A VALUE FOR MONEY REVIEW OF NURSING HOME CARE COSTS

Contents

Tables

Graphs

Boxes

Abbreviations

ABS	Aggressive Behaviour Scale
ADL	Activities of Daily Living
ADLH	Activities of Daily Learning Hierarchy
CHESS	Changes in Health, End-Stage Disease, Signs and Symptoms
CHO	Community Healthcare Organisation
CIHI	Canadian Institute for Health Information
CMI	Casemix Index
CPS	Cognitive Performance Scale
CRE	Comprehensive Review of Expenditure
CVA	Cerebrovascular accident
DoH	Department of Health
DPER	Department of Public Expenditure and Reform
DRS	Depression Rating Scale
DSIDC	Dementia Services Information and Development Centres
ESRI	Economic and Social Research Institute
GMS	General Medical Services
HCA	Health Care Assistants
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
IFMS	Integrated Financial Management System
IGEES	Irish Government Economic and Evaluation Service
INMO	Irish Nurses and Midwives Organisation
interRAI	international Resident Assessment Instrument
interRAI HC	interRAI Home Care
interRAI LTCF	interRAI Long-Term Care Facility
MMSE	Mini Mental State Examination

NHI	Nursing Homes Ireland
NHSS	Nursing Homes Support Scheme
NTPF	National Treatment Purchase Fund
OT	Occupational Therapist
PIC	Person in Charge
PRSI	Pay Related Social Insurance
PURS	Pressure Ulcer Risk Scale
RUGs	Resource Utilisation Groups
SAT	Single Assessment Tool
SIPTU	Services, Industrial, Professional and Technical Union
SLT	Speech and Language Therapy
US	United States
VFM	Value for Money
VFMPR	Value for Money and Policy Review
WTE	Whole Time Equivalents

Executive Summary

Introduction

This is the Final Report of the Value for Money and Policy Review (VFMPR) of Nursing Home Care Costs, undertaken between March 2018 and March 2021 under the direction of a Steering Committee comprising representatives of the Department of Health (DoH), the Department of Public Expenditure and Reform (DPER), the National Treatment Purchase Fund (NTPF), the Health Service Executive (HSE), and the Economic and Social Research Institute (ESRI), and led by an independent chair.

The purpose of this VFM Review is to identify, quantify and analyse the reasons for any cost differential between private/voluntary and public nursing homes, and following analysis, to make recommendations for improving the value for money obtained by the Health sector.

This Review has taken longer to complete than originally anticipated. Initially, delays were encountered while attempting to obtain sufficient private sector data to allow for a meaningful comparison between the sectors. As work was progressing to resolve this issue, the COVID-19 pandemic struck. As a result, this review was temporarily paused in order to focus all resources within the Department of Health in responding to the crisis. The data used in this report precedes COVID-19 and must be read in this context. The underlying reasons for the cost differential are no less valid, but it must be acknowledged that there is a significant change in the economic and social landscape and delivery of health services and services for older people as a result of COVID-19. Therefore, the recommendations contained in this report must be considered in tandem with the recommendations of the final report of the COVID-19 Nursing Homes Expert Panel, which was published on 19 August 2020.

Terms of Reference

The Terms of Reference, as agreed by the Steering Committee are as follows:

1. Having regard to the overall objectives in provision of long stay care supported by the Nursing Homes Support Scheme, identify the cost differentials between the private/voluntary and public sectors.
2. Quantify and analyse the reasons for the cost differentials between the private/voluntary and public sectors.
3. Define outputs and inputs associated with activity in the private/voluntary and public sectors and identify the level and trend of these outputs and inputs.
4. Examine the extent to which the objectives of the Nursing Homes Support Scheme have been achieved, and comment on the effectiveness with which they have been achieved.
5. Identify, examine, and compare the cost differential and how it is dealt with for Residential Care Centres in other jurisdictions.
6. Evaluate the degree to which the objectives warrant the allocation of public funding on a current and ongoing basis and suggest recommendations for improving the value for money obtained by the State.

The Nursing Homes Support Scheme

The Nursing Homes Support Scheme (NHSS) was established by the Nursing Homes Support Scheme Act 2009. The NHSS covers long-term nursing home care only. It does not cover short-term care such as respite, convalescent care, or day care although these types of services may be provided in some nursing homes.

The HSE has statutory responsibility for administering the scheme. The role of the HSE includes the preparation of guidance material and application forms, accepting applications, assessing an applicant's care needs, conducting a financial assessment to determine the level of contribution from the resident and disbursing payments to approved nursing homes in respect of the State contribution towards the cost of care.

Once an individual has been assessed as needing long-term residential care a financial assessment is carried out to determine the financial contribution that the individual should make towards the cost of their care. Participants in the Scheme contribute 80% of assessable income and 7.5% of the value of any assets per annum, or 40% of assessable income and 3.75% of the value of any assets if they are part of a couple. The first €36,000 of an individual's assets, or €72,000 for a couple, is not counted in the financial assessment. A person's principal residence is only included in the financial assessment for three years of a person's time in care, capping the contribution from a principal residence at 22.5%.

Applicants to the NHSS choose the nursing home they wish to reside in. Regardless of whether it is a private, voluntary or public nursing home the resident's financial contribution is the same; the price of care has no direct impact on the resident.

