Commission on Care
for Older People

Commission on Care for Older People:

Module 1 Report

An Roinn Sláinte
Department of Health

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List of abbreviations

AAC	Augmentative, alternative communication
ABF	Activity-based funding
ADL	Activities of daily living
AHB	Approved Housing Body
AHBRA	Approved Housing Bodies Regulatory Authority
AI	Artificial intelligence
ASC	Adult social care
ASI	Alzheimer Society of Ireland
ATT	Assistive technologies and telecare
ATTILA	Assistive technology and telecare for independent living
BIU	Business information unit
BPSD	Behavioural and psychological symptoms of dementia
CALF	Capital Advance Leasing Facility
CAS	Capital Assistance Scheme
CDHC	Community-directed home care
CDM	Chronic disease management programme
CEO	Chief executive officer
CFS	Community Funded Schemes
CHI	Children's Health Ireland
CHN	Community Healthcare Network
CHNM	Community Healthcare Network Manager
CHO	Community Healthcare Organisation
CIT	Community Intervention Team
CLSS	Capital Loan and Subsidy Scheme
COPD	Chronic obstructive pulmonary disorder
CRQoL	Care-related quality of life

CSAR	Common Summary Assessment Report
CSO	Central Statistics Office
CST	Community specialist team
dADL	Difficulty with activities of daily living
DHLGH	Department of Housing, Local Government and Heritage
DML	Dublin Midlands HSE Health Region
DNE	Dublin North East HSE Health Region
DRCD	Department of Rural and Community Development
DRG	Diagnosis-Related Group
DSE	Dublin South East HSE Health Region
DTOC	Delayed transfer of care
ECC	Enhanced Community Care
ED	Emergency department
EHR	Electronic health record
EMA	European Medicines Agency
EQ-5D-3L	European Quality of Life-5 Dimensions-3 Levels
ESRI	Economic and Social Research Institute
EU	European Union
FEDS	Feeding, eating, drinking, swallowing
GAA	Gaelic Athletic Association
GNI*	Modified gross national income
GP	General practitioner
GSM	Global System for Mobile
HAFH	Healthy Age Friendly Homes
HCP	Home care package
HIQA	Health Information and Quality Authority
HIS	Health information systems

HLY	Healthy life-years
HNDAT	Housing Need and Demand Assessment Tool
HOP	Housing Aid for Older People
HRB	Health Research Board
HSE	Health Service Executive
IADL	Instrumental activities of daily living
ICA	Irish Countrywomen's Association
ICB	Integrated Care Board
ICECAP-O	ICEpop CAPability measure for Older people
ICGP	Irish College of General Practitioners
ICPCD	Integrated Care Programme for Prevention and Management of Chronic Disease
ICPOP	Integrated Care Programme for Older People
ID	Intellectual disability
IDS-TILDA	Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing
IHA	Integrated Care Area
IHCP	Intensive home care package
IPH	All Island Institute of Public Health
ISAX	Ireland Smart Ageing Exchange
IT	Information technology
KPI	Key performance indicator
LAAWS	Local Authority Adaptation Works Scheme
LGMA	Local Government Management Agency
LOS	Length of stay
LTRC	Long-term residential care
MAG	Mobility Adaptation Grant
MAPLe	Method for Assigning Priority Levels

MASS	Memory Assessment and Support Services
MCI	Mild cognitive impairment
MMSE	Mini Mental State Examination
MTRR	Memory Technology Resource Rooms
MW	Mid West HSE Health Region
NAS	National Ambulance Service
NASS	National Ability Supports System
NCCN	National Community Care Network
NDO	National Dementia Office
NDS	National Dementia Services
NGO	Non-governmental organisation
NHI	Nursing Homes Ireland
NHS	National Health Service
NHSS	Nursing Homes Support Scheme
NICE	National Institute for Health and Care Excellence
NIDD	National Intellectual Disability Database
NIDMS	National Intellectual Disability Memory Service
NMES	Neuromuscular Electrical Nerve Stimulation
NSP	National Service Plan
NTPF	National Treatment Purchase Fund
OOH	Out-of-hour
OpCo	Operating company
PCRS	Primary Care Reimbursement Scheme
PHN	Public health nurse
PN	Practice nurse
PropCo	Property company
PRSI	Pay Related Social Insurance

PSD	Postural support devices
QALY	Quality-adjusted life year
QQI	Quality and Qualifications Ireland
RAPID	Rationalising Antipsychotic Prescribing in Dementia
REIT	Real Estate Investment Trust
REO	Regional Executive Officer
RSMC	Regional Specialist Memory Clinic
SMART	Specific, measurable, attainable, realistic and timely
SW	South West HSE Health Region
SWOT	Strengths, weaknesses, opportunities and threats
TAPS	Temporary Assistance Payment Scheme
TCD	Trinity College Dublin
TCF	Transitional Care Fund
TD	Teachta Dála
TESN	Transcutaneous Electrical Stimulation
TILDA	The Irish Longitudinal Study on Ageing
UK	United Kingdom
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
VCN	Veterans' Community Nursing
WHO	World Health Organization
WNW	West and North West HSE Health Region
WRC	Workplace Relations Commission
WTE	Whole-time equivalent
YOD	Young-onset dementia

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Summary / lessons learned

Recognising the disproportionately negative impact of the COVID-19 pandemic on older people and in fulfilment of the commitment in the *Programme for Government: Our Shared Future* (2020), in March 2024 the Government established an independent Commission on Care for Older People (hereinafter referred to as 'the Commission') 'to examine care and supports for older people'.[1] In addition to the imperative to learn from the pandemic, the need for a fundamental review of how health and social care for older people is organised, delivered and funded in Ireland, with which the Commission is charged, has been set in relief by the challenges presented by *Sláintecare* implementation within the context of Ireland's ageing population.

Following the appointment of Professor Alan Barrett (Economic and Social Research Institute (ESRI)) as the Commission's Chair, eleven individuals were invited to join the Commission to collectively provide expertise across the areas of geriatrics, gerontology, health economics, health policy and management, primary care, health ethics, health technologies, and ageing and disability, as well as representation of the community and voluntary sector and of older people.[2]

In the initial meetings of the Commission, Commission members reflected on the Commission's 'Terms of Reference' and distilled the instructions that had been provided to the Commission in the following way. In Module 1 the Commission was charged with setting out the current situation in respect of health and social care—essentially 'what is'. In Module 2 the Commission was requested to change direction and to set out 'what should be'. This report represents the output of Module 1 of the work of the Commission.

Collated themes from Commission members' learning submissions

The paragraphs below bring together the key lessons that the Commission has learned in Module 1, which will be used to inform the work that is carried out in Module 2. The lessons learned draw on the existing expertise and knowledge of the Commission members and on what members learned through the information-gathering process in Module 1, including the insights provided by stakeholders through the Commission's Reference Group; a public consultation; presentations from experts; and discussion amongst members.[3]

1. Government of Ireland, *Programme for Government: Our Shared Future* (Dublin: Government of Ireland, 2020), p. 51.
2. The membership of the Commission is detailed in Appendix I.
3. The membership of the Reference Group is detailed in Appendix IV; the meetings of the Reference Group during Module 1 are detailed in Appendix V; and the presentations made to the Commission during Module 1 are detailed in Appendix III.

Supporting people to live their best lives

It is a triumph of modern society that, by addressing the wider social determinants of health and through better healthcare provision, our population is living longer and our older population is projected to double in the coming two decades. We have opportunities across the lifespan to build resilience, enable functional capacity and to support healthy ageing in place.

One key learning from Module 1 is that, based upon these demographic changes and opportunities that exist, there is a need to change the narrative about care for older people. Rather than being thought of in terms of managing decline, care should be seen as facilitating the ongoing enjoyment of life and as helping people to thrive in later life. Care should help people to remain in their homes, with their families, and in their communities for as long as possible and to continue participating in the life of their communities. The Commission learnt about the importance of a psychosocial as well as a biomedical approach to achieving the goals of meeting older people's care-needs and allowing them to participate in family and community life.

Healthy ageing

There has been increased focus on healthier ageing in Ireland, and policies and frameworks such as the Health Service Executive (HSE)'s *Health Services Healthy Ireland Implementation Plan 2023–2027* (2023) aim to 'increase the proportion of people who are healthy at all stages of life'.[4] This framework provides the central platform for addressing the social determinants of health that affect how well people can live their lives. It includes a suite of actions to encourage and enable the population to keep well. The Commission also learned of the many health benefits of physical movement and strength-training to improve balance and reduce the risk of falls as well as of the positive mental health benefits that this type of movement provides. These benefits not only improve physical and mental outcomes but they help develop the confidence and autonomy in older people.

The 'shift left, stay left' model that is a central feature of *Sláintecare* advocates for shifts in focus from illness to wellness, from hospital to home and from a clinician-centred to a person-centred health system. While inroads into developing the model are being made, the current system often remains reactive instead of proactive, with a heavy focus on downstream rather than upstream funding to tackle risk-factors that may impede healthy ageing earlier in the life-course.

For example, the Commission noted that a Lancet Commission report showed that up to 45% of cases of dementia worldwide are potentially preventable by addressing modifiable risk-factors throughout the life-course, starting in childhood and continuing throughout life.[5] Primary care can play a crucial role in dementia prevention, managing conditions like diabetes, mid-life hypertension and obesity, and supporting people to adopt healthy behaviours such as increasing physical activities, adopting healthier diets and encouraging social engagement to reduce loneliness and depression.

4. Health Service Executive, *Health Services Healthy Ireland Implementation Plan 2023–2027* (2023), p. 4.
5. G. Livingston et al, 'Dementia Prevention, Intervention, and Care: 2024 Report of the Lancet Standing Commission', *The Lancet*, 404/10452 (2024): p. 572–628.

Individual needs, rights, autonomy and independence

Focusing on the person and their autonomy acknowledges that the older population is diverse and not homogenous. Care-needs vary between individuals and over the lifecycle of each individual. Focus on the person and their entitlement to autonomy in older age is viewed as something to be encouraged and supported by public policy, especially in relation to choice of care-settings and service-delivery within all care-settings. Feedback from older people is also key to understanding those people who have greater health and social care-needs, especially as people transition across the care continuum. The interface between ageing and disability on the one hand, and ageing and end-of-life care on the other, should be acknowledged and supported through an emphasis on ageing-in-place across the care continuum. In this context, the Commission also notes the recent launch of the Department of Health's *National Adult Palliative Care Policy* (2024), which sets out to support people to live their best lives while living with a life-limiting illness.

Family and community support frameworks

Family and community support frameworks are very important for good quality care and both strengthen inter-generational solidarity. Families provide unpaid care, which remains the main source of support for people with care-needs. With family-structure and dynamics projected to change in the future—with smaller family-sizes, high levels of employment, and greater distance between family members—this reliance on family care will pose major challenges in the years ahead.

Caring has emotional rewards but is it also very challenging. For example, the Commission learnt that family carers of a person with dementia face very high levels of stress and depression as well as a higher probability of requiring care themselves in the future. In addition to mental health challenges, they face physical challenges and financial pressures in caring for their loved one with dementia. However, there is limited availability of the day care and respite care services that are very important for family/unpaid carers.

Challenging ageism

A narrative of ageism continues to permeate the system. Older adults frequently face discrimination—which can be subtle or overt—in accessing services, in expectations of outcomes, and in the design of care-pathways. The implicit assumption that older people's lives are of lesser value undermines their rights, their autonomy, and the urgency with which system-reforms are pursued. Ageism is reflected in attitudes, resource-allocation, and the absence of parity of esteem between older adults and other population-groups.

Pre-existing disability and ageing

People with intellectual disabilities are diagnosed with age-related conditions up to 20 years earlier than the general population and they face higher rates of chronic illness, frailty, dementia, and social isolation. Their successful and healthy ageing is disadvantaged by access to services being limited to individuals aged 65 years or older. It is also disadvantaged by general population-ageing and health systems being unprepared to meet the unique needs of this population, including the health and social care workforce being largely untrained for this purpose. Yet there is much to be learned for everyone from incorporating disability-focused services for all ages that are human-rights focused and based upon an enablement agenda. Instead, current systems often default to institutional care with little opportunity to tailor resources for changing needs, to pay attention to chronic disease management, to support innovative housing models or to implement disability-inclusive services—encompassing pathways for prevention, community-based housing and inclusive health services. Every stage of life for people with intellectual disabilities has been enriched by a focus on rights-based, person-centred approaches. This is no less true for ageing. Ireland risks re-institutionalising people under current models and offering poor-quality care and support in older age. Instead, the focus should be on delivering dignity, choice, inclusion and equality for people ageing with intellectual disabilities. Such an emphasis will strengthen ageing policy and services for all.

Local initiatives

The Commission is aware that there are many valuable activities happening throughout the country, often provided with inputs from volunteers and funded in part by bodies such as the local authorities and the Department of Rural and Community Development, often through Pobal. For some people, their first connection with state-funded services for older people might not be 'care' as such but more in the realm of activities and places where the maintenance of social engagement is the key objective. Examples include men's sheds and visitation programmes, meals-on-wheels or Local Link transport services.

Given levels of loneliness among older people and the negative health outcomes associated with loneliness, local services play an important role and should be seen as part of a broader strategy of preventing the development of conditions which lead to care-needs. There are advantages to having many innovative small-scale, local initiatives—for example, drawing on a community spirit of volunteerism and tailoring schemes to locally identified needs—but there are challenges too.

Community and social supports are not utilised by every older person and not every community activity can be said to have an impact on health, given a shortage of evaluation of these services. Many programmes rely on volunteers and there are questions over the sustainability of some volunteer-based programmes. Through the Reference Group, the Commission also learned that many local bodies struggle with funding models which are typically based on annual allocations, thereby creating year-to-year uncertainty. The Commission also learned from both the Reference Group and the public consultation that there is often a lack of information on what is available, and that this negates the ability for people to take advantage of social prescribing of such services and activities.

Access

During the course of the Commission's work, equity of access to many different care services was consistently noted to be a key challenge for older people across Ireland. Many people experience long waiting lists to access some health services, a lack of access to transport to facilitate mobilisation to services and supports, as well as a lack of accessible information on what services and supports are available. In some instances, for example for home support and community-based care, there is a severe lack of supply across the country. For others, access to public services is dependent on possession of a medical card, and lack of a medical card (or GP visit card) effectively locks some older people out of community-care services. The Reference Group also spoke of the lack of rural transport links which deprives older people from accessing social activities or day-care centres and thus further limits their access to care and social engagement. The Reference Group also spoke of the importance of rural transport links for facilitating older people's access to services and supports.

Increased private for-profit sector involvement

The Commission was struck by parallels in social housing policy and older people's care policy in terms of a greater reliance over time on a model based on public funding and private provision. Over 80% of long-term residential care and over 60% of home support is now provided by the private sector. Within the private sector, while not-for-profit agencies are still important providers of care, their role has reduced over time, and the private sector is now dominated by for-profit agencies. The increase in for-profit agency provision of care may be causing some of the inequalities in access to care as private agencies are more likely to locate in regions where profits can be made. It also is leading to an increasing scale of long-term residential homes, often located in greenfield sites closer to major urban centres, which works against aims such as maintaining people close to their communities and in more home-like settings. Within the private care sector there has been a drift towards internationally owned private firms dominating the sector, with complex ownership and operating structures. This also creates a growing vulnerability for the State if these large private operators were to exit quickly and unexpectedly.

It seems to the Commission that this movement with regards to greater private provision and the consolidation of provision in older people's services is happening without appropriate debate and analysis. There is no overarching policy which outlines what is considered to be an acceptable level of privatisation of nursing homes or of other health and social care services: there is no health or social care policy in Ireland which considers the positives and negatives of private care versus public care and which commits to maintaining publicly provided services.

Workforce supply and capacity

Although Ireland is not unique in its workforce shortages—the World Health Organization (WHO) expects a shortage of 4.1 million healthcare workers in the European Union (EU) by 2030—staff shortages are causing significant waiting lists, delays in care, and improper care. Supply-side issues are about more than staff numbers. They involve recognition of staff-needs; the social status of care-workers; mobility of workers; migration policy; and pay and career structures.

The Commission learnt that there are gaps in initial and ongoing training, especially for health and social care staff looking after people with dementia. Carers require dementia-specific training in order to meet the needs of a person with dementia and to understand their communication; provide cognitive stimulation and therapies; and, at times of aggressive behaviour, have the skill to intervene and de-escalate a situation by meeting the person with dementia where they are at.

The Commission notes that the Department of Health's *Report of the Strategic Workforce Advisory Group on Home Carers and Nursing Home Healthcare Assistants* (2022) makes recommendations to improve the pay and conditions of care-workers in Ireland, including the call for all providers to pay the National Living Wage to all care-workers and the call for the establishment of an appropriate mechanism to reach agreement in the private and voluntary sector in respect of pay and pensions for home-support workers and healthcare assistants. However, employment terms and conditions are not sufficient to attract and retain the sort of skilled workforce that is needed in home support and long-term residential care. Placing long-term care workers on a par with other healthcare professionals by matching pay and improving career prospects has not yet occurred.

There is also a significant information deficit—for example, in the case of the home support workforce, there is no accurate estimate of the number of home care workers and their skillsets in the sector in Ireland. This makes it difficult to plan for the future when the situation on the ground currently is not well understood. Under-staffing today may be compounded moving forward, as staff shortages are projected to increase internationally.

Organisation and coordination of care

Despite progress in recent years, the lived experience of care for many older people remains fragmented and inconsistent. Services vary depending on region: many specialist services are not available in every local community, resulting in older people being required to travel long distances to access care. While significant strides have been taken to pilot new programmes, they lack consistency of implementation. No HSE clinical governance structure exists at national, regional, or local levels to bring together the full continuum of health and social care services for older adults to plan and deliver integrated care to this population. As a result, care-integration for older people is limited and services are often delivered in silos.

The health and social care system must operate in alignment with universal design principles and a 'single door' health system. As discussed, the system is currently fragmented, with separate services having been designed for people with different diagnoses, regardless of whether their service or support-needs are similar. An older person must be able to access services based on a holistic understanding of their need rather than on an individual diagnosis. The Commission notes the opportunity to learn from the Department of Children, Disability and Equality's recently published *National Human Rights Strategy for Disabled People 2025-2030* (2025), which states that a significant proportion of disabled people 'can and should be catered for via mainstream services, rather than specialist or segregated disability services'.[6]

Continuum of care across the lifespan

Transitions across the continuum of care are where major vulnerabilities in provision and support are exposed: care at the various margins needs to be provided through integrated care programmes that support home-living where possible and practicable. However, Ireland lacks a coordinated, whole-system approach to care across the spectrum, healthy ageing, living with chronic conditions and managing frailty and complex needs. Evidence-based interventions and policies exist for many stages of older people's care-pathways. However, these potential evidence-based improvements are not systematically implemented across the system. An example identified for potential evidence-based improvements is the establishment of integrated primary care supports tailored for older adults following a programme that exists already for chronic disease management.

Primary and community care

While fragmentation and issues with care-coordination are highlighted above, improvements are happening. The Commission has found that improvements are occurring in enabling primary and community care and in caring for people's healthcare needs in a more integrated way. The Enhanced Community Care (ECC) programme—a key pillar of *Sláintecare*—aims to bring health services closer to home. The ECC targets specific population-groups, namely people living with chronic illness (through the Chronic Disease Management (CDM) programme) and older people (through the Integrated Care Programme for Older People (ICPOP)). The ECC model is centred on a person-centred approach in which services work together and talk to each other with the service-user at the centre of care. In line with *Sláintecare*'s emphasis on a 'left shift' of resources and activity, the ECC model enhances general practice and the integration of community-based therapy services, with general practitioner (GP)-led multi-disciplinary teams. Community specialist teams (CSTs) for older people support vulnerable adults to avoid unnecessary hospital admissions. The CDM and ICPOP models allow for better coordination of wraparound services to be provided to the population. Dementia advisers are reporting that, in areas where ICPOP teams are operational, the integrated care system has a hugely positive impact on the quality of care a person with dementia receives and that it is working very well in terms of meeting their needs.

6. Department of Children, Disability and Equality, *National Human Rights Strategy for Disabled People 2025–2030* (Dublin: Government of Ireland, 2025), p.19.

The Commission understands the need for community integration of services and has noted that there is a strong evidence-base for this and for the ECC programme. The ECC programme plays an important role in creating the conditions that allow people to age well at home and remain in their communities. Investment in the ECC programme is necessary to alleviate pressure on acute services, ensure treatment at the appropriate level of need, and expand the provision of GPs, occupational therapists, physiotherapists, practice teams, and community-based diagnostic services in line with *Sláintecare*'s vision of primary and community-based care.

Evidence shows that multidimensional assessment in primary care—leading to interventions such as medication reviews and advance care planning—improves outcomes, extends life-expectancy and enhances quality of life. However, implementation is piecemeal across the country, under-resourced, and not embedded at scale.

There remain significant capacity issues in general practice with large regional variation in GP-supply and with many people struggling to find a general practice with space to take them as a patient. Without sufficient workforce and resourcing, potential is limited. The Department of Health-led 'Strategic Review of General Practice' is also looking at ways to sustain the GP workforce including by addressing training and capacity issues. Such capacity constraints and the lack of specific funding for GPs that aligns with ICPOP and the care of older people may prevent development of an expanded, CDM-like programme for older people that has the potential to address the specific health challenges of ageing. Lack of GP-supply also has an adverse impact on the availability of out-of-hours services.

Continuity of care is a fundamental aspect of primary care. The Commission heard from experts about the adverse impact that cognitive and functional decline has on mobility and on a person's susceptibility to illness and falls, increasing the probability of their hospitalisation and admission into long-term residential care (LTRC). Primary care offers an opportunity for early detection and prevention of illness through a comprehensive approach encompassing care co-ordination and advocacy.

Hearing, vision, oral and foot health

Within primary care, these services are core to maintaining an older person's wellbeing, communication skills, social connectedness, mobility and nutrition but are often overlooked with, for example, hearing, vision and oral care are omitted from the ECC programme. Poor oral health is associated with pain and malnutrition. Reduced hearing is a risk-factor for dementia, social isolation and loneliness and—in combination with poor vision and foot health—there is an association with falls, fractures, morbidity and mortality. Services in these areas are not well-developed within the public health system in Ireland and often are subject to long waiting lists and or co-payments. Older people without means often do without while those with means self-fund these services.

The Commission learnt that not all older people with frailty will require assessment by CSTs for older people and that this would not in any case be feasible. The Commission also learnt that nurse practitioner-led case-management, in which those >75 yrs had a health check-up performed by a GP nurse practitioner by telephone to find the higher-risk cohort, decreased GP visits by 50%.

Home support

Funding for home support has increased substantially in very recent years and the stated policy objective behind these increases—helping people to remain in their homes for as long as possible—is to be applauded. However, there are still a number of weaknesses in the system. The tasks undertaken by carers do not always align with the actual needs of the people receiving care. This was mentioned in the public consultation. The Commission heard from the Reference Group that the prioritisation of the provision of personal care over the provision of assistance with domestic tasks is resulting in significant gaps.

At the root of this problem is the lack of a consistent care-needs assessment and the lack of a case-mix classification model that would link people's assessed care-needs with the allocation of funding. Second, the number of publicly funded hours provided are insufficient for many people and vary across the country. For people who cannot afford to purchase additional care, this leads to unmet need and associated difficulties. Third, the terms and conditions of paid care-workers are relatively poor and so the sector is characterised by high turnover with implications for the continuity of care. Fourth, in the absence of a 'Fair Deal'-type scheme for home support, people are likely to be moving to LTRC sooner than necessary.

Assisted and supported living

Currently in Ireland it seems that the only option for many older people who need additional support is LTRC. The Commission learned more about alternative supported living arrangements in which older people live in independent housing units with collectively provided supports, such as medical care and security, along with communal areas and activities. Examples include age-friendly houses and housing with support. Commission members were struck by the many positives which these supported living arrangements can offer. Located in close proximity to services, the social interaction and sense of community provided enables older people to live independently as part of their own communities.

However, national models of care and support have proven difficult to achieve and implement. For example, there are over 20 different alternative housing models in Ireland. This level of fragmentation prevents the achievement of economies of scale and consistent, equitable levels of service across the country. There is a challenge in balancing decentralisation with better implementation of national strategies across all administrative levels while still supporting innovation.

Most providers of these services receive funding through grants, availability of these services is inconsistent, and they are dependent on insecure annual funding mechanisms. Furthermore, there are gaps in the policy or legislative infrastructure to provide and promote supported living for older people. Existing grants/funding schemes that older people can apply for can provide good support for upgrading their houses but the application process is not straightforward. In terms of capital delivery for housing with supports, match-funding to meet grant criteria can be challenging for voluntary/non-governmental organisations.

Long-term residential care (LTRC)

LTRC remains a central part of care for many older people, and people report very good experiences in residential care homes. Since the *COVID-19 Nursing Homes Expert Panel Report* was published in 2020, interagency collaboration has progressed recommendations improving the care provided to older persons in the residential setting. The Commission is equally cognisant of the isolation that LTRC facilities experience within the health system: it is this isolation that increases vulnerability in times of crisis, such as during a pandemic, inclusive of the vulnerability to abuse of residents within a facility.

The Commission formed the view that there is the potential to reframe perceptions of residential care. Long-term care facilities form part of the continuum of care of housing options and should be considered first and foremost as a person's home.

However, the current model of long-term care is not person-centred. Older people are often required to 'fit' into services, rather than services being built around their needs and preferences. A majority of older adults in nursing homes are there because of gaps in community supports rather than because institutional care is their preferred or most appropriate option.

The premature or inappropriate placement in LTRC of any person should be addressed. The funding mechanism for the Nursing Home Support Scheme (NHSS), commonly known as 'Fair Deal', provides clarity on the level of personal contribution towards the costs of personal care and limits the extent to which a person's home and other assets are used to fund their care. However, the prices paid to LTRC providers does not account for levels of dependency or cognition. Funding may be inadequate for older people with more complex needs. The NHSS does not provide additional funding to nursing homes for dementia care, despite the Health Information and Quality Authority (HIQA) requiring nursing homes to meet the standards of care for a person with dementia.

The NHSS does not cover the costs of therapies, such as physiotherapy; dental or ophthalmic services; social activities; or personal care services, such as hairdressing, which residents may feel are very important to them. LTRC is not just about medical need. There are examples of positive practice in LTRC such as promoting inclusivity and social engagement through initiatives such as buddy systems and community engagement programmes. The incorporation of diverse social activities such as crafting, art, gardening, music, and dancing in daily life within LTRC creates a positive and engaging environment. However, very structured care routines and timetables can result in a loss of autonomy and independence for residents.

While older people value continuity of care, at present, on entry to a nursing home, older people lose access to healthcare services and to the chronic disease management programme previously provided in the community, potentiating experiences of isolation and institutionalisation. The current resourcing of general practice and community-based health and social care for the provision of primary care to residents in LTRC is wholly deficient and does not reflect the complexity of the care required.

The Commission accepts that improvements in nursing homes have been achieved in recent years under HIQA regulation and inspection systems. However, a number of concerns remain. The RTÉ Investigates programme, 'Inside Ireland's Nursing Homes', which aired during the Commission's deliberations, showed that weaknesses in the overall system of management, governance, regulation and inspection exist although it might be difficult to identify the precise point of breakdown within the system. Even if the practices shown in the programme were rare and isolated, they were unacceptable.

The lack of integration of private nursing homes within the wider health and social care services is a major concern of the Commission and similar concerns were also voiced by the COVID-19 Nursing Homes Expert Panel. Integration of private nursing homes with wider health and social care services has the potential to transform care from institutional to a co-ordinated person-centred approach, maintaining connection with the local community, strengthening safeguards, allowing for efficiencies of cross-service planning and delivery while empowering older persons to live their best lives across the continuum of care.

Rehabilitation and recovery pathways

Since 2015, and particularly since COVID-19, there has been a growth in short-term care provision in LTRC homes, driven largely by hospital discharge pressures and financial incentives within the LTRC sector. These pathways are poorly governed, with no national or local oversight of outcomes. Emerging evidence indicates that older adults are harmed by this model, with increased conversion to long-term care, reduced rates of returning home, longer lengths of stay and higher rates of falls, infections, pressure ulcers, and inappropriate prescribing.

Access to rehabilitation for older adults is grossly inadequate. National reports show both the recorded need and the capacity in inpatient and acute hospital rehabilitation are underestimated, leaving a major deficit. Without access to rehabilitation, older adults experience preventable functional decline, often leading to premature or inappropriate long-term care placement.

Technology

Technology can play an important role in helping older people live well, maintain independence when they have functional difficulties, and provide remote monitoring for those with more intense levels of need. Other practical benefits can include a reduced need to travel to healthcare and other appointments that can be conducted remotely.

The Commission learnt about the wide availability of technology and the vast pace of its evolution and also about how many attempts have been made to demonstrate its usage across multiple areas of healthcare provision at home, in the community and in hospital settings. Many older people experienced a lack of awareness of assisted technologies that would aid their independent living.

Perhaps the most notable point was the importance of managing expectations with regards to its usage through a 'less is more' ethos. If deployed appropriately it will have the potential to prevent the onset of health conditions through healthy lifestyles and targeting of risk-factors; to support self-management of long-term conditions; and to accommodate those with significant need to either remain at home longer or within supported living environments.

Weaknesses do, however, currently exist in respect of the lack of clear guidance regarding the availability of technology; where it can be best used to address the aforementioned areas; which technology provider is most trusted; and how it will be financed through both public or private funding options. There is a lack of policy focus on technology and design in improving the living conditions of older people in both private housing, supported living and nursing homes.

The Commission learned about the tight coupling of the use of technology and its adoption, with the overcoming of the barriers of inability and/or inexperience of using core technology platforms such as mobile phones, the internet and pervasive devices having positive effects on its intended function. Training programmes for both service-users and carers have demonstrated the potential to move one step closer towards a wider uptake of technology-based solutions and should therefore be considered key for future developments of technology deployments.

While technology and most specifically artificial intelligence (AI) is changing the society that we live in at an unprecedented rate, the Commission was cognisant of the need to manage expectations carefully in relation to what the future may actually hold. While AI will be expected to play a role, the nature of this role is at present not clear.

Policy and implementation

Finally, Ireland has produced many thoughtful and progressive policies on older people's care over the years. In the past there has been some successful implementation of key policies. The NHSS was welcomed and provides centralised funding and streamlined applications, ensuring equitable and high-standard care based on HIQA compliance. Population-based resource-allocation has also been adopted as the plan to apportion resources more efficiently and effectively across the system.

However, implementation has repeatedly lagged due to the absence of robust, costed implementation plans and sustained funding commitments. Promises from Sláintecare objectives in 2018 have been under-delivered, causing further delays in care due to the hospital-centric nature of the existing system, workforce issues, funding pressures and a significant need for a digital transition.

Promises and deadlines that were initially established have not been met and new plans (such as in Sláintecare 2025+) have been set with continued risks of not meeting these goals either. This results in a persistent 'policy–practice gap' in which aspirations are not translated into delivery. Many recommendations of the COVID-19 Nursing Homes Expert Panel also remain unimplemented. The Commission welcomed the HSE's 'Model of Care for Dementia in Ireland' (2023) but noted that there is no time-bound implementation plan or dedicated funding stream to support this.

The efficiency and effectiveness of public spending on care-provision has also not been subject to rigorous scrutiny. The consistent lesson is that while Ireland has strong policy intent and clear evidence on what works, the absence of systematic implementation, coordination, and accountability mechanisms means older adults continue to experience fragmented, reactive, and often ageist care. A step-change is required to ensure that care for older people is truly person-centred, integrated, and rights-based.

To conclude, this Summary represents the collated lessons learned by the Commission members over approximately twenty months of consultation and discussion. Following the completion of Module 1, the task of the Commission will be to take these learnings and to move onto Module 2, in which the Commission will formulate recommendations for the future of care for older people in Ireland.

The Commission thanks all who have contributed to its deliberations—the experts who presented, stakeholders who participated in Reference Group meetings, and members of the public who responded to the Commission's public consultation. The knowledge which the Commission assembled, which is presented in this report, provides an excellent basis on which to develop recommendations.

Introduction

Context and 'Terms of Reference'

In March 2024 the Government established an independent Commission on Care for Older People. In so doing the Government met a commitment made in the *Programme for Government: Our Shared Future* (2020), which stated:

> The impact of COVID-19 has been particularly difficult for older people. It has been challenging for those who live on their own and for those residing in nursing homes. Learning from COVID-19, we will assess how we care for older people and examine alternatives to meet the diverse needs of our older citizens. We will establish a commission to examine care and supports for older people.[7]

The reference to COVID-19 points to one of the factors which prompted the decision to establish the Commission. However, even in the absence of the pandemic, a strong case existed for a fundamental review of how social and health care for older people is organised, delivered and funded in Ireland.

Population-ageing is rapidly and fundamentally altering the demographic structure of populations across most OECD countries, including Ireland. Older people use a range of social care and healthcare services and the changing age-structure will result in more older people requiring care. However, other relevant factors are also shifting. Traditionally in Ireland, much care for older people was provided by families and this remains the case. However, with declining fertility rates, increases in female labour-force participation and changing social mores and expectations, this traditional model is increasingly unsustainable.

When the Commission was established, 'Terms of Reference' were provided, which can be seen in Appendix II. The core elements of the 'Terms of Reference' are as follows:

In the first module of its work, the Commission was asked to:

- Determine the effectiveness, adequacy and efficiency of the care and supports which are currently provided within the health and social care system, including the plans for their further development, in meeting the evolving care needs of the increasing diversity of older people within the context of the ageing population.

7. Government of Ireland, *Programme for Government: Our Shared Future*, p. 51.

In the second module, the Commission was asked to:

Examine the broader policy options for older people's care, as determined in Module 1, to include:

- A strategic focus on the continued shift to community-based health and social care, to enable older people to access timely supports to live and age well in their own communities.
- The provision of health and social care supports for older people across a continuum of supported living options, inclusive of low, medium, and high-support residential care.
- The emerging potential of new digital and assistive technologies to support and transform health and social care for older people.
- The principles of universal design for infrastructural development to support care for older people.
- Other potential policy reform options.

Other important considerations raised in the 'Terms of Reference' include the need to be cognisant of existing policy in this area—in particular *Sláintecare*—and also of on-going work on the implementation of recommendations from other review exercises. The broader vision of *Sláintecare* places integrated primary, and community health and social care at its core, with older individuals identified as a priority group to shift care from hospitals to the community. This has influenced some recent policy shifts towards the provision of appropriate care close to home and towards empowering people to remain at home for longer. The 'Terms of Reference' also set some parameters for the Commission's work, including that the scope of this should focus on health and social care provided *in the community*.

Reflecting the breadth of the remit of the Commission and following the appointment of Professor Alan Barrett (ESRI) as the Commission's Chair, eleven individuals were invited to join the Commission to represent academic, clinical, technological, ethical, and lived-experience perspectives of older people. Commission members reflected on the 'Terms of Reference' in the Commission's initial meetings and distilled the instructions that had been provided in the following way. In Module 1, the Commission was charged with setting out the current situation in respect of health and social care—essentially 'what is'. In Module 2, the Commission was requested to change direction and to set out 'what should be'.

This report represents the output of Module 1 of the work of the Commission. In this introductory chapter, a number of themes are addressed. First, some data on population-ageing in Ireland is provided by way of context. Second, a description of how the Commission has gone about its tasks is provided and an account is given of the various strands of the Commission's work, including its approach to consultation during Module 1. Finally, this introductory chapter sets out some very broad themes and principles which have informed the Commission's work to date.

The remainder of this report is structured as follows: the following chapters examine the various dimensions of health and social care and strive to assess the effectiveness, adequacy and efficiency of the various supports (as per the Commission's 'Terms of Reference'). The Commission also reflects on policy developments. The Commission's objective is to provide a broad overview of the current system, partly to inform stakeholders and interested parties but also to provide a benchmark against which the Commission will develop recommendations in Module 2.

The Commission's 'Terms of Reference' require the Commission to present the lessons which the Commission has learned from its deliberations in Module 1, which will be carried forward into Module 2. These lessons are presented in the 'Summary/lessons learned' above, which draws heavily on the material in chapters 1–9 and which can therefore be read as a distillation of the key messages in those chapters, augmented by other inputs into the work of the Commission which are described below.

Population-ageing

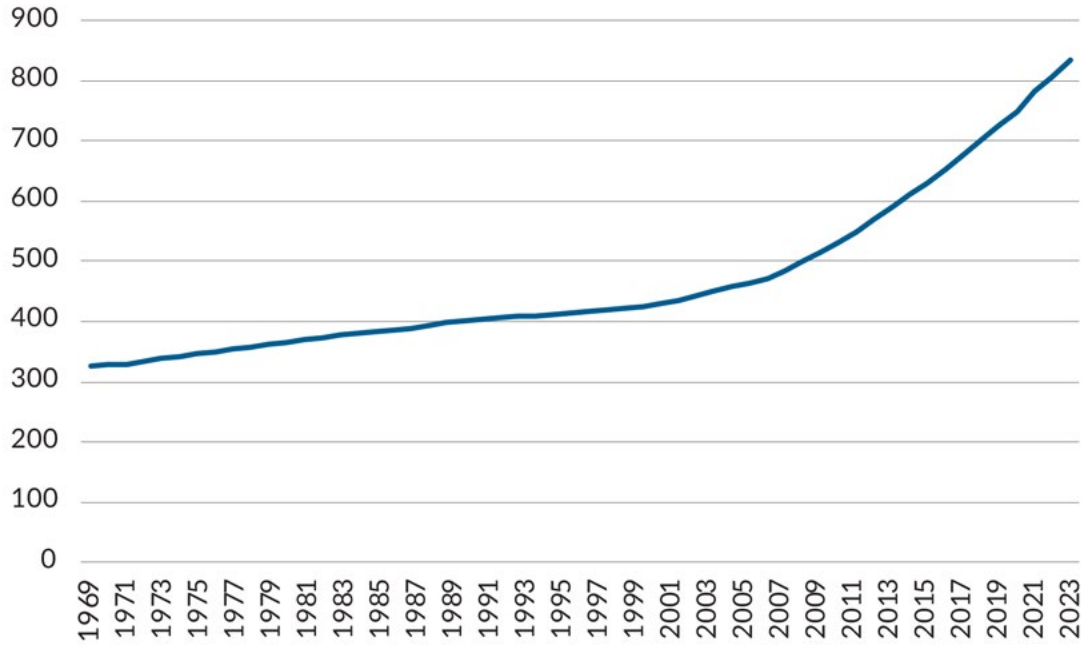
Population-ageing refers to the phenomenon which is observable in most developed countries in which the proportion and number of people aged 65 and over has been increasing and is projected to increase further. The causes of the phenomenon are twofold: falling rates of mortality whereby people are living longer and falling rates of fertility whereby people are having fewer children.

One of Ireland's greatest achievements in recent decades has been the sharp decline in mortality rates, accompanied by significant gains in life-expectancy. Where Ireland once recorded mortality rates well above the OECD and EU average, it now ranks among the countries with the highest life-expectancy in the world. While this is clearly a very welcome trend, it should be noted that progress on extending 'healthy life years' (HLY) has been less impressive over the last decade. HLY measure the number of years that a person aged 65 years is expected to live in a healthy condition and is an indicator which combines information on mortality and morbidity. The value has largely stalled in Ireland over the last decade.

There are many ways to illustrate how population-ageing and its underlying causes are evolving but below the Commission looks at long-running trends in the numbers of people aged 65.

Figure i is based on simple data in the sense that what is shown as a count of people rather than proportions of the population. Two striking points emerge. First, the population of older people has been increasing in Ireland continuously since the late 1960s. Second, the rate of increase has accelerated since the mid-2000s, with Ireland now on a different trajectory in terms of the increase in the number of older people. By 2024, there were 833,000 people aged 65 and over, out of a total population of 5.4 million (or 15.4%).

Figure i: Number of people (in thousands) aged 65 and over, 1969–2023



Source: CSO data.

As noted above, Ireland has been less successful in increasing HLY compared to life-expectancy. This means that there is a greater prevalence of medical conditions associated with ageing which, according to the WHO, include 'hearing loss, cataracts and refractive errors, back and neck pain and osteoarthritis, chronic obstructive pulmonary disease, diabetes, depression and dementia'.[8] In the case of dementia, there are currently about 65,000 people living with the condition but this is projected to rise to 99,000 by 2036 to 150,000 by the mid-2040s. The WHO notes that:

> older age is also characterized by the emergence of several complex health states commonly called geriatric syndromes. They are often the consequence of multiple underlying factors and include frailty, urinary incontinence, falls, delirium and pressure ulcers'.[9]

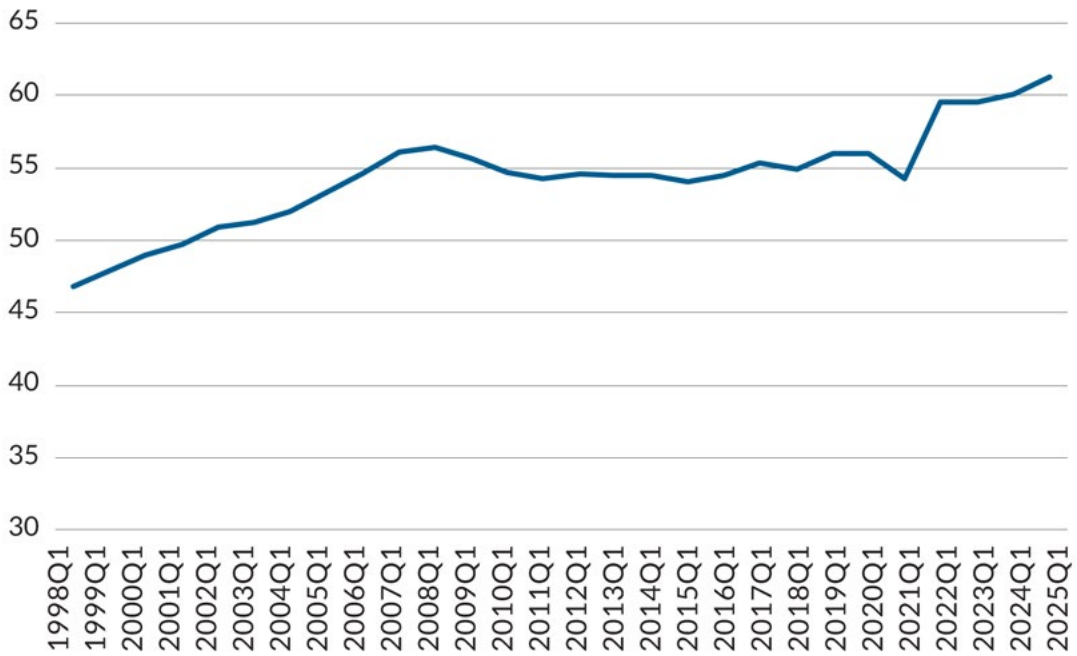
On frailty, the Irish Longitudinal Study on Ageing (TILDA) has demonstrated that there is a strong age-gradient: 8.7% of those aged 50–64 were recorded as frail but this rises to 14.9% for those aged 65–74 and to 39.1% for those aged over 75.[10] Old age can also lead to reduced opportunities for movement and exercise if deconditioning sets in. These factors add to the complexity of the care required.

8. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health.
9. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health.
10. https://tilda.tcd.ie/publications/reports/pdf/w4-key-findings-report/TILDA-Wave-4-Key-Findings-report.pdf.

Population-ageing has significant implications for the volume and complexity of care and supports which are needed. Societal changes also impact on the provision of care. One such change in many countries, and especially in Ireland, is increased female labour-force participation.[11] Resulting from traditional gender roles, much care was provided by women for both children and older relatives. In Figure ii, the Commission shows the trend in female labour-force participation and it is immediately evident that a source of family/unpaid care has been reducing over the past quarter century (and before).

Rates of female labour-force participation rose rapidly between the late 1990s and 2007/8, reflecting the 'Celtic Tiger' years and then the 'Great Recession'. The rate stabilised around 55% for much of the 2010s but there seems to have been a post-COVID effect after 2021 when participation rates rose and then remained higher. This is likely to be related to remote working but, whatever the cause, the implications for female-provided family/unpaid care are clear.

Figure ii: Female labour-force participation (%), 1998–2025



Source: CSO data.

Figures i and ii provide insights into recent trends which point to current challenges in providing care for older people. It is also important to look ahead and to have a sense of how population-ageing will continue to evolve. In Figure iii the Commission draws on population projections from the Central Statistics Office (CSO) and presents projected values for the old-age dependency ratio—the population aged 65 years and over as a percentage of the population aged 15–64 years.

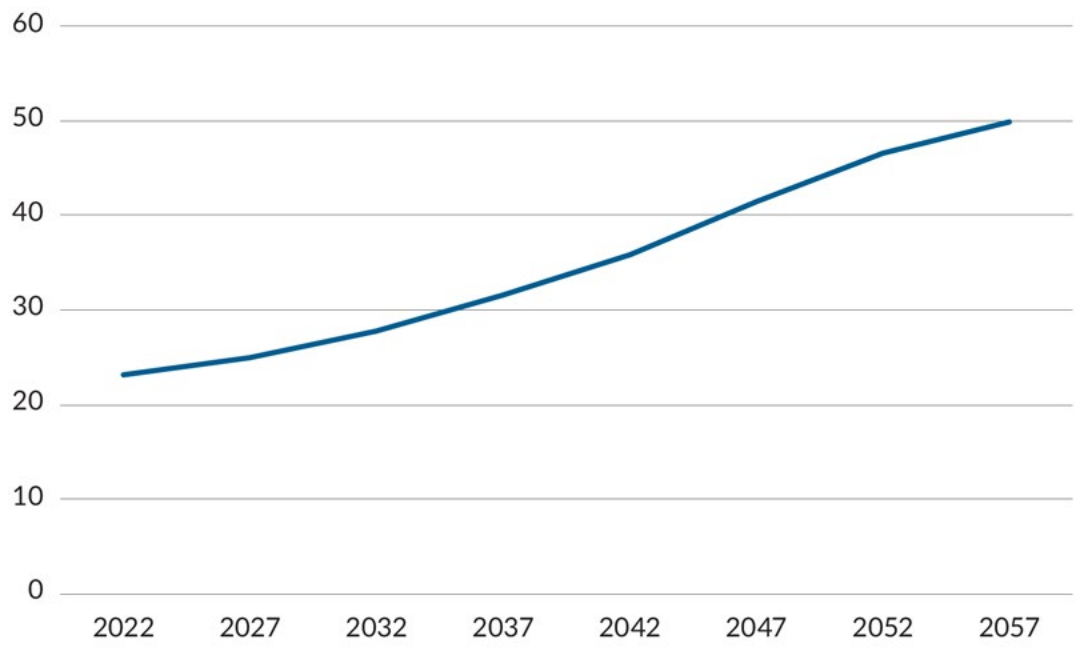
11. It is important to stress that the Commission is not suggesting that caring is a responsibility for women only nor that the increase in women working is to be viewed negatively. The Commission's focus on female labour-force participation simply reflects a reality that caring roles in families have tended to be taken on by women to a greater extent than by men.

The slope of the line in Figure iii is unsurprising but the speed with which the dependency ratio will change is noteworthy. In 2022, the ratio of just over 20% implies that there were five people aged 15–64 for every one person aged 65 or older. By around 2040, this will have fallen to three people aged 15–64 for every person in the older age cohort and by 2057 the ratio will be 2:1 younger to older.

It is always important to note, when presenting numbers such as these, that much else will change in the years to 2057, alongside the changes in dependency ratios. For example, as reduced mortality is partly a result of improved health, the care-needs of those in their 70s or even in their 80s might be very different in 2057 compared to 2025. It is also possible that improved health and a move away from physically demanding jobs will facilitate longer working lives, resulting in the concept of a 'dependency' ratio being measured with reference to 65 years of age becoming obsolete.

In spite of those caveats, it is still important to be aware of on-going population-ageing, its speed and the potential consequences for health and social care systems. It is the aspiration of every country to extend the healthy life-expectancy of its population as much as possible. Even with this aspiration being achieved, there is still a strong case for building a resilient care-system, organising existing resources efficiently and, most importantly, optimising the quality of care and support for those who need them. This must be achieved at a time when population-ageing is also placing pressures on public pay-as-you-go pensions systems.

Figure iii: Old-age dependency ratio 2022 and projected values 2027–2057

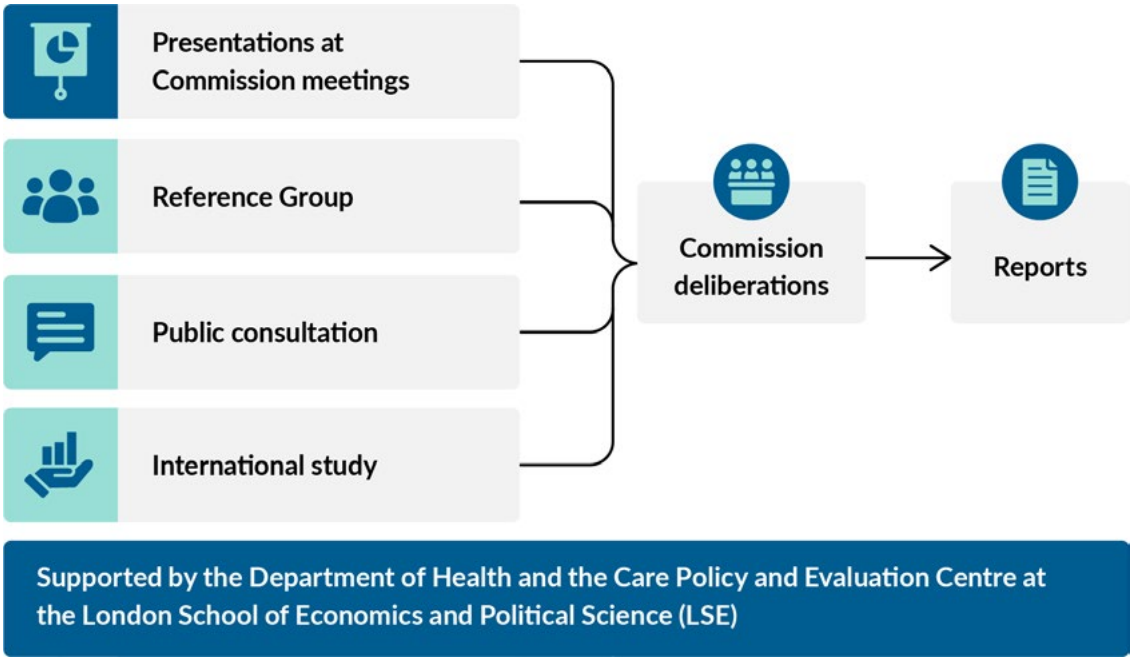


Source: CSO projections, based on their M2 scenario.

Work of the Commission

In order to illustrate how the Commission has organised its work, Figure iv provides a representation of the process which was adopted. The Commission's task has been to accumulate information from multiple sources (the left-hand column in the figure) whereby the expertise embodied in the Commission members was augmented to the greatest possible degree. Drawing on Commission members' collective existing knowledge and on what the Commission has learned through the information-gathering process, Commission members are working together to write the Commission's reports, including its recommendations.

Figure iv: The structure of the Commission's work



Immediately after the appointment of members in the spring of 2024, the Commission met and discussed how to go about its work. As shown in Figure iv, there were a number of strands to the Commission's work in Module 1 which are listed here and then discussed in turn:

- Meetings of the Commission, with presentations from relevant experts and discussion among members.
- The establishment of a Reference Group made up of stakeholders with whom the Commission met to elicit views.
- A public consultation through which members of the public and organisations could submit views.
- A study of practice and experience in three international settings.

In all aspects of the Commission's work, it was assisted by officials in the Department of Health and by the Care Policy and Evaluation Centre at the London School of Economics and Political Science (LSE). However, it is important to emphasise that the Commission is independent and has acted accordingly.

Meetings of the Commission

Although each member of the Commission brought a depth of knowledge and experience from their own perspective on health and social care for older people, the Commission recognised that it was important that all members became as well-informed as possible about the broad spectrum of issues, challenges and modern thinking. With this in mind, from June 2024 the Commission set about meeting every two weeks and inviting experts on various topics to present to the Commission and to take questions. These meetings were also informed by briefing notes prepared by the Commission's research consultants, the Care Policy and Evaluation Centre at the LSE. One important outcome across many of these meetings was a recognition on the part of Commission members that there are many positive policies being implemented and proposed. While the Commission recognises the many positives, it was often concerned about inadequate and/or unequal delivery of services.

Towards the end of 2024 and the beginning of 2025, the Commission began to draft the chapters in this report with the support of the LSE. Referring back to the 'Terms of Reference', in each chapter the Commission aimed to assess the effectiveness, efficiency and adequacy of various supports and to build up a knowledge base for the Commission itself and for interested parties.

On occasions, the Commission took time during meetings to reflect on what its learning and to develop an initial sense of the key issues and the possible direction which would be taken in the Commission's reports. A meeting in early September 2024 was devoted to discussing the 'Summary/lessons learned' section of this report, in which the Commission brings together the lessons learned in Module 1 to inform Module 2.

A full list of the Commission's meetings and of presentations to the Commission is detailed in Appendix III.

Reference Group

Under the 'Terms of Reference', the Commission was asked

- to convene a Reference Group of non-governmental and civil society organisations and other key stakeholders working in the area, including those with lived experience. The Reference Group will engage, in an advisory capacity, with the Commission and the Cross-Departmental Group, established under its auspices. The Reference Group will not make recommendations or have any decision-making authority.
- Early in the Commission's deliberations, Commission member Catherine McGuigan was asked to establish the Reference Group and to act as its Chair. The approach adopted by the Commission was to be as inclusive as possible when inviting people and organisations to join.

The Commission was eager to draw on the experience and views embodied in the Reference Group and so a series of consultations was organised, as detailed in Appendix V. At each consultation, all of which were attended by the Commission Chair and by a number of members, a mix of plenary and breakout discussions was held. Much effort was invested in ensuring (a) that those present had an opportunity to contribute and (b) that the views expressed were captured through note-taking. These notes were subsequently written up and provided to all Commission members so that the views would act as a further input in the Commission's information-gathering efforts.

Public consultation

The Commission's 'Terms of Reference' refer to how 'engagement and collaboration with stakeholders (inclusive of representatives from across Government and civil society) will be a central component of the work of the Commission'. One form of this engagement was to be a public consultation and the Commission set about arranging this soon after being established.

The All Island Institute of Public Health (IPH), through the Department of Health, was asked to organise the public consultation. On 29th August 2024 an online survey (English, Irish and easy-to-read formats) was opened and it remained open until 8th November 2024. The consultation was advertised in the national print media and various social media channels were also used. The survey included a combination of closed (quantitative) and open-ended (qualitative) questions on health and social care services and supports for older people. The topics covered included information, communication, access, quality, affordability, care-needs assessment, service-provision, care options, workforce, safeguarding, technology, funding and family/unpaid carers. In total there were 1,489 valid responses.

With so many responses, it was not possible for Commission members to read through each. Instead, the IPH was asked to employ methods from qualitative research whereby the views expressed could be condensed and presented in a way that captured the major themes and concerns. The resulting report was provided to Commission members. As with the reports on the Reference Group consultations, Commission members were eager to hear views and to ensure that the views expressed impacted upon its deliberations.

International experience

The 'Terms of Reference' specified that the Commission should 'undertake an international review of best practice in older people's care in selected countries to identify options for Ireland'. In order to fulfil this, but more importantly by way of generating more information and insight, the Department of Health (on behalf of the Commission) asked the Health Research Board to undertake this review.

It was agreed that a review covering three countries would be useful and tractable and discussion ensued on which three countries could provide most insights. The countries chosen were Finland, New Zealand and Alberta, Canada. The HRB recruited experts in each of these countries and, informed by the experts' advice, the HRB researchers produced three evidence briefs outlining the information gathered. In addition to being provided with these evidence briefs, the Commission also met with the HRB researchers and the national experts to discuss their findings.

Summarising our approach to our work

Since March 2024, the members of the Commission have met almost every two weeks (in person and online). For much of 2024, the Commission worked to develop its knowledge both individually and collectively by inviting national and international expert to address the Commission. Parallel to Commission meetings, the information available to the Commission was enhanced through the provision of reports on the meetings of the Reference Group, the public consultation and the HRB's evidence briefs.

According to the 'Terms of Reference', in Module 1 the Commission was asked to 'prepare for the consideration of the Minister for Health and Minister of State for Mental Health and Older People a report detailing the Commission's work in respect of Module 1 including any learnings for inclusion in Module 2'.

For much of 2025, the Commission drafted the chapters of the requested report. Based on the information gathered, these chapters seek to address the request in the 'Terms of Reference' to assess the effectiveness, adequacy and efficiency of the various health and social services. The Commission also reflected on the lessons learned to date and, again with reference to the 'Terms of Reference', incorporated the opening chapter (above) which summarises these lessons.

Concluding comments

Before proceeding into the body of this report, the Commission has set out here some principles which were agreed among Commission members and which have served as an important framework for much of the Commission's work and discussion.

1. Much discussion about *Care for Older People* has a negative tone in terms of language and sentiment, which is unhelpful. These discussions and narratives seem to view *Care for Older People* as merely managing decline later in life and paving a tolerable path towards death. Rather than seeing care in this way, we are eager that *Care for Older People* should be re-framed as facilitating people in living their best lives and in thriving for as long as possible.
2. Older people are a highly heterogenous group and care-needs form a spectrum. Many older people are living well and happily and have no care-needs. Others may have minimal needs. Needs evolve over time for individuals. Systems should ideally cater for this, including seamless transition between, for example, homecare and residential care.
3. While the role of the Commission is to make recommendations on how care and support for older people can be improved, the Commission accepts that there are, and have been, positive developments and initiatives in this area in recent times. Examples include work across the local authorities. The imperative to build on these positives where they exist is acknowledged.
4. Care should facilitate people to remain in their homes and communities for as long as possible, with the independence and autonomy of older people respected.
5. Where it is no longer possible for people to remain at home, long-term care should be as home-like as possible in terms, for example, of location and the scale of facilities and autonomy for residents.
6. Equity of access to services and supports should be central to all the Commission's recommendations, with equality covering many dimensions such as income, wealth, urban/rural, disability status and others.
7. The role of informal carers—both relatives and others—should be fully recognised. While nobody should be forced into a full-time caring role due to a lack of state support, services should strive to complement informal care where this is the choice of individuals and families.
8. A range of specific issues arise in the cases of people with dementia and with disabilities which the Commission needs to address. In the case of people with intellectual disabilities, we also need to be aware that the ageing process occurs more rapidly in this group, with implications for ages at which interventions and supports are needed.
9. Loneliness is a recurring theme and while all age groups are susceptible, there is an imperative for the Commission to address the problem among older people.
10. The remit of the Commission notwithstanding, it should be stressed that care-needs can be minimised and postponed through a variety of prevention strategies, and that health and social care services should expand efforts in this realm.

1

Primary and community care: part 1

1.1 Summary

This chapter is the first of two linked chapters on the state of primary- and community-based health and social care services and supports for older people in Ireland.

This chapter focuses on policy context and provision of services provided by local authorities and non-governmental organisations (NGOs), as well as community groups, to help older people continue to live well at home and age in place. The chapter therefore focuses on issues such as social functioning, maintenance of independent living and early intervention for ageing well at home. It also sets out the context in which these activities are integrated with other elements of the primary and community care continuum. However, detailed analysis of the state of these other aspects of primary and community care is discussed in detail in a second chapter, 'Primary and community care: part 2'.

1.2 Introduction

1.2.1 Policy landscape

The majority of all health and social care in Ireland is delivered within the community. These services are vital to allow people with health and social care needs to remain living at home and in their communities and to live the lives they want.

The *Sláintecare Report* has been an important impetus in providing a model to help enable living well at home. The report provided a number of recommendations to help develop a more universal system of care for older people [1] and key recommendations based on the development of a more progressive integrated care system that centres itself in primary and community health and social care services. The proposed model places a renewed focus on moving care and support further away from the hospital and instead being delivered by an interlinked and integrated set of community-based services.

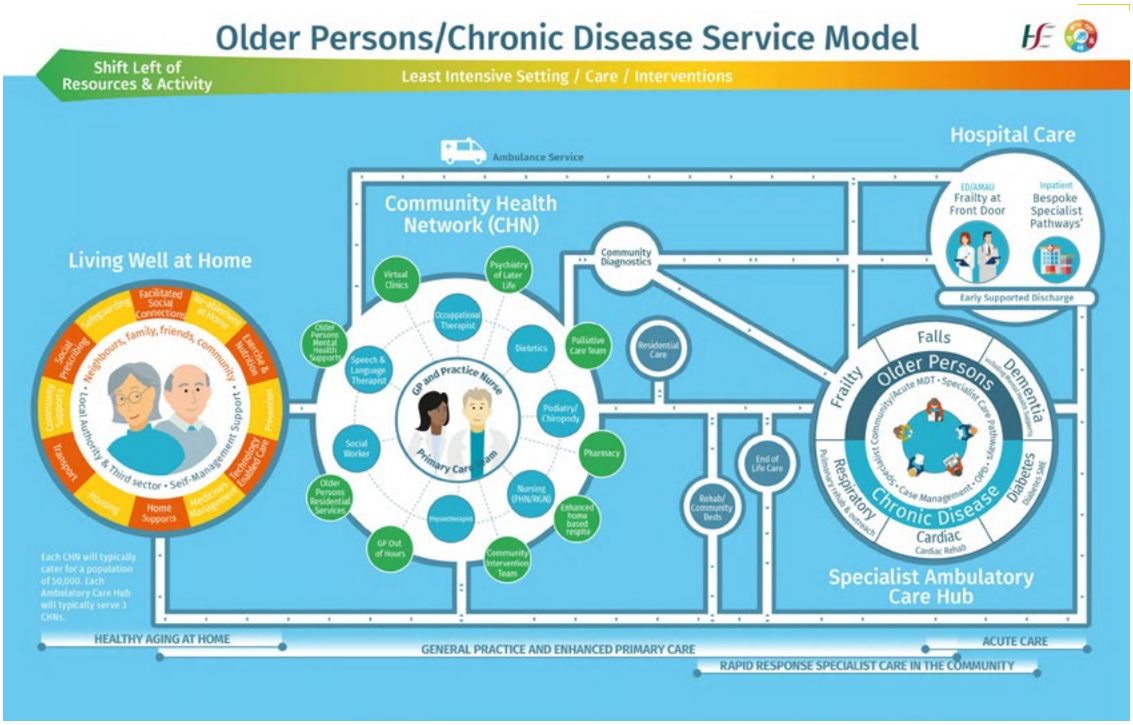
At the same time in Ireland, and many other high-income countries, there has also been a growing recognition of the importance of wellbeing. A 'Well-Being Framework' covering 11 domains, including physical and mental health, as well as community, connections and social participation, where loneliness is one of indicators, provides an opportunity to assess performance of health and social care in improving older people's outcomes in a more holistic way [2, 3]. The *National Volunteering Strategy 2021–2025* also 'aimed to recognise, promote and grow the unique value and contribution volunteers make to Irish society', including the benefits of volunteering to older people [4]. The *Strategy*, for example, featured a case-study of a volunteer befriender visiting a visually impaired older person.

The *National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland 2020-2025* built on this policy approach describing a continuum of health promotion, disease prevention, diagnosis, treatment, disease management and rehabilitation services that are coordinated across different healthcare providers and healthcare settings [5]. It pointed not only to the ageing of the population, but also that more than half of all adults aged 50 years and over were living with at least one or more of four chronic diseases: asthma, chronic obstructive pulmonary disorder (COPD), diabetes or cardiovascular disease.

A new model of older people's care that has emerged since the publication of the *Sláintecare Report* emphasises the provision of healthcare in less intensive settings, enhancing general practice and primary care, and integration of healthcare services such as community-based therapy services, community nurses, with GPs and primary care staff being at the centre of this new model of care. These services will be the focus of the next chapter. As Figure 1.1 illustrates, this focus should mean that there is a 'shift left of resources and activity' to help support healthy ageing at home, as well as towards prevention and early intervention to meet needs of older people, as well as the needs of people of all ages living with chronic diseases [5].

This chapter will concentrate on the left-hand side of this model, looking at the state of services and supports for living well at home, much of which will be provided by NGOs and/or local authorities, as well as by community groups. General practice and enhanced primary and community care services are discussed in the chapter, 'Primary and community care: part 2'.

Figure 1.1: Reframing the focus of primary and community care in Ireland



Source: [5].

1.2.2 Healthy ageing / living well at home

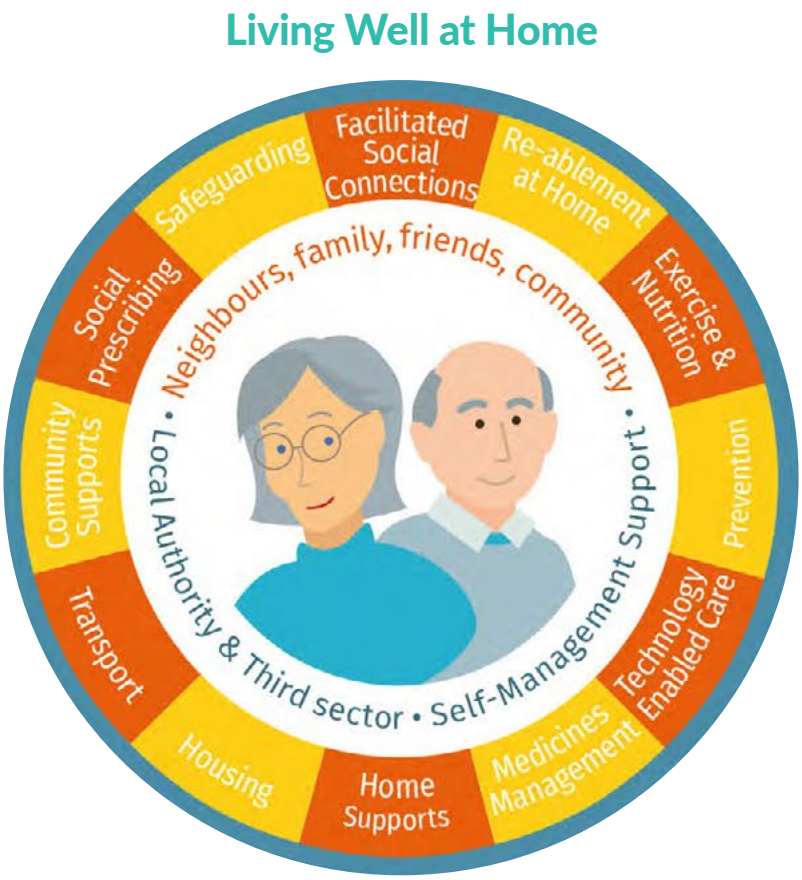
Many different activities, including those delivered within people's homes and in the wider community, can facilitate living well at home. The *National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland 2020–2025* highlighted a number of these activities as shown in Figure 1.2. The Framework outlines that these activities require the input of many different actors. In addition to older people themselves, they include local authorities, NGOs, as well as friends, families, neighbours and local communities. Areas covered include potential legal, quality assurance and regulatory mechanisms for safeguarding, as well as the importance of transport as an enabler for people to engage in local activities and/or connect with health and social care services. Prevention, better nutrition and exercise are also highlighted.

Several areas focus on social and community inclusion, for instance helping to tackle social isolation and/or loneliness through the promotion of social connections. One way of doing this is through social prescribing. Social prescribing has been defined in Ireland as 'a means of enabling healthcare professionals and other professionals to refer people to a range of local, non-clinical services, primarily provided by the voluntary and community sector' [6]. The approach recognises that health can be promoted, and ill-health addressed or prevented, through non-medical means, for instance focused on enhancing participation in social activities. Workers known as 'community connectors' link older people to social activities in their local communities. These activities can be diverse. Examples include taking up a new hobby, including arts or creativity, green activity [7], or becoming a volunteer [8]. Social prescribing can include referrals to group-based exercise (e.g., participation in various dance-related activities), or to one of more than 100 parkruns and parkwalks all over Ireland[9][12].

Other steps to help people live well at home, such as housing (supported living) and home supports, medicines management, technology-enabled care and rehabilitation at home are not discussed in detail here, as they are covered extensively in other chapters of this report.

12. See https://blog.parkrun.com/ie/2025/03/19/social-prescribing-day-2025/.

Figure 1.2: Key themes / approaches for living well at home



Source: [5].

1.2.3 Multiple funding sources and multiple service-providers

Section 1.2.7 looks specifically at the formal role of ALONE in the integrated primary and community care ECC programme. However, there are many other non-state actors involved in the provision of services to help older people to live well at home, including services supported by local authorities and other NGOs. These schemes may also have funding from many different sources including different Government departments, other state-funded bodies and local authorities. Many activities may also rely on donations from the public, nominal user-charges and/or be reliant partly on support from philanthropic organisations. The range of organisations involved in older people's care is far too broad to cover adequately in this chapter, but here we highlight their role, and the role of local government through the example of Age Friendly Ireland.

1.2.4 Age Friendly Ireland

The Age Friendly Ireland shared service, 'supports cities, counties and towns across Ireland to prepare for the rapid ageing of the population by paying increased attention to the environmental, economic and social factors that influence the health and well-being of older adults' [10]. It is fully affiliated to the World Health Organization's (WHO) 'Global Network of Age Friendly Cities and Communities'[13] and works across the eight domains of the WHO's 'Age Friendly Framework' [11]. Originally established in 2009 and initially funded by Atlantic Philanthropies, Age Friendly Ireland is now directly funded by the Government, having transitioned into a shared service of local government in 2017, and it is hosted by Meath County Council.

Within the Age Friendly Ireland shared service, there are 39 shared services with a cost to the local government sector of over €22 million *per annum*. 20 of the shared services are managed by the Local Government Management Agency (LGMA) and the remaining 19 shared services are managed by an approved single lead authority or by regional structures, which involve 17 local authorities.

The national shared service office manages its operational structures through the 31 local authorities and delivers programmes and services for older people from its national head office. It 'brings together, supports and provides technical guidance to the 31-local authority-led, multi-agency Age Friendly City and County Programmes'[12]. Each local authority funds and sustains the Age Friendly Programme in their jurisdiction under the auspices of the shared service and this is anchored in multi-stakeholder collaboration and working in partnership with the critical agencies across Ireland who support ageing in Ireland.

The local Age Friendly Programmes act as a central co-ordinating function for a range of initiatives and services that support older people in their communities. They actively promote partnerships and collaboration. An important element of the approach to planning is the involvement of older people through Older People's Councils.[14] These are

> two tier structures that have a wide membership base representing older people in the community, and an elected Executive Committee. The membership is made up of individual older people and older people's groups, [...] for example active retirement groups, people with dementia, people living in residential care, and people of different ethnicities' [13].

There are approximately 7,000 members across the country. Through the Older People's Councils, each local Age Friendly Programme produces a 3–5 year strategic plan in consultation with older people.

13. See https://extranet.who.int/agefriendlyworld/network/.
14. https://agefriendlyireland.ie/older-peoples-council/.

In addition, following a pilot in nine areas, there has been a national rollout of another Age Friendly Ireland initiative: the *Healthy Age Friendly Homes Programme*. This is a support coordination initiative which aims to support up to 10,500 older people annually [14, 15]. With recurring funding from the Department of Health's older persons' budget of €5.2 million *per annum*, a Local Healthy Age Friendly Homes Coordinator

> in each of the 31 local authorities conducts home visits and assess[es] needs across six domains: health, housing, social and community supports, assistive technologies, climate, and finance. They then work with each older person to design a personalised action plan to support their health and independence [15].

Age Friendly Ireland (and the Older People's Councils) also work with the Integrated Care Programme for Older People (ICPOP) to establish structures to help map the local resources to which older people can be directed (i.e., co-production of integrated care approach).[15]

1.2.5 Examples of NGOs supporting older people to live well

NGOs play a key role in the provision of services for older people in Ireland. In Section 1.2.7 we will focus specifically on the role played by the NGO ALONE, in delivering 'Living Well at Home' services as part of the HSE's ECC programme. This section will briefly highlight some of the other NGOs that are undertaking diverse activities that can help older people to live well across the country.

Third Age/Age Well

Third Age is a national voluntary organisation celebrating the third age in life when people may no longer be in paid employment, but can remain healthy, fulfilled and continue to contribute to society. Third Age delivers a number of innovative national programmes and supports older people to remain engaged and to contribute to their own community for as long as possible. Revenue is generated from many different sources, including income from the HSE for the AgeWell programme [16]. AgeWell is a community-based model of integrated care, supporting older people to remain safer and healthier in their own homes for as long as possible, by identifying potential health problems at the earliest possible point. This is done by combining peer-based social engagement and mobile technology to improve health outcomes and wellbeing among older people. AgeWell Companions conduct home-visits to older people to provide social engagement and, if required, act as a link to the healthcare system and local community services to promote health and build stronger connections between older adults and the services available to them in their community. Other programmes include the *Fáilte Isteach* ('Welcome In') programme in which older volunteers support new migrants through conversational English classes and a senior confidential listening service for older people, which is delivered by trained older volunteers and open 365 days a year, from 10am–10pm.

15. https://www.hse.ie/eng/about/who/cspd/ncps/older-people/resources/making-a-start-in-integrated-care-for-older-persons-a-practical-guide-to-the-local-implementation-of-integrated-care-programmes-for-ncp-older-persons.pdf.

Age & Opportunity

'Age & Opportunity Active' is the National Programme for Sport and Physical Activity for Older People, funded by Sport Ireland and the HSE. The programme is designed to get older people to be more active and participate in recreational sport and physical activity. They deliver a number of initiatives such as physical activity training, including for carers, and a telephone mentoring service that encourages participants to start getting more active.

Age Action

Age Action delivers a 'Care and Repair' scheme which carries out small DIY jobs, free of charge, for older people to help them maintain their homes and their independence. This service prioritises carrying out jobs in the homes of older people who are being discharged, or have recently been discharged, from hospital. The service is funded on an annual basis by a number of statutory agencies and its own independent fundraising efforts. Grant aid from the HSE represents the bulk of the statutory income that Age Action receives [17].

Muintir na Tire

Muintir na Tíre is the National Association for the Promotion of Community Development. They manage the 'Community Alert' scheme—a crime-prevention and community-safety programme involving 1,400 local groups which operates in partnership between *Muintir na Tíre* and *An Garda Síochána*. Other schemes include action to ensure essential medical information is readily available in a prominent location in the homes of older and vulnerable people and help to encourage and support the participation of late-adopters of technology in an inclusive knowledge society. Nearly all of *Muintir na Tíre*'s State grant income is provided by the Department of Justice and the Department of Social Protection, with 13% provided by the Department of Health [18].

Gaelic Athletic Association (GAA)

The GAA is the largest voluntary organisation in Ireland. It runs a social initiative with the aim of making GAA clubs more age-friendly by increasing the participation of older members of society, with a focus on older men. The social initiative runs events specifically designed to enrich their lives and respect the important contribution they have made, and can continue to make, to community life. Although the GAA does receive some funds from the HSE and the Department of Health, these are for suicide-prevention and broader health promotion issues [19]. ALONE have also established links with the GAA as part of its support coordination activities (see Section 1.2.7).

The National Meals on Wheels Network / Irish Rural Link

Irish Rural Link has set up a national network for meals-on-wheels groups that provide community-led services dedicated to meeting the nutritional and social needs of older and vulnerable people. HSE Section 39 agreements[16], as well as the Pobal Dormant Accounts Fund and Community Services Programme, are among the funders of meals-on-wheels providers [20].

Society of St Vincent de Paul (SVP)

The SVP's main area of work is personal visiting with people of all ages who need help and assistance. They state that they 'aim to provide practical, emotional, and social support to adults and older adults to increase their skills, their coping skills, their mental health and their physical wellbeing' [21]. They are also one example of an NGO that has a strong focus on one of the wider determinants of health, namely poverty. They engage with, and provide direct assistance to, families and individuals of all ages to alleviate the impact of poverty. Their supports are aimed at both immediate relief and long-term self-sufficiency.

1.2.6 Examples of activities supporting older people to live well

Activities delivered by different non-health sector actors are multi-sectoral focusing on cross-cutting issues. Examples, in addition to health-specific interventions, can include housing and interventions to promote social inclusion, for instance through intergenerational projects in schools, digital upskilling (which also can tackle isolation), as well as cultural, sports or leisure activities. Local authorities also deliver 'Healthy Ireland' programmes of work and 'Healthy Communities' targeting areas of greater need in urban locations, as well as programming through public libraries, arts offices, museums and cultural centres, and active travel teams that directly supports older people in their communities.

Projects undertaken by different community groups and NGOs vary in size. Age Friendly Ireland has compiled an online directory of many projects across the country. This has been utilised to give some examples of the types of activities that are undertaken. Table 1.1 provides examples that have been grouped by Age Friendly Ireland under selected WHO 'Healthy Ageing Framework' themes. In total the directory contains brief descriptions of 399 projects, as well as varied information on their implementation and outcomes.[17] Some limited information is provided on budgets, with 95 of these projects having a cost in excess of €10,000, although the actual level and source of funding is not usually provided.

16. HSE Section 39 refers to Section 39 of the Health Act 2004, which is the legal basis for the Irish Health Service Executive (HSE) to provide assistance, funding, and support to voluntary and non-statutory organisations that deliver services similar to those the HSE provides.
17. Available at https://agefriendlyireland.ie/initiatives/initiatives-directory/.

Under the WHO's 'Community Support and Health Services' category there is a description of a programme of various fall-prevention activities, including tai chi, step classes, Pilates (followed by a social 'cuppa') that were delivered in four local libraries across a rural county in Leinster. A challenge highlighted in the implementation of this scheme was the recruitment of the right class instructor for each participating group, as levels of fitness varied. Under the 'Transportation' theme, Table 1.1 provides some information on a project involving the Irish Red Cross. This is a volunteer driver service in a rural county in the west of Ireland to help people (mainly older people) get to health care services. Many of the volunteer drivers are themselves older people. One key implementation challenge highlighted is recruitment of volunteers.

There is much diversity in the types of programmes delivered and sources of funding of these programmes. For example, there are relevant projects carried out under the 'Creative Ireland Programme' that is supported by the Department of Tourism, Culture, Arts, Gaeltacht, Sport and Media.[18] Some of these, but not all, are included directory of programmes collated by Age Friendly Ireland. 'Creative Ireland' is an all-of-government culture and wellbeing programme that aims to 'inspire and transform people, places and communities through creativity.'[19]

One of the work-streams of 'Creative Ireland' pertains to health and wellbeing. Some projects have targeted the whole population, including older people, while some have focused specifically on older people. For example, the programme has supported a number of social prescribing projects such as a programme of libraries and community creative cafés in a town on the east coast, bringing together people of all ages with disabilities to help improve the mental health and wellbeing of participants and reduce their sense of isolation. Another social prescribing example in a county in Connacht involved creative cafés/hubs offering creative writing courses, book clubs, social storytelling, visual art and craft, choirs and other creative disciplines with a social theme for different age-groups.

In partnership with Age Friendly Ireland, 'Creative Ireland' have also invested in regional creative initiatives, such as songwriting and music taster sessions and opportunities for older people to become *céilí* dance trainers in their local communities. Funding is variable depending on the scheme for example, in 2022 €0.56 million was awarded to 16 new 'Creativity in Older Age' projects to be delivered by local authorities. These projects were diverse, including radio soap operas, community gardens and development of lace-making skills in Men's Sheds [22]. There are also examples of technological interventions to help people live at home. The 'Seniors Alert Scheme' run by the Department of Rural and Community Development and the Gaeltacht, is administered by Pobal.[20] This scheme is intended, in part, to facilitate social inclusion by providing personal alarms for people aged 65 and over, so that they have more confidence about continuing to live in their own homes.

18. https://www.creativeireland.gov.ie/en/about/.
19. https://www.creativeireland.gov.ie/en/.
20. https://www.pobal.ie/programmes/seniors-alert-scheme-sas/.

Table 1.1: Illustrative examples of different community activities (funding over €10,000) to help older people live well at home

WHO Theme	Project Lead and Focus	Target Group	Location	Observations
Civic Participation & Employment	National NGO, focus on supporting migrants with English-language skills needed for integration in Ireland	2,500 older people who become volunteer tutors supporting integration of migrants (including older migrants)	National (all counties)	Need to fundraise to meet growing demands, particularly after start of Ukraine war. Recognises the benefits to older people of volunteering.
Communication and Information	Local NGO. Befriending home visits as part of meals-on-wheels and household help services	Older people at risk of isolation who are living in their own homes.	County town, central Ireland	Funding from Pobal which works with many Government departments to support marginalised individuals and groups in Ireland. Travel costs remain an issue that limits reach of service, there being only one vehicle to deliver services.
Community Support and Health Services	Local authority and HSE. Fall-prevention fitness classes (including tai chi and Pilates) delivered in local libraries with 'social cuppa' afterwards.	Older people at risk of isolation who are living in their own homes.	Several towns and villages in central Ireland.	Higher-than-expected level of demand required additional funding to provide a class in an additional venue
Respect and Social Inclusion	'Creative Ireland'-funded, local authority and community group delivered drama-production that was written, designed and performed by older people in a theatre and nursing homes.	All older people in a specific area, with particular attention to people in more socially isolated communities and nursing homes.	Performance in a main town in a border county and in surrounding rural communities	Time-limited. First tranche of budget just over €12,000; further funding. Performances were free-of-charge. Key to success was having drama director with MA in Dramatherapy, and local authority help in sourcing venues for performances and creative development workshops.

WHO Theme	Project Lead and Focus	Target Group	Location	Observations
Social Participation	Delivered by national NGO, supported by HSE and local government, with funding from 'Creative Ireland' and Healthy Ireland. Cultural companions programme to build a network of older people with similar cultural and arts interests.	All community dwelling people aged 55+. Specific groups mentioned include socially isolated and people with limited mobility.	Focused on a large city in Munster with many cultural activities, as well as satellite groups in neighbouring towns.	Active co-ordinator engaging with various community groups, e.g.. Men's Sheds to promote local buy-in. Peer-designed programme of cultural events and activities. Referrals from social prescribers and also ALONE into programme. Financial constraints on participants may limit activities to free events only.
Transportation	Delivered by Irish Red Cross and reliant on fundraising and donations. Volunteer driver transport to healthcare appointments.	Volunteers are often older people and service targeted mainly at older people who have difficulty getting to medical appointments due to physical, mental or emotional illness and disabilities.	Rural county in the west of Ireland	Challenges of constant fundraising to sustain service. Challenge in recruiting and retaining volunteers. Process of applying for grants lengthy, impacting on vehicle and training centre improvements.

1.2.7 Example: ALONE, 'Living Well at Home' and the Enhanced Community Care programme

The chapter has already shown that many different NGOs and local authorities are involved in delivering services to help people live well at home. Here, we highlight the experience of a national NGO, ALONE, which since 2022 has had a formal partnership with the HSE to deliver 'Living Well at Home' services as part of the HSE's ECC programme. It is specifically focused on supporting the needs of older people and looks at issues including social isolation, loneliness, frailty and housing difficulties. Insights gained from examining the experience of ALONE's involvement are also likely to be relevant to other NGOs, local authorities and community groups involved in delivering similar services. For example, the chapter has noted that 'community connectors' in ALONE and other organisations promote social connectedness and facilitate social activities.

