by medical staff in hospital, by a public health nurse co-ordinating HCPs and by the organsiation appointed to provide the care. Similarly, double or triple means testing of an older person also occurs, e.g. for home help services, for HCPs and for a medical card.

Those in receipt of HCPs are generally very positive about their experiences with the scheme and the improvement in quality of life that has resulted from the scheme. However, in terms of resource allocation, while the overall allocations to the four HSE areas are broadly equitable in terms of the proportion of the population aged over 65, there are substantial variations in the allocations to individual LHOs that cannot be explained by differences in age profile, let alone need. For example, in 2008, the allocations under the HCP scheme per person aged 65+ ranged from €91.70 in Wicklow to €502.76 in Dublin North Central. In terms of the actual value of HCPs, a survey of eight LHOs found that the maximum amount payable per week per recipient varied from €252 to €1,500, with the result that *this provides at best inconsistencies, and at worst inequities, in the amount of care which people can access through a HCP*. [31] Industry sources confirm that the situation has not changed in the intervening years.

In terms of data collected which would aid evaluation and further development of the HCP scheme, the HSE requires that each LHO provide monthly data on the number of HCPs being provided, the number of recipients, their age, where they are referred from, as well as pay and non-pay costs. However, these are essentially inputs and no information on outputs or outcomes are currently collected. NESF remarked; *when inputs and outputs and outcomes cannot be compared, then the efficiency and effectiveness of the monies being spent cannot be assessed*. [32]

In terms of the delivery of HCPs, lack of integration with other service providers has been highlighted. This manifests itself most obviously in terms of assessment, where duplications in assessments are common. It also arises in respect of confusion over the various schemes administered by the HSE, most notably the relationship between the HCP scheme and the home

[30] There may be some confusion about the difference between the HCP scheme and the existing home help scheme. HCPs are essentially a more comprehensive service, incorporating medical services as well as home help services.
[31] National Economic and Social Forum, 2009: 56.
[32] op cit NESF: 78.

help services scheme. NESF has noted that inconsistencies between the funding and mean tests for HCPs and nursing home care mean that residential nursing home care is still favoured, even though policy on older people aims to maintain as many as possible at home.

Finally, while it is envisaged that providers of services covered by HCPs would be part of primary care teams, this is currently not the case. Both the Fair Deal and the HCP scheme involve the use of alternative methods of allocating resources for the delivery of services for older persons. In the absence of operational standardised needs assessment guidelines and criteria, however, the allocation of resources may serve to perpetuate existing inequities in the delivery of such services. In terms of the initial allocation of resources for the two schemes, funding for the HCP scheme is still based on an historic budget basis, while funding for Fair Deal is based on a statutory assessment of need as laid out in the Nursing Homes Support Scheme Act 2008.

In terms of integration, a concern arises in relation to the administration of the two schemes. Individuals wishing to avail of Fair Deal must apply to one of 18 Nursing Home Support Offices, while those wishing to avail of the HCP scheme must apply to their LHO. The NESF evaluation of the HCP scheme highlighted the lack of operational standardised guidelines for the assessment of need. It is clear that standardised guidelines on care and financial assessments need to be enforced for both schemes. In addition, given that the relevant populations are likely to be very similar, it would make sense to have standardised needs and financial assessment guidelines for all services for older persons. [33]

The HCP scheme includes extra services and supports that are over and above the normal community services that the HSE provides directly or through a HSE funded service i.e. where more than five hours of home help is required.

While people over 65 are the main beneficiaries, in limited circumstances - the early onset of dementia for instance – younger people are assisted. Indeed the majority of service provision benefits persons aged 80 and older; the average age of those receiving a HCP is 83.

The HCP is not means tested but requires the completion of a Care Needs Assessment by a healthcare worker.[34]

In February 2012, the HSE awarded contracts following a procurement process for the provision of new 'enhanced' home care packages (**EHCP**) approved after the commencement date. A very significant weighting (85 per cent) was attached to the achievement of quality standards.

The services provided, which are subject to a Service Level Agreement, include personal and essential domestic care services in addition to the levels normally available in the community to support the assessed needs of clients. For example, these services include additional home care over and above what is usually available at times when services would not normally be available i.e. evenings or at weekends.

[33] op cit. ESRI (2010).
[34] Home Care Package scheme, Information Booklet, HSE (2011).

Importantly, only the elements of enhanced home care that the HSE is not in a position to provide direct may be awarded to the service providers approved under the HSE Framework Agreement. Thus the existing 11,000 clients covered by the current home care packages will not be affected.[35]

Prior to the completion of the tender competition, these services would have been provided through a mix of HSE direct provision i.e. by HSE employed staff (including home help workers and nurses); by grant aided Section 39organsiations; and by a range of private providers.

In total, 26 service providers were identified across 32 lots based on the former Local Health Office (**LHO**) areas. Service providers were evaluated against three main criteria: technical merit and service standards; service delivery proposals by LHO area; and ultimate cost. Only 15 percent of the approved providers are Section 39 organisations.

A pre-condition of acceptance into the HSE Framework was that each successful service provider had to demonstrate its ability to meet the minimum standards of service delivery specified in the technical requirements set out in the Request for Tender (**RFT**) and could deliver defined standards of care through appropriately trained and qualified staff to support defined care plans.

The SLAs were concluded for a period of one year only i.e. until July 2013. The HSE reserved the right to extend the SLAs for a period of a further year or to re-tender.

In 2013, some 10,870 people will receive home care packages.

Social Welfare Schemes

The Domiciliary Care Allowance (**DCA**), which is means tested, represents a very important support to people who live with and care for children with disabilities. The allowance is paid in respect of 26,000 children, an increase of over 2,000 since the Department of Social Protection took over responsibility for the scheme from the HSE in April 2009. [36]

Spending on the scheme and the annual respite care grant (€1,375) which is automatically paid to all recipients has increased from €138m to €145m between 2011 and 2012 and expenditure in 2012 is expected to be some €146m. The monthly rate of the grant is €309.50. Parents of children who receive the DCA also qualify for the Carer's Allowance and the Household Benefits Package, subject to fulfilling certain criteria, and some 40% of those on the scheme receive these payments. For example, a carer aged over 66 caring for one person receives €12,525 per annum (based on the 2012 rate of carers' allowance).

In 2011, some 51,666 people receive the carers' allowances (including 22,000 who get the Half Rate Carers' Allowance that is available to people in receipt of another social welfare entitlement).

In 2011, some 76,701 carers received the respite care grant at a cost of €130.4m.[37]

A Carer's Benefit is a payment made to insured people who leave the workforce (and undertake not to work for more than 15 hours a week) to care for a person (s) in need of full-time care and attention and is payable for two years for each person being cared for i.e. some €10,660 per annum

[35] Noel Mulvihill, Assistant National Director, Older Persons, HSE, February 2012.
[36] Oireachtas, Dáil Eireann Debate, 9 May 2012.
[37] Department of Social Protection, Social Welfare Statistics, 2012.

for minding one person and €15,990 for caring for two persons. Some 1,637 carers get the carers' benefit (2011).

The cost of these allowances and benefits in 2011 was some €762m. [38]

Home Carers' Tax Credits

In addition, and quite separate from the D/SP allowance, a home carer's tax credit may be claimed, subject to certain conditions, by a couple in a marriage or civil partnership where one spouse or civil partner cares for one or more dependent persons, including a child, a person over 65 or a person who is permanently incapacitated. The dependent persons do not have to reside with the home carer. In addition, a separate tax credit is available for an employed person taking care of an incapacitated person. The home carer's credit benefits some 77,500 and the credit for persons taking care of an incapacitated taxpayer is availed of by 1,470 people (2009).[39]

The income tax foregone by granting the home carers' tax credits was as follows.

Table 2 Home Carers' Tax Credit – Income Tax Foregone (2007-2010)

2007	**€69m**
2008	€80m
2009	€75m
2010	€71

Source: Revenue Commissioners [40]

Informal Carers

Informal carers provide most of the more frequent care that older people with disabilities receive; and within informal carer categories those who live in the same household as the person receiving care provide more intensive care than those who do not co-habit. Some 9.9 per cent of the population over 65 receive informal care from some source; with 8.8 per cent receiving relatively intense daily or all-day informal care. Co-habiting family members provide 78 per cent of recipients' intensive care.

According to Census 2011, some 187,000 people provide regular unpaid personal care to a friend or a member of the family with a long-term illness, health problem or disability, including those due to age.[41] Over 39,000 people provide in excess of 57 hours of care per week.

[38] Houses of the Oireachtas, Dáil Éireann Debates, Adjournment Debate on the National Carers' Strategy, 14 July 2011. See also Statistical Information on Social Welfare Services, 2011.
[39] Houses of the Oireachtas, Dáil Éireann Debate, reply to a Parliamentary Question, 18 September 2012. More up to date figures were not provided.
[40] Houses of the Oireachtas, Dáil Éireann Debate, reply to a Parliamentary Question, 21 July 2011.
[41] The Census (2006) asked persons aged 15 years and over whether they provided regular unpaid personal help for a friend or family member with a long-term illness, health problem or disability, including problems due to old age (Government of Ireland (2007), *Census 2006: Volume 11 - Disability, Carers and Voluntary Activities*, Dublin: Stationery Office: 2007).

Some 10 per cent of those between the ages of 50 and 64 and 30 per cent of those older than 75 have some level of disability. The primary source of support for disabled recipients of care is the family and, by and large, the spouse. [42]

A National Carers' Strategy to address the needs of informal and family carers has been published.[43] The strategy does not apply to people who are paid to undertake a caring role, such as formal care workers engaged under a contract of service, or those who provide voluntary care work for a charity or community organsiation.

Fair Deal

The Nursing Home Support Scheme (**NHSS**) was introduced in October 2009 as a demand-led, means-tested, resource-capped national scheme. The purpose of the scheme was to introduce more equitable and transparent financial support for people in long-term residential care. It provides a co-payment, uniform system of financial support irrespective of whether the person is in a public or private bed. The resident contributes 80% of assessable income and 5% of the value of any assets per annum above €36,000 (or €72,000 for a couple). The 5% contribution based on land or property assets may be deferred and collected from the person's estate.

Some 22,914 long-term public and private residential places are supported under the scheme. [44] Demand continues to be quite strong with 6,243 new clients supported by Fair Deal in the first nine months of last year (2012).

Residential long-term care utilisation, including limited-stay utilisation is forecast to be between 4.2 per cent and 4.7 per cent of the population aged 65 and older by 2021 i.e. that between 33,300 and 37,200 older people are projected to require long-term residential care on a business-as-usual basis.

There was a net increase of 1,520 clients during 2011. In 2012, some 6,516 clients will leave Fair Deal. This suggests a turnover (churn) rate of 3.5 (years).

In 2013, a budget of €998m will provide 22,761 residential places to older people and disabled.

Some 12.8 percent of those availing of the Fair Deal are classified as 'low maintenance' with a further 22.3 per cent in the 'medium maintenance' bracket; some 7,600 people. [45] A reasonable working assumption is that a third of Fair Deal users would, in fact, be better off in terms of well-being by being at home and benefitting from an enhanced HCP. This assumption is sustained because nursing staff have on average only 3.1 hours of direct contact time per day with their patients.

The cost of providing people with low/medium dependencies with an enhanced HCP of 21 hours per week is around €22,932m per annum or €174.3m (for 7,600 people). This compares with a Fair

[42] Evidence by Professor Rose Anne Kenny, Trinity College Dublin, to the Seanad Public Consultation Committee, March 2012.
[43] *The National Carers' Strategy*, Department of Health, July 2012.
[44] Performance Report, National Service Plan 2012, HSE, September 2012. At some 4.8 per cent of the population over 65 this places Ireland close to the average of countries with broadly comparable data (Wren, 2009). The HSE National Service Plan for 2013 indicates the number will fall to 22,761.
[45] *Health in Ireland: Key Trends 2012*, Department of Health, December 2012.

Deal cost (2012) of €333.3m; a significant potential saving of some €159m per annum (2012) assuming an average cost of €43,847 per person per year.

The interim report following a public consultation on the future of Fair Deal (that attracted some 60 submissions) made several findings, as follows, that are pertinent to this submission.[46]

- There was a general consensus that investment in community supports should be increased to enable people to remain in their homes and that long-term nursing home care should not be the only option available to people.
- The scope of HCPs should include night nursing and day care nursing.
- A well-resourced and managed community home support programme makes more economic sense (than the Fair Deal scheme).
- The scheme incentives older people to choose long-term residential care instead of staying at home.
- The perceived lack of a clear and consistent approach to financial support for community services was considered to create a financial incentive to enter long-term residential care.
- There is wide support that the Fair Deal scheme should be extended to other community-based services. To this end, a new scheme for community services should be introduced on a statutory basis and mirror the principles of the NHSS i.e. a co-payment model, uniform assessment, and budgets allocated to an individual in accordance with a care plan and patient preference.

Section 39 Funding

In 2009, €600m was allocated directly by the HSE to the 23 large Section 39 organsiations providing primary, community and continuing care services. [47] By 2011, it is estimated (on the assumption they provide 30 percent of direct home help services) that some €58m in Section 39 funding was provided by the HSE to 35 organisations. [48] The grants ranged from €7.5m to €111,000. These organsiations have received some €355m in the past five years. A number of reports by the Comptroller and Auditor General (2005 and 2009) criticised the funding arrangements between the HSE and such service providers, particularly in terms of the lack of SLAs which detail the link between the funding, the service provided and the standards to be met.