Under Sections 40-41 of the Nursing Home Support Scheme Act 2009 the National Treatment Purchase Fund (NTPF) is empowered "to make arrangements with a person it considers to be appropriate, being a proprietor of a nursing home, relating to the price at which long-term residential care services will be provided by such person to persons requiring such services and who are in receipt of financial support under the Nursing Homes Support Scheme Act 2009." A private or voluntary nursing home cannot participate in the scheme unless it has agreed a price with the NTPF. The NTPF is independent in the performance of its functions.

The HSE, at a national level, determines the a reasonable maximum cost of care for each public nursing home. This cost is the 'price' paid to the public nursing home under the Scheme.

The Cost Differential

There is some difficulty in comparing costs between sectors as the eligible cost criteria differ somewhat between sectors. Public nursing homes are subject to a list of eligible cost components as laid before the Oireachtas. Private nursing homes are not subject to the same list but the following guidelines are taken into account in negotiating prices; (a) costs reasonably and prudently incurred by the nursing home and evidence of value for money, (b) price(s) previously charged, (c) local market price and (d) budgetary constraints and the obligation of 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. Some costs, such as mortgage repayments and insurance costs, are specific to the private sector, while capital costs for public nursing homes are met from the HSE's

capital budget. Other costs, such as pensions, differ significantly between the sectors. Given these issues, it is important to note that a cost comparison cannot be made on a purely like-for-like basis.

In 2019, the average price paid to a private/voluntary nursing home from the NHSS budget was €992 per resident per week, while the average price charged to that budget in respect of a public nursing home was €1,616 per resident per week. This is a substantial difference, with the amount charged to the NHSS in respect of public nursing homes being, on average, 62% more than was paid, on average, to private nursing homes.

This is the average maximum amount each public nursing home can charge to the NHSS. However, in 2019, public nursing homes, on average, incurred costs of €100 per resident per week higher than the cost of care set by the HSE. This variance falls to be addressed by the Community Healthcare Organisation (CHO) in the first instance and by the wider community service budget thereafter. If the full cost of the eligible cost components had been charged to the NHSS, the cost differential would have been 73%. As already stated, the data used in this report predates the advent of COVID-19. However, since March 2020 significant additional direct and indirect financial supports have been provided to private nursing homes in order to enable them to build-up their resilience to prevent outbreaks of COVID-19, and to manage outbreaks where these occur. These supports included:

- The HSE taking an active front line operational role in service delivery in a number of private nursing homes.
- HSE staff being deployed to private nursing homes when required.
- The provision of funded personal protective equipment (PPE) to private nursing homes by the HSE/State.
- The provision of training, support, and advice in respect of Infection Prevention and Control (IPC) to private nursing homes by the HSE.
- The provision of payments under the Temporary Assistance Payment Scheme (TAP) to private nursing homes by the State.

The cost differential examined in the VFM is based on the differences in funding under the NHSS. If the review encompassed the year 2020, the value of additional supports provided in 2020 would have to be factored. It is likely that the cost differential would be significantly different to previous years.

Reasons for the Cost Differential

While the Review team had access to substantial public sector data, the availability of comparable private sector data was limited. From the data available it is evident that the majority of the cost differential is as a result of difference in pay costs. The pay cost differential is largely due to variances in nursing-to-resident ratios and skill mix.

Basic salary for nurses is broadly similar between the sectors but health care assistants receive almost a third more in basic pay in public nursing homes.

There are approximately two and a half times as many nurses to residents in public nursing homes compared to private nursing homes. Private nursing homes have more than twice as many healthcare assistants (HCAs) than nurses than their public sector counterparts. In both sectors, the basic salary for healthcare assistants is considerably less than nurses; approximately 20% in the

public sector, and 40% in the private sector. Having more healthcare assistants and fewer nurses in private nursing homes results in far lower overall pay costs in the private sector.

In the absence of a safe staffing and skill mix framework, and without knowing the individual care needs of residents, this report can only record the difference in staffing and skill mix ratios but cannot comment on their appropriateness.

The HSE have previously noted that the dependency levels of residents are higher in public nursing homes thereby requiring higher staffing levels, and especially higher levels of nursing staff. A study, using the InterRAI Assessment Tool, to assess how individual care needs are aligned with resources was commissioned as part of this review. This study was extremely limited and cannot be considered in any way statistically representative. Overall, the study found that there was little difference in the levels of dependency between the mix of public and private nursing homes that participated in the study. With only approximately 1% of nursing home residents who receive NHSS funding taking part in the study it would be necessary for a much larger study to be carried out before any conclusions could be drawn.

A comparison of high-level data shows that differences in non-pay costs do not significantly contribute to the cost differential. Energy costs are €13 higher per resident per week in the public sector, which is likely due to the older stock of nursing homes in the public sector. The capital refurbishment programme will likely help to bring these costs in line between the sectors. The cost of medical supplies and training were both significantly lower in the public sector. The amount of medical supplies charged to the NHSS budget is likely due to the narrow definition of eligible medical supplies in the list of NHSS eligible cost components for public nursing homes, rather than fewer medical supplies being consumed by residents. The lower cost of training is likely due to the provision of global training within the HSE.

Outputs, Inputs, Effectiveness and Efficiency

In December 2019, there were 23,629 people supported by the NHSS. Of these 4,747 resided in a public nursing home, while 18,882 were in a private nursing home.