Overall, through all of its activities, including the ECC programme, ALONE supported almost 44,000 people in 2024 [23]. In addition to the support co-ordination described in more detail later in this section, the full range of activities delivered by ALONE include a 'National Support and Referral Line' to allow direct access to ALONE's integrated service model. They also have both telephone and home visitation support and befriending, have social prescribing integrated into their services, as well as creating an infrastructure to help empower older people to use technology. They receive funding to build the capacity in the NGO/ community sector and provide back-office support to other NGOs.

ALONE is one of many actors, including Age Friendly Ireland, with local authorities at the lead, and other approved housing bodies (NGOs and private sector) involved in the provision of supported living services. These are discussed in the 'Supported living' chapter. This includes a 'housing with support' model of universal design housing for older people to help reduce the need for residential care [23].

More than half of all services co-ordinated by ALONE are delivered in collaboration with multiple government and State agencies, as well as various advocacy organisations, and community-based service-providers [24]. Many of these services are delivered though a volunteer-orientated model, thus the reach and sustainability of many of these activities in all organisations will depend on the availability and continued participation of volunteers of all ages. That said, the functioning of ALONE programmes is also dependent on having a substantial professional workforce. There are now almost 250 ALONE staff including those delivering support coordination, 'housing with support' and other services [23].

Within the ECC programme the focus of ALONE's work has been

> to develop an integrated model to deliver quality approved Support Coordination, Visitation Support and Befriending, and Telephone Support and Befriending driven by assistive technology and volunteers, with a structured network of contact and support at Community Health Network level across all health regions [24].

Social prescribing is also a part of this approach. In 2024 it received €8 million from the HSE for these activities [25].

ALONE provides support co-ordination services…

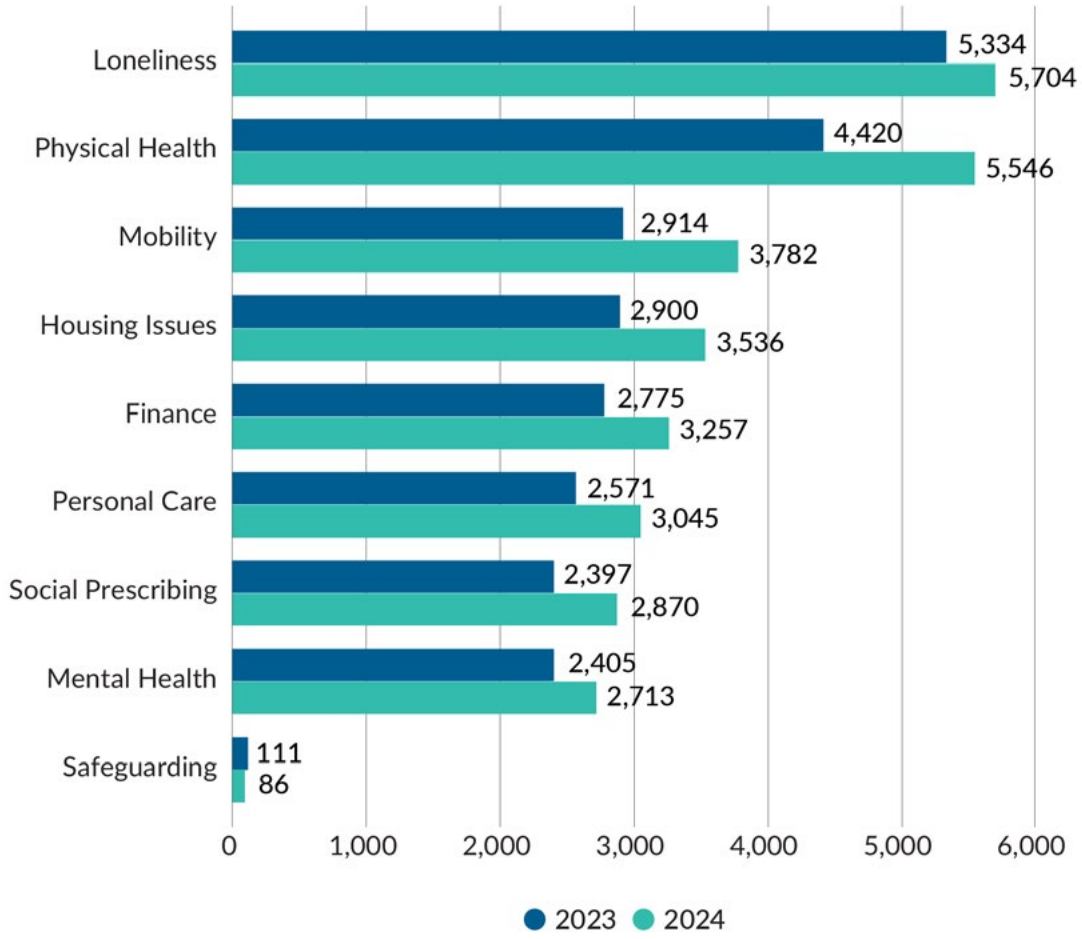
> to empower older people by devising personalised support plans to address challenges and find solutions. [They] offer access to their own services while coordinating and enabling older people to access other services in the community. These are medical as well as non-medical sources of support to improve physical, emotional and mental wellbeing [23].

Following an assessment of needs of the older person, personalised support plans are developed. These may include direct provision of services, or coordination and help to access other non-medical support within their community. This could involve the use of assistive technologies and social prescribing. Examples of links to community and voluntary supports through ALONE include links with the GAA, the Irish Countrywomen's Association (ICA) and Men's Sheds in the different areas.

1.2.8 What sort of needs do people have to continue to live well at home?

One source of information on the types of needs older people in Ireland have to live well at home are the assessments carried out by ALONE. In 2024 10,979 assessments were conducted in which individuals are asked about the different areas in which they feel that they need support. Figure 1.3 shows that in both 2024 and 2023 loneliness was the most frequently noted area of concern, with approximately 30% of assessment participants indicating their last social outing was more than a month ago. Of the 5,546 people who expressed physical health concerns in 2024, 29% reported falls, and 12%, 9% and 7% reported memory, eyesight and hearing issues respectively. Other frequently noted issues included personal mobility and housing concerns (a third wanted housing adaptations), while approximately one-third had worries about their personal finances and a quarter about their mental health. Another earlier evaluation of almost 4,400 older adults who had their needs assessed by ALONE in 2022 and 2023 identified four core clusters of need: low levels of need (but often experiencing loneliness), physical issues, psychosocial issues and high need for multiple supports [26].

Figure 1.3: Areas of concern recorded in ALONE support coordination assessments



Source: [24].

As part of a recent impact evaluation of ALONE ECC services [27], the quality of life of 273 older people newly using services was measured, using the EQ-5D-3L, which is HIQA's recommended outcome measure when comparing the cost effectiveness of health and social care services in Ireland [28]. The sample had broadly similar socio-demographic characteristics to all older people making use of these services. It suggested that the older people who are making use of services have, on average, much lower levels of quality of life compared to mean quality of life for older people reported for 15 European countries based on the Survey of Health, Ageing, and Retirement in Europe (SHARE) dataset (utility values 0.32 versus 0.75)[21] [27]. This might suggest that older people being referred to various 'living well at home' services have much greater physical and mental health needs than the general older population. They were also found to higher levels of loneliness than reported for older people in the most recent TILDA data measured using the three-item loneliness scale [29] (5.65 versus 4.7).[22] The capabilities of older people measured using the ICECAP-O which has five domains *Attachment*, *Security*, *Role*, *Enjoyment* and *Control* were also lower than that seen in the UK older person population (0.68 versus 0.83)[23].

21. 1 is maximum score representing perfect quality of life; 0 is notional quality of life score if dead. There can also be negative scores for states of health that are considered to be worse than death.
22. 9 is maximum level of loneliness and 3 is lowest level of loneliness.
23. 1 is perfect capability. 0 is no independent capability.

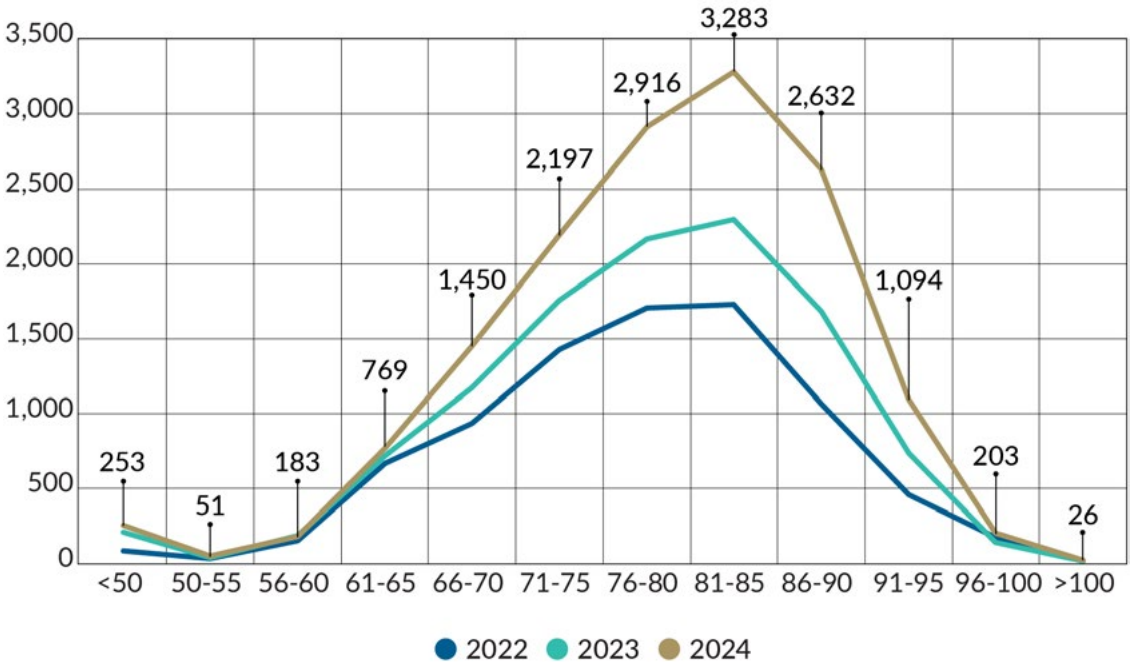
1.3 Adequacy

In this section on adequacy we use the experience of ALONE when looking at non-health-sector services and supports funded by the HSE through the ECC programme. This, it should again be stressed, is not because this is the only relevant work going on: as we have indicated earlier there will be a large number of activities carried out by local authorities and non-governmental third sector organisations. Many of these activities are very fragmented. In the case of the ALONE ECC activity however, there are annual reports which provide an overview of activities over the three years that this programme has been in operation. They provide information on the number of people making use of services and on the total number of services provided. The reports also provide information on the volunteers who are absolutely critical to the delivery of most of these services. Sources of referral to ALONE are also recorded.

1.3.1 Uptake of services

In 2024 ALONE reached about 2% of all older people in Ireland [27]. The number of people newly supported by ALONE through its support coordination service almost doubled from 8,939 in 2022 to 15,516 in 2024. Following an assessment of their needs, most of these individuals go on to receive a range of interventions, notably home visitation support and befriending, or telephone support and befriending. In addition, a further 10,183 people from 2023 continued to receive support services. As Figure 1.4 shows, the number of newly engaged clients over the age of 75 have seen the highest rates of growth over this three-year period. Although it is not possible to determine what proportion of the total older population could benefit from services, data from the final quarter of 2024 indicate that 15% of older people who had been previously been supported by ALONE were 'awaiting assessments, waiting for a match with an alternative Support and Befriending Service, or awaiting a volunteer match' [24].

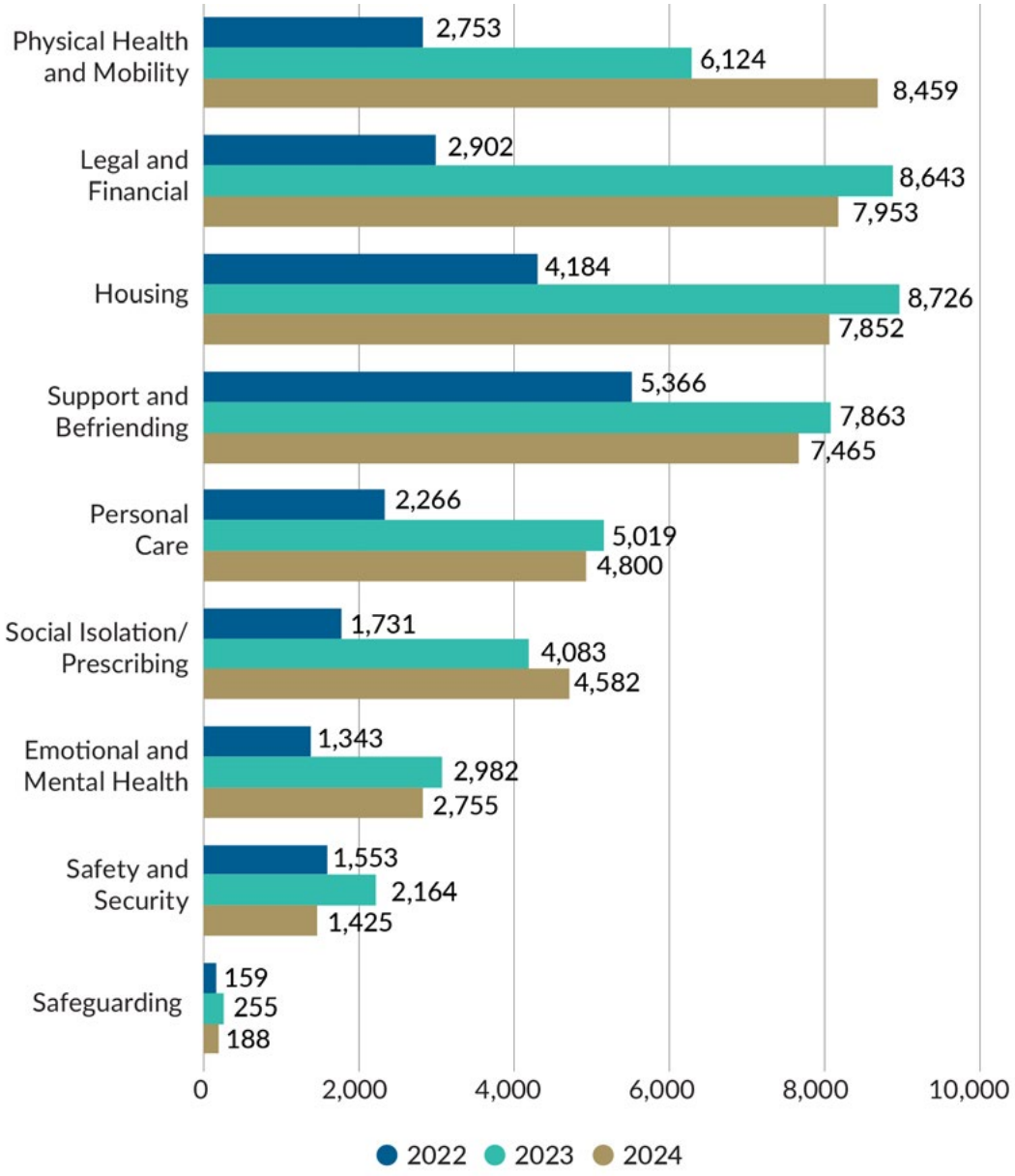
Figure 1.4: Number of new ALONE clients through ECC programme, 2022–2024*



Notes: *2024 numeric values shown.

Figure 1.5 provides an overview of the thematic areas where ALONE have provided support. This figure makes clear that among the most pressing needs of older people are legal and financial support.

Figure 1.5: Thematic areas of intervention to help older people live well at home: the experience of ALONE, 2024*



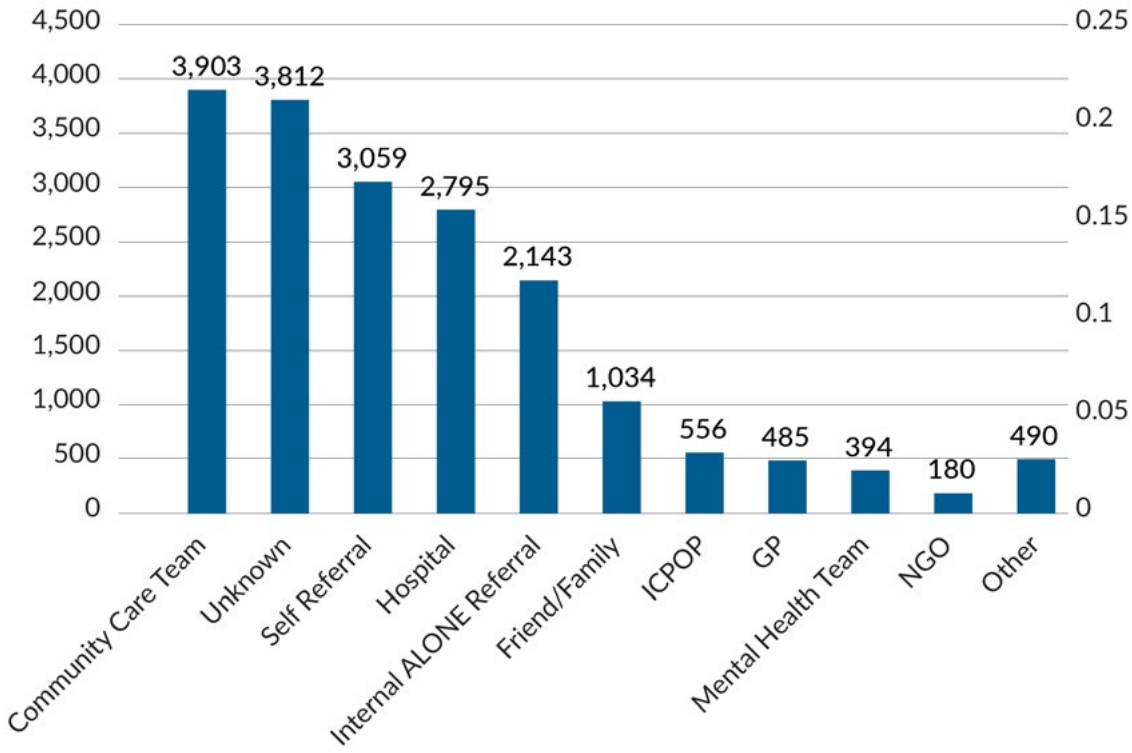
Source: [24].

Notes: *Many individuals have multiple needs.

1.3.2 Sources of referral

Information on sources of referral to 'living well at home' supports, such as those coordinated by ALONE, can help give a sense of how well these services are interlinked into the wider primary and community care support model for older people. Figure 1.6 shows that in 2024 there were 18,551[24] referrals to ALONE. Figure 1.6 shows all the principal referral routes recorded, with 21% of referrals from community care teams. Self-referral was the second-most frequent route to ALONE at 16%. Hospitals (15%) and friends/family (11%) also accounted for more than one in ten referrals. ICPOP and GPs were among other significant sources of referral, although the number of recorded referrals were much smaller than those from community care and hospital teams.

Figure 1.6: Sources of referral to ALONE, 2024



Source: [24].

24. The number of referrals is greater than number of individuals, as there may be multiple referral routes for the same person.

1.3.3 Volunteer input

Volunteers are critical to many NGOs and local community services to help older people live well at home. In Table 1.1, some challenges in recruiting and sustaining volunteers for projects were highlighted. The ALONE ECC report provides information on volunteer support over a three-year period. In 2024 volunteers provided 109,040 visitation and befriending visits, plus a further 213,506 telephone support and befriending calls to 5,614 people. In total, volunteers provided 264,430 hours of support to older people for ALONE. Using the Eurostat estimate for the average working week of 35.1 hours per week[25], this is equivalent to 7,534 full-time equivalent working weeks contributed by these volunteers. The economic value of this volunteer input is substantial: if conservatively valued using the minimum wage rate for the over 20s in Ireland in 2025 (€13.50 per hour), this would amount to a value of €3.57 million. 32% of ALONE volunteers responded to a volunteer survey in 2024 [30] with 94% indicating that they benefited from being a volunteer.

Table 1.2 shows that while the number of volunteers engaged with ALONE has increased substantially since 2022, the average number of hours contributed per volunteer *per annum* has fallen from 45.33 to 29. There is variation in the supply of volunteers across different HSE regions. This can be seen when looking solely in Table 1.3 at the number of volunteers available for the months of July, August and September 2024. The number of volunteers in the HSE Mid West and HSE South West regions were much lower than the other four areas, having, respectively, a maximum of 244 and 328 volunteers available in any one month, although the average number of monthly hours per volunteer during this time-period was very similar in all regions at just over 8 hours per month.

Table 1.2: Volunteer contributions to ALONE delivered services 2022–2024

	2022	2023	2024
Volunteers	4,956	**6,679**	9,117
Total hours contributed	224,656	**218,497**	264,430
Average hours *per annum* per volunteer	45.33	**32.71**	29.00
Minimum Economic Value of Volunteering*	€3.03m	**€2.95m**	€3.57m

Source: [24].

Notes: *Conservatively valued using 2025 Minimum Wage rate of €13.50 per hour.

25. https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Actual_and_usual_hours_of_work.

Table 1.3: Variations in volunteering for ALONE, July, August and September 2024

	July		August		September	
HSE Region	**Volunteers**	**Mean Hours**	**Volunteers**	**Mean Hours**	**Volunteers**	**Mean Hours**
HSE West and North West	561	8.04	568	8.04	516	8.03
HSE Dublin and North East	651	8.14	657	8.16	620	8.08
HSE Dublin and Midlands	521	8.23	540	8.19	474	8.08
HSE Midwest	224	8.07	229	8.03	244	8.00
HSE Dublin and South East	488	8.21	540	8.18	476	8.08
HSE South West	276	8.12	328	8.07	326	8.05

Source: [24].

1.4 Effectiveness

1.4.1 Coordination of care and support

There is some, mainly qualitative, data pointing to the development of better coordination between local authorities and/or NGOs and primary/community health and social care services, including community primary care specialist teams (also see the 'Primary and community care: part 2' chapter). In a qualitative evaluation of the nine pilot-sites of the *Healthy Age Friendly Homes Programme*, for example, local support co-ordinators assisted 27% of service-users to obtain occupational therapy services [31].

This issue of coordination has also been examined in a recent impact evaluation of activities to help people live well at home by ALONE [27]. 83% of 227 respondents to a survey of individuals who had referred at least one individual to the service found that the referral and support co-ordination process was straightforward and would continue to make referrals. However, only 60% felt that there was good awareness of the role of these services among the wider health and social care stakeholder community.

1.4.2 Effectiveness of assessment and subsequent tailored support

Changes over a 6-month period in levels of loneliness, capability, quality of life and mental wellbeing in 273 older people newly referred to ALONE support coordination services have also been examined [27]. This evaluation found that there may be a significant association over time between receipt of living well at home service, with small (but statistically significant) improvements in all of these measures bar mental wellbeing (which remained unchanged). It also indicated that participation in these services may be significantly associated with lower community health care costs, as well as lower emergency department visit costs. One important limitation in the analysis, however, is the lack of a comparator population, but the results nonetheless suggest that the non-medical 'living well in the community' approach may pay health dividends in the short term at least.

1.4.3 Value of social prescribing

Potentially social prescribing may also be an effective approach. In looking at the effectiveness of social prescribing, we also here include experience where the community connectors (sometimes called link workers) have been based in GP practices, as well as in NGOs and local authorities. One systematic review of social prescribing interventions for adults of all ages found only eight studies with little evidence of effectiveness [32]. One reason for this limited evidence may be the small scale and time-limited nature of many social prescribing schemes, meaning that they do not have the resource to conduct formal evaluations.

That said, a recent exploratory trial looked at the cost-effectiveness of social prescribing, recruited 251 people with multi-morbidity (the majority of whom were over the age of 60) from across 13 GP practices in deprived urban areas of Ireland [33]. This trial took place during the COVID-19 pandemic, so it did not meet its recruitment target. However, if the intervention were to operate at 'full capacity' with each community connector supporting 100 people *per annum*, there would be a 79% chance of having a cost per quality-adjusted life-year gained below a €45,000 threshold—a value often used to determine whether interventions are cost effective in pharmacoeconomic analysis in Ireland.

In England, a well-designed quasi-experimental study[26] looked at the impact of social prescribing for more than 8,000 middle-aged and older adults (aged 40–74) who had one or more chronic health problems, including type II diabetes [34]. Using secondary healthcare registry data for the two years pre-intervention and four years post-intervention, the study found significantly lower annual non-elective healthcare use and costs in the social prescribing group, particularly for participants who had engaged more intensely with the service. The study's authors however cautioned that the service was very intensive so may not be generalisable to all social prescribing schemes.

26. A difference in difference approach was used. Areas where social prescribing was provided were compared with similar areas where the intervention was not available. The approach assumes that outcomes and costs in the intervention (social prescribing) area would have been the same as in control (no social prescribing area) if there was no intervention.

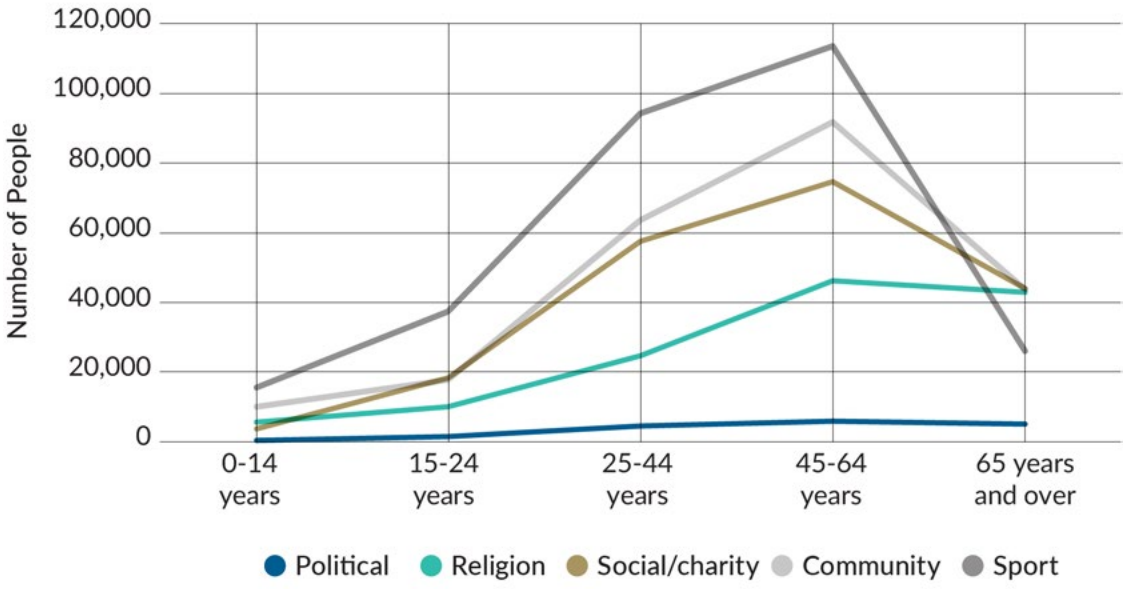
Although not discussed in detail in this chapter, there is considerable international evidence from meta-analyses of trials on the effectiveness of some types of activities that may be facilitated by NGOs, local authorities and community groups to help people live well at home and/or maintain or regain social connections within their communities. For example, there is strong evidence on the effectiveness of many types of group-based exercise activities on physical and mental health as well as risks of fall-related injuries [35]. Examples of well-studied programmes including dance and tai-chi [36], as well as some activities that help facilitate social connections.

1.5 Efficiency

1.5.1 Challenges in reliance on volunteers

In the 2022 Census 13.8% of people were engaged in volunteering in Ireland, including more than 162,000 people aged over 65 (almost equally split by gender), representing 23% of all volunteers in 2022 [37]. Social and community activities are important areas for volunteering for older volunteers in 2022 (Figure 1.7). All of this indicates that there is a substantial potential pool of volunteers to help deliver services, but as the illustrative examples in Table 1.1 and the data on ALONE volunteers indicate, there can be challenges in recruiting and sustaining the involvement of volunteers. Volunteering is of substantial economic value, but it is not a costless task, potentially there are training, supervision costs, liability and other insurance costs, in addition to volunteer travel and other expenses.

Figure 1.7: Overview of volunteering by age in Ireland, 2022



Source: [37].

1.5.2 Short-term and insecure funding

There are at least 457 registered charities in Ireland with a focus on the promotion of health and relief of health problems for people of all ages and another 752 with a focus on the social welfare needs of specific groups including older people. Around one-third of these institutions have an annual income below €100,000 [38]. A perennial problem for many small charitable NGOs is their reliance on grant-funding to ensure their sustainability. Organisations may also have to frequently pivot on their focus and type of service provided in order to apply/compete for new funding, which may be linked to the delivery of a specific activity. In England, for example, in a review of more than 600 NGOs with revenues of less than £1 million, the time-limited nature of funding was highlighted as problematic, with one theme being that they 'can't keep reinventing themselves just to fit funding criteria. Time-limited funding has led to organisations having to sometimes change the focus on their target population groups, e.g. moving away from a focus on older adults to adults of all ages who are in need [39].

1.5.3 Challenges of fragmented service-delivery and funding mechanisms

A common thread throughout this chapter is the involvement of many different organisations in the delivery of services to help older people continue to live and age well at home. Diversity in provision can create space for innovation and potentially more person-centred support services but it also means more fragmentation in provision—and all of this is within the context often of time-limited funding and uncertainty about the level of need and demand for services. This could mean that in some areas there could be multiple organisations available providing similar services whereas in others access to services may be very limited.

One example of how fragmentation can be a challenge concerns meals-on-wheels services, which as was highlighted in Table 1.1 can also offer valuable social connections. Nationally, the National Meals on Wheels Network lists over 250 providers,[27] but many areas do not have access to these services.[28] While the HSE provides much financial support through block-grants, donations and fundraising remain important funding components for these services. Reliance on fund-raising and retrospective State funding makes it difficult to plan and innovate. Also, as highlighted in a Healthy and Positive Ageing Initiative report[29], the meals provided to people could be better used to target obesity, chronic illness and inflammation, frailty, and cognitive function. Developing a more systematic funding approach could better utilise the service for other important health and social outcomes.

27. https://mealsonwheelsnetwork.ie/.
28. https://mealsonwheelsnetwork.ie/critical-need-for-community-group-as-portlaoise-without-meals-on-wheels-for-second-christmas/.
29. https://assets.gov.ie/180883/7f38971f-7aea-4f89-8717-03d17069fbf9.pdf.

Meals-on-wheels are also an important example of the challenges of a volunteer-led service. Many volunteers are older people themselves. Providers have highlighted that they find it difficult to recruit volunteers due to time pressures and limited finances, and a lack of recruitment expertise. Insurance costs have also become challenging and there is no specific insurance policy currently available for the meals-on-wheels' sector. While, similar to all community-care services, listing all providers of meals-on-wheels and their contact details could make it easier to coordinate services.[30]

1.6 Limitations in analysis

1.6.1 Fragmented information on availability of services to help older people live well at home

Some information is available: for example, ALONE in their reports indicate that they reached approximately 2% of all older people in Ireland, while information on service-utilisation is also available via Age Friendly Ireland's project directory. However, the large number of NGOs and community groups who are involved in delivering services to help older people continue to live well at home, and the many different pathways to contact with these services, means that it is currently very difficult to determine the extent to which these services are reaching people in need. It is difficult to judge whether the current model of primary and community care, with the focus on 'shifting left', is working as well as it could do without this information. As touched on above, funding for various relevant community projects is likely to be very time-limited, which also makes it difficult to map the availability of services that could meet need.

1.6.2 Fragmentation of services may limit scope for the evaluation of their effectiveness

Although, with support from universities and other research partners, some evaluations have been undertaken on the activities of some larger-scale service-providers, the small size of many organisations which deliver services makes it difficult to evaluate how effective these services are. This may mean that there are lost opportunities to identify what works best in what circumstances, for which people and at what cost. This may contrast with evidence on the medical and clinical side of primary and community care, in which evaluation is more feasible and there is more experience in conducting evaluations.

30. https://mealsonwheelsnetwork.ie/wp-content/uploads/2023/07/National-Meals-on-Wheels-Network-Pre-Budget-2024-Submission.pdf.

1.7 Learnings

There is a strong emphasis in the development and implementation of the primary and community care model in Ireland on integrating non-health service organisations into the continuum of care and support, there being a recognition that the services that these actors provide can be very important in helping people continue to live well at home and in their local communities. There is some emerging evidence of the beneficial impacts of these services, such as for quality of life and maintaining capability. Moreover, the services are receiving referrals from primary and community care health service providers, including GPs and community specialist teams. There is some limited evidence of the potential benefits of social prescribing and, in addition, for some areas of activity, such as the many different forms of exercise activity, there are robust meta-analyses indicating that there are a wide range of activities that are effective. Many of these activities, such as round dancing and tai chi, are being delivered by non-health system actors in Ireland, although the extent to which they are available is not easy to determine.

This also raises the issue of adequately mapping the availability of services. Positive steps have included the development of various directories and websites providing information on service-use. However, there are potentially hundreds of NGOs and community groups involved in the delivery of care. The experience of the delivery of services provided by ALONE was cited in this chapter because of the larger scale of this operation and the publication of annual service reports. ALONE, however, reach and support around 2% of older people in Ireland and it difficult to ascertain how and where to strengthen access to services provided by NGOs, local authorities and community groups because of fragmentation.

There is strong volunteering ethos in Ireland, with more than 160,000 people over the age of 65 engaged in various forms of volunteering. This will have benefits for their mental and physical wellbeing as well as helping others in the community. Volunteering has a substantial economic benefit as well. Nevertheless there are challenges in the recruitment and retention of volunteers and in the costs of support. These issues are raised generally by Volunteer Ireland, they are seen in some examples in this chapter and they are also acknowledged in the *National Volunteering Strategy 2021–2025*. Another key challenge for NGOs and, in particular, for community groups is their reliance on short-term sources of funding. This hampers their ability for future-planning as well as potentially forcing them to change direction and to limit the scale of their ambition in order to meet the requirements of the available grants rather than focusing on where they can best meet needs.

1.8 Strengths, weaknesses, opportunities and threats

Strengths

- The emphasis on the 'shift left' towards an integrated model of primary and community care in which non-health system actors, including NGOs, local authorities and other community groups, assess and provide support to help older people to continue to live well at home, thereby reducing the need for more intense levels of care and support.
- The involvement of older volunteers in the delivery of services is in itself beneficial for their physical and mental health and inclusion.
- There is an emerging evidence-base on the positive impact of integration and support co-ordination in these 'living well at home' services. Referrals are being made to these services by healthcare system actors.
- There is an emerging evidence-base on the value of social prescribing as a mechanism to reach and support people. There is also a long-standing and robust evidence-base on the effectiveness of some interventions which are delivered through social prescribing, most notably exercise-related activities.

Weaknesses

- The very fragmented delivery of services to live well at home and in the community is making it difficult to determine the extent to which services are available to meet needs.
- The reliance by many charitable NGOs on time-limited sources of funding leads to uncertainty and to reduced ability to plan to meet future needs.

Opportunities

- The involvement of many different actors in the delivery of these services potentially allows for more tailored supports to be developed to meet the needs of older people. There are also opportunities for learning from the positive and negative experiences of many different mechanisms to support people.
- The involvement of national-level NGOs as well as local authorities in the delivery of HSE-funded 'living well at home' services provides opportunities to embed evaluation into service-delivery contracts to strengthen the evidence-base.

Threats

- As the older population increases, if there is a continued reliance on volunteer-led services, then there is risk that there will be insufficient financial and other supports for volunteers. Recruiting and retaining volunteers is already challenging, even though Ireland has a long tradition of volunteering for the common good.
- Fragmented delivery-structures may mean that there will be insufficient robust evaluation on what works well and for whom compared to more medical and clinical aspects of care, which may mean that not enough priority will be attached to services delivered in the non-healthcare sector.

2

Primary and community care: part 2

2.1 Summary

This chapter is the second of two linked chapters on the state of primary and community-based health and social care services and supports for older people in Ireland. A detailed overview of these services for older people is provided in the preceding chapter.

This chapter focuses on the policy context for, and the provision of, the key primary and community healthcare services which are provided in general practice and community-based healthcare settings as well as those that are provided as part of the ECC programme.

2.2 Introduction

2.2.1 Definition

Primary and community care are broad concepts. In Ireland and across the academic literature, primary care is generally used to describe general practice care carried out by general practitioners (GPs) and practice nurses (PNs). However, as stated by the HSE, a broader definition of primary care includes

> all of the health or social care services that you can find in your community, outside of hospital. It includes GPs, Public Health Nurses and a range of other services. They provide a single point of contact to the health system' [40].

Therefore, we use this definition to examine general practice and other key community-based healthcare services in this chapter.

Primary and community-care provide vital healthcare services. While only a small proportion of the older population may use acute hospital care, or even home support and residential care services in a given time-period, virtually all older people will interact with primary and community care services, such as visits to their GP or the use of practice or community nurses. In addition to the general practice care provided by GPs and primary/community nurses, other key primary care services provided by the HSE in Ireland include physiotherapy, occupational therapy, speech and language therapy, podiatry, ophthalmology, audiology, dietetics, community-based psychology, and social work. Many of these services are provided alongside key community services discussed in the 'Primary and community care: part 1' chapter. All of these services can help prevent and/or treat chronic health problems, or illnesses at an early stage. This may prevent more complex care requirements in the future.

2.2.2 Policy landscape

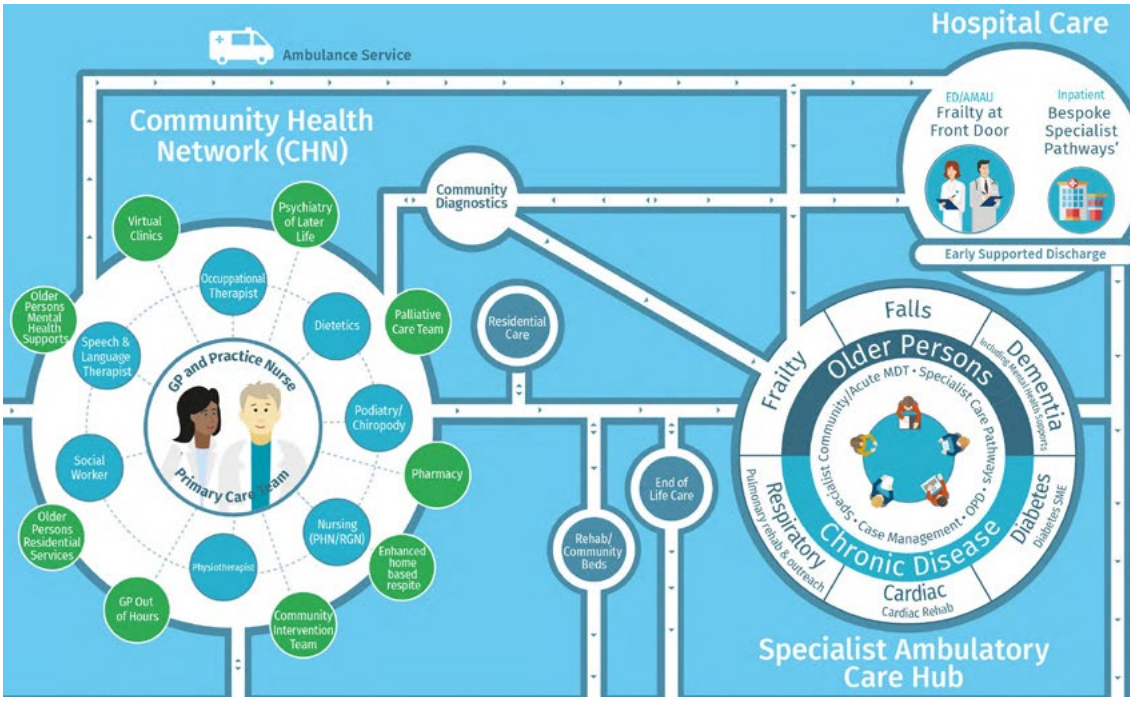
As discussed in Primary and community care: part 1, the majority of all health and social care in Ireland is delivered within people's homes and local communities. Historically in Ireland, the delivery of community-based care for older people has evolved significantly through policy reform and the development of primary care teams (PCTs), as envisaged in the 2001 policy document '*Primary Care: A New Direction*' [41]. This policy highlighted the fragmented and inconsistent nature of primary care services in Ireland and called for a transition toward a more integrated, prevention-focused, and community-oriented model. It proposed the establishment of over 500 PCTs across the country. These PCTs were to be made up of multidisciplinary health and social care professionals delivering coordinated care at a local level. These PCTs were to be supported by the development of primary care centres (PCCs) across the country. PCCs would act as centralised hubs for delivering integrated community-based services. However, the initial target of rolling out 500 PCTs was not fully achieved, despite updated policies in 2012 [42].

However, while some improvements in primary care did take place following the publication of these government policies, the shift away from a hospital-centric system stagnated after 2012. In 2017, the *Sláintecare Report* was published as a key new instigator of health system change in Ireland. It provided a number of recommendations to help develop a more universal system of care, especially for older people, that would empower policymakers to develop the health care system in a way that focused more on care provided in people's communities, and where possible, move away from a hospital-centric mindset [1].

Key recommendations from *Sláintecare* are based on the development of a more progressive integrated care system that centres itself in primary and community health and social care services. This new model of care emphasises the provision of healthcare in less intensive settings; the enhancement of general practice and primary care; and the integration of healthcare services, such as community-based therapy services and community nurses, with GPs and their staff at the model's centre. In addition, this model proposed integration with key community-based social care services that aid people, and these services are the focus of the accompanying 'Primary and community care: part 1' chapter.

Figure 2.1 visualises key elements of the ECC programme. This places GPs and primary care nursing at the heart of the Community Healthcare Networks (CNHs)—local organisational structures to deliver healthcare which are discussed in more detail below. New integrated care programmes have been developed under the ECC which align closely with the CHNs by supporting a shift toward integrated, GP-led primary care services. These integrated care programmes emphasise multidisciplinary collaboration, including the inclusion of key community-based services including occupational therapy, podiatry, speech and language therapy, mental health services and community pharmacy. This model enhances care within the community and reduces hospital dependency by providing rapid response specialist community teams to address factors that could be a risk to continued living at home.

Figure 2.1: HSE older persons/chronic disease service model



Source: [5]

Two integrated care programmes, which are central to the ECC, are referred to in Figure 2.1. The first is the ICPOP, through which multidisciplinary teams address three gerontological conditions—frailty, falls and dementia—which, if unaddressed, have the potential to reduce the likelihood that older people can continue to live in their own homes. The second is the Integrated Care Programme for Prevention and Management of Chronic Disease (ICPCD). This programme develops multidisciplinary teams to support the prevention, early detection, and ongoing management of chronic conditions such as diabetes (type 2), cardiovascular disease (including heart failure, angina, stroke, and atrial fibrillation), and respiratory illness (specifically COPD and asthma). By addressing these conditions proactively within the community, the programme aims to reduce hospital admissions and improve patients' ability to manage their health while remaining at home.

Other aspects of the integrated care and support pathway include access to community-based end-of-life care; a *National Adult Palliative Care Policy* was also launched in September 2024 [43]. There are also rehabilitation services to allow people to return more quickly to their own homes after a spell in hospital (for instance following a fall). The ambulance services can also provide support to people in their homes to help them continue to live in their own homes. This new approach to integrated care has been shown to improve population-outcomes (See Section 2.4). In the subsections below, we discuss general practice, community-based care, and ECC programmes in more detail.

2.2.3 Organisational landscape

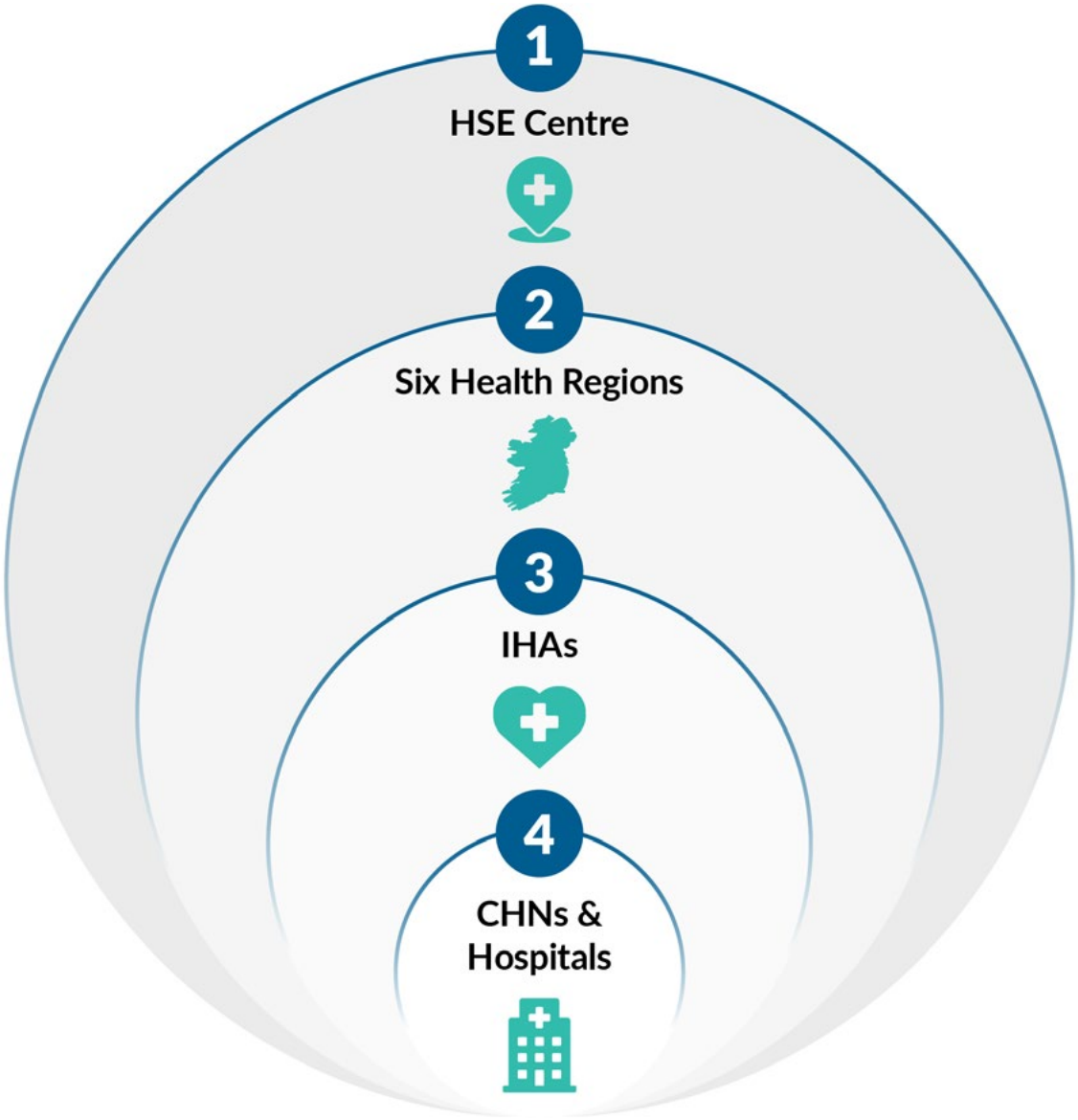
The new models of care for older people and people living with chronic disease are being developed in tandem with large organisational shifts in how healthcare is delivered in Ireland. Following the *Sláintecare* recommendations, there is a shift towards decentralisation of decision-making to new regional health authorities, HSE Health Regions. The new HSE Health Regions were established in 2024[31], and take over from the existing community-care (called Community Healthcare Organisations – CHOs) and hospital care (Hospital Groups) structures. Some of impediments to the integration of acute hospital and community-based services were also built into the system. Furthermore, CHOs and Hospital Groups were separate geographic entities and were largely non-coterminous (i.e. they do not share the same boundary). On a practical level, this made the integration of acute and community care difficult. These structural and organisational changes are important to understand within the new model of care for older people illustrated in Figure 2.1.

Figure 2.2 outlines the key restructuring currently taking place within the HSE. A smaller HSE Centre will continue to provide national planning and policy, and performance accountability [44]. Underneath the HSE Centre, six Health Regions have been established across the country. They will be responsible for service planning, coordination, and management of integrated service-delivery. Within each Health Region, there will be between 2 and 4 Integrated Health Areas (IHAs). Each will cover a population of between 150,000–300,000 people. IHAs will provide integrated acute and community care to their populations. All IHAs will be integrated with a large specialised (Model 4) acute public hospital, smaller (Model 3 and Model 2) hospitals that concentrate on providing less specialised emergency care, elective care and day case care, and a clinical leadership team made up of medical, nursing and health and social care professionals, to help support the clinical governance of integrated services.

This new service-delivery model also should mean that health and social care services when needed should, in principle, be delivered in the least intensive setting through a wide range of services within 96 CHNs that each cover approximately 50,000 people of all ages. CHNs 'provide the organisational structure through which integrated care is delivered locally' [45]. The structure of a CHN includes a Community Healthcare Network Manager (CHNM), a GP Lead and a Multidisciplinary Network Management Team. As discussed above, ECC teams, are being coordinated through these CHNs.

31. Six Regional Executive Officers have been recruited to lead each HSE Health Region, and an Executive Management team for each Health Region is being put in place.

Figure 2.2: New HSE regional organisational structures



2.2.4 Primary and community care services

General practice

General practice is at the fulcrum of the Irish health system and of the new delivery model for primary and community care outlined in Figure 2.1. General practice serves as the initial point of contact for most individuals seeking health and long-term care services. In most cases, the preventive and curative services offered from GPs and GP practice nurses (PNs) are adequate to address the most prevalent healthcare needs [46]. In Ireland GPs also functions as gatekeepers, managing the transition for patients between general and more specialised secondary care or acute hospital services.

Table 2.1 shows that, on average, people in Ireland visit their GP 4.1 times *per annum* and have 1.3 visits to a PN. The older population have much higher contacts than younger age groups, with average GP and PN visits *per annum* for the 65+ age group with a medical card being 6.1 and 2.1 respectively. Medical card and GP visit card (GPVC) coverage-rates are very high in the population aged 65+ and these cards do increase GP and PN utilisation, all other things being equal [47, 48] (see also Table 2.1). This regular visitation rate highlights the opportunity for GPs to work with their patients in developing pathways of care, including referral to the non-health sector 'living well at home' services outlined in the accompanying 'Primary and community care: part 1' chapter.

Table 2.1: Average annual GP and public nurse visit rates

	GP visits *per annum*	PN visits *per annum*
Population		
Total	4.1	1.3
Excl. children	4.5	1.4
Gender		
Male	3.5	1.1
Female	4.8	1.5
Age bracket		
0–14 years	3.3	0.7
15–24 years	2.9	0.7
25–49 years	3.5	0.9
50–64 years	4.6	1.5
65+ years	6.8	2.5
Medical Card/GPVC		
Yes	6.1	2.1
No	2.6	0.7

Source: Healthy Ireland Survey (Waves 1-3,5).

Community-based primary care

Community-based services have in the past been placed under PCTs, and more recently CHN structures. A consistent concept of both organisational models has been the development of community-based teams made up of multidisciplinary health and social care professionals delivering coordinated care at a local level alongside GPs and other services.

In addition to general practice care, community nurses, often referred to as public health nurses (PHNs), are a key aspect of primary care in Ireland. These healthcare professionals in particular play a vital role in the care of older people in Ireland. They work with GPs and other community-based services as part of the multidisciplinary teams and often serve as a critical link between the GP and the wider community. Their remit is extensive, ranging from sharing information, coordinating care-plans, managing patients with complex or ongoing health needs—particularly older adults—and assessing people for home support and the NHSS. PHNs also often work with GPs in developing care-pathways for older people: for example, if a GP identifies an older patient at risk of deterioration or in need of follow-up after a hospital discharge, they may refer the patient to the PHN for home-based assessments and ongoing support. In this sense, PHNs are key in enabling more effective management of chronic conditions in the community, and flow across services. The supply of PHNs will be critical to minimising unmet needs, as they will be supporting all age-groups and not just older people.

As data-limitations prevent examination of multidisciplinary care in practice, care provided via community-based services may be thought of as relating to a single service provided to treat specific health impairment(s) (e.g. physiotherapy or occupational therapy). More optimal community-based care-pathways involve numerous services that 'wrap around' a person and that require a level of coordination and integration across specialist, mental health, disability, and social care services [49]. The overarching goal of an integrated care model, which is not yet near full realisation in Ireland, should be to allow people to remain healthy at home for longer by providing coordinated services at the appropriate level of complexity. In addition to PHNs, PCTs were designed to offer a broad range of services, such as physiotherapy for mobility, occupational therapy to support independence in daily activities, dietetics for nutritional management, speech and language therapy for communication and swallowing issues, as well as audiology and ophthalmology for sensory health.

Table 2.2 uses information from TILDA Wave 5 (2018) to show the most commonly used community-care services among older people (aged 70+). Each year almost 1 in 5 older people had ophthalmology care, while almost 1 in 10 used a chiropodist, a PHN, and a physiotherapist. However, care should be taken when interpreting these figures as we show in a later section that significant waiting lists for these services exist and that in many instances people are still availing of many of these services in hospitals.

Table 2.2: Average utilisation *per annum*

Service	% Use previous 12 months
Ophthalmology (Optician Services)	18.6%
Chiropodist	9.0%
Public Health Nurse (PHN)	7.9%
Physiotherapy	7.4%
Audiology (Hearing Services)	3.8%
Occupational Therapy	1.5%
Dietetics	0.7%
Speech and Language Therapy	0.5%

Source: https://tilda.tcd.ie/publications/reports/pdf/Report_Covid19HealthcareUtilisation.pdf.

Enhanced Community Care (ECC)

While primary care policies have outlined the importance of an integrated multidisciplinary approach to care, an important concept that has emerged from *Sláintecare* [1] is the need to develop an integrated care model that shifts care closer to home. Such an integrated care model should ensure that all services work together and are centred on the needs of the person. The HSE has developed the ECC programme to enable integrated care within the new HSE regional structures.

The ECC programme provides the foundational structures through which integrated care is provided in local communities, with services organised, coordinated and provided by multidisciplinary Community Specialist care Teams (CSTs). This model is focused on providing targeted, intensive, specialist care to specific population groups: populations with certain chronic illnesses and older people who require care and support. Two CSTs have so far been constructed:

- ICPOP. The ICPOP teams should typically include a geriatrician, nurses, as well as health and social care professionals, such as speech and language therapy, occupational therapy and physiotherapy. The ICPOP teams can also include a community connector (on which see the above 'Primary and community care: part 1' chapter) for social prescribing to help promote social connectedness in older people.
- ICPCD. This covers diabetes, asthma, chronic obstructive pulmonary disease and cardiovascular disease. This programme is due to be expanded to include other services.[32]

These ICPOP and ICPCD teams will typically support a population of 150,000 or 1 IHA. Access to the ECC ICPOP or ICPCD community teams is via referral from a GP (or also consultant geriatrician for ICPOP). The ICPOP teams prioritise older people with more severe frailty, with 65% of ICPOP clients [50] having a Clinical Frailty Score [51, 52] of 5-9[33], and almost 90% aged 65+.

The ECC programme includes a number of key deliverables and outputs, which are discussed below in section 2.3.3. Many of these deliverables are related to reducing the reliance on acute hospital services (the 'shift left'), including reducing delayed discharges from hospital and the use of emergency department care. These deliverables highlight that it is important that the new HSE Health Regions and IHAs have the capability to also integrate with services that allow people to live well in their communities, as well as to access primary care services and more specialist acute hospital care. If this can be fully achieved it has the potential to be a game-changer in the model of care in Ireland.

32. https://www.drugsandalcohol.ie/38448/1/HSE-second-report-of-the-structured-chronic-disease-management-treatment-programme-in-general-practice.pdf.
33. 1 on scale = very fit and 9 = terminally ill). Level 5 is defined as 'mildly frail': 'These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.' [52].

As highlighted in Figure 2.1, there are other important elements of the ECC which aim to reduce the requirement for care in more intensive settings such as hospitals. These include:

- Collaborations with local authorities, NGOs, and community connecters, such as Age Friendly Ireland and ALONE, are discussed in the preceding chapter.
- **Community Intervention Teams (CITs). These are community nurse-led** teams of health professionals that provide rapid access to short-term care for those experiencing an acute episode of illness. There are 23 CITs across the country. These are nurse-led.
- **GP Access to Community Diagnostics**. This scheme, which is aligned to the ECC programme but separately funded, allows GPs to directly refer adults of all ages for diagnostic tests (e.g. X-rays, ultrasounds, CT scans and MRIs), which are undertaken by private providers based in PCCs or in other community-based facilities. The scheme aims to facilitate the early detection and management of illnesses and to reduce the need for hospital-admissions.

Other initiatives

More broadly, through the Pathfinder Service—a collaboration between the National Ambulance Service (NAS) and hospital-based teams—trained paramedics, physiotherapists and occupational therapists provide on-site assessments and, when appropriate, care at home in response to 112/999 calls received from older adults. In addition, the HSE's Community Funded Schemes (CFS) allow for essential medical products and supports, such as home aids, continence products and nutrition-support, to be provided to individuals living at home.

2.2.5 Entitlement and eligibility for primary and community care

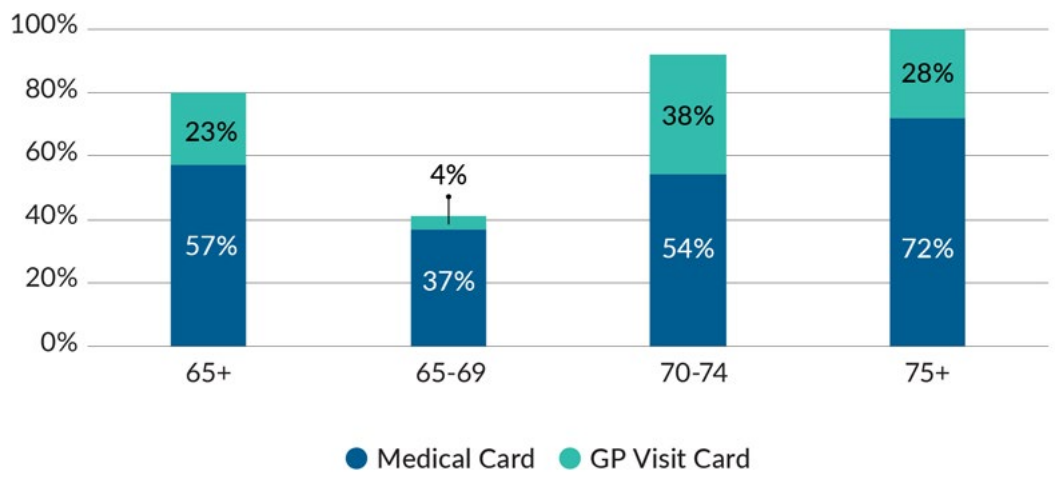
While *Sláintecare* recommended changes to the model of care and organisational restructuring, it was also critical of the difference in eligibility for primary and community care. The structure of eligibility in Ireland means that many older people may miss out on gaining the benefits from primary and community care as well as from the integrated care programmes developed under the ECC.

Historically, the healthcare system in Ireland has involved a mixed public / private system of funding and provision [53]. This has often been termed a two-tier system, and a complex system of means-tested schemes that provide free access to various health care services or reduced-cost medication exists. Not all individuals are eligible to access many of the services outlined in the previous sections, and access to public services is often dependent upon holding a medical card. Generally, people are qualified to receive services either under eligibility Category I or Category II. Those falling within Category I are entitled to a medical card which affords access to primary, community and hospital services without charge. (Home support and LTRC are not linked to the medical card). The majority of the population within Category II (or limited eligibility) incur some charges for these services, including having to pay fees to visit their GPs, though some people have a GPVC that provides free general practice care.

Accessing a medical card is mainly based upon a household being in the lowest third of the income distribution, with eligibility for most recipients based upon a household-level income means-test [54]. However, other factors are considered when determining medical card eligibility and therefore a more detailed discussion of the medical card system is included in Box 2.1 at the end of this chapter. In 2005 the GPVC was introduced, providing free access to GPs for an estimated 230,000 Category II individuals whose incomes were slightly above the maximum limit to qualify for a medical card. In 2015, automatic eligibility for GPVCs was extended to everyone over the age of 70. All other Category II individuals still have to pay privately for GP services.

Figure 2.3 shows that 57% of people aged 65+ hold a medical card, with a further 23% holding a GPVC [55].[34] Nearly everyone over the age of 75+ is likely to have either a medical card or a GPVC. Nearly 10% of people aged 70–74 do not hold either card which will significantly curtail their ability to access public community-based care services (other than through the ECC) model. Moreover, the situation is more acute for people aged 65–69 as only 41% hold a medical card or GPVC.

Figure 2.3: Medical card and GP visit card coverage rates for older people, September 2025



Source: Primary Care Reimbursement Scheme (https://www.sspcrs.ie/portal/annual-reporting/report/eligibility) and Census 2022.

Medical cards can significantly reduce the cost of healthcare in Ireland. Evidence shows that for the older populations with multimorbidity, having a medical card (or GPVC) decreased the out-of-pocket cost-burden by up to 67% [56]. While private health insurance has failed to reduce out-of-pocket costs, and in many instances increased the cost-burden for older people with multimorbidity, a medical card or GPVC reduced costs, mostly for primary care and prescribed medications.

34. Estimates used Primary Care Reimbursement Scheme Data from September 2025 and CSO estimated population data from April 2025 to estimate Medical Card and GP Card recipient rates.

2.3 Adequacy

2.3.1 General practice

It is difficult to put an exact figure on the number of GPs in Ireland. One source of information is the Medical Council's Workforce Intelligence Report which has data on GPs who completed the Medical Council's annual retention process in 2023 [57]. This indicates that there were 4,456 GPs, of which 2,353 (53%) were women. The Medical Council report states that one third of GPs work for 30 hours or less a week, with 55% working between 30 and 48 hours per week and 12% working more than 48 hours per week [57]. Taking account of this, and using 2022 data, there were approximately 2,800 GP Whole-Time Equivalents (WTEs; a measure of supply) practising in Ireland [58].[35]

Recent Economic and Social Research Institute (ESRI) research estimates that significantly more GPs will be required in the coming years to keep up with demand and demographic change [59]. Similar sentiment has been expressed by the ICGP [58]. One particular concern is the increasing average age of GPs. The Medical Council report notes that the mean age of GPs was 49.3 years with 32% aged 55 years or older and approaching retirement [57].

In terms of future supply, there has been an increase in the number of GP training places in recent years, e.g. a 23% increase between 2022 and 2023, from 287 to 350. In 2019 there were only 193 places and there have also been record applications for these training places [60]. A Strategic Review is also looking at ways to sustain the GP workforce, including training and capacity issues, such as the role of primary care nursing and development of wider community services through the ECC Programme [61]. The terms of reference for this Strategic Review also 'include consideration of the possible role of HSE-employed GPs and other mechanisms to attract GPs to rural and urban deprived areas' [62].

One additional aspect of GP supply in Ireland is that the composition of GPs is moving away from more traditional single-handed GP to larger GP practices with multiple GPs, PNs and administrative tasks. Some larger group providers of care now have over 60 GP practices in Ireland, which employ hundreds of GPs. Many of these large providers are also now predominantly owned and financed by private equity [63]. Similar to residential care, these examples show there has been a consolidation of GP providers in Ireland and large changes to ownership structures in recent years.

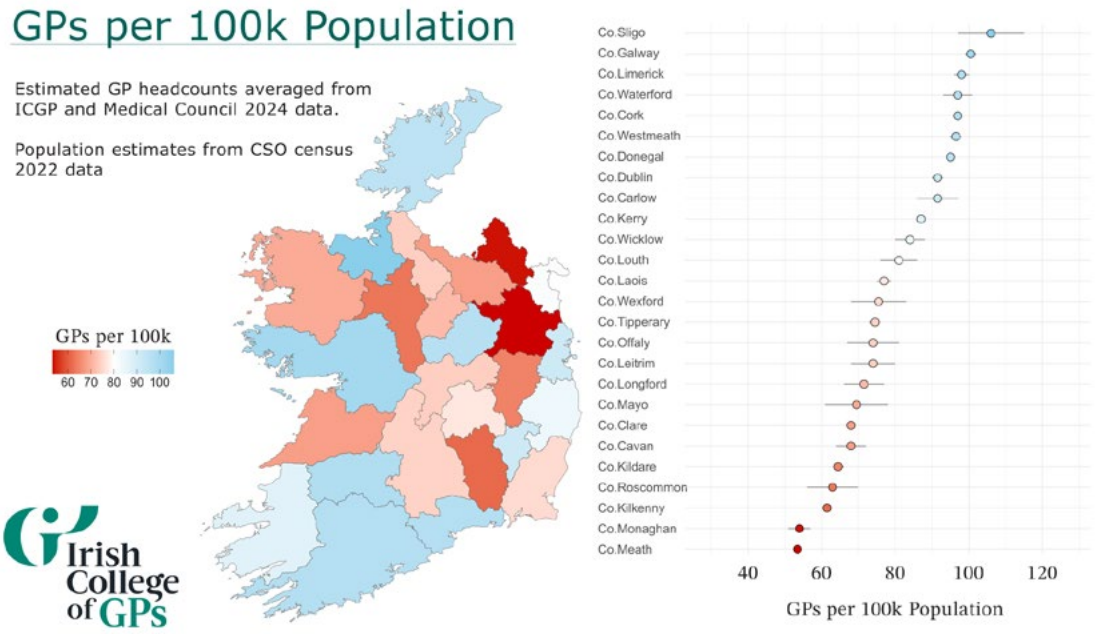
35. Most GPs have a contract with the HSE to provide care to Medical Card and GP Visit Card holders, and in March 2023, the Primary Care Reimbursement Scheme reported that 3,100 GPs hold a contract with HSE. A list of GPs on the GMS Scheme is available at https://www.sspcrs.ie/libr/html/AllGPs_GMSContract.pdf. ESRI research estimates that there are 3,928 GPs practicing in Ireland in 2023 [59].

In addition, in recent years, out-of-hour (OOH) GP co-ops have emerged to provide care outside of traditional workday work-times (i.e., at the weekend, during the night or on public holidays) and to reduce the use of emergency department (ED) care for less urgent issues. Currently, there are 17 OOH co-ops operating across most regions in Ireland. The GMS contract obliges all GPs to make arrangements for their patients to have access to care outside of normal clinic hours—in some cases, the OOH co-ops do not include all GPs, but the obligation on the GPs remains. Nevertheless, OOHs have been faced with rising demand and an insufficient GP supply.

Regional variation

The ICGP also reports significant variation in GP supply across Ireland [64]. Figure 2.4 shows that measured as the number of GPs per 100,000 population, there are large differences across counties. The highest supply of GPs is seen in Sligo, Limerick, and Galway. The lowest supply is in Monaghan and Meath. Supply across all counties is under the ICGP recommendation of 120 GPs per 100,000 population with Ireland, with the reported average currently being around 70 GPs per 100,000 population [65].

Figure 2.4: GPs per 100,000 population



Source: [64].

These regional differences are impacting access to care. There is increasing evidence that many people, including those with a medical card and GPVC, find it difficult to access care in their locality.[36]

36. https://www.thejournal.ie/investigates-gp-shortage-6647266-Mar2025/.

2.3.2 Community-based care

There are substantial issues with unmet demand for community-based care in Ireland. Table 2.3 shows the substantial waiting lists for public community-based care for all key services delivered by the HSE. The extent of the waiting list issues, and the actual length of time on the waiting list, can be seen by the large numbers on the waiting lists (for an initial assessment), and also the large percentage of people on a waiting list waiting for more than 52 weeks. This waiting threshold far exceeds the 8–14 week target for these services traditionally used in the NHS and recommended in the *Sláintecare Report*. This signifies the severe issues with access in the system.

Even using this 52-week threshold, more than a quarter of people awaiting an assessment remain waiting for occupational therapy, podiatry, audiology, ophthalmology, dietetics and psychology services for at least 1 year. The importance of early access to audiology and ophthalmology services is increasingly recognised as part of strategies related to detection and better management of dementia [66].

Table 2.3: HSE primary care service-use and waiting lists

	Numbers seen	Numbers waiting	% waiting >52 weeks
Physiotherapy	507,114	63,819	17%
Occupational Therapy	344,932	35,275	29%
Speech & Language Therapy*	185,770	19,848	16%
Podiatry	64,396	9,118	33%
Ophthalmology	99,872	17,500	45%
Audiology	56,322	24,820	24%
Dietetics	69,869	23,461	30%
Psychology	41,290	20,902	40%

Source: HSE Performance Report, 2023. https://about.hse.ie/publications/.

*N.B. The 'numbers waiting' for speech and language therapy refer to the numbers waiting for initial assessment while the 'numbers seen' refer to all of the patients seen for both assessment and therapy.

2.3.3 The Enhanced Community Care programme

The ECC programme is still becoming embedded in the system, but information on the use of the CSTs is becoming clearer. In 2024 there were 133,000 patient-contacts with CSTs for older people—a 37% increase on the number of patient-contacts (97,000) in 2023. Of these contacts, 81% were discharged home after community-based interventions were provided and 5% of older people required LTRC. An estimated 7,000 older people who were supported by CSTs for older people avoided unnecessary hospital admissions.

Large increases in the activity of CSTs for chronic disease have also occurred, and in 2024 there were over 645,000 reviews carried out by the GP-led patient teams acting through the Chronic Disease Management (CDM) programme. As of end 2023, 27 of 30 planned ICPOP CSTs and 26 of 30 planned CSTs for ICPCD were reported to be in place [50]. While as of June 2023, 76% (2,643) of the overall planned WTEs 3,500 clinical front-line staff for all aspects of the ECC programme were in place.

2.3.4 Funding

It is difficult provide an accurate estimate of total expenditure on primary and community-care services in Ireland, especially on those services that may be delivered in part through the ECC programmes and on healthcare that is privately purchased. However, some information does exist on funding and expenditure for general practice.

General practice

The majority of GPs provide care to both public patients (those with a medical card or GPVC) and private patients. GPs receive an annual capitation and allowance fees from the State to provide care to public patients. Table 2.4 shows the revised capitation rates for the new 2023 GP contract with the HSE [67]. Capitation rates differ across age, with GPs receiving a higher capitation fee for older patients. An additional much higher fee is provided for patients residing in LTRC (a nursing home).[37]

Table 2.4: Revised capitation rates, 2023 cohort

	Capitation
Child patient aged between 0 and 5 years (inclusive)	€125.00
Child patient aged between 8 and 12 years (inclusive)	€100.00
Male patient aged 13 years and less than 16 years	€70.71
Male patient aged 16 years and less than 45 years	€90.26
Male patient aged 45 years and less than 65 years	€180.29
Male patient aged 65 years and less than 70 years	€189.92
Female patient aged 13 years and less than 16 years	€71.52
Female patient aged 16 years and less than 45 years	€147.60
Female patient aged 45 years and less than 65 years	€198.10
Female patient aged 65 years and less than 70 years	€211.87
Patient aged 70 years and over	€403.39
Patient aged 70 years and over	€644.77

Source: [67]. Capitation rates can also be found at https://www.sspcrs.ie/portal/annual-reporting/report/gp.

37. OOH care typically provided at the weekend or weekday evening/night-time, falls outside the traditional capitation and allowance system. The HSE reimburses GPs OOH care using a sperate payment system, and GPs claim an OOH fee.

More generally, there has been a shift away from capitation towards allowances in the most recent HSE GP contracts, and only approximately 50% of HSE funding to GPs is now provided via capitation. In addition to capitation, allowance fees are provided for a range of services such as the CDM programme [68]. However, there is as yet an insufficient patient-centred funding mechanism framed around the patient and the services they receive. While currently, unlike the funding provided to GPs for chronic disease under the CDM, there is no specific funding for GPs that aligns with ICPOP and the care of older people (for falls, dementia and frailty).

Private patients pay out-of-pocket for their primary care, and many will receive some repayments (up to 50% of the cost of a visit) from private health insurance. Recent estimates place the average cost of a private GP visit as between €50 and €80, with higher costs in Dublin [69].

Despite the importance of general practice within the wider health care system, and the fact that almost every individual in the population interacts with general practice annually, a relatively small amount of expenditure is spent on general practice care in Ireland. The most recent evidence finds that in total, just over €1 billion is spent on general practice services annually [70]. The majority of this expenditure come from the state for patients with a medical card or GPVC, [71]. This compares to over €2 billion spent on LTRC.

Recent analyses have examined the potential cost-implications of expanding free GP care to the full population. It is estimated that the cost to the State of expanding free GP care would require additional expenditure of almost €900 million *per annum* [72], and these costs would be fully borne by the state. However, while these costs are high, they assume that GP supply would be able to increase to meet the higher demand that would occur were co-payments or out-of-pocket costs removed for the full population. It is this lack of GP capacity that is likely the biggest challenge to expanding free GP care.

Community-based care

The HSE state that it has invested €240 million in the ECC, but it is difficult to ascertain the full amount of expenditure on community-based services in Ireland. In 2019, €270 million was spent by the HSE on community nursing and an additional €155 million was spent on key community-based services such as occupational therapy, physiotherapy, and speech and language therapy [70]. However it is difficult to differentiate between care provided within, and outside of, defined ECC programmes. There also remain significant limitations in the data and financial systems within the HSE to accurately capture community-based care activity and apply a cost to such activity. It is also difficult for similar reasons to ascertain the amount of expenditure on community mental health teams for older people, or the proportion more generally of mental health spend for older people. Similar information limitations exist on the amount spent on privately purchased community-based services.

2.4 Effectiveness

While evidence on the effectiveness of ECC programmes is just emerging, some positive outcomes appear to have been achieved. The ECC has shown the ability to support GPs in accessing community-based care services for complex patients. The ICPOP has allowed GPs to focus their efforts on supporting preventive care and patients with lower-level dependency, demonstrating their capability to provide more specialised care for older people with higher frailty scores. GPs also feel more empowered from greater access to community-based diagnostic services. Many of the outcomes being used to measure the effectiveness of the ECC programmes in Ireland are based upon shifting care out of more complex settings including the ED, acute hospitals and residential care.

ECC outcomes currently being measured include:

- 10% reduction in acute hospital bed-days used in acute hospitals.
- 10% reduction in ED attendances for COPD, asthma, diabetes and heart failure.
- Health and wellbeing in CHNs.
- Community / non-governmental sector volunteer-delivered services (ALONE model).
- Dementia advisors.

Early results have shown that the ICPCD and ICPOP have seen significant reductions in the use of acute hospital and residential care services for participants. The recent Sláintecare Progress Report [50] indicates that in 2023, of the total patient contacts delivered by ICPOP CSTs, the following outcomes were achieved:

- 74% were discharged home.
- 6% were admitted to acute hospital.
- 3% were admitted to long-term care.
- 12% of people (target is 10%) were reviewed on same day / next day of referral.

It appears even better outcomes were achieved in 2024.[38] However, these results do not reflect causal effects. Caution must however be exercised in attributing all of these changes in service-use to provision of the CSTs alone. Information is needed on the relative contribution of all of the different elements of the ECC programme, including the development of community-supports and other wrap-around care as well as primary care services and other volunteer supports.

38. https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland/.

That said, there is considerable international evidence of the effectiveness of integrated care delivered through multidisciplinary teams in the community. Many of these studies identify important structural and system-level factors that contribute most to improving outcomes for older people. For example, a large systematic review including 157 studies examined the impact of the integration of health and social care services on effectiveness as well as on costs, service-utilisation and quality of care [49]. With regards to interventions for older people, the review pointed to improved access to services and better satisfaction when receiving integrated community care, with mixed evidence on the impacts on health-service utilisation and costs. Better outcomes were seen in older people with more complex needs.

A more recent systematic review and meta-analysis of 12 international randomised controlled trials investigated the effectiveness of community-based GP-led multidisciplinary integrated care strategies for older people [73]. The review found that integrated community-based care with GP participation improved functional status, reduced risk of hospitalisation and increased service-user satisfaction. There were no impacts on other health outcomes or on quality of life, emergency department presentations and LTRC admissions.

Another recent systematic review and meta-analysis [35] found that individualised care planning—including medicines optimisation, regular follow-up reviews and assessment of individualised care plans—as the most likely intervention to sustain independence, particularly for people who receive home support. Evidence from Australia has also shown that more integrated packages of care, provided through the Veterans' Community Nursing (VCN) programme, was much more effective than the Home Care Package (HCP) programme at preventing admission into LTRC. The authors identified the delivery of care by skilled community-based nurses and a combination of clinical and personal care as key to reducing risk of admission to LTRC, while the use of comprehensive assessment and case-management were also found to be important factors [74].

2.5 Limitations

2.5.1 Limitations of current funding mechanism

This better integration of GPs within wider community-based care services is welcome. However the funding approach for GPs is currently based upon expanding allowances and fees to GPs as, firstly, capitation is insufficient to adequately capture the resources needed to provide these new integrated care approaches. Secondly, there is as yet an insufficient patient-centred funding mechanism framed around the patient and the services they receive.

2.5.2 Data-availability

There is a dearth of administrative information on primary and community-based care in Ireland. Even simple information such as the number of consultations with PHNs and community-based therapists on an annual basis does not exist, while there exists little information on the characteristics of primary and community-based service-users [70]. There also is a lack of information on the nature of needs or people accessing primary and community care and no accurate estimate of the number of times individual patients attend community-based services in Ireland. These issues are magnified for privately purchased care, where there is little sense of the size of private community-based care in Ireland.

2.6 Learnings

The development of a new model of care for older people based upon living well at home and access to key health and social care in the community is an important change in direction for care in Ireland. The development of more integrated care pathways and multidisciplinary teams to provide care has the potential to improve patient and population outcomes.

Eligibility for primary and community care services remains based upon medical card/GPVC status rather than need. This contrasts with access to other key services for older people including home support and LTRC. Such a system of eligibility militates against equity of access to the benefits of the new model of care and of the ECC programme for almost 40% of the older population in Ireland. Tying access to community-based services to possession of a medical card may exclude some older people and result in the need to access care privately, which may disrupt care-pathways.

Early data from the ECC programme suggest it may be associated with positive impacts on key outcome measures such as use of ED and hospital services. However, it is important to also look at health and other functional outcomes. Furthermore, many of the reported outcome improvements from the ECC programme are based upon simple comparisons, and there is a lack of evaluation of the effectiveness of the programme. While outcomes are measured for those who use the services, determining whether there is sufficient support available within ECC and community-based services to help older people initially access care services and navigate the health system would be of significant value to policymakers.

One of the key pieces of information presented in this chapter is the significant waiting lists for community-based care, and the large regional variation in GP supply that exits in Ireland. Without sufficient workforce, the potential of integrated primary and community care is likely to be limited. Ensuring the availability of health, social and community services in the locality is vital to the success of the new model of care for older people proposed in *Sláintecare*. Ageing in place requires sufficient wrap-around services working together. However, as highlighted, waiting lists for many services are large and waiting times long.

2.7 Strengths, weaknesses, opportunities and threats

Strengths

- The increasing emphasis on the 'shift left' and on the development of the ECC programme and GP-led multidisciplinary teams is a key strength of the new model of care for older people.
- ICPOP is becoming increasingly embedded in the system and there is evidence that ICPOP is reducing use of acute services and improving patient outcomes.
- Specialist community integrated care teams at the heart of the ECC programme are supported by services from NGOs, community groups and local authorities to help coordinate supports. This includes broader non-medical needs that can have an impact on the need for health and social care services. The interface between the clinical and the psychosocial requires ongoing nurturing and support.

Weaknesses

- There are considerable issues with unmet need for primary and community health care services. Waiting lists for community-based care are large, and the length of time people are waiting is excessive.
- Many people, specifically those without a medical card, may not have full access to publicly available community-based care.
- Data and information systems within general practice are amongst the best in the Irish health system. But contrastingly, data and information systems for community-based services are arguable the least developed within the system.

Opportunities

- There is scope to expand funding for GPs to specifically help older people with falls, dementia and frailty using a similar approach to the CDM. Evidence from other countries has shown that GPs can play a crucial role is dementia prevention [75], especially as health conditions like diabetes, midlife hypertension and midlife obesity are important risk factors of dementia [76].
- Primary care can also reduce the risk of dementia by supporting people to adopt healthy behaviours, such as increasing physical activities and adopting healthier diets, and by encouraging social engagement to reduce loneliness and depression. Aligning the CDM programme (as most service-users are older people) with older people's care has the potential to further improve the effectiveness of ECC.
- As discussed in the 'Residential care' chapter, residents typically do not have the same access to primary and community-care after entering LTRC homes. GPs, PHNs, and community-based allied health professionals could work more closely with care-home staff and families of older people to manage medication and make decisions on care-provision. While in the UK especially, a significant part of the GP role in care-homes involves detecting and reporting abuse or neglect of older residents [77, 78].

- GPs have one of the best health information systems across the healthcare system. Standardised practice management software is used by all GPs and these systems allow for continuity of care within GP practices. The HSE Healthlink electronic referral system is also compatible with practice management software and this improves the efficiency of patient referrals. However, without a broader health information system that covers the entire health system, emails, fax, and paper referrals remain common. GPs often are not provided with information from outpatient clinics, inpatient hospital-stays, or care provided in the community. This reduces the ability of GPs to coordinate care-pathways and help ensure continuity of care. Community-based care has arguably the most limited data and health information systems across the HSE.

Threats

- Inability to access care in a timely fashion within one's community is a key threat to the development of the new model of care for older people in Ireland. Significant improvements in reducing unmet need for care will be needed along with actions to further empower people to take ownership of their health.
- Inadequate data and health information systems are key threats. Ease of communication and coordination are key to allow for the benefits of integrated care to be realised.

Box 2.1 Medical Cards

Access to public community-based care is mainly based around the medical card scheme, introduced as part of the 1970 Health Act. Medical cards are issued by the HSE. They entitle cardholders and their immediate family to free public healthcare services in primary care and in the community (e.g., physiotherapy). Other benefits accrued by a medical card holder are free access to dental, aural, and optical care and lower cost prescription medication. As of July 2024, 1.58 million individuals were medical card holders, representing approximately 30.5% of the population[39]. 60% of individuals aged 65+ hold a medical card.

Medical card entitlement is mainly determined at the level of the family unit. The majority of medical card eligibility is determined by an income means-test based upon household-level income. Importantly, the income-thresholds vary by age and dependent circumstances. In general, the lowest income households, including households reliant on social welfare, generally meet the criteria for medical card eligibility. A smaller number of medical card holders qualify on a discretionary basis as they have life-limiting condition and/or a health condition the results in medical costs being deemed to be excessively financially burdensome for the household.

> It is important to understand that the main purpose of a medical card is not to expand access to healthcare *per se* but to the reduce the cost-burden for individuals/families with low incomes or in cases in which the burden of accessing healthcare would be very high.

For households with a member aged <70 years old, means-test deductions for childcare expenses and housing costs are permitted. However, households with a member aged 70 years and older are subject to an income means-test based solely on gross income. It is important to note that medical card income-limits have not changed for most households since 2005: those increases to the income threshold of €50–€100 per week were enacted for over 70s in 2023. A detailed breakdown of the scheme can be found in Keane et al [54]. The table below outlines the medical card weekly income limits. All older people over the age of 70 automatically qualify for a GP visit card.