During 2009, the HSE initiated a process whereby SLAs would be standardised for all Section 39 organisations (as required under the Health Act 2004). Revised arrangements, including a new SLA template, were put in place in January 2012.

Despite these improvements, there is still no transparency about the use by beneficiaries of Section 39 funding of HSE grant aid used to cross-subsidise their home help services. Also due to the limitations of HSE management information is not known how many home help personnel in Section 39 organisations are actually funded by the HSE.

[46] Department of Health, *Summary of Submissions Received to Inform the Review of the NHSS*, December 2012. The submissions will inform the final review process.

[47] The list of voluntary providers set out in Schedule II of the ERHA Act 1999 have a direct funding relationship with the HSE i.e. resources are not administered via the LHOs or any other agency (e.g. PCRS) (Prospectus, 2003).

[48] Reply to a Parliamentary Question from the Minister for Health, 27 November 2012.

Furthermore they had the benefit of a pre-paid guaranteed cash flow from the HSE which private providers do not have. Private providers on the other hand have to wait at least two to three months before they get paid by the HSE.

More importantly, the provision of care by three Section 39 assisted home help service companies (in Clontarf, the North Inner City of Dublin and in Stillorgan) have had to be taken over by professional private operators due to incidents of fraud and mismanagement. These organisations received an estimated €18m in subsidies from the HSE in 2011.

It is arguable that under EU procurement rules all services co-funded by the HSE should be the subject of competitive tendering. It is also arguable, on grounds of EU State aid policy, that non-core services provided by Exchequer funded Section 39 organisations that compete with private operators to deliver similar commercial services, including the provision of the HCP scheme, should be put on a level playing field by way of a competitive tender.

Conclusions

If there was political willingness, private health care providers could provide more clinical services to older people and disabled in their homes.

For this to happen all the separate budgets that assist older people (and disabled) should be amalgamated and better flexibility introduced to allow the switching of resources more rapidly than is the case at present to reflect users' ever changing care needs.

For example, **there is no medical reason why persons with low and medium dependency in nursing homes co-financed by the Fair Deal scheme should not be cared for at home by way of an enhanced HCP**. [49]

However, for as long as the Fair Deal, Section 39 financing and HCP budgets are viewed as quite separate and distinct sources of funding it is not possible to resource the HCP scheme to meet the potential demand for high quality and intensive home care services.

[49] Some 34.3 per cent of patients in voluntary welfare homes are in the 'low dependency' category. Source: reply to Parliamentary Question by the Minister for Health, 15 February 2012.

PART 3

Benchmarks and Trends

Introduction

This section reviews in brief the delivery of home care services in some other common law jurisdictions.

While each country has quite distinctive characteristics, all are faced with a rapidly growing population of elderly people who are placing greater demands on their respective health services to provide home care packages that are 'fit for purpose'.

The best practice prevalent in other countries should inform the most appropriate delivery model for the outsourcing of HCP.

Northern Ireland

A key aim of the Department of Health, Social Services and Public Safety in Northern Ireland is to support an increasing number of older people to live independent lives, preferably in their home. Care is delivered through a number of channels, including informal care-givers, home help, domiciliary care, long-term hospital care and institutional care. Older people living at home can avail of support under the home help service provided by five HSC Trusts. Unlike in the rest of the UK, the supervision of home helps is largely undertaken by social work assistants who assess needs, recruit home helps, as well as allocating services. [50] Once a need is established, home help services are provided free of charge to those aged 75 and over, and to those in receipt of income support or family credits. However, all others are subject to a means test to establish their contribution to the cost of the service. [51]

Care management is a key element of long-term care for older people. Care managers assess an individual's needs in respect of care at home and placement in care homes. A care package is the main form of care recommended for an individual and one of three options are available: domiciliary care, residential care or nursing home care. Some 23,400 people are in receipt of publicly funded domiciliary care, of whom 28 per cent recieve intensive care i.e. more than six or more visits a week; some ten contact hours.

The integration of all forms of home care provision in Northern Ireland differentiates the way similar care is managed and allocated in Ireland.

UK

Some 90 per cent of home care in England is commissioned by local authorities and virtually all of this work is outsourced.[52]

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[50] Pierce, M., S. H. Fitzgerald, and V. Timonen (2010), *Summary and Comparison of Key Social Provisions for Older People in the Republic of Ireland and Northern Ireland*, Centre for Ageing Research and Development.
[51] *Domiciliary Care Services for Adults in Northern Ireland,* 2009. Belfast: Community Information Branch, Department of Health, Social Services and Public Safety.
[52] Laing & Buisson (2013), *Care of Elderly People: UK Market Survey 2012/2103*.

The UK is looking at emerging best practice to help shape a transition to personal budgets and service personalisation. *Putting People First* is the UK Department of Health's vision for the transformation of social care through personalisation, prevention and early intervention. [53] Part of this vision is the extension of choice and control through self-directed support and personal budgets to all those with ongoing care and support needs. Making personal budgets accessible can be by way of direct payments or individual service funds. Making sure that a range of quality, personalised services are available for people to choose will mean providers working in partnership with local people to develop them, which will require changes in local authority contracting practice. A common feature underpinning the proposed changes has been a shift from traditional and often adversarial relationships towards collaborative and constructive partnerships between the public providers (local authorities) and private sector providers. Age UK has pointed out that people in later life are less likely to want to take responsibility for managing their budget and organising their care, but they do welcome the opportunity to exercise choice and control over the care and support they receive. [54] Support planning and brokerage services are seen as crucial to the take-up of self-directed support.

The Department of Health actively promotes the use of electronic monitoring in the delivery and contracting of home care by local authorities. As a result, these authorities have delivered a 12% increase on client contact time; electronic monitoring reduces the leakage of hours. Local authorities are achieving a 5 to 8 per cent saving on independent sector home care spend. Greater operational efficiencies have resulted, for example in relation to the automation of invoices.

Table 3 UK Care and Support – Key Statistics

- Over six million hours of regulated home care are delivered a week in England with private operators delivering 74 per cent of these services.
- Public expenditure on home care, including direct payments, is some £2.2 billion and privately purchased care is some £3.3 billion. [55]
- Some 1.6 million people are employed in care and support services, including 20,000 social workers. [56]
- Some 400,000 older people received a State funded home care services with over 250,000 at any one time.
- While the numbers receiving home care and the total number of hours delivered may have fallen, there has been a 37 per cent increase in the average number of contact hours per service between 2005 and 2011.
- Some five million people in England care for a friend or relative. Expenditure in England on day and domiciliary provision is £7.8 billion, or 46% of the total personal social services budget.
- A sharp increase in the cohort needing home care by 2030 is forecast.[57] Some 76 per cent of UK citizens will need care and support at some point in later life.

[53] *Putting People First, Contracting for Personalised Outcomes: learning from emerging practice*, Department of Health, UK, 2012.
[54] *Personalisation in Practice: lessons from experience*, Age UK, October 2010. Almost 10 per cent of people aged over 65 in the UK currently in receipt of community-based services are receiving self-directed support.
[55] *Community Care Market News*. Laing and Buisson, May 2012.
[56] *The size and structure of the adult social care sector and workforce in England 2011*, Skills for Care, 2011. In addition there are some 355,000 people working as personal assistants.

The Dilnot Commission highlighted that the UK's current funding system was in need of urgent reform as people are left exposed to potentially catastrophic care costs with no way to protect themselves. The core recommendation was that individuals' life time contributions to their social care costs (including home care services) should be capped at £35,000 and over this limit full State support should be available. In addition, the means-tested threshold, above which people are liable for their full care costs, should be increased from £25,000 to £100,000. However, all those entering adulthood with a care or support need should be eligible for free State support immediately and without a means test. The Commission described the UK system as 'confusing, unfair and unsustainable.' In response, a White Paper and a draft Care and Support Bill were published. [58] While for some high quality care and support had transformed the way they lived their lives, for others the current system was letting down older and disabled people.

The home care sector now works to a set of essential standards of quality and safety which are underpinned by regulations, which have legal foundation. The regulators have more power in law and can bring prosecutions against those people not meeting standards. Anyone meeting or exceeding the old national minimum care standards will likely meet the essential standards of quality and safety but there is less emphasis on paperwork and more on outcomes for the people using the service.

Table 4 UK Reform of Care and Support Services – Key Recommendations

1. There is no point in pouring more money into a system that does not work.
2. A radical reform is needed to give people independence and real choice and control over their lives.
3. Resources will be re-focused to promote peoples' well-being and independence instead of waiting for people to reach a crisis.
4. People will be given more options to keep them well and independent.
5. Better information and advices will be provided to facilitate planning care needs. A new national website will be set up as will better online local services.
6. People will be given control over their own budget and their own care and support plans.
7. The National Institute for Clinical Excellence should develop quality standards.
8. A legislative duty will be introduced to promote diversity and quality in the provision of services.
9. Better skills and training are an important part of raising standards overall.
10. A phased approach over ten years is envisaged.

Source: White Paper (2012) Caring for our Future; reforming care and support

[57] *Commission on Funding of Care and Support*, Fairer Care Funding, 2011. The Commission was chaired by Andrew Dilnot.
[58] *Caring for our future; reforming care and support,* White Paper, HM Government, July 2012. The UK's Law Commission said the UK's law about care and support was confusing and too complicated.

With a majority of home care commissioned by local authorities and the NHS, but being provided by the private sector, contracting models have a considerable impact on the structure, delivery model and capacity of provision. The move from block contracts to framework agreements introduced greater flexibility and choice into the market but for providers this resulted in greater uncertainty about cash flow and volumes of activity. With competitive tendering some providers reduced their prices to gain market share. The White Paper has vowed to rule out this 'crude contracting by the minute.' The vast majority of local authority councils in England (who along with the NHS commission home help services) have outsourced the provision of home care and see outsourcing home care as *a logical step*. [59]

Australia

Over one million older Australians receive aged care services and this cohort will rise to 3.5 million by 2050. The current system was assessed as difficult to navigate; services are limited, as is consumer choice; quality is variable; coverage of needs, pricing, subsidies and user contributions are inconsistent or inequitable.

In the light of these findings (that were the subject of a public enquiry), [60] the Australian Government introduced the Commonwealth Home and Community Care (**HACC**) programme on 1 July 2012.[61] The Australian Government now has full funding, policy and administrative responsibility for HACC services in all but two state and territories for persons over 65 who are at risk of premature or inappropriate admission to long term residential care. The HACC also covers carers (who receive an allowance and a payment). The programme enables older people to move seamlessly from basic maintenance, support and care services through more complex care packages or residential care as their needs change.

Table 5 HACC Services

- Nursing care
- Allied health services (including physiotherapy)
- Domestic assistance (cleaning, washing and shopping)
- Personal care (bathing, dressing, grooming and eating)
- Social support
- Home maintenance and modifications
- Assistance with food preparation at home
- Delivery of meals
- Transport
- Assessment, care coordination and client management
- Counselling
- Centre-based day care
- Support for carers including respite care

Source: www.health.gov.au/hacc

[59] The Department of Health's Care Services Efficiency Delivery Unit provides detailed guidance to Local Council's who wish to consider an outsourcing solution for home care provision.
[60] *Caring for Older Australians*, Productivity Commission Inquiry Report, No 53, 28 June 2011.
[61] Department of Health and Ageing (2012).

Aged Care Assessment Teams (**ACTS**) help older people and their carers work out what kind of care will best meet their needs when they are no longer able to manage at home without assistance. ACTS provide information on suitable care options and can help arrange access or referral to appropriate residential or community care. For example, Community Aged Care Packages (**CACP**) are individually planned and coordinated packages of care tailored to help frail older Australians remain in their homes. The Australian Government provides CACP approved providers with a daily subsidy per package to supply and coordinate care services. The individual services within a CACP are provided by a variety of organisations in a patient's local area. The patient, a carer or a family member has the right to negotiate with the approved provider on the types and levels of care to be provided. Once this is done a Care Recipient Agreement and a Care Plan are concluded. In addition, an Extended Aged Care Home Dementia package is available as is the Extended Aged Care at Home package aimed at persons with a higher level of care, including clinical care.

The Australian Aged Care Commission has been asked to develop a quality and outcomes data set for use by care recipients. In addition, all approved providers must by law meet Community Care Common Standards under which all CACP recipients are entitled to:

- Quality services that meet their assessed need;
- Where possible, their preferred level of social independence;
- Having their dignity and privacy respected at all times;
- Access to information about the care options available;
- Access to details of the care being provided; and
- Take part in developing a package of services that best meets their needs.

Given that many of the issues facing Ireland and Australia are somewhat similar it is instructive to list the characteristics of the Australian system.

Table 6 Characteristics of the Australian Home Care System

- Delays in care assessments and limits in the number of care packages;
- Providers have reduced incentives to become more efficient, improve quality, innovate or respond to consumer demand;
- Changes in an older person's care needs can lead to a change in their care package, care provider and personal carer;
- Financial inequities; the levels of user co-contributions are inconsistent and inequitable;
- Variable care quality;
- Uncertainty about care availability;
- Complex, overlapping and costly regulations; and
- Incomplete and overlapping interfaces with health, disability, mental health and income support.

Source: Caring for Older Australians, Productivity Commission Inquiry Report, No 53, 28 June 2011.

As part of the reform of care for older people, the Australian Government has also removed restrictions on the number of community care packages and the distinction between residential high care and low care places.