Between 2015 and 2019:

- The number of people receiving NHSS funding increased by 2.4% from 23,073 to 23,629.
- The NHSS budget increased by 12.99% from €873.9m to €986.2m.
- The average price paid to a private nursing home per resident per week increased by 10% from €903 to €992.
- The average price charged to the NHSS in respect of a public nursing home per resident per week increased by 13.3% from €1,426 to €1,616.
- Full cost of eligible cost components (as opposed to the amount charged to the NHSS) per resident per week in public nursing homes increased by 20.3% from €1,426 to €1,716.

Despite an increase of almost 13% in funding over the period 2015 – 2019, the total number of people receiving funding from the NHSS had only increased by 2.4%. This shows that additional government expenditure has been consumed by price rather than increasing capacity. The price/cost increases are disproportionally higher in public nursing homes, with the cost of care increasing by more than double the rate of the private sector over the period. Despite this, the

number of people being supported in public nursing homes remained more or less static. Additional capacity is therefore driven by increases in the number of voluntary and private beds.

The ESRI have forecast that demand for long-term residential care will increase to between 40,700 and 44,600 places by 2030[1]. While new policy measures, such as the introduction of a statutory home support scheme, should offset some of this demand, it is still likely that significant additional capacity will be required. The Health Service Capacity Review adjusted for anticipated increases in home care, and forecasts that demand for long-term residential care will increase to 33,000 beds by 2030.

Existing data does not allow for care outcomes to be measured. With the rollout of the Single Assessment Tool[2], a suite of Key Performance Indicators could be developed by clinical experts to help measure care outcomes and determine if there are any sectoral differences.

The HSE contends that public nursing homes have a much greater proportion of residents with high levels of dependency than private nursing homes, which requires a higher cost of care to meet these needs. Due to the small sample size the assessment of needs study commissioned was not sufficiently statistically robust to either conclusively prove or disprove this claim. However, the real value of the study is in illustrating the benefits of rolling out a Single Assessment Tool nationally. Without data showing the levels of dependency of residents in nursing homes, and in the absence of a safe staffing and skill mix framework, it is not possible to conclusively comment on the efficiency of provision. Without outcome data or quality assessment it is not possible to compare the effectiveness of provision or impact on the experience of residents.

International Evidence

An examination of systems of provision of residential care for older people in other jurisdictions highlights the relative uniqueness of Ireland's public/private approach. Due to the lack of a comparable structure, the international evidence chapter examines ownership models and efficiency. It should be noted that even with this broader remit, a lack of government information on the ownership, costs, and the quality of services provided make it challenging to conduct robust studies exploring causal links.

Many countries have privatised nursing home care, in the hope of achieving cost savings from the stronger incentives linked to private ownership and competition. However, with these incentives to the fore, it can be hard to achieve and maintain appropriate quality levels, especially where it is hard to define, measure and verify quality dimensions of the services contracted. It has also been the experience in some jurisdictions that as large nursing home chains and companies grow in dominance in the market, governments' ability to control the cost of care is reduced.

The literature review found that publicly operated nursing homes had higher levels of staffing, a key indicator of quality. In some jurisdictions private operators appeared to adjust staffing levels according to the payment received from the State, rather than client needs. This emphasises the need for a payment system based on care needs and a staffing and skill mix framework.

[1] ESRI (2017), *Projections of Demand for Healthcare in Ireland, 2015-2030: First Report from the Hippocrates Model*

[2] The Single Assessment Tool is a comprehensive IT based standardised assessment currently being piloted by the HSE to assess the health and social care needs of people (primarily those over the age of 65 years) who may be looking for support.

The Rationale for Continued Allocation of Public Funding

The public and private sectors both have an important role in meeting demand for nursing home care; a demand which is expected to increase significantly due to Ireland's aging population. Rather than questioning the rationale for continued funding of the NHSS, this Review is focused on whether there is a rationale for the cost differential between the sectors. The lack of data, especially in terms of levels of dependency and care needs, makes it difficult to comment conclusively on the current efficiency of provision. Closer alignment of payments to care needs, via a single assessment tool and a staffing and skill mix framework would increase transparency and result in a more evidence-based system of funding.

Recommendations

The Steering Committee has brought forward a range of recommendations that are substantial and would likely require primary legislation and substantial redevelopment of the NHSS. The first recommendation proposes the establishment of an inter-agency project team, with the range of expertise required, in order to drive the delivery of the other recommendations. The work arising from these recommendations would involve significant research, policy analysis and development work, and a wide-ranging mix of clinical, economic, and legal input.

Recommendation 1: An inter-agency project team, with the range of expertise required, should be established to drive the delivery of the recommendations.

Recommendation 2: The NTPF and Department of Health should explore a potential change to the Deed of Agreement between the NTPF and private operators to allow for the sharing of the information collected by the NTPF with the Department. It is likely that a change in the legislation would be required to facilitate this. A clearly defined process would need to be agreed to provide reassurance to the sector with regards to the purpose, use and availability of the data transferred, with safeguards in place to protect any commercially sensitive information.