39. See https://www.sspcrs.ie/portal/annual-reporting/report/eligibility.

Weekly Medical Card Thresholds

	Over 70s	
Single Person	€550	
Married/Co-habiting Couple	€1,050	
	Under 66	**66-69**
Single Person Living Alone	€184	€201.50
Single Person Living with Family	€164	€173.50
Married Couple / Single Parent Families with Dependent Children	€266.50	€298
Allowances	**All Ages**	
First 2 children under 16 financially dependant on applicant	€38	
3rd and subsequent children under 16 financially dependent on applicant	€41	
First 2 children over 16 years financially dependent on applicant	€39	
3rd and subsequent children over 16 years financially dependent on applicant	€42.50	
A dependant over 16 years who is in full time third level education and not grant aided	€78	

3

Home support

3.1 Summary

The wish to live independently at home has consistently been expressed by older people and their families in Ireland and internationally. By allowing older adults to age in familiar surroundings, home support services can help maintain independence, enhance quality of life, and reduce the risk of unplanned hospitalisation as well as premature admission to LTRC. Home support delivered by professional carers is an integral component in facilitating people to remain living independently amongst their families and communities.

This chapter looks at the current state of home support delivered by professional carers to older people in Ireland. It presents the policy context and reports on the availability and adequacy of existing services nationally and regionally, including issues with the recruitment and retention of carers. It assesses the effectiveness of home support services in achieving outcomes that help older people remain in their own homes and communities for as long as possible. It also looks at the efficiency concerns within the home support system, in particular in relation to the assessment of care-needs and the integration of home support with other health and social care services.

The chapter also highlights the large role played by the outsourcing of care to the private sector and the increasing role played by private providers over voluntary and public care. This chapter will draw a distinction between professional and family/unpaid care and will highlight that the policy landscape for home support reflects a State and societal reliance on family-based care.

3.2 Introduction

3.2.1 Definition

In this chapter we focus on home support provided by professional carers to people aged 65 and older. The HSE-funded home support service helps older people with everyday tasks, including getting in and out of bed and dressing and undressing, and with personal care, such as showering and shaving [79]. It is important to consider these professional home support services within the context of a wider integrated community-based care system that is centred around the person and their support system. This support system relies heavily on family/unpaid carers but many other services are a critical part of the care-pathway, including primary and community-based care and supported living services (see the 'Primary and community care' chapters and the 'Supported living' chapters in this report).

While the home support service is focused mainly on services for people aged 65 years and over, many of the messages in this chapter will also apply to home support and personal assistance services for younger people ageing with disabilities, including intellectual disabilities. These will be examined in more detail in a subsequent chapter on services and supports for people ageing with disabilities. We also go into further detail on additional issues pertaining to home support for older people living with dementia and their carers in another chapter.

3.2.2 Policy landscape

The first legislative provision in respect of home support in Ireland was detailed in the 1970 Health Act [80], which included provision for administration of 'home help' at the regional health board level. In 2006, a home care package (HCP) scheme was introduced to provide enhanced levels of care and support exceeding the levels available through mainstream home help services [81]. Initially this HCP scheme targeted individuals in hospital in need to additional support to help them return home. Both schemes operated independently but in 2018 they were merged into the HSE's home support service, which is currently operating in Ireland and is the main focus of this chapter.

Although home support policy has developed over 50 years in Ireland, the primary aim is to supplement the family/unpaid care arrangements older people have in place. The vast majority of caring and support in Ireland is still delivered by family/unpaid carers [82, 83]. The substantial role played by such carers places Ireland within a home support model that resembles models in Mediterranean countries (e.g., Greece, Italy), as opposed to in neighbouring northern European countries [82]. Countries such as the Netherlands and Nordic countries provide a much larger proportion of professional care which means that family/unpaid carers provide fewer hours of care [84].

The HSE explicitly states that the home support service 'does not intend to, nor would it be possible within the limit of the funding available, to replace informal care arrangements but rather the intent is to support valuable informal care arrangements' [81]. This differs from the home support policy in many northern European countries where there is a greater focus on using home support to promote independence and on the integration of home support with other health services, home adaptation and assisted technology, and social services such as transportation services (e.g., Netherlands[40] and Sweden[41]).

Another feature of home support policy in Ireland is the lack of placement of home support on a statutory footing, as provided for in the domain of residential care for older people by the NHSS ('Fair Deal'). Numerous calls have been made for the establishment of home support on a statutory basis since at least 1968[42], and again in 1993 [85], 2005 [86] and 2021 [87]. The *Sláintecare Report* also had several recommendations to place home support at the centre of long-term care [1]. In addition, each of the last four *Programmes for Government* have included a commitment to the establishment of a statutory home support scheme. The 2020 *Programme for Government*, for example, stated a commitment 'to introduce a statutory scheme to support people to live in their own homes, which will provide equitable access to high quality, regulated home care' [88]. This current *Programme for Government* also reaffirms a commitment to 'design a statutory homecare scheme' [89].

40. https://eurocarers.org/country-profiles/netherlands/.
41. https://eurocarers.org/country-profiles/sweden/.
42. The Care of the Aged: Report of an Inter-Departmental Committee (1968) stated: 'There is at present no statutory provision for the employment of home helps. In some areas' they have been remunerated from public assistance funds. The Committee considers that their employment should be under the aegis of health authorities and it recommends that health authorities should be given statutory authority to employ home helps or to arrange for their employment by other bodies.'

There also appears to be an appetite for a greater role for increased State responsibilities for caring for older people and other groups with care and support needs in Ireland from society at large. In 2016, 99% of a Citizen's Assembly membership recommended that the Government expedite the current commitment to place home support for older persons on a statutory footing [90]. While there were likely numerous reasons why the 40th Amendment of the Constitution (Care) Bill 2024 was rejected by Irish voters, some analysis argued that the result was a rejection of a bill that would mirror the status quo in which care remains a private responsibility.

The lack of a statutory home support scheme is inextricably linked to a number of issues discussed in detail later in the chapter on adequacy of supply, regional inequalities, and workforce issues. The lack of such a scheme also means there is a current lack of independent regulation of the sector. Regulation of professional home support providers is currently being advanced through three strands: (1) primary legislation which is being developed by the Department of Health to register professional providers of home support; (2) the development of regulations by the Department of Health, with which providers will have to comply in order to be registered. Thirdly the Health and Information Quality Authority (HIQA) is developing new national quality standards to support quality-enhancement [91].[43]

3.2.3 Structures, assessment and application process

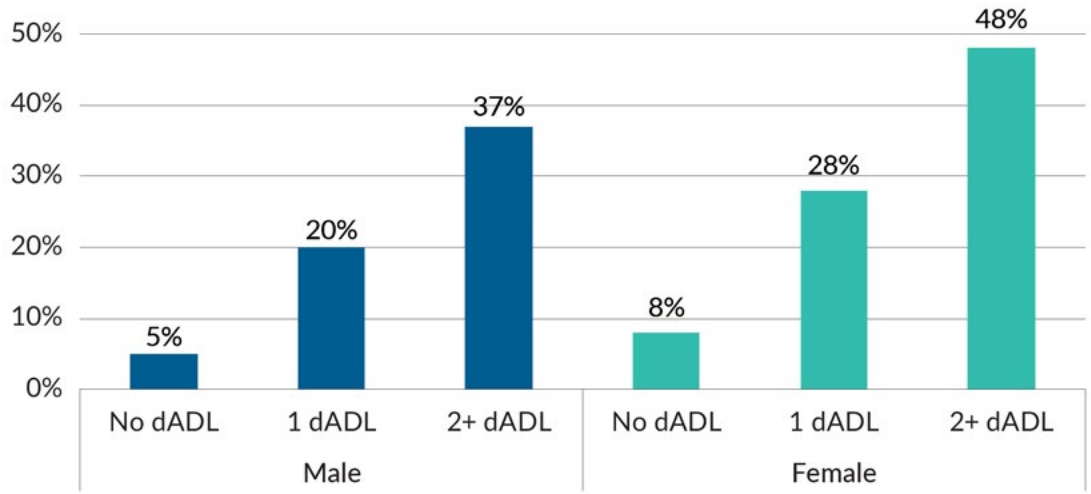
Access to the HSE home support service is not means-tested and is delivered free of charge.[44] To apply, the older person (or in the case of limited capacity a nominated decision-supporter) fills out a short form with basic personal details, GP name and address, nursing home or hospital ward (if applicable), and family/informal support contact details. This is sent to the local HSE office who then arrange a care-needs assessment carried out by a public health nurse or allied health and social care professional.

There is no standardised assessment approach, but the assessor will examine an applicant's difficulties carrying out activities of daily living (dADL, e.g., getting up in the morning, dressing, personal hygiene, toileting and eating) and their health and personal support service needs, and take account of family and other social supports. Based on the assessment, the HSE determines the appropriate level of home support services to be provided. The current assessment process will also capture if a new home support package is being sought following a medical event such as a fall. It can also assess whether a person's need (for example following a hospital stay) is likely to be temporary and require reassessment.

43. The Health (Amendment) (Licensing of Professional Home Support Providers) Bill, 2024 will empower HIQA to develop national standards, grant licenses, and conduct inspections of home support providers to ensure quality and safety.
44. A notable exception to this is that younger adults with ID are often subject to a family unit means-test assessment.

This assessment process means that home support is not typically being provided in a preventative manner, or to provide support to those with modest needs, but rather as a response when significant needs for support are identified. As such, currently the home support service focuses on individuals progressing towards the higher end of the care-needs spectrum. Data from TILDA highlight that the number of dADLs is a significant predictor of home support receipt. For example, almost half of all women aged 65 years and over with 2 or more dADLs are in receipt of home support. This compares to only 8% of those without any dADL (Figure 3.1).

Figure 3.1: People aged 65+ living at home in receipt of home support by sex and difficulty with activity of daily living

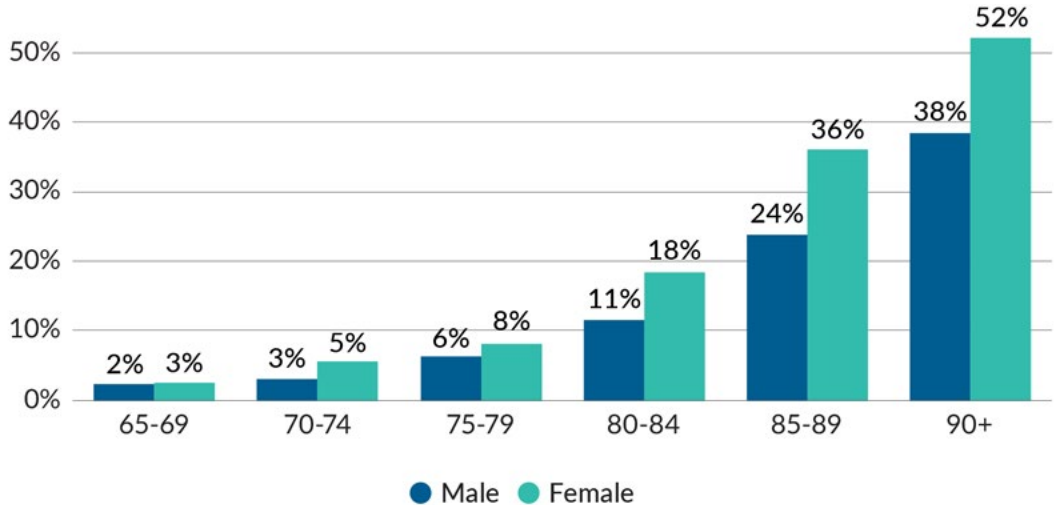


Notes:		dADL: difficulties with activities of daily living.
Source:		TILDA Waves 2-4 data.

Moreover, there is a strong relationship between dADLs and age. 36% and 24% respectively of women and men (living at home) and aged 85–89 now receive home support. This increases to 52% and 38% of women and men living at home over the age of 90 (Figure 3.2). As Ireland ages, future need for home support is therefore likely to increase.

As the care-needs assessment process takes current use of healthcare services into account, this will also tend to concentrate support in older adults who are more likely to be heavy users of health care services.

Figure 3.2: People aged 65+ living at home in receipt of home support by age



Source:		TILDA Waves 2-4 data.
Notes		Women tend to live longer, resulting in a higher proportion of older women living alone at older ages [92], and older men are more likely to have a spouse who can provide informal care thereby lowering their use of formal home support [93].

3.3 Adequacy

During the course of the work of the Commission, issues with adequacy of home support were highlighted as a key concern of the older population in Ireland.

3.3.1 National supply

In 2023 an estimated 70,000 people (approximately 9% of the population aged 65 and over) received almost 29 million home support hours (Table 3.1). This figure included privately funded home support. In 2024, excluding intensive home support, 58,546 older people received 23.7 million hours of publicly funded home support [94]. The average home support package provided via the public home support scheme is 7–8 hours per week, or approximately 1 hour per day. This suggests that carers only have time to focus on the most fundamental daily living needs for most of the people they support.

The limited time within a home support package is one reason why 24% of all home support is privately purchased (Table 3.1). This level of private purchase has been steady for some time. A survey of home care recipients in 2017 reported private purchases to account for 21% of all home support. 13.9% of older people paid privately to “top up” their existing home support services, while a further 2.5% paid privately while being on a waiting list. 2.3% of survey participants paid privately because they had not been approved for public home support, with 1.9% not being aware of the home support scheme [95].

The cost of privately funded home support hours was estimated to be €25 per hour in 2019 [70] rising to over €33 per hour in 2025, potentially putting significant financial pressures on many families.

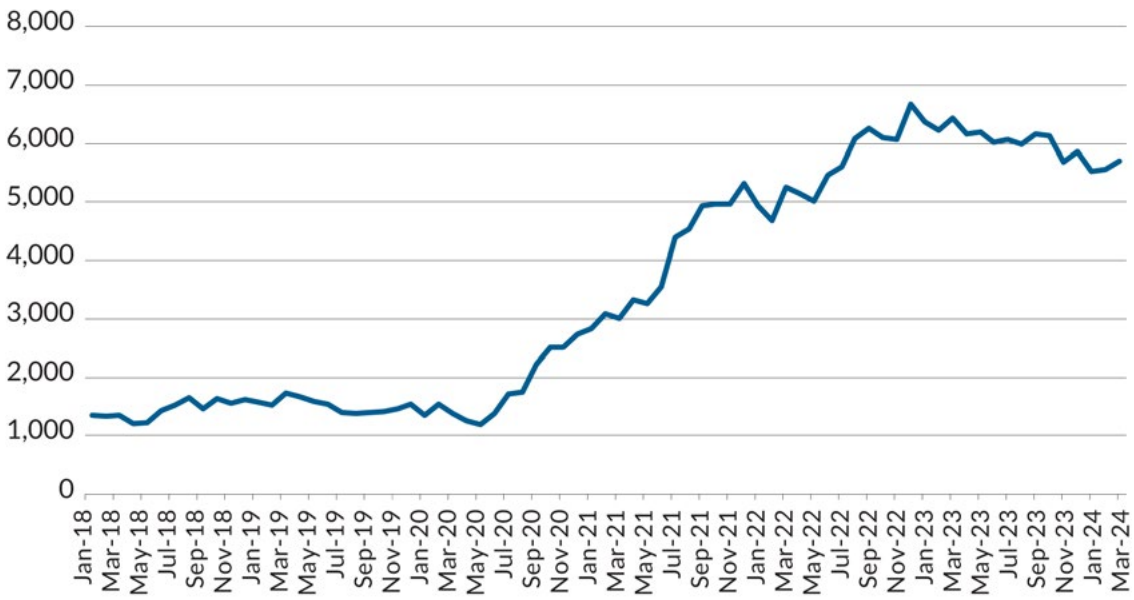
Table 3.1: Home support recipients and hours, 2022

Category	Recipients	Hours
	N	Million
HSE home support service	56,162	20.66
Intensive home care package	80	0.36
Private home support[a]	13,411	7.67
Total	**69,808**	**28.69**

Notes:	a	Some private home support recipients also receive public home support.
Source:		Walsh, Keegan [70] [96], TILDA Waves 2-4, and HSE administrative data (2022).

The 'topping-up' of public home support suggests insufficient public home support hours. Contributors to the reference group highlighted that time-limits on visits and overall service availability were issues; there were just not enough home support hours available to people. Waiting lists are further indicators of unmet need for public home support. Figure 3.3 shows the number of new service-users waiting for home support, as well as existing service-users waiting for additional support, have risen considerably since 2018. In January 2018 they numbered 1,353 service-users, peaking in December 2022 at 6,673 and falling slightly to 5,708 (2,716 new and 2,992 existing service-users by March 2024 (Figure 3.3) [97, 98].

Figure 3.3: Public home support waiting list—waiting on carers, January 2018–March 2024



Source: [97, 98].

These inadequacies are only worsened when lack of supply means people are forced to remain in hospital,[45] enter residential care facilities, or rely on family and community support. Almost all of those on the waiting list are waiting for carers

There is also likely to be additional unmet need not captured by the waiting list data, as some older people do not apply for home support and continue to rely solely on family [99], while applicants assessed as not having met the required threshold for home support would also not be captured in waiting list data. At national level no data are collated on the average time people spend on the waiting list. This is a further limitation in terms of assessing the adequacy of the home support scheme.

Projection analysis undertaken by the ESRI also shows between 2022 and 2040, demand for home support is projected to increase by approximately 57%–91%, and up to an additional 26 million home support hours will be required to meet this demand. The growing number of people of older ages is the key driver of this projected increase [96].

3.3.2 Funding

Table 3.2 shows that overall approximate spending on home support is almost €900 million *per annum*. Of this, over €723 million was allocated for expenditure on home support by the State. This table also shows that older people spend over €150 million annually on private home support.

Table 3.2: Home support funding and expenditure

Category	Expenditure
	€ millions
HSE home support service[a]	€723.0
Intensive home care package[b]	€8.9
Private home support[c]	€159.9
Total	**€891.8**

Notes:	[a] Relates to 2023 expenditure. [b, c] Relates to 2019 expenditure.
Source:	Walsh, Keegan [70], TILDA Waves 2-4, and HSE administrative data (2022).

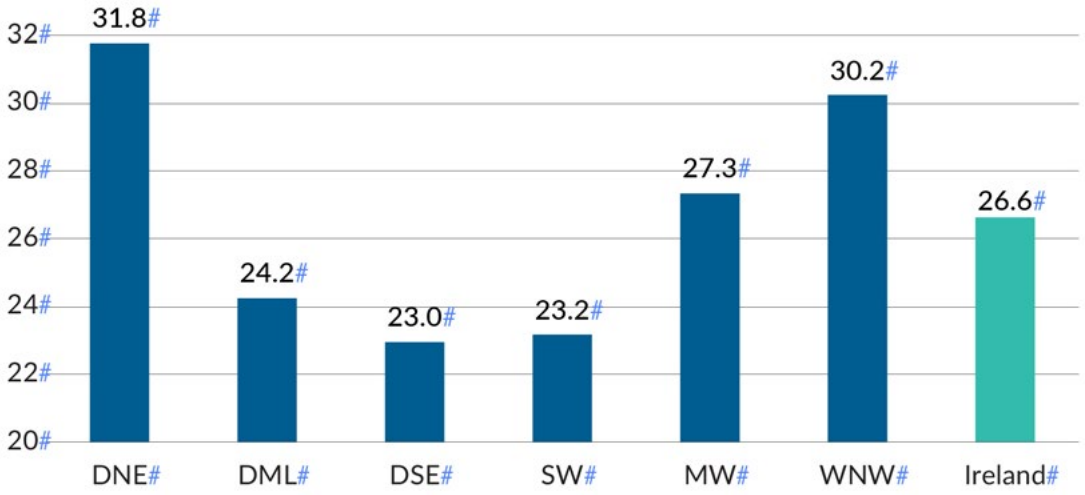
The €723 million spent by the State on home support in 2023 reflects a 66% increase on home support since 2019, as expenditure by the state on home support increased consistently since the onset of the COVID-19 pandemic. In 2025, an estimated €838 million was spent on home support by the State, while in Budget 2026 an additional €82 million has been assigned to home support for older people.[46]

45. HSE data shows that in 2022, there were almost 45,000 public acute hospital inpatient bed-days used by older people who were medically fit for discharge but awaiting home support.
46. https://www.gov.ie/en/department-of-health/press-releases/older-persons-services-budget-2026/.

3.3.3 Regional inequalities

The national supply estimates shown in Table 3.1 hide the substantial variation in HSE home support supply across regions in Ireland. Figure 3.4 presents public home support hours per capita (population aged 65+) across the 6 HSE Health Regions. The highest supply of public home support is seen in DNE (Dublin North East) and in the WNW (West North West) Health Regions. Supply is much lower in Dublin Midlands, Dublin South East and the South West. The scale of variation is extensive; per capita supply in DNE is 38% higher than in the DSE and SW Health Regions.

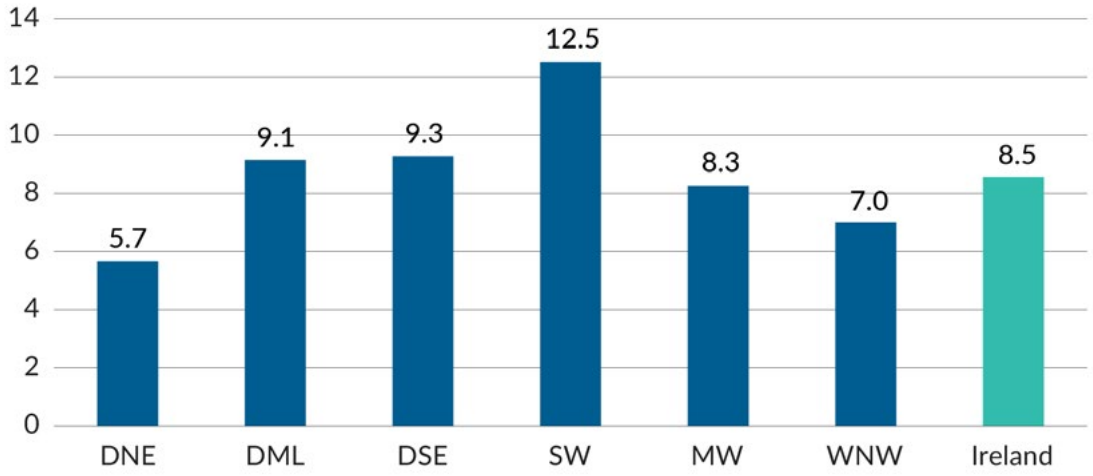
Figure 3.4: Public home support hours per population aged 65+



Notes:	a	DNE: Dublin North East; DML: Dublin Midlands; DSE: Dublin South East; SW: South West; MW: Mid West; WNW: West North West.
Source:		HSE administrative data (2022)

There is also considerable variation in the length of waiting lists across regions. Figure 3.5 presents numbers waiting for public home support (presented per 1,000 people aged 65+) across HSE Health Regions. Those Health Regions with the lowest supply, most notably the South West, have the highest waiting lists per capita. While it may not be possible to draw a direct casual effect between supply and waiting list variation, it could be inferred from Figure 3.5 that much of the lower supply in some regions is due to the lack of professional carers to provide care in those regions.

Figure 3.5: Public home support waiting list numbers per 1,000 population aged 65+



Notes:	a	DNE: Dublin North East; DML: Dublin Midlands; DSE: Dublin South East; SW: South West; MW: Mid West; WNW: West North West.
Source:		HSE administrative data (2022).

These results follow previous analysis showing that a home support supply Eircode lottery exists in Ireland [100], and historically, variation cannot be explained by differences in need characteristics or age distributions [101].

3.3.4 Perceptions of the service

The tables and figures above provide an overview of home support supply in Ireland. Qualitative information is also available on individuals' experiences of the service. For those who do have access to support, recipients highlight a broad range of experiences with the service and their carers. Many recipients and their families point to the brilliant experience that they have had when they found the right carer(s), who have provided them not just with care, but confidence, autonomy and friendship.

However some people have expressed frustration about the ability of the service to support them, their loved ones, and the broader older population. As highlighted by the long waiting lists for care, and the variation in availability of services across Ireland, many people may speak of a 'Eircode lottery' in access to services. Some examples now highlighted are taken from several studies in which home support recipients were interviewed [102–105].

Continuity of care. A lack of continuity of care and persistent turnover of carers visiting has been identified as a key issue by home support recipients. It is difficult for many people to accept someone they that they do not know into their home and having to do this continually puts pressure on care recipients and their families. For many home support recipients, the acceptance of home support may represent the fact that they now require help with household tasks that they have previously been able to carry out independently. Therefore, carer turnover, the continuous introductions and discussions of care plans, and the development of relationships with new people, can be a difficult and emotionally draining task.

Tailored services: There can also be an inability to match carers skillsets with recipients care-needs, leading to basic homogenous packages provided to many recipients. In particular, there exists insufficient dementia-training among carers. In interviews with 2,000 qualified home carers and healthcare assistants in 2020, 16% of carers had no professional caring qualification and over 50% had no training in dementia care [106].[47] There are good arguments that many people in residential care facilities, especially those with dementia, would be able to live at home if more tailored home support and care package requirements were available. Walsh and Lyons [99] show that over 30% of home support recipients have moderate or severe cognitive impairment such as dementia, but home support is poor at meeting the needs of people living with dementia. An intensive home care package (iHCP) has been established to provide a more intensive set of support for people with complex needs such as severe dementia [107]. Funding for the iHCP scheme was partly from Atlantic Philanthropies, a philanthropic organisation set up in Ireland [107], but the number receiving care via the scheme never exceeded 250, and expansion plans for the scheme have failed to materialise. This is despite evidence showing that an iHCP may have cost less, for similar levels of care, than LTRC [108].

Flexibility: In general there is a lack of flexibility and of person-centred care packages. Often more intensive care packages are required for a short period of time (e.g. post hospital admission), with lower levels of support needed subsequent to the post-admission period. However, there are fears that signalling that care support hours can be reduced would result in the whole care package being removed. This leads to people 'holding on' to their home support service due to the fear of starting from the beginning were more intensive supports required at a future stage. Similarly, many people are now being funnelled into the residential care sector to receive rehabilitative care, when receiving reablement and rehabilitative care at home as part of a more comprehensive care package would be optimal to the recipient, their family, but also the State due to the cost of residential care [104].

47. The strategic workforce advisory group on home carers and nursing home healthcare assistants has recommended the provision of specialised training such as in dementia care for care workers.

Consumer-directed home care (CDHC): Personalised care budgets have been proposed as an alternative model to develop home support and integrated support care packages in Ireland. This allows people to choose and purchase their own care support and can be requested by someone wanting home support although it is not available in all areas of Ireland. Initial experience with this type of scheme was mixed. In 2017 and 2018 a CDHC pilot programme was initiated. An evaluation of the pilot [103], did not recommend expansion of the programme. It concluded that while CDHC was a potentially viable model for home support, any introduction should be integrated into the broader home support service rather than replacing the current approach. Positive elements surrounding choice and flexibility were found. People appreciated the broad concept of designing home support to be at the centre of an integrated health and social care, where care plans can be tailored towards peoples personal, health, and social support needs has not occurred. However, the evaluation identified three key issues:

- Lack of understanding of personalised budgets among participants, highlighting the need for clearer communication and education.
- While flexibility was valued, it came with a lot of work and challenges, and identifying services placed additional administrative burdens on family carers.
- The lack of carers, quality assurance, and regulation of home support services were also identified as barriers.

Caring and emotional wellbeing: The mental and emotional health aspects of caring must not be overlooked. International experience indicates that unmet care-needs are strongly correlated with poorer mental health and lower life-satisfaction in the older population [109]. Moreover, caring not only encompasses meeting physical needs of older people but also involves an emotional dimension. The provision of care entails the activation of social support networks and leads to emotional bonding between carers and care recipients, which can have important consequences for the wellbeing of both sides. Indeed, in the process of caring, it is impossible to completely separate providing physical assistance to an older person from providing emotional support. The two activities are constantly accompanying each other. In addition, people with functional difficulties but have no access to help and support are fully exposed to the stress associated with those difficulties, which has a negative impact on their wellbeing. The relatively low levels of contact with home support services, e.g. one hour per day, may make it difficult to foster this emotional support.

3.3.5 Workforce challenges

Home support in Ireland (and internationally) is facing a crisis in recruiting and retaining enough carers to provide home support. In the past, insufficient funding explained the long waiting lists within the HSE home support service, but now the large waiting lists highlighted above are driven by insufficient carer numbers.

There exist a number of challenges facing the caring workforce. Firstly, caring is a difficult and often under-appreciated profession and not viewed as an attractive career [110]. Employment conditions, particularly of workers employed in the private sector make the jobs unattractive. Given this concern the cross-departmental Strategic Workforce Advisory Group was formed by the Department of Health for the purpose of improving many aspects of the working conditions of carers. In 2022 it published a report with 16 key recommendations to address workforce challenges in recruitment, retention, pay, training, and sectoral reform among home carers and nursing home healthcare assistants [110].

One of the key recommendations involved establishing the national Living Wage as the base-pay for carers and allowing for payment for travel-time and mileage to be included in pay. Applying the average Living Wage to workers, equates to an annual wage of approximately €30,000. In addition, there was a recommendation on developing a competency framework to recognise prior learning and qualifications, to try and align employment grades with qualifications, and support career development [110]. There are also potential learnings from the Department of Health and Social Care in England. They have outlined the development of 8 role categories for carers to work in, and progress to, with additional responsibilities, training, and remuneration in higher category roles.[48] In England, focus has also been placed on digital skills training and development with the establishment of a new digital leadership qualification, which has not yet occurred for carers in Ireland.

Lack of career development, and job insecurity have also been identified as key challenges for the carer workforce. Barriers to workforce recruitment in the care sector are not unique to Ireland. For example, low pay, lack of training, lack of career growth opportunities, and long working hours are some of the reasons for the labour shortage in adult social care seen in England [111]. A survey of more than 500 social care staff in England also reported that more than half of social care staff intending to leave their jobs, intended to quit the sector completely [112]. Recommendations have also been put forward to help recruit and retain staff in England. As well as the emphasis on better rates of pay and job security, factors such as job quality, opportunities for learning and development and improved organisational culture and leadership have been highlighted [113].

48. https://www.gov.uk/government/publications/care-workforce-pathway-for-adult-social-care/care-workforce-pathway-for-adult-social-care-overview.

Protecting the health of the care workforce is another issue. Working in the care sector has also been associated with poor health. In previous analyses comparing the health of employment groups, carers[49] were found to be predominantly female (84.8% overall, and over 95% among HSE-employed carers) [99]. Risks to health from working conditions may also be compounded by the underlying higher risk of poor health for many care workers, given that a higher percentage live in the most deprived areas than any other occupation group, and even more than the unemployed population [114]. 28.5% of carers were living in the most deprived quintile of areas (i.e. the most deprived 20%), compared to only 10% of nurses.

3.3.6 Privatisation of home support

In addition to a quarter of home support hours being purchased from private providers, the majority of all the HSE home support service hours are also provided by private providers (and to a lesser extent voluntary sector providers). The dominance of the private sector has increased in recent years. In 2022, 61% of all HSE home support hours were provided by the voluntary/private sector (it is difficult to differentiate between voluntary providers and for-profit providers using the data available, but the majority are for profit providers)[96]. This is an increase from 54% in 2019 [99] and there is evidence that the percentage continues to rise in 2025.

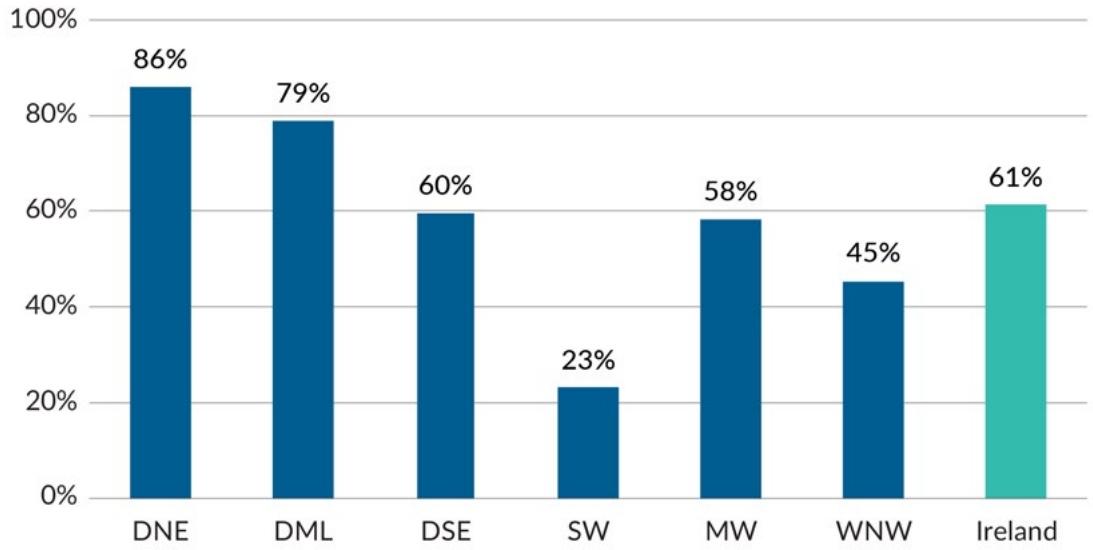
The reliance on private providers mirrors a similar phenomenon observed in LTRC [115] and home support across most European countries [116]. The increased dominance of private providers began in the early 2000s [117]. This privatisation of the service has also seen a reduction in provision of home support by the voluntary sector, who in the past, along with direct provision from HSE employed carers, provided the majority of home support hours. The State has historically had a low level of direct provision of home support in Dublin, with voluntary providers providing most care [118], and the voluntary sector in Dublin still remains a key provider of home support. However, there has also been clear evidence of increases in for-profit private provision in Dublin since the mid-2000s [118].

Since the early 2010s, both voluntary and for-profit providers have essentially been in competition to provide HSE-funded home support services as all providers are now required to tender for potential home support recipients. This changed the previous arrangement in which voluntary providers were funded through block grants by the HSE to provide care. Since the establishment of this tendering process, voluntary providers now must compete with for-profit providers, and they have come under increasing pressure. The National Community Care Network (NCCN) [119] and the Home Care Coalition [120], which represent voluntary home support providers, have previously argued that this process has resulted in uncertainty and insecurity for its members and carers.

49. Carers were defined as those with an occupation as a 'care worker or home carer' who cared for people in residential facilities or in their own home.

There also exists regional variation in the reliance on private providers. Figure 3.6 shows the percentage of public home support outsourced to the voluntary/private sector across HSE Health Regions in Ireland. In DNE and DML almost all public home support is provided by the private sector. In SW (Cork and Kerry), less than a quarter of public home support is provided by the private sector. The urban/rural split in private sector reliance observed in Ireland is common in home support internationally, as the private sector prefers to operate in urban settings in which it is easier to provide services and in which there are lower costs [121].

Figure 3.6: Percentage of public home support provided by the private sector



Notes:	a	DNE: Dublin North East; DML: Dublin Midlands; DSE: Dublin South East; SW: South West; MW: Mid West; WNW: West North West.
Source:		HSE administrative data (2022).

In recent years the composition of private providers has also changed. There now exist a small number of large private providers that are organised using a franchise platform, with local branches providing care and administrative and bureaucratic responsibility centralised. These large organisations are also now largely owned by international organisations and/or predominantly financed by international organisations that are funded via private equity, similar to LTRC [115]. Evidence points to these providers stepping in when the State's capacity to deliver home support services is inadequate [121], and the subsequent reduction in direct State provision in the market can further reduce State capacity to deliver services over time. In other words, once these large institutional providers begin to dominate a market, their consolidation will further increase over time [121].

There has been extensive discussion in the literature about the pros and cons of the new dominance of large private providers of care. Some argue that the goals of these providers do not align with those of the State or recipients, and outcomes may be impacted [121]. There are worries that funds may be diverted to profits, potentially at the expense of carers and care quality. In economic terms, as consolidation and market power increases, larger providers have moved away from being more passive price-takers to holding a stronger hand when negotiating prices, thereby driving costs higher. The newly proposed HIQA regulation of the sector may ensure better alignment of goals between providers, the State and care-recipients.

3.4 Effectiveness

Home support can play a vital role in maintaining the independence of older people and helping them live longer healthier lives. Evidence from international systematic reviews over many years indicate professional home support recipients have lower mortality rates than those not in receipt of support [122, 123].

For many people home support, along with their social support networks, can reduce the likelihood they are admitted into a LTRC facility [122, 124]. There is similar evidence in Ireland that shows that higher levels of home support were associated with a lower likelihood of LTRC admission [125].

There is also evidence that people who receive home support have lower rates of emergency department use and hospital admissions [126] and lower mortality rates [127] compared to people within a need for, but no receipt of, home support. Evidence from Ireland also shows that more availability of home support in a person's area reduced how long older people stayed in hospital [128]. Similar evidence has been found internationally [129, 130]. There is also more recent evidence that more intensive home support packages, termed 'hospital at home' provided care that was just as beneficial as admitted hospital care for certain older patients [131].

3.5 Efficiency

Here we consider efficiency in the current system.

3.5.1 Assessment of need

Currently there is no standardised care needs assessment as part of the HSE home support service. This may lead to inconsistencies in determination of both care need and the level of care provided. Attempts have been made to introduce a single assessment tool called interRAI to assess care needs, but rollout of this assessment has been slow (see Box 3.1).

Box 3.1 Rollout of interRAI single assessment tool in Ireland

The HSE established plans to introduce a single care assessment tool called interRAI (https://interrai.org/) to help determine the eligibility and needs of home support applicants. Such a tool could be used to match older people (as well as people ageing with disabilities) to home support services on the basis of their particular care-needs. It could also be used in times of tight supply to allocate resources to those most in need in a systematic manner.

However, the national rollout of interRAI has failed to materialise and faced a number of barriers. Due to limitations in Ireland's health information systems, interRAI faced implementation complexity, as it represents a health practitioner's intuitive tools used to assess need, and is a shift away from paper-based assessment to technology-based assessment [132]. Initial interRAI interviews can take up to 90 minutes and they require a considerable number of assessors. In 2024, the HSE aimed for 18,100 interRAI care assessments but only 4,407 were undertaken suggesting that significant issues exist in rolling out the system [133].

3.5.2 Integrated care

The lack of a standardised care assessment approach also hinders the development of a personalised integrated care plan that could be used to, not only estimate home support needs, but also other health and community support needs and determine how home support fits within individuals' wider support systems.

It is important to consider the role of home support within the context of a wider integrated community-based care system that is centred around the person and their support system, ensuring good coordination to make the most of the potential for prevention and rehabilitation and complementary services such as day care, meals-on-wheels, social prescribing, etc. By connecting home support with acute, primary care (including dental, vision and hearing services), and community care and supports, and encouraging independence, self-management and healthy ageing, home support contributes to a holistic approach that addresses both health and social care needs. Such a connection can further enable a more social model of care, centred on the individual, their family, home, and community.

3.5.3 Payment mechanisms

Currently, HSE home support services are free from co-payments from recipients, though many people do pay for private home support. In the context of a proposed statutory home support scheme, there have been discussions about how such a scheme will be funded and whether co-payments will be required as they are for the statutory NHSS. Research has shown that people are somewhat indifferent to means-tested co-payments for home support, especially if such co-payments could help ensure access to home support if required [134].

There are, however, concerns about co-payments for public home support. Firstly, co-payments are often introduced into healthcare to curb some demand, but there is no evidence internationally that co-payments for long-term care services such as home support reduce demand [135]. Secondly, co-payments could be used to alleviate some pressures on the state in terms of spending on the scheme. However, Department of Health commissioned research found that the introduction of flat rate co-payments (e.g. €5 per home support hour) would only yield a small percentage of overall costs and be regressive, affecting the poorest families disproportionately [136].

Importantly, in their analyses, Keane et al [136] did not model the possibility that a person's primary residence could be taken into consideration in any means-testing that may be used to determine co-payment requirements, as it does for the NHSS. Such a scenario would be regressive but practically it would be difficult for individuals to access the equity in their home to contribute towards their home support costs. Finally, due to the poor health information system structures in Ireland, and home support in particular (e.g. the lack of a standardised care assessment), practically, it would be difficult to implement a processing system that accurately captures co-payments from recipients. All of these challenges with funding notwithstanding, the issue of funding mechanisms needs to be considered in the context of the substantial care workforce shortfall seen in Ireland.

3.6 Limitations in analysis

3.6.1 Data-availability

The key issue concerns data-availability. Firstly, there is a dearth of administrative information on home support recipients, and until recently, HSE data did not capture the age or sex of home support recipients [70]. Due to the lack of a fully rolled-out standardised care assessment, there is a lack of information on the nature of needs and services provided to home support recipients. There is also a lack of information on the average time spent waiting to receive home support. There is also no single source at national level of information on the availability of consumer-directed home support.

There is also little information on the home support carer workforce, especially those employed by voluntary private providers. Currently is it not possible to estimate the total number of carers working in the sector or available to work in the sector. There is also a dearth of information on the skills of these carers and on the scope to increase carer numbers. Collection of comprehensive and up-to-date data on carers in Ireland, for example through a carer register or regular large-scale surveys, would be of assistance to policymakers, employers, carers and home support recipients. A good template exists in England. The Adult Social Care (ASC) Workforce database (formerly the National Minimum Data Set for Social Care) is an online database that collects and collates workforce information for the adult social care sector.

3.7 Learnings

Publicly funded home support is a longstanding element of care and support for older people in Ireland, but the system has always explicitly acknowledged that families remain the primary providers of support.

With the number of future family carers is projected to decline, this will potentially place more pressure on the home support scheme and other services that support older people.

The current HSE home support scheme is provided free of charge and is not subject to any means-testing. This should help facilitate access but waiting lists for home support services have grown fivefold since 2018; this growth in waiting lists is due to major workforce shortfalls coupled with continued ageing of the population. These workforce shortfalls would need to be addressed for any expansion of the home support scheme, even if more funding is made available.

Workforce shortages do not just reflect issues around pay, they also reflect issues around working conditions and career opportunities, in a sector where many people are employed by many different voluntary and private sector organisations. Working in the care sector can be rewarding but it is also demanding, and care workers can be at increased risk of poor health. The Strategic Workforce Advisory Group have a 16-point plan with recommendations to tackle this issue. These workforce issues are by no means unique to Ireland, and there will be learning opportunities from other countries. Here we highlighted approaches that are being used in England to try and address the same issue.

There are also variations, and therefore inequities, in access to home support across the different regions of Ireland. Understanding the full magnitude of these variations has been hampered by limitations in the existing information systems. This includes the lack of information at national level on the availability of consumer-directed home support and duration of time spent on waiting lists.

While multiple policy documents have committed Ireland to developing a statutory home support scheme, the move from policy commitment to implementation has not progressed. This is despite evidence from Irish and international sources on the benefits of home support and potential to help people age in place and reduce the risk of unplanned hospital admissions. They can also delay admissions to LTRC.

A statutory scheme would help facilitate a standardised approach to assessment of care needs and also support regulation and quality assurance in a sector which increasingly includes new private-equity entrants to the market. These new entrants may be unlikely to expand access to home support in areas of the country where it is currently limited, such as the south–west, if this is not deemed profitable.

While data-tools have been developed to inform local authority development plans on the need for supported housing for older people, as well as for people with disabilities, there is less data available at a national level and datasets on housing stock may not contain information on the age, health and tenure status of residents. Strengthening and linking these data-systems, as well as more visibility on current waiting lists, could also help with future planning and accountability.

3.8 Strengths, weaknesses, opportunities and threats

Strengths

- The increasing emphasis on home support, and additional funding in recent years from the Government, reiterates the importance of home support and the need to invest in the system.
- Ireland has a long-term care model that values family carers, though this is not often seen in policy.
- Relatively straightforward process to make initial application for home support.

Weaknesses

- There has been a very longstanding commitment to develop a statutory home support scheme but this has not been followed by implementation.
- Although there is the intention to have a standardised care-needs assessment process, this is still not in place. Moves towards the use of interRAI have progressed slower than expected. This means that there may be inconsistencies in assessment across the country. This would hamper integrated care planning.
- There has been a substantial rise in the number of people waiting for initial home support and/or an increase in the level of home support received, particularly since COVID-19. This is partly due to ageing in the population, but the key challenge is the workforce shortfall. Caring has not been well-paid, and career prospects have not been good. There has not been a substantive change in the number of people waiting because of a lack of funding.
- The average level of care available, 7–8 hours per week, practically means that only a very limited amount of help with activities of daily living can be provided for many people. This may reduce the likelihood that it makes a meaningful difference to their lives and provides little respite for family carers.
- Access to home support varies considerably across Ireland. This contributes to the view that accessing home support is a postcode lottery.

- The limitations in the availability of home support have meant that the support has mainly been concentrated in people who already have high level of needs, including those who may have been recently hospitalised. If more support were available, older people with more modest level of needs could also benefit, which could potentially reduce future demands for more intense levels of support.
- The State has allowed the private sector to dominate and therefore determine supply and more recently costs.
- Continuing limitations on available information on home support and the recipients of the scheme at national level. This includes a lack of information on the length of time people spend on waiting lists for home support.

Opportunities

- The recent reaffirmation of the commitment to designing a statutory home support service provides another opportunity to take concrete measures for implementation.
- The recent Report of the Strategic Workforce Advisory Group (2022) provides an impetus to take measures to further improve the working conditions, career development and job security of professional home support carers.

Threats

- Demographic change means that there are likely to be fewer family carers available; the system remains heavily reliant on the input of family carers. This reduction in the availability of family carers is likely to lead to further increases in demand for home support, and the risk of needs not being met may increase further in future.
- Continuing cost-pressures. While there have been increases in budgets, these have not seen increases in people receiving care, but increases in prices paid to private providers for care packages. At the same time there is a need to increase funding to support workforce recruitment and retention.
- The increased dominance of private-equity funded providers may be a cause for concern. There is some evidence internationally that this can reduce quality and access.

4

Supported living

4.1 Summary

This chapter looks at the current state of publicly funded supported living for older people in Ireland. It looks at the availability and adequacy of existing services, as well as their effectiveness in achieving outcomes that help older people to remain in their own homes and communities for as long as possible. It also looks at the efficiency concerns within the system, for instance related to payment mechanisms and the assessment of need. The chapter should not be viewed in isolation: while there are benefits from supported living it is also important to ensure the availability of health, social and local supports in any locality. These are issues that are discussed in other chapters of this report.

4.2 Introduction

In the introduction to this report we indicated how Ireland's population will age over the next 25 years, including substantial growth in the over 80s. By 2051, there are projected to be more than 300,000 people aged over 85, which represents an almost four-fold increase since 2021. This has implications for the future planning of new homes and services to accommodate the needs of an ageing population, including the increased provision of supported living.

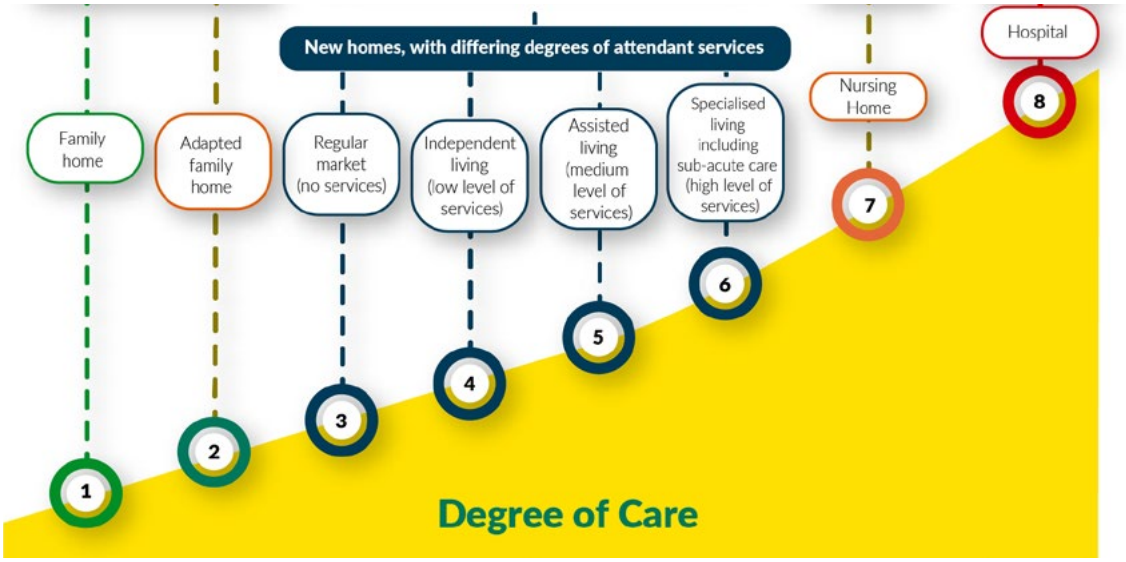
There are many different ways in which the term supported living can be defined. In this chapter, supported living (often called 'supported housing) is defined as housing with care and support provided to older people (or younger adults and children living with a disability). The key aim of supported living is to allow people to continue to live as long as possible in their own homes and as members of their local communities. While supported living can refer to measures taken to modify an existing home, more typically it refers to having a tenancy agreement in 'purpose-built, non-institutional accommodation where older people have their own front door and where support or care services are available' [137]. This is what we predominantly focus on in this chapter, although the chapter also looks at services to help people adapt their existing homes in order to help them age in place, notwithstanding the key role of other factors such as support and engagement with family, friends and the local community.

In reading this chapter it is important to see supported living within the context of a wider integrated community-based care system that is centred around the person and their support system, including home support and community-based care (see earlier chapters). The chapter focuses on supported living for older people, but many of the messages equally apply to access to supported living for younger people aging with disabilities, including intellectual disabilities (see also the chapter on 'Ageing with a pre-existing disability through the lens of intellectual disability').

4.2.1 Policy landscape

Policy on housing for older people in Ireland is strongly focused on helping people to age in place in their own homes for as long as possible. A review commissioned by the Ireland Smart Ageing Exchange (ISAX) and the Housing Agency in 2016 [138] highlighted the gap in the supply of supported living options for older people with differing degrees of care-need, in between the needs of older people continuing to live in their own family homes and those older people moving into LTRC (Figure 4.1).

Figure 4.1: Spectrum of housing and care needs for Ireland's older population



Source: [138, 139].

A joint policy statement on 'Housing Options for our Ageing Population' was launched in February 2019 [139]. The statement set out a framework for the Government to help facilitate more housing options for older people, including different types of supported living. It acknowledged that while innovative practice was emerging in localities, 'there was a need for a more strategic and collaborative approach to ensure the best possible outcomes for all'. One outcome of this has been the creation of Age Friendly Housing Technical Advisor roles in each local authority, who provide advice to the local authority and private-sector organisations interested in providing age-friendly housing and to the public.

Housing for All built on the 2019 joint policy statement and included commitments to increase the housing options available to older people to facilitate ageing in place with dignity and independence [140]. It commits to building more than 90,000 social homes over the lifetime of the strategy.

Among other objectives set out was continued support for the development of the Age Friendly Homes portal and website to promote awareness of age-friendly housing and support for pilots of innovative forms of housing re-design. Subsequently, in line with *Housing for All*, local authorities, in their role as housing and planning authorities, produced Housing Delivery Action Plans by the end of 2021[141]. These action plans should include information on how social housing meets the needs of older people (and people with disabilities), although the visibility of the housing-needs of both these groups is very variable between plans and in some cases was very limited.

A Housing Need and Demand Assessment Framework tool is used in the development of local authority plans, which potentially means that they can take account, not just of future projections of the number of older people who require some form of social housing, but also their of level of support needs through collaboration with the local Age Friendly Housing Technical Advisor [142]. However, by the time of the 2023 *Housing for All* Action Plan Update, a new set of priority and second-tier actions was published [143]. None of these actions specifically mentioned older people or people with disabilities.

In the meantime the second *National Housing Strategy for Disabled People 2022–2027* was published focused on providing a framework for delivering housing for disabled people through mainstream housing policy [144]. This includes looking at the housing-needs of people ageing with disabilities, including people with intellectual disabilities. (This *Strategy* is covered in more detail in the chapter 'Ageing with a pre-existing disability). Some of the actions in the earlier 'Housing Options for our Ageing Population' policy statement overlap with this *Strategy*. For example, the policy statement committed to an action

> in partnership with industry, [to] introduce measures to ensure that over a five-year period delivery is increased to ensure that 30% of all new dwellings are built to incorporate universal design principles to accommodate our ageing population [139].

This commitment to universal design is at the heart of the *Housing Strategy for Disabled People*. These universal design targets are also included in local authority county/city development plans.

Housing for All also included a commitment to develop a policy to support for older people who might want to move from their current homes to smaller accommodation ('right-sizing'). In 2025 the new *Programme for Government* contained a commitment to 'review and standardise the Older Persons Housing Financial Contribution Scheme' [145]. Currently local authorities may operate schemes to offer smaller, manageable housing options to older people who find their current homes too large. The rules of these schemes vary, but they allow homeowners to sell their homes to the local authority and then make a financial contribution from this sale to the local authority for their new accommodation.

A revised version of the National Planning Framework was published in 2025, setting out the Government's goals to 2040 on development, including housing and related issues, such as having accessible communities with good transport infrastructure [146]. It contains a section on an Age Friendly Ireland. One of the 108 policy objectives detailed therein, objective 40 is that

> local planning, housing, health facilities and services, transport/ accessibility and leisure policies will be developed with a focus on meeting the needs and opportunities of an ageing population along with the inclusion of specific projections, supported by clear proposals in respect of ageing communities as part of the core strategy of city and county development plans [146].

A final important policy development that should be noted is the formal recognition of the link between health and housing through the appointment of a joint Minister of State at the Department of Health with special responsibility for older people and at the Department of Housing, Local Government and Heritage with special responsibility for housing. This potentially provides an opportunity for more joined-up thinking, for instance through the publication of a White Paper, outlining proposals for future legislation and other actions.

4.2.2 Wider context: housing shortage in Ireland

The need to expand the availability of new forms of supporting living for older people in Ireland must be set within the broader context of work to inform long-term housing policy for all of the population of Ireland. Land is limited. The 2024 *Report of the Housing Commission* estimated that, as per the 2022 Census, there was a housing deficit of between 212,500 and 256,000 homes in Ireland [147].

They also projected that Ireland would need up to 2.16 million additional dwellings[50] to be built between 2024 and 2050 (or 81,400 *per annum),* assuming a population of 7.25 million and an average household size of 1.9 people by 2050 [147]. The Housing Commission recognised that housing policy needs to address the needs of specific cohorts that are most affected by the failure of the housing system, including older people and people with disabilities. They noted that 'as Ireland ages, it is likely that the cost of not meeting Ireland's housing requirements will increasingly be felt by older people'. They also called for future housing policy to 'facilitate independent and assisted living in the community by providing appropriate accommodation and services for people with additional needs, including older people and those with disabilities'.

4.2.3 Overview of supported living

In Ireland, while there is no specific definition and/or model of supported living (which can also be known as housing with support) in housing or health legislation, there are three broad approaches for supported living that generally involve moving to purpose-built homes that are in compliance with universal design principles—that is they cater to the needs of all regardless of age, levels of ability, mobility and size. These three models of supported living, independent living, assisted living and specialised living will vary with dependency levels and the needs of recipients (Figure 4.2). They range from *independent living*, with limited available services, including a caretaker/house manager being available for part of the time, through to *assisted living* (medium level of services) with home support and day care included in model, and *specialised living* (high level of services) with 24/7 medical and social care available. All three levels refer to properties that are fully contained with their own front doors, with communal spaces and facilities that can also be used by the wider local community. Safety and security are also built in features of all of these properties.

50. The *Report of the Housing Commission* stated that these calculations 'include own door housing, whether apartment or house, where these are targeted at older cohorts. This includes 'independent living' or 'assisted living' developments. However, the analysis does not include nursing homes or healthcare capacity'.

Figure 4.2: Typical features included in supported living models

Independent Living	Assisted Living	Specialised Living
1/2-bedroom apartment/ bungalow – own kitchen, living room, outdoor space	1/2-bedroom apartment/ bungalow – own kitchen, living room, outdoor space	Bed-sitting room, bathroom, kitchenette and may include own outdoor space
Own front door	Own front door	Own front door
Universal Design principles	Universal Design principles	Universal Design principles
Communal room and office space	Communal room and office space	Extra communal and office space
May have a café	May have a café or residents restaurant	Shared sitting rooms, kitchens, and dining rooms
Secure personal alarms/ emergency response	Secure personal alarms/ emergency response	Secure personal alarms/ emergency response
Caretaker/housing manager on site for some time each week	Caretaker/housing manager on site for some time each week	Social and healthcare staff on site
No home help or day care costs included in model for this paper	Co-located with an HSE day care centre	24/7 social and or/medical care costed
	Day care costed in model, but no home help costed	Day care and home help costed in model
May have a guest apartment in scheme for overnight visitors	Often a primary care centre on same site	
	May have a guest apartment in scheme for overnight visitors	

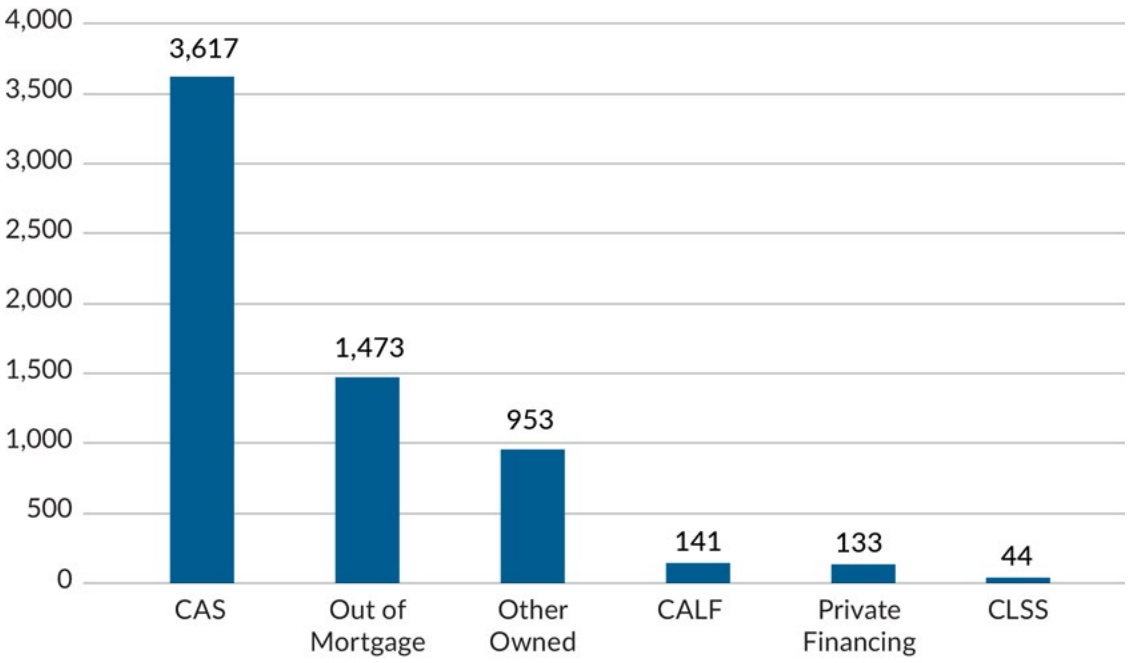
Source: [148].

There are an extensive number of State agencies and other bodies involved in supported living initiatives in Ireland. This includes city and county councils which play a central role as housing and planning authorities in both future planning of local housing needs and in the provision of supported living. The Department of Housing, Local Government and Heritage and the Housing Agency have also both become more central figures since the publication of the *Housing for All* policy [140].

Approved Housing Bodies (AHBs) also are involved in the funding and delivery of supported living. These are largely charitable or voluntary organisations. There is large diversity to the types of supported living arrangements provided to clients, and the types of organisations involved in providing supported housing. For example, there are a number of 'welfare homes' throughout the country that provide supports to clients with low dependency level. While some providers of this type of housing themselves provide care services to their tenants with access to on-site support staff, some providers simply provide the housing, and their staff may assist tenants to access care from third parties. This extent to which these models of care promote autonomy and choice for residents rather than dependency also needs to be considered.

Local government provides financial support for the capital development of supported living for older people through several schemes, including the Capital Assistance Scheme (CAS) which provides funding of up to 100% to AHBs for supported housing for older people and people with disabilities. The capital costs for 148 AHBs who provide housing for older people with care and support needs are primarily funded through the CAS (57%), followed by out-of-mortgage (23%) and other owned (15%) (Figure 4.3). Other schemes such as the Capital Advance Leasing Facility (CALF) and Capital Loan and Subsidy Scheme (CLSS) are used for very few of these 'Care and Support' dwellings. This is in contrast to all AHB dwellings where CALF represents 38% of all funded dwellings. Most of the day-to-day costs for people who live in supported living are covered by the HSE, typically through Section 39 block grants[51].

Figure 4.3: Funding of owned AHB 'Care and Support' dwellings, 2023



Data source: [149].

There are also new initiatives to enable older people to remain living in their own homes and to reduce LTRC requirements, including support co-ordination initiatives, for instance delivered by local authorities and voluntary organisations. Necessary adaptations and other works to existing homes, including for needs identified through the Healthy Age Friendly Homes (HAFH) initiative, can be funded through various grant schemes: Housing Aid for Older People (HOP) scheme (maximum €10,700); Mobility Adaptation Grant (MAG) (maximum €8,000); and the Housing Adaptation Grant for Disabled People (maximum €40,000). Examples of adaptations could include making homes wheelchair-accessible or adding a ground-floor bathroom, toilet or stair-lift.

51. Section 39 of the Health Act 2004, allows for funding to be given to groups that provide health and social care services. These services are often ancillary to those provided by the HSE, but their staff are not public servants.

85% of the funding for these grants is from the Department of Housing and Local Government and Heritage (DHLGH), with 15% from local authorities. These maximum levels for grants came into effect in 2025, with grant-levels recently raised by 30% following a review [150, 151]. All grants are means-tested (maximum household yearly income from 2025 of €75,000). There is no co-payment for households with an income of up to €37,500, increasing to 70% co-payment for households of €75,000. In addition, local authority tenants can apply for grants for renovations and adaptations though the Local Authority Adaptation Works Scheme (LAAWS).

4.3 Adequacy

4.3.1 Supported living dwellings

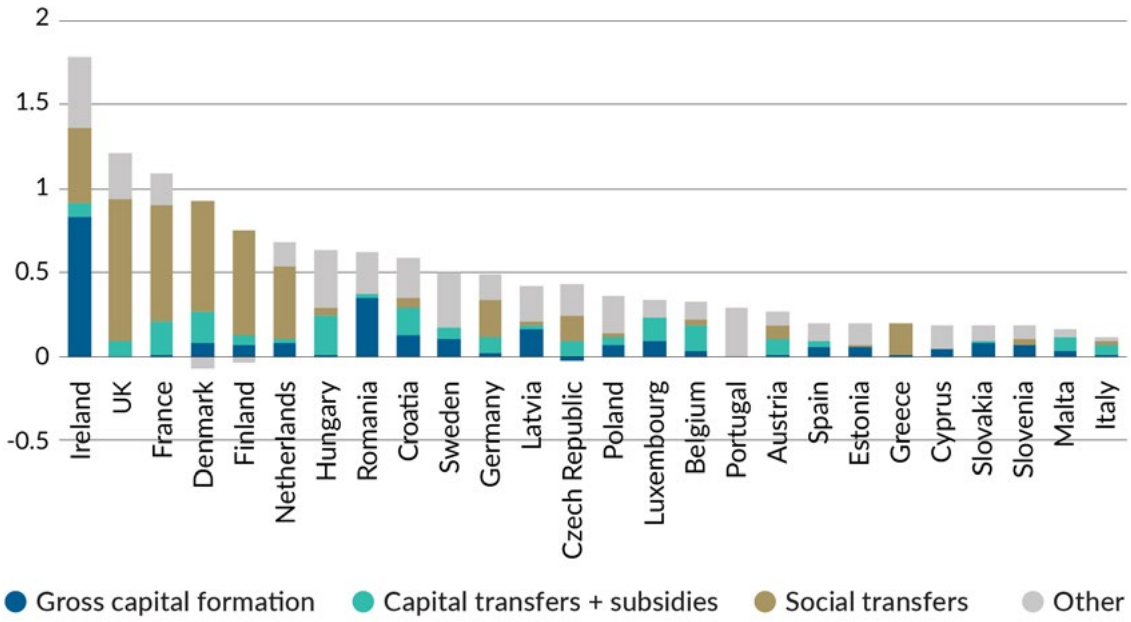
The joint policy statement on 'Housing Options for our Ageing Population' made it clear that there is a gap in models of supported living and that this provision needs to be scaled-up [139]. While the number of older people who might benefit from supported living needs to be fully determined, it has been argued that more than 24,000 supportive living housing unit are needed by 2040, 70% of which would be supported living homes, with 23% being co-housing and retirement village units and 7% in housing with support [152]. The Housing Agency have also acknowledged the need to scale-up supported living dwellings across Ireland. Using earlier calculations from the report, *Housing for Older People: Thinking Ahead* [138], the policy statement estimated that 15% of those aged over 65 would be willing move to a different home in their community and that a further 15% would choose to move to age-friendly accommodation, if it were available, with 66% of those over 65 would preferring to stay in mainstream housing. They then estimated the requirements for housing suitable for older people by 2031 to include 150,000 age-friendly dwellings and a further 150,000 moves to 'right-size' housing [139].

Ireland has the third highest rates of home under-occupancy (having more rooms that considered adequate) in Europe, with 88% of people aged 65 and over in under-occupied homes [153]. There is, however, much uncertainty on estimates of willingness to move (to a more 'right-sized' home), even with financial incentives. A survey of 1,213 homeowners aged over 55 in 2019 found that only between 3% and 6% might be willing to move to a smaller property [154]. Emotional attachment to their homes was the main barrier to moving, with factors such as social networks and community services also being influential. There were also variations in willingness to move—older people were less likely to move while people in Dublin and wider Leinster were more willing to move. The study did however suggest that between 15% and 20% might be willing to move if there were 'policy measures designed to promote agency, deliver choice and to assist households when navigating the many risks and complexities of moving home' [154]. This may be particularly important also from an equity perspective, to help ensure that older people are in control of decision-making. They would also be more willing to move if they buy a smaller, purpose-built property in the same area at a lower price. This research also may have implications for the plan to standardise the Older Persons Housing Financial Contribution Scheme that is stated in the new *Programme for Government*.

In addition, currently the majority of older people in Ireland live in an owner-occupier home without a mortgage. However, the overall number of older people accessing social housing is increasing. In the 2022 Census there were 31,124 people aged 65+ in social housing and almost 17,000 in the private rental sector over the age of 65, representing an 83% since 2016 [155]. In future, a declining home-ownership rate, (17% of all private rental sector tenants are now over age 45) means that the tenure-profile of future older-population cohorts is also projected to see a substantially higher percentage of the older population living in private and supported rental homes [156, 157]. This also has implications for demand for supported living and is likely to become a major policy concern in future decades.

All of this means that while there could be more investment in adaptations to existing homes, this nonetheless implies a substantial increase in the current provision of supported living. In a general context, the recent *Report of the Housing Commission* noted that Ireland had by far the highest level of spending of national income on public housing in the EU in 2019 (Figure 4.4) but that the social housing output was 0.86 per 1,000 inhabitants—much lower than countries such as Austria (2.25) and the Netherlands (1.5). This is partly due to the higher costs of construction in Ireland (costs which have continued to increase).

Figure 4.4: Spending on housing in the EU (% of national income), 2019



Source: [147].

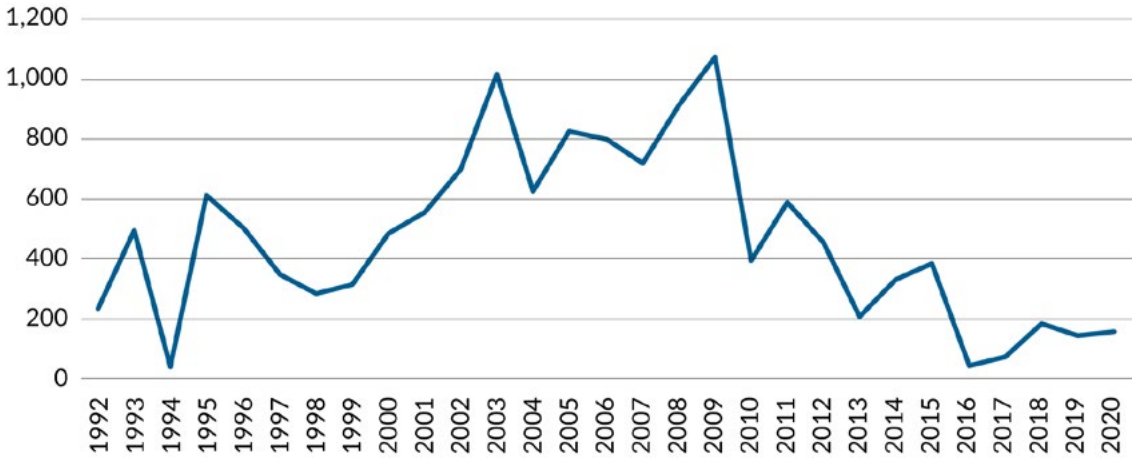
For example, AHBs are a major provider of specialist supported living, but there are only around 7,500 supported housing dwellings for older people provided by AHBs. The Approved Housing Bodies Regulatory Authority (AHBRA) stated that in 2023 148 AHBs, provided 7,489 'Care and Support' type of dwellings [149]. This housing is typically allocated to older people with care-needs as well as to people with disabilities. The ABHRA note they are much more staff-intensive that other AHBs, with a total of 18,375 staff and 696 volunteers. 'Care and Support' AHBs account for 89% of all staff in the AHB sector, but just 13% of all AHB dwellings. This workforce requirement might be a barrier to scale-up, although that needs to be examined as it could be a major constraint and deserving of more policy focus.

Another indicator of potential unmet need is the waiting list for social housing in Ireland. In total for all ages, the number of households on a waiting list for social housing in Ireland in November 2024 was 59,941—an increase of 1.9% on those waiting in November 2023 [158]. While the list only captures a fraction of households who could benefit from supported living, it states that there were 4,959 and 2,208 households where the household head was aged 60–69 and 70+ respectively. Together they account for 12% of all on the waiting list. These figures represented increases of 1.5% and 4.7% respectively on the 2023 figures, while compared to the first year these figures were produced (2013), they represent 27% and 93% increases respectively [159].

However, only 1,655 of these 59,941 households (2.8%) were on the waiting list for social housing in 2024 specifically due to an old-age need, with another 4,348 (6.7%) households on the waiting list because of a physical, sensory, mental or intellectual difficulty. While there was no material change in numbers in the waiting list due to older age, the number of people with a disability increased by more than 10% compared to 2023. Compared to 2013 the number on the waiting list due to old age or disability are 10% lower and 11% higher respectively.

The Housing Commission also suggested that investment in supported housing is below the level of need for all people with disabilities, including older people, identified through social housing assessments. At its peak under the CAS scheme 1,076 new dwellings were built in 2009, but in the following decade an average of only 455 dwellings were built every year (Figure 4.5). As Figure 4.5 further shows between 2016 and 2020 the number of properties built was well below this average[52]. The Housing Commission notes that the number of new dwellings fell while households with a person with a disability rose from 4.4% of the total in the 201 assessment of social housing need to 8.2% in 2020 [147].

Figure 4.5: AHB social housing output under the Capital Assessment Scheme, 1992–2020



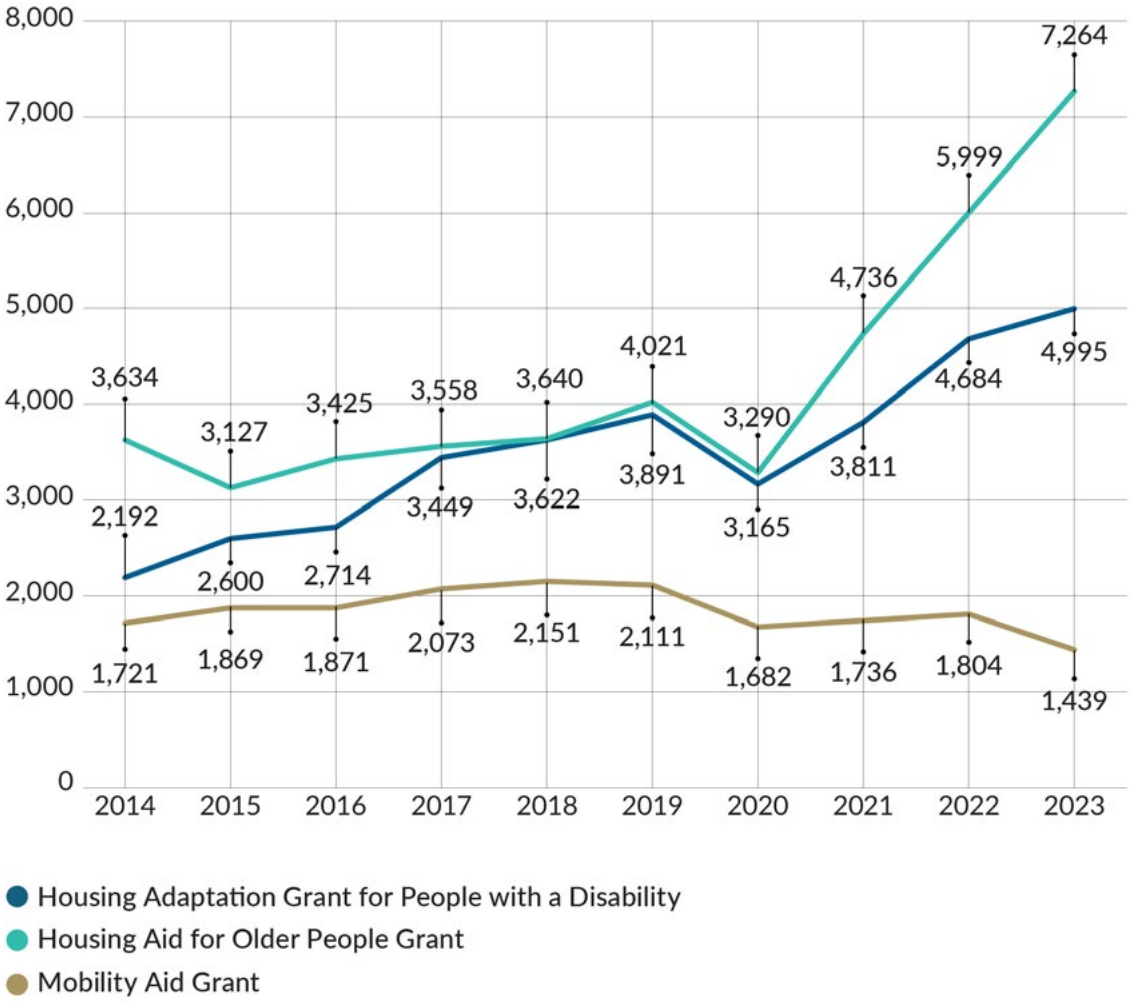
Source: [147] .

52. Note in 2022 the Minister for Housing, Local Government and Heritage stated that 'the target for CAS delivery has generally been 400 units, which takes into account the capacity of the AHBs involved which are frequently smaller, locally-based organisations'. https://www.oireachtas.ie/en/debates/question/2022-03-30/38/.

4.3.2 Housing adaptation grants

It is unclear how many households could benefit from housing adaptation grants across all of Ireland due to the lack of centralised data. However, in 2023, there were 13,698 grants delivered at a total cost of €94.1 million [151]. 53% of these grants were under the Housing Adaptation for Older People Grants scheme (Figure 4.6). €93.1 million was allocated to grants in 2024, with the expectation of a similar number of housing adaptation grants made for older people has more than doubled since 2020. There is little change in the average value of awards under the Housing Adaptation for Older People Grants scheme over the last decade, being €7,931 in 2014 and €8,162 in 2023. The recent *Report of the Housing Commission* also states that, due to costs pressures in the construction sector, 'in many cases, these grants have become insufficient to meet the costs involved in carrying out adaptation works' [147].

Figure 4.6: Number of housing adaptation grants for older people and people with disabilities, 2014–2023



Source: [151].

4.4 Effectiveness

4.4.1 Effectiveness of supporting living

Supported living, as an alternative housing option, could potentially help older people to live independently for longer and to avoid early and potentially unnecessary admission to LTRC. Evidence on the effectiveness and impact of different models of supported living remains limited but generally positive. There are a few systematic or scoping reviews that have collated evidence on the impact of different living arrangements.

The HRB undertook a review on the effectiveness of housing with support for older people. Much of the evidence included in the review points to some benefits to physical and mental health of different types of supported living models, found mainly in North America and the UK, including their potential to avoid some healthcare costs. However, the review noted that there was 'insufficient high-quality evidence to date to make definitive conclusions regarding the impact of housing with support' [137]. There is also little evidence about the impacts of supported living arrangements for older people from minority groups or diverse sexual orientations. For example, analysis in the UK indicates that residents living with dementia in generic supported living (extra care) dwellings were likely to be at higher risk of social exclusion due to attitudes of other residents [160]. More work is needed on how to maximise benefits of these schemes for groups with specific needs, such as dementia and intellectual disabilities.

4.4.2 Housing adaptation grants

Impacts of the receipt of housing adaptation grants were assessed as part of the evaluation of the piloting of the Healthy Age Friendly Homes support co-ordination service for 2,133 participants across nine sites in Ireland [31]. Housing adaptation grants were the most frequently identified need, affecting 27% of participants. Overall, participants who received grants had a 2.2% improvement in quality of life, 4.5% improvement in self-efficacy and 2.2% reduction in loneliness. However, no information on the statistical significance of these changes was reported. In qualitative analysis, housing adaptations and mobility aids were identified by participants as the most common and helpful supports that they received.

4.5 Efficiency

4.5.1 Time from planning to completion of supported living dwellings

Getting supporting living schemes from the initial planning and design stage to completion can be a lengthy process. This may reflect general challenges in housing and planning regulations that go beyond the scope of the Commission's work, but the time needed for completion can be substantial. There are many different complexities and challenges to be overcome for each individual supported living scheme.

One detailed example of this is seen in an evaluation of the planning stage for a 52 independent unit supported living scheme in Dublin [161]. In this case initial approval for the project was granted by what is now the Department of Housing, Local Government and Heritage in March 2017, but actual construction only began in October 2022. Building work has now been completed and the supported living units are being rented by tenants.

The intention here is not to focus on any one individual scheme, especially as this is a 'pathfinder scheme' which will help with future scheme-design, but simply to note that the process is complex; there are four separate stages in making an application for CAS funding for an AHB. The whole process from start to finish should take no more than 75 weeks; in this particular case the process took 4.3 years. COVID-19 was certainly a factor, but many other technical and regulatory complexities were involved. Separately. the Housing Commission in their recent report have also noted this process is bureaucratic and that delays can lead to increased costs of construction of social housing [147]. Time-delays and increasing costs are also opportunity costs, as some these resources could be alternatively spent on actions to help people remain in their own homes.

4.5.2 Funding mechanisms for supported living

In the section 4.3 of this chapter, we noted that the construction of new supported living dwellings has remained low while there has been a growth in potential need. In their recent report, the Housing Commission argue that there has been an 'overreliance on the use of CAS' as a source of funding for AHBs providing supported living housing for older people and people with disabilities [147]. They argue that other financing mechanisms, notably the CALF, would help extend capacity but note that this scheme is currently available only for general housing.

The Housing Commission also state that the revenue funding provided by CAS is 'not adequate to cover the full costs of management and maintenance' of AHB dwellings [147] which is of particular concern for people with disabilities and older people. They state that AHBs 'receive only short-term funding for support services. As a result, funding for support services can only be secured and managed over the short term and is often inadequate to meet the level of need.' They also note that 'HSE funding for the costs of providing care and support services, which is provided under the terms of sections 38 and 39 of the Health Act 2004, should also be reformed to address deficiencies in how such services are funded'.

Challenges in funding arrangements may have implications for sustainability while there potentially might also be workforce issues if the services are expanded, given the high level of workforce in the 'Care and Support' AHBs described earlier in this chapter.

4.5.3 Planning the expansion of supported living dwellings to meet needs

The expansion of supported living dwellings to better match need should be positively aided by the introduction of Local Authority Housing Delivery Action Plans that should detail how social housing will meet the needs of older people and people with disabilities who require supported living [142, 162]. This uses an adapted version of a Housing Need and Demand Assessment Tool (HNDAT) first developed in Scotland. Local Age Friendly Technical Advisors should be able to provide information on local needs for supported living housing stock. Experience of how well this system works in practice is not clear: one initial review of Local Authority Housing Delivery Plans found that while some authorities are using the HNDAT, others are not.

4.5.4 Economic case for supported living

Detailed modelling analysis looking at the potential benefits of different models of supported living in Ireland did however indicate that all models (independent living, assisted living and specialised living) had positive long term (30 year) net present value from the perspective of the State, regardless of whether the accommodation was State or privately funded [148]. Potential assumptions on benefits in terms of reduced health and social care utilisation were derived from multiple UK literature on supported and extra-care housing. Annual benefits per home ranged from €2,200 to €4,700 for State funded supported living versus regular social housing, and from €4,700 to €20,000 for privately funded supported living versus regular private-market housing.

One example is an evaluation of 19 extra-care housing schemes in England that showed that schemes that combined housing management and care arrangements, as well as those with lower staff-turnover rates, have lower costs [163]. Moreover, at a six-month follow-up, residents had better functioning (Activities of Daily Living Barthel Index) and lower costs compared with a matched (on age, gender and health status) cohort of older people who moved to residential care [164].

4.5.5 Economic case for home-adaptations to support ageing in place

There is also some evidence of the costs and benefits of investing in home-adaptations to support ageing in place. The recent review of Housing Adaptation Grants for Older People in Ireland, suggested that substantial costs could be avoided if individuals can continue to age in place rather than be admitted to nursing homes [151]. The review assumed that older people who received housing adaptations would be able to remain at home for an additional 2.7 years compared to those similar older people who did not receive this help. This assumption was based on a Scottish modelling analysis [165]. The combined cost of a home care package for six months plus a housing adaptation grant would be €13,804 compared to €39,676 in costs for a publicly funded bed in LTRC. If time to nursing home admission was delayed by 2.7 years, these comparative costs for remaining at home versus a nursing home would be €38,629 versus €214,250.

In the UK a review, which was commissioned by a large provider of housing repairs and maintenance and regeneration services across the UK, pointed to a range of evidence of differing strengths of a range of primary and secondary care costs that might be avoided, for instance related to falls, and also suggested that the likelihood of entering LTRC was also reduced [166]. The analysis estimated that there were positive health and social care net benefits *per annum* of £2,441 (2017 prices) per resident.