Australians will be expected to co-finance the costs of their aged care and support. The maximum fee is capped at 17.5% of a person's pension with people on higher incomes expected to contribute up to 50% of any income above the maximum pension rate.

Most importantly, the Australian Government is moving away from service provision by the not-for-profit sector given evidence of inefficiencies with the current delivery model. Instead elderly people as approved beneficiaries will be provided, subject to a means test, with the funds that meet their individual needs and they will decide who should provide them with home care. The Australian home care delivery model is becoming truly consumer centric.

Canada [62]

Over the past few years there has been continued progress in moving toward greater integration of health systems in Canada. A growing body of evidence supports integrated models of care as critical frameworks for improving health outcomes and quality of life and for producing efficiencies within the system. Like all other elderly people, Canadians want to remain at home for as long as possible. An integrated care model is seen as a key strategy for helping them realise that goal. There is a growing urgency (given general population ageing and the prevalence of chronic diseases) to move to a better coordinated, fully streamlined system to meet the increasingly complex health needs of an aging population.

Although there are a range of models and approaches to integration, there are several key elements that make some models more effective than others. Collaboration, a focus on the individual (person-centred care), and the appropriate use of technology are just some of the essential ingredients to an effective integration model.

Table 7 The Canadian Model of Integrated Care – Key Characteristics

Defined populations that support relationships between health care teams and a specific population or local community. Thus individuals in most need of care are targeted for a more coordinated approach.

Aligned financial incentives that support providers to work collaboratively. This includes joint responsibility for the management of financial resources.

Shared accountability for performance through the use of data to improve quality and account to stakeholders through public reporting.

Information technology that supports the delivery of integrated care.

The use of guidelines that promote best practice, support care coordination across care pathways and reduce gaps in care.

Patient engagement in making decisions about their own care and support in enabling self-management.

A collaborative culture that emphasises team work.

Source: Health Systems Integration Synthesis Report (2012)

[62] *Health Systems Integration: Synthesis Report*, Canadian Home Care Association, March 2012.

Specific challenges in integrating home care within the broader health system include developing a coordination mechanism; identifying and targeting those individuals most in need of integrated care; ensuring access; providing case management; creating coordinated provider networks; educating providers; and making a compelling case for increased integration to policy-makers. [63]

Many success stories are continuing to emerge in Canada as new evidence is published and knowledge is shared among practitioners and policy-makers. For example, the *Home is Best* project in the Frasier Health Authority (British Columbia) and Prince Edward Island's Integrated Palliative Care Initiative.

Canadian home care providers see home care in a much wider context than their Irish counterparts. They define home care as follows: *...,an array of services for people of all ages, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaption and integration and support for the family caregiver*.

Demand for home care in Canada has grown by over 50 per cent within the past decade and some one million people benefit from a range of services. Statistics Canada is forecasting a steady rise in demand as the population ages.

The Canadians accept that the integration of home care provision requires new thinking and working.

Also worth referencing is Accreditation Canada's Home Care Service standards that apply not just to those delivering home care but to all organisations (public or private) offering clinical services to support clients, families and carers in the community as well as home nursing care.[64]

Conclusions

Emerging trends and best practice in other jurisdictions suggests that a new model for the outsourcing of home care services for older people should take into account some or all of the following features:

1. **Living independently:** There is overwhelming evidence that elderly people wish to live at home for as long as possible. Most Western health systems are shifting the balance of care from acute hospital provision to community sectors. [65]
2. **Integration of services:** Furthermore, there is a growing literature on the integration of care. Two trends have emerged: *real integration* sees organisations merging their services; *virtual or contracting integration* involves providers working together through networks and alliances. This allows the flexible use of budgets to provide services directly or to commission services from other parties. [66] The key message is that without integration all aspects of care suffer. Patients get lost in the system, needed services fail to be delivered,

[63] Lum, J. (2008), *Integrated Care*, presentation at Look Globally, Act Locally: Integrated Care in the Community for Vulnerable Population conference, Toronto, Ontario, 20 October.
[64] www.accreditation.ca/accreditation-programs/qmentum/standards/home-care/
[65] *Analysis of Irish Home Care Market*, a report for the Irish Private Home Care Association, PA Consulting, February 2009.
[66] Goodwin, N. Et al, (2011) *Integrated care for patients and populations: Improving outcomes by working together*, The Kings Fund, London.

the quality of the care experience declines and the potential for cost-effectiveness diminishes. [67] This suggests that a single budget for all home care services, including nursing home care, should be prepared and administered and supervised by the HSE as a seamless single service.

3. **Outsource needs assessment:** Patients should have the option to use a HSE approved service provider to determine their needs and requirements.
4. **Vouchers:** Once an annual personal care budget is agreed within defined limits set by the HSE, all eligible patients would be issued with ('electronic') vouchers that can be exchanged as payment for services received.
5. **Choice:** There is a clear trend towards what is called 'the personalisation of social services'. The basic idea is that technology will enable people in the near future to be given the choice of spending their individual care needs budget on the services they believe are best suited to their personal requirements.[68] This suggests that patients should be free to decide who provides them with the care determined by their needs assessment on condition that all potential service providers, including the HSE and not-for-profit organsiations, meet the HSE's standards for professional health care.

[67] Kodner, D., and Spreeuwenberg C. (2002), Integrated care: meaning logic, applications and implications (a discussion paper), *International Journal of Integrated Care*, February 1:2.

[68] Statement by Professor Gerard Quinn to the Seanad hearings on the rights of older people, November 2011.

Identify self-contained service areas that could be outsourced to the private sector. [69]

1. Croke Park Agreement

The Croke Park Agreement contains provisions that should be followed when public sector management decides to involve a private sector entity in the provision of a new or existing public service. [70] The Labour Relations Commission proposals for a new public service agreement reaffirm the principles and procedures set out in the Croke Park Agreement as regards outsourcing.[71]

But according to the trade union IMPACT this understates the rigour of the agreement's provisions, which oblige management to ensure:

- The use of direct labour to the greatest extent possible (where consistent with the efficient and effective delivery of public services).
- The maintenance of wages and employment standards in all procurement policy.
- No compulsory redundancies as a result of any outsourcing.
- Consultation with unions on all aspects of the procurement process at key stages before decisions are made.
- The development of a service plan and an evaluation and comparison on in-house and outsourcing options and an agreed plan to change in-house arrangements if necessary before any outsourcing option can be used.
- The inclusion of all relevant costs – not just pay rates – in this evaluation.

Public sector management is also required to continue regular consultation with unions even if outsourcing goes ahead. And the pay, pensions and other conditions of staff remaining in the public service cannot be worsened if outsourcing takes place. The parties are also committed to establishing a mechanism for monitoring contractors' compliance with employment law. [72]

It was subsequently clarified that the Appendix dealing with service delivery options (outsourcing) has general application across the public service. [73] The Health Sector Action Plan 2012 expressly states there is a need for (possible) external service delivery.[74]

[69] Circular dated 2 June 2011 from the Secretary General, Department of Public Expenditure and Reform to Heads of Department and Offices.
[70] *Public Service Agreement 2010-2014*, June 2010.
[71] Labour Relations Commission, draft Public Service Agreement, 25th February 2013.
[72] Outsourcing Options, *The Public Sector Magasine*, 2012.
[73] Clarification to the (draft) Public Sector Agreement (2010-2014), signed by Kieran Mulvey and Kevin Foley (Facilitators), 6 May 2010.
[74] Public Service Agreement (Croke Park), Health Sector Action Plan 2012, 22 February 2012.

2. Reform of the public sector

In the context of the Comprehensive Review of Expenditure, [75] the Secretary General of the Department of Public Expenditure and Reform (**D/PER**) wrote to all heads of Departments and Offices to submit proposals for self-contained service areas that could be considered for outsourcing to the private sector. It was noted that the over-arching objective of the review is to equip Government with the full range of options (including outsourcing) to make major savings in overall expenditure. [76]

The discourse about outsourcing was advanced in the context of the Government's ambitious public sector reform plan. [77] It is important that this proposition is viewed against the key strategic aims of the reform plan, in particular that the policy objectives of securing new ways of working are implemented and that the needs of customers are placed at the core of service delivery. The Government's clear view is that external delivery of services can potentially deliver a range of benefits for the provision of public services. These include cost and efficiency savings arising from better work and management practices and from enhanced performance measurement. There is also, according to Government, greater potential for innovation in business practices through access to a wider set of skills, knowledge and technologies. **The external delivery of non-core services also provides an opportunity to redeploy scarce HSE resources to core activities and front line services.**

The plan notes there are a number of different sourcing models for service delivery in other countries in terms of in-sourcing, co-sourcing and outsourcing. These models range from basic managed services, through partial private service delivery, to full outsourcing of functions. The plan, in line with the Programme for Government, states that the external delivery of non-critical functions should be considered by all public bodies. D/PER's view is that the public service of the future will be leaner, more responsive and more effective. It will provide better services. [78]

Good progress has been made in the meantime. A Commercial Delivery Manager has been recruited and is based in the Reform and Delivery Office with a mandate to oversee development and implementation of a strategy for external service delivery and provide subject-matter expertise in this area. Work is ongoing to identify potential non-core activities suitable for external service delivery, with the health vote a priority target area. In addition, the Department of Health, in common with some other Departments, has been instructed to prepare and implement a detailed benefits-driven external service delivery plan. D/PER is conducting a consultation exercise with public service organisations, the market and relevant representative bodies. A short list of potential services for external delivery will then be identified and tested.

International evidence suggests that the quality of Ireland's public administration has fallen below the EU-15 average but is above the EU-27 average. This is an important assertion given that in 2011

[75] *Comprehensive Review of Expenditure*, Department of Public Expenditure and reform, 18 August 2011.
[76] Guidance material from the Secretary General of the Department of Public Expenditure and Reform regarding the Comprehensive Review of Expenditure, circulars dated 13 May and 2 June 2011.
[77] *Public Sector Reform*, Department of Public Expenditure and Reform, 17 November 2011. Section 7 deals with external service delivery.
[78] *Progress on the implementation of the Government's Public Service Reform Plan*, Department of Public Expenditure and Reform, September 2012. On policy implementation, Ireland scores third last of the EU-15. Ireland ranks around the EU-15 average in terms of achieving desirable health outcomes.

some 105,000 people were employed in the health sector and the health pay bill (€6.2 billion) represents some 42.1 per cent of total public sector pay costs. [79]

Examples of public sector outsourcing include the following: speed cameras; call centres (for a wide variety of users), grant administration, technical inspections, home care packages, ICT support (across a wide range of Departments and Offices), and the issuing of driving licences.

It is generally recognised that the reform programme will succeed or fail on its support at senior management levels.[80]

3. Croke Park 2

Against this background, and the ongoing reform agenda, the Minister for Public Expenditure and Reform has invited members of the Public Services Committee of the Irish Congress of Trade Unions to discussions on a new agenda for improvements in the productivity of public servants and reductions in the cost of delivery of public services. [81]

IMPACT and other trade unions have insisted that detailed safeguards and procedures set out in the Croke Park Agreement are followed in any moves to outsource activities within Government Departments. Unions' concerns about the impact of outsourcing on jobs and service quality was the subject of intense scrutiny and discussion during the negotiations that led to the agreement. If anything attitudes have hardened since then as a result, for example, of the decision to outsource domestic refuse services in the Dublin city and county councils.

The Public Service Executive Union's view is that not all public services have to be delivered by public servants. Instead, and acknowledging that Ireland is 'in receivership', pragmatic decisions have to be taken depending on which sector (public or private) will produce high quality, efficient and cost effective outcomes.[82]

SIPTU's (unpublished) assessment of outsourcing in the health services purportedly found that there are no real savings to be found and that in some cases outsourcing would cost more than providing services through direct labour. SIPTU notes that while private employers can make a profit from providing outsourced services workers inevitably endure poorer wages and conditions than if employed directly. [83] SIPTU has organised street protests about the HSE tender for enhanced HCPs.

The Transfer of Undertakings (Protection of Employment) legislation (**TUPE**) is seen as a key issue for both trade unions and service providers. However, advice to hand suggests TUPE will not apply in this situation; see Part 6 below that assesses the TUPE legislation in the context of the proposed outsourcing of home help care.

On the other hand, historically there has been a mix of public, voluntary and private provision in the delivery of Irish public services and few, if any, Irish unions have taken a position of blanket opposition to any private provision.

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[79] Boyle, R., *Public Sector Trends 2011*, State of the Public Service Series, Institute of Public Administration, November 2011. At the peak (2005), the health share of the Exchequer pay bill was nearly 44%.
[80] Editorial, *The Irish Times*, 18 November 2012.
[81] Government press statement, 20 November 2012.
[82] Geraghty, T., General Secretary, Public Service Executive Union, *Shared Services and Outsourcing – a Trade Union Perspective*, presentation to Public Affairs Ireland conference, 29 March 2012.
[83] SIPTU press statement, 6 September 2012.

4. Outsourcing in the private sector in Ireland

Outsourcing has been embraced by many Irish firms with many companies increasingly turning to outsourcing as a means of addressing the economic downturn. The main reason given for outsourcing is to enhance process efficiency and quality and to relieve internal resources to concentrate on core functions. Over 90% of organisations believe that outsourcing adds value to their company. [84] Arguably, the same logic applies to public bodies. There have been no issues with the trade unions in relation to companies' decisions to outsource.