Recommendation 3: The interRAI Single Assessment Tool should be rolled out nationally, along with a set of national operational policy and guidelines, to determine the care needs of the applicants to the NHSS. Within a defined period of time (determined by the Department of Health) care needs assessments used to determine funding under the NHSS should be undertaken using the interRAI Single Assessment Tool.

Recommendation 4: A programme of work should be established to examine and develop, as appropriate, a model for the allocation of resources through the use of Resource Utilisation Groups to align resources/payments to care needs. This should include an examination of international evidence and best practice and should include a comprehensive capture of data using the interRAI assessment tool for a minimum period to determine a baseline profile of care needs in residential care settings. Work on such resource allocation models should fully align with development work being undertaken with regard to the development of the statutory home support scheme.

Recommendation 5: The Safe Staffing and Skill Mix Framework for Residential Care should be agreed as a priority.

Recommendation 6: An extensive review and audit process be established as a matter of urgency to examine the operation, costs, staffing, rostering, use of agency staff and cost assignment in public nursing units prioritising the most expensive nursing homes. The process should be supported by external expertise as required.

Cost improvement measures should be a key outcome along with recommendations for future use and/or alternative service models where costs improvement measures cannot be achieved.

Recommendation 7: The published cost of care for public nursing homes should be explicit whereby the cost of care referred to is the maximum cost of care that can be charged to the NHSS. For the purposes of transparency, a list showing the actual eligible costs incurred by each nursing home, highlighting any variances against the maximum cost of care, should be published shortly after the end of each financial year.

Recommendation 8: The Department of Health and the HSE should examine if a cohort of existing long-term care residents supported under the NHSS could have remained at home for longer had the right package of supports been available.

Recommendation 9: The recommendations of this review should be implemented having regard to the recommendations of the final report published by the COVID-19 Nursing Homes Expert Panel on 19 August 2020.

Chapter 1: Background and Context

1.1 Introduction

This is the Final Report of a Value for Money and Policy Review (VFMPR) of Nursing Home Care Costs. The review was undertaken between March 2018 and March 2020 under the direction of a Steering Committee led by an independent chairman and comprising representatives of the Department of Health (DoH), the Department of Public Expenditure and Reform (DPER), the National Treatment Purchase Fund (NTPF), the Health Service Executive (HSE), and the Economic and Social Research Institute (ESRI). Membership of the Steering Committee is listed in Appendix 1.

1.2 Background

There are 553 nursing homes for older people in Ireland currently eligible to accept residents under the Nursing Homes Support Scheme (NHSS), with an average of 22,989 people receiving financial support for long-term residential care places in 2019. There are three types of provision within the residential care sector: private and voluntary (439), and public residential care centres under the remit of the HSE (114). Expenditure charged to the NHSS was €998.4m[3] in 2019.

Table 1 shows that expenditure increased by 14.3% between 2015 and 2019, with a 6.4% increase in the number of people in receipt of NHSS funding. The Health Service Capacity Review[4] estimated that estimated that there was demand for 24,000 Long-term Residential Care beds in 2015. The Review predicts that capacity will need to reach 33,000 by 2030 to meet demand; a 37.5% increase. Therefore, it is imperative that value for money is achieved in the sector and efficiencies maximised.

Table 1: NHSS Residents and Expenditure 2015-2019

	2015	**2016**	**2017**	**2018**	**2019**
Average Number of People Receiving NHSS Support	21,596	22,237	22,426	22,551	22,989
Expenditure (€000)	873,900	896,900	939,902	960,612	998,844

Source: *HSE & DPER (Revised Estimates of Public Expenditure 2015 – 2019)*

Box 1. What is the Nursing Homes Support Scheme?

The Nursing Homes Support Scheme (NHSS) was established by the Nursing Homes Support Scheme Act 2009 and amended by the Health (Amendment) Act 2013, and the Health (General Practitioner Service) Act 2014.

The NHSS, or Fair Deal as it is commonly referred to, is a system of financial support for people who require long-term nursing home care. The scheme covers approved private, voluntary, and public nursing homes. It does not cover short-term care such as respite, convalescent care or day care, although these types of services may be provided in some nursing homes.

[3] DPER, *Revised Estimates for Public Services 2020*

[4] Dept of Health (2018), Health Service Capacity Review

Once an individual has been assessed as needing long-term residential care, a financial assessment is undertaken to determine the person's financial contribution towards the cost of their care. Assets, such as pension, savings and property are taken into consideration when determining the amount an individual will have to pay towards their nursing home fees, subject to a maximum percentage of assets or income. The amount they contribute is the same, regardless of whether the individual chooses a private, voluntary, or public nursing home. The State, via the HSE, pays the balance.

1.3 Price Setting

All nursing homes, private, voluntary, and public, that participate in the NHSS are subject to a weekly payment per resident which is calculated on a nursing home by nursing home basis. The methodology employed in setting prices differs between the private/voluntary and public sectors. For public nursing homes the NHSS payment is the agreed price per resident in a nursing home, whereas the NHSS payment for a private/voluntary nursing home is a price agreed between the nursing home and the National Treatment Purchase Fund.

1.3.a Private and Voluntary Nursing Homes

The NTPF has a specific remit under the NHSS to negotiate prices with private and voluntary nursing homes on behalf of the State. Following negotiations, the NTPF may then enter into an 'Approved Nursing Home Agreement' with the proprietor, setting out the maximum price payable to the nursing home for the term of the agreement.