4.6 Limitations in analysis

4.6.1 Data-availability

A key issue concerns data-availability. A recent research project looked at key housing related datasets in Ireland [167]. Information on housing conditions, as well as knowing about the age of residents, is important for identifying older people at risk and planning future needs. While data are available at local authority level on the types of housing available and their condition, and the need to adapt existing properties for older people with needs, the review highlighted the lack of a centralised dataset on housing conditions in Ireland. Another limitation of existing datasets is that while it may be possible to identify whether people are tenants or privately own their homes, 'much of the data contained within these datasets does not specify the age of participants in any more detail past 65+ years of age (where likelihood of disability or older housing increases)' [167]. The review also found that datasets do not identify the proportion of households with disabilities or health conditions that may be impacted by their housing situation. It would also be helpful to have a central repository of all local authority housing delivery action plans in order to make it easier to assess the extent to which plans include work to support the needs of both older people and people ageing with disabilities.

4.7 Learnings

Various policy documents in both the health and housing spheres commit Ireland to increasing the availability of supported living dwellings for older people who may find it difficult to remain living in their current homes. Different tiers of supported living are available: while all of the accommodation models provide access to communal areas and some nearby support, these are all fully independent homes, where residents have their own front door and live their own lives. There is some evidence that this type of accommodation can reduce pressures on nursing homes and hospitals, although the evidence-base needs strengthening. The chapter has also looked at the use of financial supports to help people make adaptations to their existing homes, so that they can continue to age in place. This can also make a positive difference to their quality of life and potentially avoid some costs to health and social care systems.

Given the broadly positive evidence on supported living and home adaptation, the challenge is to facilitate better implementation. The stock of supported living dwellings in Ireland appears to be low, although it is difficult to know the exact level of stock because of fragmented data. The Housing Commission reports make it clear that there are shortages in stock and that the number of social homes built in Ireland is low by international standards. Funding through the Capital Assistance Scheme has meant that on average less than 500 social homes for AHBs have been built each year over the last decade.

There appears to be a need to look at different ways of funding this type of housing for older people, but it is not just an issue of funding. The complexities in the planning and funding process can mean that there are significant delays in bringing projects from the initial planning stage to construction. While data tools have been developed to inform local authority development plans on the need for supported housing for older people, as well as people with disabilities, there is less data available at a national level and datasets on housing stock may not contain information on the age, health and tenure status of residents. Strengthening and linking these data systems will help with future planning.

The recent appointment of a joint Minister of State at the Department of Health with special responsibility for older people and at the Department of Housing, Local Government and Heritage with special responsibility for housing is an indication of the importance of strong collaboration and joined-up thinking between the two departments to further progress supported living in Ireland.

4.8 Strengths, weaknesses, opportunities and threats

Strengths

- Recognition of the importance of ageing in place in policy documentation in both the housing and health spheres.
- Recognition of the importance of different models of supported living to meet the needs of older people who cannot easily age at home but do not need to be in residential care.
- Investment in local housing strategic development plans that should take account of the care and support needs of older people, including the specific needs of people with dementia as well as those with intellectual, physical or sensory disabilities. This includes use of the Housing Need and Demand Assessment Toolkit with input from local Healthy Age Friendly Technical Advisors.
- Putting in place evaluation of initiatives such as Pathfinder projects and other pilot programmes to help inform future supported living developments and/or helping people with adaptations to remain in their own homes.

Weaknesses

- There is a low level of supported living dwellings relative to need.
- Slow and/or limited implementation of various previous policy commitments relating to supported housing for older people.
- Lack of a model and suitable funding mechanisms both for the build (CAS) and the supports (HSE) in supported housing.

- The Housing Commission highlight limitations in the current CAS which is the primary funding source for social housing for AHBs. They argue that reliance on this mechanism has constrained the expansion of social housing stock.
- The Housing Commission also argue that HSE section 38 and 39 funding for care and support social housing has deficiencies that need to be addressed. These can affect the sustainability of AHBs.
- The planning process can be very lengthy: the CAS process involves four separate applications. Some applications, despite a 75-week time-limit, may actually take years to be concluded. The cost of construction can rise during this time.
- Lack of a central collated data-system disaggregated by age.

Opportunities

- Increased collaboration between health, housing and local government.
- The recognition of the link between health and housing through the appointment of the joint departmental Minster of State for Older People and Housing.
- The evaluation of Pathfinder projects and initiatives such as Healthy Age Friendly Home pilot programme provides a path forward for further supported living developments and/or help for people with adaptations to remain in their own homes.
- Ongoing scoping work to look at reform of CAS.
- Increase in monies available and income thresholds for Housing Adaptation Grants for Older People with Disabilities.

Threats

- Removal of housing for older people and for people with disabilities as priority actions within *Housing for All*.
- Lack of follow-through on commitments to reform CAS creates a risk of AHBs moving away from provision of housing for older people.
- Wider context of housing shortages; ensuring that needs of older people and people with disabilities remain a priority.
- Weak understanding among public and policy makers of autonomy, choice and rights in older age.
- Falling home ownership; future generations more likely to be renters.
- Rising costs on construction; Irish investment in publicly funded housing very high compared to EU but costs of construction mean the number of dwellings built is lower than in many other EU countries.

5

Residential care

5.1 Summary

Residential care, specifically LTRC, provides support with personal, health, and nursing care within residential facilities, primarily nursing homes. First and foremost however, it is important to recognise that LTRC accommodation should always be seen as a person's home, in the same way that a community private residence would always be seen as an older person's home. That said, it is important to note that for many people, LTRC is not their preferred living arrangement, and many people move into LTRC because personal supports, including home support, may be limited and the wider health and social care services they require to live independently at home are unavailable in their communities. It is also important to recognise that LTRC facilities are also used to provide short-stay care without specification of function and evaluation of effectiveness. This short-stay care may potentially do harm and increase the risk of institutionalisation.

This chapter looks at the current state of LTRC in Ireland. It begins by outlining the definition and scope of LTRC, before going on to describe the policy and governance framework. It looks at the availability and adequacy of existing services, including issues around independent advocacy and safeguarding, as well as efficiency concerns within the system.

5.2 Introduction

5.2.1 Definition

LTRC in Ireland, as defined by the Nursing Homes Support Scheme Act (2009), refers to the provision of 'maintenance, health or personal care services, or any combination thereof,' delivered in residential facilities registered with HIQA to provide care. This care is provided on a 24-hour basis. LTRC primarily serves older adults experiencing significant challenges with activities of daily living (ADL) and health impairments, but it can also be used by other age-groups, including younger people living with intellectual or physical difficulties. Approximately 88% of the users of State-funded residential care are long-stay residents, with an average length of stay of 3 years. However, 12% of users of residential care are short-stay residents [168], although the function of these beds is not clearly specified or evaluated. In general, these short stays are for less than 3 months.

5.2.2 Context and policy landscape

Ireland has a long history of addressing social issues or care-need through institutional confinement dating back at least to the Poor Laws in the 19th century [169], and this historical context can be seen in how Irish society cared for people with disabilities and older people in particular [118, 170]. People who resided in LTRC were often overlooked or marginalised, and in many ways moved to the periphery of society.

A major change in 2009 was the introduction of the NHSS [171]. It replaced an earlier system of nursing home subvention schemes that had been impacted by regional inequalities in assessment, inconsistency in funding allocations across different Health Boards, and the placing of large, and often unpredictable financial obligations on residents and families [172]. The NHSS is discussed later in the chapter but in brief it has provided a statutory standardised financial framework for assessing eligibility for support. As a consequence, it includes more certainty for older people on their own funding contributions to the costs of care, avoiding the risk of catastrophic out-of-pocket costs being incurred.

While the Department of Health provides strategic oversight, the HSE manages public residential care facilities and funds care provided by voluntary (not-for-profit organisations) and private (for-profit) providers. The fees paid by the HSE to LTRC providers are agreed through negotiation between the National Treatment Purchase Fund (NTPF) and the service-providers. There is also regulatory oversight through HIQA. It has set clearer standards for service-provision (for long-stay residents only) and many facilities have been modernised, with improvements in physical infrastructure and basic care practices contributing to more acceptable living conditions.

However, despite these positive changes the sector still faces significant challenges. Concerns have been raised that the care and support system still operates in a way that often positions nursing home care as the default option for older adults with increasing dependency and support-needs. Often, this default option is due to lack of home and community-based supports funded by the State (as highlighted in previous chapters), as well as a reduction in the availability of family/unpaid carers. This default exists despite most older people's preference to remain in their own homes for as long as possible.

Another challenge is that existing LTRC structures and policies tend to favour large-scale facilities, frequently operated by for-profit providers whose business models are shaped by the regulatory and funding environment. Moreover, LTRC facilities are not always located in areas close to where people want to live and there are persistent challenges related to staffing. In June 2025 serious concerns raised about safeguarding and standards in two nursing homes featured in a recent RTÉ Investigates programme have also been a catalyst for wider debate on safeguarding and standards of care.[53]

While this chapter outlines the structure and functioning of the current LTRC system, it also recognises the limited development and availability of alternative models of care, including different models of housing with support (see the 'Supported living' chapter). Addressing these limitations will require further policy attention and investment to support a more diverse and person-centred continuum of care.

53. The RTÉ Investigates programme is available at https://www.rte.ie/player/movie/rte-investigates-inside-ireland-s-nursing-homes/ 677760040314.

5.2.3 The influence of COVID-19 on the policy landscape

Recent LTRC policy has also been shaped by the COVID-19 pandemic. This had a disproportionate impact on people living in LTRC in Ireland and internationally [173]. In the first year of the pandemic, prior to the rollout of vaccinations, two-thirds of all LTRC centres in Ireland had a COVID-19 outbreak [174]. During that period there were more than 2,100 LTRC resident deaths attributed to COVID-19, with larger homes being much more badly affected.

The Minister for Mental Health and Older People at the time, Mary Butler, stated that the pandemic had 'shone a light on older persons' care and highlighted many fragilities within' the sector.[54] The fragmented nature of governance structures and the sector's poor integration with public health services were identified as key concerns by an independent COVID-19 Nursing Home Expert Panel [87]. HIQA also identified gaps in clinical governance arrangements for many public and private LTRC homes, and developed a framework to support LTRC homes during the pandemic [175].

Since the pandemic, and the publication of the COVID-19 Nursing Homes Expert Panel Report, there has been new legislation that enhances governance. HIQA has been granted enhanced enforcement powers, including the power to issue compliance notices for breaches of regulations.[55] The Care and Welfare Regulations for nursing homes have also been revised to strengthen requirements in the sector.[56] Following the pandemic the document, 'A Design Guide for Long-Term Residential Care Settings for Older People', was also released for public consultation by the Department of Health [176]. The intention is that the final version of the guide will 'provide clear, best practice guidelines for the building, extension, and conversion of public, private, and voluntary residential care settings for older people' [177]. One of the options set out, for example, in the consultation, was that LTRC homes should have no more than 84 residents. A report on the public response to the consultation was recently published [178]. Accordingly, the fallout from the pandemic is likely to continue to determine policy in the sector for the foreseeable future.

5.2.4 Regulation, assessment and application process

Regulatory and legislative framework

The vast majority of LTRC homes in Ireland hold a NHSS contract. For LTRC to be eligible for NHSS funding they must provide 24-hour nursing care (e.g. have at least one registered nurse on site at all times). All LTRC homes that provide long-stay care via the NHSS also must be registered with HIQA and comply with HIQA safety and quality standards[57]. Registration covers a three-year period, and an application to renew registration must be made at least six months before the end of this period [179].

54. https://www.ucd.ie/newsandopinion/news/2022/july/14/COVID-19nursinghomeexpertpanelfinalprogressreportseesgovernmentcommittoreformforolderpersonscare/.
55. https://www.hiqa.ie/hiqa-news-updates/hiqa-welcomes-significant-change-nursing-home-regulations-which-take-effect-today.
56. https://www.gov.ie/en/department-of-health/press-releases/minister-butler-welcomes-the-signing-into-law-of-the-health-miscellaneous-provisions-no2-bill-2024-by-the-president/.
57. National standards for residential care settings for older people in Ireland (2016). National standards for infection prevention and control in community services (2018). National standards for adult safeguarding (2018).

The Chief Inspector within HIQA is legally responsible for the monitoring, inspection and registration of residential care homes (including for younger people with disabilities) in Ireland. However, HIQA does not regulate all residential care provided to older people. Short-stay beds provided in LTRC homes are not regulated by HIQA [180]. Often, this leads to situations where some beds in a facility are subject to HIQA quality and safety standards but other beds are not. This regulatory gap has prompted on-going discussions about expanding oversight to cover the full spectrum of older persons' care services.

Entitlement to publicly funded residential care

The NHSS introduced in 2009 provides statutory financial support for residential care based on an assessment of both care-needs and a financial assessment. Approximately 77% of all LTRC residents are funded under the NHSS [168], highlighting its centrality in the provision of residential care.[58]

To apply for NHSS-funded care an applicant (or a representative acting on their behalf) completes an application form that includes details on personal care and medical care requirements, as well as income and asset details. This is sent to the local HSE nursing homes support office who then arrange a care-needs assessment, carried out typically by a public health nurse. This assessment determines whether LTRC is required. The HSE uses a standardised assessment called the Common Summary Assessment Report (CSAR). The CSAR includes evaluations of ADLs (using the Barthel Index—a frequently used measure of functional independence [181]), cognition, communication abilities, medical and social risk-factors, use of medications, and other specialised care-needs if applicable.

A financial assessment determines how much the resident, or their family, will contribute to the cost of their residential care. Eligible NHSS applicants must contribute 80% of their income and 7.5% of the value of any assets, including land and property, towards the cost of their care. However, a person's home is only included in the financial assessment for 3 years in a nursing home, so no more than 22.5% of the value of a home would go towards the costs of care. The first €36,000 of assets for an individual are also not counted in the financial assessment.[59] The State then pays the balance, regardless of the fees of the approved nursing home. NHSS residents can also apply for a deferred payment based upon the value of their home through a Nursing Home Loan, but only 15% of NHSS residents use this loan to pay for their care [182].[60] The loan allows postponement of payment based on the asset (house/land) contribution for up to 12 months after the death of the resident or within 6 months of the sale of all or part of the asset.

58. Approximately 9% of residents pay for LTRC privately. Some individuals who have the high levels of income or assets may choose to pay privately due to concerns about the asset-contributions required under the NHSS making their care more costly. Others may want to be cared for in non-NHSS-participating LTRC homes.
59. Factors such as farms and private business receive special dispensation.
60. The 3-year cap on assets applies regardless of whether people use the loan. The repayment is subject to an inflation adjustment calculated from the time the loan was taken out https://www2.hse.ie/services/schemes-allowances/fair-deal-scheme/nursing-home-loan/. Additional interest is charged for late repayments.

While waiting for a decision on NHSS funded care, individuals have to pay privately for their residential care. People who successfully apply to the NHSS but are still waiting for a LTRC bed to become available may briefly receive residential care through the Transitional Care Fund (TCF). Established in 2015, the TCF funds short-term placements for those awaiting NHSS approval and its role expanded during the pandemic to operationally support discharges from acute hospitals.

The eligibility for, and funding of, short-stay care differs considerably from long-stay care. Typically, short-stay beds in residential facilities are used to support earlier discharge from acute hospital settings as well as to provide respite care. Discharge teams will assess a patient's care-needs and initiate a process to allow for temporary placements in community or transitional care settings. However, this assessment is hospital-site specific and discharge-determination is likely to be influenced by factors such as waiting lists and trolley numbers within acute hospital. Short-stay care is typically free from co-payments and costs are covered by the HSE for a limited period.

5.3 Adequacy

5.3.1 National supply

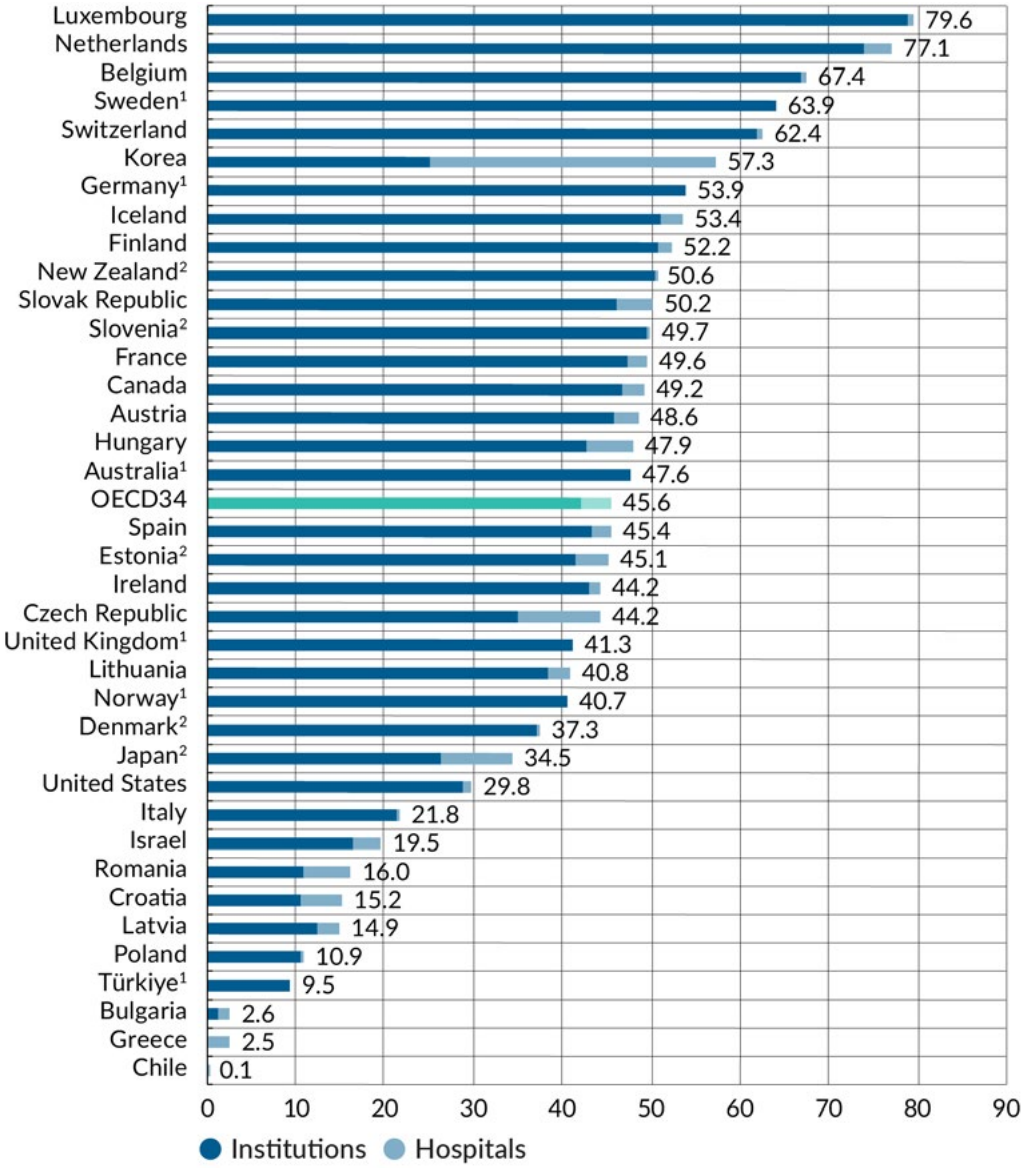
In December 2022, Ireland had 577 LTRC homes with 33,324 beds across the system; 88% of beds were long-stay and 12% short-stay [168]. While occupancy-rates reduced during the COVID-19 pandemic, since 2022 they have grown to approximately 90% [183].

There is some unmet demand for LTRC but, compared to other services in the health system, this unmet demand may be seen as relatively low. Nevertheless, some unmet need does exist and often reflects the lack of availability of a bed in the LTRC home of a person's choice (often a LTRC facility in their local community). In December 2022, 633 people deemed eligible for NHSS were awaiting an NHSS bed, with two-thirds already in a LTRC home, with care funded by the TCF. In general, waiting times for an NHSS bed have been 4 weeks for a number of years, and this 4-week target is a key performance indicator (KPI) used by the HSE to measure unmet demand.

LTRC bed-supply in Ireland equates to 44.2 beds per 1,000 people aged 65 and older. This places Ireland slightly below the OECD average (45.6 beds per 1,000), similar to Spain and marginally above the UK [184] (Figure 5.1).

Recent analysis by the ESRI also shows between 2022 and 2040, demand for LTRC beds is projected to increase by approximately 60%–80%, and up to an additional 27,000 LTRC beds will be required to meet this demand. The increase in the population at older ages is the key driver of this projected increase [96].

Figure 5.1: Long-term care beds in institutions and hospitals in OECD countries, 2021 (or nearest year)



Source: [184]

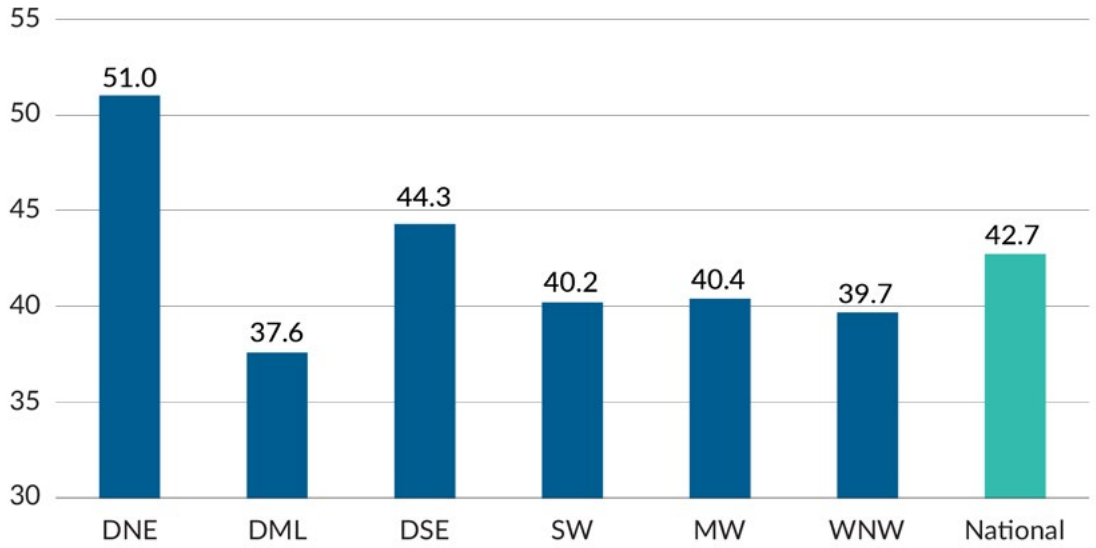
Notes: (1) Number of long-term care beds in hospitals are not available in these countries. (2) Number of long-term care beds in hospitals excluding psychiatric beds.

5.3.2 Regional inequalities

While supply at the national level is similar to other OECD countries, significant disparities exist regionally. Figure 5.2 presents residential care beds per capita (1,000 population aged 65+) across the 6 HSE Health Regions. The highest supply of beds is seen in DNE (Dublin North East) and in the DSE (Dublin South East) Health Regions. Supply is much lower in the other HSE Health Regions. The scale of variation is extensive; per capita supply in DNE is 36% higher than in the DML (Dublin Midlands) Health Region. These regional inequalities reduce the probability for many people who are admitted into LTRC, to access such care in their local communities. This makes it much more difficult to maintain ties with their community, friends and family. It may also mean that a long-standing relationship with their GP is also lost.

This may increase emotional distress for many people and place strains on family carers not just when LTRC is being considered but also after admission as travel to visit loved ones becomes more difficult and time-consuming. In addition, since lack of residential care beds contributes to delayed transfer of care in hospitals, regional disparities in access to residential care may amplify regional variations in delayed discharges from hospitals.

Figure 5.2: Residential care bed-supply in HSE Health Regions in Ireland



a	DNE: Dublin North East; DML: Dublin Midlands; DSE: Dublin South East; SW: South West; MW: Mid West; WNW: West North West.
Source:	HSE and CSO data [168].

The regional imbalances shown in Figure 5.2 can be explained to some extent by the closure of one-fifth of all smaller (<30 beds) LTRC centres in recent years in certain rural areas, with the majority of most recently opened LTRC homes having more than 100 beds [185]. Between February 2020 and December 2022, 28 small LTRC centres closed, with the majority of these located outside of the Dublin commuter-belt region. Most of the new large LTRC homes (>120 beds) have been constructed in, or close to, urban areas, for instance in Louth, Dublin and commuter-belt counties.

There are a number of reasons for LTRC home-closures. Many smaller LTRC homes were no longer deemed viable business entities, especially when occupancy rates reduced during the COVID-19 pandemic. HIQA also identified that many LTRC homes, especially older and smaller LTRC homes, had (and have) an inability to meet new HIQA standards [186].[61] Many LTRC homes report staffing shortages (addressed later in Section 1.4.2), while funding for care (via the NHSS) was seen as insufficient. There were also concerns over business-viability and burnout after the COVID-19 pandemic [187].

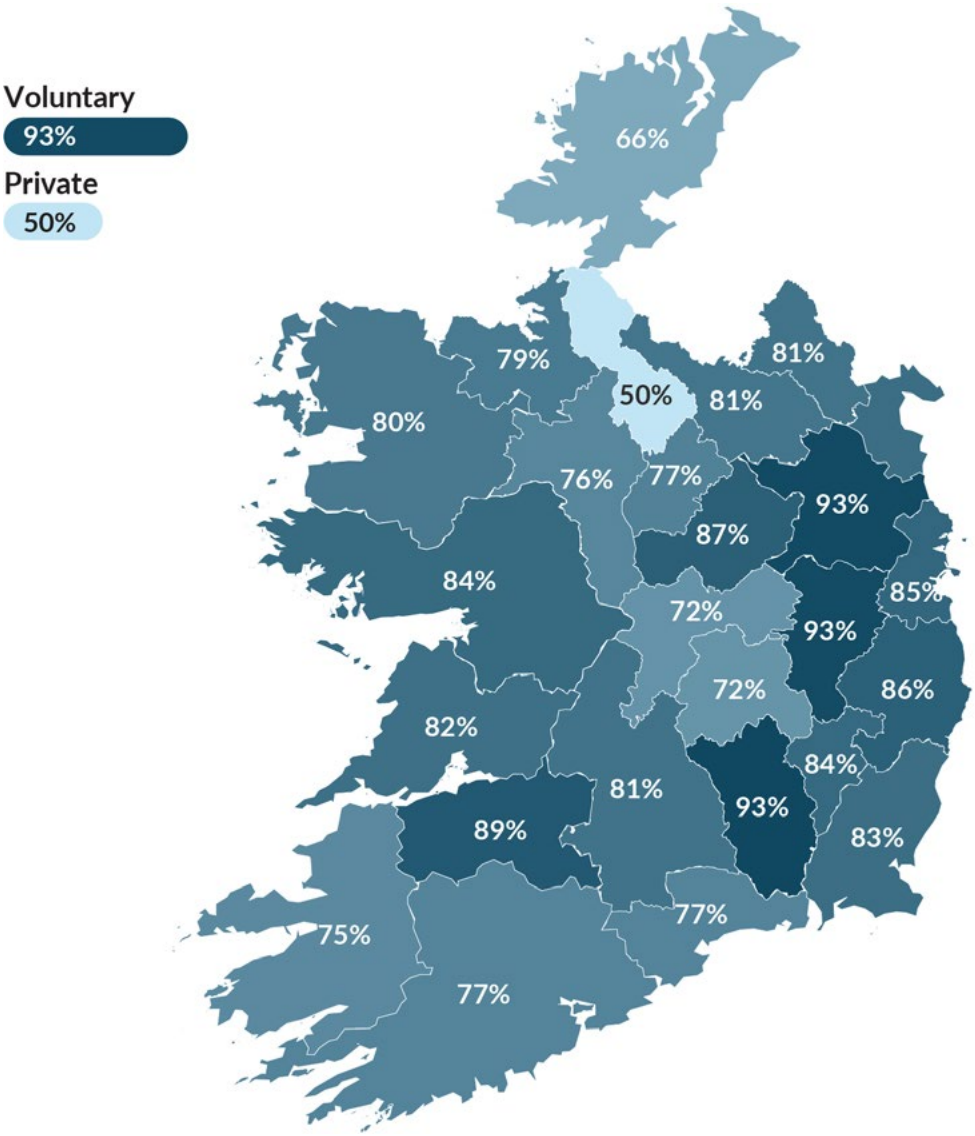
61. In 2022 new regulations stated that 'no bedroom would have more than four occupants and all residents are afforded an area of not less than 7.4m2 of floor space in their bedroom, which includes the space occupied by a bed, a chair, and personal storage space' [187].

In a small number of instances HIQA also received court agreements to have LTRC centres closed due to safety concerns for residents, for example related to COVID-19 [188]. In the case of many LTRC, the HSE had to step in to takeover financially unviable homes, at least on a temporary basis [189].

5.3.3 Privatisation of residential care

Similar to home support, the majority of residential care is publicly funded and privately provided, with the reliance on for-profit private sector provision increasing in recent years. The predominant ownership category of LTRC centres (public, not-for-profit voluntary or for-profit private) also differs across counties. In December 2022, overall across Ireland, 18% of beds were in public LTRC homes, 9% in voluntary not-for-profit sector homes, with the majority (74%) in private for-profit homes. Figure 5.3 shows the percentage of LTRC beds by counties that are provided in voluntary or private LTRC homes in individual counties. Regional variation in the reliance on private provision is considerable, with Dublin and commuter-belt counties having the highest rates of private bed-provision: Kildare (93%); Meath (93%); and Wicklow (86%). These counties also have amongst the highest number of beds per capita for the over-65 population in Ireland.

Figure 5.3: Percentage of LTRC beds in voluntary/private LTRC homes by county, December 2022



Source: [115].

This reliance on private providers mirrors what has been observed in home support in Ireland and across LTRC in most European countries [116]. The increased dominance of private providers began in the early 2000s [117]. This privatisation of the service has also seen a reduction in provision by the HSE and also by the voluntary sector. The majority of private LTRC beds are now provided by a small number of for-profit providers, that are predominantly financed by private equity from international funds. In 2022, approximately half of all LTRC beds were provided by 14 large private equity providers [115]. These providers have in recent years purchased a number of medium and large LTRC centres, and built some large LTRC centres, mainly in the east of Ireland. This consolidation of supply and investment by private equity is a common feature of health and long-term care provision worldwide [190–195], but it receives relatively little attention from policymakers and the general public.

The existing model tends to favour large-scale facilities, frequently operated by for-profit providers. These large providers business models are shaped by the regulatory and funding environment. Key issues with the consolidation of care amongst a small number of private providers are that they decide to locate predominantly in urban areas, enticed by higher NHSS prices in those areas. This autonomous decision-making further exacerbates regional variation in supply. It also means that the ability to access LTRC is often determined by the profit-maximisation decisions of private entities as opposed to public policymakers' decisions determining where supply is needed. A clear disconnect currently exists between public need and private provision. This issue is not isolated to the LTRC area (it is also an issue for home support), but it is exacerbated in this sector by the heavy reliance on private provision of care.

5.3.4 Funding

Table 5.1 shows that overall approximate total public and private spending on all residential care in 2019 (the most recent estimate available) was around €2 billion *per annum*. Over €1.4 billion (70%) was spent on the NHSS in 2019. More recent figures for NHSS expenditure only (so not including private expenditure) for 2023 indicate that the public purse costs for all NHSS LTRC were €1.31 billion, compared with €1.26 billion in 2022 [196].The State contributes approximately three quarters of NHSS spending, with the remainder falling on residents.

We have previously noted that not more than 22.5% of the value of an older person's home can be used to contribute towards the costs of care. Moreover, fees for private beds are broadly similar to those for publicly funded beds in the same LTRC. However, approximately 1 in 10 LTRC residents privately purchase care (i.e. outside of the NHSS). There will be different motivations for use of private LTRC: for instance some individuals (and sometimes their primary family/unpaid carers) may be concerned about the asset-contribution under the NHSS and, as a result, look for care in a non-NHSS participating LTRC home. In some cases this may also be because an individual has not been deemed appropriate for NHSS care after assessment.[62]

62. For example, some reasons for making use of private residential care can be seen in discussions on online chat forums, such as https://forum.familycarers.ie/, in respect of caring for someone with dementia. These include a person who has not been found eligible for care and worries about the rules on asset-contributions.

Table 5.1: All public and private LTRC expenditure by category of bed and financing in 2019

Category	Expenditure €m
NHSS long stay residents	1,422.2
Publicly financed long stay residents under legacy schemes	28.7
Privately financed long and short stay residents	206.6
Publicly financed short stay residents	299.1
Total	**1,956.6**

Source: [70].

5.3.5 Pricing within the NHSS

According to a review of the pricing system of the NHSS [197], the NTPF bases the prices for NHSS beds in LTRC homes on four key criteria:

- Costs reasonably and prudently incurred by the nursing home and evidence of value for money
- Price(s) previously charged
- The local market price (i.e. within a county or region)
- Budgetary constraints and the obligation on the State to use available resources in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public.

However, large differences exist in the NHSS amount paid to LTRC centres. First, HSE and other 'public' LTRC homes (where care is provided by section 38 [of the 2004 Health Act][63] agencies) receive NHSS rates that are over 50% higher than those for voluntary and private LTRC centres. Previous research has shown that NHSS rates for private LTRC centres are highest in Dublin, Wicklow and Kildare, and lowest in Clare, Tipperary and Donegal. This variation in rates is of critical importance, as in recent years, these funding allocations have been key determinants on where new LTRC centres are located. The majority of new LTRC homes are located in those counties with the highest NHSS rates. This has further exacerbated regional variation in supply. As of December 2025, the NHSS maximum agreed weekly price for voluntary and private LTRC centres ranged from €1,150 to €1,492 compared with weekly costs in public nursing homes ranging from €1,157 to €3,146.[64]

63. Non-Acute/Community Agencies provided with funding under Section 38 of the Health Act, 2004.
64. See 'Nursing home costs' at About the Fair Deal scheme.

The *Value for Money Review of Nursing Home Care Costs* commissioned by the Department of Health identified and analysed the reasons for cost-differentials between private/voluntary and public nursing homes [198]. Previously there were suggestions that the public-–private payment differentials were due to higher-dependency residents in public LTRC homes. However, the *Value for Money Review* instead concluded that…

> from the data available it is evident that the majority of the cost differential [between public and private LTRC homes] is a result of difference in pay costs. The pay cost differential is largely due to variances in nursing-to-resident ratios and skill mix [198].

Public nursing homes have higher nursing-to-resident ratios and rely more on registered nurses in care-provision than private homes. While some of this may be due to differences in care-needs, the *Value for Money Review* was unable to show this. In their submission to the *Value for Money Review*, Nursing Homes Ireland called for costs in HSE nursing homes to be 'published on a consistent basis to inform regarding the expenditure being incurred within HSE nursing homes' [198].

5.4 Effectiveness

As levels of multimorbidity, complex needs and risk of mortality are consistently found to be higher in LTRC home residents than in people living at home, it is prudent to examine the effectiveness of LTRC based upon ability to meet the needs and preferences of residents, the provision of care services within LTRC settings and its use for non-long-stay care.

5.4.1 LTRC home characteristics

There is evidence that smaller nursing homes tend to have better outcomes. This was seen during the COVID-19 pandemic, when internationally [199] and in Ireland [200] smaller LTRC homes were less likely to have a COVID-19 outbreak, and had lower levels of COVID-19 related mortality. However LTRC homes in Ireland are increasing in size. This suggests a misalignment between the more positive outcomes seen in smaller LTRC homes and their economic viability.

There is also evidence that LTRC residents tend to prefer care provided to them that aligns most closely with their specific personal and healthcare needs, and care that is informed by their life-history and lifestyle preferences [201]. This more social approach to care puts greater emphasis on prioritising the autonomy and personal preferences of residents [202]. It can be contrasted with what are risk-averse and paternalistic perceptions of safety. HIQA stated that 'institutional practices, outdated premises and a prevailing culture of a medical model of care' seen in many nursing homes [203].

Although a re-medicalised model was emphasised during the COVID-19 pandemic, HIQA has been moving more towards developing standards that emphasise a more social and person-centred model [203]. They have acknowledged that LTRC regulation compliance could improve in the areas of fundamental human rights of residents' rights such as ensuring that residents get to keep their personal possessions [204].

The final version of the 'A Design Guide for Long-Term Residential Care Settings for Older People' will provide recommendations and suggestion on the architecture of the built environment of LTRC homes in Ireland. There is growing awareness of the built environment as critical to developing a more social model of LTRC [205]. Designs that integrate universal design principles, co-created with older people, can create spaces that are accessible, supportive, and facilitate social connections as well as being inclusive of all residents in line with a more social model of care [206]. Similar principles have been highlighted by Age Friendly Ireland.[65] Smaller household-type homes, with increased outdoor space and access to social amenities, are also at the centre of universal design principles.

Often LTRC homes are built on green-field sites on the edge of town. It is difficult to reconcile these planning and development decisions with the ideas of social connectedness or with values of care and dignity. HIQA now include standards that monitor LTRC homes on their ability to improve connectedness and integration with other care services,[66] provide access to outdoor space,[67] and create an environment that improves the independence of residents.[68]

5.4.2 Workforce challenges

Significant issues with workforce recruitment and retention are observed in the LTRC sector. This will hamper the quality and effectiveness of LTRC. We have noted in section 1.3.5 that the *Value for Money Review* showed large differences in the skill-mix of workers in public and private LTRC homes [198]. In general, there tend to be slightly higher overall staff-to-resident ratios in public LTRC centres. There also tends to be a greater reliance on healthcare assistants compared to registered nurses in private LTRC homes. Private LTRC centres included in the *Value for Money Review* analysis had more than twice as many healthcare assistants as nurses, compared to public LTRC homes. However, currently there are no recommendations for adequate staff–resident ratios in LTRC homes in Ireland.

Many of the workforce issues highlighted in the 'Home support' chapter also apply to LTRC. There are issues in recruiting and retaining enough nurses and healthcare assistants in LTRC. As discussed in the Report of the *Strategic Workforce Advisory Group* [110], LTRC is a difficult and often underappreciated profession, and employment conditions and relatively low pay mean it is not viewed as an attractive career. In 2022 the Strategic Workforce Advisory Group published a report with 16 key recommendations to address workforce challenges in recruitment, retention, pay, career development, training, and sectoral reform among home carers and nursing home healthcare assistants [110].

65. https://agefriendlyireland.ie/wp-content/uploads/2021/10/AFI-Pre-Plan-Guide-for-Residential-Care.pdf.
66. HIQA Standard 1.3.9: Each resident has opportunities for recreation, travel and leisure outside of the designated centre, in line with the resident's will and preferences. HIQA Standard 1.4.2: Each resident is facilitated and encouraged to integrate into their community. The residential service is proactive in identifying and facilitating initiatives for participation in the wider community, developing friendships and involvement in local social, educational and professional networks.
67. HIQA Standard 1.3.8: Each resident is supported and facilitated to access safe and appropriate outside space.
68. HIQA Standard 2.6.1: The living environment is designed to promote the independence of residents, and the residential service adheres to evidence-based practice and national legislation in achieving and promoting accessibility.

The *Value for Money Review* also called for a 'Safe Staffing and Skill Mix Framework for Residential Care' to be agreed as a priority [207]. Work on this Framework is currently underway.[69]

5.4.3 Independent advocacy and safeguarding

There are a number of professional advocacy organisations providing advocacy services to residents in nursing homes.

Sage Advocacy is the National Advocacy Service for Older People. It provides a free, confidential and independent (of family, service-provider or systems interest) service that aims to 'promote, protect and defend the rights and dignity of vulnerable adults, older people and healthcare patients'.[70] This includes older people living in LTRC. Advocates can provide advice on issues such as the risk of deprivation of liberty and help ensure that older people live in LTRC because they choose to do so or freely agree that living in LTRC is the best option for their needs. Advocates can also provide a support for residents with issues around the NHSS process, charges, help in leaving a nursing home and safeguarding against abuse and neglect, as well as promoting safety and welfare.

With almost €2 million in public funding in 2023, SAGE Advocacy received 1,975 individual advocacy referrals in 2023 and also provided information and support to almost 6,000 people. These numbers increased to 3,086 and over 9,000 in 2024. The workforce consists of 38.5 staff and 17 volunteers.

The Patient Advocacy Service is an independent, free and confidential service, funded by the Department of Health, which provides information and support to people who want to make a formal complaint through the relevant complaints policy about the care they have experienced in a nursing home.[71]

The National Advocacy Service for People with Disabilities provides free and independent representative advocacy services to adults with disabilities across Ireland, including those living in nursing homes.[72]

In 2024 the Law Reform Commission produced a report 'A Regulatory Framework for Adult Safeguarding' [208]. It noted that while safeguarding legislation is in place, for instance under the Health Act, 2007 and the Assisted Decision-Making Act, 2015, it stated that:

> this legislation does not establish an overarching statutory framework for adult safeguarding in Ireland, and significant gaps remain. Although there are existing guidelines, policies and operational measures relevant to adult safeguarding in Ireland, they are limited in their effectiveness and in the range of settings and services to which they apply.

69. https://www.gov.ie/en/department-of-health/publications/framework-for-safe-nurse-staffing-and-skill-mix-phase-3/.
70. https://sageadvocacy.ie/.
71. https://www.patientadvocacyservice.ie/.
72. https://advocacy.ie/.

In December 2025 the Government approved and published a *National Policy Framework for Adult Safeguarding in the Health and Social Care Sector* and approved the development of legislation to underpin the commitments detailed therein.

As noted earlier, during the COVID-19 pandemic an Expert Panel on Nursing Homes was established. One of the 15 areas where recommendations were made by the COVID-19 Nursing Homes Expert Panel concerned the issue of a broader range of statutory care-supports for older people. It called for an exploration 'of a suitable structure and process for external oversight of individual care concerns arising in nursing homes, once internal processes have been exhausted without satisfaction' [209] [208]. The suggested time-scale for this reform was within 18 months of the publication of the Expert Panel's report.

In general, people are at greater risk of becoming isolated if LTRC facilities do not adhere to best practice, especially if there is little contact with external groups, such as primary care practitioners and social workers who could check up on safety and wellbeing. Indeed the Expert Panel recommended that 'access to social work services for older people is essential; many older people have to negotiate difficult life altering decisions and transitions' [209]. It also called for a GP in each CST to also have a GP lead role in nursing homes.

The Expert Panel also called for the prioritisation of the integration of private nursing homes into the wider framework of health and social care. It also recommended that 'the Department of Health and HIQA explore introducing a requirement that all nursing home providers promote, facilitate and engage meaningfully with independent advocacy services' [209]. This would mean that it would cover both private and public nursing homes. This requirement was included in revised Care and Welfare regulations for nursing homes in 2022.[73]

Issues raised in the 2021 Ombudsman report around poor experiences of younger people living in LTRC [210] are likely also to apply to people over the age of 65. That report identified funding problems, lack of person-centred care, advocacy and safeguarding as key reasons for inappropriate placement in LTRC. That report highlighted the importance of development of more suitable alterative residential care options and increasing access to specialised home support packages.

5.4.4 Access to healthcare services

LTRC residents often have less access to healthcare services such as GP care than people who live at home. Although GP payment capitation rates are highest for people over the age of 70 who reside in nursing homes, these rates may still be considered low by GPs [211]. These capitation rates, while higher, still do not account for differences in clinical needs (See also the chapter on 'Funding and resource-allocation').

73. https://www.gov.ie/en/department-of-health/press-releases/ministers-for-health-welcome-changes-to-regulations-to-strengthen-access-to-advocacy-services-and-to-standardise-complaints-processes-in-private-nursing-homes/.

Access to GPs is fundamental; not only do GPs provide a medical link between the community and LTRC but in doing this they also have an opportunity to be an additional independent monitor of whether a resident is being supported to live well with autonomy and dignity. Problems in this respect might be more likely to be identified if regular GP contact is maintained. There is also a need to promote better integration and linkages with community care services [211]. The absence of integrated community-based care for people in residential care creates further and accelerating dependency for residents—physical, social and emotional. It is a major equity issue, further excluding residents from society and increasing the risk of loneliness [212].

Some improvements have occurred in recent years and ICPOP teams now include clinical nurse specialists that aim to deliver specialist care to LTRC residents. If the planned further expansion of primary and community care services to LTRC residents is implemented this could make a real difference. In March 2024 the Chief Executive Officer (CEO) of the HSE highlighted that primary and community care services routinely available for people in their own home would be made equally available to LTRC residents (in public and private LTRC homes).[74] Improving access to integrated community-based care can help not just functional health but also many of the aspects of universal design highlighted above.

5.4.5 Short stay-care in residential settings

Earlier we reported that 12% of all LTRC beds in Ireland are utilised for the provision of short-stay care. Current funding schemes such as the TCF provide what might be an inappropriate incentive to pay private nursing homes to provide short-stay care in order to free up inpatient beds. It is not a service to meet what older adults need and want and is utilized in lieu of access to timely support services closer to home and rehabilitation. The use of short-stay care for such purposes has not been evaluated for effectiveness or value for money. In fact, data shows there may be some increased harm for older adults in short-stay care. Such care is also not subjected to HIQA quality and safety standards.

As highlighted in the HSE's *Post-Acute Inpatient Rehabilitation Service Provision: A National Overview of HSE-Funded Services* report, the current model for post-acute care reflects a reliance on short stay care in LTRC homes as a substitute for home-based rehabilitation or better discharge planning [213]. It reflects systemic gaps in Ireland in timely access to home support or community-based services.

Short-stay care beds can also have less stringent monitoring and regulatory oversight. While short-stay beds within LTRC homes that predominantly provide long-stay care are subject to regulatory oversight from HIQA, residential facilities that only provide short-stay care are not required to be registered as a designated centre with HIQA and are subject to less strict monitoring [214].

74. https://data.oireachtas.ie/ie/oireachtas/debateRecord/joint_committee_on_health/2024-03-20/debate/mul%40/main.pdf.

5.5 Efficiency

5.5.1 Assessment of need

The CSAR tool is still the main tool used to assess needs for the NHSS. This is a systematic assessment of whether any applicant is deemed clinically appropriate for LTRC. The assessment is usually undertaken by a community or public health nurse or a hospital discharge co-ordinator. It is a broad assessment that assesses functional ability, cognition, behaviour, rehabilitation potential and family/unpaid care supports.

The CSAR is, however, limited in providing evidence on the health and, especially, social care needs of potential LTRC residents. There have been attempts to begin rolling out the interRAI tool to assess an individual's need for LTRC, with positive evaluation of pilot schemes in Beaumont, Tallaght and University Hospital Galway published back in 2017 [215]. InterRAI would allow assessment of more (up to 20 standard) domains (ADLs, cognition, medications etc), and it includes more systematic priority scoring (Method for Assigning Priority Levels (MAPLe) scoring) which can allow for more accurate care plans to be tailored to residents.

The Department of Health's *Value for Money Review* recommended that interRAI should become the prescribed assessment instrument for all LTRC and that it should be used to support policies and guidelines in the sector [207]. An additional benefit of using interRAI is that it offers digital recording, which would be a move away from the handwritten records utilised in the CSAR. If fully implemented, integration of interRAI may also allow for better integration of assessment, resource-allocation, and prices paid to LTRC homes for NHSS residents.

5.5.2 Limitations of the current funding approach

Earlier in this chapter we noted that the considerable variation in the level of funding for NHSS nursing home placements across Ireland and between public, voluntary and private-sector providers may influence where new nursing homes are established, rather than this being determined by need.

A second limitation in the current funding approach is that it does not recognise dependency levels. For example, extrapolating from UK data, it has been estimated that 72% of LTRC residents in Ireland are living with dementia [216]. Higher levels of funding may be needed to best meet the needs of people with higher levels of dependency and more complex needs. However, despite HIQA standards requiring appropriate dementia care, the NHSS does not specifically provide additional funding to manage cognitive impairment and address personhood issues for people with dementia, creating gaps in care-provision.

If interRai is fully rolled out this would allow for complexity to be considered in a standardised way, enabling the alignment of resources with care-needs. A further important point, which may be critical to the adoption of a more social approach to supporting people to live well in LTRC, is access to ancillary services such as hairdressing, physiotherapy, and pastoral care. The NHSS funding scheme does not cover these services and residents may have very limited funds to pay for them separately.

5.5.3 Implications of the expansion of new models of private provision of LTRC: emergence of OpCo–PropCo and franchise platforms

We have noted the rapid expansion of private, for-profit LTRC in Ireland. These new models of private provision have implications for the accountability and sustainability of LTRC in Ireland. There now exists separation between the legal entity that provides care, and the legal entity that owns the LTRC centre in which the care is provided, for approximately 20% of LTRC centres [185]. This separation has been used as a vehicle to increase profits from LTRC provision in the private sector. Most recently purchased and built LTRC centres in Ireland now operate using what are known as OpCo–PropCo arrangements:

- Operating company (OpCo): The legal entity responsible for the day-to-day operations and management of a LTRC centre, such as providing care, administration services and hiring workers.
- Property company (PropCo): The legal entity (normally registered as a Real Estate Investment Trust (REIT)) that owns the physical property or real estate where the LTRC centre operates.

OpCo–PropCo arrangements result in operating entities paying a rent to REITs (who do not pay corporation tax on property rental income): OpCos are essentially tenants and PropCos are landlords. Rent is tied to inflation. Importantly from a resident care point of view, these arrangements create a distance between ownership and resident care, regulations, and the workforce.

Evidence from the US has found some negative effects of REITs and private equity in healthcare and LTRC during the COVID-19 pandemic [192]. The Irish division of the global commercial real estates and investment company CBRE have highlighted that inflation shocks in recent years (and the smaller relative increase in NHSS prices) mean most OpCos were loss making since 2023. In contrast, PropCos have seen their investments rise as rents have increased and the cost of real estate has increased [185].

In recent years the composition of private providers has also changed. There now exist a small number of large private providers that are organised using a franchise platform, with local branches providing care, while administrative and bureaucratic responsibility is centralised. These large organisations are also now largely owned by international organisations and/or predominantly financed by international organisations that are funded via private equity [115]. Evidence points to these providers stepping in when the State's capacity to deliver home support services is inadequate [121], and the subsequent reduction in direct State provision in the market can further reduce State capacity to deliver services. In other words, once these large institutional providers begin to dominate a market, their consolidation will further increase over time [121].

There has been extensive discussion in the literature over the pros and cons of the new dominance of large private providers of care. Some argue that the goals of these providers do not align with the State or recipients, and outcomes may be impacted [121]. There are worries that funds may be diverted to profits, potentially at the expense of carers and care-quality. In economic terms, as consolidation and market power increases, larger providers have moved away from being more passive price-takers to holding a stronger hand when negotiating prices and thereby driving costs higher.

Any moves to strengthen various financial and other rules governing these new type of private providers may ensure better alignment of goals between providers, the State and care-recipients.

5.6 Limitations in analysis

5.6.1 Data-availability

There is a dearth of administrative information on residential care. While the NHSS collects and collates information on NHSS residents, much less is known about privately purchased care and short-stay care. This includes the motivation to choose private care as well. Furthermore basic demographic data such as the age and sex of short-stay residents is not collected within administrative data [70].

There also is a lack of information on the nature of residents' needs and the services provided in residential care. For example, there is no accurate estimate of the rates of cognitive impairment or dementia among LTRC residents, although we have noted that these would be expected to be over 70% in Ireland if similar to the situation in the UK [216].

Accurate information on workforce, both composition and absolute staff-numbers, especially in voluntary and private LTRC homes is also missing. It would also be helpful to have information on the level of specific training staff have in managing complex conditions, for instance dementia awareness and skills training. The lack of such information is particularly important when considering issues such as the extent to which a social model of care and support is being delivered, as well as adherence to future policies on safe staffing and skill-mix. Recent legislation has provided HIQA with a new power to collect and publish data from nursing homes, including in relation to the profile of residents and staff.[75]

5.7 Learnings

While a greater emphasis being placed upon home support and provision of community-based care by policymakers is essential to help achieve the stated health policy goal of helping more older people to live well at home, residential care will remain an important element of the care system. In this context the success of LTRC centres should be judged partly on whether they can function well as an older person's home.

Long-stay residents, such as those receiving care through the NHSS tend to have high levels of care-need, with the majority having significant frailty and/or cognitive impairments such as dementia.

75. https://www.gov.ie/en/department-of-health/press-releases/minister-butler-welcomes-the-signing-into-law-of-the-health-miscellaneous-provisions-no2-bill-2024-by-the-president/.

As a consequence of this, the current model of residential care is based upon a narrow set of parameters that meet the medical needs of older people within an institutional setting. While some moves towards a more social-oriented care model have been made, substantial changes are still required to move to a much more social model of living similar to the ethos expressed in supported living models, supporting autonomy, personhood and privacy.

Short-stay care makes up 12% of residential care in Ireland. Due to the overcrowding in acute public hospitals, residential care facilities are used to free up inpatient beds in lieu of access to rehabilitation. However, the reliance on residential care settings for such care—instead of dedicated home-based care, ambulatory care, inpatient specialist rehabilitation, or better discharge-planning—may be impacting people's healthcare outcomes and preferences on where best to receive such care. It may increase the likelihood of an older person moving permanently into long-term residential care as the longer they are away from their home, the more difficult it is to return. Such care is also not subject to HIQA quality and safety standards, which creates uncertainty for patients and their families.

The NHSS scheme has provided a more sustainable funding model to people who require LTRC compared to the previously convoluted nursing home subvention schemes. Waiting times for the scheme have also been relatively low in recent years, especially since the establishment of the TCF. However, the large differences in prices paid to public LTRC homes compared to voluntary and private LTRC homes, as well as the large differences paid across regions, suggests that improvements in funding may be required. Funding that accounts for residents' healthcare needs, such as dementia care and social care requirements, would allow for a more equitable and efficient allocation of NHSS resources. More understanding is needed on the motivations for some older people to use purely private LTRC.

The COVID-19 pandemic shone a light on the fragmented governance of LTRC. Some changes, including new HIQA regulatory responsibilities for care-standards and potentially new powers to assess new planning applications and LTRC home registrations, show improvements in regulatory governance. However, more public oversight of the management and planning of the LTRC sector may be warranted to ensure that LTRC services provide a good environment for people to live in that values their autonomy and dignity. LTRC services also need to be accessible (within the local community) to those who require care. This could also aid the integration of LTRC with the other health and social care services (including primary care) which are also important in helping to prevent residents of LTRC from becoming isolated.

The LTRC system is now increasingly reliant on a small number of for-profit providers of care. Decisions on the location of LTRC facilities is now largely provider-led, with increases in provision based upon the opening of new large LTRC centres in eastern counties. Such an environment lends itself to large regional inequalities but also calls into question the sustainability of the current LTRC sector.

This means that more decisions on the availability of care are now acutely tied to profit-maximisation opportunities. As the sector consolidates, market-competition may be reduced, placing providers in a stronger position to negotiate higher prices from the State. The emergence of private equity-funded providers, and the use of OpCo–PropCo arrangements, may also inhibit sustainability by making the sector move vulnerable to international economic shocks. This risk is compounded by the separation within the OpCo-PropCo model between, on the one hand, the legal entity that provides the care and, on the other hand, the legal entity that owns the LTRC centre in which the care is provided.

5.8 Strengths, weaknesses, opportunities and threats

Strengths

- The NHSS funding mechanism provides clarity on the level of personal contribution towards the costs of personal care and limits the extent to which a person's home and other assets are used to fund their care.
- Relatively straightforward process to make initial application for NHSS.
- Waiting lists for access to NHSS funding appear to be short. Transitional Care Funding support is also available to fund care while an NHSS-funded bed is being located.

Weaknesses

- The NHSS prices paid to LTRC do not account for levels of dependency or cognition. Funding may be inadequate for older people with more complex needs.
- The variability in prices paid for LTRC have meant that new LTRC facilities are more likely to be concentrated in areas with higher prices rather than areas in which needs are greater. More generally, the current system does not mean that the LTRC facility chosen will be close to the potential resident's current locality.
- GPs may consider funding to provide care within LTRCs to be low. A lower level of contact between GPs and residents of LTRC means an opportunity to monitor whether residents are being supported to live well with autonomy and dignity is missed.
- In addition, the NHSS does not cover the costs of therapies (such as physiotherapy and occupational therapy) or of ophthalmic and dental services, nor does it cover the cost of social activities or of personal care services, such as hairdressing, which may be important to residents. LTRC is not just about medical need. Meeting these broader needs is important for a more socially oriented model of care and support.
- The State has allowed the private sector to dominate and therefore determine the supply, and more recently costs, of LTRC. This has increased regional inequalities in access to LTRC.

- Historically, many LTRC facilities have been small businesses and some are struggling to sustain themselves. Recent regulations which require improvements to facilities, such as single/double occupancy bedrooms, are likely to be key reasons why many public LTRC centres have closed (or are being replaced) or have reduced their number of beds. Such regulations, and the requirements to invest in better facilities, are also reasons given as to why smaller private and voluntary LTRC centres closed.
- Increased regulation results in a consolidation of provision amongst a small number of providers and significantly reduces the viability of voluntary-sector providers.
- LTRC is being used for short-stay care without specification of function and evaluation of effectiveness.

Opportunities

- In an era in which designing and building new health and social care infrastructure is expensive, there are opportunities to use LTRC facilities for expanded purposes. The COVID-19 Nursing Homes Expert Panel recommends the delivery of rehabilitation in lieu of permanent transition to long-term care. This includes rehabilitation units within the context of an integrated frailty care-pathway [87].
- The COVID-19 pandemic revealed critical gaps in governance, oversight, and integration of LTRC. This provides an opportunity to look at ways of having stronger public oversight and more cohesive policy approaches. A range of legislative changes have already been made in recent years to strengthen the regulatory framework, and HIQA has begun to develop standards that may better allow for a more social model of care.
- InterRAI has been recommended as an approach to assessing the broad health and social care needs of older people. If it is feasible to scale-up use of this approach it could allow funding to be further adjusted to take account of complexity of support-needs.

Threats

- The increased dominance of private equity-funded providers, and their use of OpCo–PropCo arrangements, may be a cause for concern.
- In the longer-term, the tenure profile of future older population cohorts is also projected to see a substantially higher percentage of the older population living in private and supported rental homes [217]. Currently 25% of the cost of NHSS care is derived from the resident's income and assets, with a family home the chief asset used to fund the resident's proportion of the NHSS cost. As homeownership rates decline in the future, so too may the proportion of the cost that can be borne by the resident.
- Short-stay residential care may potentially be harmful. It may contribute to the inappropriate institutionalisation of individuals in both the short and medium-term, and in essence it draws the system back into an institutionalisation mindset for those groups who actually require rehabilitation.

6

Supporting people with dementia

6.1 Summary

This chapter looks at the current state of services and supports for people living with dementia in Ireland. It presents the policy context and reports on the availability and adequacy of existing services nationally and regionally, including issues with the recruitment and retention of professional carers. It provides an overview of the effectiveness of existing home support services in achieving outcomes that help people living with dementia to maintain their independence and dignity and remain in their own homes and communities for as long as possible, taking into account their changing needs as the condition progresses. It also looks at efficiency concerns while also highlighting the large role played by family/unpaid carers in supporting their loved ones living with dementia, and considers the support available to these carers, many of whom will also be older people. It also highlights the commitment in policy documentation, albeit not always fully realised, to a more personalised biopsychosocial approach to the management of dementia which places the person living with dementia visibly at the heart of the care and support system, emphasising their personhood and autonomy.

6.2 Introduction

6.2.1 Definition

Dementia is an umbrella term for a series of symptoms that cause changes to the brain. It is a progressive neurological condition, associated with a range of cognitive, behavioural and psychological symptoms including memory-loss, problems with reasoning and communication, and changes in personality that impair day-to-day living. People with dementia, with the right support, treatment and adjustments, can live well and continue to have an active role in society. The experience of having dementia differs between individuals. It is important not to assume that people living with dementia are unable to make decisions, as recognised in the Assisted Decision-Making (Capacity) Act, 2015 (which came into full effect in 2023)[76].

The most common form of dementia is Alzheimer's disease (estimated to be 60%–70% of cases), but other common forms include vascular dementia, mixed dementia, dementia with Lewy bodies and a group of diseases that affect the frontal lobe of the brain (referred to as frontotemporal dementia). The different forms of dementia are not always identified and often people have more than one type. Indeed, unspecified dementia is the third most recorded cause of death in Ireland, with 1,663 deaths from unspecified dementia in 2022 being 5.5.% of all deaths and a 109% increase on reported deaths in 2012 [218]. In addition, there were 519 and 301 cases where the cause of death was recorded as Alzheimer's disease or vascular dementia respectively.

76. For detailed information on the Act see https://decisionsupportservice.ie/about-us/legislation.

While dementia affects mainly older people, young onset dementia (defined as the onset of symptoms before age 65) has been estimated to account for up to 9% of cases. People with an intellectual disability (ID) require specific consideration as they have a particularly high risk of developing dementia compared to the general population [219]. This includes people with Down Syndrome, the most widely known frequent cause of ID. For example, a longitudinal study in Ireland that followed 77 women with Down syndrome showed that the risk of dementia was 23% at 50 years, 45% at 55 years and 88% at 65 [220]. All but two women developed dementia over a 20-year period. (The 'Ageing with a pre-existing disability' chapter in this report focuses specifically on the needs of, as well as on the state of services and supports available to, people with intellectual disabilities and their families).

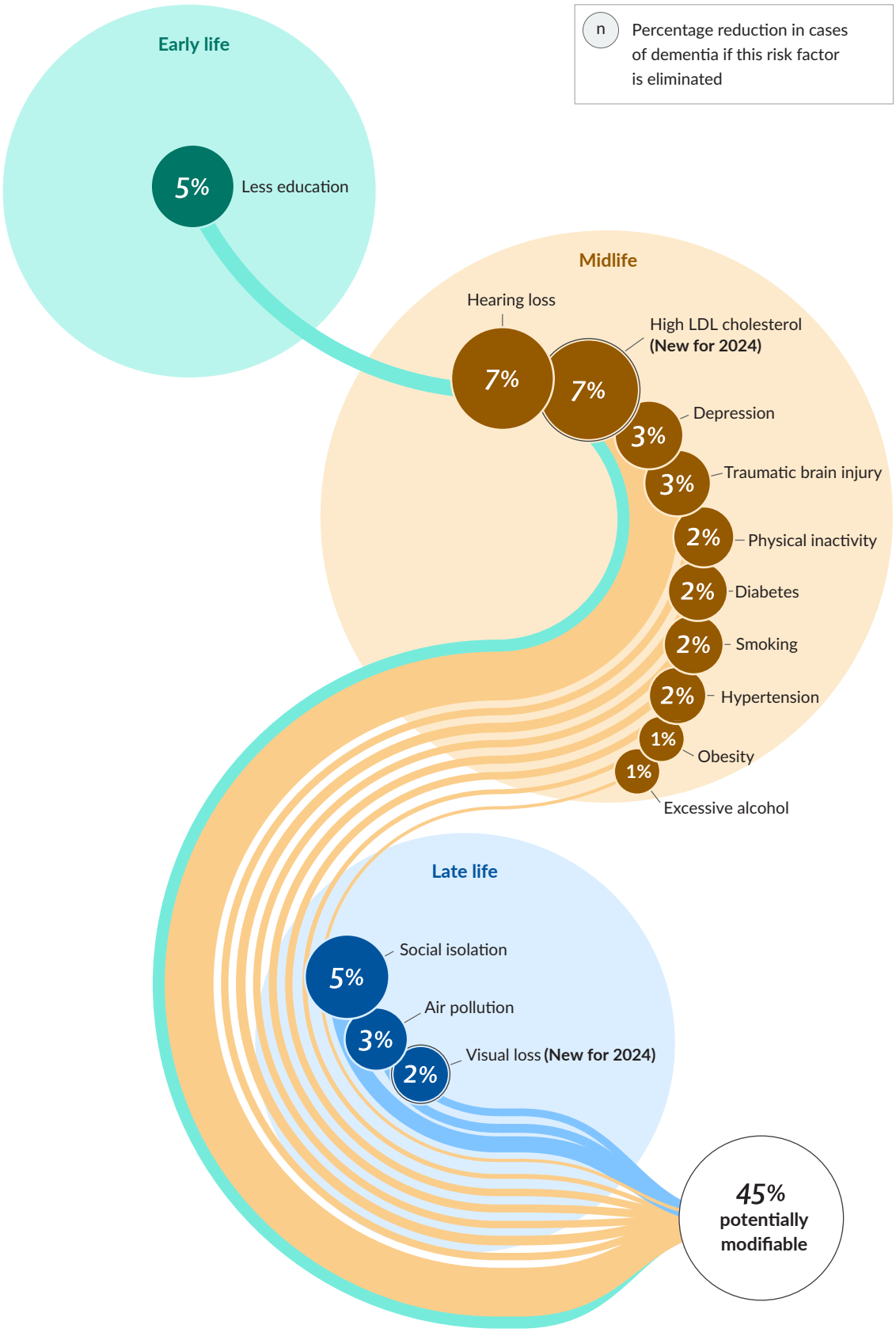
Mild neurocognitive disorders, also known as mild cognitive impairment (MCI) or prodromal dementia, are also associated with an increased risk of dementia [221]. They are characterised by memory and cognitive problems, but these do not affect the ability to carry out everyday activities. These disorders are not always progressive, and some of these neurocognitive disorders can be treated, depending on the cause.

6.2.2 Modifiable risk-factors for dementia

A Lancet Commission report on the prevention, intervention and treatment of dementia estimated that up to 45% of cases of dementia worldwide are potentially preventable by addressing modifiable risk-factors throughout the life-course, starting in childhood and continuing throughout life (Figure 6.1). The 14 risk factors are less education, head injury, physical inactivity, smoking, excessive alcohol consumption, hypertension, obesity, diabetes, hearing loss, depression, infrequent social contact, air pollution, vision loss and high cholesterol [222]. The World Report on Hearing also highlighted hearing loss as one of the largest potential modifiable risk-factors for dementia [223]. While meta-analyses of studies are not conclusive, e.g., [224], the evidence-base supporting the link with hearing loss is growing, including from longitudinal studies [225, 226].

Other potential factors that may be associated with prevention of dementia are continuing to emerge. For example, a very recent study published in Nature, looked at the impact of a new policy on shingles vaccine eligibility for all people in Wales aged 80 from 2013 (those born from 1933 onwards). Comparing all people in Wales without a diagnosis of dementia at age 80 who were born between 1925 and 1942, the study reported a 3.5% lower rate of dementia for those who had received the vaccine, equivalent to a 20% relative risk-reduction [227].

Figure 6.1: Risk-factors for dementia—'2024 Report of the Lancet Standing Commission'



Source: [222].

6.2.3 Emerging new disease-modifying drugs

There is currently no cure for dementia, but there are some medications that can help manage the symptoms. New innovative disease-modifying drugs have started to become available and others are under development. These new drugs are antibody-based therapies that require biomarker confirmation of the diagnosis, need to be administered through intravenous infusions and are associated with serious side-effects such as brain oedema or microhaemorrhages that require monitoring through MRI scans.

For example, Leqembi (which contains the active substance Lecanemab) has been approved for marketing by the European Medicines Agency (EMA) for the treatment of adults with early Alzheimer's disease[77] [228]. It has been shown to slow cognitive decline in people with early Alzheimer's disease compared to placebo. However, this drug has significant risks of swelling and bleeding in the brain, which needs careful management, and it is under additional monitoring by the EMA. Another drug, Kisunla (Donanemab), has been initially refused approval by the EMA [229].

In the UK, the National Institute for Health and Care Excellence (NICE) has decided that both Lecanemab and Donanemab are not cost-effective and has recommended that they should not be provided by the National Health Service (NHS) [230]. This is due to the very high cost of the drugs (including the costs of administering them) compared to their relatively modest effectiveness. A full pharmacoeconomic assessment of Lecanemab has now been commissioned by the HSE [231]. If the drug were to be made available through the Irish health system, a study has suggested that memory services are best placed to administer them and to provide ongoing monitoring and care, in parallel to their brain health clinic model. This would require substantial investment in equipment and qualified staff [232], and it would need to be considered within the wider context of the overall balance of funding for different aspects of dementia care.

6.2.4 Prevalence and incidence of dementia in Ireland

There is no definite estimate of the number of people living with dementia in Ireland, but different projections have estimated this to be around 65,000 by 2021 [233]. Women are disproportionately affected by dementia, as they account for 62% of all people living with dementia in Ireland in 2020 and they also provide the majority of family/unpaid care for people living with dementia.

Forward projections indicate that the number of people living with dementia will more than double between 2020 and 2045, mainly due to the ageing of the Irish population, with around half of all people with dementia being over the age of 85 [234] (Figure 6.2). In 2020 there were estimated to be 4,435 people living with dementia who were under 65; this number is projected to rise to 5,023 in 2045.

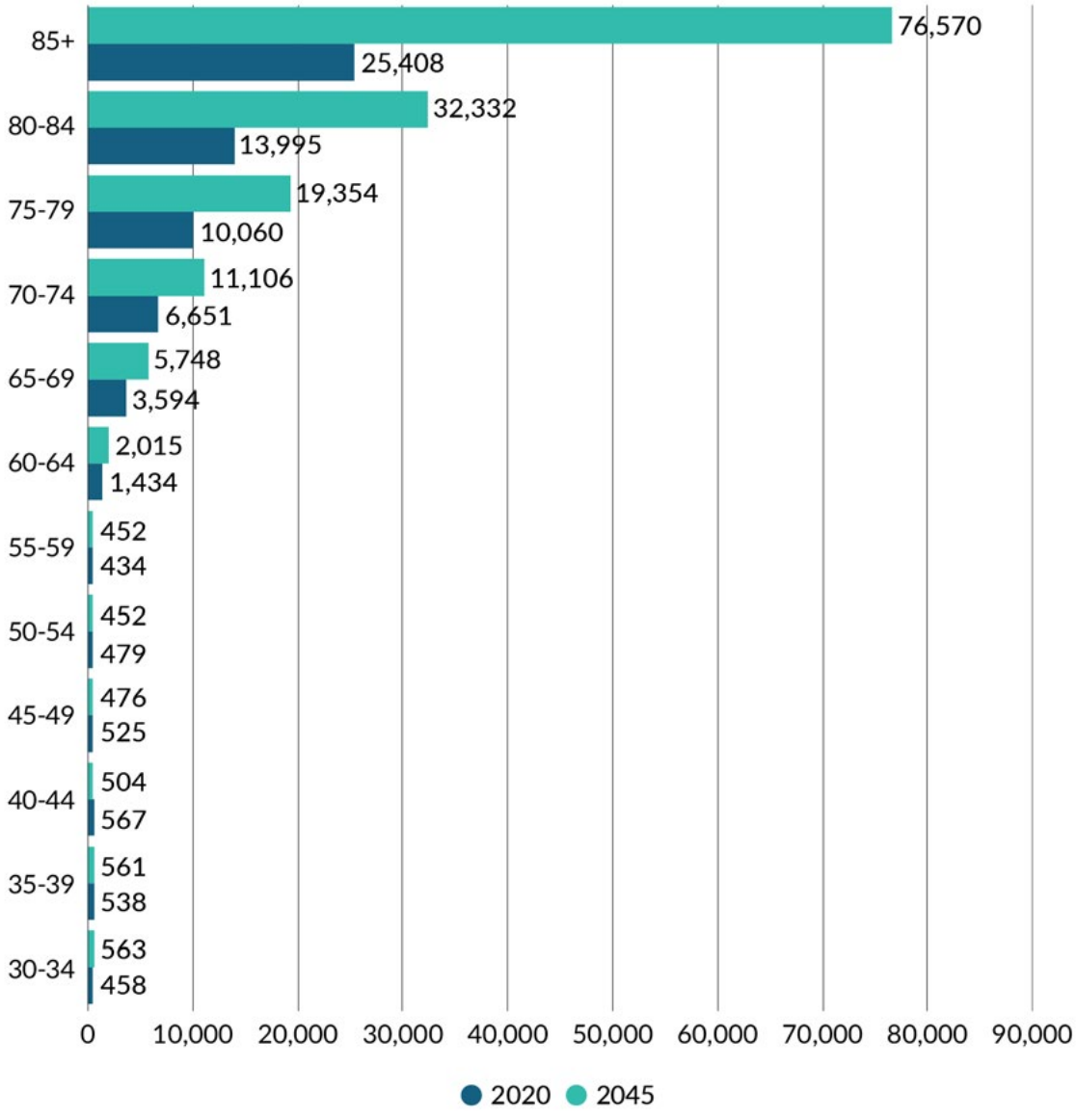
An earlier study estimated that the incidence of new cases of dementia was at least 7,754 per year; it also assumed, using UK data, that the prevalence of dementia within residential care homes was 72% [216]. In that study the relative balance between people living with dementia in the community versus residential care broadly ranged from 1:1 to 2:1 depending on methodology used. This could mean that by 2045, around 50,000 people with dementia would potentially be in LTRC.

77. It is for use in people who have only one or no copy of ApoE4—a certain form of the gene for the protein apolipoprotein E—and who have amyloid beta plaques in the brain.

Additionally, it was also estimated that in 2020 there were between 120,000 and 150,000 people living with mild neurocognitive disorders in Ireland (2020). There are wide variations in international estimates of the prevalence of these conditions, in part because of changes in how these conditions have been defined. Some prevalence estimates for the over 65s internationally are as high as 42% [235], but in the UK mild cognitive impairment (a cognitive score on the Mini Mental State Examination (MMSE) of between 19 and 23) has actually declined from 13.5% to 6.3% over the last two decades [235].

Approximately 20% of people who survive a stroke develop dementia and a further 40% have cognitive impairment [236]. A modelling study has estimated that the number of people with post-stroke dementia in Ireland is projected to increase by 58.9% from 10,688 people in 2022 to 16,978 by 2045 under a baseline stable scenario assuming no changes in age-specific stroke-incidence or case-fatality [237]. This increase is largely driven by more people living to the oldest ages, when the risk of post-stroke is highest, and the progression of dementia more prevalent.

Figure 6.2: Projected change in number of cases of dementia in Ireland between 2020 and 2045



Source: [234].

6.2.5 Policy and funding landscape

There has been great progress in dementia supports, services and the wider understanding of dementia in the last decade. Ireland arguably has been one of the leading countries worldwide in this respect. At the centre of the policy-landscape was Ireland's first *National Dementia Strategy* [238]. Adopted in 2014, the *Strategy* recognises the potential to live well with dementia with adequate services and supports [239], stating that it sought to

> progress the dual and overarching principles of personhood and citizenship by enabling people with dementia to maintain their identity, resilience and dignity and by recognising that they remain valued, independent citizens who, along with their carers, have the right to be fully included as active citizens in society [238].

The *Strategy* was supported by €12.5 million investment by Atlantic Philanthropies in 2014, which was then matched by €15 million from the Department of Health and the HSE.

There was also a strong emphasis on more timely diagnoses and intervention for dementia, alongside better public awareness and understanding, as well as more focus on integrated services, supports, and care. The *Strategy* also recognised a need for better dementia-specific training and education for health and social care professionals as well as for families, and for better research and information systems to record and code dementia within health system records.

As part of the *Strategy*, the National Dementia Office (NDO)—now known as National Dementia Services (NDS)—was established in 2015. The NDS has responsibility for overseeing the implementation, monitoring and ongoing evaluation of the *National Dementia Strategy*. It reports and aligns with the HSE's ECC programme. There was also an independent strategy oversight monitoring committee, which was however discontinued during the pandemic and has not reconvened.

Much more recently, the *Programme for Government* [145] contained commitments to establish 20 new dementia-specific day care centres; increase ringfenced home support hours and funding for dementia-specific intensive home care packages; double the funding for dementia day care at home; and double the number of dementia advisers. It also committed to rolling out more Memory Assessment and Support Services teams and more early-age dementia services.

In addition to further Government funding for the *National Dementia Strategy*, the HSE's *National Service Plan 2025* (NSP) also has commitments to ensure timely access to, and reduce waiting times for, dementia assessment, diagnostics and post-diagnostic support services, and to allocate a minimum of 20% of new home support hours to people living with dementia or a cognitive impairment [240]. The NSP also highlights dementia diagnostic and community services, including their expansion through the allocation of six consultant posts in Donegal, Galway, Kerry, Mullingar, Waterford and Wexford and of additional funding to increase community services.

There is also a commitment to the establishment of a National Dementia Registry. On 23rd May 2025 the Minister for Older People and Housing committed the Government to the implementation of the registry to map services, identify needs and plan the delivery of services [241]. A preliminary scoping exercise and report conducted in 2021 [242] will further inform the design and implementation of the registry, which will be implemented and maintained by the National Centre for Clinical Audit.

There is specific annual funding for the *National Dementia Strategy*: the Government allocated €6 million for its implementation in 2021, €7 million in 2022 and €5 million in 2023. Moreover, Budget 2021 funded a €13 million investment in community supports, partially in response to the deterioration in health of both people with dementia and their family carers caused by the COVID-19 pandemic. Most recently €2 million was allocated to the *National Dementia Strategy* by the HSE in 2025, with €3.1 million planned for 2026 [240].

While the *National Dementia Strategy* provides an important reference point for dementia, policy engagement through the budget allocation to the sector in the past decade has tended to fluctuate on an annual basis, resulting in uneven progress in achieving the targets set out in the *Strategy*. Overall, public spending has lagged behind policy ambition in relation to support for people with dementia in Ireland.

Indeed, it is important to recognise that it remains the case that family/unpaid carers are likely to be the main source of support for most people living with dementia. In 2010 it was estimated that family/unpaid care made up 48% of the cost of dementia care in Ireland [243]. This estimate is not dissimilar to that reported in other much more recent studies, including an analysis of 11 European countries in which family/unpaid care made up between 50% and 90% of the total costs of dementia [244]. However, analysis in Ireland indicates that the public would be willing to pay more in general taxation to support family/unpaid carers [245].

The bulk of State funding is for residential care through the NHSS (see previous chapter on residential care). Over €2 billion is spent on this scheme every year. If the estimate of the prevalence of dementia in nursing homes (shown in section 6.2.2) is 72%, around €1.4–€1.5 billion of NHSS expenditure *per annum* is for people with dementia.

It remains difficult to identify specific levels of spending on dementia and only relatively old data seems to be available. In 2010 it was estimated that public-sector expenditure on existing service-provision for dementia care accounted for an estimated €1.7 billion or 52% of the total economic costs of dementia, with the remaining 48% provided by unpaid carers, who typically would be family members.[243]. Most of this public expenditure (83%) was for LTRC, with just 9% on health and social care services, including just €65 million (4%) on community-care expenditure. This was estimated to be €65 million in 2014, rising to €138 million (or an average of €3,862 *per annum* per person with dementia) by 2018 [246]. If the balance between expenditure on LTRC and other health and social expenditure has not changed substantially since the 2010 estimate, this would suggest that around €300 million is spent on dementia by health and social care services, including around €150 million on community-care services, including GP support.

In addition to the direct provision of services by the HSE, the Alzheimer Society of Ireland (ASI) plays a prominent role. It provides information, support and care services to those with Alzheimer's disease and other types of dementia and to their families and carers on behalf of the State. This includes packages of dementia-specific home support and specialist day care centres for people living with dementia. 'Day care at home' to support people unable to attend day centres and/or who have a preference for such services to access activities and stimulation at home is also provided. This service is delivered in blocks of hours offering meaningful breaks for family/unpaid carers. In 2023 HSE funding totalled €20.7 million, approximately 79% of ASI's total income during the year [247]. This was a 21% increase on the HSE grant in 2022. In total €21.7 million was spent by ASI on care services in 2023. It also provides social clubs, Alzheimer cafes, choirs, support groups, family carer training, advocacy and research.

Finally, when looking at policy and funding it can be noted that the development of dementia-specific policy in Ireland has evolved in a context of strong advocacy from various stakeholders, including the significant funding and advocacy from Atlantic Philanthropies, (an organisation that closed in 2020). In addition, the ASI has been a strong advocate for community-based supports for people with dementia and is also a major provider of these supports across the country. The pharmacological industry has also been a strong advocate to make the case for new dementia drugs (such as innovations in biological disease-modifying drugs).

Tensions can sometimes arise between, on the one hand, the more psychosocial and human rights-based approach to dementia and, on the other hand, the more traditional medical model approach. There is, however, an emerging consensus on the importance of a biopsychosocial model as a means of integrating personal and social needs with clinical frameworks. These tensions can be eased by greater awareness and understanding of dementia in society. As part of the *National Dementia Strategy*, the HSE's Understand Together[78] campaign, implemented in partnership with the ASI, aims to increase awareness about dementia, fight stigma and improve the inclusion of people with dementia in society.

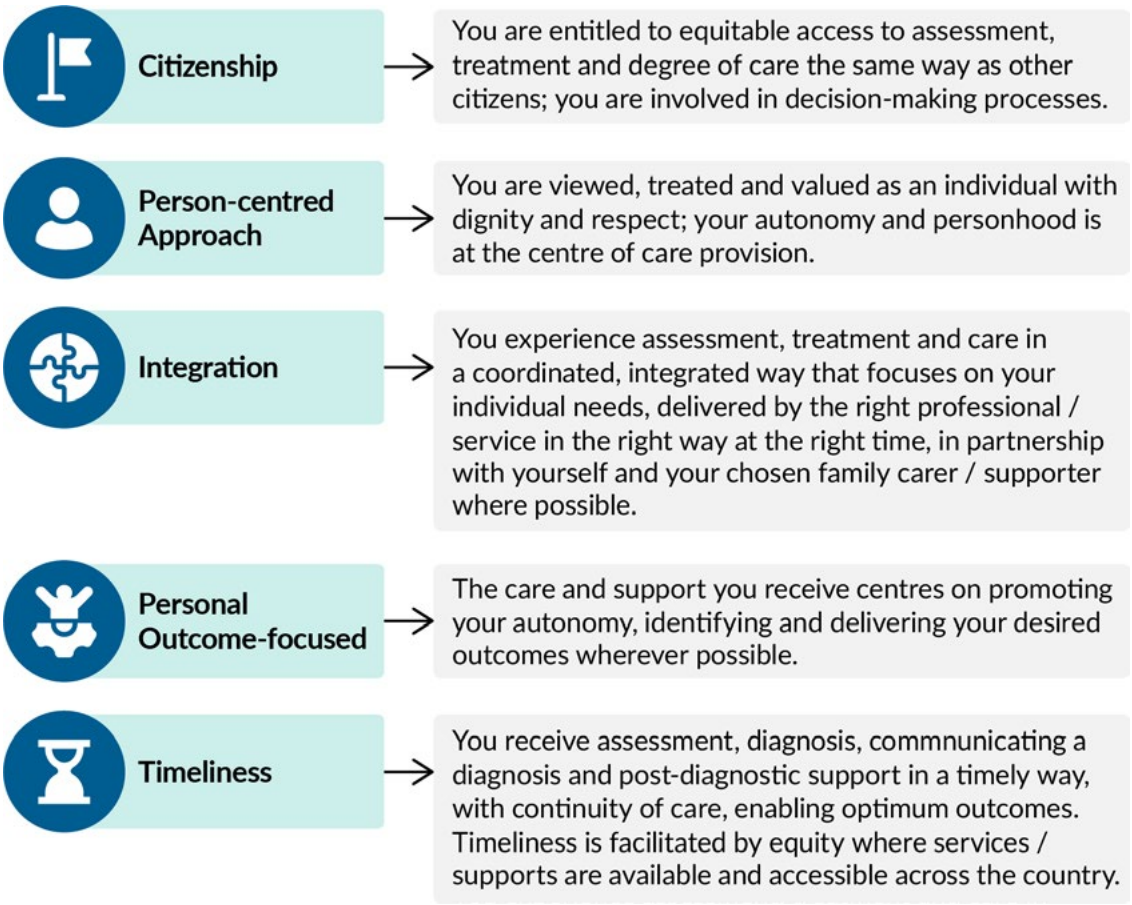
6.2.6 'Model of Care for Dementia in Ireland'

In 2023 a 'Model of Care for Dementia in Ireland' was published by the NDS [248]. It provided detailed information on how the assessment and care-pathway for both people living with dementia and their families should be shaped in Ireland. The 'Model of Care' is intended to be person-centred, with autonomy at the heart of the model. It is underpinned by five principles that align with a personalised psychosocial and human-rights based approach to support (Figure 6.3). It emphasises personalised care pathways and includes 37 outcome-related targets and practice recommendations to help realise this approach to care. These include having a minimum of one memory assessment and support service per 150,000 people (equivalent to 3 Community Health Networks) and five regional specialist memory clinics, of which at least two should be outside of Dublin.