Trends in Outsourcing

1. Reasons to outsource

The rationale advanced by international experts as to why the outsourcing option makes commercial sense could be summarised as follows.[85]

Quality: Driven by the need to meet key performance indicators set in SLAs, outsourcing providers have no option but to improve quality and productivity. Because the provision of this service is not price sensitive with patients making decisions very much on quality, the introduction of competition will, in the absence of regulation, help to drive an improvement in standards.

Cut costs and improve efficiencies: Strategic initiatives being undertaken by businesses are all predicated on the need to spend less money. The agenda is all about controlling the cost base and making savings. That said it is not necessarily about providing services more cheaply, but smarter with more proactive monitoring.

Concentrate on the core business: Outsourcing service providers have a scale and capability that their customers (in this case the HSE) cannot build within their organisations. Understanding one's limitations is key; knowing when and where to invest in activity that is central to the strategy of the business is also critical. Outsourcing also drives greater productivity. By taking away the hassle of providing non-core services allows the customer (the HSE) to concentrate on their core activities.

Reduce overheads and in-house IT: Any organisation (such as the HSE) that tries to do everything in-house burdens itself with ongoing investment, not just in technology, but in finding and the keeping the people to run the service. Having an outsourced solution mitigates the burden and cost of having to hire people. Keeping staff up-skilled is another cost that can be avoided.

Leveraging the latest technology: In certain outsourcing solutions customers get access to technologies and service applications that they would not normally be able to afford. Technology moves on so most businesses find it impossible to stay ahead of the curve. A good example is the use of virtual desktops which can transform the way a service is delivered on the ground.

Choice: Only by differentiating different home care services, and for each being clear about their purpose and intended impact can consumers of these services, the HSE and providers ensure that different types of intervention are appropriately delivered at the right time to the right people by the most qualified provider .

[84] *Mazars Annual Outsourcing Survey 2011*.
[85] *Four Good Reasons to Outsource*, Sunday Business Post, November 2011.

2. The UK's Perspective

The UK Government has published the submissions received on foot of its Green Paper Modernisation Commissioning that signalled a move to a much greater use of outsourcing in public services. It is envisaged that both civil society and private providers will have a much greater involvement in the running of the UK's public services. [86] A White Paper will set policy that will reform the manner in which public services are delivered. In fact, it is understood that the direct provision by the public sector will become the exception rather than the norm.[87]

Competition usually works well in private markets in the absence of market failure. Public service markets are different however. Competition and choice mechanisms can play an important role in helping to deliver some public services, provided they are implemented in a way which recognises the unique features of these markets; the existence of choice in public services is likely to have value in itself. Competition on price may be inferior to competition on quality as the former may lead to quality deterioration. Where choice and competition are feasible mechanisms, one can think of public markets as having a demand side (the users of the service who exercise choice) and a supply side (the providers who compete to provide a service). It is critical that awareness of choice is promoted; that users can access the information to make informed decisions; and that they have a capacity to act.[88]

Local authority councils have been encouraged to set the ambition for the volume of service users expected and the service outcomes i.e. the levels of independence achieved for individuals. Effective learning and continuous personal development for home care staff is another important issue as is meticulous performance management. Most importantly, the outsourcing of home care services should be done in an integrated and coordinated manner.[89]

3. Developing a business case for outsourcing

There is a large literature about how best to go about developing a business case for outsourcing.

The following table sets out the key elements (at a high level) of a typical outsourcing business case and checklists if these issues have been addressed in this submission.

Table 8 Business Case Checklist

Overall vision	√	**Economic and financial appraisal**	√
Scoping and review	√	**Affordability**	√
Strategic fit	√	**Implementation issues**	√
Options appraisal	√	**Procuring the VfM solution**	√

[86] *Moderning Commissioning*, Cabinet Office (2010).
[87] *The Shrinking State: why the rush to outsource threatens our public services,* a report for UNITE by Howard Reed, Landman Economics, March 2011. Reed says that social care provision in all sectors has improved over time because of better training and technology.
[88] *Choice and Competition in Public Services: a guide for policy-makers*, a report prepared for the Office of Fair Trading by Frontier Economics, March 2010.
[89] *Homecare Re-ablement Toolkit*, Department of Health, 2011. This toolkit looks at the outsourcing of homecare re-ablement services and sets out the issues to be considered when adopting this approach.

According to the literature, failure of an outsourcing project is usually due to performance or financial issues that were not dealt with in the contract. More specifically, organisations underbid for the project and the buyer expects over and above what they have paid for. [90]

Conclusions

What is proposed here, the outsourcing of the HCP scheme and home help services provided by Section 39 organisations as part of a phased approach to the outsourcing of all low to medium dependency care, is entirely consistent with and indeed supportive of Government policy on outsourcing. Furthermore, this submission addresses the relevant provisions of the Public Spending Code and the sections in the Croke Park Agreement that deal with outsourcing.[91]

[90] Chapman, J., *Outsourcing in a Week*, Hodder & Stoughton (2003).
[91] *Public Spending Code*, Department of Public Expenditure, July 2012.

PART 4

The Business Case

Introduction

The Department of Public Expenditure and Reform has issued guidance to assist the public service to determine whether a preliminary business case exists for external service delivery. [92] Thus it will fall to the Department of Health to assess, based on this submission, if a business case exists to outsource HCP and home help services.

This submission has endeavoured to provide much of the qualitative analysis that is recommended by the Department of Public Expenditure and Reform. Thus this section addresses, for instance, the possible constraints, an assessment of options, a SWOT analysis, the selection of the preferred option, the issue of piloting the service, a risk assessment of the preferred option, a description of the proposed service and a comparison between the current and proposed HCP service delivery and a summary of the principal benefits. The previous sections covered the policy rationale for the outsourcing of service. Part 6 addresses operational issues and impacts and evaluation proofing.

Thus in large measure this submission seeks to give assurance to policy-makers that a robust case exists to outsource HCP and home help provision and to switch some beneficiaries of the Fair Deal to an enhanced HCP arrangement.

However, as the HSE and the Section 39 organisations do not provide key financial data such as salary levels, numbers employed, a redundancy calculator, non- labour cost, the nature of the service contracts with employees nor the residual resources required to manage an outsourced service, it is not possible to provide a net financial benefit nor a sensitivity analysis. On the other hand, much of the quantitative data provided in Part 5 below will assist the Department of Health complete its full business case assessment.

Constraints

There are invariably constraints in reaching objectives. Therefore this section discusses the key potential constraints as in addressing them at this stage, solutions can be found. In turn, the technical specification for the tender competition for the outsourcing of the HCP will be better informed.

The following is based on the checklist set out in the Public Spending Code.

Financial: There are no such constraints. In fact, the proposed outsourcing could save the Exchequer some €117m in 2014 rising to €373m by 2021. **Over the eight year period to 2021 the cumulative savings could be in the region of €2 billion.** It is envisaged that a multi-annual budget be set for the proposed services.

Technological: If the proposed approach was adopted then some of the savings achieved could be used to fund the start up costs of a call centre for all home care patients and a supporting web site.

[92] Department of Public Expenditure and Reform, Service Delivery Options, Preliminary Business Case Template, January 2013 (unpublished).

This centre (that would have to be procured by tender) and the associated technology could also be used for hosting patients' care needs assessments, making appointments; scheduling staff, facilitating payments, generating reports, and monitoring quality standards. Once set up all providers should be asked to contribute to the running costs of the call centre/web site in proportion to their market share. This cost will more than offset the economies of scale and lower administration costs that will be achieved by having a central and common service centre.

Legal/regulatory: As part of the HCP scheme is already outsourced no primary legislation is required. While it would be welcomed, there is no immediate imperative to have home care standards set by primary legislation. In due course this will need to be done and the role of HIQA better defined. If the wider issues identified in this report are accepted by Government then primary legislation would be needed to put home care provision on a par with the Fair Deal in terms of providing legal certainty and to address the important issue of some patients making a contribution to costs. Outsourcing will be covered by the full rigours of the EU public procurement Directives.

State aid rules: The proposed outsourcing of the HCP scheme will not result in any EU State aid issues as the services will be procured by open tender and market rates set accordingly. However, it is arguable that the subsidies paid by the HSE to the Section 39 organisations for the delivery of non-core services are in fact a notifiable State aid.

Availability of manpower and skills: It is to be anticipated that private operators will provide employment opportunities to some HSE staff currently on zero hours contracts for service. With current rates of unemployment sourcing new staff will not be a problem. All providers will have to invest in continuous staff training. The one potential bottleneck is the required vetting of care staff by An Garda Síochána as demand for care services increases.

Timing: The revised HCP scheme could be procured by way of an extension to the current framework agreement tender that is due to expire in July 2013. The provision of home help services provided by Section 39 organisations could be added to the scope of the tender. In other words, the full outsourcing of the HCP and Section 39 supported home help services could become operational by end-year.

Administrative and managerial ability: As the proposed services already exist both public and private providers have administrative and managerial resources in place. Private providers would have to recruit to cope with the proposed levels of new demand. In the current economic climate finding skilled managers will not be a significant issue. The HSE's administrative and managerial resources could be re-deployed as the private sector takes greater direct responsibility for more patients. It is a matter for the HSE to determine the most appropriate overhead needed to manage and monitor a phased outsourcing of all home care provision.

Social: The main issue here is the need of those in care. As has been evidenced above, what is proposed is entirely consistent with patients' wishes i.e. to remain at home for as long as possible while in receipt of high quality care.

Cooperation required from other interests: This proposition falls to be addressed under the relevant provisions of the Croke Park Agreement. It is therefore recommended that a Task Force comprising the HCCI, the HSE, and the Departments of Health and Public Enterprise representatives be set up and given a mandate to discuss this submission with a view to making recommendations

about the optimal path towards an outsourcing model. These findings should then inform the HSE's procurement strategy and the publication by mid-2013 of a tender for home help services and HCP.

General policy considerations: What is proposed is entirely consistent with the Government's public sector reform plan; with Government policy on home care provision and care of older people; with the emerging findings on the reform of the Fair Deal scheme; and with the health service action plan (2012) under the Croke Park Agreement.

Assessment of options

Against the background of available evidence, benchmarks and trends in the delivery of home care services, a SWOT assessment was conducted with the following outcome.

Table 9 SWOT Analysis of Outsourcing the HCP

Strengths (of outsourcing)

- **Standards in place**
- **Single assessment of need**
- **Future demand predictable**
- **Outsourcing model works**
- **Positive VfM proposition**
- **Consistent with community care delivery model**
- **Can be delivered within a year**
- **More competition will drive costs down**
- **Sharp reduction in HSE overhead**
- **Needed ahead of rising demand for home care services**
- **Choice of local provider**
- **Standards improve through competition**

Weaknesses (of outsourcing)

- **Expenditure cap needed**
- **Capacity of private providers to deliver increased level of service**
- **Standards not supported by legislation**
- **Bad practices and mismanagement may continue**
- **No guarantee of patient choice**
- **Scalability within time frame envisaged**
- **No cost transparency between providers**
- **No policy framework for home care in place**
- **Section 39 organisations will suffer if they lose business**
- **HSE not resourced to manage outsourced services**
- **Knock-on effects in relation to Fair Deal providers needs to be assessed**

Opportunities (with outsourcing)

- **Learn from outsourcing experiences in other countries**
- **30% of those in Fair Deal could benefit from enhanced HCP**
- **98,450 will require home care by 2021**
- **HCCI manage and operate call centre**
- **€370m+ in savings pa by 2021 (if**

Threats (to outsourcing proposition)

- **Trade union opposition**
- **HSE and voluntary organisations not geared to apply higher standards**
- **Voluntary organisations not competitive**
- **Outsourcing in the healthcare sector not fully tested in Ireland**

full outsourcing)
- **Providing options to patients**
- **Fair Deal budget savings**
- **Address Oireachtas concerns**
- **Better cost transparency**
- **Use technology to drive efficiencies e.g. electronic monitoring**
- **Low cost of switching providers**
- **Lower Section 39 subsidies**
- **Private sector can expand services**
- **Stakeholders will need convincing**
- **Nursing home providers opposition to reduced Fair Deal budget**
- **Carers (161,000) may feel threatened**
- **Too many providers**

The key messages from the SWOT are as follows:

1. **There are solid reasons on grounds of cost efficiency and operational effectiveness to outsource the entire HCP scheme.**
2. **Such an initiative would require the auditing of current (robust) quality standards driven by competition for home care professionals.**
3. **Additional efficiencies could result if the HSE had an integrated multi-annual budget for the provision of community based services to older people (and the disabled).**
4. **The HCP's remit would be expanded to include some of the nursing and medical services provided currently by public health nurses.**
5. **Competition through competitive tendering should become the norm.**
6. **HCP and indeed home help services generally is not a core HSE service.**
7. **In the detailed design of a scheme for an expanded HCP service by way of an outsourcing opportunity, the weaknesses and threats identified will need to be considered in detail.**

Several options are considered hereunder before a preferred option is recommended.

They are, in summary, as follows.