The NTPF shall only agree prices with nursing homes where it considers that those prices deliver value for money to the Irish State. In negotiating prices, the NTPF shall have regard to the following considerations (which are in no particular order of priority):

a) costs reasonably and prudently incurred by the nursing home and evidence of value for money,

b) price(s) previously charged,

c) the local market price; and

d) budgetary constraints and the obligation of 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.

1.3.b Public Nursing Homes

The NTPF has no role in setting prices for public nursing homes. The maximum weekly cost per bed for each public nursing home is calculated by the HSE. The HSE use historic running costs under defined 'Cost Components in Respect of Care Services (Nursing Homes)'[5]. This per bed cost is calculated using the total eligible costs of the nursing home with an assumed 95% occupancy rate.

[5] Appendix 2

Throughout this Review any reference made to the 'price' of public nursing homes is the cost charged to the NHSS per bed per week.

1.4 Background to Value for Money and Policy Reviews

The Comptroller and Auditor General (Amendment) Act 1993 and the Public Service Management Act 1997 laid the foundations for Government Departments to develop individual evaluation strategies in line with the activities they support. In 1997 the Department of Finance introduced the Expenditure Review Initiative to provide a consistent framework for examining public expenditure across all areas of Government. While this significantly improved evaluations within Departments, a report by the Comptroller and Auditor General in 2001 noted that evaluations focused on inputs rather than outputs. In 2003 external quality assessments of review reports were introduced. In 2004 the first Formal Report of the Expenditure Review Central Steering Committee found that the reviews should have greater focus on informing the decision-making process for resource allocation.

In 2006 the Value for Money and Policy Review (VFMPR) Initiative replaced the Expenditure Review Initiative. A Central Expenditure Evaluation Unit was established within the Department of Finance to promote best practice and oversee programme evaluation under the VFMPR Initiative. The revised initiative included 92 formal reviews approved by Government for the 2006-2008 Round.

Following the Comprehensive Review of Expenditure (CRE) in 2011, in 2012 the Department of Public Expenditure and Reform (DPER) published updated guidelines[6] for reviewing and assessing expenditure programmes to address shortcomings identified by VFMPR practitioners. Issues identified included the delays in completing VFMPRs due to their time-consuming and administratively burdensome nature, the difficulty in covering a broad range of spending areas in one or two years, the shortage of staff with analytical expertise and the lack of a uniform standard for reporting the outcomes of a review.

The updated VFM Code involves a number of changes to the VFMPR procedures including more targeted reviews, more focused steering committees limited to key officials, greater alignment with expenditure allocation processes, an enhanced role for the Oireachtas in selecting and assessing reviews, and the compulsory inclusion of a 'balanced scorecard' to assess the programme against a range of criteria common to all evaluations.

In the light of budgetary reforms, a further update (IGEES, 2018)[7] to the VFM Code was introduced in 2018 which included a number of additional issues to be considered when undertaking a VFM. These issues include medium-term fiscal planning, performance budgeting, a medium-term expenditure framework, and economic advisory and legal frameworks. This updated VFM Code also specified a role for the Irish Government Economic and Evaluation Service (IGEES).

[6] *The VFM Code: Expenditure Planning, Appraisal & Evaluation in the Irish Public Service - Standard Rules & Procedures,* Central Expenditure Evaluation Unit, Department of Public Expenditure and Reform (2012),
[7] *Value for Money Review and Focused Policy Assessment Guidelines*, IGEES, January 2018

1.5 Scope of the Review

An analysis of the published residential care costs[8] shows that a public residential care place in 2019 costs 62% more on average than a private or voluntary residential care place. It is important to note that the cost differential does not impact upon residents.

The primary purpose of this VFM Review is to identify, quantify and analyse the reasons for the cost differential, and following analysis, to make recommendations for improving the value for money obtained by the health sector on behalf of the State. This Review provides greater insight of the foregoing variance.

This VFM Review differs from a traditional VFM Review in that it is not a review of a programme per se, but instead is a review of price differences between the public and private/voluntary sectors. Therefore, traditional aspects of a VFM Review, such as the prescribed Terms of Reference laid out in the Public Spending Code, have had to be modified in order to fit the scope of this review.

The Terms of Reference, as agreed by the Steering Committee are as follows:

1. Having regard to the overall objectives in provision of long stay care supported by the Nursing Homes Support Scheme, identify the cost differentials between the private/voluntary and public sectors.
2. Quantify and analyse the reasons for the cost differentials between the private/voluntary and public sectors.
3. Define outputs and inputs associated with activity in the private/voluntary and public sectors and identify the level and trend of these outputs and inputs.
4. Examine the extent to which the objectives of the Nursing Homes Support Scheme have been achieved, and comment on the effectiveness with which they have been achieved.
5. Identify, examine, and compare the cost differential and how it is dealt with for Residential Care Centres in other jurisdictions.
6. Evaluate the degree to which the objectives warrant the allocation of public funding on a current and ongoing basis and suggest recommendations for improving the value for money obtained by the State.

1.6 Methodology

The Steering Committee agreed the following methodology for its Review.

- Desk based cost comparison review of public and private sector accounts to identify cost components with the largest variances.
- Identify public and private residential care centres of similar size/capacity that are located within the same catchment area, but where costs are significantly different in order to carry out cost comparisons on a micro level.