78. https://www.understandtogether.ie/.

There are maximum waiting-time targets for access to diagnostic services, with a commitment that everyone presenting with symptoms of dementia should receive a comprehensive diagnostic assessment with local support thereafter as required. They should also be given the contact details of their local dementia advisor. The post-diagnostic model of care includes the role of the arts, and creative arts therapies, in supporting cognition and emotional wellbeing. Minimum multidisciplinary staffing requirements are also set out.

Figure 6.3: Five principles underpinning the 'Model of Care for Dementia in Ireland'



If implemented fully, the 'Model of Care' should lead to a more integrated model of support. It looks at the entire pathway for people living with dementia from identification of symptoms / signs, through to assessment, diagnosis, communicating a diagnosis, care-planning and post-diagnostic support. Again, the aim is to enable people with dementia to live as independently as possible in their own homes and communities, and the model emphasises the importance of timely diagnosis and early intervention.

One limitation of the new model is that there does not appear to be any formal process in place to determine how well it will be implemented. Earlier evaluation of the *National Dementia Strategy* had highlighted inequities in access to services across the country, as well as better navigation and signposting to services for both people living with dementia and family/unpaid carers [249].

All of these services should also be viewed within the wider context of the implementation of the ECC programme. This provides the foundational structures through which integrated primary and community care is provided in local communities, with services organised, coordinated and provided by multidisciplinary CSTs for older people (see the chapters on 'Primary and community care'). GPs and dementia advisors can help people with dementia link to this care model.

6.2.7 Overview of services and the dementia care-pathway

This section provides a brief overview of the principal health and social care services with which people with dementia and their families may come into contact along the dementia care-pathway. Some of these are very long-standing services while others are newer developments that have been highlighted in the 'Model of Care'.

GPs / primary care

Primary care is often the first point of contact for people experiencing decline in cognitive functioning or dementia symptoms. GPs' knowledge of dementia and preparedness to carry out cognitive tests are crucially important to the early and timely diagnosis of dementia. Therefore, GPs play a core role in the service-pathway as the primary point of contact for people who are worried about their memory as well as for people living with dementia and their family/unpaid carers. The 'Model of Care for Dementia in Ireland' should help improve awareness among GPs of signs and symptoms of dementia as well as of the availability of regional memory clinics to which people may be referred for specialist diagnosis and support [248]. It is important that GPs also have the time and expertise to support people with intellectual disabilities and identify those who need to be referred for a timely diagnosis of dementia.

Primary care is also vital in co-ordinating health and social care services and shaping the care-pathways for people living with dementia. The care-needs of people with dementia are often complex, demonstrating physical, psychological, and cognitive symptoms. Therefore effective dementia care requires a collaborative approach, linking primary, secondary, and social care services. GPs will also continue to provide care for people living in LTRC. In the near future GPs will be able to use HealthLink—the national health messaging broker system that facilitates the secure transfer of clinical patient information between hospitals, healthcare agencies, and medical practitioners—to refer people to memory assessment and support services and dementia advisers.

Primary care can also play a crucial role in dementia-prevention [75]. Health conditions like diabetes, midlife hypertension and midlife obesity are important risk-factors of dementia [76]. Effective management of these conditions in early and mid-life reduces the likelihood of developing dementia in later life. Primary care can also reduce the risk of dementia by supporting people in adopting healthy behaviours, such as increasing physical activities and adopting a healthier diet, earlier intervention for hearing loss and by encouraging social engagement to reduce loneliness and depression.

Memory assessment and support services

The new 'Model for Care for Dementia in Ireland' envisages the establishment of nine memory assessment and support services (MASS) in Ireland, in which assessments are carried out by a multidisciplinary team that also provides post-diagnostic support. The MASS post-diagnostic service provides personalised assessments, a risk-reduction intervention and care-planning and should arrange a point of contact and follow-up. It also provides a brain health service. There should be one MASS per 150,000 population.

Additionally, there are three Regional Specialist Memory Clinics (two in Dublin, one in Galway and shortly one in Cork), these clinics are for complex, atypical and unclear cases, suspected young-onset dementia, or where a more detailed evaluation is needed. There is one National Intellectual Disability Memory Service (NIDMS), with national access, performing a target of approximately 200 assessments per year. Other important resources include a number of Level 2 ID service-providers with specific expertise and multi-disciplinary teams to support the assessment of memory concerns and to provide post-diagnostic support to people with an ID who are attached to their service.

Other post-diagnostic support

Post-diagnostic support aims to support people with dementia and their families. In addition to continuing GP and primary care, key services available include dementia advisers, dementia cafes, home support, day care, memory technology resource rooms, a national dementia service finder[79], housing with support, LTRC and palliative care.

Dementia advisers

On receiving a diagnosis, dementia advisers help people with dementia and their families navigate the health and social care system so that they can access the appropriate care and support services that are available as well as offering practical assistance, advice and information, and a signposting service. The dementia adviser service is a key part of the post-diagnostic ecosystem that works alongside the MASS service. It is provided in collaboration with the ASI, which currently has 29 advisers around the country with five more coming on stream by mid-2025, bringing the total to 34 dementia advisers nationwide.

Dementia cafés

There is an Irish Dementia Café Network which offers monthly meetings to people affected by dementia: they are run by voluntary groups and are free of charge.[80] These services have been shown to provide support for family/unpaid carers of people with dementia, helping them manage the challenges associated with dementia while also having an enjoyable experience [250].

79. https://www.hse.ie/eng/dementia-pathways/care-pathways/post-diagnostic-care-and-support/.
80. https://dementiacafe.ie/.

Memory technology resource rooms

As part of the implementation of the 'Model of Care', a network of memory technology resource rooms (MTRR)[81] has been established. MTRRs are staffed by occupational therapists who provide an assessment and support people with finding out about products and devices to help them manage difficulties. There are currently 29 MTRRs in Ireland but there has been fluctuation in their availability due to staffing challenges.

Home support: community health and social care services

As people's needs change they will also require additional primary and community health and social care services. These can include public health nurses who can help people access services such as home support; arrange home visits; and make referrals for carer-training, day care, respite care and meals-on-wheels. Other HSE services relevant to people with dementia include physiotherapy, occupational therapy, chiropody, speech and language therapy, psychological services and social workers.

As well as standard home support, in principle people with dementia and cognitive impairment can access enhanced dementia home supports [251]. Funding for the intensive home care packages scheme was partly from Genio, a philanthropic organisation set up in Ireland [107]. However, there is no uniformity in how these home support packages are allocated; the number receiving care via the scheme has remained very low (c.250); and expansion plans for the scheme have failed to materialise. They can be difficult to access and have differing interpretations and names in different local areas. Yet there is evidence showing that these packages may cost less for similar levels of care than LTRC [108].

There are also dementia-specific daycare-at-home services provided by the ASI in collaboration with the HSE. These are generally for a period of 2–3 hours. These are aimed at people living with dementia or cognitive impairment in the community. The eligibility criteria require that the person has a diagnosis of dementia or mild cognitive impairment, lives in the community, requires support at home and whose family members are unable or are having difficulty providing care. The service targets both functional care and psychosocial needs. Following a needs-assessment, a personalised care and support plan should be designed with the person with dementia and their primary carer to give them choice and control over how they receive care.

There are also many other support services throughout the country that offer support in their localities. For example, the Western Alzheimer's, funded through the HSE and the Department of Social Protection, provides services and supports to people living with dementia and their families in the west of Ireland, namely, Galway, Mayo and Roscommon[82].

81. https://www.hse.ie/eng/dementia-pathways/services-and-support/memory-technology-resource-rooms/.
82. https://westernalzheimers.ie/.

Supported living and residential care

The care-pathway will also include different forms of supported living and LTRC. While home is usually the preferred option for people living with dementia, there will always be a need for more enhanced accommodation which can provide dementia-specific care. As discussed later in the chapter, the current funding model in Ireland favours LTRC over specialist supported living or home support. Nursing homes can enable people to enjoy a good quality of life despite any health problems and they become the homes of the people who live there. However, there are opportunities to extend time in community living through the development of specialist dementia supported housing [252]. Such housing, along with dementia-specific LTRC, remains limited in Ireland.

Palliative care

Dementia palliative care is another element of the care-pathway. It can treat distressing symptoms to optimise a person's quality of life and that of their families, addressing and relieving pain, distress and discomfort and supporting people to make decisions about their future care through 'advance care planning'. There is limited evidence on the effectiveness of palliative care for people with dementia, including an absence of information on costs and cost-effectiveness. Reseach has shown that, compared to usual care, advance care planning interventions probably increase the documentation of advance directives and discussion about goals of care. Furthermore changes in the way care for people with advanced dementia is organised and delivered may increase comfort in dying [253].

Support for carers of people living with dementia

The chapter has already highlighted that family/unpaid carers are likely to be the main source of support for people living with dementia. Formal support is very limited. Family carers and other carers of people with dementia are generally supported and advocated for by Irish Dementia Working Group, the Dementia Carers Campaign Network and Family Carers Ireland. One service provided to such carers is respite care, which enables family/unpaid carers to have breaks. Respite care does not always have to be residential but can be in the form of a block of hours of home support that enable the family/unpaid carer to have a real break. The Orchard Respite Centre in Blackrock, County Dublin, provides specialist respite care centre for people with dementia and cognitive impairment. Operating seven days a week, it provides overnight respite care and access to a day care centre[83]. The centre is run by Mowlam Healthcare in collaboration with the ASI and the HSE.

Carers already in receipt either of Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance are entitled to the Carer's Support Grant[84], which is an annual non-means tested payment (€2,000 in 2025). Carers not receiving one of those benefits may still be eligible for this Support Grant if aged over 18, caring full-time for more than 6 months (including the first Thursday in June), living with person they care for, and not working more than 18.5 hours per week. This was previously known as the Respite Care Grant and there are no restrictions on how it can be used by carers.

83. https://alzheimer.ie/service/respite-care/.
84. https://www.citizensinformation.ie/en/social-welfare/carers/carers-support-grant/.

6.3 Adequacy

6.3.1 Availability of services

The *National Dementia Strategy* set out a broad range of areas in which action could be taken to improve the lives of people with dementia. These included clear clinical pathways and guidelines, better information about community and other supports, improved linkages between care-streams, public awareness, research, and the removal of stigma. In practice the Strategy has had a major focus on reducing stigma as well as increasing intensive home care packages and investing in psycho-social initiatives. However, in practice access to these packages is very patchy across the country. There has also been a focus on supply-side training and education, especially for GPs.

The 'Model of Care for Dementia' has been developed in recognition of the need to address variations in service-provision and access to timely diagnosis and care across all of Ireland. Before the publication of the 'Model', there were no targets on dementia care service-provision. Full implementation of the recommendations of the 'Model of Care' will reduce inequalities in access to services in Ireland that were noted in the 'Model'. However, gaps in access to services are likely to widen, given the projected increase in the number of people living with dementia, unless there is further investment in dementia support that enables the full implementation of the 'Model of Care'. Funding for dementia care in Ireland has consistently lagged behind need, resulting in absent care and/or inappropriate last-resort placement in LTRC.

For example, previously qualitative research with people living with dementia, family members and GPs in Longford and Westmeath has pointed to significant delays in obtaining a dementia diagnosis [254]. GPs attribute this to limitations in the public's knowledge about dementia symptoms as well as to their perception that there are no effective interventions for dementia. GPs also report delays due to difficulty accessing specialised dementia services.

Timely assessment and diagnosis

The waiting-time for assessment from receipt of referral is hugely variable across Ireland from, ranging from 1–2 weeks to as much as 2 years. The 'Model of Care for Dementia' includes targets for a minimum of one MASS service per 150,000 people (300 assessments per year) and for a minimum of five regional specialist memory clinics (RSMCs) nationally, with two of these based outside of Dublin, performing approximately 500 assessments per year on each site.

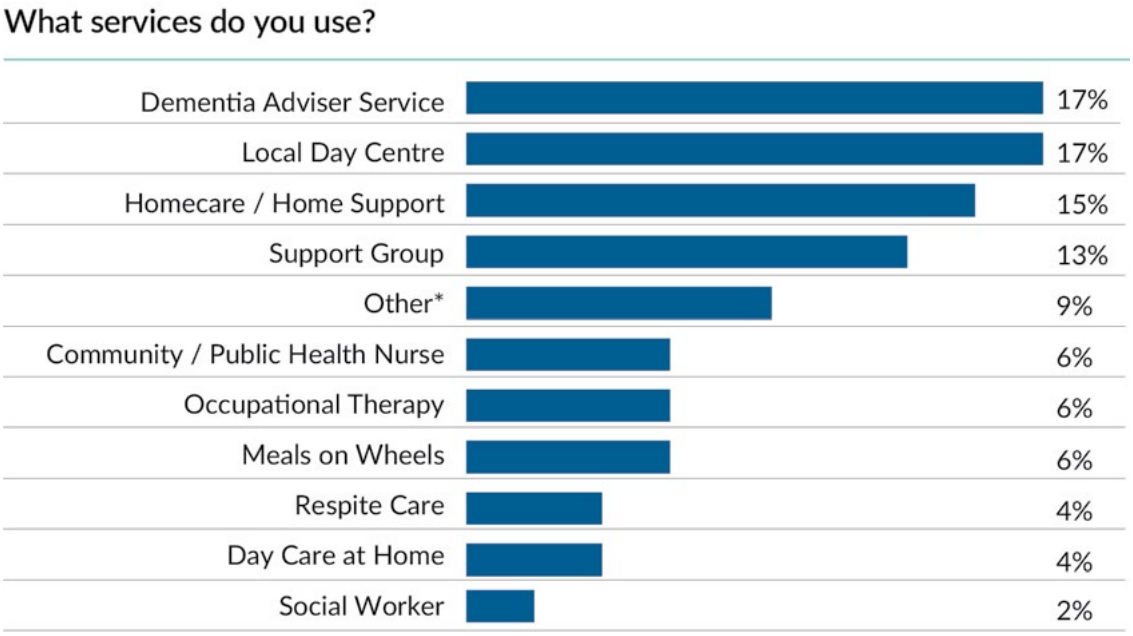
Young-onset dementia (YOD) has distinct impacts compared to late-onset dementia. Qualitative research involving people living with YOD, family members, as well as health and social care professionals from across Ireland, suggests that the path towards diagnosis is commonly difficult and that this is aggravated by dementia support systems being designed to support older populations [255]. People with YOD live on average 10 years after their diagnosis but tend to be disparately located, which means that many dementia professionals do not often come across people with YOD. There are high levels of unmet need for support among people with YOD.

Ireland is one of only a small number of countries to have a specialist national service to address dementia in people with intellectual disabilities. The NIDMS was set up at Tallaght University Hospital (Dublin) in 2022 and is funded through the HSE. People with intellectual disabilities who are worried about their memory can be referred by their GP to NIDMS. An initial memory assessment is then conducted by phone, with subsequent face-to-face appointments at the NIDMS as appropriate.

Inequalities in access to community services

The ASI recently undertook a survey to capture a snapshot of living with dementia in Ireland in 2023 [256]. The survey was completed by 72 people living with dementia and 597 current carers from across Ireland. This is not a random sample of people living with dementia as it only includes people (and families) with a diagnosis who also are known to the ASI. However, arguably these respondents will be more aware of services and supports that are available than people living with dementia who are unknown to ASI. Moreover, there was a good mixture of people with long and shorter-term experiences: 40% of respondents had between 4 and 7 years' post-diagnosis experience. 90% of respondents with dementia were living at home while 80% of carers were supporting a person with dementia living at home. Figures 6.4 and 6.5 show the services that people living with dementia and family/unpaid carers reported using at the time of the survey.

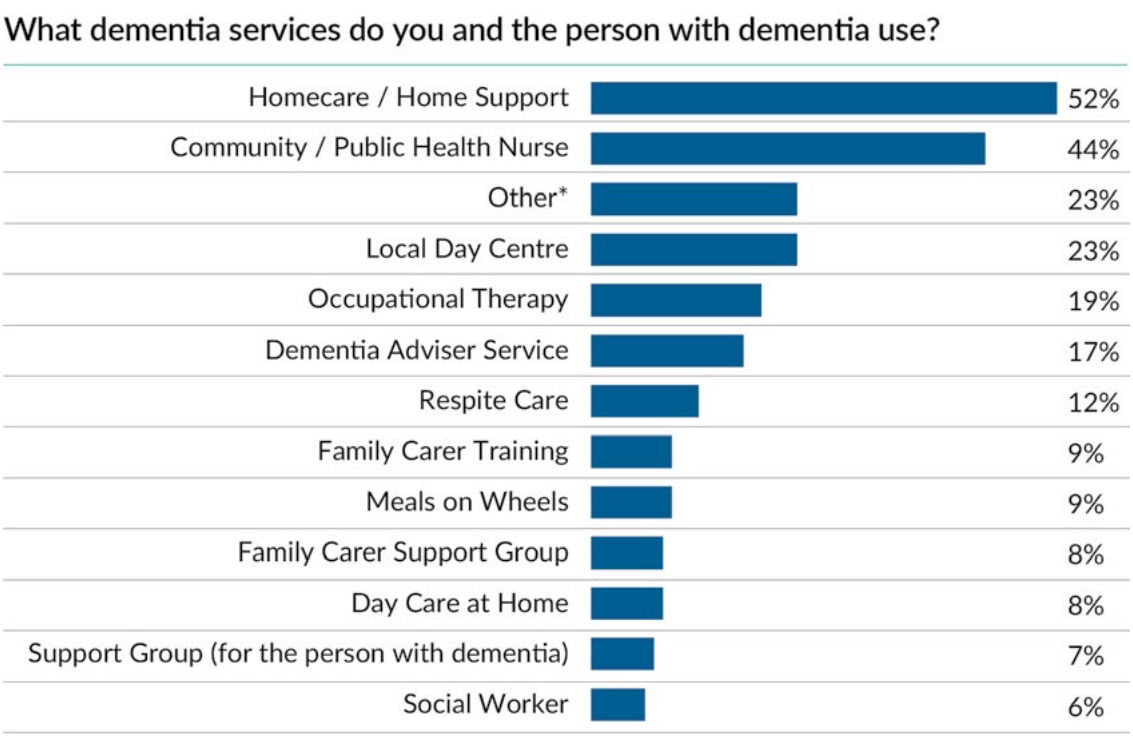
Figure 6.4: Services used by people living with dementia



Source: [256].

Notes: * Other responses listed were a local Dementia Alliance and activities with a registered charity that provides training and resources for those who care for people with dementia.

Figure 6.5: Services accessed by carers



Source: [256].

Notes: *Other responses included private home support, speech and language therapy, private live in carers, and befriending services. The majority listed 'none' or 'nursing home care'.

Overall, only 20% of people living with dementia and 12% of carers indicated that they had access to all of the services that they needed, by comparison with 33% and 26% of these two groups indicating that they did not have access to any of the services that they needed. Even though home support was one of the most frequently used services, qualitative responses from participants pointed to the lack of statutory funding for home support, coupled with the high cost of private home support, as barriers to the use of these services.

They also noted 'a large discrepancy between the number of [home support] hours needed, the number of hours granted and the number of hours received'. Other themes from qualitative analysis highlighted in the report included excessive bureaucracy when seeking services, long wait-times for services as well as the limited availability of day care and respite services—all reflecting the funding issues referred to earlier in the chapter.

The findings on access to day care are not dissimilar to those seen previously. A national survey found that, in 2018, only 2,805 people with dementia attended day care[85] [257]. If approximately half of all people in Ireland were living with dementia at home in 2018, which would equate roughly to 30,000 people, only 10% of community-dwelling people with dementia were using day care.

85. Defined as day centres that were open for a minimum of five hours per day for at least one day per week and where participants are referred by health care professionals).

Three-quarters of the 317 day-care centres identified provided some places for people with dementia, including 58 dementia-specific day-care centres run by the ASI on behalf of the HSE. The limited use of day care does not simply reflect a limited number of places; in fact almost 6,000 places were available nationwide. Challenges include geographical variations in the capacity of day centres, particularly in the parts of the country with low population-density. 18% of people with dementia lived further than 15km from their nearest day centre, and transportation can be an important barrier to use. While ASI-run day-care centres provide dementia-specific training for staff to meet the needs of people with dementia, there can be a lack of training in some day-care centres that are not run by the ASI.

In 2024, there were 78,653 attendances at ASI day-care centres (a 24% increase on 2023) while 89,212 hours of day-care-at-home were provided—a 14% increase on the previous year. 121,124 hours of home support were provided, a marginal drop of 3.8%, while there was a 21% increase (to 12,716) in attendances at social supports, including social clubs, Alzheimer cafes, choirs and support groups. Although ASI-provided services have increased, in their most recent submission for Budget 2025 the ASI called for further 'funding for Dementia Specific Day Services, Therapeutic Support and Education for Family Carers; Dementia Home Care, Dementia Nurse Specialists, Memory Clinics and Research'.

A study exploring the experiences of social workers examined whether older people's preferences for staying at home were being met and found that there were geographical inconsistencies in the ability to access community supports and that people with dementia were often excluded from decisions about their care regardless of their capacity [258].

Counselling and emotional support are very important following a diagnosis of dementia. Often there are feelings of loss, grief and sadness which may be compounded by experiences of stigma and discrimination. The 'Model of Care' notes the importance of 'counselling and psychotherapeutic interventions, e.g. for specific issues related to diagnosis, or for issues such as stress management, anxiety or depression.' However, such counselling and other emotional and mental health supports have not been widely available in Ireland [259].

6.3.2 Support for family / unpaid carers

Despite the centrality of family/unpaid care to dementia care in Ireland, the *National Dementia Strategy* and the 'Model of Care for Dementia in Ireland' recognise that services and supports for these carers need to be strengthened. A qualitative study involving 17 family carers of people with dementia in Ireland was used to elicit prioritisation-ranking for personal psychosocial supports and social services [260]. Day care, short-break respite and long-break respite were highly valued by family carers and were deemed preferable to a permanent move to LTRC.

A non-means tested carer's allowance (as opposed to the existing means-tested Carer's Allowance), was also seen by carers as a priority given the financial challenges of caring. More recently the ASI has also called for meaningful increases in social protections for family carers, to take account of the significant financial costs of caring. They highlighted the substantial financial challenges faced by 129 family carers of people with dementia [261] (Box 6.1).

The average age of these carers was 53 (range 22–79), 74% were women and 71% were caring for a parent/parent-in-law. These dementia carers represent a subset of carers in a larger survey for The *State of Caring 2022* report produced by Family Carers Ireland[86].

Box 6.1 Financial challenges faced by family carers of people with dementia in Ireland

55% (n=71)
said they are having difficulty making ends meet.

17.8% (n=23)
of family carers also stated they were cutting back on household essentials.

12% (n=15)
of family carers state they are having *great difficulty* making ends meet.

22.5% (n=29)
have had to cut back on seeing friends and family.

In some cases, financial difficulties were so impactful that people had fallen into arrears with mortgage payments (4.7%) and utility bills (5.4%).

Source: [261].

> Projections of the future availability of family/unpaid carers (not specific to dementia) suggest that this is unlikely to keep up with demand for care at home, particularly in the context of a shift away from residential care to home and community-based care. This is because the future supply of family/unpaid carers is expected to be limited by a decline in fertility-rates, delays in starting a family, and the increased labour-force participation of women [262].

6.4 Effectiveness and efficiency

Here we look at some issues that affect the effectiveness and/or efficiency of the state of care and support for people with dementia.

6.4.1 Workforce sustainability

Challenges for the sustainability of the health and social care workforce which supports older people have been discussed in detail in other chapters of this report. (See, for example, the discussion in the 'Home support' and 'Residential care' chapters.) In a survey conducted by the ASI in 2023, almost two-thirds of respondents in receipt of home support experienced a delay or reduction in this service over the last two years due to the home care staffing crisis [256].

86. See https://familycarers.ie/research/research-publications/state-of-caring-reports.

Pay and conditions are key concerns. There are pay disparities between employees of NGOs and those employed directly by the HSE to support older people including people with dementia. The ASI, for example, has been campaigning for the Government to address the inequality in terms and conditions for all section 39 employees by including these employees in public-sector pay deals and funding organisations to apply those increases, including increments. They have also highlighted the need, in relation to dementia-specific home care workers, to standardise home care rates of pay and benefits across Ireland, as well as to introduce meaningful career-progression opportunities for these workers.

Agreement was reached at the Workplace Relations Commission (WRC) in March 2025 for a 9.25% pay-increase (albeit typically from a lower base-salary than HSE employees), backdated to October 2024. There is also a commitment to an automatic link to all future public-sector pay agreements for section 39 employees [263]. However, there is still no funding to pay for their increments and pension contributions, while their travel expenses, which are crucial for home care workers, are lesser than those paid to their HSE counterparts. The need to have parity in pay and conditions to sustain and increase the availability of home support and other care workers is particularly critical because 42% of the care workforce in Ireland in 2020 were over the age of 60 [264].

6.4.2 Dementia-specific training for the health and care workforce

Dementia training of healthcare professionals has been found to improve service-users' outcomes (such as agitation), as well as improving staff practices, improving engagement with activities and reducing role strain [265]. There are gaps and weakness in dementia awareness and training within the health and social care system. For example, there exists insufficient dementia training among carers. In interviews with 2,000 qualified home carers and healthcare assistants in 2020, 16% of carers reported that they had no professional caring qualification and over 50% had no training in dementia care [106].[87]

To address this need as part of the implementation of the *National Dementia Strategy*, a programme to train home support workers has been developed, the 'Dementia Care and Support: Home Care Education Programme'[88], which is gradually being delivered. This is freely available to healthcare support assistants and takes 18 weeks to complete. The 'Model of Care for Dementia' recognises that more dementia-specific training is needed for health and social care staff. Implementation of a community model of palliative care in Ireland has also been hampered by home support workers being under-skilled in dementia care [266]. Earlier work explored the implementation of Irish Hospice Foundation guidance on hydration and nutrition, pain assessment and management and medication management in three LTRC homes with predominantly people with dementia. It found that limited staff-time was a key barrier to the implementation of guidance as well as limited support from other healthcare professionals [267].

87. The strategic workforce advisory group on home carers and nursing home assistants has recommended the provision of specialised training such as in dementia care for care workers.
88. https://www.hse.ie/eng/dementia-pathways/education-and-training/knowledge-skills-development/dementia-care-and-support-homecare-education-programme/.

A Quality and Qualifications Ireland (QQI) level 5 'Certificate in Dementia Care' course was developed in 2022 to address this training skills-gap. There is a small course-fee and it is only available to people with a specific health, social care or related healthcare qualification who also have at least 6 months' experience in providing dementia care.

Although acute hospital care is not the focus of the Commission's work, without sufficient training, including for discharge-planning teams, people with dementia are likely to have negative experiences of hospital-stays. It is essential to ensure that people with dementia are not inappropriately transferred to LTRC following contact with acute care services.

6.4.3 Resource-allocation

Other chapters have discussed in detail some of the consequences of the lack of a statutory funding scheme for home support in Ireland, in contrast to the statutory NHSS. The current *Programme for Government* also reaffirms a commitment to 'design a statutory homecare scheme' [145]. The lack of a statutory home support scheme is one reason for the limited access to home support for people with dementia, even though this service can be invaluable in helping people to remain living at home. This potentially could mean there is a risk that some older people may be moved into long term residential care against their wishes and/or could be managed better at home. Other chapters have also highlighted the issue of a lack of standardised assessment of care needs, even though there have been plans to move to a single assessment tool (interRAI) to assess care needs. Funding allocated to individuals for home support, and also for residential care, also does not fully take account of differences in need. This can mean that funding is insufficient to meet the needs of people with more severe levels of dementia (and other morbidities), even though some enhanced dementia home support can be available to take account of specific psychosocial and functional needs of people with dementia.

At a more fundamental level it has also been argued that while 'the *Irish National Dementia Strategy* is based on the principles of personhood and citizenship, this policy rhetoric is not matched by resource allocation' [268]. An audit of dementia services in Ireland in 2018 reported that less than 1% of the €138 million spent on community dementia services was for psychosocial support, with the vast majority of support being for home support hours [246]. This means that it is difficult to reconcile existing funding models for dementia care in Ireland with the stated commitment to personhood and citizenship in the *National Dementia Strategy* and the aspiration of prioritisation of home support over residential care.

A qualitative study also identified structural barriers (linked to budgetary constraints) to personhood in the health and social care system in Ireland, with formal carers expressing frustration over time constraints, and family carers and people with dementia reporting having to accept inappropriate provision [269]. In that study the concept of personhood for people with dementia was explored in a study that identified as core elements: interest and preferences, life-course experiences, social interactions, and family and place. However, family and formal carers expressed some ambiguity about the continued existence of personhood as dementia progresses.

6.4.4 Use of anti-psychotic medication and polypharmacy

Antipsychotics have adverse effects for people with dementia but despite this they are used to manage so-called 'behavioural and psychological symptoms of dementia' (BPSD). A national clinical guideline published in Ireland provides strict recommendations on when they can be used, urging caution in use and specifying that they should not be used for people with Alzheimer's, vascular dementia, mixed dementias, dementia with Lewy bodies or Parkinson's disease dementia when they only have mild to moderate cognitive problems due to the risk of adverse events, including strokes [270].

While the number people with dementia who are currently being prescribed antipsychotic medication is unclear, there is some evidence that indicates that rates of antipsychotic prescribing are high, above international norms and increasing over time. The clinical guideline pointed to an audit of admissions to acute care in 2013 which indicated that 46% of people with dementia coming from LTRC, and 19% of people with dementia coming from the community, were being prescribed antipsychotics. The audit noted that this was 'substantially higher than the European average of 27%, and the rate in the UK of 19%' [271]. In the second national audit undertaken in 2019 these respective figures on anti-psychotic medication use at admission had risen to 55% and 20% respectively [272]. The extent to which the 2019 clinical guidelines may have changed prescribing rates is unclear.

A survey of GPs in Cork and Kerry found that there was good knowledge among GPs about the lack of effectiveness and risks of antipsychotics for people with dementia and that GPs routinely recommend non-pharmacological strategies as a first response [273]. However, the majority of GPs reported that they would prescribe antipsychotics to people with dementia who were physically aggressive and nearly half reported that they would prescribe them to people who were agitated, suggesting the perceived lack of practical resources, both in the community and in nursing homes (particularly in terms of having sufficiently trained staff). GPs reported high pressure from nursing home staff to prescribe antipsychotics. The GPs identified increasing staff-levels in nursing homes as the single change that would most help them reduce the prescription of antipsychotics for people with dementia.

An intervention to reduce inappropriate prescriptions of antipsychotics in nursing homes, 'Rationalising Antipsychotic Prescribing in Dementia' (RAPID), was piloted in a large nursing home in Ireland, showing promising results [274]. More broadly, an implementation programme, which aimed to raise awareness of the guideline and the risks, initiate a programme of educational activities, develop an audit tool and evaluate the impact of the guideline started in 2022 [275]. The results have not yet been published.

Another issue of concern is the high prevalence of polypharmacy (five or more medications) among people with dementia. Previous research undertaken in Ireland found that 84% of older people with dementia admitted to hospital met the criteria for polypharmacy, with 27% taking ten or more medications [276]. Psychotropic polypharmacy (two or more psychotropics) was significantly more common among people with dementia than among people admitted to hospital without dementia.

6.4.5 Lack of alternative housing options

The lack of specialist community supported housing for people with dementia reduces their ability to continue to live in the community. A review indicated that 'in Ireland, few real alternatives exist for people living with dementia who want to continue to live independently as the disease progresses, outside of traditional long stay care facilities'. It further noted that:

> Sheltered housing is the most common form of alternative accommodation for older people in Ireland, but, as currently interpreted and provided, it does not specifically target people with dementia. Sheltered housing caters mainly for older people who are relatively independent and do not require much in the way of services and supports [252].

The continuum of care model for people with dementia in Ireland is weaker than for other types of dependent older people. Different forms of age-friendly housing that cater specifically for the needs of people with dementia are lacking. The review noted examples of approaches that have been used in other countries, such as, for example, formal assessment with a view to adaptation of the homes of people with dementia in France; small-scale group homes as an alternative to residential care in Japan; and the creation of 'dementia villages' providing a different form of living environment [252].

One such 'dementia village' is operated in Bruff, Co Limerick, by a private operator, CareBright. It is Ireland's first and only purpose-built community for people living with dementia and it follows the Dutch Household Model approach[89]. The community has three bungalows, each containing six private living spaces and each of which is staffed in accordance with the needs of the residents in that house. It is built around sensory gardens and has a community hub centre with a café, sensory room, activities, art room and ancillary services, including a hair salon etc. The café is open to the wider community of Bruff, thereby ensuring the integration of the facility into the village.

6.4.6 Dementia care in long-term residential care

There is a need to strengthen safeguarding in LTRC. The briefing paper, 'Adult Safeguarding and People with Dementia in Nursing Homes' (December 2022), commissioned by the Irish Dementia Working Group [277], provides insights and recommendations into ways to uphold the rights of people with dementia as their care-needs progress and they move to LTRC. The report contains 30 recommendations, including people being involved in decisions about their own care, the risk of structural abuse due to inadequate care or support, and the importance of moving towards restraint-free environments, including chemical restraints (as discussed above). It is essential that care-staff receive training that enables them to understand and respond appropriately to expressions of distress. Funding will also be an issue as the NHSS does not allocate additional funding for dementia care, despite HIQA requiring LTRC homes to meet standards of care for people with dementia.

89. For more see https://hogeweyk.dementiavillage.com/.

Despite the relatively large number of people with dementia living in LTRC, there are relatively few dementia-specific care homes in Ireland. One example is St. Joseph's in Shankill, County Dublin. There are some good examples of Irish LTRC homes which have been developed from an understanding of the principle of good environmental design in dementia [278]. As in other countries, new models are emerging, including for example the organisation of care homes into households of 10 people with dementia, building on international experiences such as the US Greenhouse model [279].

6.5 Limitations in analysis

6.5.1 Data-availability

There remains a lack of hard data on the specific number of people living with dementia in Ireland. This makes it difficult to accurately plan for current and future care and support-needs. However, as we have noted the Government has committed to the establishment of a National Dementia Registry to improve data-collection on dementia. It will map services, identify needs and deliver equitable access to services [145]. Implementation is just commencing.

6.6 Learnings

This chapter has highlighted important policy developments in Ireland over the last decade, with the welcome development of a *National Strategy* and 'Model of Care'. There is also a very rich level of policy-relevant research on dementia in Ireland, including considerable input from people living with dementia and their families.

There is a strong focus on personhood and psychosocial functioning in policy documentation, although in practice these aspects can be strengthened: for example the relatively low level of funding-allocation to psychosocial supports is a barrier to progress. As the recent survey from the ASI indicates, despite the increase in funding, contact with, and use of, many services by people with dementia and their families can be low, with 33% of people with dementia and 26% of family members in the survey indicating they did not have access to any of the services that they needed. The new 'Model of Care' also has a strong emphasis on increasing the availability of services to allow for earlier assessment and diagnosis.

Earlier assessment can help with future planning and there is a focus on post-diagnosis planning as well. Issues remain about access to home support, and there are limited opportunities to access specialist supported housing options to help reduce the need for LTRC. One potentially concerning issue is the high rate of antipsychotic prescribing; guidelines have been published on this, but it is not yet clear whether prescribing patterns have changed. Finally, the challenges facing carers are also evident. Family/unpaid carers continue to be the main source of support for people with dementia. There are challenges for their physical and mental health but in addition they can come under great financial pressure as well.

6.7 Strengths, weaknesses, opportunities and threats

Strengths

- Strong commitment to a tailored approach to all aspects of dementia in the *National Dementia Strategy* and 'Model of Care for Dementia' that is based on a rights-based, bio-psycho-social model which has personhood and autonomy at its core.
- Publication of 37 targets and recommendations for the implementation of the 'Model of Care for Dementia'.
- Recognition in the *National Dementia Strategy* and the 'Model of Care for Dementia' of the importance of also supporting family/unpaid carers.

Weaknesses

- Resource-allocation for home support and other community services does not take account of the needs of people with differing levels of dementia-severity.
- A lack of uniform availability of services across the country, particularly for community-based care and in rural areas. There are inequalities in access, e.g. a wide variation in waiting times for diagnostic assessment.
- The funding system favours LTRC as the NHSS provides statutory funding for LTRC in Ireland. This potentially could mean there is a risk that some older people may be moved into LTRC against their wishes and/or could be managed better at home. Moreover, there is little dementia-specific LTRC.
- Although there has been an increase in funding for home support, there is still no statutory home support funding scheme, and on average the provision of HSE-funded home support is limited to approximately one hour per day for all older people. Access to intensive home care packages is also patchy around the country.
- Workforce shortages can be attributed to structural problems that reflect the low societal value of care-work, such as the terms and conditions of pay, travel expenses and the lack of a career-progression pathway. There are relatively few carers trained in dementia care both in home support services and nursing home settings.
- The new 'Model of Care' is not accompanied by a dedicated funding stream or a formal plan to monitor implementation.

Opportunities

- If well-implemented, the 'Model of Care' presents an opportunity to reduce regional inequalities in timely access to diagnosis and care across Ireland.
- Commitment and allocated funding for the National Dementia Registry provides an opportunity to better ensure that needs are met in future planning.
- There is potential for reducing the risk of developing dementia by addressing modifiable risk-factors as well as through potential innovation in diagnosis and treatments. For example, biologic disease-modifying drugs could improve the quality of life for people with dementia and their families.

- Enhanced diagnostics associated with the 'Model of Care' framework, and also with the advent of blood-based biomarkers, will increase the number of people who may be identified early and benefit more from intervention.
- On implementation, the National Dementia Registry will provide an opportunity for better identification of needs as well as service-planning.

Threats

- Without action to reduce the risk of dementia earlier in life as well as to better help people with dementia continue to live where they want to live for as long as possible the LTRC system may be put under intense pressure, with the number of people living with dementia expected to double over the next twenty years.
- There are possible opportunity-costs of investment in new treatments, particularly if they require significant infrastructure for delivery and ongoing management, and if this is done at the expense of the provision of early care and support or prevention.
- Enhanced diagnostics associated with the 'Model of Care' framework may also increase demand for services, which implies the need for greater investment.
- The ageing of the population and changing household-composition, with more single-person households, is likely to reduce the future availability of family/unpaid carers.

7

Ageing with a pre-existing disability through the lens of intellectual disability

7.1 Summary

This chapter focuses on the current state of publicly funded care and support for those people who already have a pre-existing disability (such as people ageing with cerebral palsy, spina bifida, ID, and autism spectrum disorder). It has a particular focus on pre-existing disability through the lens of people who have a primary diagnosis of an ID. This is for two key reasons: firstly people with ID age prematurely compared to the general population and secondly there is more information available in Ireland on the experiences of this population group.

In examining at the policy context in which health and social care services are delivered to people ageing with disability, the chapter also considers the protection of human and social rights. It looks at the availability and adequacy of existing services as well as at their effectiveness in achieving outcomes that help people ageing with pre-existing disabilities live as independently as possible in their own homes and communities. It also considers the effectiveness and efficiency of the current system. Although the focus of this chapter is on a younger population with a pre-existing disability, and in particular on those with an ID, many of the issues pertaining to the policy approach, as well as to the provision of services and supports, will be very relevant to the discussion of the challenges faced by older people in other chapters of this report.

7.2 Introduction

The focus of this chapter is on people in Ireland who are ageing with a pre-existing disability. This should be distinguished from *ageing into disability*—when an older person experiences the onset of periodic or sustained disability during mid and later life [280]. That said, although the concepts are different, many actions that can help older people ageing with a pre-existing disability can also be used to help support older people ageing into disability. For example, some of the issues arising in respect of early-onset dementia for the general population (which are examined in the chapter on dementia) also arise in respect of people ageing with intellectual disabilities, particularly those with Down syndrome who are at greater risk of dementia at an early age [220].

Emerging evidence highlights the unique and often unmet needs of individuals with long-term physical disabilities as they age. A recent review on the ageing of people with long term physical disabilities [281], indicates that this population is at increased risk of accelerated physical decline, a higher incidence of secondary health conditions, and greater vulnerability to falls and injuries.

While emotional distress is frequently reported in this population, many individuals also demonstrate psychological resilience and wellbeing as they age, drawing on diverse personal and social supports. However, pervasive social barriers such as physical inaccessibility, attitudinal bias, and socioeconomic disadvantage continue to limit social participation and reduce overall quality of life.

Of particular concern are findings from studies that highlight attitudinal bias and a lack of appropriate skills and knowledge. For example, a study of 714 doctors across the United States, both in primary and secondary care, revealed 59.3% lacked confidence in delivering equitable care to patients with disabilities [282]. This included 62.3% of primary care providers, highlighting systemic gaps in training, preparedness, and inclusive practice. Another US study involving more than 25,000 healthcare providers highlighted that, implicitly, 82.7% preferred treating non-disabled people, including 70.1% who 'moderately or strongly preferred non-disabled people' [283]. These findings underscore the urgent need for policy measures that address structural inequalities, promote disability competence in healthcare, and support inclusive ageing strategies across sectors.

The case of intellectual disability

A recent scoping review of the evidence on ageing well with any lifelong disability identified 81 studies worldwide; 70% focused on the experiences of people with ID, with the authors highlighting the lack of research with other population groups [284]. Given this relatively limited data on ageing among individuals with lifelong disabilities, this chapter primarily focuses on the experience of people with ID. Another reason for this focus is the availability of information from the Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing (IDS-TILDA) [285]. Since 2011 this study has provided critical insights into the ageing process among individuals with ID in Ireland. We also know that people with ID make up the majority of recipients of specialist disability support services in Ireland, particularly in relation to cognitive impairment and dementia [286].

For the first time in Ireland we are seeing people with an ID living to an older age [220], which is something to be celebrated. Nonetheless, they still have a much shorter average life-expectancy than the general Irish population. Data covering the period 2003–2012 indicates that life-expectancy for people with ID in Ireland was just 55—a difference of almost 20 years compared to the general population [287]. Another Irish study utilising data from 2001–2016 reported mean life-expectancy of just 53 for this cohort [288].

Moreover, people with ID can age more quickly than the general population. For example, there is a five-fold increased risk of dementia in people with ID compared to the general population [219].[90] The risks of dementia in older age can be even higher for some specific conditions. In Ireland a longitudinal study followed 77 women aged 35 and older with Down syndrome over 20 years [220]. 97.4% developed dementia, with the mean age for diagnosis being 55. There was a 23% risk of dementia at age 50, 45% at age 55 and 88% by age 65. This compares to approximately a global age standardised prevalence of 119.0 per 100,000 population in the age range 30–64 [289]. Women with ID die, on average, 20 years earlier than their peers, enter menopause at a much younger age, and face disproportionately poor physical and mental health outcomes [290].

90. Ageing reflects accelerated biological and functional decline rather than just years lived (chronological age).

In addition, while the ID population do not currently reach a similar older age to the general population, many experience premature ageing through the early onset of chronic health conditions [291, 292], meaning that they will be more likely to be in need of services and supports at an earlier age than the general population. Data from IDS-TILDA also highlight that people with ID experience age-related health challenges earlier and more severely than the general population. Multimorbidity is more prevalent and complex, with 71.2% of people with ID aged 40 and over living with two or more chronic conditions [293] compared to only 48.9% having at least one chronic condition in general Irish population aged 65 and over[294] [295]. Furthermore, people with severe to profound intellectual disability were significantly more likely to be multimorbid (90.7%) than those with mild or moderate ID. A care-pathway for the management of chronic conditions is needed for all people with ID but particularly for people with severe and profound intellectual disabilities.

IDS-TILDA indicate that preventable physical health issues remain common, including chronic constipation, poor bone health, frequent falls and fractures, and low physical activity. The findings show that adults with ID experience accelerated biological ageing, with earlier onset and greater severity of frailty compared to their peers without ID [296]. Fragility fractures in women with ID aged 65+ are reported at 17.8%, nearly double the rate in the general population (9%). Furthermore European evidence indicates cancer deaths are disproportionately high among this group [297, 298], yet often go undiagnosed during life [299].

Medication-use is significantly higher, with 20% of adults with ID experiencing hyper-polypharmacy (10+ medications) [300], compared to just 6% in data from TILDA on people aged over 50 in Ireland [301]. Prescribing patterns also differ sharply, with high use of psycholeptics, anti-epileptics, analgesics, and laxatives—none of which is among the top 10 therapeutic classes for the general population [290, 302, 303].

Oral health remains a major concern, with 40% of adults over 65 being edentulous (without any natural teeth) and 72% of these having no dentures compared to just 5% in the general population. These poor outcomes are seen despite more than 80% visiting a dentist in the previous two years [304].

These findings point to an urgent need for earlier diagnosis and prevention, targeted health promotion, and accessible care-pathways. Ireland is particularly well-positioned to implement such a strategy given its unique reliance upon, and recent further development of, Registered Nurses in Intellectual Disability (RNIDS) [305].

Building the capacity of mainstream services through disability-inclusive health environments, reasonable accommodations, and staff-training will not only support people with intellectual disabilities as they age but also improve care for the wider ageing population. The integration of RNIDs throughout healthcare will ensure that this potential is realised.

The increasing age of people with intellectual disabilities and the challenges arising for health, wellbeing, quality of life and community engagement are not unique to Ireland—it is an international phenomenon, with few answers about critical issues, best practices and required policy-responses [306-308]. For the general population, the WHO and the United Nations (UN) are seeking answers, with a renewed emphasis on healthy aging and functional ability: the UN Decade of Healthy Ageing (2021–2030) aims to improve the lives of older people, their families, and the communities in which they live [309]. Yet little attention is given to people with intellectual disabilities as they age in these initiatives.[91]

Rights, participation and community inclusion

People with disabilities may also be at increased risk of having their human and civil rights overlooked or denied. Fundamental rights including self-determination, choice, and active participation in civic and political life are not always upheld in practice. Access to independent advocacy is often essential to support self-determination and empower people with disabilities to make informed decisions about how they live their lives and ensure their voices are heard in matters that affect them.

Despite advances in disability rights and service-provision, data from IDS-TILDA show that many older adults with ID continue to face significant barriers to full participation in society. While self-directed and supported decision-making has improved over the past 12 years, one in three older adults with ID is still not involved in making fundamental life-decisions, such as where or with whom they live [310].

Civic engagement remains limited. More than 70% of people with ID aged 40 and over had not voted in a recent election, with voting rates lowest among those in congregated settings. Institutional living environments and more severe disabilities are associated with restricted choice and limited access to independent advocacy [311].

Social inclusion is also lacking. Fewer than 1% of older adults with ID are married or have families compared with over 90% of their peers in the general population. Only around 10% are in paid employment [311]. Despite wider access to digital technologies, many remain digitally excluded, which limits their ability to maintain social connections or access health and social care supports [312].

These findings underscore the need for sustained policy action to promote autonomy, civic engagement, digital inclusion, and access to advocacy for people living with long-term disability, particularly for those in more restrictive or isolated living environments.

91. Mary McCarron, 'Where to From Here in Research, Policy and Practice?', Keynote address at the International Association for the Scientific Study of Intellectual and Developmental Disabilities (IASSIDD) World Congress 2024, Chicago.

7.3. Policy landscape: protecting the fundamental human rights of people ageing with disabilities

Lifelong disability has been associated with an affirmation of personal disability identity, validated through the disability rights activist movement [313], in contrast to people first experiencing disability at an older age who tend not to take on a disability identity, perceiving their functioning as 'normal' for their age and because of a lifetime's identification as 'non-disabled' [314]. This may, in part, explain why the disability sector has been much stronger than the older persons' sector in promoting a more social model of support, with a different policy discourse to that for ageing [315].

The needs of people with disabilities, and in particular ID, including their rights to autonomy and choice on all aspects of their lives, has been a prominent issue in Irish disability policy and discourse for many years. Consequently, progress on these issues is much more advanced than is the case for the fundamental human rights of older people, which have been influenced by a predominantly medical model of care that has prioritised clinical need over social need of older people. There is a valuable opportunity to learn from the disability sector and apply its person-centred, community-integrated approaches to the broader design of ageing and care models for all older adults.

7.3.1 UN Convention on the Rights of Persons with Disabilities (UNCRPD)

The UN Convention on the Rights of Persons with Disabilities (UNCRPD), ratified in Ireland in 2018, also provides a set of binding instruments setting minimum standards for rights of people with disabilities [316]. (While there is at present no equivalent UN convention on older persons' rights, a resolution on the establishment of an 'open-ended intergovernmental working group for the elaboration of a legally binding instrument on the promotion and protection of the human rights of older persons' was adopted during the 58th session of the United Nations Human Rights Council on 3rd April 2025.) The National Disability Authority states that:

> The Convention applies established human rights principles from the UN Declaration on Human Rights to the situation of persons with disabilities. It covers civil and political rights to equal treatment and freedom from discrimination, and social and economic rights in areas like education, health care, employment and transport' [317].

The Department of Children, Disability and Equality also published a *National Human Rights Strategy for Disabled People 2025–2030* in September 2025 [318].

For example, Article 12 of the UNCRPD affirms the right of people with disabilities to make decisions with legal consequences and to be supported to make such decisions in accordance with their will and preferences. It acknowledges that nobody should have this right removed and vested in another person without their consent [319]. Aso noteworthy is Article 19, which affirms the right of people with disabilities to live in the community with choices equal to others and to access a range of home and community support services, including personal assistance.

In October 2024 the Government acceded to a further Optional Protocol to the UNCPRD. This Protocol allows for the UN Committee on the Rights of Persons with Disabilities to receive and examine the cases of people in Ireland who claim to have had their rights under the UNCPRD violated, and further to 'undertake inquiries in cases where they receive reliable evidence of grave or systemic violations of the Convention' [320]. This complaints process comes after all existing domestic (and European Court of Justice or European Court of Human Rights) legal routes of redress have been exhausted.

7.3.2. The Assisted Decision-Making (Capacity) Act

Nationally, the Assisted Decision-Making (Capacity) Act, 2015[92] has been an important piece of legislation for people living with disabilities. It established a new legal framework for supported decision-making in Ireland, allowing people to make legal agreements on how they can be supported to make decisions about their personal welfare, property and affairs. It also includes provision for Decision Making Assistants to gather information and help people, such as those with ID, to consider the pros and cons of different choices they could make. These assistants can also help let other people know about the decision that the person living with disability has decided to make. There are also co-decision-makers who can make some decisions jointly with the person with disabilities. The Act came into force belatedly in April 2023, along with the Decision Support Service established to support its implementation, with the aims of protecting and upholding people's rights to make their own decisions about their personal welfare, property, and affairs[93]. While the Act is an important step forward, it does not fully comply with all aspects of UNCRPD, including, for example, Article 12 since not all of the 'legal consequences' to which this Article refers are covered by the Act (e.g. those related to wills and guardianship)[94].

7.3.3 Housing policies

A dedicated *National Housing Strategy for Disabled People 2022–2027* is focused on providing a framework for delivering housing for disabled people through mainstream housing policy [144]. It includes looking at the housing needs of people ageing with disabilities, including people with ID. Promoting accessible housing, accessible communities and universally designed homes are key themes. The vision includes enabling equal access for people with disabilities to housing with integrated support services. The *Strategy* has also been informed by the UNCRPD.

92. For detailed information on the Act see https://decisionsupportservice.ie/about-us/legislation.
93. See https://www.decisionsupportservice.ie/.
94. For a detailed analysis of how Ireland is realising Article 12 of the UNCRPD see https://nda.ie/publications/background-paper-realising-article-12-of-the-un-convention-on-the-rights-of-persons-with-disabilities-irelands-journey-from-wardship-to-supported-decision-making.

The Strategy builds on previous policy documents concerned with helping people to live in the community. Historically many people with disabilities, particularly ID, were living in congregated settings ('living arrangements where ten or more people share a single living unit or where living arrangements are campus-based') [321]. In 2011 *Time to Move on from Congregated Settings: A Strategy for Community Inclusion* recommended that all adults still in congregated settings should move to 'ordinary neighbourhoods (dispersed housing) in the community, with individualised supports (supported living) designed to meet their individual needs and wishes' [321].

In 2012 the Department of Health also published a *Value for Money and Policy Review* of *Disability Services in Ireland* in which it recommended that:

> Priority should be given to putting a new model of community-based supports in place for persons moving from congregated settings, discontinuing admissions to existing settings and ending the commissioning of new settings [322].

This policy commitment is in line with Article 19 of the UNCRPD on living independently and being included in the community. The 2011 report recommended that all those in congregated settings should have moved to the community within seven years, with minimum targets set each year in order to reach that goal [321].

Research consistently demonstrates that people with ID living in smaller, community-based settings experience better outcomes across health, wellbeing, and social inclusion measures [323, 324]. These environments foster more person-centred care and stronger community connections conditions in which individuals can truly thrive as they age.

While the needs of those still living in congregated settings still need to be addressed, the 'new old' are more likely to be in family and independent settings which may need a different range of services and supports. Supporting people with intellectual disabilities is not only about adding years to life, but also about adding life to those years.

7.4 Adequacy of services and supports

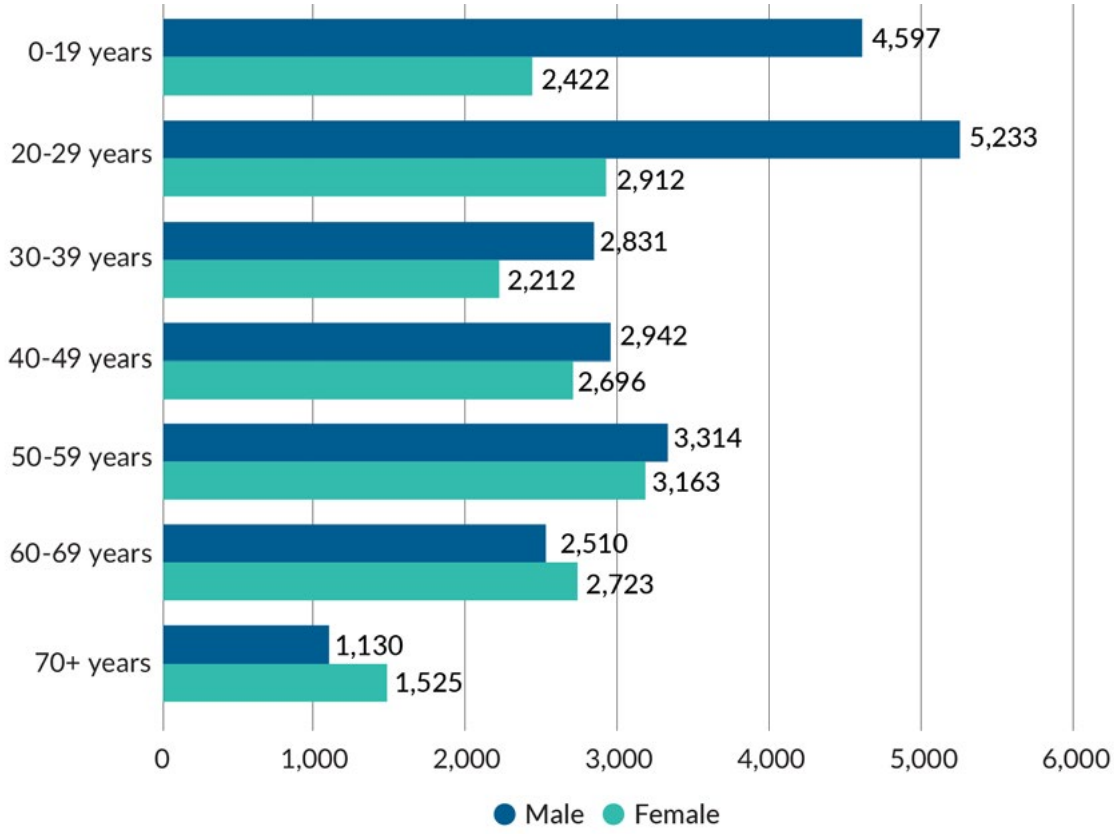
7.4.1 Overview of people receiving support for disabilities

To make an assessment on the adequacy of services for people ageing with any disability, it is important to understand the level of potential need for support. All individuals who receive or require an HSE-funded disability service due to an ID, or a persistent physical, sensory, neurological, learning, autism spectrum, and/or speech/language disability arising from disease, disorder or trauma, should be registered on the National Ability Supports System (NASS).[95] This data gives an indication of current and future numbers of people who will be ageing with existing disabilities, although these numbers almost certainly be a underestimate of the number of people needing support. Many people never register with the NASS system and only become known to services when they experience a crisis and have immediate service needs later in life.

95. This compares to the National Intellectual Disability Database (NIDD), to which returns were made on a voluntary basis with those in receipt of services or their next of kin being required to give their written consent [325]. See Brick, A., C. Keegan, and M.-A. Wren, 'Utilisation of Specialist *Disability Services in Ireland*: Baseline Analysis for the Hippocrates Model', *ESRI Survey and Statistical Report Series* 89 (2020), Dublin: ESRI.

Despite this caveat, the latest available data provide a breakdown by age and gender of all 40,210 people using HSE-funded disability services in 2024 [286]. 34,652 (86%) were aged 18 and older. There were greater numbers of males than females in all age categories below age 59. The greatest number of women were in the 50–59 category, while the greatest number of men using HSE disability services were aged 20–29 (Figure 7.1).

Figure 7.1: Number of service-users registered in disability services on NASS by age-group and sex, 2024



Source: Supplementary Tables [286].

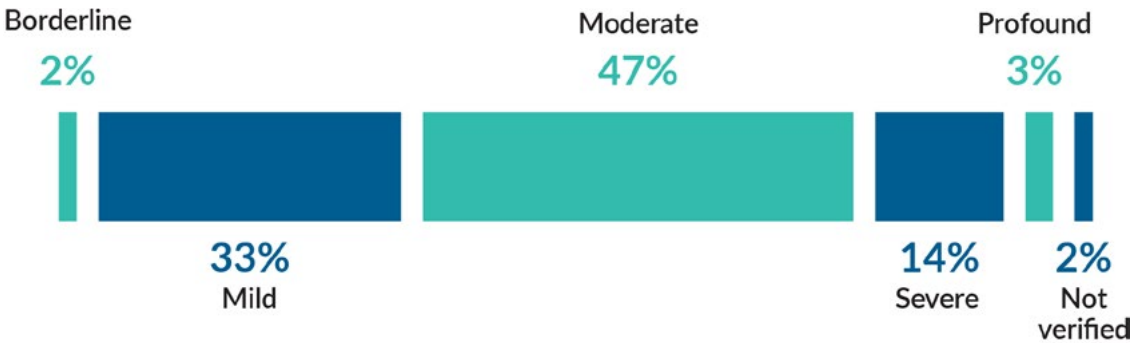
19,261 (55.7%) of all adult disability service-users reported having an ID as their primary disability type, followed by 6,068 people (17.5%) with neurological conditions and 3,146 (9.1%) with autism, 2,908 (8.4%) with physical disabilities and 2,619 (7.6%) with visual and/or hearing impairments [286].

Less than 2% had a mental health condition, or a specific learning difficulty other than ID as their primary type of disability. People with ID face an increased risk of mental health problems from a combination of biological, psychological and social factors, with prevalence rates much higher than the general population ranging from 40–50% [326, 327]. IDS-TILDA confirms continued high levels of mental diagnoses across survey waves, ranging from 49.9% in Wave 1 (2010–2011) to 44.4% Wave 5 (2023) [328].

In 2023 anxiety (24.1%) and depression (13.0%) were the most common conditions reported. Diagnosed mental health conditions are most prevalent in those aged 65 and over (54.6%), compared to people aged 50–64 years (46.6%) and under 50 years (27.9%) respectively. Overall, this level of poor mental health is much higher than that reported by TILDA for the general population aged 50 years and over.

NASS also reports on the severity of ID (Figure 7.2) 17% have a severe or profound disability, with another 47% having moderate disability [329]. These percentages have also been found to be consistent over time [325].

Figure 7.2: Degree of intellectual disability (all adults)



Source: [286].

7.4.2 Current provision of services and supports

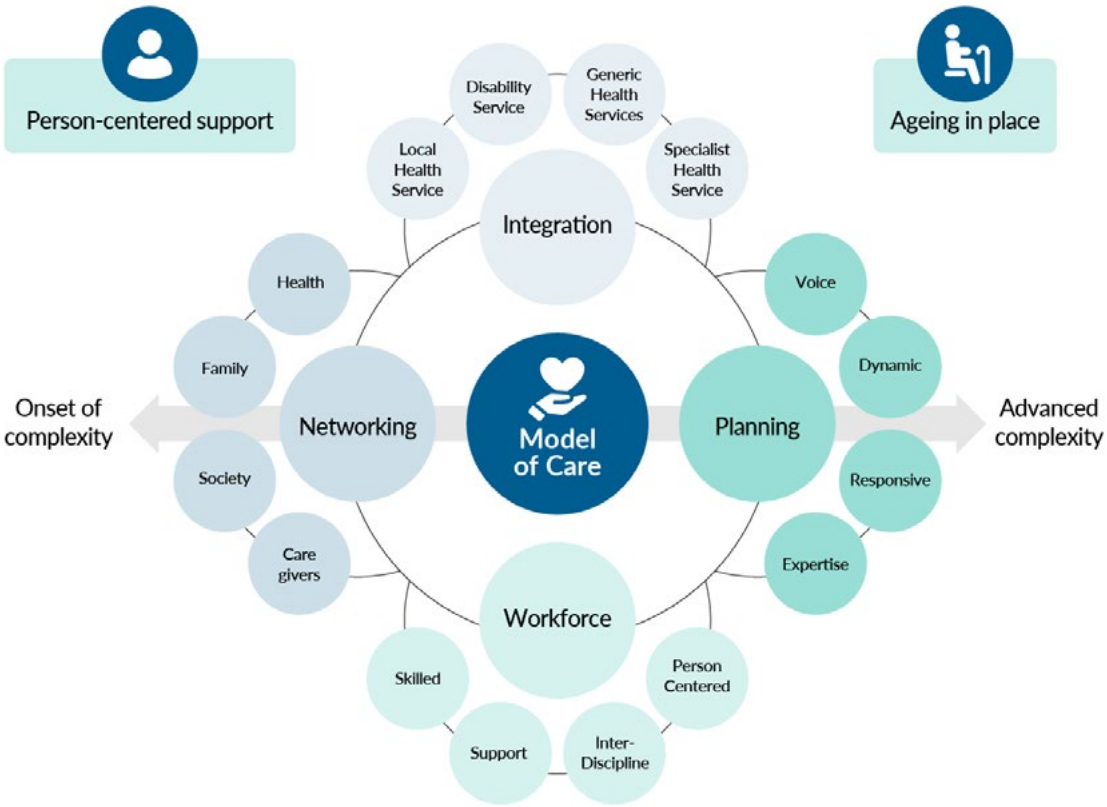
This section focuses primarily on the experience of people ageing with ID, although some of these experiences will also be relevant to people with other disabilities.

The mix of services that should be in place to support people with disabilities as they age is complex. A mixed-methods study commissioned by the National Disability Authority did not find any specific model of care for older people with disabilities, indicating that this increased the risk of widening health and other inequalities compared to the general older population. It found the need for tailored information, care and resource for dementia was a particular issue of concern [330, 331].

The report noted that 'in the absence of a dedicated, structured approach [to service-provision], intellectual disability services, staff and family members have had to develop alternative possibilities, often an eclectic mix of health and social care provision often cobbled from adjustments to services for other age groups, to provide the support required for people with intellectual disabilities to achieve healthy ageing' [330].

Figure 7.3 provides an illustration of the prospective components of an integrated model of care, highlighting the role of services in helping people to age in place while providing person-centred support. This includes future-planning and networks of formal and family support.

Figure 7.3: Components of a model of care for older people with intellectual disabilities and age-related complex needs



Source: [330].

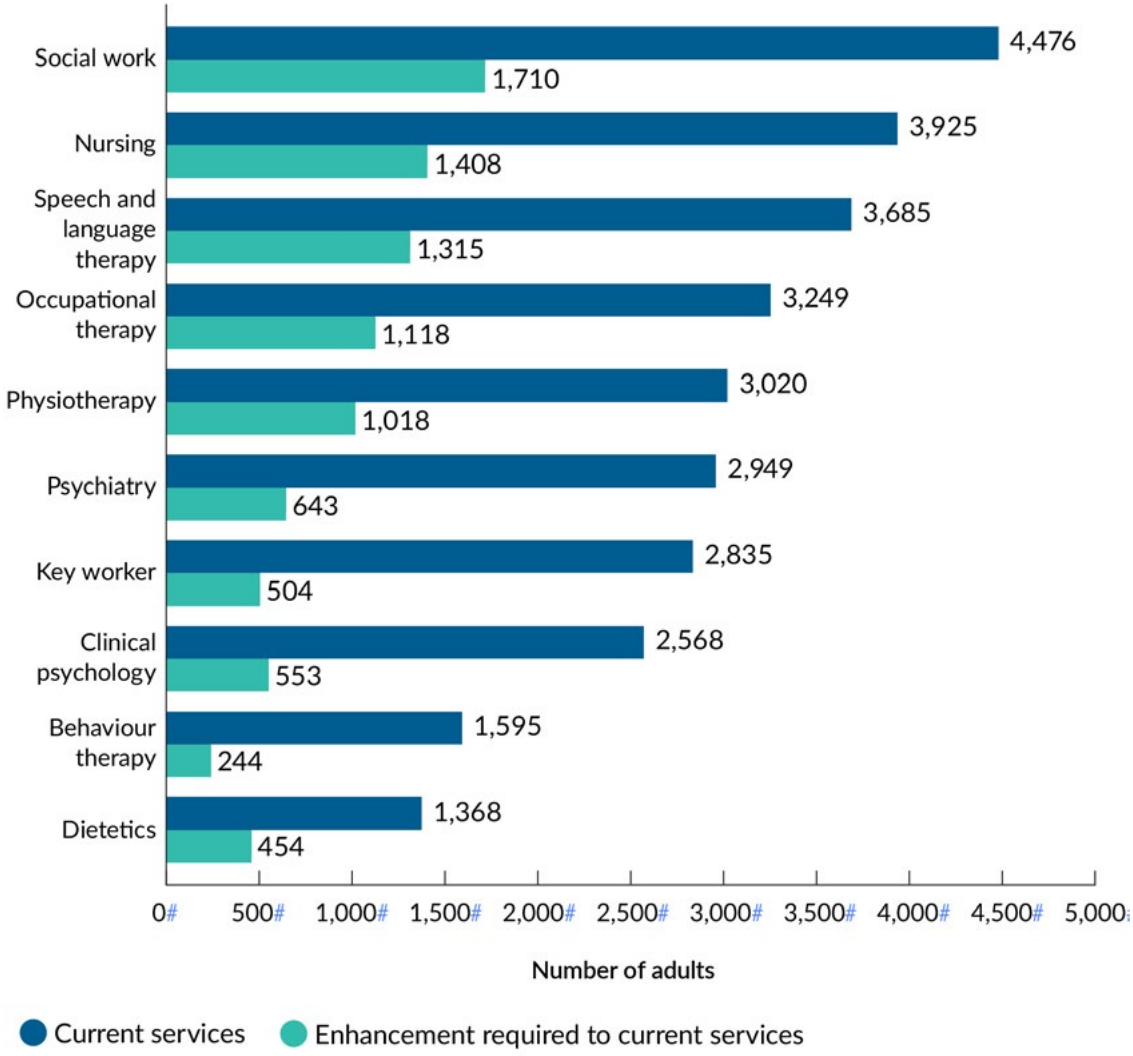
Information is available from NASS on the HSE-funded disability services that people currently use. In addition to residential support, services provided to adults with disabilities include assisted living services, as well as respite (day and overnight) services. The use of services differs substantially between people with ID and those with physical or sensory disabilities.

Looking at data from 2023, 2,688 people with ID of all ages were making use of assisted living services (2,423 home support; 299 personal assistants). 2,783 adults also made use of overnight respite (median 18 nights), and 599 used day respite [329]. For people with physical or sensory impairments, 3,371 adults and 130 children were making use of assisted living services (2,128 home support; 1,526 personal assistants). 351 adults (all ages) used overnight respite (median 12 nights), with just 14 using day respite.

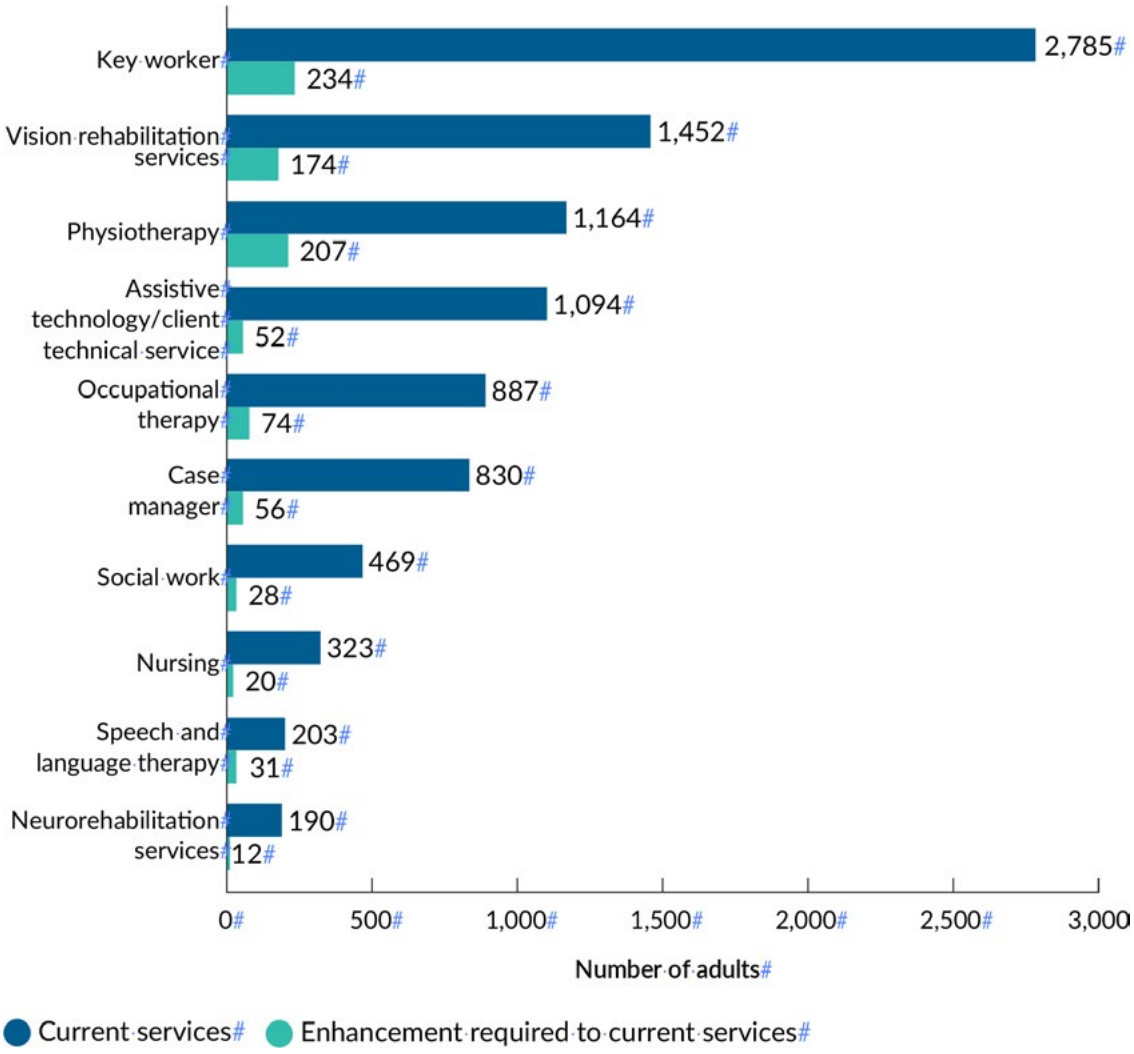
Figure 7.4 shows the use of various support services in 2024 for adults with disabilities. It also shows the number currently waiting for further enhanced care to meet their needs, such as additional hours of support. This level of unmet need is much greater for people with ID.

Figure 7.4: Most commonly received support services for adults on NASS by primary disability (places currently being accessed and enhancements required to current places), 2024

Intellectual Disability



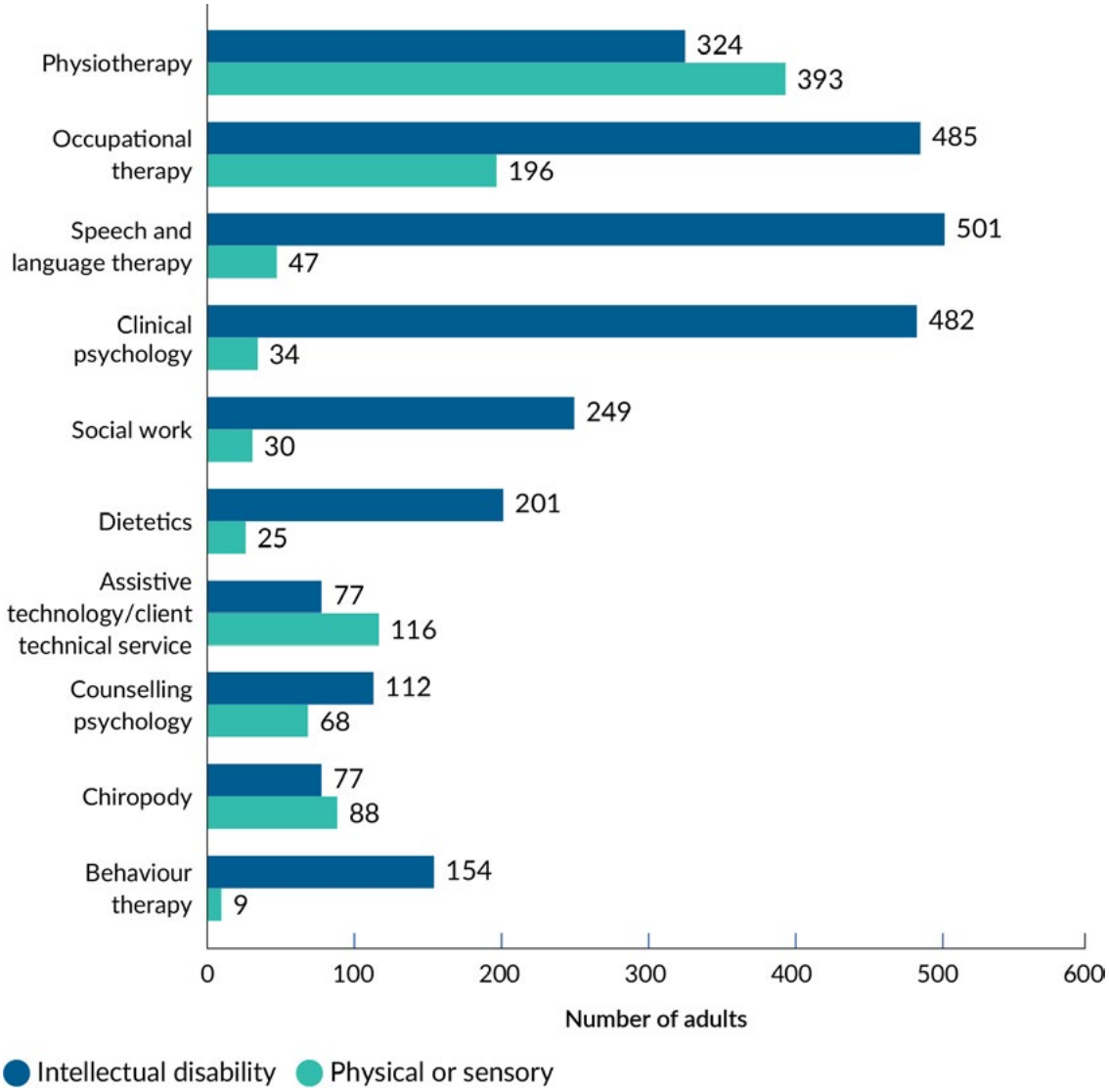
Physical or sensory disability



Source: [286].

NASS also collate information for adults who are not yet in receipt of a particular type of service but who need it now or will need it within the next five years. Once again there are concerns that not all of those who may be in need of services now, and who may need services in the future, are registered with NASS. However, 2,044 adults, were newly identified as needing residential services in 2024, of which 1,833 (89%) have an ID. 59% of all those in need of residential care are over the age of 35 [286]. In addition, 709 people (65% over 35) are in need of assisted living services. 59% (416) have an ID and are in need of home support (355) or a personal assistant (84) [286]. The number of adults waiting for a whole range of support services, is often much higher for people with ID compared to people with physical or sensory disability (See Figure 7.5).

Figure 7.5: Most commonly required support services for adults on NASS with a primary disability of ID or physical or sensory disability, 2024



Source: [286].

7.4.3 Housing

In the 'Supported living' chapter we looked at supported living arrangements in Ireland for older people. The need for housing that can accommodate different levels of independence and need is very similar when looking at ageing with disabilities. In the 'Supported living' chapter we discussed in detail some of the messages that have come out of the recent *Report of the Housing Commission* [147]. The *Report of the Housing Commission* makes it clear that there are shortages in general housing stock and that the number of social homes built in Ireland is low by international standards.

In that chapter we also look at funding through the CAS, which is a key source of funding used by Approved Housing Bodies to fund social homes, including those for people with disabilities. The 'Supported living' chapter indicated CAS funding has declined substantially in recent years, meaning that on average fewer than 500 social homes in total have been built each year over the last decade. The Housing Commission concluded therefore that the 'output of supported housing is below the level of need for people with disabilities, as identified in the social housing need assessments'.

The Housing Commission called for an increase in the availability of appropriate housing built using universal design principles[96]. In addition, they also noted a need for raising the grant limits and thresholds on Housing Adaptation Grants to better meet the needs of people with disabilities (See the 'Supported living' chapter for more on this issue).

7.4.4 Designated residential centres for people with disabilities

In 2023 there were 1,574 designated centres for residential and respite care for people of all ages with disabilities, provided by 90 registered provider-organisations. There were 9,147 places in these 1,574 designated centres [332]. The vast majority of places are for adults; in 2024 there were 192 children with disabilities using residential care services [286].

Table 7.1 shows the ten largest registered providers in 2023 of designated centres. The Brothers of Charity run 12% of all designated centres followed by the HSE with just over 10% of all designated centres. Eight of the ten largest registered providers are not-for-profit (voluntary sector) organisations. Collectively these 10 organisations have increased the number of designated centres they operate by almost 25% over the six-year period. Only one of the ten largest registered providers, Nua Healthcare Services, is a for-profit private-sector organisation. Overall, out of all 90 registered providers, only 26 are for-profit organisations, and the involvement of the private sector in residential care for disabilities (unlike residential care for older people) is a recent development.

Table 7.1: Ten largest registered providers and number of designated centres, 2018–2023

Registered provider	2018	2019	2020	2021	2022	2023
Brothers of Charity	152	166	175	182	191	194
Health Service Executive (HSE)	122	138	142	152	159	164
St John of God Community Services	86	91	93	95	100	105
Avista (formerly Daughters of Charity)	87	89	94	95	97	100
Muiríosa Foundation	68	74	83	84	85	92
Nua Healthcare Services	40	48	56	65	71	79
St Michael's House	76	77	78	78	77	77
The Rehab Group	55	61	63	62	65	68
COPE Foundation	39	40	42	44	43	47
Western Care Association	35	35	35	35	35	44
Total designated centres	**760**	**819**	**861**	**892**	**923**	**970**

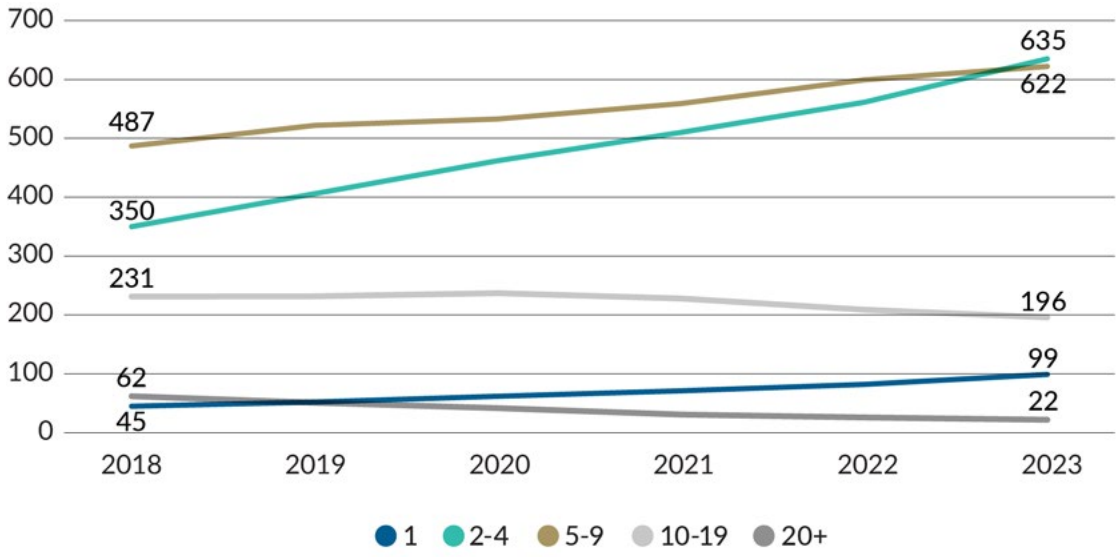
Source: [332].

96. For instance see https://agefriendlyhomes.ie/topics/design-build-information/universal-design/.

The number of places in these designated residential centres, either directly provided or funded by the State, for all people with disabilities has changed little between 2018 (8,894 places) and 2023 (9,147) [332]. So even with decrease in the number of people with disabilities in congregated settings, there is a continuing demand for residential places, which may suggest that alternative community-based services and supports are insufficient.

In 2023 more than 90% of adults with disabilities living in residential settings had ID [333]. A positive development has been the shift towards more places being located in residential settings with 2–4 places, with a reduction in the use of settings with more than 10 places (Figure 7.6); hence the increase in the overall number of designated centres in Ireland. One caveat though is that some of the larger campus-style congregated centres that have closed have been split up into smaller residential units still located on the same campus.