Option 1: Business as usual

Option 2: Full outsourcing of both the home help service and the HCP scheme

Option 3: Partial outsourcing of the home help service and the HCP scheme

Option 4: Full outsourcing of the HCP scheme

Option 5: Tender all home help services provided by Section 39 organisations

Option 6: Outsourcing of the HCP scheme and home help services provided by Section 39 organisations

Option 1: Business as Usual (BAU)

Advantages

- **Clients are generally satisfied with the services provided.**
- **The status quo would protect the State's funding of the Section 39 sector.**
- **Legislative under-pinning of the required standards will not be ready until 2016.**
- **The trade unions would raise serious objections at a time when the Government is trying to secure additional reforms in the healthcare sector through the Croke Park agreement.**

Disadvantages

- **The proven savings identified (at least €117m (2014)) would not materialise.[93]**
- **The many incidents of mismanagement and poor quality service delivery would increase.**
- **HSE would not be able to re-deploy its personnel to core frontline services.**
- **The reform of home care delivery would be postponed at a time when demographic trends point to a rising demand for home care services.**

Option 2: **Full outsourcing of both the home help service and the HCP scheme**

Advantages

- **By achieving significant economies of scale the level of the potential saving could be much higher than a partial outsourcing approach.**
- **The private service operators have the capacity and ability to deliver such a service while meeting and indeed in some cases exceeding the draft HSE standards.**
- **A full outsourcing, including the provision of a single care needs assessment, would provide patients with a genuine choice from a panel of approved service providers.**
- **There would be a significant saving in HSE overhead and staffing costs.**
- **Would encourage a cadre of professional home care providers.**
- **Section 39 funding would fall as not-for-**

Disadvantages

- **The transition to such a reforming solution would take time and might confuse older people during this period.**
- **Trade union opposition.**
- **HSE opposition as the non-core services they control and provide would be transferred outside the public sector.**
- **Possible TUPE implications.**
- **A common call centre for all service providers would have to be in place (following a tender competition).**

[93] op cit. PA Consulting (2009).

profit organisations would have to operate on a commercial basis (to the extent that these voluntary organisations become approved providers).

- **All approved service providers would have to comply with the HSE/HIQA standards for professional care providers.**

Option 3: **Partial outsourcing of the home help service and the HCP scheme**

(Additional) Advantages to Option 2

- **A more manageable bundle of services would be tendered.**
- **Potential savings but they would be less than in option 4.**
- **Less disruption to older people.**
- **A phased approach could result in less criticism from public sector unions.**

Disadvantages

- **The same level of trade union and HSE opposition would be voiced even if a more limited volume of services was tendered.**
- **It might not be necessary to have a call centre if a lower volume of business was outsourced.**
- **The current enhanced HCP is, in effect, a partial outsourcing.**
- **The level of potential savings would be much reduced.**

Option 4: **Full outsourcing of the HCP scheme**

Advantages

- **A clearly defined service offering using the template of the enhanced home care package programme would be provided.**
- **The estimated saving in terms of service delivery compared to current costs.**
- **Additional savings in Section 39 funding could arise.**
- **The HSE would save in operational costs and some staff (other than those needed for quality control and**

Disadvantages

- **Private sector providers may not have the capacity to deliver a significant increase in service provision from the get go.**
- **Opposition from trade unions, the HSE and voluntary groups at a time when significant and further reform of healthcare sector is under negotiation.**
- **It would be best to postpone a full outsourcing until the potential of proving an enhanced HCP to clients not**

performance monitoring) could be transferred to core front line duties.

- **Service provision would be by way of a competitive tender thereby facilitating the determination of a budget to support the level of service deemed by the HSE as being necessary.**
- **All approved service providers would have to comply with the HSE/HIQA standards for professional care providers.**
- **The current private and voluntary providers have the capacity to deliver.**
- **If implemented successfully, it would be easier to include home help services at a later date.**
- **Private operators have flexible arrangements and longer working hours than their public sector counterparts.**
- **A cadre of professional providers capable of expanding current service offering.**

availing of the Fair Deal (following its review) became clearer.

- **It would be best to postpone a full outsourcing until a full VfM review of the grant, allowance and tax credits driving demand was completed.**
- **Elderly patients in particular do not like change.**
- **Possible TUPE implications.**

Option 5: Tendering of home help services provided by Section 39 organisations

Advantages

- **Cost savings as service provision will reflect the actual cost of delivery.**
- **Elimination of Section 39 funding and commensurate cost savings.**
- **Approved Section 39 suppliers would be required to adopt higher quality standards and to meet more robust delivery requirements.**
- **Improved transparency.**
- **Reduced incidences of fraud and mismanagement.**
- **Efficient (and approved) Section 39 organisations would continue to provide home help services.**

Disadvantages

- **Disruption of services to some patients.**
- **Lack of continuity of services to some patients.**
- **The Section 39 organisations are not equipped to submit competitive tenders.**
- **Disruption to other services provided.**
- **All home help services should be outsourced with the Section 39 organisations allowed to tender for services provided by the HSE (some 70 per cent of total service provision).**

Option 6: Outsourcing of the HCP scheme and home help services provided by Section 39 organisations

Additional Advantages (over Options 5 and 6)	Disadvantages
• **Accelerates reform of the home care sector.** • **Better economies of scale.** • **Reduces level of HSE subsidy** • **Make Section 39 organisations more commercial.** • **Incentives private providers to become more innovative.**	• **One step too far at this point in time.** • **This is the core business of Section 39 organisations.** • **Section 39 organisations need more time to adapt.** • **Could disrupt other elements of Section 39 organisation service delivery.**

Preferred Option

A robust assessment of the six options suggests that the outsourcing of the HCP scheme and home help services provided by Section 39 organisations (Option 6) by way of competitive tender would be a cost effective and achievable solution and one that could be implemented within six months i.e. taking account of the recommended procurement strategy (see below).

Once this tender is awarded, the provision of all home care provision directly provided by the HSE should be outsourced on a phased basis with the HSE servicing some 10,000 patients by 2021. This tender should be followed in Q1/2014 by a further tender for the provision of enhanced home care packages to low to medium dependent people who would otherwise avail of the Fair Deal arrangement.

Pilot implementation

As the delivery of an enhanced HCP scheme is being implemented following the 2012 tender competition, both the HSE and service providers have tested the robustness of the scheme's requirements and specifications.

While adjustments will need to be made in the light of operational experience, such as increasing the number of approved providers, such amendments are not of a fundamental nature.

Therefore there are no strong arguments to support the proposition that the proposed outsourcing of the HCP scheme should be conducted on a pilot basis in the first instance.

Risk assessment of preferred option

Risk management is a structured approach to identifying, assessing and controlling risks that emerge during the course of a project life cycle. Its purpose is to support better decision-making through understanding the risks inherent in a proposal and their likely impact. Effective risk management

helps the achievement of wider aims such as effective change management, the efficient use of resources, better project management, and supporting innovation.

A risk register, or risk log, is a useful tool to identify, quantify and value the extent of risk and uncertainty as well as the bearer of the risk.

The risk register as follows, would need to be discussed in more detail with stakeholders and all mitigation measures assessed prior to the publication of the tender's technical specifications.[94]

Table 10 Risk Register – HCP Outsourcing

Category	Nature of the risk	Expected impact	Proposed mitigation measures
High	Economic risk	The budget for HCP is subject to annual fluctuations	A four-year budgetary commitment is provided
	Legislative risk	Poor response to tender if quality standards not underpinned by legislation	Enact legislation in due course. Audit existing quality standards as an interim measure
	Buy-in risk	Suppliers will be reluctant to commit resources unless the buyer (HSE) supports outsourcing	Both HSE and HIQA declare their support for the proposed outsourcing model
Medium	Solution design	The design cannot deliver the services at the required performance or quality standards	Introduction of a more robust SLA
	Availability risk	The quantum of the service provided is less than that required	HSE set volume targets for each region
Low	Demand risk	Demand for the service does not match the levels planned	HSE allocates the volume of approved HCP packages across the five regions
	Business risk	The service providers cannot deliver	If key performance indicators are not met, suppliers will be removed from the panel of approved suppliers
	Operational risk	Operating costs vary from those budgeted, that standards slip, or that the service cannot be provided	RFT requires all bidders to breakdown their proposed costs
	Reputation risk	Undermining of client/media perception of service provider if requirements not delivered	Close supervision by HSE of all suppliers
	Policy risk	The delivery model is changed or the period of the framework agreement shortened	The RFT should clearly explain what issues may be the subject to a critical review

Source: HCCI and EPS Consulting (2012)

Some risks could be mitigated by inclusive and extensive consultation with stakeholders.

Other risks could be transferred to service providers via SLAs.

[94] A template could be based on HM Treasury's *The Green Book*, Annex 4, (2011).

All risks should be discussed with potential service providers before a RFT is published.

Description of proposed services

The services to be covered by the HCP scheme and home help services should be clarified in the technical specifications of the RFT.

It is acknowledged that the preferred option will require further refinement before a final solution is determined.

To this end, the starting point should be an extension of ongoing dialogue between HCCI and the HSE about their plans to issue a new Request for Tenders (**RFT**) for enhanced home care packages.

Unlike many other outsourcing opportunities, HCP delivery is already governed by contract on foot of a recent tender competition. Thus many of the essential elements of the HCP are already in place.

Table 11 Comparison between current and proposed service delivery

Current	Proposed
Covers enhanced HCP only where HSE unable to offer service	HSE does not provide HCP
Only covers services over five hours	All HCP service hours covered
Strict quality control	Same
Delivered via SLAs monitored by HSE	Same
LHO determines choice	User selects provider from a panel
Budget capped	Same
No central point of information	New web site will be set up
Delegated customer care service	All providers contribute to call centre
HSE determines user's budgets	Users decide what is best (with option to top up)
No output nor performance indicators	These will be included in SLAs
Voluntary approach to training	Industry standards will be set
Public health nurse decides on timing	Empower users to choose the timing of their care
Only Section 39 organisations provide home help services	Market opened to approved suppliers
HSE provides home help service	Same

Benefits

The benefits of the proposed outsourcing, which have been elaborated earlier, are, in summary, as follows.

1. The improvement in the quality of service provision.
2. Cost savings as private sector provision is some 30 per cent cheaper and more cost effective.
3. The HSE would have the ability to re-deploy personnel to focus on core value-added activities by allowing the private sector to deliver the non-core services which it currently provides.
4. Greater flexibility in meeting forecast demand as more elderly people require home care services.
5. Access to specific skills and technology which the HSE does not have.
6. The delivery of the highest quality standards that are both audited and monitored.
7. More effective budget management through predictable costs.
8. Access to innovation and best practice given providers' experience of home care delivery in other jurisdictions.
9. Patient choice and better outcomes.
10. The best possible costs as all services will be procured by way of competitive tender.
11. The option of changing provider if KPIs set in SLA are not met.
12. Limited implementation costs as the approved service providers will meet these expenses.

PART 5

Economic and Financial Appraisal

VfM is achieved when one is doing the right thing (i.e. achieving the right objectives) and doing it right (i.e. spending public money as efficiently as possible)

Introduction

This section provides empirical data and evidence to inform the Department of Health's business case assessment of the issues set out in this submission.

Thus for example it is important to get a sense of the current level of beneficiaries and to have to hand the latest forecasts of future demand for home care. The most recent Census figures provide compelling evidence of growing demand as the population ages.

A critical assumption under-pinning this submission is that the cost of public sector and Section 39 provision is too high in comparison with private providers' costs.

With high forecast demand through to 2021 and a potential switch of resources from the Fair Deal to the HCP budget, a preliminary assessment is made of the indicative levels of potential savings. The precise level of savings depends on the quantum of service outsourced and the mix of private and Section 39 provision; thus sensitivity analysis will need to be carried out to determine the cost savings under various scenarios.

Further work will also need to be done by the Department of Health as there no data to hand about the employment levels, training needs and numbers involved in the provision of home help services and HCP by the HSE and the Section 39 organisations. Given market conditions, private operators will be able to increase their capacity. The only unknown is the numbers of contract workers employed by the HSE and the Section 39 organisations who may wish to get more secured employment from approved private service providers.

The Market

Some 75 per cent of older people are self-sufficient and nearly two-thirds have no functional disability. Of those who need help 6 per cent reported major difficulties and a further 8 per cent have severe impairment in their ability to undertake daily living tasks.[95]

The degree of overlap between home help and HCP beneficiaries is not known.[96]

[95] Barry, U., *Elderly Care in Ireland – Provisions and Providers*, UCD School of Social Justice Working Papers Series, April 2010.

Some 220,000 people benefit from the Government's policy to support older people and disabled to remain at home as the following table illustrates.

Table 12 Number of Beneficiaries

Programme	Cost	Beneficiaries
Home care services	€195m	48,000
HCP	€130m	10,942
Tax Credits	€71m	77,500
Carers' and other allowances	€762m	76,701
Fair Deal (third)	€332m	7,600
Total	€1.49 billion	220,743

Source: EPS Consulting based on Government statistics

There is obviously an element of double counting as, for example, those receiving the home carers tax credit may get other supports.

It is not suggested that these budgets be touched. These figures are provided to complete the picture.

Some 3.5% of those aged over 50 are cared for by State-provided home help services.[97]

Some 70% of all home help services are provided directly by HSE staff.

The average age of an HCP beneficiary is 83.

Overall, there has been a significant increase in the number of older people in receipt of formal home care in Ireland, from almost 16,000 in 2000 to the current figure (2012) of over 59,000. [98]

Private provider's share of the HCP market is around 10 per cent and the Section 39 organisations account for some 28 per cent. In general, private providers offer a greater range of home care services than the HSE, including for example companionship, recreational activities and 24 hour emergency assistance.

Future Demand

As the following table demonstrates, and as a broad indicator of potential demand, persons over 75 have a high probability of needing home care services.