[8] *Cost of Care*, HSE, 2019

- Testing of Single Assessment Tool[9] to test for acuity/dependency and skill mix, with input from the Department's Statistics Unit.
- Identify any linkages between higher acuity and cost.
- Review of international funding methods, in order to highlight alternative models.
- Review of public procurement procedures.
- Review of public price setting mechanism.

1.7 Challenges and Limitations of the Review

It is important to note that this review is not a VFM Review of the NHSS per se, but rather a review of the price/cost differential between the sectors that receive funding from the NHSS.

While public sector financial and skill mix data was made available from the HSE, there were difficulties in obtaining equivalent private sector data. As part of the negotiating process, private and voluntary nursing homes are required to provide comprehensive financial information to the NTPF, including detailed accounts and relevant additional information such as skill mix and staffing numbers. The Department formally requested access to this information. However, as no provision is made in the Deed of Agreement between the NTPF and the private/voluntary nursing homes to share data with a third party, the NTPF referred the request to its legal advisors. The legal opinion raised issues regarding data protection, competition law and breach of confidence, with a recommendation to provide the Department with high level aggregate data in lieu of detailed data. Alternative sources were subsequently explored. Nursing Homes Ireland provided the Review Team with a report it had commissioned from Crowe Horwath to support workforce planning in the private nursing home sector. The private sector skill mix data collected in the Crowe Horwath report is the primary source of private sector skill mix data used in this Value for Money Report. It should be noted that the VFM Review Team was not able to validate the data, as the data in question was not accessible.

While public nursing homes record their costs according to the Cost Components in Respect of Care Services (Nursing Homes)[10], private nursing homes are not required to provide their financial data to the NTPF under the same headings. Therefore, if accounts were to be made available to the Department, comparability, and the ability to carry out a detailed analysis, would still be a significant issue to overcome.

Issues with comparability are compounded by the use of different methodologies to calculate the weekly rates for private/voluntary homes and public nursing homes. The NTPF negotiates the prices for the private and voluntary sectors and the HSE sets the prices for the public sector.

The absence of prescribed ratios in terms of skill mix and staff numbers, coupled with a lack of data regarding individual care needs, means that while comparisons can be made between the sectors,

[9] The Single Assessment Tool is a comprehensive IT based standardised assessment currently being piloted by the HSE to assess the health and social care needs of people (primarily those over the age of 65 years) who may be looking for support.

[10] Appendix 2

the Steering Committee is not in a position to comment on whether staff levels are too high, too low, or sufficient.

The Review includes a study which utilised the InterRAI Single Assessment Tool, (international Resident Assessment Instrument), (formerly known as Single Assessment Tool (SAT) pilot). The purpose of the study was to assess whether care needs differed significantly among centres with significant price differences. However, its application was limited in its size due to the resources available. Of the five public and private nursing homes participating in the pilot, 234 residents took part in the study and underwent a detailed care needs assessment. While the study illustrates the detailed individual information that can be obtained by applying a universal care needs assessment tool, the small sample size of this study is not statistically representative and therefore the findings cannot be considered representative on a sector-wide basis.

Chapter 2: Paid Cost of Care in Public and Private Nursing Homes

2.1 Introduction

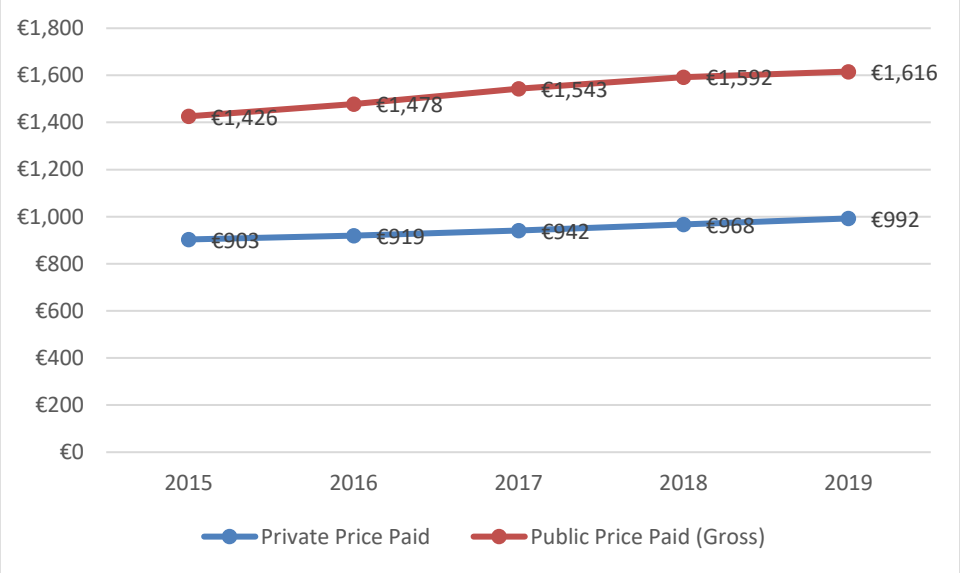
The HSE has statutory responsibility for administering the NHSS (Fair Deal). This role includes disbursing payments to approved nursing homes in respect of the State contribution towards the cost of care.