Figure 7.6: Number of designated centres according to categories of bed-numbers*



Source: [332].

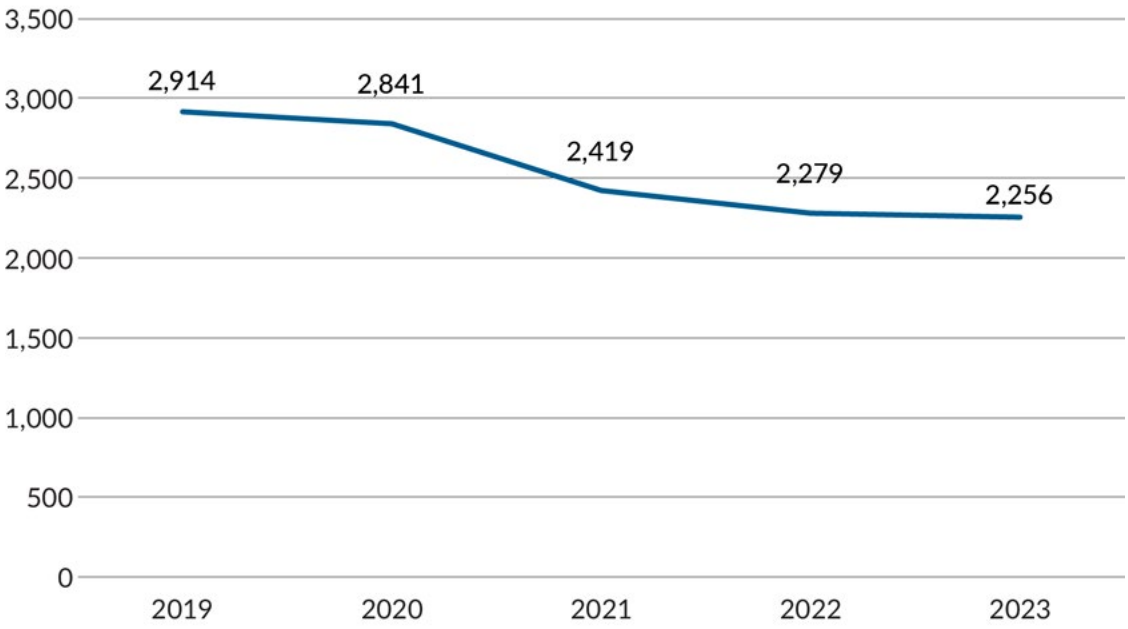
Notes: * The availability of bed-number data prior to 2018 is limited as only centres that had been fully registered were counted. In 2018, the Chief Inspector completed the initial registration of all designated centres for people with disabilities. As such, reporting data before 2018 could be misleading.

Looking specifically at the use of congregated settings, placements have almost halved since the publication of *Time to Move On from Congregated Settings* in 2011, when there were more than 4,000 residents (93% with ID). These numbers have been reduced over time through the deaths of those living there as they have aged, as well as by some moves back to the community. However, HIQA have noted that:

> While there has been some progress towards this goal, the target for completion (2018) has long passed and by the end of 2023, almost 25% of all people with disabilities living in designated residential centres were still living in congregated settings [332].

Figure 7.7 shows that the rate of reduction in the number of placements in congregated settings has slowed considerably, something which HIQA states is concerning and which could mean that it is many years before these settings are phased out.

Figure 7.7: Number of places in congregated settings, 2019–2023



Source: [332].

This is consistent with data from IDS-TILDA which show a significant shift away from residential care settings. In 2011 (Wave 1), 47% of participants lived in residential care. By 2023 (Wave 5), this figure had declined to 28.5%, with those remaining in these settings typically having severe-to-profound ID and complex health needs. The shift is even more pronounced among younger cohorts. Among participants under 50, the proportion in residential care dropped from 44.8% in Wave 1 to just 7.7% in Wave 5, an indicator of the broader success of de-congregation policies and increased community-based support.

However, this trend also reflects a growing reliance on family carers, particularly ageing parents and increasingly, siblings. While many older adults with ID now live with family members, these caregivers are themselves ageing and often managing their own health challenges. This raises serious concerns about the long-term sustainability of care. Findings from the IDS-TILDA Carer Study reveal a clear generational shift in caregiving responsibility from parents to siblings. While most carers reported positive emotional rewards, such as feeling useful and needed they also identified significant challenges, including being constantly on call, high levels of stress, and emotional strain [334].

In their review of disability social care demand and capacity requirements up to 2032, the Department of Health has indicated that additional funding may be needed to complete the transition of people from congregated settings to the community. This is because there may be dual costs associated with supporting people living in the community, while at the same time having to maintain funding for those people still in congregated settings. This need for dual funding was previously seen during the process of shifting from institutional to community-based care for people with mental health conditions in many European countries [335, 336].

The Department of Health also suggests that there may be a loss of economies of scale as a result of a move away from group-based residential care. They note that:

> Supporting people in community housing can require higher staffing costs, e.g. due to the requirement for night staffing ratios to ensure safe evacuation in case of fire, and additional dedicated time for a greater number of Person-in-Charge roles [337].

There will also be a need for further capital investment to ensure appropriate housing is available.

While funding constraints are a legitimate concern, they do not constitute a sufficient justification for reversing or stalling progress toward community living, particularly in light of existing Government policy and Ireland's obligations under the UNCRPD and robust evidence demonstrating improved quality-of-life outcomes in smaller, community-based settings [324].

A more sustainable and rights-aligned approach would involve expanding community-based options such as respite care, individualised budgets, enhanced day programming, and home support. These measures could extend the time individuals with disabilities remain in the community, reduce reliance on more costly residential placements and improve overall quality of life [338].

There is also a lack of innovative, community-based housing solutions, such as wellness-focused village models, in which small groups of individuals live together in ordinary homes within integrated, supportive neighbourhoods. These settings offer a more dignified, person-centred alternative to large-scale residential care, aligning with both human rights principles and evidence-based best practice in ageing and disability support.

7.4.5 Use of LTRC homes

In 2024 1,242 adults under 65 years of age were funded via the NHSS to live in LTRC (nursing) homes. There were approximately 27 new admissions every month [339]. This trend raises significant concerns as nursing homes are often ill-suited to the needs of younger people, particularly in terms of social engagement, peer relationships and opportunities for independent living [340].

This data suggests that nursing homes are being used as default long-term residential placements, rather than as settings for short-term or end-of-life care. In Ireland, the average length-of-stay in a private or voluntary-sector nursing home (which together account for more than 80% of all places) in Ireland was 2.5 years [183], which is similar to that seen in several other European countries [341]. However, Freedom of Information requests in 2023 also indicate that the average length-of-stay in nursing homes in Ireland for younger people, the majority of whom are aged between 40 and 65 was 4.5 years [342]. If Ireland were to even more fully align with international best practice—viewing nursing home care as a time-limited, high-support option for the final stages of chronic illness, paired with strengthened community-based services to delay or avoid such placements—any concerns over undue length-of-stay could be substantially mitigated.

The 2021 Ombudsman Report, *Wasted Lives: Time for a Better Future for Younger people in Nursing Homes*, examined and considered the impact on people aged under 65 years of age of living in nursing homes [210]. Some younger nursing home residents described being isolated from family and friends, and having a lack of social engagement, particularly as many older residents were living with dementia. The report made several recommendations aimed at both improving the quality of life of younger people who choose to remain in LTRC homes and providing meaningful support for those who wish to transition out. This report may also have lessons for the way in which nursing homes can support all people (including those with disabilities) over the age of 65: lives do not stop being 'wasted' when people turn 65.

Emerging models highlight how person-centred support plans can be developed by redirecting funding up to the equivalent cost of a nursing home placement towards tailored community-based alternatives. Additionally, tools such as interRAI and other standardised assessment frameworks can be used, not only to evaluate eligibility for LTRC and home support but also to identify less costly, more appropriate options that enhance independence and quality of life. These approaches support more responsive, rights-based care-planning that aligns with individual needs and preferences. The utility of tools such as interRAI needs further consideration before implementation for people with ID, and the building of recommendations for nursing home alternatives must be considered.

There are also case-management models to review the suitability of each nursing home placement and to support requests for alternative support. In a 2024 update, the Ombudsman has called progress to address concerns slow, citing a lack of funding being a barrier to people under 65 leaving nursing homes [343]. As long as NHSS funding remains restricted solely to nursing home placements, it will continue to act as a barrier to more flexible, person-centred care-options. The lack of support under the NHSS for home support and other community-based services means that there remains an opportunity to significantly improve the availability of alternatives that better align with the needs and preferences of people living with long-term disabilities.

7.4.6 Future funding needs

More generally, funding is a concern. As the population grows and ages, there is evidence that large increases in funding will be required to keep up with increased demand for disability care. The Department of Health projects that, relative to a 2018 baseline (of around €2 billion of 12.3% of current HSE spending) [325], spending on disability care in 2032 would need to be €550 million–€1,000 million higher *per annum* to address unmet need in the system [337]. Capital expenditure would also need to increase. The Department of Health also projects that, relative to a 2018 baseline, additional capital spending for housing to meet residential care needs and complete the closure of residential institutions could cost between €500 million–€800 million over the period to 2032.[97] Most of this will be to support continuation of care for those currently served and does not provide for the anticipated increase in numbers seeking care.

7.4.7 Older carers of people with disabilities

Older primary family carers of people with disabilities, including parents and siblings, will also need more support. NASS data for 2023 indicates that 14,274 (60%) of adults on NASS reported having a primary carer [333]. When age was reported, 41% (4,739) of carers were 60 years and over, including 1,494 aged between 70–79 years, and 471 aged over 80. There may be more carers for people who are not on the NASS system.

Older people with ID may experience a shrinking social network in later life as they out-live their family members, some of whom may be their main caregivers. A decrease in the opportunities to interact with family members and changes in caregivers can lead to social isolation and increased sense of loneliness [344]. However, there does not appear to be any structured approach in place to consider carer succession planning.

Succession planning plays a vital role in identifying the types of care and support needed when a primary family carer is no longer available, particularly as health-needs increase with age or become more complex. A recent systematic review has shown that this lack of proactive planning is not unique to Ireland but is also a concern internationally. The review further highlights a lack of robust evidence on the effectiveness of supports for family carers, who are often older adults themselves [345].

Critically, there is no evidence to date on how providing supports earlier in the caregiving journey might influence future care outcomes. Research in Ireland did find that when family solutions such as sibling caregiving were not available, individuals and families faced severely limited options for planning future care and accommodation. The study suggested that strengthening the capacity of people with intellectual disabilities through in-home supports and independent living skill-development may form a key part of future planning in such cases [346].

97. These figures do not include capital cost inflation that has occurred since 2021.

7.5 Effectiveness

7.5.1 Care-pathways for people ageing with intellectual disabilities

A recent review and mixed-methods study conducted by the Trinity Centre for Ageing and Intellectual Disability highlighted the lack of care-pathways to promote health ageing and ageing in place as well as to address the complex healthcare-needs of older people with ID. The authors argued that this contravenes the right to equal access to general and specialised care asserted under Article 25 of the UNCRPD to achieve the highest attainable standard of health without discrimination [331].

The same report also highlighted limitations affecting both the professional workforce and family/unpaid carers. It noted that different patterns of staffing and skill-mix are required to meet the needs of older people with ID compared to those required to meet the needs of younger people with ID. It also noted a need for additional training to build the knowledge and skills of both professionals and family/unpaid carers on the specific issues around ageing with ID as well as on person-centred approaches to the provision of support and care.

7.5.2 Differential experiences and impacts on fundamental rights in community and congregated settings

HIQA has highlighted that the experiences of people living in congregated settings are poorer than for people in living in other residential settings. It noted that 'some residents spent the majority of their time doing very little, without meaningful contact or engagement during the day' [347]. A 2020 inspection report also found that:

> Residents living in campus-based or congregated settings experienced disparities in the quality and safety of their care and in their ability to independently exercise their rights, compared with residents living in community settings.[98]

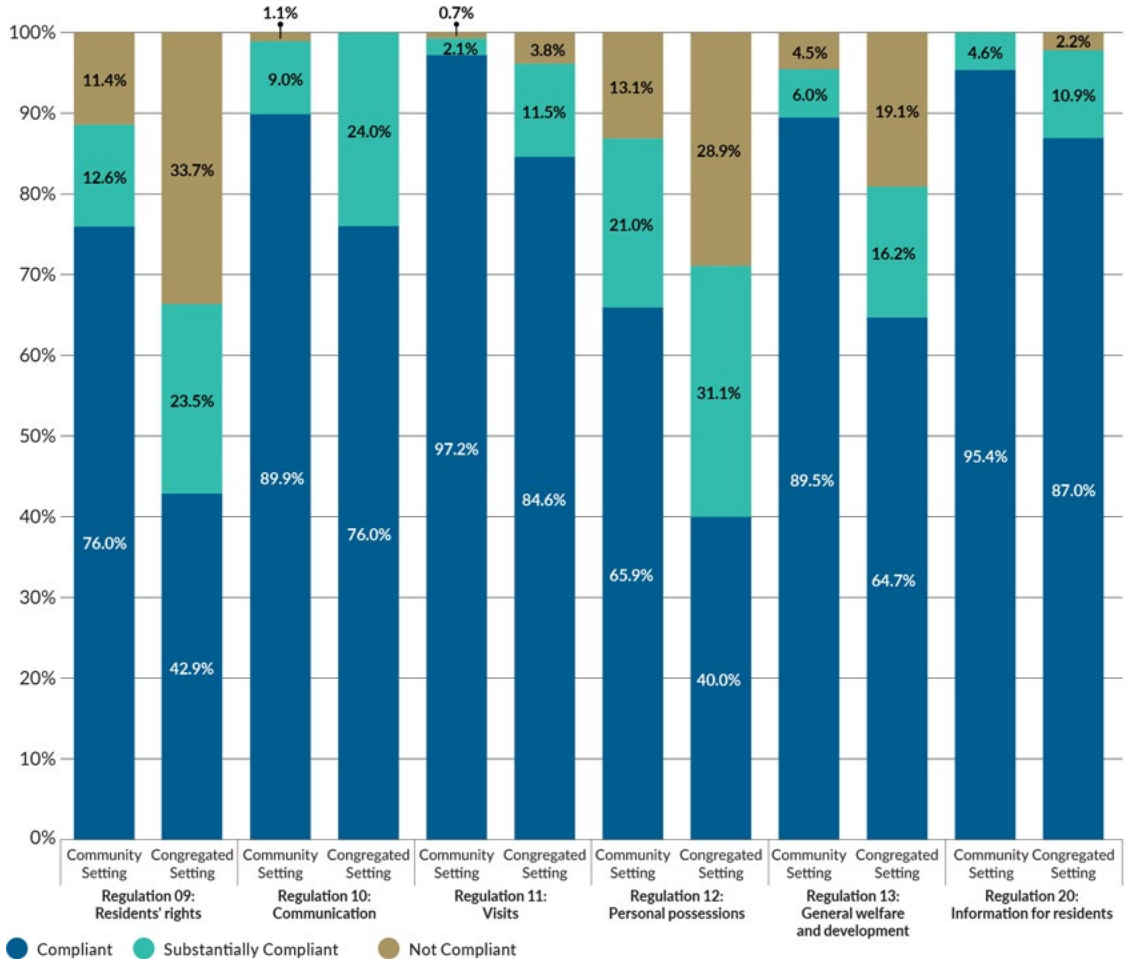
It is acknowledged that the care needs and the impact of underlying intellectual disabilities and of co-occurring chronic conditions is likely to be greater for those living in residential settings. That said, it is important to pursue optimum quality of life for everyone with an intellectual disability regardless of setting.

98. https://www.hiqanews.com/residents-in-campus-based-or-congregated-settings-experience-poorer-quality-of-life/.

Although people with ID still residing in congregated settings are likely to have higher rates of severe and profound ID than people in other residential settings, overall, in 2023 the level of non-compliance with all regulations in congregated settings was almost twice that for non-compliance in community residential settings (18.4% versus 10.8%). For example, Figure 7.8 compares rates of compliance between congregated and community settings for several rights-based regulations. A third of congregated settings were not compliant with regulation 09 on resident's rights. This includes the standard that 'each person exercises choice and control in their daily life in accordance with their preferences' and that 'each person makes decisions and, has access to an advocate and consent is obtained in accordance with legislation and current best practice guidelines' [348]. Congregated settings were also much more non-compliant in respecting and protecting the personal possessions of residents, as well as for the regulation on general welfare, which includes a standard that 'each person develops and maintains personal relationships and links with the community in accordance with their wishes' [348].

Findings from five waves of IDS-TILDA support this, with consistently poorer outcomes regarding social networks and interpersonal relationships, community participation, and overall quality of life for people living in residential care compared with community-based residences. In systematic reviews while findings on cost-effectiveness on the movement of people with intellectual disabilities from residential to the community were mixed [349], consistent findings for improvements in quality of life were reported [324].

Figure 7.8: Comparisons of rights-based regulations in congregated and community settings, 2023



Source: [332].

7.6 Efficiency

7.6.1 Imbalance in incentives for the use of LTRC versus home support

There are more than 1,200 people under the age of 65 in nursing homes for older people, with 27 new admissions every month. The Ombudsman's *Wasted Lives report* [210] highlighted problems with the current funding model which favours residential care rather than home support. The report stated that:

> The funding systems are balanced in favour of nursing home care. There is a statutory entitlement to funding under Fair Deal, but no statutory scheme to support people in the community. There is no proper co-ordination between services. At worst, this means that people can have access to a suitably adapted house, but can't access funding for the support they need to live in it.

(Similar concerns are seen in the 'Residential care' chapter of this report).

As well as potentially meaning that principles of choice and autonomy may be breached (the Ombudsman raised concerns over whether people with disabilities fully understood what they were doing when signing NHSS forms), there are additional financial and other barriers to overcome to help people leave nursing care when they choose to do so. The Department of Health has estimated that the additional costs per year of moving younger people who are inappropriately in nursing homes to an alternative disability-specific residential support package could be €80,000 *per annum* [337].

The use of nursing homes by younger people also points to the lack of appropriate community services for people living with disability, for instance when people need to be discharged from hospital [340]. This chapter has previously noted that there is a shortfall in assisted living housing for people with disabilities.

7.6.2 Inefficiencies in resource-allocation

The Department of Health is set to introduce population-based resource-allocation (PBRA) funding for health and social care for the first time in Ireland in 2025. This will apportion funding to the new HSE Health Regions based upon the composition of the population in terms of size, age and sex as well as deprivation and rurality [350]. However, this new funding structure is explicit in stating that disability funding will not be included, at least initially [351]. The exclusion of disability funding within the PBRA mechanism, differs from the approach used in England, Scotland, and many other countries. This exclusion may also impede any moves to create integrated pathways of care for older people with disabilities as these typically need to have more flexible funding arrangements in place through formal contractual or voluntary arrangements [352].

There are also concerns that the specific needs of people with intellectual disabilities may be overshadowed by those of larger, more vocal, or more politically mobilised groups, echoing patterns seen in previous policy eras. Equal allocation of resources across populations does not necessarily equate to equitable outcomes. For people with lifelong disabilities, whose needs are often more complex and cumulative over the life course, parity in funding may in fact result in insufficient support. Tailored investment is essential to ensure this population is not left behind in broader ageing and disability policy developments.

A further complication of funding for care for older people with disabilities is that a substantial proportion of care is provided by the not-for-profit (voluntary) sector. These bodies are ordinarily funded via block-grants, which are less favoured by health economists as it is often difficult to de-couple the funding amounts provided from historic grants, and block-grants make it difficult to incentivise efficiency in resource-use.

The HSE's 2023 *Roadmap for Service Improvement 2023–2026: Disability Services for Children and Young People* highlighted the need to integrate services. It outlined a roadmap that contains a detailed plan of SMART (Specific, Measurable, Attainable, Realistic and Timely) actions to integrate services between HSE disabilities, primary care, mental health services, and Tusla (the Child and Family Agency)[99] [353]. However, this proposed integration is difficult when different funding sources are used, a large number of providers is involved, and health information system inadequacies make communication and coordination difficult.

There has also been some consideration of moving away from block-grants to service-providers towards more personalised resource-use allocation, including the possibility of personal (also known as personalised) budgets [337]. A Taskforce set up to look at personalised budgets specifically for people of any age with disabilities within the scope of HSE-funded personal social supports and services had recommended that, before large scale implementation, demonstration personalised budget schemes should be set up and evaluated [354].

In response to this recommendation, the 'Personalised Budget Demonstrator Pilot' was launched in August 2019 with expressions of interest for participation sought from disabled adults in receipt of HSE-funded specialist disability services. At present, there are approximately 130 active participants with disabilities in the pilot, with more than 50 participants at Stage 4, the 'living life' phase.

Led by the National Disability Authority, an evaluation of the pilot is due to commence shortly and is expected to be completed by the end of the year. The main data-collection method for the evaluation will be post hoc interviews with pilot participants about their experiences of the pilot. By gathering data in this way, the evaluation should provide critical insights into the barriers and facilitators to rolling out personalised budgets on a larger scale while ensuring that the experiences of disabled people inform the next steps towards developing an effective model for personalised budgets in Ireland.

99. Tusla was established in 2014 and is the dedicated State agency responsible for improving wellbeing and outcomes for children (https://www.tusla.ie/).

7.7 Limitations

There are multiple sources of data on disability in Ireland. However, there are limited data on the ageing trajectories and life-experiences of people with life-long disabilities. This is compounded by significant data-deficits in the area of disability services which makes it difficult to fully capture disability service-need [325], though improvements have occurred since the introduction of the NASS.

More is known, however, about the experiences of the ID population because IDS-TILDA has filled much of this gap with comprehensive longitudinal data on ageing and related service-needs in support of health, wellbeing, and inclusion for this cohort. There is a pressing need for longitudinal research to examine the biopsychosocial ageing-trajectories of individuals with other pre-existing disabilities (e.g. cerebral palsy). Such research will be vital in identifying the determinants of accelerated ageing and in designing evidence-based, targeted interventions to improve health-outcomes and quality of life for these often-overlooked and underserved populations. This work will support more equitable and informed policy-development across health and social care systems.

7.8 Learnings

Ireland has moved towards a human rights-based and social model of care and support for people with disabilities, as reflected in the publication of the *National Human Rights Strategy for Disabled People 2025–2030* [318]. This is more advanced than seen for older people, in part because of the existence of the UNCRPD. This is backed up by a range of policies and strategies across different sectors to support people with disabilities, which are intended to align with the UNCRPD. There is an opportunity for the ageing sector to learn from the experience in the disability sector, given that there is a framework in which autonomy is important, which is not seen to the same extent in age-related policy and practice. The disability sector has also generally focused more on an empowerment-based model.

In 2024 there were 20,003 people with any disability over the age of 40 in receipt of HSE-funded, disability-related services and supports [286]. They make up 58% of all adults receiving these services. Roughly 56% have a primary diagnosis of an ID. 52% of all people with ID registered with disability services in 2023 were aged 40 or older [329]. The need for complex services and supports is pronounced in the ID population, given that they have a much lower life-expectancy than the general population and can 'age' more quickly. For example, they have a much higher risk of developing dementia, in addition to higher risks of multi-morbidity.

The delivery of services and supports is complex and fragmented, making it difficult to determine the extent to which needs are being met. However, data are available indicating that substantial numbers of people with disabilities are waiting for both residential and community-based services [329, 355].

Longitudinal evidence from IDS-TILDA has also identified significant disparities in health-outcomes and higher preventable mortality, which raises concerns about inequitable healthcare access and utilisation [290]. There is also a need for more focus on workforce. Any movement toward shared resources with other ageing groups requires that the ageing, home support, nursing home and healthcare workforces must be adequately trained to work with people with intellectual disabilities and their family/unpaid carers.

There is currently a lack of an approach to forward care-planning to replace the care by family/unpaid carers when they are no longer available. The Housing Commission also makes clear that there is an inadequate supply of appropriate social housing for people with disabilities, which in part reflects broader issues of supply and regulation in the housing sector. The system of care has been focused on those who were previously in congregated settings and on current older adults. As well as the need to support such individuals, future needs will be impacted by the imperative to address increased longevity and the reality that fewer individuals with ID will be in congregated and provider-delivered care. This means changing from the reliance on building and regulating housing. Issues to consider include alternative models, such as individual budgets, and changing from a crisis-oriented to a planned and expected approach to the inevitability of ageing. Ireland is not alone in facing these dilemmas.

Limited availability of suitable, tailored and planned support for all of the health and social care needs of people ageing with a pre-existing disability may also mean that they are more likely to enter residential care prematurely. In policy over the last 15 years, much attention has focused on moving people (largely with intellectual disabilities) out of congregated settings (settings with more than 10 places) into smaller community-based settings. Much progress has been made, although approximately 25% of all adults with disabilities are still in congregated settings. Evidence from HIQA indicates that the risk of non-compliance with regulatory standards, including on fundamental human rights, is much higher in congregated settings than in community settings.

There are more than 1,200 people under 65 who are in nursing homes. While this will be appropriate for some, and reflect their informed choice, for many others nursing homes are not a suitable type of accommodation and/or placement in nursing homes may be occurring much earlier than is necessary given the absence of alternatives. The Ombudsman raised issues concerning the fundamental rights of individuals and called for more to be done to assist people who want to move out of these nursing homes to do so as soon as possible. Both as a reason why people may end up in nursing homes, and as a barrier to accessing other alternatives, the statutory financial support from the NHSS is for nursing home placements; there is a lack of a similar statutory home support scheme to enable ageing in place.

More generally, the current funding approach does not fully help provide more individualised tailored care and support as it does not fully allocate resources on the basis of need. This may hinder better integration of disability care, healthcare, and social care as well as training needs across these sectors. Health inequalities between people ageing with disability and the rest of the older population will continue to widen without attention to change. The new PBRA scheme for resource-allocation addresses some concerns but does not appear adequate to encompass disability.

More focus needs to be placed on strengthening the advocacy for people ageing with disabilities to make choices about all aspects of their lives; potentially funding mechanisms that allow flexible use of funding to obtain services across multiple sectors can help empower people. Personalised budgets may be one possible approach and the evaluation of pilot schemes in Ireland is due to be completed soon. More work also needs to be undertaken to understand the needs of groups of people ageing with conditions other than intellectual disabilities, as this evidence both in Ireland and internationally appears to be limited.

7.9 Strengths, weaknesses, opportunities and threats

Strengths

- A focus on disability rights in policy for two decades.
- The UNCRPD underpins policy-development and there is a move towards a much more human rights-based (rather than a medical) approach to care and support for people ageing with disabilities.
- The Assisted Decision-Making (Capacity) Act and HIQA regulations also place an emphasis on choice, autonomy and the protection of human rights.
- The National Disability Authority can play an important role in helping progress policy.
- Recognition of the importance of moving away from congregated settings.
- Comprehensive data through IDS-TILDA to inform policy and resource-allocation decisions.
- Despite workforce challenges, people with intellectual disabilities in Ireland have access to Specialist Registered Nurses in Intellectual Disability (RNID) including at clinical specialist (CNS) and advanced practice levels (ANP) to support their health and social needs.

Weaknesses

- Funding mechanisms that do not fully take disability into account in resource-allocation, which could widen inequalities given the expected increase in number of people ageing with disabilities as the whole population ages.
- A lack of information on the trajectories, needs and experiences of people ageing with existing disabilities in existing health data. (This is partially mitigated for people with intellectual disabilities through the IDS-TILDA).
- The assumption that reliance on constructed housing and provider provision of care and ageing services is the best/only alternative.
- Almost 25% of all designated residential centre places are still in congregated settings[100], in which outcomes and compliance with standards on rights is poorer than in community settings [332].

100. HIQA have noted that *"by the end of 2023, almost 25% of all people with disabilities living in designated residential centres were still living in congregated settings"*.

- Imbalance in funding incentives for use of HSE-funded residential care through the NHSS compared to home support services.
- Health and social care professionals working with older people, both in the community and in residential care settings, may have limited knowledge of the specific needs of people ageing with disabilities, including people with intellectual disabilities. Decision-making by health and social care professionals to the exclusion of the voices of people with ID themselves and of their families may not result in person-desired outcomes. This may increase the risk of poorer health and other outcomes for older people ageing with disabilities.
- Many services for older people with intellectual disabilities have developed in an *ad hoc* fashion; there is limited focus on promoting healthy ageing for older people ageing with disabilities.
- A lack of developed pathways for older people within intellectual disability services and a lack of support to help people age in place in their own homes. A lack of forward-planning to anticipate the changes in the levels of need for support.

Opportunities

- Potential to better integrate disability, healthcare, and long-term care services by expanding the scope of the new PBRA financing mechanism, assuming that the specific needs of people ageing with existing disabilities, including intellectual disabilities, are included in any related allocation formulas.
- There is an opportunity to develop innovative, community-based housing solutions such as wellness-focused village models, in which small groups of individuals live together in ordinary homes within integrated, supportive neighbourhoods.
- Devolution of funding to the HSE Health Regions and Integrated Health Areas can be used to better align disability care, healthcare and long-term care.
- If pilot programmes are successful, the potential expansion of personalised budgets can help empower older people ageing with disabilities to determine what services and supports they want to receive.
- There is also an opportunity for the ageing sector to learn from the experience in the disability sector, given that there is a framework in which autonomy is important, which is not seen to the same extent in age-related policy and practice. The disability sector generally has also focused more on a human rights/empowerment-based model.
- There is a valuable opportunity to learn from the disability sector and apply its person-centred, community-integrated approaches to the broader design of ageing and care models for all older adults.
- There is an opportunity to dramatically improve care and care-pathways by integrating RINDs at CNS and ANP level at primary, secondary and tertiary care.
- Opportunity to build the capacity of mainstream services through disability-inclusive health environments, reasonable accommodations and staff training, which will not only support people with intellectual disabilities as they age but also improve care for the wider ageing population.

Threats

- Policy must move towards a more dynamic and life-course approach to support the planning and structuring of care over time, rather than reacting only at points of crisis or transition.
- Insufficient community-based service-availability, and staffing issues (volume and skill-mix).
- There is an urgent need for policy measures that address structural inequalities, promote disability competence in healthcare, and support inclusive ageing strategies across sectors.
- There is an urgent need for care-pathways for older people with ID to promote healthy ageing and ageing in place as well as to address complex healthcare needs.
- Any movement towards shared resources with other ageing groups requires that the ageing, home support, nursing home and healthcare workforces must be adequately trained to work with people with ID and their family/unpaid carers.
- The population of older people living with a disability is growing and resource requirements will need to increase at a higher rate to meet the growing levels of new and unmet needs.
- Most resource-allocation is focused on supporting the continuation of care for those currently served and does not provide for the anticipated increase in numbers seeking care.
- With a growing population of people ageing with an existing disability, there is a corresponding growth in the population of ageing family carers. As such, without adequately support for family carers throughout the life of an individual with an existing disability, there is an increased risk of crises resulting from the loss of family care and the loss of residence in the family home through the death or incapacity of the family carer.
- As long as NHSS funding remains restricted solely to nursing home placements, it will continue to act as a barrier to more flexible, person-centred care-options.
- The substantial and sustained shortfall in building of new suitable social homes for people with disabilities: without more capital resources for community housing there is a risk of avoidable transfers to LTRC homes.
- Although still a small player, the private sector is beginning to provide more designated residential care for people with disabilities. There may be risks that some populations will not be attractive to for-profit providers, as seen in the LTRC sector for older people.
- Appropriate support and advocacy for people ageing with an intellectual disability need to be addressed to meet the UNCRPD principles. A return prematurely to institutional care would be a serious breach of Article 19 of the UNCRPD and a broken promise to people with ID and their family/unpaid carers.

8

Technology

8.1 Summary

This chapter looks at how technology is currently being used to help support older people in Ireland to age well, either at home or in residential care settings, as well as to meet their care-needs. The chapter covers the use of all technologies and, in particular, focuses on how digital and assistive technologies are now being used to support and transform health and social care for older people. It also looks at issues pertaining to access to more traditional aids and adaptations that have been used to support people, such as access to technologies that help with mobility and with performing basic activities of daily living. The chapter also briefly examines the state of the broader technological infrastructure in Ireland which will have a bearing on the extent to which digital technologies are implemented across the country.

8.2 Introduction

8.2.1 Technological support to help people to live well as they age

Technological aids and supports have long been important elements of the health and social care system in Ireland. Traditional technological supports, for example, might include access to rollators or wheelchairs and analogue telephone support systems as well as basic but fundamental supports such as specialist beds and mattresses. Many traditional technologies are also being transformed to make more use of digital technologies, including, for instance, powered wheelchairs and mobility scooters or pressure-sensors in beds and seats. Over time a range of communication, alarm and navigation devices have become available, such as fall-detectors, pendant alarms and wandering/GPS tracking devices. Hearing aids and various supports for visually impaired older people are further examples of technology that can help people live well.

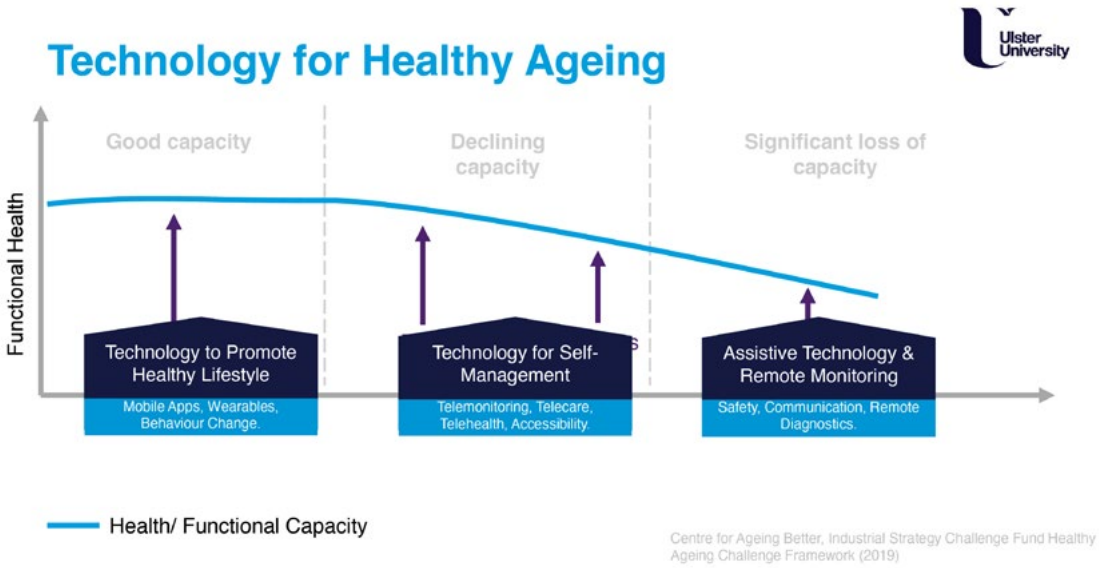
Many technologies, both traditional and digital, are delivered within people's homes. Some further information on how technology is used to help people age well in place can also be found in the 'Supported living' chapter, in which for example, smart home modifications and the use of technology in accordance with universal design principles are discussed.

8.2.2 Technological support across the continuum of care

Technology can be used in different ways to help protect and promote the health, wellbeing and independence of all older people, in addition to providing support for those with differing levels of functional, physical and mental health needs. The potential use of technology will be influenced by the level of functional need or capacity of older people, with different types of intervention being delivered to promote health and a healthy lifestyle and to support self-management by people with reduced capacities and more intensive assisted-living technologies being utilised to assist people with a significant loss of capacity (Figure 8.1) [356].

Looking at each of these three broad areas along the continuum of care in Figure 8.1, commercial wearables, such as smartwatches, which can record step-counts and provide health 'nudges' are one example of a way in which technology can promote healthy living. With more constraints on functional health, technology may be more focused on self-management, including light-touch monitoring and greater use of telecare, while for more significant constraints on functional activity, it may be more strongly focused on safety and communication as well as on remote monitoring of vital health statistics. Where functional support needs are at their greatest level, technology is starting to be used to create 'virtual wards', allowing levels of care and support normally only provided in hospital to be provided in people's own homes in Ireland. Furthermore, for everyone across the continuum of care, technology has the potential to make it easier to communicate with health, social care and other relevant services, and to have better access to information on health and on the availability of services.

Figure 8.1: Use of technology for healthy ageing at different levels of functional health



Source: [356] adapted from [357].

In Table 8.1 we provide some illustrative examples of how digital technologies are being used to support the needs of older people with different levels of functioning and/or health conditions. Most of these examples concern relatively well-developed technologies, many of which can be delivered with readily available, commercially produced devices.

For example, commercial voice-controlled smart virtual assistant technology, often delivered through 'smart speakers' can, for example, aid reminiscence and enhance mood by providing access to large catalogues of music that may specifically appeal to older people with cognitive impairments. They can also be very helpful to people with visual impairments, for instance through voice-controlled access to radio and television and through software for audio-reading of books and newspapers. Using the internet or phone apps to order groceries and other shopping can also be very helpful for people with more limited mobility.

We have not given examples of the use of robots and similar types of devices (electric dolls etc.) to provide companionship as, although novel, they are not widely available. There is also interest in different virtual reality applications and increasing use of artificial intelligence (AI). However, the impacts of AI are not yet known. Other innovations include virtual reality technologies, e.g. as an aid for reminiscence therapy and to enhance communication, but again their use is currently limited.

Table 8.1: Examples of the potential use of digital technologies

Condition / functional State	Example technologies
Good health / functioning	Wearables such as smartwatches / fitness trackers to encourage participation in physical activity. Exergaming and more cerebral gaming ('serious gaming') using commercial gaming consoles and smart TVs.
Experiencing chronic levels of moderate to severe loneliness	Telephone support lines, online social groups, video and other communication devices.
Chronic cardiovascular disease	Wearables such as smartwatches /fitness trackers to give an indication of blood pressure, heart-rate, oxygen-intake.
Depression / anxiety / low mood	Mobile apps with access to brief self-help, talking therapies, meditation, mindfulness. Potentially also collect information on mental state.
Limited mobility	Powered wheelchairs.
High levels of physical frailty	Sensors to detect falls; personal alarms to trigger help.
Hearing impairment	Hearing aids and other communication infrastructure.
Visual impairment	Smart speakers and other smart devices to help with instrumental activities of daily living, including shopping and transport booking.
Dementia	Wearable GPS tracking devices (for risk of wandering); smart apps that provide access to music/other audio and visual stimuli.

8.2.3 Policy landscape

8.2.3.1 Digital health innovation to support the shift away from hospital-based care

Within the health and social care system, the importance of digital interventions, including telehealth solutions, became very visible in Ireland during the COVID-19 pandemic. It was possible to deliver many services and supports digitally. Continuing digital health innovation is seen as vital to help in shifting from hospital to community and home-based support, to meet the goals of *Sláintecare* [1]. There is a specific HSE division, Technology and Transformation (formerly known as eHealth), responsible for the delivery of technology to support healthcare across the Irish health service.

The current *Programme for Government* contains commitments to digital transformation in health, including greater use of remote health-monitoring and virtual care solutions, as well as full digitisation of healthcare records [145]. The *Programme for Government* also contains a commitment to a 'dedicated funding stream for assistive and digital technology, to maximise independence and harness efficiencies' to support independent living.

Additionally, the *HSE Telehealth Roadmap 2024–2027* outlined a strategic plan to enhance telehealth services in Ireland [358]. The report acknowledged the ability of telehealth to improve patient-outcomes, experiences, and safety, and built upon many of the learnings of COVID-19. This report also emphasised the need for a broader health information system and information and communication technology infrastructure to be developed in order to achieve the maximum benefits of telehealth.

8.2.3.2 Enhanced access / use of health information and e-health infrastructure

Much of the focus of current policy on technology in Ireland is not on any one technology but rather on developing the infrastructure, processes and governance for the effective use of digital technologies as well as on the further implementation of electronic health records (EHRs) and on improving access to health information.

A strategic plan to modernise health and social care through digital innovation was published in 2024. This plan, *Digital for Care: A Digital Health Framework for Ireland 2024–2030*, notes that this innovation is

> key to supporting the health service in delivering universal healthcare, in planning for the population's health needs, building integrated care models, and ensuring safety, quality and sustainability in delivering health services [359].

The plan stressed the importance of empowering people of all ages to have more access to their health information and of providing more access to health and social care services, including virtual services. It also stressed the importance of better communication and secure data-sharing between healthcare professionals and healthcare systems and of greater use of data-analytics in service-planning.

A *Digital Health Strategic Implementation Roadmap* is taking forward plans for more digital innovation, with particular emphasis being given to the development of a harmonised electronic health record scheme that could be used by service-users and professionals to support the provision of more integrated care [360]. It is looking for 4%–6% of the total health budget to be spent on these digital innovations by comparison with the actual spend of about 2.2% of all health expenditure on IT (information technology) in 2023.

A Health Information Bill is going through the legislative process. If enacted, it should make it easier to share patient-records across different organisations and structures within the health and social care system (including public, voluntary, and private providers).

In addition, the Government is committed to completing the rollout of highspeed broadband for all, as part of the National Broadband Plan [361]. The national digital strategy *Harnessing Digital: The Digital Ireland Framework*, sets out an ambition for all populated areas in the country to have 5G broadband access by 2030. It also aims to ensure that 90% of all relevant Government services, including those in the health sector, are accessed online by 2030 [362]. Section 8.6 (below) provides an overview of the current state of broadband infrastructure.

8.3 Adequacy

8.3.1 Community Funded Schemes (CFS)

The principal way in which older people can gain access to assistive technologies, aids and adaptations is through the HSE's Community Funded Schemes (CFS). The CFS cover a wide range of services and supports which can be provided via primary and community care to people of all ages. There are six broad categories of support, namely aids and appliances; respiratory therapy products; orthotics, prosthetics and specialised footwear; continence wear, urinary, ostomy and bowel care; nutrition; and bandages and dressings. Some of the new innovative technologies discussed in this chapter can be funded under this scheme, for instance various types of sensor technologies and high-tech communication and mobility devices. In total the HSE spends more than €300 *per annum* on all CFS for people of all ages [363].

In the past, a criticism of the CFS pertained to a lack of information on the types of technologies, aids and devices that were funded [364]. To address this criticism a national list of aids and appliances for people of all ages with functional restrictions and disabilities funded under the CFS, including prescribing criteria [365], is now published online by the HSE. This, it has been stated, should 'improve the equity of access to appropriate aids and appliances, following assessment, for all eligible persons, including those requiring care in their homes' [366]. Similar lists of technologies that can be at least partially funded publicly exist in all three of the jurisdictions examined for the Commission by the Health Research Board, namely Finland, New Zealand and Alberta, Canada [367].

Broad categories of the aids and adaptations that can be provided through the CFS are shown in Table 8.2. While some IT appliances and services, such as communication aids and electronic systems for mobility devices, are covered in this list, they are focused on mechanical support for the activities of daily living, e.g. help with lifting, reducing the risk of falling out of bed, and help with eating and drinking. There are also important technologies which are not included under this scheme, such as hearing aids.

Table 8.2: Aids and adaptations funded under the CFS Aids and Adaptations Scheme

Categories of aids and adaptations	Examples of aids and adaptations
Moving and handling	Manual handling aids
	Powered hoists, slings for powered hoists
Augmentative, alternative communication (AAC) and assistive technology and mounts	Light-tech basic communication aids (no voice output), mid-tech electronic communication devices (with voice output), high-tech electronic communication devices, speech-generating devices and software
	High-tech ICT devices and software use as the primary AAC communication aid
Standing and walking mobility aids	Mobility safety rails, household trolleys, walking sticks, pods, crutches, walking frames, rollators, standing frames
Aids for daily living	Toileting aids, commodes, showering and bathing aids, manual bathing aids, powered bath-lift
	Feeding, eating, drinking, swallowing (FEDS) utensils and software
Domestic bed aids, electric profiling beds and pressure-reducing mattresses and elbow/heel/foot protectors	Bed lever (bed bar) for domestic bed; electric rotating bed and mattress; bed sensor; safety alarm pad; specialised memory foam mattress; static, powered, dynamic, air alternating and rotational mattress and bed.
Therapeutic aids	Transcutaneous electrical stimulation (TENS) and neuromuscular electrical nerve stimulation (NMES), exercise aids, positioning support aids, oral motor aids
Wheeled mobility, compatible seating systems and cushions	Manual wheelchairs, 'add-on' non-powered and powered assistance for manual wheelchairs, powered wheelchairs, mobility scooters, primary and secondary postural support devices (PSD) compatible with adult wheeled mobility equipment seating systems, pressure-reducing cushions

Historically, the budget and management of the CFS were managed by the 9 regional Community Healthcare Organisations (CHOs) across Ireland, but since October 2024 CFS they have been a responsibility of the six new HSE Health Regions. To qualify for free CFS scheme aids and adaptations an assessment must be made by an appropriate community healthcare professional. This can be a complex process and the type of professional that can make the assessment is set out alongside the national list of aids and appliances. (Box 8.1 highlights the example of applying for a powered wheelchair through the CFS).

Different professionals may prioritise in different ways and historically these have been developed locally rather than nationally. Contracts with providers of relevant technology were historically locally arranged, but since the initiation of a Service Improvement Programme for the CFS there has been a move towards more national oversight and alignment of contracts. Key objectives of the Service Improvement Programme include 'national standards, equity of access, and elimination of the existing 'postcode lottery' [368].

Box 8.1 Applying for a powered wheelchair through the CFS

An older person who would like to have a powered wheelchair would first need to be referred by their GP or occupational therapist to their local health office. They would then be assessed by an appropriate healthcare professional. In the case of a powered wheelchair, this would be either an 'occupational therapists, physiotherapist, clinical engineer or multi-disciplinary specialist wheelchair seating team. Assessment of the service-user is completed by an appropriately qualified and experienced prescriber with powered wheelchair knowledge and seating skill competency or by a prescriber working under the supervision of a co-prescriber with that skill.'

There are many factors that will be considered in determining whether the powered wheelchair will be provided, including the older person's ability to walk; whether they have sufficient cognitive, perceptual and physical skills necessary to operate a powered wheelchair; the typical number of hours per day and days per week that the chair will be used (as it not meant for all-day use); the likely long-term use of the wheelchair; and whether sufficient postural support would be provided by the wheelchair. The environment in which someone lives would also be considered.

If the assessment is positive, it is then passed on to the HSE for the provision of a new or appropriately refurbished powered wheelchair. Obtaining information on waiting times to receive a chair is difficult as decisions are made locally and waiting times vary around the country. However, multiple sources indicate that the waiting time can be very significant (potentially months) before the older person will receive the chair. (See further discussion in section 8.4.2.) As decisions are made at regional rather than national level, waiting times may also vary around the country and/or depending on the type of wheelchair technology requested.

Some aids and adaptations can also be funded through Department of Housing, Local Government and Heritage mean-tested housing adaptation grant schemes [151]. There are two relevant schemes, Mobility Aid Grants and Housing Adaptation Grants for People with a Disability. (See also the 'Supported living' chapter). Again, these schemes are focused on mechanical aids and supports rather than on technological innovation. The Mobility Aid Grants provides funding for adaptations to make it easier for someone to get around their home, e.g. by installing a stairlift. The Housing Adaptation Grants for People with a Disability are for people of all ages and cover adaptations that improve access, such as ramps, accessible showers or a space for a wheelchair. A third scheme, Housing Aid for Older People, only covers essential housing repairs.

8.3.2 Seniors Alert Scheme

Another notable programme is the Seniors Alert Scheme which provides personal monitored alarms. It is intended 'to enable older people of limited means to continue to live securely in their homes with confidence, independence, and peace of mind' [369]. It has been in operation since 1996, when it was known as the Community Support for Older People, becoming the Senior Alert Scheme in 2010. The scheme is funded by the Department of Rural and Community Development (DRCD), with additional support from the Dormant Accounts Fund. The Dormant Accounts Fund enables unclaimed funds from accounts in credit institutions, including banks and building societies, to be used to support people who are economically or socially disadvantaged or living with disabilities. Since 2015 it has been administered by Pobal, a State-supported organisation that manages funding and provides support to a large number of Government-funded programmes in areas such as social inclusion and equality.

Eligible recipients receive an alarm and a device that can be worn on the wrist or as a pendant. The alarm can either be connected to a landline telephone or to a mobile network via GSM (Global System for Mobile) technology. When activated, a call is made to a 24-hour monitoring centre which enables two-way communication. The monitoring service is free for the first year, further to which there is an annual monitoring fee of around €70 *per annum* (2024 fee). There may also be additional charges for SIM rental fees for the alarms that use the GSM system.

People are eligible to apply for an alarm if they are aged 65 or over and of limited financial means. They must either live alone, live with someone else who meets eligibility criteria, spend significant amounts of time alone during the day or provide care to someone else in their household. They can apply for an alarm via a local community or voluntary group that collaborates with Pobal to manage the scheme. These groups help the older person complete the application form and submit it on their behalf.

As of June 2025 there were more than 800 community/voluntary groups providing this service across all counties. Expenditure for the scheme in 2022 and 2023 was €4.75 million and €4.73 million respectively [369, 370]. Between 2015 and 2022 106,088 older people had their applications for personal alarms approved, including 15,577 in 2022. A further 1,755 applications in 2022 (11%) were rejected either because the person was already on the scheme or they changed their mind prior to installation.

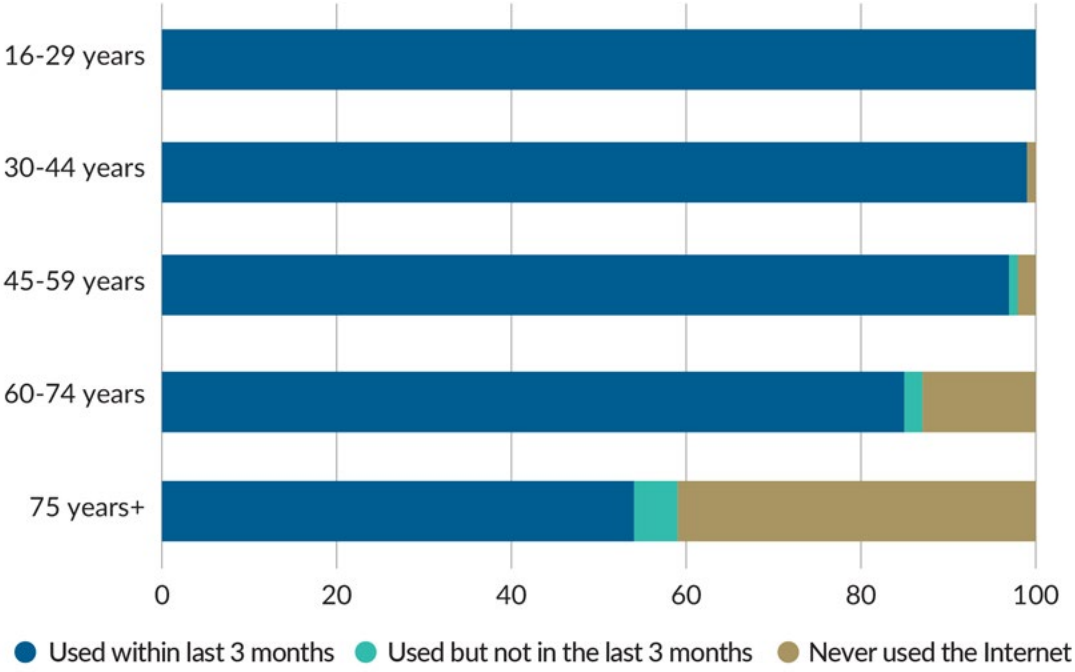
8.3.3 Internet-use by the general older population

Beyond the CFS and the Senior Alert Scheme it is difficult to ascertain the level of access to technologies that may be funded through public sources. There does not appear to be a database that contains this information, as many of the decisions on procurement are still made at a local level. We have noted in the 'Supported living' chapter that smart technologies are installed in different types of supported living through schemes that may be delivered by NGOs and local government-led services, including Age Friendly Ireland. The National Ability Supports System also collates information on the use of aids, adaptations and technologies by people with disabilities. However there is no comparable mechanism for collecting data on the use of these technologies by older people.

Some information is regularly collected on patterns of use of the internet and other digital technologies by older people. This information is important because potential digital technological solutions can only make an impact on the health and wellbeing of older people if they are used by older people. In the case of the use of the internet, this is not just about access to broadband, it is also about digital literacy and digital equity.

Recent survey data for 14,794 people from the Central Statistics Office indicate that there is still a digital divide in Ireland, with older people being much less likely to use the internet than younger population-cohorts [371]. While overall, only 6% of all people aged over 16 had never used the internet, this figure was much higher for the oldest cohort in the survey. As Figure 8.2 shows 41% of all people aged over 75 had never used the internet, compared with just 12% of those aged 60–74. These data point to a continuing digital divide by age in Ireland.

Figure 8.2: Use of the internet by individuals aged 16 years and over, classified by broad frequency of use and age-group, 2024



Source: [371].

The CSO also have collected data on the types of devices used to access the internet. This is important, given that apps, including the new HSE app (see later section), can only be accessed via a smartphone. In a survey in 2023, 1,282 people aged 16 and over responded to questions on ICT use [372]. Of those people aged 60–74 who reported using the internet, 92% made use of smartphones and 51% used laptops. This is similar to younger age-groups and suggests that access and use of smartphones should not be a barrier for the greater digitisation of information on phones. That said, the CSO was unable to provide data on the use of smartphones by people aged over 74 because of the small sample size.

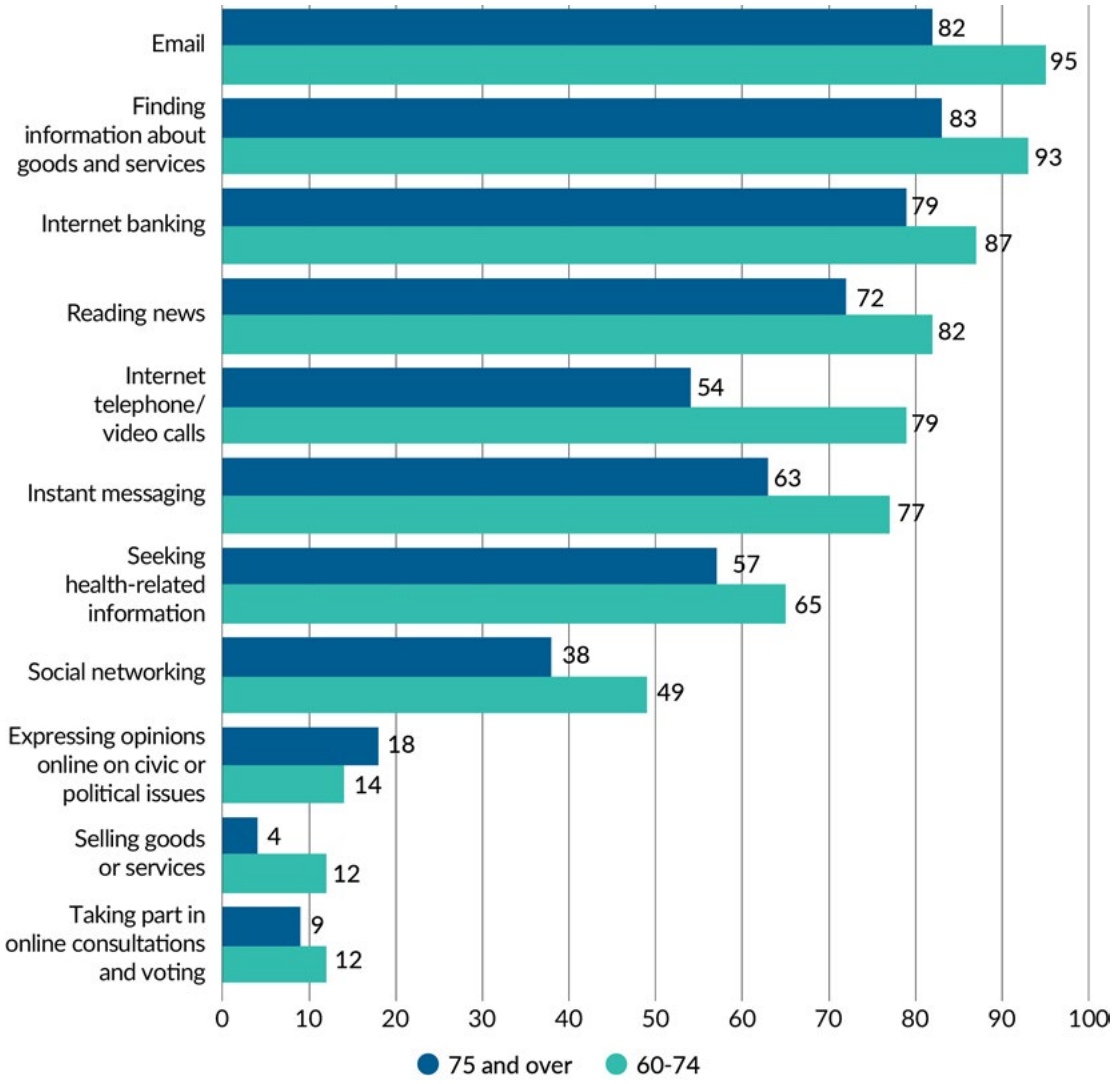
Data from TILDA in 2018 indicated that just 30% of men and 28% of women over the age of 80 had access to a smartphone or tablet [373]. While these figures are now very dated, they still suggest that the very oldest cohorts will still be much less likely to make use of smart phones, reducing the reach and use of apps in this older age group.

Another study in 2022 investigated factors influencing digital poverty and its effects on older people throughout Ireland through peer-led interviews with almost 900 purposively sampled people aged over 65 from five local administrative areas: Clare, Donegal, Fingal (covering North Dublin), Kerry and Kildare [374]. 64% owned a laptop, 50% a tablet and 25% a desktop computer. (N.B.: The study did not look at smartphone ownership.)

There were clear differences in ownership across age-cohorts: 81% of people in their 60s owned a computer compared with 68% for people in their 70s and 45% for people in their 80s. 60% of interviewees in nursing homes owned some type of computer. However, only 15% of older people from an Irish Traveller background owned a computer. The interviews also looked at levels of digital literacy: 41% of the over 80s said their literacy was 'non-existent' compared with 12% of people in their 60s. Access to the internet varied markedly across counties, from nearly 90% in Fingal to 55% in Kerry. Although no explanation was put forward for the variation in use of the internet, Fingal was the only area where no participant reported the internet to be unreliable all the time or some of the time, in contrast to Kerry where this was perceived as an issue by nearly 20% of participants.

Computer ownership (desktop, laptop or tablet) was also highest in Fingal at over 80%. Overall, the most common reason given for not owning a computer was 'getting along fine without one' (31% of respondents). This may suggest that behaviour change strategies might be needed to increase uptake. In that survey 60% of those who owned a computer made use of it every day. Data from the CSO in 2024 reported that 87% and 75% of those aged 60–74 and over 75 respectively who were internet-users made use of the internet every day or almost every day [371]. Data from the CSO also show that, for those older people who do make use of the internet, accessing health-related information is a relatively common activity, with 65% and 57% of 60–74 year olds and the over-75s respectively reporting doing this in the last 3 months (Figure 8.3). Almost 50% and over a third of these two age-groups respectively are also using the internet for social networking, which may help reduce the risk of loneliness. They use the internet even more for e-mail, banking and seeking information on general services.

Figure 8.3: Reported internet activities in the last 3 months for people aged 60 and over who make use of the internet



Source: [371].

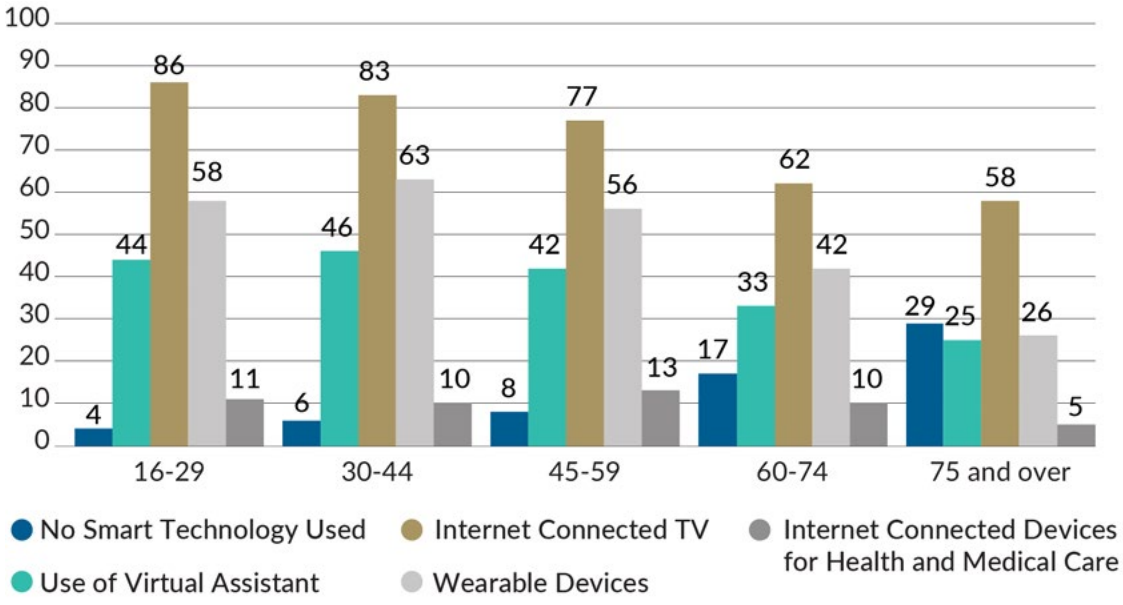
Taken together, these different sources of information indicate that, overall, there is a high rate of access to computers and smartphones in people aged up to 74, but beyond this age the current use of these technologies appears to be more limited (although data on use by older age-groups is also limited). There seems to be digital divide, mainly linked to age, although other issues such as socio-economic circumstance, living in rural locations with poorer internet connectivity and being a member of the Irish traveller community may also play a role.

8.3.4 Use of smart technology by the general older population

In addition to data on use of the internet, there is a 2024 CSO survey in which internet users were asked about their use of smart technology or 'Internet of Things'[101] in their private lives. [375]. It covered the use of internet-connected devices and systems in their homes, including the use of wearable devices and e-health solutions, as well as in their cars. Figure 8.4 shows some of the findings from this survey.

Older people who used the internet were much less likely to use any smart technology compared to younger age-groups. Less than 10% of those under the age of 60 did not use smart technology at all in their home, compared with 17% of those aged 60–74 and 29% of those aged over 75. Only a very small proportion, 10% and 5% of these two age-groups respectively, used some form of internet-connected medical device. The most commonly used device was an internet-connected television. There are potentially opportunities to partner with older people to help enhance their health by analysing health-related data on wearables, as 42% of those aged 60–74 and 29% of those aged over 75 already make use of these devices. Virtual assistants, which could, for example, be used to help find health-related information and health services, were only used by 33% and 25% of survey respondents respectively.

Figure 8.4: Selected smart technology use by age-groups in Ireland, 2024



Source: [375].

Notes: Usage data refer to last 3 months. Health and medical care examples reported include internet-connected devices for monitoring blood pressure, sugar level, body weight (e.g. smart scales), care robots or other internet-connected devices for health and medical care. Virtual assistants include a smart speaker or of an app, such as Google Home, Amazon Alexa/Echo/computer, Google Assistant, Siri, Cortana, Bixby, etc. Wearables include smart watches, fitness bands, connected goggles or headsets, safety-trackers, internet-connected accessories, internet-connected clothes or shoes, etc.

101. The 'Internet of Things' (IoT) refers to the connection of everyday items such as fridges, cars etc. to the internet. This then allows communication between the internet and the devices, and also allows for the storage and analysis of information.

8.3.5 Use of the internet and technology by older people with intellectual disabilities

Recent findings from the IDS-TILDA longitudinal study found that, although access to technology for older adults with intellectual disabilities increased throughout the 15–year duration of the study, it remained significantly lower than that of the general population [376]. For example, while mobile phone ownership almost doubled over the lifetime of the study (23% to 45%) amongst older adults with intellectual disabilities, this was significantly lower than 76% reported for the over-50 general population in Ireland [377], while both were considerably lower than 96% among the general Irish population aged 18–75 [378]. Nine out of ten IDS-TILDA participants (90%) reported access to the internet at home, which was slightly higher than the general TILDA population (86%).

However, despite these relatively high rates of internet access, significantly fewer older adults with intellectual disability used the internet at home (54%) compared to the TILDA population (83%) [377]. Furthermore, rates for IDS-TILDA participants aged 65 years and older was significantly lower, with less than half of this group (45.3%) using the internet at home. These findings align with a recent international review following the impact of COVID-19, which concluded that, despite raised awareness and some advances, 'digital poverty, literacy and exclusion remain significant issues for people with ID internationally' [379].

IDS-TILDA participants were also asked about use of smart devices or technology, with 62% using such devices—the most common being tablets (47%), smart phones (21%), and computer/laptops (13%), while more than a third (38%) did not use any such devices [376]. While use of these devices was lowest among the over-65 group, analysis revealed that having internet access and digital skills were more important in determining the use of these technologies [380]. The main reasons for using smart devices/technology were for leisure/personal reasons (80%) and connection/social reasons (54%). Use of smart devices/technology for productive reasons (19%)—which included healthcare, domestic, education, work/occupation, and information purposes—was much lower. Although many participants had access to these digital devices, very few were able to use them independently, relying instead on staff or family support, and very few used them to enhance independent living. This raises important concerns when compared with the general population, where independent use of such technologies is far more common—for example, almost 90% of adults aged 65 years or older in a recent study reported having the skills to use digital devices [381].

8.4 Efficiency

8.4.1 Lack of information on the use of new technologies

As indicated, other than the survey data collected for the CSO, and some data in TILDA, there is generally a lack of information on the extent to which new digital technological innovations for older people are being introduced in Ireland and also on the costs associated with implementation. There are examples of pilot schemes and individual local projects but no overall picture of technological availability and uptake [358]. This includes information on differential rates of uptake by age, gender and other characteristics. The extent to which older people are paying out-of-pocket for these technologies is also not clear.

Given that the latest CSO data point to a high proportion (41%) of people over the age of 75 who do not use the internet at all, and the probable low use of smart phones among this age-cohort as well, there may be risks that investment in technology may not be cost-efficient without careful assessment of needs, ensuring the appropriateness of the technological innovation, and focusing on addressing barriers to uptake, including training and support. Such investment may also widen inequalities. There does not appear to be very much information in the Irish context on these issues, although in section 1.5 some international experience looking at the cost-effectiveness of technologies is considered.

8.4.2 Recognition of limitations in CFS assessment and procurement processes

There is a recognition that the current CFS system that is used to assess need for and then allocate aids and adaptations to older people has been disadvantaged by the fragmented way in which this process is undertaken. The CFS operates at a regional level and this means that there are differences in waiting times for access to adaptations and devices. However, identifying the extent and variation in waiting times is difficult as there is no readily available data on waiting times for technologies through the CFS in Ireland. However, there are multiple anecdotal examples of reported cases of long waiting times for some people in some areas.

The issue of waiting lists appears to be a long-standing issue and can be illustrated with the example of motorised wheelchairs. In 2016, Jack Chambers, T.D., highlighted that, in his constituency, people were waiting significant lengths of time to get an assessment from an occupational therapist and that, following this assessment 'and the evident need [for a motorised wheelchair] had been progressed by the HSE, people told me they had wait up to a year and in certain constituencies it is nearly two years [in Limerick]' [382]. In 2023, Rose Gowran, a Lecturer in Occupational Therapy at the University of Limerick, argued in RTÉ Brainstorm that 'Ireland has no national policy or guidelines to ensure wheelchair services are appropriate and readily available' [383]. Furthermore, a survey of 273 adults of all ages (including older people) who were wheelchair-users also highlighted concerns that they had over long waiting times to obtain a chair, with people waiting up to four years in very extreme cases [384].

These variations in waiting times are not unique to Ireland and will also be affected by the specifications required for the wheelchair, which can be expensive: one estimate from England suggests that they cost between £1,000 (~ €1,150) for basic chairs and more than £15,000 (~ €17,300) for the most complex chairs [385]. It is however difficult to make direct comparisons with the situation in other jurisdictions. The recent HRB review of access to technologies did not provide any information on waiting times either for assessment or for access to technologies [367]. Waiting time data for access to wheelchairs are published in England: in 2024 84.5% of adults received their chair within an 18-week performance target. However, there are still some people waiting for up to two years across all of the UK [385].

The HSE has acknowledged that:

> For clients, the impact of not receiving appropriate and timely products and services can include deterioration in ability and function, associated physical and psychological decline, and a significant reduction in the quality of life. At a service level, it can lead to increased hospital admissions, delayed discharges, and increased financial and other costs being placed on the health services [368].

This is why steps are being taken to harmonise and then move from local contracts with aids and adaptation-providers to national contracts, with the aim of achieving greater value for money and reducing waiting times. A contracts and management framework has set out an approach to address these issues [368]. It is unclear how or if the system has changed since six new HSE Regions were established.

8.4.3 Barriers to the use of technology by older people with intellectual disabilities

There is a missed opportunity for using technology to support healthcare and more independent living, which may be enhanced through access to the internet and technology at home but also, critically, by supporting better digital skills for people ageing with intellectual disabilities and those who support them [380]. The importance of digital skills and supports for people with intellectual disabilities has been highlighted in an international review of 'digital inclusion and participation of people with intellectual disabilities during COVID-19' [379]. Findings pertaining to people with intellectual disabilities in Ireland include those of a study that identified a significant association between internet/PC access/use pre-COVID-19 and the use of telemedicine by the general older population during the pandemic [377]. For people ageing with ID, technology to support healthcare access and more independent living remains under-developed in many respects. Given the proven benefits of technology for independence, there being a positive impact on personal development and self-determination even for those with the highest support-needs [386], this indicates a potential gap in providing the access and skills required.

8.4.4 Addressing barriers to the adoption and continued use of technology

Some technologies are very passive: for example, some monitoring systems do not require much active-input from service-users. However, many digital technologies are dependent on multiple engagements with digital interfaces. This can be daunting for some people and earlier sections of this report have noted the risk of digital illiteracy among some older people. One theme that emerged from focus group research on the use of digital technologies in Ireland and Finland was that, in instances in which older people felt that they were unable to use new technology, they were likely to feel more alienated and out of touch [387]. This in turn might increase the risk of ageist perceptions that older people cannot make use of new technology.

There are still substantial gaps on what we know about what works to increase understanding and technology adoption (uptake). A recent rapid review in response to a request from Social Care Wales looked at the effectiveness of interventions for addressing digital exclusion in older adults [388]. Despite the importance of the issue, it only identified 21 trials or quasi-experimental studies, nearly all of which were conducted outside of Europe. Many interventions were educational, for instance home-based intergenerational ICT training or other forms of online and face-to-face digital literacy training. While all the studies were favourable, the majority were considered to be of low quality and only one looked at cost-effectiveness. Moreover, the results would be difficult to generalise to a Welsh context. The authors concluded that 'a range of complex multi-component educational interventions [may be effective], particularly with regards to improving digital literacy, and suggested that older adults are accepting of these interventions'. They also identified a lack of information on the effectiveness of strategies to reduce structural barriers and improve the affordability of interventions.

8.5 Effectiveness

8.5.1 Technological interventions to promote mental health, improve quality of life and address loneliness

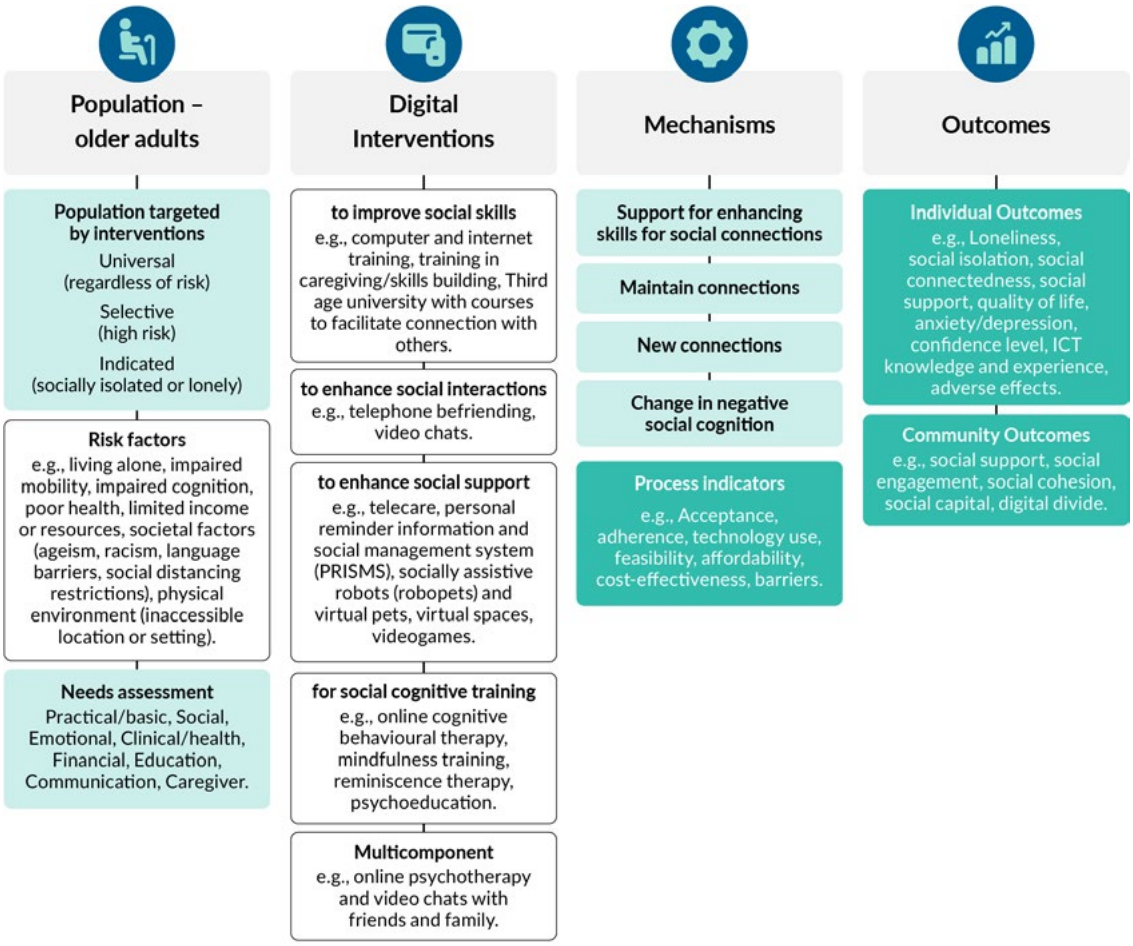
Evidence on the role of digital technologies, including the use of the internet and training in the use of computers, in supporting the mental health and wellbeing of older people is growing. Systematic reviews indicate that various forms of ICT, including video-type calls, can have a positive impact on issues affecting some older people, such as loneliness and reduced social networks [389, 390]. Previous ESRI research used data from TILDA to examine internet access among older people in Ireland [391]. In regression analyses a significant association between use of the internet and higher levels of quality of life was found, although no significant relationship with loneliness was seen.

Outside of Ireland, a survey of almost 10,000 older people living in Finland and Sweden found a statistically significant positive association between use of the internet and perceived meaningfulness in later life. Although an association rather than a causation, the authors of this study suggested that 'internet use may support the experience of wellbeing in everyday life, through the unlimited access to interest-driven activities that it provides'. This result held even for the oldest adults (aged 85+) [392].

In developing NICE guidance on promoting the independence and wellbeing of older people in England, an evidence-review identified inconsistent evidence on the potential benefits of technological interventions in addressing loneliness. This included some moderate to weak evidence from quasi-experimental studies on the benefits of training courses on the use of computers/internet. The social element of these courses may have been the reason for their impact rather than the training *per se*. There was consistent but weak evidence on the benefits of telephone and internet communication in reducing loneliness, and also some very limited early evidence on the benefits of gaming for mental wellbeing [393].

Six years on from this review, as part of a Campbell systematic evidence map, a conceptual framework on how technologies might impact on a loneliness and isolation was developed (Figure 8.5). It highlighted a similar set of interventions to the earlier review for NICE, although some new developments, such as use of robots, was emerging [394]. Many gaps in evidence remain: the evidence on effect is still mixed and the Campbell review noted the limited focus on barriers and challenges to making use of technology, including affordability and the digital divide.

Figure 8.5: Conceptual framework on the role of digital technologies in reducing social isolation and loneliness



Source: Reproduction of Figure 3 in [394].

8.5.2 Digital technologies and empowerment

A growing number of studies are looking at the impact of digital apps and other technological devices. For example, a systematic review of controlled trials assessing effectiveness of technology for empowering older adults included 30 studies covering technologies such as remote health and social monitoring solutions, ambient assisted living devices, mobile phone apps and websites. However, the review concluded that there was 'very low' to 'low' certainty of evidence that digital solutions increased knowledge and increased capacities in older people compared to usual care [395].

8.5.3 Online delivery of mental health interventions

Although the evidence on effectiveness is mixed, one notable area where there is now evidence from various systematic reviews and meta-analyses concerns online delivery of psychological therapies (talking therapies). Online interventions can be as effective as face-to-face care both for treating transdiagnostic (living with varied mental health conditions) populations of all ages [396] and specific mental health conditions such as depression or anxiety [397]. Experience from an umbrella review and meta-analysis of experience during the COVID-19 pandemic also suggests that some people preferred to receive mental health support online, although most of this evidence focused on younger populations [398]. This study also reported poor digital literacy and inequalities in access to technology to be the main barriers to the use of online mental health services.

8.5.4 Assistive technologies and telecare (ATT): 'complex versus simple ATT': the example of an intervention for people with dementia

Assistive technologies cover a very broad range of interventions, so it is difficult to easily summarise all of the evidence on these interventions, which is mixed. Here we highlight the results of one well-designed randomised study and cost-effectiveness analysis, the ATTILA (Assistive Technology and Telecare for Independent Living) study to support older people with dementia to remain independent in their own homes [399]. The authors stated that at the time of their study that there had previously been no large-scale evaluations of ATT for people with dementia.

The study is important because the results are not favourable to the use of these technologies, indicating the need to think very carefully about their utilisation. It may be that these technologies do not provide further benefits compared to simple ATT technologies, such as smoke alarms and pendant monitors.

In brief, almost 500 people who were diagnosed with dementia and living in the community in England (including in sheltered/supported accommodation) were randomised to receive all appropriate ATT or were assigned to a control group with limited ATT (smoke alarm, carbon monoxide monitor and pendant alarm) after an assessment of their ATT needs. The study was statistically fully powered to detect differences in quality of life between the two groups. At two-year follow-up, the all-ATT intervention group had significantly reduced quality-adjusted life-years than the control group. (There were no significant differences in health and social care utilisation between the two groups.) The intervention was neither effective nor cost-effective. There was also no significant difference in time to moving to LTRC between the two groups.

Although the study-findings were negative, the authors highlighted that the packages of ATT care provided to people in the intervention group may have been 'sub-optimal' as there may have been limitations in the ATT assessors' understanding of technology and need. Nonetheless the authors concluded that:

> Our data suggest that it would be premature to conclude that more extensive ATT systems to support independent home living for people with dementia are clinically important or cost-effective compared to more basic systems. This is because basic ATT such as carbon monoxide and pendant alarms are themselves effective in preventing harms, or because more extensive ATT systems are inadequately supported by providers, or inadequately tailored to the needs of people with dementia and their caregivers.

8.5.5 The Whole Systems Demonstrator Telecare for Social Care Study

Another example of how caution needs to be exercised in making decisions about the use of technology concerns the merits of upgrading existing technology. In in an evaluation undertaken in England, community-dwelling older people were randomised to receive 'second-generation' telecare in addition to their usual health services (which could include first-generation telecare, such as personal alarms). No significant difference was found in quality of life between the two trial arms, with the second-generation telecare being highly cost-ineffective at a cost per quality-adjusted life-year (QALY) gained of £297,000—well above the £30,000 threshold used in decision-making in England [400]. In this case the simpler, 'first-generation' technology represented much better value for money. The study's authors concluded that 'policy-makers should avoid characterising this technology [telecare] as a "magic bullet"'. Generally, there is a still a lack of clear evidence from multiple large-scale studies on whether these new technologies can be more cost-effective [401, 402]; for example another more recent English study looking at full assistive technology and telecare did not have an impact on the amount of time that individuals with dementia spent living in the community, nor on health and social care costs [399, 403].

8.5.6 The impact of digital technology in LTRC on hospital-usage and care-costs

This chapter has mainly focused on the use of technology for people living in their own homes but these technologies can be used in different settings, including in LTRC homes. There are examples of instances in which this can be highly cost-effective. An evaluation and economic analysis looked at the use of an app (the Health Call app system) utilised across residential care homes in the north of England [404]. The app collates vital health-monitoring data for care-home residents which are then analysed remotely by clinical staff, with a view to early identification of risk-factors for hospital admission and emergency department attendance. In this case the app did not rely on high levels of engagement by the care-home resident, as data are mainly passive monitoring data. Use of the app was associated with an 11% reduction in emergency department visits, 25% reduction in emergency hospital admissions and an 11% reduction in hospital length-of-stay. The annual reduction in cost-savings per resident per month was initially £57, rising to £121 after four years.

8.5.7 The use of virtual wards

Where there is evidence that virtual wards can be effective, evidence on their cost-effectiveness is less clear. Some studies point to higher costs in virtual wards than in traditional hospitals, albeit with better outcomes [405]. A systematic review looking at the use of virtual wards for older people found only limited evidence on the effectiveness of virtual wards compared with less intense hospital at home services [406]. In Ireland a study involving 54 older patients reported a significant reduction in emergency department presentations and hospital admissions after being admitted to a community virtual ward [407].

8.6 Infrastructure to enable the implementation and scale-up of access to technologies: the digital health landscape in Ireland

This chapter has concentrated on looking at adequacy, efficiency and effectiveness issues around the use of specific technologies for older people. However, the availability and use of many of these technologies, especially new digital technologies, will be influenced by the broader developments in technological infrastructure in Ireland, such as the availability of fast broadband across the whole country.

Another important issue arising when looking at the wider infrastructure pertaining to the use of technology is the way in which technological developments improve the collation, updating and sharing of health, social care and other information. This will have implications for the timeliness, appropriateness and continuity of care. Aspects of this include infrastructure/architecture on data-linkage and electronic health record systems as well as the extent to which all of the population can use technologies to iteratively communicate with relevant health and social care services and access their own health information. In this section, we briefly look at some of these broader infrastructure issues.