[96] op cit. CARDI (page 48, footnote to table 5.15). PA Consulting (2009) estimated that some 3,081 HCP recipients receive home help services as part of their HCP package.
[97] Houses of the Oireachtas, *Report on the Rights of Older People*, March 2012.
[98] Timonen, V., Doyle, M. & O'Dwyer, C. (2012), 'Expanded, but not regulated: ambiguity in home-care policy in Ireland', *Health and Social Care in the Community,* 20(3): 310–18.

Table 13 Lifetime Risk of Requiring Aged Care

Remaining lifetime risk of requiring care (%)	At age 65	At age 75	At age 85
At age 95	68	72	80	83
Males	48	53	62	67

Source: Caring for Older Australians (2011)

Census 2011 showed that there were 535,393 people aged 65 and older in Ireland, accounting for 12 per cent of the population. People aged 80 and over made up 24 per cent of those aged over 65, with more women than men in these older age groups; a cohort of some 128,494.[99] Population aging in Ireland is expected to advance more rapidly in the years to 2021, with a 69 per cent increase in population aged 65 and older forecast and an 82 per cent increase in population aged 80 and over. According to Eurostat, based on Census 2011, those over 65 will represent 22 per cent of the population by 2060. Furthermore, those over 80 are forecast to rise from 2.8 per cent of the population to 9 per cent by 2060. Formal home care recipients are forecasted by CARDI at between 8.2 per cent and 9.7 per cent of people aged 65 and over by 2021. Informal home care recipients with difficulty with activities of daily living who receive daily or all day informal care are projected to be 8.1 per cent of the population aged 65 and over by 2021. [100]

In summary, **compared to 2006, there will be 148,608 more people over 75 in Ireland by 2021 with the population in this cohort numbering 353,986. The number of people who will be over 65 by 2021 will be some 792,067. The increase over the fifteen years from 2006 to 2012 is 319,141; a 40 per cent increase.[101] There will be some 1.3 million people over 65 by 2045; an increase of 142 per cent on 2011 Census figures. [102] Projections for older peoples' dependency rate reveal a sharp rise of over eight percentage points from 16.1 per cent in 2006 to 24.5 per cent in 2021.**[103]

Applying the current take-up rate of 8.8 per cent (see table 14) for older people and a provision of 6,000 places for disabled people, an assumption could be made that 75,000 people may seek to avail of home help by 2021 (up from a current (2012) rate of 48,000) and that 14,250 HCPs may be required; up from 10,870 units of care currently.

Table 14 Projected Demand for Home Care Services

	Forecast 2013	Forecast 2021
Home help	50,000	75,000
of which, 65+	44,000	69,700

[99] Government of Ireland (2012), *Census 2011: Profile 2 - Older and Younger*, Dublin: Stationery Office.
[100] op cit CARDI.
[101] Morgenroth, E. 2009. *The Impact of Demographic Change on Demand for and Delivery of Health Services in Ireland 2006-2021.* Report 2: Demographic Projections for the period until 2021, Dublin. Economic and Social Research Institute, Table 5.3. The base year of 2006 was chosen because of the availability of detailed demographic, disability and utilisation data for that year.
[102] *Health in Ireland: Key Trends 2012,* Department of Health, December 2012.
[103] op cit. Barry.

HCP	10,870	14,250
of which, 65+	10,200	13,400
Fair Deal	7,600	9,200
TOTAL	68,470	98,450

Source: EPS Consulting based on CARDI forecasts (2012)

This suggests that almost 100,000 people may need home help and home care services within nine years: a substantial increase in the quantum of current delivery levels.

These projections exclude persons with medium to high dependencies in other care schemes such as Fair Deal where a significant additional requirement has been estimated. [104] A forthcoming report from Nursing Homes Ireland (**NHI**) will point out that, like home care provision, demand for long-term care will rise dramatically over the next ten to fifteen years and the Exchequer does not have the resources for direct provision of services nor is the HSE is equipped to meet the projected huge growth in demand. The NHI solution is for more private sector and Section 39 provision. [105]

CARDI concluded that population growth and ageing will present challenges to policy-makers, notwithstanding evidence of declines in disability rates and forecast reductions in age-specific need for care. There will be requirements for substantial increases in the provision of long-term care in every setting, according to CARDI's analysis. Whether the current model of (and reliance on) informal care is sustainable with such a large cohort over 75 a few years hence needs to be tested.

Another major unknown at this stage is the number of patients currently receiving care in acute hospitals and those in the Fair Deal who could be transferred to enhanced home care packages. If, for example, 15% of care was shifted from acute to community care this would be the equivalent of 250,000 patient episodes by 2020. [106]

Keeping someone in a public hospital about €900/day (HSE, 2011); private home care costs range from €21/day to €63/day depending on dependency.[107]

[104] The CARDI forecast numbers using formal community long-term home care are between 69,161 and 77,164 in 2021; in one scenario an absolute increase of 27,985 people (Table 8.7). The scenarios are based on assumptions about declining disability levels. The international literature supports a view of the development of long-term care need and demand as multi-factorial encompassing age, disability, socio-economic status etc. CARDI's approach to forecasting is based on demographic change and forecast disability rates.

[105] Getting the fairest deal, *Sunday Business Post*, 25 November 2012.

[106] op cit. PA Consulting Group (2009). Their review of hospital beds found that some 14% of patients in hospital could have been receiving home care services.

[107] HCCI analysis, January 2013.

Costs

In 2011, the HSE spent €211m on home help services and €138m on the HCP: €349m in total. The overall budget for 2013 is €392m.[108]

Almost 12 million home help hours were provided to some 54,000 clients i.e. an average of 222 hours a year: 4.27 hours a week. The average cost of providing these services per capita – excluding overhead provision - was €3,907 or €17.60/hour. The HSE target provision for home help service provision in 2013 is 10.3 million hours.

In addition, some 14,600 benefitted from home care packages at an average annual cost of €9,452. [109] The HSE's target provision for HCP in 2013 is 10,870 clients.

The overall budget is divided between service providers as follows.

Table 15 Cost of Home Care Services (€) (2011)

HSE	€244m
Section 39	€58m
Private providers	€33m
Total	€325m

Source: HCCI (2012)

But this is not the full picture as the Exchequer also spends resources on older people (low and medium dependency) and carers under other budget lines.

Table 16 Summary of costs for home care and similar schemes (2011-2012)

Service	Cost	Recipients	Cost per Recipient
Home help services	€195m (2012)	50,000	€3,900
HCP	€130m (2012)	10,870	€11,959
Carers' allowances/benefits	€762m (2011)	51,666	€14,748
Carers' tax credits	€71m (2009)	79,000	€898
Fair Deal (34% of provision)	€277m (2011)	7,600	€36,447

Source: EPS Consulting (2012)

The cost of service delivery is an issue critical to the argument as to what services to outsource.

To get an accurate figure of the total cost of HSE and Section 39 delivery, all payroll costs (PRSI/USC/pension provision etc.) and a provision for overhead (typically 25 to 30 per cent) should

[108] HSE, *Health Service Executive Service Plan 2013*.
[109] Statement on Enhanced Home Care Services in 2011, HSE, 4 May 2011.

also be added; but these figures are not available for HSE and Section 39 organisations. As some private operators have been asked to take over the operations of Section 39 organisations, the real cost of service provision has been revealed and is well in excess of the forecast data provided by PA Consulting in their 2009 analysis even allowing for salary adjustments in the meantime.

D/PER's business case model requires Departments in assessing outsourcing opportunities to include a loading for public sector pensions based on the 2009 report from the Comptroller and Auditor General so that the internal costs better reflect their true costs.

As services are provided on an hourly rate, the following table sets out the current prevailing rates for the delivery of home help services and HCPs.

Table 17 Cost of Delivery – Hourly Rates

Service	Cost per Hour
Home care services (HSE/Section 39)	€29.44
HCP (HSE)	€29.44
HCP (Section 39)	€29.44
HCP private	€21

Source: HCCI (2013) and PA Consulting Group (2009)

The average cost per hour (2012) for private sector providers was confirmed by the HCCI and is based on the cost of providing enhanced HCP under the current programme. In determining fees, private operators factor in all costs, including overhead, depreciation and a profit margin.

The price per hour for HSE home help services is not readily available and there is no transparency about costs. Therefore the derived cost used in an earlier submission to the HSE has been used. This assumed a 25% provision for overhead, which taking account of atypical costs for UK publicly provided home care is a conservative estimate.[110] The difference between HSE and HCCI member hourly rates is comparable to the difference is salary costs between HSE and HCCI employed personnel. In addition, feedback from HCCI members confirmed that the current HSE hourly rate is broadly accurate.

Again based on current rates under the enhanced HCP programme, HCCI confirmed that the average price per hour charged by Section 39 providers is the same as that for HSE workers. While both HSE and comparable Section 39 personnel share common pay scales and grades, these organisations only charge HSE for direct staff costs. As they benefit from (HSE) Section 39 funding, it is assumed they do not charge back overhead and other costs that the HSE has grant aided. Thus as a working assumption voluntary and HSE home care costs are deemed to be the same. A further complication

[110] *Analysis of Irish Home Care Market*, a report for the Irish Private Home Care Association, PA Consulting Group, February 2009.

is that in some instances patients availing of Section 39 home help services pay their carers a contribution in addition to the quoted hourly rate. [111]

In summary, current data suggests that the **hourly rate charged by the HSE and non-profits are 30 per cent more expensive than the private sector.**

In the UK, local authorities pay an average of £15 per hour for independent sector home help, with a range between £8 and £31. The average cost per adult aged 18 and over supported in residential care nursing care or intensively in their own home was £623 in 2010-2011. The average cost of home care per person per week for all adults is £204.[112]

Also for comparison purposes, it is instructive to compare the current cost of home care services with nursing home support schemes. Delivery at a location in County Kildare is taken as an illustration of typical costs. In presenting the figure for HCPs an intensive package of 21 hours per week is assumed as patients in Fair Deal typically get some 3.1 direct contact hours per day. While the vast majority of HCPs packages fall below this threshold this figure is used to demonstrate the cost effectiveness of home care over an institutional alternative for a person with limited disabilities or incapacity.

Table 18 Comparison of Home Care and Nursing Home Support (2012)

Service	Cost per week	Cost per annum
HCPs provided by HSE (21 hours)	€618	€32,136
HCPs (21 hours) provided by private companies	€441	€22,932
Nursing home support scheme – public	€430 to €2,518	€22,360 to €130,936
Nursing home support scheme – private	€650 to €1,300	€33,800 to €67,600

Source: HSE (2011, 2012) and HCCI (2012)

The cost of a privately provided enhanced HCP is 45 per cent of the cost of the provision of low to medium dependency care under the Fair Deal in a private bed (average price of €975 per week) and just 30 per cent of equivalent care in a NHSS public bed in a nursing home (average price of €1,474). Using other assumptions, higher HCP hours (30 per week) for example, still demonstrate the compelling argument that HCP provision by private operators can be delivered at a substantially lower cost. In relation to home help and HCP provision, an estimate is made hereunder about the savings arising by 2021.

[111] Reply to a Parliamentary Question by the Minister for Social Protection, 21 August 2009. Minister Burton confirmed that voluntary contributions are sought towards service provision ranging from €10-€20 per month, €5 per hour or 50 per cent towards the service providers' travel costs.
[112] *Personal Social Services: Expenditure and Unit Costs – England 2010-2011*, NHS, The Information Centre, March 2012.

Table 19 Potential Savings in 2014 and 2021

	Projected Savings in 2014	Forecast Demand 2021	Projected Cost with Outsourcing	Projected Savings in 2021
Home help – HSE	0	10,000	€39m	0
Home Help - Successful Providers	€18m	65,000	€178m	€76m
HCP - Successful Providers	€30m	14,250	€131m	€41m
Fair Deal - Assigned to Successful Providers	€69m	9,200	€211m	€256m
Total	€117m	98,450	€559m	€373m

Source: EPS Consulting estimates based on CARDI population forecasts (2012)

In addition to these savings, in switching more services to private operators, these providers will pay additional taxes, duties and charges to the Exchequer. A quantification of this contribution is not possible to calculate until the quantum of outsourcing is determined and the mix of service providers is known.

Furthermore these calculations do not take into account potential productivity improvements and other efficiency gains.

Sensitivity Analysis

Assuming that the hourly rates charged by the HSE and Section 39 organisations are 15 per cent and not 30 per cent more expensive than the private sector significant savings result as the following table demonstrates.

Table 20 Sensitivity Analysis (using 15% cost differential) Home Care/HCP

	Forecast Demand 2014	Current Cost	Projected Savings 2014	Forecast Demand 2021	Projected Cost with outsourcing	Projected Savings 2021
Home help – HSE and Section 39	50,000	€195m	€9m	10,000	€39m	
Home help - private				65,000	€178	€38m
HCP – private and Section 39	10,870	€130m	€15m	14,250	€131m	€20.5m
Total	60,870	€325m	€24m	89,250	€348m	€58.5m

Source: EPS Consulting estimates based on CARDI population forecasts (2012)

If only persons in the Fair Deal scheme with low dependency (some 12.8 per cent of total patients) were able to avail of an enhanced home care package significant savings would still arise as the following table demonstrates.