The HSE periodically publishes the cost of care in nursing homes. The HSE publishes one list showing the gross cost of care in public nursing homes; clients pay their contribution, and the balance is charged to the NHSS. A separate list shows the price paid to private and voluntary nursing homes.

2.2 Trends in Paid Cost of Care

Between 2015 and 2019 the average price paid to private nursing homes increased by 9%, while the price paid to public nursing homes increased by 13.3%. The graph below shows the average price paid per resident per week to private/voluntary and public nursing homes over the period 2015 – 2019.

Figure 1: *Average price paid from NHSS Budget 2015 – 2019*



Source: *HSE (public), NTPF (private/voluntary)*

In 2015, the price per resident per week paid to a public nursing home was on average €523 more than the price paid to a private nursing home. By 2019, the price difference had increased to €624. Year on year price increases are notably higher in public nursing homes compared to private nursing homes. As payroll is the most significant cost incurred in operating a nursing home, the increases observed for public nursing homes are likely to be as a result of pay increases for public servants under the Public Service Stability Agreements, which began the gradual unwinding of pay cuts experienced under the Financial Emergency Measures in the Public Interest (FEMPI) Acts.

Table 2 shows that the year on year increases for both sectors are generally broadly similar in percentage terms, with 2017 being a notable exception. However, the difference in the amount of the increase reflects the higher starting base cost in public nursing homes.

Table 2: Year on Year Increases in Paid Cost of Care				
	2016	**2017**	**2018**	**2019**
Public Nursing Homes				
Increase on Previous Year (€)	52	65	49	24
Increase on Previous Year (%)	3.6%	4.4%	3.2%	1.5%
Private Nursing Homes				
Increase on Previous Year (€)	33	2	27	23
Increase on Previous Year (%)	1.8%	2.5%	2.7%	2.6%

2.3 Variance between Paid Cost of Care and Actual Cost of Care in Public Nursing Homes

The paid cost of care is the cost each nursing home can charge per resident per week from to the NHSS budget. The HSE has at national level, ensured the establishment of a maximum cost of care to be funded through the NHSS. This is the published cost of care and ensures that no more than a reasonable cost of care is set for each unit in line with the legislation and regulations. As discussed in Chapter 1, the paid cost per bed in public nursing homes is based on the total eligible cost of the nursing home assuming an occupancy rate of 95%, and also includes embedded savings targets.

Where actual occupancy rates are lower, public nursing homes run a deficit as no income is generated from unoccupied beds. In these cases, the paid cost of care is lower than the actual cost. Conversely, where actual occupancy rates are greater than 95% the nursing homes are generating additional income and the actual cost of care is lower than the paid cost of care. Table 3 below shows the cost impact of variances against the target occupancy rate.

Table 3: Effect of Occupancy Targets on Costs, Jan - Dec 2019		
	Number of Nursing Homes	**€**
Deficit due to < 95% occupancy	54	(7,966,805)
Surplus due to > 95% occupancy	58	4,352,143
Net Deficit		**(3,614,662)**

Source: *HSE*

The maximum cost of care as determined by the HSE also includes provision for anticipated savings in a public nursing home's eligible NHSS costs. These savings are embedded in the HSE's National Service Plan (NSP) and are expected to be achieved by targeted reductions in both pay and non-pay costs.

Table 4 below shows that while a number of public nursing homes were able to achieve savings on their eligible costs, the majority of nursing homes incurred expenditure greater than the maximum cost they are allowed to charge to the NHSS.

Table 4: Cost Variances in Public Nursing Homes, Jan – Dec 2019

	Number of Nursing Homes	**€**
Actual costs exceeding target costs	78	(25,586,378)
Actual costs lower than target costs	30	3,640,199
Net Deficit		**(21,928,179)**

Source: *HSE*

The effect of lower than anticipated occupancy, combined with lower than anticipated savings is a total variance on NHSS eligible cost components of almost €25.4m in 2019. In many cases there was a netting-off effect within the nursing homes costs i.e. they may have generated additional income from occupancy exceeding the target rate of 95% but costs exceeding budgeted costs resulted in an overall variance against the cost of care allowed to be charged to the NHSS.

Overall, 75 nursing homes incurred costs greater than the maximum cost of care set by the HSE, while the costs of 33 nursing homes were less than the maximum cost of care.

These variances are managed in the same way as other budgetary variances and falls to be addressed by the Community Healthcare Organisation in the first instance and by the wider community service budget thereafter. The rationale for this approach is that if expenditure above the maximum cost of care was permitted to be charged to the NHSS fewer people could be supported by the Scheme and/or could result in a significantly longer waiting period for applicants to access funding. This could lead to people in need of long-term care remaining in hospital or at home inappropriately for longer periods of time.

In the period January – December 2019, 10 nursing homes were responsible for over half of the net variance, with an average cost variance over paid cost of care of €374 per bed per week.