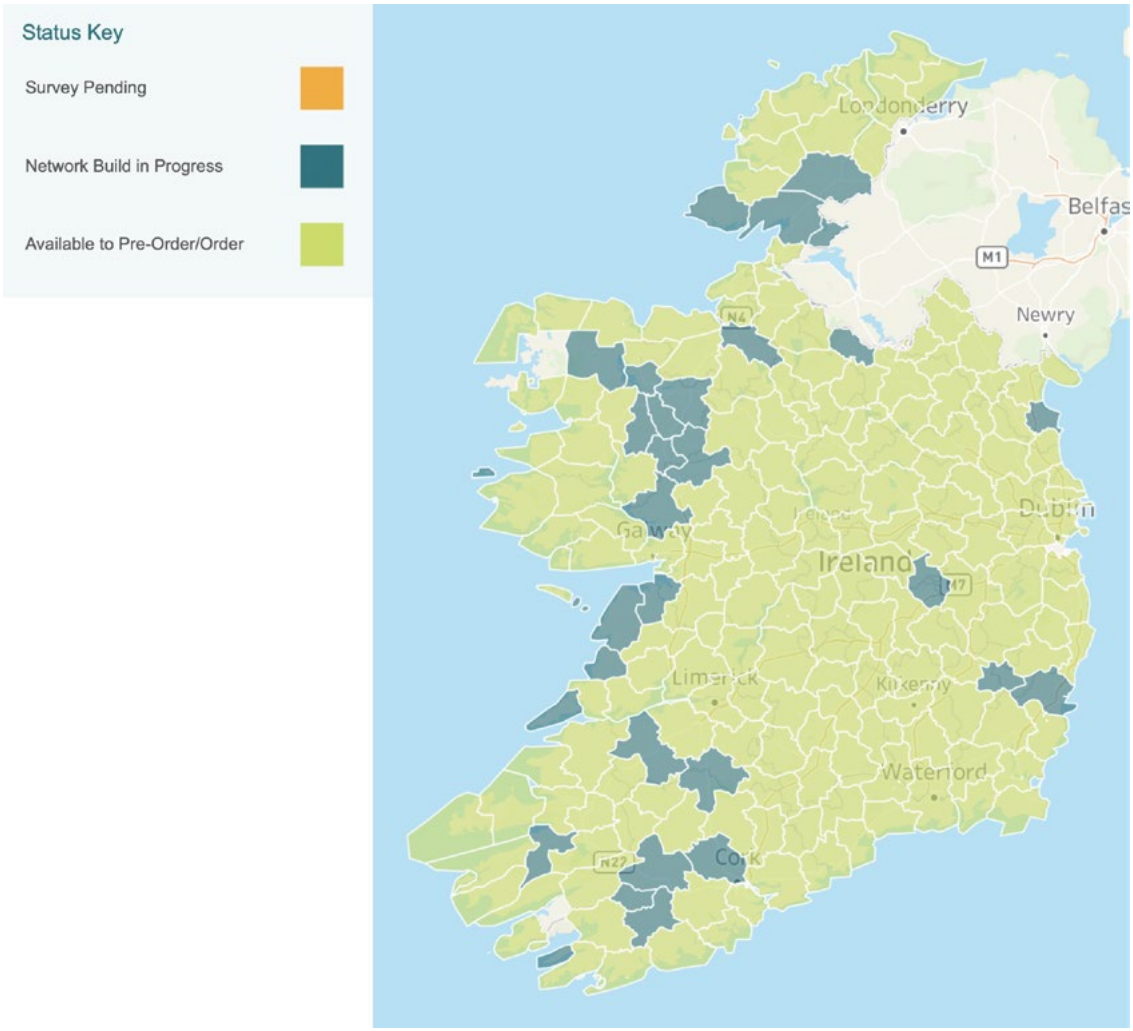
8.6.1 Broadband rollout

As part of the National Broadband Plan a private company, National Broadband Ireland, was contracted in 2019 to build, operate and maintain a high-speed broadband network [361]. This was to ensure service to all premises in the State where commercial operators do not provide, and have no plans to provide, this service. It is a major infrastructure project involving the laying of more than 140,000 kilometres of fibre-optic cables.

Figure 8.6 provides an overview of the current rollout. Households and other premises in various shades of green or yellow, where network build is not yet in progress, are mainly in the rural west of the country, including parts of Clare, Cork, Galway and Sligo. For example, there are 9,286 premises in Clare, where connection is anticipated to be completed by the end of 2026.

As the rollout is completed Ireland, like other European countries, will be able to complete the transition from traditional copper-based telephone and broadband networks to modern, all-IP (internet protocol) networks. This could raise some short-term challenges for the continued operation of some older medical devices. There are also some potential safety issues: while traditional landlines continue to operate even when there is a power outage, this is not the case with the new technology.

Figure 8.6: Rollout of broadband connectivity through National Broadband Ireland



Source: Reproduced from: [408].

8.6.2 Health information systems

The HSE's *Digital Health Strategic Implementation Roadmap* recognises that 'although Ireland is currently ranked the 5th most advanced digital economy in the EU, we are still significantly behind in terms of digital health maturity' [360]. The Roadmap pointed to OECD analysis on access to EHRs, in respect of which Ireland continues to languish at the bottom of the EU league table (Figure 8.7) [295]. The reliance on paper-based record-keeping is not an issue confined to the care of older people but it is indicative of the need to move to an integrated EHR system. The lack of digital information reduces the scope for online treatment and consultations. Other issues the roadmap highlights include 'limited access to datasets, inadequate preparation for analytics and AI and challenges in governing health data' [360].

Figure 8.7: Access to electronic health records 2022 and 2023 across the EU

Source: [295].

8.6.3 A need to strengthen health information systems

In addition to the direct impact that technology has on the health and wellbeing of older people, technology can play a crucial role in better management and planning for health and long-term care services. Better information systems are needed to be able to provide information on just who is making use of new technologies, and more generally on access to information and continuity of care and support across the health and social care system. New digital health information technologies and digital information structures can promote more effective health information and data management. This is a significant need in Ireland in which health and long-term care ICT and health information systems (HIS) are significant laggards compared to other European countries [409]. Section 8.3.1 also highlighted the fact that Ireland has by far the lowest level of EHR data in the EU [295].

One of the key issues faced by HIS in Ireland is the fragmentation of information across sectors and providers. This has resulted in substantial data-availability gaps, particularly from primary care and community services, limiting the effectiveness of data-driven decision-making. In a very basic sense, even information on the number of public health nurse or public occupational therapist visits *per annum*—let alone which aids, adaptations and other technologies are being used—is unknown. Information on simple demographics of service-users, such as their age and sex, can also sometimes be missing, with paper-based records common in many areas.

A 2021 report by the HIQA emphasised the urgent need for Ireland's national HIS to be reformed in order to enhance the delivery of health and long-term care services, support strategic decision-making, and put people at the centre of their care-pathway [410]. In the report, HIQA outlined the need for ongoing policy-maker and political commitment to fund HIS and ICT across the system and to implement a consistent national HIS strategy, establish clear governance structures for providers, and ensure that all stakeholders (including the public) are engaged in the reform process.

Research has highlighted the need for HIS to be developed across both private and public health and long-term care providers [409]. This is especially important for home support and residential care, for example, as the vast majority of care is privately provided. Without the inclusion of private providers within ICT and HIS strategies, performance indicators may be skewed, leading to less accurate policy decisions that do not reflect the realities of the entire system.

Some improvements on integrating public and private service providers have taken place in primary care. The Healthlink system has improved communication between GPs and other services. The somewhat basic system enables secure electronic messaging, allowing for timely sharing of patient information among public and private providers. This example shows that some HIS and ICT improvements can be simple and less costly. Secondly, the implementation of ePrescribing (especially during the COVID-19 pandemic period) allowed prescriptions to be sent electronically from GPs and other healthcare providers to pharmacies. This streamlined the prescribing process, reduced waiting times for patients, and potentially improved medication safety. These systems have been further developed along with the chronic disease management programme in primary care.

Ireland, through its new Digital Health Framework, is now moving towards the implementation of different electronic record schemes with plans in place to roll out a 'National Shared Care Record' following piloting [411]. This will include a 'read only' summary of use of GP, community and hospital-based services. The information will also be available to patients. This should, when implemented, help promote better continuity of care. The 'National Electronic Health Record (EHR)' will also hold a person's full health and social care information in one place. The HSE note that this work is in an early phase and that, as of April 2025, a preliminary business case had been prepared for review by the Department of Health [412]. A 'Community Connect' system is also planned for implementation at the end of 2027. This will provide a digital system for managing patient information in all community services, including mental health.

8.6.4 Technology for access to health and social care services and information

New technologies continue to change the ways in which older people might contact health services and access health information. Data in section 1.3.3 indicate that seeking health information is an important internet activity for older people. For instance, they might wish to access the national HSE website for information on symptoms, self-care and treatment for many conditions, and on how to maintain and promote health. They may also access a wide range of local information resources.

The new HSE app[102], available on a smartphone or tablet, can potentially help improve access to information. It provides a secure way to access personal health information, as well as health-related information and contact information for available health services. The app continues to be refined; in future it will allow service-users to see hospital appointments as well as reminders about other services, such as vaccinations. It will also show waiting times for some tests and/or treatments. It will be important to evaluate its use (and reasons for non-use) by different segments of the population.

102. https://www2.hse.ie/health-app/.

8.7 Learnings

Most of the recent developments in Ireland have focused not on the use of any one technology, but rather on putting in place the infrastructure to allow for a more digital health and social care service. This includes implementing EHR systems and the introduction of an HSE health app. There is a recognition that Ireland needs to develop its health information system considerably.

New digital technologies and enhanced traditional technologies, if well implemented, may have the potential to help more older people age well in place. However, other than the survey-data collected for the CSO and some data in TILDA, there is a lack of information on the use of new digital technological innovations and also on the costs associated with their implementation.

There are examples of pilot schemes and individual local projects but no overall picture of technological availability and uptake. The mechanisms used to obtain aids and adaptations are also a little opaque. Personal alarms are funded under an entirely different scheme, the 'Seniors Alert Scheme', and available free of charge to people with 'limited means'. It is welcome that Ireland now publishes a list of aids and adaptations that can be funded by the HSE; but it is difficult to find information on the actual types of aids and adaptations that are then provided, and the extent to which they include some of the new digital technologies discussed above.

There is also a lack of readily available information on regional disparities in waiting time and access to technologies. The example of some long waits to access motorised wheelchairs was highlighted as one example of this. The process for the procurement of aids and adaptations under the CFS has also been recognised by the HSE as an area for improvement. There is some evidence that digital technologies can be cost effective, particularly for more 'passive' technologies that do not require constant user participation. However, much less is known about the effectiveness and cost effectiveness of digital interventions which require much more active involvement. This includes the use of virtual wards. This means that technological solutions may not always be the best solutions, and where technologies are used, it may be 'simple' technologies, such as fall alarms or memory aids, that might represent better value for money and have better outcomes than some larger-scale, more complex technologies. There will be opportunity-costs associated with any investment in technology and these need to be taken into account in policy-making. These opportunity-costs can also include the benefits of time saved by individuals through more remote tele-consultations.

The implementation of large-scale technological projects in different countries, such as in England, has not always gone well. They have not always fulfilled their promise and have not been cost-effective. There now is a lot of interest in using AI to revolutionise the lives of older people (and all of society), but expectations need to be managed. It is still too early to know what impacts AI will have, both positive and negative.

However, the potential for technology to make a real difference to the lives of older people is substantial. For this potential to be realised, the process needs to do a lot more than just look at the technology itself. Technology adoption is one issue. Large numbers of older people in Ireland still do not use the internet and may not possess smartphones. Issues of availability, acceptability and usability need to be considered.

Training has been recognised as important for technology adoption, both for healthcare professionals on the use of technology and how to engage with people on its use, as well as training and ongoing support for older people using the technology. For example, a small proof-of-concept study with 93 older people in Ireland and Belgium [413-415] noted that repeated training was needed for many participants in order to use an iPad which included a health monitoring app as well as to use a smart watch [415].

Another issue is to keep solutions simple, at least for older people who are not familiar with digital technologies. For example, qualitative research in a pilot study in Ireland looked at the adoption and use of an 'easy-to-navigate' tablet containing a curated/ limited set of information, for instance links to newspapers as well as messaging and e-mail services. There was a high level of satisfaction with training provided and a reduced sense of anxiety in using computers, which may then translate into continued use of the technology [416].

8.8 Strengths, weaknesses, opportunities and threats

Strengths

- Ireland is committed to a programme of work to enhance the digital health landscape by 2030. This should provide the conditions to allow for the greater use of digital technologies to support the needs of older people.
- The digital health framework is intended to take account of the views of potential system-users in design and implementation.
- Ireland is working to introduce a single electronic health record system as well as shared health records and digital community care records, all of which may promote better integrated care.
- Ireland has published a detailed list of aids and adaptations funded by the HSE.
- Ireland also has a dedicated funding scheme for personal alarms.
- Broadband rollout to all households and premises should be completed before the end of the decade.

Weaknesses

- There is a lack of information on the extent of use of current technologies in Ireland.
- Limitations in current health information systems, e.g. electronic health records.
- There remain significant numbers of older people, especially those over the age of 75, who do not make use of the internet and/or do not have smartphones or tablets. This digital divide means that there need to be effective, non-internet-based ways of communicating with older people.
- The Aids and Adaptations programme within the Community Funded Schemes is devolved to regions and it is difficult to identify whether there are variations in decisions on access to technologies and/or on waiting times to access technologies across regions.
- It is not clear which digital technologies are covered by the CFS Scheme.

Opportunities

- *Digital for Care: A Digital Health Framework for Ireland 2024–2030* provides an opportunity to increase the use of technology in a way that meets needs, as there are opportunities for more co-ordinated care and more sharing of information.
- The much higher use of internet and digital technologies in the under 75s means that future cohorts of older people will be even more comfortable in using digital technologies.
- Potentially, technological development could enhance opportunities for more personal human contact between services and the older people they support if, for example, technology reduces the time needed for administrative tasks.
- The increased use of commercially provided wearables in the population may also present opportunities for better health promotion and earlier identification of potential health risks.
- There are opportunities to learn from mistakes made in the implementation of digital technologies in other jurisdictions.

Threats

- There remains a lack of evidence on the relative effectiveness and cost-effectiveness of many digital technologies compared with existing interventions.
- There are many examples of IT failures in other jurisdictions. These may reduce willingness to consider the use of new technologies.
- There may be an undercurrent of ageism in relation to perceptions of the ability of older people to adapt to new technologies.
- A lack of training and collaboration with older people to facilitate better acceptability and ease of use of technologies may hamper their adoption and continued use.
- Simpler technological solutions may be overlooked in favour of complex, costly but potentially less effective approaches that do not appeal to their target audience.
- The rapidly changing technological landscape may also make it difficult to forward-plan investment, e.g. in respect of the future potential role of AI.

9

Funding and resource-allocation

9.1 Summary

Earlier chapters have described the broad range of health and social care services delivered to older people in Ireland, including primary and community-based care, home support, supported living and LTRC. This chapter is concerned with how the health system is funded and the way in which resources are then used. It does not look at whether this level of funding is appropriate nor does it examine funding and resource-allocation systems in other sectors of the economy, such as housing, that play an important role in the system of care and support for older people.

First of all, this chapter provides an overview of how revenues are raised for all health and long-term care (i.e. funding) and secondly it examines how these revenues are then allocated to services. It highlights some of the consequences of unmet health and social care needs for older people and their family/unpaid carers as well as the value of moving to a more needs-based resource-allocation system. It also notes that the current lack of alignment of eligibility, funding and resource-allocation mechanisms between residential care and home support may create incentives for the excessive use of LTRC. It recounts how the capitation systems that are partly used to pay GP practices do not take full account of the healthcare needs of the population, and notes that cash-benefits for family/unpaid carers likewise make no adjustment for the needs of the people for whom they are caring.

9.2 Introduction

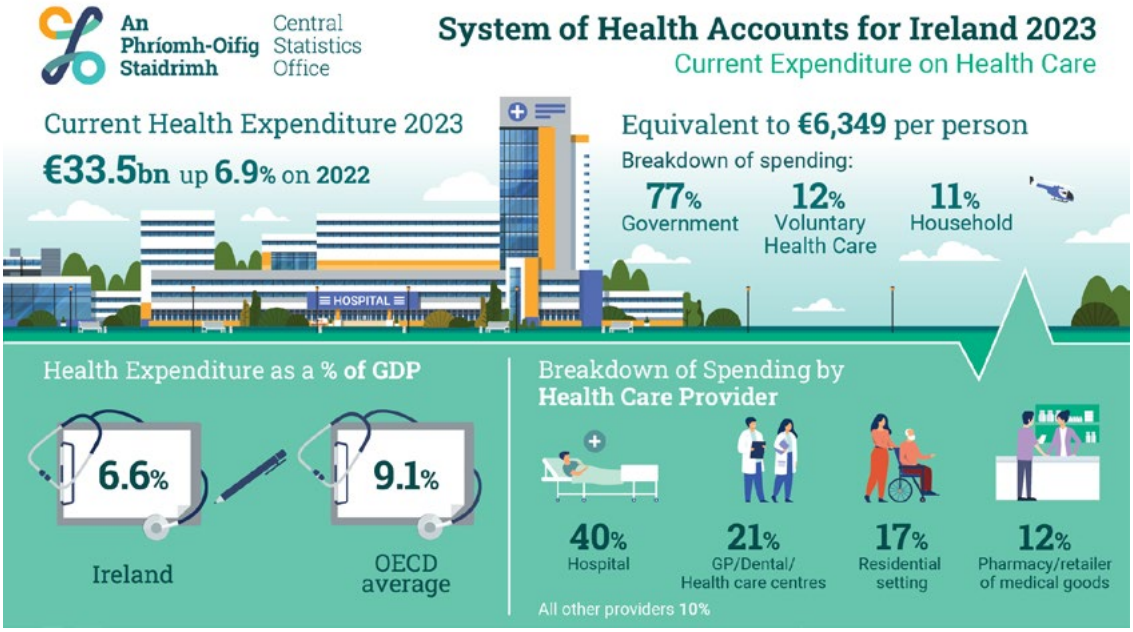
9.2.1 Overview of funding / expenditure on health in Ireland

The chapter begins by looking at how health expenditure in Ireland is funded—where the money comes from and where it is then spent. While differences exist in how health and social care are funded and organised internationally, in general systems are often categorised by the extent to which their funding models rely on public or private funding, and their use of long-term care insurance to fund social care services for older people. Countries such as the UK (via the NHS), Norway, Spain and New Zealand have Government-funded healthcare systems funded via tax revenues (often termed as Beveridge financing models). Countries such as Germany, France, Switzerland and Japan have social insurance systems that rely on the State, employers and employees/individuals paying into insurance funds to cover the cost of long-term care (often termed as Bismark financing models). While no country relies fully on the private market for funding of care, the United States tends to be categorised as a private market system where private health insurance, commonly linked to employment, is the main source of healthcare financing, supplemented with large public programmes such as Medicaid and Medicare which provide funding for specific population-groups. Within this schema Ireland has long been categorised as a mixture of Beveridge and private market, given the use of complementary private health insurance [53].

Ireland, in common with other OECD countries, produces 'System of Health Accounts' data which use a standard terminology to theoretically allow for comparisons to be made on decisions on funding and expenditure for health across countries [417]. In 2023 current health expenditure (that is expenditure on day-to-day activities rather than capital projects) in Ireland was €33.5 billion or approximately €6,349 per capita (Figure 9.1) [418]. This represented 11.5% of Modified Gross National Income (GNI*), the preferred measure of economic output in Ireland, and it was slightly above the OECD average share of the economy spent on health and social care.

The majority of current health expenditure in Ireland, 77% in 2023, was publicly funded by the State. Nearly all of the money allocated by the State to health expenditure came from general taxation (€25.4 billion), with a further €200 million coming from the Pay Related Social Insurance (PRSI) system. 12% (€4.1 billion) of expenditure is from 'voluntary health care' (mainly via private health insurance €3.5 billion) and the remaining 11% (€3.8 billion) is household out-of-pocket expenditure.

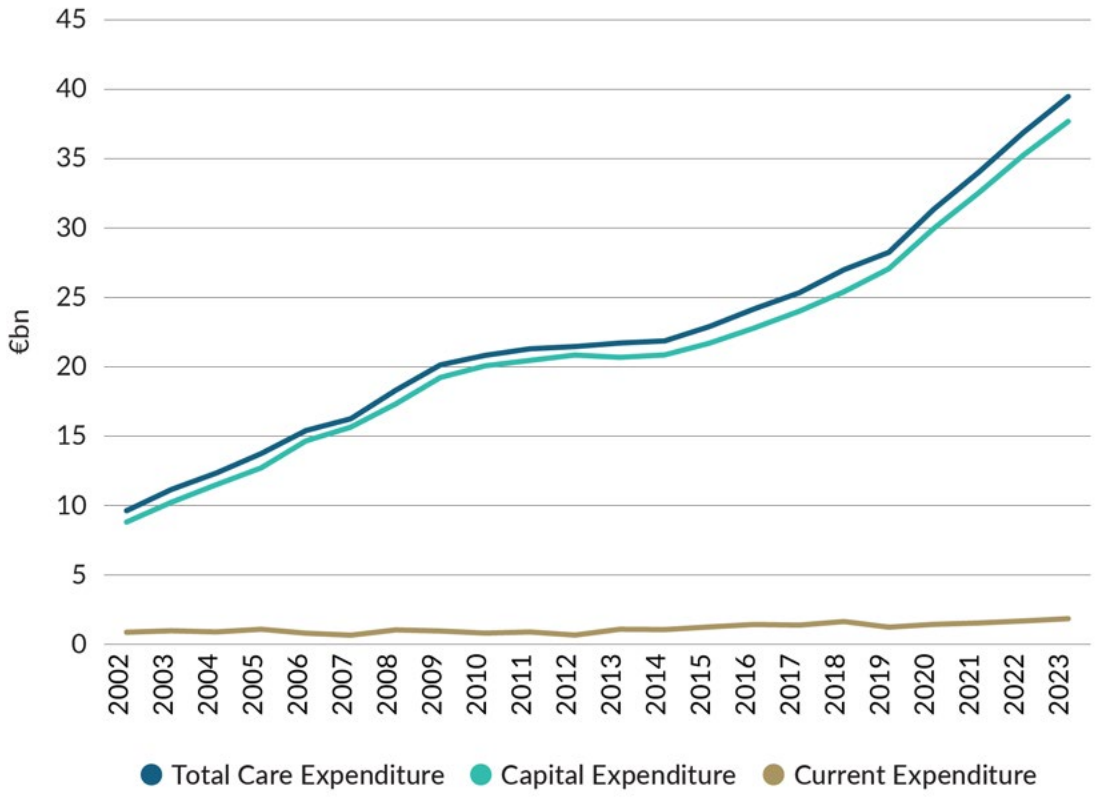
Figure 9.1: Overview of health expenditure in Ireland



Source: [418].

There have been substantial increases in health expenditure in recent years. Figure 9.2 shows that the total current and capital health expenditure (public and private) has increased from €21.5 billion in 2016 to €35.1 billion in 2022. Provisional figures for 2024 suggest a likely increase to €36.6 billion.

Figure 9.2: Total (public and private) healthcare expenditure in Ireland, 2002–2023



Source: [418].

Table 9.1 also shows how (all State, voluntary and out-of-pocket) funds raised for health are then spent by different types of healthcare provider, with 38% of all expenditure (€11.8 billion) being spent by hospitals, followed by 17% (€5.2 billion) on long-stay residential care for older people and people with disabilities. As discussed in the 'Residential care' chapter, approximately €2 billion *per annum* (from all sources) is spent on the NHSS. 11% of all health expenditure (€3.4 billion) is for medications. Additional spend (not shown in Figure 9.1) include 5.04% (€1.6 billion) for GP medical practices and 3.31% (€1.03 billion) for home healthcare providers.

Ireland is unusual internationally in including payments made to family/unpaid carers in its estimate of total healthcare expenditure [419]. In the system of health accounts these are defined as 'Households as Providers of Home Care' and they make up 4.12% (€1.3 billion) of health expenditure, which is more than is spent on professional providers of home health care. These payments include the Carer's Allowance, Carer's Benefit and Carer's Support Grants. Inclusion of such payments places Ireland within a higher comparative ranking when comparing healthcare expenditure with international peers.

Table 9.1 also illustrates how out-of-pocket expenditure as a share of total expenditure varies according to the type of service provided. For example, there are very low out-of-pocket costs for hospital care while 19% of the costs of LTRC are out-of-pocket, and the corresponding out-of-pocket costs for providers of home healthcare are 8%. For medical centres (GPs) 31% of costs are out-of-pocket while for dentists this rises to 76%.

Table 9.1: Breakdown of expenditure by funding source and service provider 2023

	Govt and compulsory Schemes		Voluntary Healthcare Payment Schemes		Household Out-of-Pocket Payments		Total Expenditure by Provider	
ICHA Code	HF.1	%	HF.2	%	HF.3	%		%
Hospitals	9,284	78%	2,361	20%	186	2%	11,831	38%
Long Term Residential Care	**4,149**	**79%**	**123**	**2%**	**1,000**	**19%**	**5,271**	**17%**
Medical Practices	963	62%	119	8%	479	31%	1,561	5%
Dental Practices	111	17%	43	7%	491	76%	645	2%
Other Health Care Practices	135	29%	86	18%	247	53%	468	2%
Ambulatory Health Care Providers	2,682	96%	100	4%	15	1%	2,797	9%
Providers of Home Health Care	917	89%	31	3%	77	8%	1,025	3%
Ancillary Health Care Provider	281	71%	55	14%	60	15%	396	1%
Pharmacies	2,599	82%	-	0%	553	18%	3,152	10%
Retail Sellers of Durable Medical Goods and Appliances	98	34%	-	0%	192	66%	290	1%
Providers of Preventative Care	**930**	**97%**	**29**	**3%**	**-**	**0%**	**959**	**3%**
Providers of Health Care Administration and Financing	237	29%	586	71%	-	0%	824	3%
Households as Providers of Home Health Care	1,277	100%	-	0%	-	0%	1,277	4%
All Other Industries as Secondary Providers of Health Care	60	29%	143	68%	7	3%	210	1%
Rest of the World	52	68%	24	32%	-	0%	76	0%
Provider n.e.c.	193	95%	10	5%	-	0%	203	1%
Total Expenditure by Funding Source	**23,968**	**77.35%**	**3,710**	**11.97%**	**3,307**	**10.67%**	**30,985**	**100%**

Source: Adapted from [418].

9.2.2 The relevance of out-of-pocket payments to services for older people

As the previous section has shown, most health and social care funding in Ireland comes from general taxation. The total estimate of health expenditure in Ireland includes all expenditure on long-term care and home support[103]. Table 9.1 also shows that the contribution of out-of-pocket payments to expenditure by different sectors varies widely. Rules and processes related to means-testing and out-of-pocket payments are particularly pertinent to some key services used by older people. These are discussed in more detail in other chapters in this report but two key issues are highlighted here.

The first of these concerns medical cards and GPVCs. Evidence shows that, for the older populations with multi-morbidity, having a medical card (or GPVC), decreases the out-of-pocket cost-burden by up to 67% [56]. Detailed information on entitlement to medical cards or GPVCs is set out in the chapter, 'Primary and community care: part 2'. The lack of public healthcare service entitlement means that many older people are not eligible to access many public services. As of September 2025, 37% of people aged 65–69 hold a medical card while 4% hold a GPVC. This means that approximately 60% of people aged 65–69 are not eligible for free GP care or for access to the full gamut of HSE-funded community-based services. Even in the 70–74 age group, 54% of people hold a medical card while 38% hold a GPVC (although all over 70s are entitled to a GPVC), which means that a small number also would not be eligible for the full range of public healthcare services[55][104]. For the 65-69 age group in particular, this is likely to have significantly reduced contacts with GPs because of the cost per visit, typically between €50 and €80. Evidence from Ireland indicates that medical card-holders have over three additional GP visits *per annum*, compared to those without a medical card [420]. Medical card-holders also have greater accessibility without co-payments to the full range of general medical services.

A second issue concerns the NHSS introduced in Ireland in 2009 to fund LTRC for older people. As discussed in the 'Residential care' chapter, it provides statutory financial support for residential care based on an assessment of both care-needs and a financial assessment. Approximately 77% of all LTRC residents are funded through the NHSS [168], highlighting its centrality in the provision of residential care.[105] A financial assessment determines how much the resident or their family will contribute to the cost of their residential care. Eligible NHSS applicants must contribute 80% of their income and 7.5% of the value of any assets, including land and property, towards the cost of their care.

103. The Irish system of health account submission does not distinguish between social care-related expenditure and healthcare-related expenditure, unlike some other countries, e.g. the UK where for example some long-term care expenditure is classified as social care expenditure and not included in the overall estimate of health expenditure.
104. Estimate based on number of medical card and GPVC-holders in these age groups in September 2025 and CSO 2025 data on population estimates April 2025.
105. Note: Approximately 9% pay for LTRC privately. Some individuals who have high levels of income or assets may choose to pay privately due to concerns about the requisite asset-contributions making it less economically viable to use the NHSS. Meanwhile others may want to be cared for in non-NHSS participating LTRC homes.

While this is a substantial contribution, most of this is time-limited, as a person's home is only included in the financial assessment for 3 years in a LTRC home, so no more than 22.5% of the value of a home would go towards the costs of care. The first €36,000 of assets for an individual are also not counted in the financial assessment.[106] The State then pays the balance, regardless of the fees of the approved LTRC home, for as long as residential care is needed. This can potentially create an inappropriate financial incentive to make use of long-term care because of the certainty about this maximum level of contribution.

Access to, and funding of, home support is treated in a different way. Currently, HSE home support services are free from co-payments from recipients. However, because of the limited availability of home support and the low level of support provided to service-users (around 1 hour per day), many people have to pay out-of-pocket for additional private home support (accounting for 8% of all home care costs in Table 9.1).

The 'Home support' chapter indicates that 24% of all home support is privately purchased. The lack of availability of publicly funded home support is the most common reason given for the private purchase of home support [421]. The cost of privately funded home support hours was estimated at €25 per hour in 2019 [70], though costs are now likely to be well above €30, potentially putting significant financial pressures on many families. This current situation raises equity concerns and the potential for the emergence of a dual system of social care between those who can and cannot afford private home support.

9.3 Resource-allocation

9.3.1 Resource-allocation in Ireland

The previous section provided information on the sources of funding for health expenditure in Ireland and on the level of subsequent health expenditure by different service-providers. In this section we focus on the process of resource-allocation. The effectiveness of health and social care systems depends on their ability to distribute resources equitably and efficiently in order to improve the health and wellbeing of the population. This is true regardless of the financing mechanisms used (e.g. public or private) and the size of the budget allocated.

However, a key limitation in Ireland, unlike many other European and contemporary healthcare systems, is that there is a lack of a systematic resource-allocation mechanism to determine how the overall health budget will be distributed. Resource inadequacy is also a key issue that arises as a result of the current lack of a systematic resource-allocation mechanism in Ireland [422, 423]. These inadequacies, especially the large regional variation in access to care, are driven primarily by the lack of a system that can match supply to demand at a local level [409]. The result has been significant inequalities in access to publicly provided home support in Ireland. Other key constraints such as a lack of health and social care services in some regions as well as insufficient physical facilities and infrastructure [424], can also, in part, be explained by the lack of a resource-allocation system designed to account for the population's healthcare needs.

106. Factors such as farms and private business receive special dispensation.

This lack of a resource-allocation mechanism makes it more difficult to reshape the whole health and care support system to help older people to live well at home. Other chapters (see for example the chapters on 'Home support', 'Supported living' and 'Primary and community care') have discussed how the *Sláintecare Report* called for a renewed focus on moving care and support further away from the hospital to instead be delivered by an interlinked and integrated set of community-based services [425].

Policy-makers in other countries have used resource-allocation mechanisms to help develop integrated funding pathways, to help incentivise co-ordinated care and a 'shift left' towards non-hospital care and support to meet the needs of older people. For example, in England, newly established Integrated Care Boards (ICBs) have adopted this integrated care approach. Within each ICB, place-based partnerships are set up between NHS, local governments and other organisations. Financial resources are delegated, to varying degrees, from the ICB to the local level, which means a move away from simple funding allocations for sectors of the health and social care system. The partnerships join up the planning and delivery of services, re-design care-pathways, and engage with local people, with a focus on critical local issues such as hospital discharge and waiting times and a strong appetite for tackling the root causes of health inequalities [426].

The lack of a resource-allocation mechanism in Ireland also has implications for medium-term to long-term service-planning for older people. Given the rapidly growing and ageing population in Ireland, and the association between an ageing population, healthcare demand and expenditure requirements [70, 427, 428], the lack of a resource-allocation system may also embed systematic under-estimations of healthcare resource needs.

For example, previous research by the ESRI examined the supply of primary, community and long-term care services in Ireland [101]. A recurrent trend of under-supply in care was seen across numerous counties, including the greater Dublin commuter-belt (Kildare, Meath, Wicklow) and the south–eastern counties. The authors outlined that a key reason behind this was the inability of the system to 'keep up' with the increases in populations seen in the Dublin commuter-belt region. The under-supply of care resources in some regions thus raises the question of whether there are resources in the system that can be better used if re-directed to those under-supplied regions. While the lack of integrated planning of services may also have aided the sharp increases in private supply (e.g. LTRC homes) in some regions, further exacerbating regional inequalities.

That is not to say that no progress has been made but rather that it has been concentrated in the hospital sector. Notably, in 2016, activity-based funding (ABF)—payment linked to activities undertaken—was adopted as the main method through which funding for inpatient and day patient care in large acute public hospitals was allocated [427]. This shift towards ABF, away from block funding in Irish acute public hospitals can be seen as an important shift in how healthcare services are funded in Ireland [429]. Subsequent reports have outlined a number of important lessons from the process of establishing and embedding ABF in public hospitals as well as its impact [430, 431].

9.3.2 Proposed population-based resource-allocation (PBRA) formula

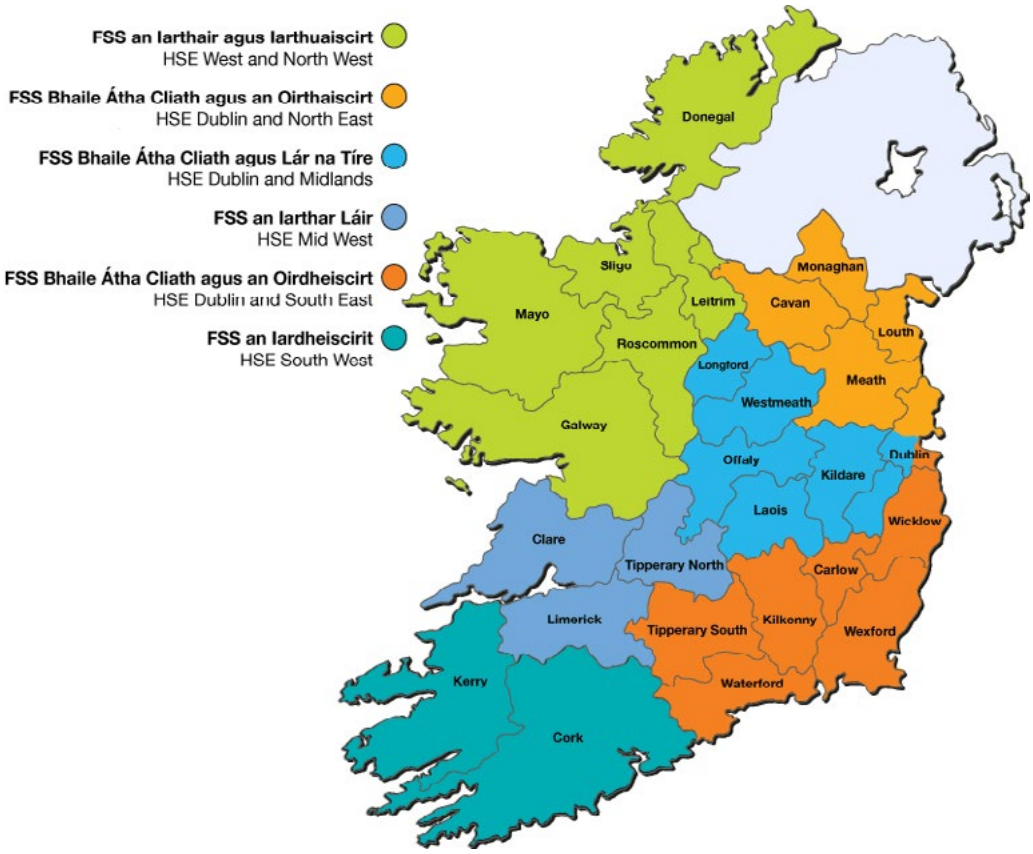
The difficulties caused by the lack of a resource-allocation mechanism have long been acknowledged. For example, two extensive reports, commissioned by health authorities, were published in 2010 outlining the necessity of such a mechanism and the potential forms these mechanisms could take [423, 432]. Policy-makers were positive about these reports and the need to begin planning for resource-allocation. Following the publication of the reports, the CEO of the HSE at the time stated that 'the HSE will be flagging a move to allocating resources on a population basis in the Service Plan 2011' [433].

However, despite these recommendations and subsequent statements, a resource-allocation system was not introduced into the Irish healthcare system and plans never materialised. The lack of a resource-allocation system in Ireland was also highlighted in the *Sláintecare Report* as a key impediment to the delivery of effective and equitable health and social care [425, 434].

Based upon recommendations in *Sláintecare*, the Department of Health have begun to introduce a PBRA approach based upon the regionalisation of health and social care [435, 436]. The approach follows that taken in Australia, England, the Netherlands, New Zealand and Scotland, all of which have developed PBRA systems to help distribute healthcare resources efficiently to meet the demands of their population [422].

A key feature of PBRA is the need to devolve decision-making to local levels. This has been done through the establishment of HSE Health Regions, IHAs, and the continued use of CHNs, discussed in more detail in previous chapters. The first *Sláintecare Implementation Strategy* was published in 2018 [437]. The report outlined 'the value of geographical alignment for population-based resource allocation (PBRA) and governance to enable integrated care' [425]. Implementation of the new HSE Health Regions commenced in 2024 (see Figure 9.3).

Figure 9.3: HSE Health Regions



The HSE Health Regions are not dissimilar to the Health Boards that existed in the past. However, unlike in the Health Boards, there will be no explicit political involvement in the Health Regions' governance. Using evidence from other countries, and analysis within previous reports [422], the Department of Health published a proposed formula for the initial PBRA in Ireland [435, 436]. The proposed PBRA formula is:

$$AdjPopHR = ProjPopHR\ x\ Age_SexIndexHR\ x\ DepIndexHR\ x\ RurIndexHR$$

where the adjusted population of each Health Region (HR) ($AdjPopHR$) accounts for the (projected) population of each HR ($ProjPopHR$), the age and sex composition of each HR ($Age_SexIndexHR$), the level of deprivation in each HR ($DepIndexHR$), and the rurality or remoteness of each HR ($RurIndexHR$).

In general, age, sex, and deprivation differences across Health Regions will account for most of the differences in factors that impact on healthcare demand across regions. Rurality is also important to capture as the resources (budgetary or staffing) required to provide some services, such as home support, will be higher in rural areas.

The proposed PBRA formula, and the sequencing of parameters included, follow closely those used elsewhere, such as by the NHS in England and Scotland, New Zealand, Ontario in Canada, New South Wales in Australia and Sweden. This makes sense, as previous work informing the PBRA undertook an extensive review of PBRA systems internationally, thereby learning from the systems used in other countries. Some small but important differences exist in each international system, reflecting specific local contextual issues. For example, Scotland places a greater weight on rurality, while New Zealand explicitly accounted for the higher level of needs seen in some population groups including the Maori and Pacific Island populations. In an Irish context, groups that would benefit from additional support include older people who are homeless and older Irish Travellers, who are likely to encounter additional barriers to the use of health and social care services, including home support [438].

9.3.3 Coverage of PBRA in Ireland and efficiency

It will not be possible, or appropriate, to include all health and social care services within PBRA formulae. Many services which are more appropriately organised at the national level (e.g. cancer screening, immunisation) will have funding 'top-sliced' prior to being distributed via PBRA. These services will be organised centrally by the HSE. Commonly used in resource-allocation models, top-slicing refers to the practice of setting aside a proportion of the overall budget for specific purposes before allocating the rest according to the standard allocation formula. In general, top-slicing occurs in programmes that may require specialised concentrated responses, often at a national level.

However, one anomaly with the proposed PBRA is the level of top-slicing involved initially. As highlighted in Table 9.2, Department of Health research has estimate that approximately 48% of all HSE expenditure (as measured for year 2021) would be excluded from the proposed PBRA mechanism, with decision-making to remain at central level (the HSE Centre) for many important health and social care services [435, 436]. For example, expenditures on the Primary Care Reimbursement Scheme (PCRS) for GP and dental care, and the NHSS, are notable exclusions from the PBRA formulae.

Table 9.2: HSE expenditure included/excluded in proposed PBRA

Included in PBRA (€000s)		Excluded from PBRA (€000s)	
Hospital Groups	5,110,908	Children's Health Ireland	347,771
Primary care	886,051	Acute national services	8,136
Social inclusion	161,149	National ambulance	171,204
Palliative care	87,577	NHSS	986,202
Mental health division	986,833	Disability services	1,992,082
Older people's services	889,246	PCRS (GP, Dental, Drugs)	2,798,048
Other community care	20,261	Other	1,802,082
Total	**8,142,385**	**Total**	**8,106,057**

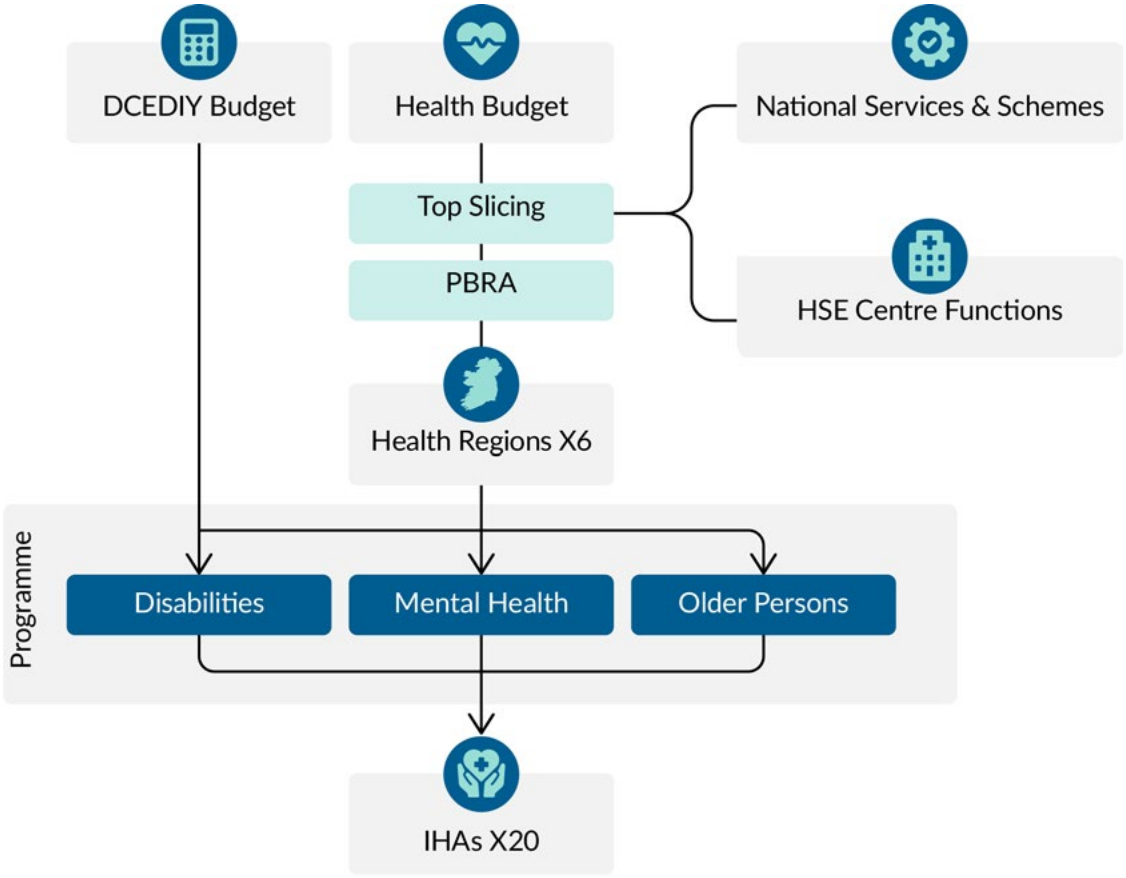
Source: [380] [385].

The top-slicing of some services (Children's Health Ireland (CHI) and the NAS) is based upon the specialisation of these services, and the fact that they often cover national populations. Similar top-slicing of these services also occurs in other countries. However, as PBRA mechanisms mature within countries, many such services often get absorbed into PBRA. Ambulance services, for instance, have been included in the NHS England PBRA formulae in more recent years.

Top-slicing may raise concerns on efficiency grounds. This is against the underlying principles of devolution of decision-making and integrated care at the local level. Without the inclusion of these important sectors and services, there is the potential that, first of all, the PBRA mechanism may not reflect a full understanding of the actual resource needs of Health Regions, potentially exacerbating inequalities in the distribution of resources across regions and population groups. Second, the non-inclusion of these services is likely to hinder PBRA and Health Regions from efficiently implementing key integrated care-pathways for significant population-groups. For example, recent Government policy revolves around reducing the use of LTRC in favour of home support. Having both the NHSS and home support funding administered at HSE Health Region level would practically allow for easier incentivisation of more home support to allow people to continue to live well at home (if that is their preference) rather than be moved into LTRC.

Figure 9.4 outlines the proposed administrative and geographic structures of the PBRA mechanism. The overall health budget will firstly separate out funding for national services (such as screening) or services controlled by HSE Centre (e.g., NHSS). The PBRA formula will then be used to distribute funding across the six HSE Health Regions, which will then distribute funding for different sectors within their region to each IHA. It is not yet known how the distribution from the HSE Health Region to IHA (and potentially subsequently to CHNs) will occur but data available at the IHA level suggest it would most likely follow a PBRA formula.

Figure 9.4: Proposed structure of allocation of HSE Health Budget



In the proposed structure outlined in Figure 9.4, there are a number of positives and negatives that have been acknowledged in various documents by the Department of Health. The key positives and negatives are outlined in Table 9.3. Strong leadership will still be required to ensure the acute hospital sector does not soak up a disproportionate amount of funding and that the resources are used to shift services out of hospitals and into communities. Data, technology, and health information structures will also have to improve to allow for PBRA to succeed.

Table 9.3: Positives and negatives of PBRA mechanism

Positives	Negatives
Increased decision-making autonomy to Health Region Regional Executive Officers (REO) regarding reallocation of funding within their region.	Some sectors (e.g. acute hospitals) or care groups may have greater influence on funding allocations.
Allocate funding to areas which need it most based on needs of local population.	Under-funded services and overruns still possible.
'Guide' allocations to regions need not be prescriptive.	High-quality and robust data required.
Fairer and transparent allocation process that can help with more integrated primary and community care, including use of specialist community care teams.	Financial governance and performance management vital.

The implementation of PBRA will change how funding allocations occur within the HSE, and Irish health and social care more generally. In other jurisdictions a convergence or transition process, such as used in NHS England, was used to gradually move from initial funding levels to target allocations, ensuring that sudden financial impacts are mitigated. Governance and oversight of the PBRA and the transition to HRs are vital for their success. An advisory group, as proposed by the Department of Health, is essential for PBRA implementation. Such a group could also facilitate routine evaluation of the formulae and guide future iterations of the PBRA mechanism.

9.3.4 Payment mechanisms

The success of the new PBRA approach will also be influenced by the final blend of different payment mechanisms / budgetary allocation mechanisms that are then used to allow needs-based resource allocation funds to flow appropriately from a payer (i.e., the State, private health insurance providers, individual clients) to service-providers. These payment decisions determine the level of resources that are available on the frontline to deliver the required care and thus have direct consequences for adequacy of care received by older people with care-needs.

Different payment mechanisms between the commissioner/payer of care and the provider of care can exist/co-exist. Policymakers often choose very different payment mechanisms across different sectors and services as they aim to meet a specific principle. Each of these payment mechanisms are coordinated around five organising principles[107]:

1. **Need:** To reflect population-need or perceived risk. Payments are distributed according to the size of population-need or due to the impact of an illness. This can therefore address equity concerns. The new PBRA scheme is intended to address need. One way of funding would be through capitation, as this form of payment can be designed to address need and differences in need across populations. For instance, GPs currently receive a payment of €403.39 for each community-dwelling list-member over the age of 70 and €644.77 for each patient list-member over the age of 70 residing in LTRC[108]. As capitation is assigned based upon population-need (as opposed to performance or outcomes), annual payments are made for each GP practice patient-list member rather than the number of visits made.
2. **Capacity:** To reflect workforce or infrastructure capacity. Payments are distributed according to the scale of the workforce providing care, or the number of beds/ facilities used to provide care. Grants can be categorised as capacity payments as they are commonly provided to voluntary organisations in Ireland, for example to ensure a certain level of workforce and capacity are funded.

107. More details can be found here: https://www.economicsbydesign.com/integrated-care-systems-financial-flow/.
108. See https://www.imo.ie/i-am-a/gp/gms-contract-agreements-a/.

3. **Activity:** To reflect levels of activity. Payments are used to cover the costs of visits to a provider/service, number of patients admitted, and the number of medicines administered. This is used to incentivise utilisation but can run the risk of over-incentivising service-use. ABF has been used in the Irish acute public hospital system for day-patients and inpatients. Specific payments to hospitals are made for each type of patient-admission (categorised according to their diagnosis in Diagnosis-Related Group (DRG)s. Other examples include allowance-fees paid to GPs for a range of services, such as the CDM programme.
4. **Performance:** To reflect positive performance or reaching a goal. Payments are provided to reward a provider for a defined achievement (e.g. patients seen, patient satisfaction). This is used to help create change and improve efficiency. These payments are not common in Ireland, but 'Best Practice Tariffs' via the 'Quality and Outcomes Framework' have been tried in the NHS in England to incentivise quality and cost-effective care in GP practices.
5. **Outcomes:** To reflect short-term or final outcomes. Payments are provided to reward treatment-outcomes or improvements in population-health. These payments are not common in Ireland. They attempt to reward providers financially for hitting pre-determined targets (e.g., waiting in times for EDs).

Each of these five approaches has advantages and disadvantages. Blended payment models that bring together several of these elements can help incentivise integrated pathways of care. While blended payment models are not common in Ireland, some examples exist. For example, the ICPOP teams bring together funding for:

- Hospital-based geriatricians—paid in part by ABF
- GPs—paid in part via capitation and also via ABF
- HSE multidisciplinary teams in the community—paid mainly via salaries
- NGOs—paid in part by block grants

The blended model puts population-groups at the centre and allows for a combination of payment mechanisms to be used to ensure disparate providers can provide care and supports to the population. This aligned payment and incentive approach has been used elsewhere, for example it was adopted in NHS England in the 2022 Health and Care Act,[109] which aimed to remove barriers to integration and allow different parts of the NHS and local authorities to work together and reduce the bureaucracy to simplify financial flows and reduce administrative burden. This is consistent with the objective of Irish health policy to 'shift left' towards provision of more support for people to live well in their own homes and communities and reduce the risk of hospitalisation and admission to long-term care.

109. https://www.gov.uk/government/publications/health-and-care-bill-factsheets/health-and-care-bill-nhs-payment-scheme.

9.3.5 Resource-allocation to family / unpaid carers

In Ireland, payments made by the Department of Social Protection to family/unpaid carers are included in the estimate of current health expenditure, accounting for 4% in 2022 [417]. A limitation of current cash-benefit schemes to support family/unpaid carers in Ireland is that the level of funding received is not linked to the needs of the person being cared for, or for that matter differences in the needs of the carer. The principal benefit, Carer's Allowance, is a means-tested benefit for people aged 18 and over providing full-time care to someone who needs full-time care. The level of the allowance will depend on income and capital, and can be a maximum of €298 per week for a carer aged over 66 caring for 1 person, rising to a maximum of €447 if caring for two or more people.

In addition, a time-limited benefit, Carer's Benefit, is paid to people who leave work or reduce their hours to care for a person in need of full-time care. The carer must be under 66, have paid sufficient social insurance (PSRI) contributions and be earning less than €450 per week after tax. The benefit can be paid for up to two years (104 weeks) for each person being cared for.[110]

As other chapters have indicated, family/unpaid carers, many of whom are older people themselves, are key contributors to the production of care and support for older people in Ireland. There is a large body of evidence internationally showing that high-intensity caregiving results in caregivers giving up employment opportunities, retiring early, or experiencing a decline in both physical and mental health, which has profound implications for the wider economy and society [439, 440]. In Ireland analysis of data from more than 2,000 carers found that carers of people with dementia were significantly more likely to report moderate to high adverse impacts on their 'caregiver burden', i.e. physical health, emotional wellbeing, social connections and finances [441]. A study in the UK also found that there is a tipping point in caregiving intensity: family/unpaid carers providing more than five hours of care report significantly worse wellbeing than non-carers while providing fewer than five hours of care does not seem to affect wellbeing noticeably [442].

Accordingly, providing cash and other supports to carers as part of any resource-allocation process, in order to help finance services and activities to support family/unpaid carers, plays an important role in protecting carers' wellbeing and helps carers to maintain their capacity to continue to provide care for their loved ones in the long term. The current lack of a needs-based mechanism when assessing cash-benefits for carers may have implications for the sustainability of the supply of family/unpaid carers in future, especially for children and other non-spousal carers.

110. See https://www.citizensinformation.ie/en/social-welfare/carers/carers-benefit/.

9.4 Efficiency and effectiveness considerations

9.4.1 Funding levels, production of care and outcomes

This chapter does not make a judgement on whether specific funding levels for services for older people are appropriate. However, adequate funding and allocation are not only instrumental to the sustainable production of care and services in the health and long-term care system but also contribute to the effectiveness of the system by improving health and wider life-outcomes for the older population. In this section we look at the relationship between levels of expenditure and the production of care and outcomes, drawing on international experience.

The relationships between care-expenditure and health-outcomes are often complex. On the one hand, increasing expenditure leads to a rise in supply of care and services, which has an impact on health-outcomes, such as improvements in wellbeing and quality of life. On the other hand, poor health-outcomes may be an indication that the system does not have adequate resources, which, in return, calls for more spending or more efficient allocation of resources. Therefore, any studies which aim to evaluate the effectiveness of increasing care-expenditure in promoting health-outcomes normally need to take great care to disentangle the causality and reverse-causality between the two.

With this causality issue in mind, it has been reported that an increase in community-based long-term care expenditure in England has significantly improved care-related quality of life (CRQoL) of service-users. Other things being equal, the impacts are greatest for people with higher levels of care-needs [443]. Another study conducted in England found similar effects, indicating that, across local authorities, increases in public long-term care expenditure per user increased care-related quality of life r[444]. Health and long-term care spending constraints between 2010 and 2014 in England have also been associated with a higher-than-expected number of deaths. Higher-than-expected deaths were concentrated among those aged 60 and over living in LTRC homes [445].

9.4.2 Health expenditure and unmet care-needs

One of the pathways that link an increase in care-expenditure and better health-outcomes is through the reduction of unmet care-needs. Unmet care-needs refer to a situation where people experience the onset or development of care-needs but do not receive the corresponding help or services. Lack of funding of care leads to a number of issues such as geographical inaccessibility, unaffordability of services, delay in service delivery, or low quality of care. To meet people's care-needs, it is fundamental to put the required resources in place in time and to make care and support available to the population with care-needs in the first place. Unmet care-needs are sometimes treated as 'care poverty'. The argument is that it is the responsibility of any welfare state to meet the most basic human needs of its population. Thus the existence of unmet health and long-term care needs in many cases is attributable to policy and system failures [446].

In Ireland, it has previously been estimated that 4% of the population report unmet healthcare-needs [447]. Affordability and waiting lists are the two major factors accounting for unmet needs. Public healthcare entitlement does not mean that there are no unmet needs. Those with largely free public healthcare entitlement were more likely than all other eligibility categories to report that their unmet need was due to a waiting list (i.e. timeliness) rather than high costs (i.e., affordability) [447]. An increasing body of literature has reported the association between unmet healthcare needs and life-outcomes. Unmet healthcare needs were found to be associated with a decline in quality of life and self-rated health in Korea [448]. Analysis using longitudinal data on older people in China and Taiwan also found that older people experiencing unmet care-needs reported more severe depressive symptoms and a lower level of life satisfaction [109].

9.4.3 Misaligned incentives

The different approaches to the public funding of home support, and LTRC in particular, mean that incentives on the use of these services are misaligned. While home support is free of charge, it is limited in availability and there may be a necessity to top up publicly funded home support with additional private home support because of these supply-constraints. There is no cap on these additional out-of-pocket costs for home support expenditure. The NHSS provides a high degree of certainty on the maximum level of out-of-pocket payments/contributions from the assets of older people, with a guarantee that the State will continue to fund long-term care. This avoids the risk of catastrophic costs being incurred by individuals and their families due to LTRC fees. While this is important, because the same level of financial support does not exist for home support, it means that there may be over-use/over-demand for LTRC. A well-funded package of home support would give an older person more freedom to choose between remaining in their current home, moving to housing with more support or moving to residential care. The continued policy-commitment to introduce a statutory home support scheme, if implemented, potentially provides an opportunity to address this issue [145].

9.5 Learnings

The principal source of funding for all health and social care services for older people in Ireland is general taxation, accounting for 77% of all expenditure. Overall, out-of-pocket payments account for 11% of all funding but represent a higher share of all sources of expenditure for some services that are more likely to be used by older people, notably LTRC. Older people who do not have a medical card or GPVC are also less likely to avail of GP services; this is also likely to mean that they are less likely to make use of other community services. This includes people over the age of 70 who are at least entitled to a GPVC, suggesting there are still issues around awareness of entitlement to these cards. The lack of resources being allocated to free home support means that 24% of all home support in Ireland is purchased privately.

There is longstanding acknowledgement in policy documents that the current model of resource-allocation, much of which does not take health and social care need into account, is a hindrance to the development of a more integrated model of care and support for older people, that will allow more intervention at home and in the community. Evidence from Ireland and other countries indicates the adverse consequences of unaddressed health and social needs, both for older people themselves and family carers. Despite this, progress in moving to a PBRA system has been slow, although this is now being implemented.

Nearly half (48%) of all expenditure is, however, not covered by the initial PBRA system. For some highly specialist services this makes sense, but services that are currently excluded from the new model for resource-allocation include GP and dental services as well as the NHSS. Capitation models for GPs, while taking account of age, gender and nursing home residence, currently do not take account of differences in healthcare-needs, for instance the additional care-needs that people in the later stages of dementia will have. Equally, while cash-benefits to carers of all ages account for around 4% of all current health expenditure, these cash-benefits do not take account of the additional care challenges faced by carers of people with more complex care-needs.

9.6 Strengths, weaknesses, opportunities and threats

Strengths

- Recognition in policy of the need to move to PBRA across the Irish healthcare system.
- Recent publication of proposed PBRA formulae, coupled with the reorganisation of the healthcare system into six HSE Health Regions to allow for greater devolution, is helping to facilitate implementation of PBRA. This, if well implemented, has the potential to significantly improve the efficient and equitable allocation of health and social care resources.

Weaknesses

- Currently unlike many other European and contemporary healthcare systems, until the full implementation of PBRA, Ireland will continue to lack a systematic resource-allocation mechanism. In the past this has contributed to inefficiencies in the system, such as a lack of healthcare workers, physical facilities and infrastructure, coordinated care-pathways and health information systems.
- Lack of alignment of funding mechanisms, eligibility criteria and resource-allocation approaches for LTRC and home support provides a financial incentive to overuse LTRC when this may not reflect the preferences of the older person.
- Capitation systems for GPs do not fully reflect the needs of the populations they support, as these capitation payments do not take account of differences in health-care and support-needs, e.g. the additional costs of supporting people with dementia.
- Mechanisms to allocate resources to carers do not take account of the care-needs of the person they are supporting. Carers' benefits are also largely restricted to carers who are supporting people who need 24-hour care; many carers therefore currently do not receive support.

Opportunities

- Innovation in resource-allocation and payment mechanisms, such as blended payment models that are being introduced, for instance for primary and community care specialist teams, can help facilitate the development of integrated funding pathways, incentivising a shift left towards non-hospital care.
- More use of PBRA can also facilitate medium-term budgeting and planning.
- Opportunities to consider how to extend the initial plans for PBRA to cover a wider range of services including the NHSS and GP care.
- Planned steps to introduce a statutory home support scheme provide opportunities to consider how better to align eligibility and funding mechanisms for home support and nursing home support.

Threats

- Inertia in policy implementation associated with an overly centralised view of health production that undervalues autonomy, connectivity and equity.
- Insufficient manpower at local level to ensure resource-allocations reflect local preferences at regional/local level. There is no past experience of making these decisions at scale at regional/local level.
- As the HSE is still allocating some health and social care resources based on historic patterns of demand for services, these may not reflect current needs, potentially widening health inequalities.
- The maximum capitation rate for GP practice list patients is for those aged 70 and above; potentially the needs of people who are considerably older than 70 are more intense, and this differential may put more pressure on the GP and primary care system as the population ages.

10

References

1. Oireachtas Committee on the Future of Healthcare, *Sláintecare Report*. 2017, Houses of the Oireachtas: Dublin.
2. Department of the Taoiseach, *First Report on a Well-being Framework for Ireland*. 2021: Dublin.
3. Government of Ireland, *Understanding Life in Ireland: The Well-being Framework 2024*. 2024, Government of Ireland: Dublin.
4. Department of Rural and Community Development, *National Volunteering Strategy 2021–2025*. 2020, Department of Rural and Community Development: Dublin.
5. Health Service Executive, *National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland 2020–2025*. 2020, Health Service Executive: Dublin.
6. Health Service Executive, *HSE Social Prescribing Framework*. Available at https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/mental-health-and-wellbeing/social-prescribing/hse-social-prescribing-framework.pdf. 2021, HSE: Dublin.
7. Naughton, H., *Written answer to question 2042/24*. Health Strategies Dáil Éireann Debate 17 January 2024. 2024, Houses of the Oireachtas: Dublin.
8. Health Service Executive, *HSE Social Prescribing Poster: Social Prescribing. Improving your Health and Wellbeing*. 2024, Health Service Executive.: Dublin.
9. Dunne, A., et al., *Social Experiences During Participation in a Community Physical Activity Initiative: A Cross-Sectional Study of Parkrun Participants in Ireland*. medRxiv, 2025: p. 2025.06.18.25329855.
10. Age Friendly Ireland. *Who We Are. Age Friendly Ireland*. 2023; Available from: https://agefriendlyireland.ie/about-us/who-we-are/.
11. World Health Organization, *The Global Network for Age-friendly Cities and Communities: Looking Back Over the Last Decade, Looking Forward to the Next*. 2018, World Health Organization: Geneva.
12. Age Friendly Ireland. *What We Do. Age Friendly Ireland*. 2023; Available from: https://agefriendlyireland.ie/about-us/what-we-do/.
13. Age Friendly Ireland. *How We Do It. Age Friendly Ireland*. 2023; Available from: https://agefriendlyireland.ie/about-us/our-structures/local-structures/.
14. Age Friendly Ireland. *Healthy Age Friendly Homes Programme*. 2024 [cited 2024 August 7]; Available from: https://agefriendlyireland.ie/healthy-age-friendly-homes-programme/.
15. Department of Health, *Minister for Mental Health and Older People Announces Additional Funding for Healthy Age Friendly Homes Programme in 2025*. 2025, Department of Health.: Dublin.
16. Third Age Foundation, *Report and Financial Statements for the Year Ended 31 December 2024*. 2024, Third Age Foundation,: Summerhill, Co. Meath.
17. Age Action, *Action Today, for Your Tomorrow: Annual Report and Financial Statements 2024*. 2024, Age Action: Dublin.

18. Muintir na Tíre, *Financial Statements for the Financial Year Ended 31 December 2024*. 2024, Muintir na Tíre Tipperary.

19. Gaelic Athletic Association, *An Chomhdháil Bhliantúil 2025*. Tuarascáil an ard-stiúrthóra agus cuntais airgid 2024. 2025, Gaelic Athletic Association Dublin.

20. National Meals on Wheels Network, *National Meals on Wheels Network Pre-Budget 2024* Submission. 2024, National Meals on Wheels Network.

21. Society of St. Vincent de Paul. *Adult and Older Peoples Services*. 2025; Available from: https://www.svp.ie/what-we-do/adult-and-older-peoples-services/.

22. Department of Tourism Culture Arts Gaeltacht Sport and Media, *Creative Ireland Awards Over €1,000,000 to Creative Projects for Older People*. 2022, Department of Tourism, Culture, Arts, Gaeltacht, Sport and Media: Dublin.

23. ALONE, *ALONE Annual Report 2024*: *Transforming Ageing at Home Together*. 2025, ALONE: Dublin.

24. ALONE, *ALONE ECC Report 2024*. 2025, ALONE: Dublin.

25. Healy, P., *Community-based Health and Social Care for Older People – Enhanced Community Care Model*. Presentation to the Commission on Care for Older People. 6 July 2024. 2024.

26. Gannon Petrie, N., et al., *Older Adults Who Receive Care Coordination from the Third Sector in Ireland: Who Are They, and What Do They Need?* Journal of Social Service Research, 2025: p. 1–13.

27. Homeniuk, R., et al., *Transforming Ageing at Home: Evaluating ALONE's Impact Through Enhanced Community Care*. 2025, ALONE: Dublin.

28. Health Information and Quality Authority, *Draft National Guidelines for the Economic Evaluation of Health Technologies in Ireland* 2024, HIQA: Cork.

29. Hughes, M.E., et al., *A Short Scale for Measuring Loneliness in Large Surveys*: *Results From Two Population-Based Studies*. Res Aging, 2004. **26**(6): p. 655-672.

30. ALONE, *ALONE ECC Quarterly Report*. Q3 2024. 2024, Dublin: ALONE.

31. McCann, A., *Healthy Age Friendly Homes. Pilot Evaluation*. 2024, Age Friendly Ireland: Dublin.

32. Kiely, B., et al., *Effect of Social Prescribing Link Workers on Health Outcomes and Costs for Adults in Primary Care and Community Settings: A Systematic Review*. BMJ Open, 2022. **12**(10): p. e062951.

33. Kiely, B., et al., *An Exploratory Randomised Trial Investigating Feasibility, Potential Impact and Cost Effectiveness of Link Workers for People Living with Multimorbidity Attending General Practices in Deprived Urban Communities*. BMC Prim Care, 2024. **25**(1): p. 233.

34. Wildman, J. and J.M. Wildman, *Impact of a Link Worker Social Prescribing Intervention on Non-elective Admitted Patient Care Costs: A Quasi-experimental Study*. Soc Sci Med, 2023. **317**: p. 115598.

35. Crocker, T.F., et al., *Community Based Complex Interventions to Sustain Independence in Older People: Systematic Review and Network Meta-analysis*. BMJ, 2024. **384**: p. e077764.

36. Clifford, A.M., et al., *The Effect of Dance on Physical Health and Cognition in Community Dwelling Older Adults: A Systematic Review and Meta-analysis*. Arts & health, 2023. **15**(2): p. 200–228.

37. Volunteer Ireland, *Reporting on the Volunteering Question in Ireland's 2022 Census*. 2024, Volunteer Ireland: Dublin.

38. Charities Regulator, *An Overview of Ireland's Smaller Charities*. 2023, Charities Regulator: Dublin.

39. National Council for Voluntary Organisations, *The Power of Small*. 2025, NCVO: London.

40. Health Service Executive. Primary Care: Health and Social Care Services. 2024 [cited 2024 4 September].

41. Department of Health and Children, *Primary Care: A New Direction*. 2001, The Stationery Office: Dublin.

42. Department of Health, *Future Health: A Strategic Framework for Reform of the Health Service 2012–2015*. 2012, Department of Health: Dublin.

43. Department of Health, *National Adult Palliative Care Strategy*. 2024, Department of Health: Dublin.

44. Government of Ireland, *Organisational Reform. HSE Health Regions. Implementation Plan July 2023*. 2023, Government of Ireland: Dublin.

45. Health Service Executive, *ECC Programme and the Network Operating Model*. Presentation Slide Deck. 2022, HSE: Dublin.

46. Macinko, J., B. Starfield, and L. Shi, *The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) countries*, 1970–1998. Health Serv Res, 2003. 38(3): p. 831–65.

47. Ma, Y. and A. Nolan, *Public Healthcare Entitlements and Healthcare Utilisation among the Older Population in Ireland*. Health Econ, 2016.

48. Nolan, A. and S. Smith, *The Effect of Differential Eligibility for Free GP Services on GP Utilisation in Ireland*. Soc Sci Med, 2012. **74**(10): p. 1644–1651.

49. Baxter, S., et al., *The Effects of Integrated Care: A Systematic Review of UK and International Evidence*. BMC Health Serv Res, 2018. **18**(1): p. 350.

50. Government of Ireland, *Sláintecare. Right Care. Right Place. Right Time. Progress Report 2021–2023*. 2024, Government of Ireland: Dublin.

51. Rockwood, K., et al., *A Global Clinical Measure of Fitness and Frailty in Elderly People*. Cmaj, 2005. **173**(5): p. 489–95.

52. Rockwood, K. and O. Theou, *Using the Clinical Frailty Scale in Allocating Scarce Health Care Resources*. Can Geriatr J, 2020. **23**(3): p. 210–215.

53. McDaid, D., et al., *Ireland: Health System Review*. 2009, World Health Organization Regional Office for Europe: Copenhagen.

54. Keane, C., M. Regan, and B. Walsh, *Failure to Take-up Public Healthcare Entitlements: Evidence from the Medical Card System in Ireland*. Soc Sci Med, 2021. **281**: p. 114069.

55. Health Service Executive. Primary Care Reimbursement Service. *Eligibility Figures Medical Card Holders and GP Visit Card Holders. September 2025* 2025 26 September 2025]; Available from: https://www.sspcrs.ie/portal/annual-reporting/report/eligibility.

56. Larkin, J., et al., *What is the Impact of Multimorbidity on Out-of-Pocket Healthcare Expenditure Among Community-dwelling Older Adults in Ireland? A cross-sectional study*. BMJ Open, 2022. **12**(9): p. e060502.

57. Medical Council, *Medical Workforce Intelligence Report 2023*. Available at https://www.medicalcouncil.ie/news-and-publications/reports/medical-workforce-intelligence-report-2023.pdf. 2023, Medical Council: Dublin.

58. Irish College of General Practitioners, *Shaping the Future: A Discussion Paper on the Workforce & Workload Crisis in General Practice in Ireland*. 2022, ICGP: Dublin.

59. Connolly, S., T. Kakoulidou, and E. McHugh, *Projections of National Demand and Workforce Requirements for General Practice in Ireland, 2023–2040: Based on the Hippocrates model*, in ESRI Research Series 215. 2025, Economic and Social Research Institute: Dublin.

60. Monahan, T., *'Long-term Plan and Certainty' are Needed to Attract New GPs*. Available at https://www.independent.ie/irish-news/long-term-plan-and-certainty-are-needed-to-attract-new-gps/a600032804.html, in Irish Independent. 2024: Dublin.

61. Department of Health, Minister for Health Publishes the *Terms of Reference for a Strategic Review of General Practice*. Available at https://www.gov.ie/en/press-release/51653-minister-for-health-publishes-the-terms-of-reference-for-a-strategic-review-of-general-practice/#:~:text=The%20Strategic%20Review%2C%20with%20input,on%20the%20principles%20of%20Sl%C3%A1intecare. 2023, Department of Health: Dublin.

62. Department of Health. *Terms of Reference for a Strategic Review of General Practice*. Available at https://www.gov.ie/en/publication/701f8-terms-of-reference-for-a-strategic-review-of-general-practice/. 2023.

63. Paul, M., *Care Centre Group Centric Secures €50m in Funding. Funding Deal Comes Following Investment in Group Earlier this Year by Rothschild*, in Irish Times. 2018: Dublin.

64. Irish College of General Practitioners, *Press Release GP Workforce*. 23 August. Available at https://www.irishcollegeofgps.ie/News/press-release-gp-workforce. 2024, Irish College of GPs: Dublin.

65. Kane, C. *New measures Put in Place to Tackle Shortage of GPs*. 2024 [cited 2024 September 4]; Available from: https://www.rte.ie/news/health/2024/0313/1437573-gp-recruitment/.

66. de Vries, K., A. Pepper, and K. Harrison Dening, *Exploring the Complexities of Symptom Recognition and Management in Older People with Dementia and Multimorbidity*. Nurs Older People, 2025. **37**(3): p. 20–25.

67. Department of Health, Health Service Executive, and I.M. Organisation, *GP Agreement* 2023. Available at https://www.hse.ie/eng/about/who/gmscontracts/gpagreement2023/gp-agreement-2023.pdf. 2023: Dublin.

68. Health Service Executive, *National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland 2020–2025*. Available at https://www.hse.ie/eng/about/who/cspd/icp/chronic-disease/documents/national-framework-integrated-care.pdf 2020, HSE: Dublin.

69. IPSOS B&A, *Healthy Ireland Survey 2023. Summary Report*. Available at https://assets.gov.ie/283794/3ef96218-68fb-4fa3-a0d2-ec687071db38.pdf. 2023, Government Publications: Dublin.

70. Walsh, B., et al., *Projections of Expenditure for Primary, Community and Long-term Care in Ireland 2019–2035, Based on the Hippocrates Model*, in ESRI Research Series 126. 2021, Economic and Social Research Institute: Dublin.

71. Doolan, M. and S. Prior, Note: *Private Expenditure on General Practice*, in Spending Review 2020. 2020, Department of Public Expenditure and Reform.

72. Connolly, S., et al., *Extending Eligibility for General Practitioner Care in Ireland: Cost implications*, in ESRI Research Series 156. 2023, ESRI: Dublin.

73. Hayes, C., et al., *Effectiveness of Community-Based Multidisciplinary Integrated Care for Older Adults with General Practitioner Involvement: A Systematic Review and Meta-Analysis*. Health & Social Care in the Community, 2024. **2024**(1): p. 6437930.

74. Jeon, Y.H., et al., *Investigating Community-based Care Service Factors Delaying Residential Care Home Admission of Community Dwelling Older Adults and Cost Consequence*. Age Ageing, 2023. **52**(10).

75. Crous-Bou, M., et al., *Alzheimer's Disease Prevention: From Risk Factors to Early Intervention*. Alzheimers Res Ther, 2017. **9**(1): p. 71.

76. Norton, S., et al., *Potential for Primary Prevention of Alzheimer's Disease: An Analysis of Population-based Data*. Lancet Neurol, 2014. **13**(8): p. 788–94.

77. O'Brien, J.G., et al., *Elder Abuse and Neglect: A Survey of Irish General Practitioners*. J Elder Abuse Negl, 2014. **26**(3): p. 291–9.

78. Manthorpe, J., *The Abuse, Neglect and Mistreatment of Older People with Dementia in Care Homes and Hospitals in England: The Potential for Secondary Data Analysis: Innovative Practice*. Dementia (London), 2015. 14(2): p. 273-9.

79. Health Service Executive, *HSE Home Support Service for Older People. Information Booklet and Application Form*. 2023, HSE: Dublin. p. 18.

80. *Health Act, 1970. Section 61*. Available at https://www.irishstatutebook.ie/eli/1970/act/1/section/61/enacted/en/html. 1970, Irish Statute Book: Ireland.

81. HSE, *National Guidelines & Procedures for the Standardised Implementation of the Home Support Service (HSS Guidelines)*. 2018: HSE.

82. Hanly, P. and C. Sheerin, *Valuing Informal Care in Ireland: Beyond the Traditional Production Boundary*. Econ Soc Rev, 2017. **48**(3, Autumn): p. 28.

83. Timonen Doyle, V.M., *From the Workhouse to the Home: Evolution of Care Policy for Older People in Ireland*. International Journal of Sociology and Social Policy, 2008. **28**(3/4): p. 76–89.

84. The Eurocare Team, *Later-life Caring in Europe*. 2024.

85. O'Shea, E., *The Impact of Social and Economic Policies on Older People in Ireland*. 1993.

86. NESC, *Care for Older People*, NESF, Editor. 2005.

87. COVID-19 Nursing Homes Expert Panel, *Examination of Measures to 2021. Report to the Minister for Health*. Available at https://www.gov.ie/en/publication/3af5a-covid-19-nursing-homes-expert-panel-final-report/. 2020, COVID-19 Nursing Homes Expert Panel: Dublin.

88. Donnelly, S. *Written Answer to Question 581: Home Care Packages. Dáil Éireann Debate, Tuesday - 23 January*. Available at https://www.oireachtas.ie/en/debates/question/2024-01-23/581/. 2024.

89. Gov.ie, *Programme for Government 2025. Securing Ireland's Future. 2025*, Gov.ie: Dublin.

90. The Citizens Assembly, *Second Report and Recommendations of the Citizens' Assembly: How we Best Respond to the Challenges and Opportunities of an Ageing Population*. 2023: Dublin, Ireland.

91. HIQA, *Draft National Standards for Home Support Services*. 2024, Health Information and Quality Authority.

92. Buczak-Stec, E.W., et al., *Frequency and Gender Differences in the Use of Professional Home Care in Late Life. Findings from Three German Old-age Cohorts*. Front Med (Lausanne), 2022. **9**: p. 924818.

93. McCann, M., M. Donnelly, and D. O'Reilly, *Gender Differences in Care Home Admission Risk: Partner's Age Explains the Higher Risk for Women*. Age and Ageing, 2012. 41(3): p. 416–419.

94. Health Service Executive, *Health Service Executive. Annual Report and Financial Statements 2024*. 2025, HSE: Dublin.

95. Institute of Public Health in Ireland, *Improving Home Care Services in Ireland: An Overview of the Findings of the Department of Health's Public Consultation*. 2018, Institute of Public Health in Ireland: Dublin.

96. Walsh, B. and T. Kakoulidou, *Projections of National Demand and Bed Capacity Requirements for Older People's Care in Ireland, 2022–2040: Based on the Hippocrates Model*. 2025, ESRI: Dublin.

97. Health Service Executive, *Response to PQ 16963/24: To ask the Minister for Health the number of persons on a waiting list for homecare packages in each month in 2023 and to date in 2024, by CHO and LHO, in tabular form. -Róisín Shortall*. 2024, Health Service Executive: Dublin.

98. Health Service Executive, Response to PQ 7266/24: *To ask the Minister for Health the number of patients on home support waiting lists for a carer at the end of January of each year 2019-2024, inclusive; and the breakdown by length of wait, in tabular form. -David Cullinane*. 2024, Health Service Executive: Dublin.

99. Walsh, B. and S. Lyons, *Demand for the Statutory Home Support Scheme*, in ESRI Research Series 122. 2021, Economic and Social Research Institute: Dublin.

100. HCCI, *The Waiting List Lottery: Home Support Across Ireland*, H.C.C. Ireland, Editor. 2023.

101. Smith, S., et al., *Geographic Profile of Healthcare Needs and Non-Acute Healthcare Supply in Ireland*, in ESRI Research Series 90. 2019, Economic and Social Research Institute: Dublin.

102. Home Care Coalition, *The Home Care Coalition: Experiences from the Grassroots*. https://iasw.ie/download/673/19.09.23%20-%20Home%20Care%20Coalition%20-%20Experiences%20of%20Homecare%20v2.pdf. 2023, Irish Association of Social Workers: Dublin.

103. Phelan, A.A., et al., *Evaluating a Consumer-directed Health Care Pilot for Older People in the Community*. Innovation in Aging, 2019. **3**(Suppl 1): p. S498.

104. Age Friendly Ireland, *ReAblement is a Home-based Rehabilitation Service for Older People*. https://agefriendlyireland.ie/initiative/reablement-is-a-home-based-rehabilitation-service-for-older-people/. 2023, Age Friendly Ireland: Navan.

105. Family Carers Ireland, *The State of Caring in Ireland*. https://www.familycarers.ie/media/3549/family-carers-ireland-state-of-caring-2024.pdf. 2024, Family Carers Ireland: Tullamore.

106. Conyard, K.F., et al., *Healthcare Assistants and Qualified Carers, A Trained, but Untapped Underutilised Resource: A Population-based Study in Ireland of Skillset, Career Satisfaction, Wellbeing and Change Across all Sectors and Care Settings*. 2020, UCD CSTAR & HCA & Carers Ireland.

107. Keogh, F., et al., *Intensive Home Care Packages for People with Dementia: A Realist Evaluation Protocol*. BMC Health Serv Res, 2018. **18**(1): p. 829.

108. Carter, L., et al., *Intensive Home Care Supports, Informal Care and Private Provision for People with Dementia in Ireland*. Dementia (London), 2021. **20**(1): p. 47–65.

109. Hu, B. and Y.C. Chou, *Care Poverty Among Older Adults in East Asia: A Comparison of Unmet Care Needs Between China and Taiwan*. Arch Gerontol Geriatr, 2022. **102**: p. 104738.

110. Strategic Workforce Advisory Group, *Report of the Strategic Workforce Advisory Group on Home Carers and Nursing Home Healthcare Assistants*. 2022, Department of Health: Dublin.

111. Foster, D., *Research Briefing: Adult Social Care Workforce in England*. 2024, London: House of Commons Library, UK Parliament.

112. Silversides, K. and M. Astakhov, *Understanding the Reasons Care Workers Move On and Their Future Intentions*. Scoping Study 2023, Leeds: Skills for Care.

113. Skills for Care, *A Workforce Strategy for Adult Social Care in England*. 2024, Leeds: Skills for Care.

114. Walsh, B., P. Redmond, and B. Roantree, *Differences in Risk of Severe Outcomes from COVID-19 Across Occupations in Ireland, in ESRI Survey and Statistical Series 93*. 2020, Economic and Social Research Institute: Dublin.

115. Walsh, B. and S. Connolly, *Long-term Residential Care in Ireland: Developments Since the Onset of the COVID-19 Pandemic*, in ESRI Research Series 174. 2024, Economic and Social Research Institute: Dublin.

116. Mercille, J., *European Long-term Care Marketisation: A Political Economy Framework*. Social Policy & Administration, 2024. n/a(n/a).

117. Mercille, J. and N. O'Neill, *The Growth of Private Home Care Providers in Europe: The Case of Ireland*. Social Policy & Administration, 2020. n/a(n/a).

118. Doyle, M. and V. Timonen, *Breaking the Mould: New Trajectories in the Domiciliary Care of Older People in Ireland*. International Journal of Social Welfare, 2008. 17(4): p. 324–332.

119. National Community Care Network. *National Community Care Network Opening Statement to Joint Oireachtas Committee on Health*. 2017; Available from: https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_health/submissions/2017/2017-11-15_opening-statement-national-community-care-network-nccn_en.pdf.

120. Home Care Coalition. *Home Care Coalition Submission from the Home Care Coalition to the Joint Oireachtas Committee on Health*. 2024; Available from: https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/joint_committee_on_health/submissions/2024/2024-10-09_submission-the-home-care-coalition_en.pdf.

121. Mercille, J. and N. O'Neill, *Institutional Business Power: The Case of Ireland's Private Home Care Providers*. Journal of Social Policy, 2024. **53**(2): p. 348–365.

122. Elkan, R., et al., *Effectiveness of Home Based Support for Older People: Systematic Review and Meta-analysis*. BMJ, 2001. **323**(7315): p. 719–25.

123. Gitlin, L.N., et al., *Long-term Effect on Mortality of a Home Intervention that Reduces Functional Difficulties in Older Adults: Results From a Randomized Trial*. J Am Geriatr Soc, 2009. **57**(3): p. 476–81.