Table 21 Sensitivity Analysis (low dependency only) Fair Deal Private Bed

Forecast Demand 2014	Current Cost	Projected Savings 2014	Forecast Demand 2021	Projected Cost BAU 2021	Projected Savings with HCP Provision 2021
970	€47m	€26m	3,925	€199m	€109m

Source: EPS Consulting estimates based on CARDI population forecasts (2012)

Obviously different results would emerge if different assumptions were made about the numbers of people covered by the outsourced services. However, the underlying reality is that home care provision by professional private operators is less expensive than direct HSE/Section 39 provision and when comparing an enhanced home package against residential care the former option will always be less expensive even if the level of care was raised to 30 hours a week.

Using these figures and the data from table 19 the potential savings over the period to 2021 is as follows.

Table 22 Potential Savings Over the Period to 2021 (€m)

	2014	2015	2016	2017	2018	2019	2020	2021	
Home Help	18	30	50	60	76	76	76	76	
HCP	30	32	34	35	36	38	39	41	
Fair Deal	69	138	207	219	231	243	256	256	
Total	117	200	291	314	343	357	371	373	1,993

Source: EPS Consulting

A sensitivity analysis, adding assumptions about wage inflation and volumes, would produce different bottom line outcomes. However, in all cases private care provision is less expensive and generates savings against a business as usual scenario.

Employment

The HSE employs some 9,752 persons in its older people care group. [113] It is not known how many are involved in the delivery of home help and HCP packages, or how many are employed on contracts of service. Some 517 staff have managerial and administrative roles. Similar statistics for the Section 39 organisations are not available.

In the scenario whereby the delivery of the HCP scheme and home care services provided by Section 39 organisations are open to competition, and that private providers secure the vast majority of the work, it is anticipated that a significant number of HSE and Section 39 employees delivering home help services will be available for other duties. As the HCP is not a core service, the HSE and the Section 39 organisations will have the option of re-deploying employees into frontline and core services where the recruitment moratorium is impacting on service. Not knowing the age profile of these employees it is not possible to make an exact forecast.

Due to the lack of transparency, it is not possible to estimate the numbers of HSE senior staff that will be needed to monitor and keep under review the SLAs to be concluded with approved private operators. If 50 per cent of the combined home help/HCP service is outsourced to 25 approved providers for example, it is almost certain that the HSE will be able to make significant savings to its head count.

Private operators will no doubt use HSE contract staff so many may secure a future within the home care sector. In addition, private operators will have to recruit additional administrative and managerial staff.

While the HSE's temptation may be to re-deploy staff, it should be born in mind that the demand for the HCP scheme is projected at some 7 per cent per annum over the medium term. Therefore in assessing the employment implications of the proposed outsourcing of the HCP scheme, due regard should be had for the increasing demand for basic home help services in the near term.

Providing evidence about the provision of basic training (to FETAC Level 5) and continuous personal development should be a pre-condition for any approved service provider.

A final consideration is that in the light of projected growth in demand for care and social services, it is critical that Ireland's skills base of health care professionals is developed and that companies who comply with the highest standards of care are given the opportunity to grow their business and as a consequence make caring a positive career choice for many more people.

Affordability

The current arrangement is that a public health nurse approves a number of hours. The user is then informed about the people who will provide the services in question. The user does not pay for care up to five hours a week or indeed for an approved enhanced home care package.

It is not envisaged that this arrangement will change. Therefore the issue of affordability does not arise.

[113] HSE, *National Service Plan 2013.*

In other jurisdictions there is a move to a situation, akin to the Fair Deal, that users pay for a (small) portion of their care from income such as their pension. In the UK the view is as well as living longer older people are also more affluent due to both housing equity and to the growth in occupational pensions. Affluence influences life expectancy and hence, all other things being equal, a greater pool of people with care needs and greater relative affluence means that older people are likely to become funders of their own care. Some 31 per cent of people receiving publicly funded care or support also made additional private purchases of care, with a further 7 per cent having additional care purchased by their families.[114]

An alternative approach is that the hourly requirement be converted into a defined contribution; using the 2012 tender as a basis, ten approved hours would generate a purchasing power of €210. The user would then, relying on the principle of choice, be able to get quotations from the approved providers in their locality.

An additional advantage is that the needs of users change often within a very short period. Having the flexibility of a voucher-type arrangement would give them the flexibility of changing provider or getting multiple providers to deliver a more focused set of personal care needs for instance.

Fixed Cash Limits

The proposed outsourcing would be based on the determination of a multi-annual budget for all home care services i.e. both home help and HCP. So while this is a demand led scheme it is envisaged that there would be a budget cap within which the HSE and service providers would operate.

Sources of Funding

As currently, the HSE would provide the funding. However, Section 39 support for HCP services would be withdrawn from Section 39 organisations. Should these organisations become approved service providers, following a tender competition, they would be compensated in the same manner as private sector providers and paid after the delivery of services (and not in advance as is the case currently).

Quality

A review of a range of quality improvement initiatives in the health services found that few studies actually included all relevant costs, meaning that evidence available to assess the costs of quality management was weak. There is strong evidence that quality improvement changes will improve outcomes for patients, but savings depend on the type of improvement, on who pays for the cost of poor quality, and the intervention cost of the solution.[115]

Conclusions

The most obvious benefit arising from the proposed outsourcing model is that the quality of care will be more consistent, more measurable and more amenable to continuous improvement.

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[114] *Domiciliary care market in the UK 2011*, Laing and Buisson, 2011.

[115] Eveborn, P., Ronnqvist, M., Einarsdottir, H., Eklund, M., Liden, K. and Almroth, M. (2009), 'Operations research improves quality and efficiency in home care', *Interfaces,* 39(1): 18–34.

The second benefit is financial in terms of direct Exchequer savings.

The option of the HSE being able to re-deploy staff to front line core services is also an important benefit.

The patients will have a better choice, more potential providers to pick from, and a care package more tailored to their unique needs.

Hidden benefits include the innovation that private providers will bring to care service delivery and with the better use, for example, of technology costs will be kept competitive while maintaining high standards. Another hidden benefit is that with the projected increase in home care provision as the population ages, the private sector providers will be better resourced, better skilled and better equipped to deliver critical (but non-core) home care services.

Demand for healthcare generally due to demographic changes is projected to increase by 60%. [116] Future home care demand is also going to rise in line with this trend. The current policy of shifting resources away from the acute sector to primary care and home care provision has significant implications for the current home care delivery model; basically, the current inefficiencies and high cost of delivery need to be addressed. Outsourcing HCP should therefore be seen as the first phase of a medium-term strategy to provide older people and the disabled with a higher quality level of service.

Despite the lack of transparency of the true cost of home care provision, the Government is spending some €1.58 billion on direct supports and services for home care services and carers. A VfM expenditure review of this quantum of Exchequer resource has not been carried out.

The evidence presented in this submission suggests that a new model of service delivery needs to be considered.

The key findings are as follows:

- **The cost of HSE/Section 39 delivered home help services is 30 per cent more expensive than comparable private sector rates.**
- **If practically all home help and HCP provision was outsourced to private operators the savings could be in the region of €117m per annum.**
- **In addition, huge savings (€256m per annum) could result if 30 per cent of current patients with low to medium dependency benefitting from treatment under the Fair Deal scheme were provided with 21 hours of intensive care at home under an enhanced HCP.**
- **If the current allocation paid by the Department of Social Protection to carers was made available to professional home care providers this could provide upwards of 36 million hours of care annually or 3.6 times more than the current HSE allocation for home care services.**

In compliance with the Public Spending Code it is the responsibility of the Department of Health to complete a full economic and financial appraisal of this proposition and to this end it is hoped that the figures and calculations provided in this section will provide the baseline for a detailed cost-benefit analysis.

[116] *Acute Hospital Bed Capacity Review*, PA Consulting Group, 2007.

PART 6

Implementation Issues

Introduction

It is fortunate that the experience of the enhanced HCP tender competition can inform the most appropriate procurement and implementation strategy.

This section looks at a procurement strategy that is best suited for the outsourcing of the HCP scheme. A framework agreement for four years procured by way of open procedure is recommended.

The current quality control arrangements could be enhanced by the requirement of an annual audit.

While most of the other technical specifications in the RFT for the enhanced HCP need slight adaptation some issues need to be debated further prior to the publication of the RFT.

Evaluation, monitoring and the setting of output and efficiency indicators are all important ingredients of the mix.

In considering implementation one should bear in mind that older people avail of home care services for an average of three to four years; the turnover rate is therefore very high.

Procurement Strategy

The outsourcing will be covered by the EU Procurement Directives, in particular Directive 2004/18/EC. [117] Government guidelines has recommended that a single stage process – the open procedure - should be used in order to provide Irish SMEs with a better prospect of bidding successfully and at a lower cost. [118]

A critical prerequisite is that the HSE's technical specifications are not only clear but are achievable. Thus the precise areas of home care covered by the tender would need to be explained.

Most importantly, as a framework agreement will need to be used, it is essential to clarify that approved providers would be placed on a HSE regional or indeed a national panel for four years provided of course they continued to meet the pre-determined quality standards. A contract of this duration would encourage all providers to invest in continuous improvements in quality.

Best practice is that the HSE should engage in a market consultation phase to gauge market appetite and to probe, for example, the performance management targets that will be included in new Care Provider Service Level Agreements.

The HCCI has submitted feedback to the HSE about the limitations of the enhanced HCP tender and how the proposed tender to replace the current arrangement (from July 2013) might be better structured. Many of the issues, as follows, would also need to be considered when the HCP outsourcing tender is published.

[117] This Directive was implemented in Ireland by way of S.I. No 329 of 2006, European Communities (Award of Public Authorities Contracts) Regulations 2006.
[118] Department of Finance, Circular 10/10, August 2011.

Choice: The HSE has instructed families and its own staff that only the number one ranked approved provider must provide the service. While this matter has been clarified more recently, it illustrates the need to have very clear rules about patient choice not only in the tender specification but by way of a wider awareness campaign, including a dedicated web site (as happens in other jurisdictions). It is a fundamental tenet of an outsourced HCP business model that service users are truly empowered to decide how, when and by whom their care is provided.

Lack of input by service users and families when determining care needs: Contrary to express HSE policy, patients' needs are rarely respected. Nor are users and their families told about the quality standards that approved providers must deliver, complaints procedures, nor about the wider responsibilities of approved providers.

Lack of supervision of service providers due to limited HSE resources: The HSE is not auditing the SLAs it has concluded. If co-funded by the HSE, the HCCI could assume an interim quality assurance role in the period before HIQA assumes this function. Breaches of the HCCI Code of Practice would be published thereby applying peer pressure on all approved suppliers to maintain and indeed exceed the minimum quality standards.

Lack of resources: Some LHOs are experiencing a shortage of qualified professional staff, partly because the HSE has been recommending the use of one approved provider only.

Lack of LHO buy-in: This problem has arisen as local HSE staff were not consulted about how the framework agreement was to work in practice. Approved providers with no local physical presence have had issues with LHOs. Under the outsourcing model LHO's role will be limited to home help services only. Therefore an internal HSE communications strategy should be implemented once the HCP outsourcing tender is published.

Lack of clarity about hours to be tendered: Several LHOs have informed approved providers that they have the capacity to meet all new requirements. In the event that the HCP scheme is outsourced this should no longer be an issue. In fact, the outsourcing business model that is preferred recommends that all providers who meet enhanced quality standards should be admitted to a panel and that this arrangement apply in the HSE's four regions.

Quality assurance: The enhanced HCP tender sent a powerful message that quality improvement was a core requirement. However, as is evidenced by recent cases involving fraud and mismanagement, some Section 39 organisations (as approved suppliers) have not complied with the RFT's requirements as regards quality control. There is an urgent need, in the absence of HIQA engagement until 2016, for external quality assurance audits to be carried out both before contract award and during the period of the contract at six monthly intervals (or more regularly if complaints have been made). The costs of these audits should be met by the HSE.

Given the scale of the outsourcing the HSE would also need to explore whether a single call centre/centralised customer service centre is needed and in the affirmative could this operation be funded by approved service providers, for example in proportion to their share of the overall contract value. For example, this resource would work with users and their families to select an approved provider from the panel in their locality.

In addition, careful consideration needs to be given as to the optimal role for a public health nurse in assessing a patient's short and medium care needs and in the preparation of an approved care plan. There is an argument that if a common template care plan assessment was available that approved providers could carry out these care needs assessment.

Detailed selection criteria should be used to assess companies' ability, capacity, track record and economic and financial standing. Provided the required evidence is submitted and all concerned meet a minimum pass mark (of at least 60 per cent), then the bid submissions would fall to be considered under award criteria.

The award criteria (involving many sub-criteria) should cover the following for example.

Quality	Performance Indicators	Project Management
Price	Value added services	Professional qualifications
Training	Security vetting	Complaints and dispute resolution
Use of ICT	Recruitment	Supervision
Compliance	Physical presence	

As the HSE has conducted a tender competition for enhanced HCPs much of this work could be adapted, with little additional effort, with a view to publishing a tender for the full outsourcing of the HCP scheme.

There are however, several important issues that would require careful consideration before a tender competition was launched. These include how many companies should be included in panels and what geographical areas provide the best 'fit' for client choice. The industry would much prefer that no more than four geographical areas be selected and that all approved service providers who meet the minimum standards be put on a panel.

Quality Control and Assurance

The majority of home care is not yet subject to the (2008) HSE national quality standards. [119]

1. Introduction

One of the key issues with any outsourcing project is the quality of the service to be provided and quality control.

In the context of this submission the absence of enforced quality standards, such as variable practices on the vetting and training of staff, and inconsistent monitoring of services delivered

[119] op cit. NESC report.

across the country creates risks for clients.[120] Being aware of this risk, many providers have secured independent quality accreditation.

This section therefore looks at the issue of quality control in some detail.

2. Quality and Standards – Current Situation [121]

In sharp contrast to residential care, formal home care in Ireland is largely unregulated, although a variety of draft standards to promote quality services do exist. Some of these draft standards are being implemented, by HCCI member companies for instance, but they cover only a small part of overall home care delivery and apply on a voluntary basis.

Draft standards to regulate the quality of care of older people in their homes were first agreed by the HSE in 2008, in partnership with stakeholder groups. Years later, the HSE does not fully implement these standards in relation to the home help and home care packages it provides and contracts for. In 2010, the HSE drafted the *National Guidelines and Procedures for Standardised Implementation of the Home Care Package Scheme*. These procedures do not apply to home help services. The HCCI has adapted this standard and it is being implemented by its 25 member companies.

Some private home care service providers have been accredited with the Q Mark and ISO quality standards. In the HSE's tender (2011) for enhanced home packages there was a requirement on successful bidders to demonstrate quality standards in a range of areas with the aim of increasing the overall quality of management and care in home care packages. No sanctions apply where standards are not met. Nor is there any provision for State resources to help home care providers comply with Government standards. In practice, the quality standards set out in the SLAs covering enhanced home care packages are being enforced in an inconsistent manner.

The Government committed in 2011 to bringing in standards for home care which would be inspected by the Health Information and Quality Authority (**HIQA**). The latest information from industry sources suggests that HIQA does not intend to get involved in home care standards until 2016. The HSE has issues with the cost of ensuring that all existing HSE staff meet the standards' requirements, such as those on training, which not all HSE staff currently meet. There has also been resistance from unions and a lack of consistent engagement from some staff in the HSE.

No details are available about the HSE's costs allocated to this critical quality control function.

The quality of care services for older people in Ireland is rated at just 59% (of 100%) when compared to comparable services at EU-15 level; an average assessment. [122]

The consequences of this lack of action are that older people have less a say in how care is provided and by whom. In addition, there have also been regrettable incidents of clinical and financial

[120] PA Consulting Group (2009), *Analysis of Irish Home Care Market*, Dublin: Irish Private Home Care Association.
[121] op cit. NESC report.
[122] Watson, D., *Quality of Public Services: Irish Public Perceptions and Implications For Renewal*, ESRI Renewal Series, Paper 6, December 2011. The data is dated as it is based on the 2007 European Quality of Life Survey.

mismanagement, poor quality care and negligence within the home help sector where serious breaches of SLAs have been reported.[123]

3. Legal Aspects of Professional Home Care

In addition to these HSE-developed standards, the Law Reform Commission (**LRC**) has made a number of recommendations as to how legislation can be changed to regulate the provision of professional home care. The LRC looked at the lack of regulation of home care in Ireland not just for older people, but for all who need such care. [124] The LRC was particularly concerned that lack of standards and regulations for home care was leading to inconsistencies in terms of quality and delivery, and that people needing home care are a vulnerable group, and so in need of greater protection than currently exists.

The 2009 report noted that there is no clear legislative provision stating that HIQA can set standards for, and carry out, inspections of home care providers. Consultation on this recommendation showed that there was broad consensus that Government should regulate professional home carers. Therefore, the LRC recommended that the relevant section of the Health Act 2007 be amended to allow HIQA to set standards for home care, and to register and monitor all home care providers; and for the Minister for Health to be empowered to make regulations regarding the provision of professional home care services. It was also recommended that the principles underlying the proposed legal framework include independent living (similar to person-centred care); privacy and dignity for the care recipient; and protection from abuse.

In terms of standards, the LRC recommended that HIQA should publish standards specifically tailored to home care, based on the existing *Draft National Quality Guidelines for Home Care Support Services* (which also reflect provisions in the HIQA standards for residential care). According to the Commission, attention should be paid, in particular, to needs assessment, complaints, involvement of the service user, elder abuse, administration of medications, the care contract, health and safety, and the recruitment, training and supervision of staff.

A number of other recommendations focus on the potential employment relationship between a carer and care recipient, and how this can best be handled. For example, it is recommended that a care recipient should have the option to contract with an intermediary to supply care, which would mean that the intermediary takes on the employer responsibilities of hiring a carer, rather than the care recipient. The HSE, or a voluntary body, could act as such an intermediary. Standards should cover the working arrangements with such intermediary bodies.

4. Health (Professional Services Home Care) Bill

This private member's Bill provides for the regulation of professional home care. [125] The Bill, which is not supported by Government, defines home care as: services which are required to ensure that an adult person can continue to live independently in their own home. This may include the services of nurses, home care attendants, home helps, various therapies and personal care and palliative care. It proposes to extend the functions of HIQA to include the setting of standards in relation to services

[123] Freedom of Information Request C141/12.
[124] The LRC has published two papers – a 2009 consultation paper, *Legal Aspects of Carers*, and a final report in 2011, *Legal Aspects of Professional Home Care* (Law Reform Commission, 2009, 2011): 37.
[125] Introduced by Deputy Billy Kelleher, February 2012.

provided by professional home help providers; provides for the setting up of a register; and sets down guiding principles to be applied by HIQA. In addition, the Bill amends section 101 of the Health Act 2007 by extending the powers of the Minister for Health to make regulations in relation to the providers of professional home care services.

5. International Standard on Assurance Engagements (ISAE) 3402

ISAE 3402 reports would appear to be an ongoing requirement for many public organisations (outside Ireland) which outsource activities to third parties. The International Standard on Assurance Engagements (ISAE) Standard Number 3402 was issued in December 2009 by the International Auditing and Assurance Standards Board (IAASB) to provide an international assurance standard for allowing public accountants to issue a report for use by user organisations on the controls at a service organisation that are likely to impact or be a part of the user organisation's system of internal control over financial reporting. [126] In short, ISAE provides a public sector body with an independent audit on the outsourcing supplier's undertakings, typically set out in a Service Level Agreement (**SLA**), and the level of compliance. The inclusion of a 'right to audit' clause in SLAs would allow the HSE to conduct audits on service suppliers in order to obtain assurance over the risks associated with the outsourcing of home care provision.

6. Conclusions

In the view of the NESC, the practice whereby home care services (other than new enhanced packages) are not subject to standards compromises the ability of the existing standards framework to prevent abuse and serious harm in the area of home care. The NESC therefore recommends a legislative under-pinning to these standards and inspections to ensure they are met. The NESC points out that this will become increasingly necessary in the future with more elderly people likely to be cared for at home.[127] Given the support of the Law Reform Commission there is a case to regulate both home help services and HCPs to the highest possible standard. A Government decision to outsource part of this service should give the HSE and HIQA an incentive to proceed with a greater degree of urgency than has been the case to date.

In the meantime, and reflecting practical realities, the HSE should require independent audits of compliance with agreed standards from approved third party inspectors. Users should be empowered to feel ownership of their care and to act as private clients do expecting and indeed demanding a high level of care. State funded users need to be made feel as if they are funding their care needs themselves. This will help to drive quality more than any regulations.

There is an ambition to move beyond the strong budgetary command and control of recent years to a form of delegated accountability. Tailored and accountable services at the front line require a supportive centre that could, for example, ensure quality and safe standards. In addition, home care as well as other social services needs an over-arching narrative that has been missing to date. [128]

[126] www.isae3402.com. ISAE 3402 replaced SAS 70.
[127] op cit NESC.
[128] Concluding remarks by Dr Rory O'Donnell at the NESC conference on quality and standards in human services held on 21 November 2012. The dialogue revealed ideological differences do exist as regards the role of markets, the role of choice, the value of separating regulation and purchase of service.

Governance Arrangements

Many stakeholders will want to ensure that the proposed outsourcing is a success.

The Department of Health as the ultimate source of the funding needs to secure value for money.

The HSE will need evidence that the delivery of a quality service is in line with the Key Performance Indicators set out in SLAs.

The approved service providers will need a forum to voice their concerns should operational issues arise and fall to be settled.

The users and their representatives will also need to provide feedback.

The home care workers will also need to be in the communications loop.

In the circumstances, and given the unique and cutting edge nature of this proposition, it is recommended that a multi-party Monitoring Committee be set up, chaired by an independent academic, with a remit to keep the delivery of the HCP service under review from a strategic perspective leaving operational issues to the HSE.

TUPE

The transfer of undertakings is governed by the European Communities (Protection of Employees' Rights on Transfer of Undertakings) Regulations 2003. The TUPE regulations protect the terms and conditions of employment when transferring from one employer to another. In a TUPE situation the employees of a business which is being transferred must transfer to the new employer with their accrued years of service, their existing terms and conditions of employment, and also with the benefit of any collective agreement.

While in principle TUPE applies to outsourcing, the Regulations do not automatically apply to every outsourcing situation in Ireland, as unlike in the UK, the rules are not as clear cut.

To trigger TUPE, the outsourcing must involve the transfer of an economic entity which retains its identity. In an outsourcing situation, there must be an associated and related transfer of significant tangible and intangible assets or the transfer of the major part of the workforce in terms of numbers or skill. In the absence of a transfer of assets or a major part of the workforce in terms of skills or numbers, which would not necessarily happen following a competitive tendering process, there is no transfer and TUPE will not be triggered. Case law suggests TUPE only applies in a situation where a new contractor accepts a major part of the workforce from the original employer.[129]

One major potential issue is the area of pensions which are not covered by TUPE arrangements.

As framed, TUPE issues will not arise if new service requirements are tendered.

Evaluation Proofing

Evaluation is similar in technique to appraisal although it obviously uses historic (actual or estimated) rather than forecast data and takes place after the event. Its main purpose is to ensure

[129] Briefing note from CollierBroderick, Management Consultants.

that lessons learned are widely communicated and applied when assessing, in this case, a possible extension of the period of the contract.

Despite the size of the market, the different delivery channels and the amount of Exchequer money invested in home care services, this area of public expenditure is poorly served by evidence-based evaluations of impact. UK studies, however, of preventative services concerned with intensive support for people with complex home care support needs have been able to demonstrate their value. [130] In addition, some well targeted home care interventions have been identified as having an effect on overall demand for other health care services and thereby a positive impact in terms of cost and efficiency.[131]

In line with the Public Spending Code, a mid-term review of the operation of the HCP outsourcing should be undertaken so that informed policy choices can be taken well in advance of a tender being published to extend or indeed amend the service delivery requirements.

To this end it will be important for the HSE to determine, as part of the tender's technical specifications, output and efficiency indicators from the outset. In relation to HCP outsourcing these could include hours of care delivered; cost per hour of care; level of complaints; hours of care per office staff etc. The SLAs to be concluded with approved suppliers could include such issues as reporting formats and frequencies, targets, and KPIs.

It will be important for both the buyer and suppliers that there is a clear understanding under what circumstances the HCP outsourcing might be curtailed or even withdrawn and in the event of a major review how this will be dealt with between the parties.

[130] *Care Services Efficiency, Delivery Guide to Crisis Response Services*, Department of Health, 2011.
[131] *Joining Up Health and Social Care: improving value for money across the interface*, Audit Commission, 2011.

PART 7

Conclusions

Key Messages

- More patients will get a higher quality service at about 70% of the current cost to the HSE.
- There will be a significant reduction in the Fair Deal budget as resources are switched to home care provision.
- Savings will arise in the HSE's administration overhead.
- There will be a reduction in HSE head count (as private operators employ some former HSE staff).
- Possibilities of re-deploying some HSE staff to front line 'core' services.
- Giving patients what they want i.e. care at home and choice of service provider will improve outcomes.
- Option of providing own resources and/or family funds to top up the desired level of home care provision.
- Service level delivery based on agreed KPIs, approved quality standards, robust monitoring and reporting requirements.

The UK Department of Health believes the single most important factor in successful outsourcing of home care provision is a clear vision for what is to be commissioned. This submission provides such a vision. The Department also stresses the importance of setting down the characteristics of the services to be outsourced and setting relevant contract performance measures. Again, this submission addresses these issues. [132]

Policy towards care of older people in Ireland has largely been based on the assumption that family-based or community-based care is the preferred option and role of public provision should only arise where carers are not available. [133]

Given the demographic trends evident from the recent Census, such a model is no longer sustainable.

The time has come for a reform of home care delivery in Ireland.

[132] Department of Health, *Care Services Efficiency Delivery Homecare Re-ablement Toolkit*, March 2011.
[133] op cit. Barry (2010).

As a first step the entire HCP scheme and home help services provided by Section 39 organisations should be opened forthwith to competitive tender.

Once this has been done (Q3/2013), and when the quality standards are firmly embedded, all home help services should be outsourced in a phased manner.

The next logical step would see low and medium dependency patients in expensive Fair Deal beds being looked after at home. To this end a competitive tender should issue in Q1/ 2014.

The significant savings generated could be used in part to provide more HCP services or to be applied to core front line services such as primary care.

The bottom line is that the proposed outsourcing of HCP provision and home help services provided by Section 39 organisations will go a very long way to giving elderly patients and the disabled what they want; choice, care at home and better outcomes.

This is a dynamic agenda as private home care providers are pro-actively expanding the services they can offer. Home care teams now include nurses, physiotherapists, and occupational therapists to enable 'acute' home care to be delivered at home. Intermediate care teams provide a short term rehabilitation service following illness or accident. Home care re-ablement is being piloted. In addition, private providers are making greater use of technology to support home care management.