124. Boland, L., et al., *Impact of Home Care Versus Alternative Locations of Care on Elder Health Outcomes: An Overview of Systematic Reviews*. BMC Geriatr, 2017. **17**(1): p. 20.

125. Aspell, N., et al., *Predicting Admission to Long-term Care and Mortality Among Community-based, Dependent Older People in Ireland*. International Journal of Geriatric Psychiatry, 2019. **34**(7): p. 999–1007.

126. Hass, Z., et al., *Unmet Need for Help with Activities of Daily Living Disabilities and Emergency Department Admissions Among Older Medicare Recipients*. Gerontologist, 2017. **57**(2): p. 206–210.

127. He, S., et al., *Unmet Need for ADL Assistance Is Associated with Mortality Among Older Adults with Mild Disability*. J Gerontol A Biol Sci Med Sci, 2015. **70**(9): p. 1128–32.

128. Walsh, B., et al., *Does Formal Home Care Reduce Inpatient Length of Stay?* Health Econ, 2020.

129. Gonçalves, J. and F. Weaver, *Effects of Formal Home Care on Hospitalizations and Doctor Visits*. International Journal of Health Economics and Management, 2017. **17**(2): p. 203–233.

130. Gaughan, J., H. Gravelle, and L. Siciliani, *Testing the Bed-blocking Hypothesis: Does Nursing and Care Home Supply Reduce Delayed Hospital Discharges?* Health Econ, 2015. **24 Suppl 1**: p. 32–44.

131. Shepperd, S., et al., *Is Comprehensive Geriatric Assessment Admission Avoidance Hospital at Home an Alternative to Hospital Admission for Older Persons?* : A Randomized Trial. Ann Intern Med, 2021. **174**(7): p. 889–898.

132. HIQA, *As Is Analysis: ICT Enablement of Older Persons Services*. 2022: HIQA, Dublin.

133. Health Service Executive, *National Service Plan 2025*. 2025, Health Service Executive.

134. Walsh, S., et al., *Public Preferences for Home Care Services for People with Dementia: A Discrete Choice Experiment on Personhood*. Social Science & Medicine, 2020. 245: p. 112675.

135. Durvy, B., E. van Ginneken, and J. Cylus, *Improving Home Care Sustainability in Ireland: Are User Charges a Promising Option?* 2023, European Observatory on Health Systems and Policies: WHO Regional Office for Europe, Denmark.

136. Keane, C., et al., *Home Support Services in Ireland: Exchequer and Distributional Impacts of Funding Options*, in ESRI Survey and Statistical Series 111. 2022, Economic and Social Research Institute: Dublin.

137. Coyle, C., et al., *Housing with Support for Older People: An Evidence Review*. 2021, Health Research Board: Dublin.

138. Amárach Research, et al., *Housing for Older People: Thinking Ahead*. 2016, Housing Agency: Dublin.

139. Department of Housing Planning and Local Government and Department of Health, *Housing Options for Our Ageing Population: Policy Statement*. 2019, Government of Ireland,: Dublin.

140. Department of Housing Local Government and Heritage, *Housing for All: A New Housing Plan for Ireland*. 2021, Government of Ireland: Dublin.

141. Government of Ireland, *Housing for All. Q4 2021 Progress Report*. 2021, Government of Ireland: Dublin.

142. Department of Housing Local Government and Heritage, *Guidance on the Preparation of a Housing Need and Demand Assessment*. 2021, Government of Ireland: Dublin.

143. Government of Ireland, *Housing for All. Action Plan Update and Q3 2023 Progress Report*. 2023, Government of Ireland: Dublin.

144. Government of Ireland, *National Housing Strategy for Disabled People 2022–2027*. 2022, Government of Ireland: Dublin.

145. Department of the Taoiseach, *Programme for Government 2025: Securing Ireland's Future. 2025*, Dublin: Gov.ie.

146. Government of Ireland, *Project Ireland 2040: National Planning Framework First Revision*. 2025, Government of Ireland: Dublin.

147. The Housing Commission, *Report of the Housing Commission*. 2024, Dublin: Gov.ie.

148. Mulholland, R. and R. Molloy, *Thinking Ahead: The Financial Benefits of Investing in Supported Housing for Older People*. 2020, The Housing Agency: Dublin.

149. Approved Housing Bodies Regulatory Authority, *Second Sectoral Analysis of the Approved Housing Bodies Sector 2023*. 2023, Approved Housing Bodies Regulatory Authority: Dublin.

150. Department of Housing Local Government and Heritage, *Ministers O'Brien and Dillon Announce Reforms Following Review of the Housing Adaptation Grants*. 2024, Gov.ie: Dublin.

151. Department of Housing Local Government and Heritage, *Report on the Review of the Housing Adaptation Grants for Older People and People with a Disability*. 2024, Department of Housing Local Government and Heritage,: Dublin.

152. ALONE and Social Justice Ireland, *Policy Options to Support Ageing Well at Home*. Budget 2025 submission. 2024, ALONE and Social Justice Ireland: Dublin.

153. Burke-Kennedy, E., *More Than Two-thirds of People are Living in Homes Too Big for Their Needs, ESRI Research Finds*, in Irish Times. 2024, Irish Times: Dublin.

154. Corrigan, E., O. Joyce, and G. McGuinness, *Attitudinal Survey of Mature Homeowners*. 2020, Irish Government Economic and Evaluation Service: Dublin.

155. Central Statistics Office, *Census of Population 2022 Profile 2: Housing in Ireland*. 2023, CSO: Dublin.

156. Haran, N., P. Butler, and J. Finnerty, *Double Deficit: Older and Ageing Persons in the Irish Private Rental Sector*. 2023, Threshold Preventing Homlessness and ALONE: Dublin.

157. Slaymaker, R., et al., *Future Trends in Housing Tenure and the Adequacy of Retirement Income*. 2022, ESRI: Dublin.

158. The Housing Agency, *Summary of Social Housing Assessments 2024. Key Findings*. 2025, Housing Agency: Dublin

159. The Housing Agency, *Summary of Social Housing Assessments 2013. Key Findings*. 2013, Housing Agency: Dublin

160. Evans, S.C., et al., *Can Extra Care Housing Support the Changing Needs of Older People Living with Dementia?* Dementia (London), 2020. 19(5): p. 1492–1508.

161. Walsh, K., *Evaluation of Phase 2 of the Dublin City Age Friendly 'Housing with Support' Model in Inchicore*. 2022, The Housing Agency: Dublin.

162. Walsh, K., *How to Develop a Housing with Support Scheme for Older People. Framework Toolkit*. 2022, The Housing Agency: Dublin.

163. Netten, A., et al., *Improving Housing with Care Choices for Older People: An Evaluation of Extra Care Housing*. 2011, Kent: PSSRU.

164. Bäumker, T., et al., *Evaluating Extra Care Housing in the United Kingdom Social Care Context: A Comparative Cost and Outcome Analysis with Residential Care*. Journal of Service Science and Management, 2011.

165. Kempton, O. and A.G. Warby, *Measuring the Social Return on Investment of Stage 3 Adaptations and Very Sheltered Housing in Scotland*. 2011, Envoy Partnership: London.

166. Housing Learning Improvement Network, *The Health and Social Care Cost-Benefits of Housing for Older People*. 2019, Mears Group PLC: Gloucester.

167. Grey, T., et al., *Housing Conditions and Integrated Care for Older People,. Tallaght University Hospital and Partners, Identifying Common Housing Conditions Affecting Older People in South Dublin*. 2024, Meath Foundation: Dublin.

168. Walsh, B. and T. Kakoulidou, *National Projections of Demand and Workforce Requirements for Older People's Care in Ireland, 2023–2040: Based on the Hippocrates model*, in ESRI Research Series 215. 2025, Economic and Social Research Institute: Dublin.

169. Cox, C., *Institutionalisation in Irish History and Society*, in *Palgrave Advances in Irish History*, M. McAuliffe, K. O'Donnell, and L. Lane, Editors. 2009, Palgrave Macmillan UK: London. p. 169-190.

170. Timonen, V. and M. Doyle, *From the Workhouse to the Home: Evolution of Care Policy for Older People in Ireland*. International Journal of Sociology and Social Policy, 2008. **28**(3/4): p. 76-89.

171. *Nursing Homes Support Scheme Act 2009. Part 1, Section 3*. Available at https://www.irishstatutebook.ie/eli/2009/act/15/section/3/enacted/en/html. 2009, Irish Statute Book: Ireland.

172. O'Shea, E., *Review of the Nursing Home Subvention Scheme*. 2002, Government of Ireland: Dublin.

173. Comas-Herrera, A., et al., *Mortality Associated with COVID-19 in Care Homes: International Evidence*, I.L.-T.C.P.N. Article in LTCcovid.org, Editor. 2021: CPEC-LSE.

174. Walsh, B., S. Connolly, and M.-A. Wren, *COVID-19 in the Community and Outbreaks in Long-Term Residential Care in Ireland*. 2023.

175. HIQA, *The Impact of COVID-19 on Nursing Homes in Ireland*. 2020, Health Information and Quality Authority: Dublin.

176. Department of Health, *Design Guide for Long-Term Residential Care Settings for Older People*. 2023, Department of Health: Dublin.

177. Department of Health, *Press release. Minister Butler Announces Public Consultation on a Design Guide for Long-Term Residential Care Settings for Older People*. 2023: Dublin.

178. Department of Health, *Design Guide for Long-Term Residential Care Settings for Older People*. Public Consultation Report 2025, Department of Health: Dublin.

179. Health and Information Quality Authority, *Registration Handbook: Guidance on Making Applications, Providing Prescribed Information and Submitting Registration Notifications*. Available via https://www.hiqa.ie/guidance-providers/older-peoples-services/registration-information. 2023, HIQA: Dublin.

180. HIQA, *Exploring the Regulation of Health and Social Care Services: Older People's Services*. 2017: Health and Information Quality Authority.

181. Mahoney, F.I. and D.W. Barthel, *Functional Evaluation: The Barthel Index*. Md State Med J, 1965. **14**: p. 61–5.

182. Doyle, J. and A. Timoney, *Background to the Nursing Home Support Scheme (Amendment) Bill 2021*. 2021: Dublin.

183. BDO Ireland and Nursing Homes Ireland, *Private and Voluntary Nursing Home Survey 2023–24*. 2024, BDO Ireland, Nursing Home Ireland: Dublin.

184. OECD, *Ageing and Long-term Care - Figure 10.12. Long-term Care Beds in Institutions and Hospitals, 2021 (or nearest year)*. Available at https://stat.link/gtalmc, in *Health at a Glance 2023*. 2023, OECD: Paris.

185. CBRE Research, *The Irish Nursing Home Market: Ownership, Operators and Investment. Investment Summary*. 2023, CBRE Ireland: Dublin.

186. HIQA, *Overview Report on Monitoring and Regulation of Designated Centres for Older Persons – 2022*, Health Information and Quality Authority. 2023: Dublin.

187. Health and Information Quality Authority, *Overview Report Monitoring and Regulation of Older Persons Services in 2022*. 2023, HIQA: Dublin.

188. Hutton, B., *HIQA Granted Order to Shut Nursing Home Over COVID-19 Risk to Residents*. Available at https://www.irishtimes.com/news/health/hiqa-granted-order-to-shut-nursing-home-over-covid-19-risk-to-residents-1.4309805 [Paywall], in The Irish Times. 2020.

189. Sheehan, M., *Two Nurses Looked After 70 Residents Overnight at Cash-strapped Private Nursing Home*. Available at https://www.independent.ie/irish-news/two-nurses-looked-after-70-residents-overnight-at-cash-strapped-private-nursing-home/a1523928040.html, in *Irish Independent*. 2024.

190. Batt, R., E. Appelbaum, and T. Katz, *The Role of Public REITs in Financialization and Industry Restructuring*. Institute for New Economic Thinking Working Paper Series, 2022(189).

191. Braun, R.T., et al., *Association of Private Equity Investment in US Nursing Homes with the Quality and Cost of Care for Long-Stay Residents*. JAMA Health Forum, 2021. **2**(11): p. e213817.

192. Braun, R.T., et al., *The Role Of Real Estate Investment Trusts In Staffing US Nursing Homes*. Health Aff (Millwood), 2023. **42**(2): p. 207–216.

193. Braun, R.T., et al., *Comparative Performance of Private Equity-Owned US Nursing Homes During the COVID-19 Pandemic*. JAMA Netw Open, 2020. 3(10): p. e2026702.

194. Terry, K., *Tame The Private Equity Beast By Shifting Its Focus To Value-Based Care*. Health Affairs Forefront, 2024.

195. Singh, Y., M. Reddy, and J.M. Zhu, *Life Cycle of Private Equity Investments in Physician Practices: An Overview of private equity exits*. Health Aff Sch, 2024. **2**(4): p. qxae047.

196. Health Service Executive, *Health Service Executive. Annual Report and Financial Statements 2023*. Reforming our System to Deliver Better Care. 2024, Health Service Executive: Dublin.

197. National Treatment Purchase Fund, *Review of Pricing System for Long Term Residential Care Facilities*. Available via https://www.gov.ie/en/publication/41377-review-of-pricing-system-for-long-term-residential-care-facilities/. 2021, Gov.ie: Dublin.

198. Department of Health, *A Value for Money Review of Nursing Home Care Costs*. Available at https://www.gov.ie/en/publication/3859f-a-value-for-money-review-of-nursing-home-care-costs/. 2021, Department of Health: Dublin.

199. Young, Y., et al., *Assessing the Influence of Nursing Home Size and Care Models on COVID-19 Case and Mortality Rates*. Geriatric Nursing, 2024. **60**: p. 21–27.

200. Walsh, B., S. Connolly, and M. Wren, *COVID-19 in the Community and Outbreaks in Long-Term Residential Care in Ireland*. Journal of long-term care, 2023. **23–32**.

201. Gurung, S. and H. Chaudhury, *Relationship-Centered Care for Older Adults in Long-Term Care Homes: A Scoping Review*. Journal of Applied Gerontology, 2025. **0**(0): p. 07334648241309761.

202. Bhattacharyya, K.K., J. Craft Morgan, and E.O. Burgess, *Person-Centered Care in Nursing Homes: Potential of Complementary and Alternative Approaches and Their Challenges*. J Appl Gerontol, 2022. 41(3): p. 817–825.

203. HIQA, *15 Years of Regulating Nursing Homes 2009–2024*, HIQA, Editor. 2024: Dublin.

204. Behan, L., C. Grogan, and L.M. Keyes, *The Impact of Regulation on the Quality of Care in Nursing Homes in Ireland: A Time-series Analysis of Change in Compliance*. HRB Open Research, 2024. 7: p. 23.

205. O'Donoghue, J., et al., *Residential Long-Term Care and the Built Environment: Balancing Quality of Life and Infection Control*. Journal of the American Medical Directors Association, 2023. 24(10): p. 1508–1512.

206. Grey, T., et al., *Long-Term Residential Care and the Built Environment: Improving Quality of Life and Resilience Through a Universal Design Approach*, in *Universal Design 2024: Shaping a Sustainable, Equitable and Resilient Future for All*. 2024, IOS Press. p. 207–214.

207. Department of Health, *A Value for Money Review of Nursing Home Care Costs*. 2021, Department of Health: Dublin.

208. Law Reform Commission, *A Regulatory Framework for Adult Safeguarding*. 2024, Law Reform Commission: Dublin.

209. COVID-19 Nursing Homes Expert Panel, *Examination of Measures to 2021. Report to the Minister for Health*. Available at https://www.gov.ie/en/publication/3af5a-covid-19-nursing-homes-expert-panel-final-report/. 2020, COVID-19 Nursing Homes Expert Panel: Dublin.

210. Tyndall, P., *Wasted Lives: Time for a Better Future for Younger People in Nursing Homes: An investigation by the Ombudsman*. 2021, Office of the Ombudsman: Dublin.

211. Sage Advocacy, *Delivering Quality Medical Care in Irish Nursing Homes: Current Practice, Issues and Challenges. A Discussion Document*, S. Advocacy, Editor. 2020: Dublin.

212. Boamah, S.A., et al., *Social Isolation Among Older Adults in Long-Term Care: A Scoping Review*. J Aging Health, 2021. **33**(7–8): p. 618–632.

213. HSE, *Post-Acute Inpatient Rehabilitation Service Provision: A National Overview of HSE-Funded Services: Full Report*. 2024, Health Service Executive: Dublin.

214. Health Information and Quality Authority, *Exploring the Regulation of Health and Social Care Services*: Older People's Services. 2017, HIQA: Dublin.

215. Health Service Executive, *Single Assessment Tool (SAT): Pilot Evaluation Report 2017*. 2017, HSE: Dublin

216. Pierse, T., E. O' Shea, and P. Carney, *Estimates of the Prevalence, Incidence and Severity of Dementia in Ireland*. Ir J Psychol Med, 2019. **36**(2): p. 129-137.

217. Slaymaker, R., et al., *Future Trends in Housing Tenure and the Adequacy of Retirement Income*, in ESRI Research Series 143. 2022, Economic and Social Research Institute: Dublin.

218. Central Statistics Office, *Vital Statistics Annual Report 2022*. 2024, Central Statistics Office,: Dublin.

219. Strydom, A., et al., *Incidence of Dementia in Older Adults with Intellectual Disabilities*. Res Dev Disabil, 2013. **34**(6): p. 1881–5.

220. McCarron, M., et al., *A Prospective 20-year Longitudinal Follow-up of Dementia in Persons with Down Syndrome*. J Intellect Disabil Res, 2017. **61**(9): p. 843–852.

221. Petersen, R.C., *Mild Cognitive Impairment*. Continuum (Minneap Minn), 2016. **22**(2 Dementia): p. 404–18.

222. Livingston, G., et al., *Dementia Prevention, Intervention, and Care: 2024 report of the Lancet standing Commission*. Lancet, 2024. **404**(10452): p. 572–628.

223. World Health Organization, *World Report on Hearing*. 2021, Geneva: World Health Organization.

224. Chandra, A., et al., *Evaluating the Link Between Hearing Loss and Alzheimer's Disease Neuropathology: A Systematic Review and Meta-analysis*. Neurobiol Aging, 2025. **154**: p. 92–102.

225. Readman, M.R., et al., *Hearing Loss as a Risk Factor for Dementia: A Systematic Review and Meta-analysis From a Global Perspective*. Aging Ment Health, 2025: p. 1–14.

226. Ishak, E., et al., *Population Attributable Fraction of Incident Dementia Associated with Hearing Loss*. JAMA Otolaryngology–Head & Neck Surgery, 2025. 151(6): p. 568–575.

227. Eyting, M., et al., *A Natural Experiment on the Effect of Herpes Zoster Vaccination on Dementia. Nature*, 2025. **641**(8062): p. 438-446.

228. European Medicines Agency. *Leqembi*. 2025; Available from: https://www.ema.europa.eu/en/medicines/human/EPAR/leqembi#authorisation-details.

229. European Medicines Agency. *Kisunla*. 2025; Available from: https://www.ema.europa.eu/en/medicines/human/EPAR/kisunla.

230. NICE, *Final Draft Guidance Finds Benefits of 2 Alzheimer's Treatments Remain Too Small to Justify the Additional Cost to the NHS*. 2025, National Institute for Health and Care Excellence: London.

231. National Centre for Pharmacoeconomics, I. *Lecanemab* (*Leqembi®*). *HTA ID: 24052*. 2025 [cited 2025 15 July]; Available from: https://www.ncpe.ie/lecanemab-leqembi-hta-id-24052/.

232. Leroi, I., et al., *Navigating the Future of Alzheimer's Care in Ireland: A Service Model for Disease-modifying Therapies in Small and Medium-sized Healthcare Systems*. BMC Health Serv Res, 2024. **24**(1): p. 705.

233. Pierse, T., F. Keogh, and S. O'Neill, *Generating National Projections of Dementia Cases for Ireland Using a Calibrated Macro-simulation Model*. BMJ Open, 2020. 10(8): p. e035463.

234. HSE and National Dementia Office, *Dementia Prevalence Figures 2020 and Estimated Projected Dementia Prevalence to 2045*. 2020, Health Service Executive: Dublin.

235. Richardson, C., et al., *Two-decade Change in Prevalence of Cognitive Impairment in the UK*. Eur J Epidemiol, 2019. **34**(11): p. 1085–1092.

236. Sexton, E., et al., *Systematic Review and Meta-analysis of the Prevalence of Cognitive Impairment no Dementia in the First Year Post-stroke*. Eur Stroke J, 2019. **4**(2): p. 160–171.

237. Sexton, E., et al., *Forecasting Stroke and Stroke-driven Dementia in a Rapidly Ageing Population: A Model-based Analysis of Alternative Projection Scenarios for Ireland*. BMJ Open, 2025. **15**(2): p. e091557.

238. Department of Health, The *Irish National Dementia Strategy*. 2014, Department of Health: Dublin.

239. Hennelly, N. and E. O'Shea, *Personhood, Dementia Policy and the Irish National Dementia Strategy*. Dementia (London), 2019. **18**(5): p. 1810–1825.

240. HSE, *National Service Plan 2025*. 2025, Health Service Executive: Dublin.

241. Department of Health, *Minister O'Donnell Announces Commencement of National Dementia Registry*. 2025, Department of Health: Dublin.

242. Hopper, L. and C. Bowen, *Development of a Model for the National Dementia Registry*. 2021, Dublin City University: Dublin.

243. Connolly, S., et al., *Estimating the Economic and Social Costs of Dementia in Ireland*. Dementia (London), 2014. **13**(1): p. 5–22.

244. Meijer, E., et al., *Economic Costs of Dementia in 11 Countries in Europe: Estimates from Nationally Representative Cohorts of a Panel Study*. Lancet Reg Health Eur, 2022. **20**: p. 100445.

245. Teahan, Á., et al., *Supporting Family Carers of People with Dementia: A Discrete Choice Experiment of Public Preferences*. Social Science & Medicine, 2021. 287: p. 114359.

246. Keogh, F., T. Pierse, and E. O' Shea, *Dementia Services in Ireland 2018: Audit of Community-based Health and Social Care Services Used by People with Dementia*. 2020, Centre for Economic and Social Research on Dementia, National University of Ireland, Galway: Galway.

247. The Alzheimer Society of Ireland, *Financial Statements for the Year Ended 31 December 2023*. 2024, The Alzheimer Society of Ireland: Dublin.

248. Begley, E., et al., *Model of Care for Dementia in Ireland*. 2023, National Dementia Services: Tullamore.

249. Hartigan, I., et al., *Evaluation of the National Dementia Strategy*. 2019, IPSOS Mori and University College Cork: Belfast

250. Teahan, Á., C. Fitzgerald, and E. O'Shea, *Family Carers' Perspectives of the Alzheimer Café in Ireland*. HRB Open Res, 2020. **3**: p. 18.

251. HSE, Dementia Home Support Service: Guidance Document. 2021, Health Service Executive: Dublin.

252. O' Shea, E., F. Keogh, and A. Cooney, *The Continuum of Care for People with Dementia in Ireland*. 2019, National Dementia Office: Tullamore.

253. Walsh, S.C., et al., *Palliative Care Interventions in Advanced Dementia*. Cochrane Database Syst Rev, 2021. **9**(9): p. Cd011513.

254. Brady, A.M., et al., *'If it Happens to Me, I Would Want to Know Earlier': A Qualitative Exploration of Views on Timing of Dementia Diagnosis within a Specific Geographical Region in Ireland*. Clinical Psychology Today, 2022. 6(2): p. 20–35.

255. Fox, S., et al., *'Give Me the Knowledge, and I Can Do What I Want with It, It's My Right and My Choice': Triangulated Perspectives on the Disclosure of Young Onset Dementia*. Dementia (London), 2023. **22**(8): p. 1757–1775.

256. O'Philbin, L., D. O'Doherty, and C. O'Reilly, *The Experience of Dementia in Ireland: A Snapshot in Time*. 2023, Alzheimer Society of Ireland: Dublin.

257. Pierse, T., et al., *Geographic Availability and Accessibility of Day Care Services for People with Dementia in Ireland*. BMC Health Serv Res, 2020. **20**(1): p. 476.

258. Donnelly, S., et al., *'I'd Prefer to Stay at Home but I Don't Have a Choice': Meeting Older People's Preference for Care: Policy, But What About Practice?* 2016, Dublin: University College Dublin.

259. Morgan, A., *A Review of Policy and Provision of Emotional Support for People Living with Early-stage Dementia in the Republic of Ireland and Call for Specialist Counselling and Psychotherapy Services*. Dementia (London), 2021. **20**(6): p. 1958–1970.

260. Teahan, Á., et al., *Establishing Priorities for Psychosocial Supports and Services Among Family Carers of People with Dementia in Ireland*. Dementia (London), 2021. **20**(6): p. 2109–2132.

261. The Alzheimer Society of Ireland, *The Cost of Living While Caring: A Brief Report on the Financial Situation of Family Carers of People with Dementia in Ireland*. 2023, The Alzheimer Society of Ireland: Dublin.

262. O'Sullivan, D., Spotlight: *Mind the Care Gap: Exposing the Health System's Vulnerability to the Gap Between Family Care Provision and Anticipated Demand*. 2019, Oireachtas Library and Research Service: Dublin.

263. Department of Children Disability and Equality, *State Welcomes Overwhelming Approval of Historic Pay Agreement for Health and Social Care Workers From Their Trade Unions*. 2025, Gov.ie: Dublin.

264. Morrow, E., et al., *Exploring a Career Pathway for Home Support Workers in Ireland: A Systematic Scoping Review of the International Evidence*. Front Health Serv, 2024. **4**: p. 1360920.

265. Zabihi, S., et al., *Dementia Training for Healthcare Professionals: A Systematic Policy and Evidence Review*. International Psychogeriatrics, 2025: p. 100088.

266. Fox, S., et al., *People with Dementia and Family Carers are Welcoming of a Model of Dementia Palliative Care, But Sceptical of Its Implementation*. Dementia (London), 2025. **24**(1): p. 91–110.

267. Coffey, A., et al., *Implementation of Evidence-based Guidance for Dementia Palliative Care Using Participatory Action Research: Examining Implementation Through the Consolidated Framework for Implementation Researc*h (CFIR). Implement Sci Commun, 2021. 2(1): p. 137.

268. Keogh, F., et al., *Resource Allocation Across the Dementia Continuum: A Mixed Methods Study Examining Decision Making on Optimal Dementia Care Among Health and Social Care Professionals*. BMC Health Serv Res, 2021. **21**(1): p. 243.

269. Hennelly, N. and E. O'Shea, *A Multiple Perspective View of Personhood in Dementia*. Ageing and Society, 2022. 42(9): p. 2103-2121.

270. Timmons, S., et al., *Appropriate Prescribing of Psychotropic Medication for Non-cognitive Symptoms in People with Dementia. National Clinical Guideline No. 21*. 2019, Department of Health: Dublin.

271. de Siún, A., et al., *Report of the Irish National Audit of Dementia Care in Acute Hospitals 2014*. 2014, Nationa Audit of Dementia Care: Cork.

272. Timmons, S., et al., *Psychotropic Medication Prescribing to Patients with Dementia Admitted to Acute Hospitals in Ireland*. Drugs Aging, 2023. **40**(5): p. 461–472.

273. Dhuny, S., T. Foley, and A. Jennings, *General Practitioners' Knowledge of and Attitudes Towards Prescribing Psychoactive Drugs in Dementia Care: A Cross-Sectional Questionnaire Study*. Ir J Med Sci, 2021. **190**(2): p. 667–675.

274. Walsh, K.A., et al., *Rationalising Antipsychotic Prescribing in Dementia (RAPID) Complex Intervention: A Mixed-methods Feasibility Intervention Study*. Explor Res Clin Soc Pharm, 2022. **8**: p. 100190.

275. Kelly, D. and M. Bracken-Scally, *Time to Reduce Inappropriate Use of Psychotropic Medication in People with Dementia*. IPU Review, 2024 (September).

276. Walsh, K.A., et al., *Patterns of Psychotropic Prescribing and Polypharmacy in Older Hospitalized Patients in Ireland: The Influence of Dementia on Prescribing*. International Psychogeriatrics, 2016. **28**(11): p. 1807–1820.

277. Donnelly, S., et al., *Adult Safeguarding and People Living with Dementia In Nursing Homes: Briefing Paper*. 2022, Alzheimer Society of Ireland: Dublin.

278. McCarron, M., E. Reilly, and P. Dunne, *Achieving Quality Environments for Person Centred Dementia Care. Designing a Home for Persons with Dementia*. 2013, Daughters of Charity Service: Dublin.

279. Williams, C. and A. Joshi, *The Greenhouse Model of Nursing Home Care: A Scoping Review*. Journal of Applied Gerontology, 2024. **43**(7): p. 803–813.

280. Putnam, M., et al., *Understanding Ageing with Disability, in Handbook on Ageing with Disability*, M. Putnam and C. Bigby, Editors. 2021, Routledge: New York.

281. Park, S., et al., *Aging with Long-Term Physical Disabilities and Its Implications for Nursing: A Scoping Review*. J Adv Nurs, 2025.

282. Iezzoni, L.I., et al., *Physicians' Perceptions of People with Disability And Their Health Care*. Health Aff (Millwood), 2021. **40**(2): p. 297–306.

283. VanPuymbrouck, L., C. Friedman, and H. Feldner, *Explicit and Implicit Disability Attitudes of Healthcare Providers*. Rehabil Psychol, 2020. **65**(2): p. 101–112.

284. Smith, K.J., et al., *Aging Well with a Lifelong Disability: A Scoping Review*. Gerontologist, 2024. **64**(9).

285. McCarron, M., et al., *Growing Older with an Intellectual Disability in Ireland 2011. First Results From the Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing*. 2011, School of Nursing and Midwifery, Trinity College Dublin: Dublin.

286. Fanagan, S., et al., *National Ability Supports System (NASS). Overview of People Engaging with Disability Services, 2024*, in *HRB StatLink Series 24*. 2025, Health Research Board: Dublin.

287. McCarron, M., et al., Mortality Rates in the General Irish Population Compared to Those with an Intellectual Disability from 2003 to 2012. J Appl Res Intellect Disabil, 2015. **28**(5): p. 406–13.

288. Doyle, A., et al., *People with Intellectual Disability in Ireland are Still Dying Young*. J Appl Res Intellect Disabil, 2021. **34**(4): p. 1057–1065.

289. Hendriks, S., et al., *Global Prevalence of Young-Onset Dementia: A Systematic Review and Meta-analysis*. JAMA Neurol, 2021. **78**(9): p. 1080–1090.

290. McCarron, M., et al., eds. *Longitudinal Dynamics in the Ageing of People with an Intellectual Disability. Evidence from the Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing (IDS-TILDA)*. Wave 5 IDS-TILDA. 2023, Trinity Centre for Ageing and Intellectual Disability, Trinity College Dublin.: Dublin.

291. Burke, E., et al., *What It's Like to Grow Older: The Aging Perceptions of People with an Intellectual Disability in Ireland*. Intellect Dev Disabil, 2014. **52**(3): p. 205–19.

292. Lin, J.D., et al., *Early Onset Ageing and Service Preparation in People with Intellectual Disabilities: Institutional Managers' Perspective*. Res Dev Disabil, 2011. **32**(1): p. 188–93.

293. McCarron, M., et al., *Patterns of Multimorbidity in an Older Population of Persons with an Intellectual Disability: Results from the Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing (IDS-TILDA)*. Res Dev Disabil, 2013. **34**(1): p. 521–7.

294. Department of Health, *New Report Highlights Positive Trends in Health and Wellbeing of Older People in Ireland*. 2025, Gov.ie: Dublin.

295. OECD, *Health at a Glance: Europe 2024. State of Health in the EU Cycle*. 2024, OECD: Paris.

296. McFeely, A., et al., *Longitudinal Frailty Transitions in Adults Aging with Intellectual Disability*. Age and Ageing, 2024. **53** (Supplement_4).

297. Liu, Q., et al., *Cancer Risk in Individuals with Intellectual Disability in Sweden: A Population-based Cohort Study*. PLoS Med, 2021. 18(10): p. e1003840.

298. Cuypers, M., et al., *Cancer-related Mortality among People with Intellectual Disabilities: A Nationwide Population-based Cohort Study*. Cancer, 2022. **128**(6): p. 1267–1274.

299. Heslop, P., et al., *Cancer in Deceased Adults with Intellectual Disabilities: English Population-based Study using Linked Data from Three Sources*. BMJ Open, 2022. **12**(3): p. e056974.

300. O'Dwyer, M., et al., *Factors Associated with Polypharmacy and Excessive Polypharmacy in Older People with Intellectual Disability Differ from the General Population: A Cross-sectional Observational Nationwide Study*. BMJ Open, 2016. **6**(4): p. e010505.

301. Doherty, A.S., et al., *Prevalence of Potentially Inappropriate Prescribing in Community-dwelling Older Adults: An Application of STOPP/START Version 3 to The Irish Longitudinal Study on Ageing (TILDA)*. Eur Geriatr Med, 2025. **16**(4): p. 1389–1402.

302. O'Connell, J., et al., *Medication Burden and Frailty in Older Adults with Intellectual Disability: An Observational Cross-sectional Study*. Pharmacoepidemiol Drug Saf, 2020. **29**(4): p. 482–492.

303. O'Dwyer, M., et al., *Medication Use and Potentially Inappropriate Prescribing in Older Adults with Intellectual Disabilities: A Neglected Area of Research*. Ther Adv Drug Saf, 2018. **9**(9): p. 535–557.

304. Mac Giolla Phadraig, C., et al., *Prevalence of Edentulism among Adults with Intellectual Disabilities: A Narrative Review Informed by Systematic Review Principles*. Spec Care Dentist, 2018. **38**(4): p. 191–200.

305. McCarron, M., et al., *Shaping the Future of Intellectual Disability Nursing in Ireland*. 2018, Health Services Executive: Dublin.

306. Bigby, C. and M. Putnam, *Enabling a Good Old Age for People with Disability, in Handbook on Ageing with Disability*, M. Putnam and C. Bigby, Editors. 2021, Routledge: New York. p. 392–396.

307. Iacono, T. and C. Bigby, *The Health Inequities of People with Intellectual and Developmental Disabilities: Strategies for Change, in Public Health: Local and Global Perspectives*, P. Liamputtong, Editor. 2022, Cambridge University Press: Cambridge. p. 331–347.

308. McCallion, P. and M. McCarron, *Ageing and Intellectual Disability, in Intellectual Disabilities: Health and Social Care Across the Lifespan*, F. Sheerin and C. Doyle, Editors. 2023, Springer Cham. p. 147–158.

309. World Health Organization and United Nations, *UN Decade of Healthy Ageing 2021–2030: Plan of Action*. 2020, Decade of Healthy Ageing: Geneva.

310. McCausland, D., et al., *Barriers to Community Participation for Adults Aging with an Intellectual Disability in Ireland: A Longitudinal Study*. Inclusion, 2023. **11**(3): p. 204–217.

311. McCausland, D., et al., *The Exercise of Human Rights and Citizenship by Older Adults with an Intellectual Disability in Ireland*. J Intellect Disabil Res, 2018. **62**(10): p. 875–887.

312. McCausland, D., M. McCarron, and P. McCallion, *Use of Technology by Older Adults with an Intellectual Disability in Ireland to Support Health, Well-being and Social Inclusion during the COVID-19 Pandemic*. British Journal of Learning Disabilities, 2023. **51**(2): p. 175–190.

313. Hahn, H.D. and T.L. Belt, *Disability Identity and Attitudes Toward Cure in a Sample of Disabled Activists*. J Health Soc Behav, 2004. **45**(4): p. 453–64.

314. McGrath, C., et al., *Reshaping Understandings of Disability Associated with Age-related Vision Loss (ARVL): Incorporating Critical Disability Perspectives into Research and Practice*. Disability and Rehabilitation, 2017. **39**(19): p. 1990–1998.

315. Leahy, A., *Disability Identity in Older Age? Exploring Social Processes that Influence Disability Identification with Ageing*. Disability Studies Quarterly, 2023. **42**(3–4).

316. United Nations, *Convention on the Rights of Persons with Disabilities. Available at* https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd. 2006, United Nations, Department of Economic and Social Affairs: New York.

317. National Disability Authority. *United Nations Convention on the Rights of Persons with Disabilities*. 2022 [cited 2024 14 October]; Available from: https://nda.ie/disability-policy/uncrpd.

318. Department of Children Equality Disability Integration and Youth, *National Human Rights Strategy for Disabled People 2025–2030*. 2025, Government of Ireland: Dublin.

319. Arstein-Kerslake, A. and E. Flynn, *The General Comment on Article 12 of the Convention on the Rights of Persons with Disabilities: A Roadmap for Equality before the Law*. The International Journal of Human Rights, 2016. **20**(4): p. 471-490.

320. Department of Children Equality Disability Integration and Youth. *Government Announces Decision to Accede to the Optional Protocol to the UN Convention on the Rights of Persons with Disabilities*. 2024 [cited 2024 14 October]; Available from: https://www.gov.ie/en/press-release/aa312-government-announces-decision-to-accede-to-the-optional-protocol-to-the-un-convention-on-the-rights-of-persons-with-disabilities/.

321. Working Group on Congregated Settings, *Time to Move on from Congregated Settings*. A Strategy for Community Inclusion. 2011, Health Service Executive: Dublin.

322. Department of Health, *Value for Money and Policy Review* of *Disability Services in Ireland* 2012, Department of Health: Dublin.

323. Kozma, A., J. Mansell, and J. Beadle-Brown, *Outcomes in Different Residential Settings for People with Intellectual Disability: A Systematic Review*. Am J Intellect Dev Disabil, 2009. **114**(3): p. 193–222.

324. McCarron, M., et al., *Effect of Deinstitutionalisation on Quality of Life for Adults with Intellectual Disabilities: A Systematic Review*. BMJ Open, 2019. **9**(4): p. e025735.

325. Brick, A., C. Keegan, and M.-A. Wren, *Utilisation of Specialist Disability Services in Ireland: Baseline Analysis for the Hippocrates Model*, in ESRI Survey and Statistical Report Series Number 89 2020, ESRI: Dublin.

326. Axmon, A., et al., *Psychiatric Diagnoses in Older People with Intellectual Disability in Comparison with the General Population: A Register Study*. Epidemiol Psychiatr Sci, 2018. **27**(5): p. 479–491.

327. Pouls, K.P., et al., *Adults with Intellectual Disabilities and Mental Health Disorders in Primary Care: A Scoping Review*. Br J Gen Pract, 2022. **72**(716): p. e168–e178.

328. Sheerin, F., et al., Psychological Wellbeing and Cognitive Health, in *Longitudinal Dynamics in the Ageing of People with an Intellectual Disability. Evidence from the Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing (IDS-TILDA). Wave 5 IDS-TILDA*, M. McCarron, et al., Editors. 2023, Trinity Centre for Ageing and Intellectual Disability, Trinity College Dublin: Dublin.

329. O'Sullivan, M., et al., *National Ability Supports System (NASS) Overview of People with an Intellectual Disability Engaging with Disability Services, 2023*. 2024, Health Research Board: Dublin.

330. Sheerin, F., et al., *The Care of Older Adults with Intellectual Disabilities and Complex Age-Related Conditions*. 2022, National Disability Authority: Dublin.

331. Sheerin, F., et al., *Challenges in Care and Service Provision for Older Adults with Intellectual Disabilities and Complex Age-related Conditions in Ireland*. British Journal of Learning Disabilities, 2024. **52**(2): p. 248–259.

332. Health Information and Quality Authority, *10 Years of Regulating Designated Centres for People with Disabilities*. 2024, HIQA: Cork.

333. Casey, C., et al., *National Ability Supports System (NASS): Overview of People Engaging with Disability Services*, 2023, in *HRB StatLink Series 17*. 2024, Health Research Board: Dublin.

334. Brennan, D., et al., *Keeping It in the Family: The Proposed and Rejected Irish Constitutional Amendment on Family Caregiving—Insights From the IDS-TILDA Carer Study*. British Journal of Learning Disabilities, 2025. 53: 498–507.

335. Medeiros, H., et al., *Shifting Care from Hospital to the Community in Europe: Economic Challenges and Opportunities*. 2008, Personal Social Services Research Unit, London School of Economics and Political Science: London.

336. Knapp, M., et al., *The Economic Consequences of Deinstitutionalisation of Mental Health Services: Lessons from a Systematic Review of European Experience*. Health Soc Care Community, 2011. **19**(2): p. 113–25.

337. Department of Health, *Disability Capacity Review to 2032: A Review of Social Care Demand and Capacity Requirements to 2032*. 2021, Department of Health: Dublin.

338. McCarron, M., et al., *Quality of Life Outcomes and Costs Associated with Moving from Congregated Settings to Community Living Arrangements for People with Intellectual Disability: An Evidence Review*. 2018, Health Research Board: Dublin.

339. Health Service Executive, *Under 65's Ombudsman Report: Recommendations Implementation Progress Update*. 2024, Health Service Executive: Dublin.

340. Pierce, M., S. Kilcullen, and M. Duffy, *The Situation of Younger People with Disabilities Living in Nursing Homes in Ireland: Phase 1*. 2018, Disability Federation of Ireland and Dublin City University: Dublin.

341. Collingridge Moore, D., et al., *Length of Stay in Long-term Care Facilities: A Comparison of Residents in Six European Countries: Results of the PACE Cross-sectional Study*. BMJ Open, 2020. **10**(3): p. e033881.

342. RTE. *Nearly 1,300 under 65s in Nursing Homes Due to Lack of Services*. 2023; Available from: https://www.rte.ie/news/2023/0515/1383629-nursing-homes-under-65/.

343. Deering, G., *Ombudsman Update on 'Wasted Lives'. Ombudsman's Update Following Receipt of the HSE's 'Recommendations Implementation Progress Update'*. 2024, Office of the Ombudsman: Dublin.

344. Wormald, A.D., P. McCallion, and M. McCarron, *The Antecedents of Loneliness in Older People with an Intellectual Disability*. Res Dev Disabil, 2019. **85**: p. 116–130.

345. Ryan, S., et al., *Improving Support and Planning Ahead for Older People with Learning Disabilities and Family Carers: A Mixed-methods Study*. Health Soc Care Deliv Res, 2024. **12**(16): p. 1–161.

346. McCausland, D., et al., *Balancing Personal Wishes and Caring Capacity in Future Planning for Adults with an Intellectual Disability Living with Family Carers*. J Intellect Disabil, 2019. **23**(3): p. 413–431.

347. Health Information and Quality Authority, *Overview Report: Monitoring and Regulation of Designated Centres for People with Disabilities in 2021*. 2022, HIQA: Cork.

348. Health Information and Quality Authority, Guidance for the *Assessment of Designated Centres for People with Disabilities*. Version 2. 2024, HIQA: Cork.

349. May, P., et al., *Effect of Deinstitutionalisation for Adults with Intellectual Disabilities on Costs: A Systematic Review*. BMJ Open, 2019. 9(9): p. e025736.

350. Walsh, B. and L. Hill, *An Analysis of Population-based Resource Allocation for Health and Social Care in Ireland* in ESRI Research Series. Number 194. 2024, ESRI: Dublin.

351. O'Malley, C., et al., *Spending Review 2022: Towards Population-Based Funding for Health: Model Proposal*. 2023, Department of Health: Dublin.

352. McDaid, D. and A.-L. Park, *Ageing with Disability: Using Financial Mechanisms to Facilitate Intersectoral Collaboration, in Handbook on Ageing with Disability*, M. Putnam and C. Bigby, Editors. 2021, Routledge: New York. p. 384–391.

353. Health Service Executive, *Roadmap for Service Improvement 2023–2026. Disability Services for Children and Young People*. 2023, HSE: Dublin.

354. Department of Health, *Towards Personalised Budgets for People with a Disability in Ireland. Report of the Task Force on Personalised Budgets*. 2018, Department of Health: Dublin.

355. Fanagan, S., et al., *National Ability Supports System (NASS) Overview of People with a Physical or Sensory Disability Engaging with Disability Services, 2023*. 2024, Health Research Board: Dublin.

356. Cleland, I. and C. Nugent, *Technology for Older People: The Past, the Present and the (Possible) Future*. Presentation to Commission on *Care for Older People*. 11 October 2024.

357. Centre for Ageing Better, *Industrial Strategy Challenge Fund. Healthy Ageing Challenge Framework*. 2019, Centre for Ageing Better: London.

358. Health Service Executive, *HSE Telehealth Roadmap 2024–2027*. Available at https://healthservice.hse.ie/documents/3663/HSE_Telehealth_Roadmap_full_report.pdf. 2023, HSE: Dublin.

359. Government of Ireland, *Digital for Care: A Digital Health Framework for Ireland 2024–2030*. 2024, Government of Ireland: Dublin.

360. Health Service Executive, *Digital Health Strategic Implementation Roadmap*. 2024, HSE: Dublin.

361. Department of the Environment Climate and Communications. *National Broadband Plan*. 2020 [cited 2024 September 20]; Available from: https://www.gov.ie/en/publication/c1b0c9-national-broadband-plan/.

362. Government of Ireland, *Harnessing Digital: The Digital Ireland Framework*. Available at https://assets.gov.ie/214584/fa3161da-aa9d-4b11-b160-9cac3a6f6148.pdf. 2022, Government of Ireland: Dublin.

363. Health Service Executive. *About Community Funded Schemes*. 2024 [cited 2025 14 July].

364. Dalton, E., *'It's a Win for Transparency': HSE Release List of Disability Equipment Covered by Medical Card*, in The Journal. 2023.

365. Health Service Executive, *HSE National List of Community Funded Aids and Appliances and Prescribing Criteria*. 2021, HSE: Dublin.

366. Donnelly, S., *Dáil Éireann Debate, Thursday - 21 March 2024. Written response to question [13526/24]*. https://www.oireachtas.ie/en/debates/question/2024-03-21/318/#pq_318. 2024.

367. Burns, A., et al., *Utilisation of Technology in the Provision of Health and Social Care Services and Supports for Older People in Three Jurisdictions: An Evidence Brief*. 2025, Health Research Board: Dublin.

368. Health Service Executive, *Framework Document for Operational Contract Management: HSE Community Funded Schemes National Service Improvement Programme*. 2022, HSE: Dublin.

369. Department of Rural and Community Development and Pobal, *Seniors Alert Scheme Annual Report 2022*. 2023, Department of Rural and Community Development, Pobal: Dublin.

370. Pobal, *Annual Report and Annual Financial Statements 2023*. 2023, Pobal: Dublin.

371. Central Statistics Office. *Internet Coverage and Usage in Ireland 2024*. 2024 [cited 2025 15 July]; Available from: https://www.cso.ie/en/releasesandpublications/ep/p-isshict/internetcoverageandusageinireland2024/frequencyofinternetusage/.

372. Central Statistics Office. *Internet Coverage and Usage in Ireland 2023: Devices Used*. 2023 [cited 2025 15 July]; Available from: https://www.cso.ie/en/releasesandpublications/ep/p-isshict/internetcoverageandusageinireland2023/devicesused/.

373. Doody, P., et al., *Internet Access and Use Among Adults Aged 50 and Over in Ireland: Results from Wave 5 of The Irish Longitudinal Study on Ageing*. 2020, The Irish Longitudinal Study on Ageing, Trinity College Dublin: Dublin.

374. Mullin, S., *Research on Digital Access and Older Persons Throughout Ireland Using Personal and Public Involvement (PPI) as a Core Principle*. 2022, Age and Opportunity.

375. Central Statistics Office. *Smart Technology 2024*. 2024 [cited 2025 15 July]; Available from: https://www.cso.ie/en/releasesandpublications/ep/p-smrt/smarttechnology2024/.

376. McCausland, D., et al., *Social Determinants of Health: Choice, Interpersonal Relationships and Community Participation, in Longitudinal Dynamics in the Ageing of People with an Intellectual Disability* M. McCarron, et al., Editors. 2023, The Intellectual Disability Supplement to The Irish Longitudinal Study on Ageing.: Dublin. p. 17-48.

377. Mao, L., G. Mohan, and C. Normand, *Use of Information Communication Technologies by Older People and Telemedicine Adoption during COVID-19: A Longitudinal Study*. J Am Med Inform Assoc, 2023. 30(12): p. 2012–2020.

378. Deloitte. *More than 7 in 10 Use Their Smartphone as Soon as They Wake Up, Deloitte Research Finds*. 2024; Available from: https://www.deloitte.com/ie/en/about/press-room/consumer-trends-smartphone-usage.html.

379. Chadwick, D., et al., *Digital Inclusion and Participation of People with Intellectual Disabilities during COVID-19: A Rapid Review and International Bricolage*. Journal of Policy and Practice in Intellectual Disabilities, 2022. **19**(3): p. 242–256.

380. McCausland, D., et al., *Use of Technology by Older Adults with an Intellectual Disability in Ireland to Support Social Inclusion*, in *IASSIDD World Congress 2024: Reimagining Connections*. 2024: Chicago.

381. Haase, K.R., et al., *Older Adults' Experiences with Using Technology for Socialization During the COVID-19 Pandemic: Cross-sectional Survey Study*. JMIR Aging, 2021. **4**(2): p. e28010.

382. Chambers, J., *Call to Tackle Waiting Lists for Motorised Wheelchairs*. Available at https://www.rte.ie/radio/radio1/clips/21078652/. 2016, RTÉ: Morning Ireland.

383. Gowran, R. *Why Getting the Right Wheelchair is So Important*. 2023 [cited 2025 12 September]; Available from: https://www.rte.ie/brainstorm/2022/1201/1339340-wheelchair-access-supports-ireland/.

384. Gowran, R.J., et al., *Wheelchair and Seating Assistive Technology Provision: A Gateway to Freedom*. Disabil Rehabil, 2022. **44**(3): p. 370–381.

385. Marsh, S. and F. Ryan, *NHS's Leading Wheelchair Provider Told to Improve as People Wait up to Two Years*, in *The Guardian*. 2024, The Guardian: Manchester.

386. Piekema, L., et al., *From Assistive to Inclusive? A Systematic Review of the Uses and Effects of Technology to Support People with Pervasive Support Needs*. J Appl Res Intellect Disabil, 2024. **37**(2): p. e13181.

387. Pirhonen, J., et al., *'These Devices Have Not Been Made for Older People's Needs': Older Adults' Perceptions of Digital Technologies in Finland and Ireland*. Technology in Society, 2020. **62**: p. 101287.

388. Wale, A., et al., *A Rapid Review of the Effectiveness of Interventions for Addressing Digital Exclusion in Older Adults*. medRxiv, 2024: p. 2024.03.21.24304670.

389. Balki, E., N. Hayes, and C. Holland, *Effectiveness of Technology Interventions in Addressing Social Isolation, Connectedness, and Loneliness in Older Adults: Systematic Umbrella Review*. JMIR Aging, 2022. **5**(4): p. e40125.

390. Sen, K., G. Prybutok, and V. Prybutok, *The Use of Digital Technology for Social Wellbeing Reduces Social Isolation in Older Adults: A Systematic Review*. SSM - Population Health, 2022. **17**: p. 101020.

391. Mohan, G. and S. Lyons, *High-speed Broadband Availability, Internet Activity among Older People, Quality of Life and Loneliness*. New Media & Society, 2022. **26**(5): p. 2889–2913.

392. Viklund, E.W.E., I. Nilsson, and A.K. Forsman, *Nordic Population-based Study on Internet Use and Perceived Meaningfulness in Later Life: How They are Linked and Why It Matters*. Scand J Public Health, 2022. **50**(3): p. 381–388.

393. Forsman, A.K., et al., *Promoting Mental Wellbeing Among Older People: Technology-based Interventions*. Health Promot Int, 2018. **33**(6): p. 1042–1054.

394. Welch, V., et al., *Digital Interventions to Reduce Social Isolation and Loneliness in Older Adults: An Evidence and Gap Map*. Campbell Syst Rev, 2023. **19**(4): p. e1369.

395. Martins, A.I., et al., *Effectiveness of Integrated Digital Solutions to Empower Older Adults in Aspects Related to Their Health: Systematic Review and Meta-Analysis*. J Med Internet Res, 2025. **27**: p. e54466.

396. Schaeuffele, C., et al., *A Systematic Review and Meta-analysis of Transdiagnostic Cognitive Behavioural Therapies for Emotional Disorders*. Nature Human Behaviour, 2024. **8**(3): p. 493–509.

397. Moshe, I., et al., *Digital Interventions for the Treatment of Depression: A Meta-analytic Review*. Psychol Bull, 2021. **147**(8): p. 749–786.

398. Witteveen, A.B., et al., *Remote Mental Health Care Interventions during the COVID-19 Pandemic: An Umbrella Review*. Behav Res Ther, 2022. **159**: p. 104226.

399. Howard, R., et al., *The Effectiveness and Cost-effectiveness of Assistive Technology and Telecare for Independent Living in Dementia: A Randomised Controlled Trial*. Age Ageing, 2021. **50**(3): p. 882–890.

400. Henderson, C., et al., *Cost-effectiveness of Telecare for People with Social Care Needs: The Whole Systems Demonstrator Cluster Randomised Trial*. Age Ageing, 2014. **43**(6): p. 794–800.

401. Knapp, M., X. Shehaj, and G. Wong, *Digital Interventions for People with Dementia and Carers: Effective, Cost-effective and Equitable?* Neurodegener Dis Manag, 2022. **12**(5): p. 215–219.

402. Eost-Telling, C., et al., *Digital Technologies to Prevent Falls in People Living with Dementia or Mild Cognitive Impairment*: A Rapid Systematic Overview of Systematic Reviews. Age Ageing, 2024. **53**(1).

403. Gathercole, R., et al., *Assistive Technology and Telecare to Maintain Independent Living at Home for People with Dementia: The ATTILA RCT*. Health Technol Assess, 2021. **25**(19): p. 1–156.

404. Garner, A., et al., *The Impact of Digital Technology in Care Homes on Unplanned Secondary Care Usage and Associated Costs*. Age and Ageing, 2024. **53**(2).

405. Jalilian, A., et al., *Length of Stay and Economic Sustainability of Virtual Ward Care in a Medium-sized Hospital of the UK: A Retrospective Longitudinal Study*. BMJ Open, 2024. **14**(1): p. e081378.

406. Norman, G., P. Bennett, and E.R.L.C. Vardy, *Virtual Wards: A Rapid Evidence Synthesis and Implications for the Care of Older People*. Age and Ageing, 2023. **52**(1): p. afac319.

407. Lewis, C., et al., *A Community Virtual Ward Model to Support Older Persons with Complex Health Care and Social Care Needs*. Clin Interv Aging, 2017. **12**: p. 985–993.

408. National Broadband Ireland. *County Mapping Progress*. 2025 [cited 2025 16 July].

409. Walsh, B., C. Mac Domhnaill, and G. Mohan, *Developments in Healthcare Information Systems in Ireland and Internationally*, in *ESRI Survey and Statistical Series 105*. 2021, Economic and Social Research Institute: Dublin.

410. HIQA, *The Need to Reform Ireland's National Health Information System to Support the Delivery of Health and Social Care Services*. 2021, Health Information and Quality Authority: Dublin.

411. Health Service Executive, Minister for Health Publishes '*Digital for Care: A Digital Health Framework for Ireland 2024–2030*'. 2024, HSE: Dublin.

412. Health Service Executive. *National Electronic Health Record (EHR)*. 2025 [cited 2025 15 July]; Available from: https://about.hse.ie/our-work/digital-health/electronic-health-record-ehr/.

413. Dinsmore, J., et al., *A Digital Health Platform for Integrated and Proactive Patient-Centered Multimorbidity Self-management and Care (ProACT): Protocol for an Action Research Proof-of-Concept Trial*. JMIR Res Protoc, 2021. **10**(12): p. e22125.

414. Sheng, Y., et al., *Home-based Digital Health Technologies for Older Adults to Self-manage Multiple Chronic Conditions: A Data-informed Analysis of User Engagement from a Longitudinal Trial*. Digit Health, 2022. **8**: p. 20552076221125957.

415. Doyle, J., et al., *Older Adults' Experiences of Using Digital Health Technology for Multimorbidity Self-Management: Findings from a Longitudinal Study*. ICCHP-AAATE 2022 Open Access Compendium 'Assistive Technology, Accessibility and (e) Inclusion' Part II, 2022.

416. Cochrane, A. and J. Larragy, *The Digital ICT Acorn Pilot: An Evaluation. Available at* https://agefriendlyhomes.ie/resources/acorn-tablet-project/. 2019, Maynooth University: Maynooth.

417. Central Statistics Office, *System of Health Accounts 2022*. 2024, CSO: Dublin.

418. Central Statistics Office, *System of Health Accounts 2023*. 2025, CSO: Dublin.

419. Wren, M.-A. and A. Fitzpatrick, *How Does Irish Health Care Expenditure Compare Internationally?* 2020, Economic and Social Research Institute: Dublin.

420. Walsh, B. and L. Hill, *An Analysis of Population-based Resource Allocation for Health and Social Care in Ireland*. 2024, Economic and Social Research Institute: Dublin.

421. The Institute of Public Health in Ireland, *Improving Home Care Services in Ireland: An Overview of the Findings of the Department of Health's Public Consultation*. 2018, Institute of Public Health in Ireland: Dublin.

422. Johnston, B., et al., *Moving Beyond Formulae: A Review of International Population-based Resource Allocation Policy and Implications for Ireland in an Era of Healthcare Reform*. HRB Open Research, 2021. **4**: p. 121.

423. Vega, A., et al., *Towards the Development of a Resource Allocation Model for Primary, Continuing and Community Care in the Health Services: Volume 2*. 2010: Dublin City University.

424. Walsh, B. and A. Brick, *Inpatient Bed Capacity Requirements in Ireland in 2023: Evidence on the Public Acute Hospital System*, in *QEC Research Note*. 2023, ESRI: Dublin.

425. Houses of the Oireachtas Committee on the Future of Healthcare, *Sláintecare Report*. 2017, Houses of the Oireachtas: Dublin.

426. Ross, S., et al., *Place-based Partnerships: Challenges and Opportunities* 2025, The King's Fund: London.

427. Keegan, C., et al., *Projections of Expenditure for Public Hospitals in Ireland, 2018-2035, Based on the Hippocrates Model*, in ESRI Research Series 117. 2020, Economic and Social Research Institute: Dublin.

428. Casey, E. and K. Carroll, *The Path for Ireland's Health Budget. Analytical Note Series No. 14*. 2021, Irish Fiscal Advisory Council: Dublin.

429. Healthcare Pricing Office *Funding Using ABF: 'Moving Away from the Block'*. 2016.

430. Valentelyte, G., C. Keegan, and J. Sorensen, *Hospital Response to Activity-Based Funding and Price Incentives: Evidence from Ireland*. Health Policy, 2023. **137**: p. 104915.

431. HSE, *ABF Programme Implementation Plan 2021–2023*. 2021, Health Service Executive: Dublin.

432. Brick, A., et al., *Resource Allocation, Financing and Sustainability in Health Care: Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector. Volume II. ESRI and Department of Health*. 2010, Economic and Social Research Institute and the Department of Health: Dublin.

433. Health Service Executive, *Annual Report and Financial Statements 2009*. 2010.

434. Burke, S., et al., *Sláintecare: A Ten-year Plan to Achieve Universal Healthcare in Ireland*. Health Policy, 2018. **122**(12): p. 1278–1282.

435. O'Malley, C., et al., *Towards Population-Based Funding for Health: Model Proposal, in Spending Review 2022*, G.o. Ireland, Editor. 2023: Dublin.

436. McCarthy, T., C. Linberg, and C. O'Malley, *Spending Review 2022 Towards Population-Based Funding for Health: Evidence Review & Regional Profiles*. 2022.

437. Government of Ireland, *Slaintecare Implementation Strategy*. 2018, Government of Ireland: Dublin.

438. Walsh, K., et al., *Countering Social Exclusion through Inclusive Homecare Provision: Utilising a Participatory Life-course Approach to Influence Policy*. Soc Sci Med, 2024. **352**: p. 117003.

439. de Zwart, P.L., P. Bakx, and E.K.A. van Doorslaer, *Will You Still Need Me, Will You Still Feed Me When I'm 64? The Health Impact of Caregiving to One's Spouse*. Health Econ, 2017. **26 Suppl 2**(Suppl Suppl 2): p. 127–138.

440. Kolodziej, I.W.K., N.B. Coe, and C.H. Van Houtven, *The Impact of Care Intensity and Work on the Mental Health of Family Caregivers: Losses and Gains*. J Gerontol B Psychol Sci Soc Sci, 2022. **77**(Suppl_1): p. S98–s111.

441. Teahan, Á., et al., *An Analysis of Carer Burden among Family Carers of People with and without Dementia in Ireland*. Int Psychogeriatr, 2021. **33**(4): p. 347–358.

442. Zhang, Y. and M.R. Bennett, *Insights Into Informal Caregivers' Well-being: A Longitudinal Analysis of Care Intensity, Care Location, and Care Relationship*. J Gerontol B Psychol Sci Soc Sci, 2024. **79**(2).

443. Longo, F., et al., *Does Public Long-term Care Expenditure Improve Care-related Quality of Life of Service Users in England?* Health Econ, 2021. **30**(10): p. 2561–2581.

444. Forder, J., et al., *The Impact of Long-term Care on Quality of Life*. Health Economics, 2018. **27**(3): p. e43–e58.

445. Watkins, J., et al., *Effects of Health and Social Care Spending Constraints on Mortality in England: A Time Trend Analysis*. BMJ Open, 2017. **7**(11): p. e017722.

446. Kröger, T., Care Poverty: *When Older People's Needs Remain Unmet*. 2022: Springer Nature.

447. Connolly, S. and M.A. Wren, *Unmet Healthcare Needs in Ireland: Analysis Using the EU-SILC survey*. Health Policy, 2017. **121**(4): p. 434-441.

448. Kim, Y.S., et al., *Unmet Healthcare Needs of Elderly People in Korea*. BMC Geriatr, 2018. **18**(1): p. 98.

Appendices

Appendix I: Commission members

Chair:

Professor Alan Barrett, Research Professor, Economic and Social Research Institute

Members:

- **Dr. Emer Ahern**, Consultant, Geriatrician, Cork University Hospital; National Clinical Advisor and Group Lead, Older Persons, Health Service Executive; President of the Irish Gerontological Society
- **Dr. Jonathan Cylus**, Head of the London Hubs of the European Observatory on Health Systems and Policies; Senior Research Fellow, the London School of Economics and Political Science; Senior Health Economist, World Health Organization Barcelona Office for Health Systems Financing
- **Dr. Lucinda Dockeray**, General Practitioner, Dodder Park Medical; Director, Care of the Older Person Course, Irish College of General Practitioners
- **Ms. Ita Healy**, Member, Meath Older People's Council
- **Professor Mary McCarron**, Professor of Ageing and Intellectual Disability, and Director of the Trinity Centre for Ageing and Intellectual Disability, Trinity College Dublin; Executive Director of the National Intellectual Disability Memory Service
- **Ms. Catherine McGuigan**, Chief Officer, Age Friendly Ireland
- **Mr. Seán Moynihan**, Chief Executive Officer, ALONE
- **Professor Christopher Nugent**, Head of the School of Computing, Ulster University
- **Professor Eamon O'Shea**, Personal Professor in the School of Business and Economics, founding Director of the Irish Centre for Social Gerontology, and Director of the Centre for Economic and Social Research on Dementia, University of Galway
- **Ms. Cathy Reynolds**, Board Member, The Alzheimer Society of Ireland
- **Professor David Smith**, Associate Professor of Health Care Ethics, Royal College of Surgeons in Ireland

Appendix II: Terms of Reference of the Commission

1. Purpose

The *Programme for Government: Our Shared Future* (2020) commits to the establishment of 'a commission to examine care and supports for older people'. In line with this commitment, the purpose of the Commission on Care for Older People (hereinafter referred to as 'the Commission') will be to examine the health and social care services and supports provided to older people across the continuum of care and to make recommendations for their strategic development.

In addition, recognising that the inequalities experienced across the life course impact upon older people's care needs, a Cross-Departmental Group will be established under the auspices of the Commission to examine whether the support provided across Government and civil society for healthy, positive, and autonomous ageing is fit-for-purpose, and to develop a costed implementation plan for options to optimise this support.

The Commission will also be charged with determining whether, on the basis of its findings, there is a need for further investigations to be undertaken. Such investigations may relate to the capacity of the health and social care system to implement the Commission's recommendations and/or to the cost-effectiveness of the recommendations.

2. Scope

The health and social care provision for older people that will be examined by the Commission will encompass the broad spectrum of services and supports provided in the community for this age-cohort by the Health Service Executive (HSE), NGOs, and other entities (such as home support services and day care services). It will also encompass the care provided to older people in residential care settings, and the provision of models of supported living for older people, inclusive of low, medium, and high-support residential care.

The Commission's examination of the health and social care services and supports that are available for older people will be cognisant of the national policy landscape within which they are being delivered and developed. Accordingly, there will be recognition that there are already a range of initiatives in train which promise to have a significant impact on the status quo in respect of the provision of care to the older age-cohort. These include the development of the statutory home support scheme; the national roll-out of community specialist teams for older people and for chronic disease management; the introduction of standardised care needs assessment across the continuum of care; the regulatory reform of long-term residential care; the development of policies in the areas of palliative care and adult safeguarding; and more broadly the implementation of the recommendations of the COVID-19 Nursing Homes Expert Panel and the *Report of the Strategic Workforce Advisory Group on Home Carers and Nursing Home Healthcare Assistants*.

Recognising the synergies between the provision of health and social care services and supports to older people and to persons with disabilities, the work of the Commission will be cognisant of the need to ensure continuity of care for persons with disabilities when they turn 65 as well as, more broadly, of the need to ensure that the care and support needs of older people with disabilities are met in accordance with Ireland's obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

In addition to ensuring that these diverse initiatives are underpinned by a coherent policy approach that advances national strategic objectives, the Commission will consider the role played by technology in meeting older people's care needs and the potential for this role to be enhanced. The deliberations of the Commission will also be cognisant of lessons learnt internationally, of the cost implications and key enablers of the recommendations made, and of their viability within Ireland's mixed economy of public, for-profit, and not-for-profit service providers of health and social care.

Informed by the findings of the Commission, and recognising the challenges and opportunities presented by Ireland's ageing population, a Cross-Departmental Group will be established under the auspices of the Commission to examine whether the mainstreaming of ageing across Government and civil society is effective in supporting citizens' healthy, positive, and autonomous ageing throughout the life-course. The Cross-Departmental Group, which will be chaired by a senior official from the Department of Health, will report to the Commission on a quarterly basis.

Engagement and collaboration with stakeholders (inclusive of representatives from across Government and civil society) will be a central component of the work of the Commission. This engagement will encompass a public consultation, bilateral meetings with stakeholder-organisations, and a facilitated stakeholder workshop. In addition, on the establishment of the Commission, the Chair will request an appropriate voluntary or community organisation, or a partnership of the same, to convene a Reference Group of non-governmental and civil society organisations and other key stakeholders working in the area, including those with lived experience. The Reference Group will engage, in an advisory capacity, with the Commission and the Cross-Departmental Group, established under its auspices. The Reference Group will not make recommendations or have any decision-making authority.

3. Terms of reference

Cognisant of the breadth of the purpose and scope of the Commission as outlined above, a modular approach will be taken to advancing its work. Accordingly, terms of reference for three discrete modules are detailed below. Each of the first two modules will be of six months' duration while the final module will be of 12 months' duration. The modules will run consecutively.

3.1 Module 1: Current services and learnings for the future

3.1.1 Determine the effectiveness, adequacy and efficiency of the care and supports which are currently provided within the health and social care system, including the plans for their further development, in meeting the evolving care needs of the increasing diversity of older people within the context of the ageing population.

3.1.2 Examine the existing policy framework for the overarching strategic development of health and social care services and supports for older people that advances national strategic objectives.

3.1.3 Undertake an international review of best practice in older people's care in selected countries to identify options for Ireland.

3.1.4 Prepare for the consideration of the Minister for Health and Minister of State for Mental Health and Older People a report detailing the Commission's work in respect of Module 1 including any learnings for inclusion in Module 2.

3.1.5 The following areas will fall within the scope of Module 1:

- Health and social care services and supports provided in the community for older people by the HSE, NGOs and other entities including home support and day care services.
- Models of supported living for older people, inclusive of low, medium, and high-support residential care, including the health and social care services and supports provided in these settings.
- Policy initiatives that are in train within the health and social care system, including but not limited to the development of a statutory home support scheme; the Enhanced Community Care Programme; the implementation of standardised care needs assessment across the continuum of care; the implementation of the recommendations of the COVID-19 Nursing Homes Expert Panel; and the implementation of the *Report of the Strategic Workforce Advisory Group on Home Carers and Nursing Home Healthcare Assistants*.

3.2 Module 2: Options for the future

3.2.1 Examine the broader policy options for older people's care, as determined in Module 1, to include:

- A strategic focus on the continued shift to community-based health and social care, to enable older people to access timely supports to live and age well in their own communities.
- The provision of health and social care supports for older people across a continuum of supported living options, inclusive of low, medium, and high-support residential care.
- The emerging potential of new digital and assistive technologies to support and transform health and social care for older people.
- The principles of universal design for infrastructural development to support care for older people.
- Other potential policy reform options.

3.2.2 Develop costed policy options (both capital and current) which are achievable within resourcing scenarios to be developed.

3.2.3 Develop a costed and detailed implementation plan for the selected options including cross-Government and civil society elements as appropriate.

3.2.4 Prepare for the consideration of the Minister for Health and Minister of State for Mental Health and Older People a report detailing the challenges and opportunities identified, and presenting a framework for the overarching strategic development of health and social care services and supports for older people that advances national strategic objectives.

3.2.5 The following areas will fall within the scope of Module 2:

- The strategic development of health and social care services and supports for older people across the continuum of care.
- The strategic development of capital infrastructure for the provision of health and social care to older people.
- New technologies that have the potential to enhance health and social care provision for older people.
- The funding and resource allocation models for health and social care services and supports for older people.
- Projected expenditure on health and social care services and supports for older people.

3.3 Module 3: Enabling positive ageing

Following completion of Modules 1 and 2, a Cross-Departmental Group is to be established under the auspices of the Commission, involving all relevant departments, to address the following:

3.3.1 Recognising the challenges and opportunities presented by Ireland's ageing demographic, consider whether the mainstreaming of ageing across Government and civil society is effective in supporting citizens' healthy, positive, and autonomous ageing across the life course.

3.3.2 Each relevant department to develop costed policy options which are achievable within likely resources available.

3.3.3 Prepare for the consideration of the Minister for Health and Minister of State for Mental Health and Older People a costed and detailed implementation plan for the selected options to enable positive ageing in Irish society.

3.3.4 The following areas will fall within the scope of Module 3:

- Age-friendly environments.
- The mitigation of inequalities that militate against healthy ageing.
- The provision of housing options for older people.
- Older people's participation in the economy, society, public and political life.
- Educational, training, and employment opportunities for older people.
- Transport accessibility.
- Digital inclusion.
- The provision of social welfare supports for older people.
- Tackling ageism.

4. Independence

4.1 The Commission will be comprised of independent experts, including an independent chairperson, who will be appointed by the Minister for Health and the Minister of State for Mental Health and Older People.

4.2 It will be assisted and supported as necessary by a secretariat from the Department of Health.

4.3 Additional support services may be commissioned from third parties as required.

4.4 The Commission may delegate administrative and other relevant tasks and administrative decisions to the secretariat.

5. Membership

The membership of the Commission will be comprised of independent experts and may encompass, *inter alia*, geriatricians and academics with relevant expertise (for example in the areas of gerontology, health economics, health policy and management, health technologies, health ethics, and ageing and disability). In addition, it is envisaged that representatives of the community and voluntary sector and of older people will be appointed to the Commission.

The appointed members of the Commission will be required to participate in meetings themselves: the delegation of this role to nominated colleagues will not be acceptable. The membership of the Commission may be changed subject to the requirements of each module of the Commission's work.

Appendix III: Commission meetings and presentations

Meeting no.	Meeting date	Meeting location	Topics	Presenter	Presentation title
1	21st March 2024	Department of Health	'Terms of Reference', 'Principles and Procedures', public engagement and approach to the workings of the Commission	Professor Roger O'Sullivan, Director of Ageing Research and Development, IPH; Dr. Ruth Neill, Public Health Research Officer, IPH; and Mr. Toby Finch, Research Assistant, IPH	Public consultation: proposal
2	26th April 2024	Online	Meeting planning and public engagement		
3	20th May 2024	Online	Work planning and home support	Ms. Patricia Whelehan, Assistant National Director, Head of Operations and Service Improvement, Services for Older People, HSE	Home support service, regulation and home support statutory scheme
				Dr. Brendan Walsh, Senior Research Officer, Social Research Division, ESRI	The role of, and demand for, home support in Ireland
				Ms. Fiona Larthwell, Principal Officer, Home Support/Older Persons' Hub, Department of Health	The statutory home support scheme
4	20th June 2024	Department of Health	Home support, the concept of care and care from the perspective of older people and family carers	Professor Virpi Timonen, Professor of Social and Public Policy, University of Helsinki	Reflections on a broader conceptualization of care
				Professor Sarah Donnelly, Associate Professor of Social Work, School of Social Policy, Social Work and Social Justice, University College Dublin	Older people and family carers: perspectives on care

Meeting no.	Meeting date	Meeting location	Topics	Presenter	Presentation title
5	5th July 2024	Online	Community-based health and social care and mental health services for older people	Mr. Pat Healy, National Director for Services and Schemes, HSE; Enhanced Community Care Lead, Sláintecare Programme Board	Community-based health and social care for older people: Enhanced Community Care model
				Dr. Fiona Keogh, Chair, National Mental Health Research Expert Group; Adjunct Lecturer, University of Galway	Community-based mental health services for older people
6	2nd August 2024	Online	Supported living	Ms. Patricia Darling, Chair of the Board, McAuley Place and Ms. Margharita Solon, Founder/ Ambassador, McAuley Place	Independent living at McAuley Place
				Mr. Maurice O'Connell, Chair, Housing with Support Model in Inchicore Steering Group	Dublin city housing with supports demonstrator project: rebuilding Ireland, Inchicore: staying socially connected
7	15th August 2024	Department of Health	Community-based dementia services and the Healthy Age Friendly Homes Programme	Dr. Seán O'Dowd, Consultant Neurologist, Tallaght University Hospital; Clinical Lead, National Dementia Services, HSE	Community-based dementia services
				Mr. Mark Harrington, National Manager and Ms. Eimear McCormack, Regional Manager, HAFH, Age Friendly Ireland, Meath County Council	Healthy Age Friendly Homes

Meeting no.	Meeting date	Meeting location	Topics	Presenter	Presentation title
8	29th August 2024	Online	Long-term residential care	Dr. Brendan Walsh, Senior Research Officer, Social Research Division, ESRI	Long-term residential care ownership in Ireland
				Ms. Susan Cliffe, Deputy Chief Inspector of Social Services, HIQA	Regulation of the nursing home sector
9	12th September 2024	Online	GP / primary care	Dr. John Travers, General Practitioner, Morehampton Clinic, Dublin	Reversing frailty and building resilience
				Professor George Heckman, University of Western Ontario, Canada	The role of primary care in the coordination of care for older people
10	26th September 2024	Department of Health	Progress review and discussion		
11	11th October 2024	Online	Technology	Dr. Ian Cleland, Research Director and Professor Christopher Nugent, Head of School, School of Computing/ Connected Health Innovation Centre, University of Ulster	Technology for older people: the past, the present and the (possible) future
				Dr. Julie Doyle, Director, NetwellCASALA, Dundalk Institute of Technology	Engaging older adults in digital health and wellbeing self-management: lessons learned from longitudinal studies

Meeting no.	Meeting date	Meeting location	Topics	Presenter	Presentation title
12	24th October 2024	Online	Services and supports for older people with disabilities	Professor Eilionóir Flynn, School of Law and Director of the Centre for Disability Law and Policy, University of Galway	Ageing and disability: human rights, care and support
13	7th November 2024	Department of Health	The Irish Longitudinal Study on Ageing (TILDA)	Professor Rose-Anne Kenny, Regius Professor of Physic, School of Medicine, TCD; Principal Investigator TILDA, TCD; Director, WHO Centre Ageing and Life Course, TCD; and Director, Mercers Institute for Successful Ageing, St James Hospital and TCD	Healthspan versus lifespan: lessons from TILDA
				Dr. Darren McCausland, Trinity Centre for Ageing and Intellectual Disability, Trinity College Dublin	Social inclusion for older adults with an intellectual disability in Ireland: evidence from five waves of IDS-TILDA
14	22nd November 2024	Online	Funding and resource-allocation	Professor Andrew Dilnot, Honorary Fellow, Nuffield College, University of Oxford	Funding social care: what role for the State and individuals and why?
				Dr. Brendan Walsh, Senior Research Officer, Social Research Division, ESRI	Population-based resource-allocation in health and social care in Ireland
15	5th December 2024	Online	Discussion and report drafting		

Meeting no.	Meeting date	Meeting location	Topics	Presenter	Presentation title
16	9th January 2025	Online	HRB evidence briefs: health and social care for older people in three jurisdictions	Dr. Kathryn Lambe, Research Officer, HRB; Dr. Annette Burns, Research Officer, HRB; Ms. Ailish Farragher, Information Specialist, HRB; and Professor Matthew Parsons, Clinical Chair in Gerontology, University of Waikato	Health and social care for older people in New Zealand
				Dr. Kathryn Lambe, Research Officer, HRB; Dr. Annette Burns, Research Officer, HRB; Ms. Ailish Farragher, Information Specialist, HRB; and Professor Teppo Kröger, Professor of Social and Public Policy, University of Jyväskylä	Health and social care for older people in Finland
				Dr. Kathryn Lambe, Research Officer, HRB; Dr. Annette Burns, Research Officer, HRB; Ms. Ailish Farragher, Information Specialist, HRB; and Professor Adrian Wagg, Professor of Healthy Ageing, University of Alberta	Health and social care for older people in Alberta, Canada
17	6th February 2025	Online	Public consultation preliminary findings and module 1 report: home support chapter	Professor Roger O'Sullivan, Director of Ageing Research and Development, IPH; Dr. Ruth Neill, Public Health Research Officer, IPH; and Mr. Toby Finch, Research Assistant, IPH	Public consultation: preliminary findings

Meeting no.	Meeting date	Meeting location	Topics	Presenter	Presentation title
18	20th February 2025	Department of Health	Module 1 report: community care chapter		
19	6th March 2025	Online	Module 1 report: approach		
20	21st March 2025	Online	Module 1 report: supported living, themes and vignettes		
21	3rd April 2025	Department of Health	Module 1 report: revised home support and introductory and concluding chapters		
22	1st May 2025	Online	Module 1 report: residential care chapter and scoping of technology chapter		
23	15th May 2025	Online	Module 1 report: disabilities and revised supported living chapters		
24	29th May 2025	Online	Module 1 report: dementia and revised residential care chapters		
25	13th June 2025	Online	RTÉ Investigates, 'Inside Ireland's Nursing Homes' programme; module 1 report: primary and community care chapters; and public consultation report findings		
26	26th June 2025	Online	Module 1 report: resource-allocation and revised residential care chapters		

Meeting no.	Meeting date	Meeting location	Topics	Presenter	Presentation title
27	24th July 2025	Online	Module 1 report: technology and revised dementia chapters		
Extraordinary meeting with HIQA	20th August 2025	Online	Regulation of the nursing home sector	Mr. Finbarr Colfer, Chief Inspector Designate of Social Services, HIQA and Ms. Susan Cliffe, Deputy Chief Inspector of Social Services, HIQA	Regulation of the nursing home sector
28	22nd August 2025	Online	Module 1 report: revised funding and resource-allocation and disabilities chapters		
29	5th September 2025	Department of Health	Module 1 report: lessons learned		
30	19th September 2025	Online	Module 1 report: introductory and revised technology chapter and structure of concluding chapter		
31	3rd October 2025	Online	Module 1 report: draft concluding chapter and revised introductory chapter		
32	17th October 2025	Department of Health	Module 1 report: all chapters		
33	30th October 2025	Online	Module 1 report: all chapters		
34	28th November 2025	Online	Module 1 report finalisation and Module 2 planning		

Appendix IV: Reference Group members

Chair:

Ms. Catherine McGuigan, Chief Officer, Age Friendly Ireland

Members:

- Acquired Brain Injury Ireland
- Active Retirement Ireland
- Age Action
- Age & Opportunity
- Alcohol Action Ireland
- All Ireland Institute of Hospice and Palliative Care
- ALONE
- Alzheimer Society of Ireland
- Arthritis Ireland
- Association of Occupational Therapists of Ireland
- Care Alliance Ireland
- Céile Care
- Chime
- Community and Voluntary Pillar
- CORU
- Disability Federation of Ireland
- Family Carers Ireland
- Health Informatics Society of Ireland
- Home and Community Care Ireland
- Huntington's Disease Association of Ireland
- Inclusion Ireland
- Irish Association of Social Workers
- Irish College of General Practitioners
- Irish Council for Social Housing
- Irish Dental Association
- Irish Farmers' Association
- Irish Heart Foundation
- Irish Hospice Foundation
- Irish Men's Sheds Association
- Irish Motor Neurone Disease Association

- Irish Patients' Association
- Irish Pharmacy Union
- Irish Rural Link
- Irish Senior Citizens Parliament
- Irish Society of Chartered Physiotherapists
- Irish Traveller Movement
- Irish Wheelchair Association
- LGBT Ireland
- Medical Council
- Mental Health Ireland
- Migrant Rights Centre Ireland
- MS Ireland
- Muintir na Tíre
- National Advocacy Service for People with Disabilities
- National Community Care Network
- National Federation of Voluntary Service Providers
- National Network of Older People's Councils
- National Public Participation Network Advisory Group
- National Women's Council
- Neurological Alliance of Ireland
- Nursing and Midwifery Board of Ireland
- Nursing Homes Ireland
- Parkinson's Ireland
- Patient Advocacy Service
- Pavee Point
- Polio Survivors Ireland
- Pre-Hospital Emergency Care Council
- Rehab Group
- Royal College of Physicians of Ireland
- Safeguarding Ireland
- Sage Advocacy
- Social Justice Ireland
- The Alliance: Supporting Nursing Homes
- The Wheel
- Third Age

Appendix V: Reference Group meetings

National plenary meetings

First meeting: 10.30am–4pm, Tuesday 18th June 2024, Ashling Hotel, Dublin.

- Theme 1: Home support
- Theme 2: Other community-based health and social care supports for older people

Second meeting: 10.30am–4pm, Tuesday 8th October 2024, The Gibson Hotel, Dublin.

- Theme 1: Long-term residential care for older people
- Theme 2: General practice and primary care

Focus group meetings

- 'General practice and primary care', 2pm–4.30pm, Monday 9th September 2024, online.
- 'Models of supported living—housing with supports', 10am–12.30pm, Wednesday 25th September, online.
- 'Home support and other community-based health and social care services for older people with intellectual disability', 10am–1pm, Friday 18th October 2024, The Glenroyal Hotel, Maynooth.

Webinars

- 'Update on the Commission on Care for Older People', 2pm–3.30pm, Monday 22nd September 2025, online.

Commission on Care
for Older People