Table 5: Public Nursing Homes with the Largest Variance Against Paid Cost of Care							
Nursing Home	**Actual Cost of Care (Weekly)**	**Paid Cost of Care (weekly)**	**Variance Actual v Paid**	**Overall Occupancy 2019**	**Variance Due to Occupancy**	**Total Variance Due to Cost**	**Total Variance**
	€	**€**	**€**		**€**	**€**	**€**
A	2,358	2,040	318	93.5%	241,813	2,327,860	2,569,673
B	1,926	1,607	319	92.9%	163,558	1,493,520	1,657,078
C	1,781	1,441	340	94.6%	25,423	1,444,570	1,469,993
D	2,374	1,795	579	94.5%	23,014	1,404,919	1,427,934
E	2,581	1,917	664	95.3%	-14,008	1,394,619	1,380,611
F	1,740	1,623	117	84.2%	775,272	494,120	1,269,393
G	2,080	1,902	178	96.2%	-173,218	1,318,994	1,145,776
H	2,432	1,593	839	96.0%	-23,895	1,164,368	1,140,473
I	1,973	1,682	291	92.2%	156,246	907,802	1,064,048
J	1,689	1,593	96	91.4%	348,241	547,880	896,121

Source: *HSE*

If all eligible components were charged to the NHSS the total average cost per resident is a week would be €1,715 compared to the average amount paid of €1,616. If the full cost of the eligible cost components had been charged to the NHSS, the cost differential would be 73%.

However, the variances between cost of care charged to the NHSS and actual eligible costs incurred in operating public nursing homes should not be a distraction; the predominant issue is the overall differential between public and private nursing homes.

2.4 Single Price

The legislation governing the NTPF negotiations provides for the negotiation of a "Maximum Price", which in practice is applied to all Fair Deal residents.

Although prices can vary considerably between nursing homes, at an individual nursing home level a single price is paid for all residents. While all residents undergo a care needs assessment to determine their need for long-term residential care, there is still likely to be a wide range of care needs within this cohort, with varying impact on resources.

Public Community Hospitals/Community Nursing Units, in general, operate a no refusal policy for residential care placements unless specific, high level, one-to-one care is required. In theory a single price is more likely to disincentivise private nursing homes from catering for high dependency residents with complex needs who require significant nursing care as significant additional costs above those required to cater for a resident with average care needs would be incurred. However, the absence of care needs data means that this theory cannot be proven or disproven.

Ideally pricing would be more closely aligned with individual care needs for both sectors, allowing for the allocation of resources to meet specific needs.

2.5 Conclusion

In 2019, the NHSS funded 22,964 long-term care beds in nursing homes. Of these, 4,649 were public beds. The average additional actual cost of an occupied public bed was €692 per week compared to a bed in a private setting. If these beds were funded at private sector rates, the savings could have potentially funded an additional 3,144 beds. With demand for long-term care predicted to increase it is of utmost importance that the reasons for this differential to be explored.

Chapter 3: Cost Variances between Public and Private Nursing Homes

3.1 Introduction

Chapter 2 highlights the significant headline cost differential. However, these headline costs do not inform the reasons for the differential.

This chapter will examine the individual cost components that make up the total cost in order to determine what are the primary drivers of the cost differential. Pay and non-pay costs will be compared on a like for like basis where possible. Where variances are identified the reasons for these differentials will be explored in detail.

3.2 Pay Costs

The single largest item of expenditure for nursing homes is pay. In 2018, pay costs accounted for 87.5% of eligible NHSS expenditure in public nursing homes, and 67% of expenditure in private nursing homes. However, these figures must be considered against the fact that public nursing home accounts do not include capital costs, director's remuneration, insurance, rates and service charges etc. If these costs were excluded in the private sector, pay costs as a percentage of total expenditure would be significantly higher than 67%.

Table 6 is an analysis of pay costs for 2019. As discussed in Chapter 1, the NTPF were able to only provide high level aggregate data. Therefore, pay costs are total pay, and are not broken down by care and/or non-care staff. It is important to note that the NTPF only receive detail cost data from private nursing homes during the price negotiation process. With an average contract term of 2.1 years, some of the data contained within their figures may be significantly out of date in comparison.

Table 6 highlights the difference in average occupancy. It should be noted that higher occupancy is likely to have an effect on ability to meet fixed costs via economies of scale.

While full pay costs for public nursing homes were provided for 2019, including a breakdown of direct care and support staff for the purposes of comparison total pay costs are used.

Table 6: Comparison of Private and Public Nursing Home Pay Costs 2019

	Public	**Private**
Number of Nursing Homes	108	438
Number of Occupied Beds	4,649	22,421*
Average Occupancy	43	51
Payroll	€340,346,250	€734,495,025
Average Pay Cost Per Nursing Home	€3,151,354	€1,676,929
Average Pay Cost Per Occupied Bed	€73,208	€32,759

Source: *HSE (Public), NTPF (Private)*

**Includes non-NHSS beds*

Of the nursing homes reviewed, the average pay cost per occupied bed in the private sector is less than half of the equivalent cost in a public nursing home. There are a number of factors that are likely to explain this differential; salary costs, skill mix, and the ratios of nurses and healthcare assistants to residents.

3.3 Salary Costs

While nursing homes also employ support staff such as cleaners, chefs etc, the majority of payroll costs pay are for direct care staff; nurses and health care assistants.

The midpoint of the salary scale for a public sector nurse is €38,405[11]. This is comparable with an average salary of €41,510 for a nurse working in a private nursing home reported by Crowe Horwath. The competitive pay is likely due to a recognised worldwide shortage of nurses, with demand outstripping supply for qualified nursing services.

However, due to the payment of allowances the actual costs of employing a nurse are significantly higher. The HSE Cost Accounting team calculate the average annual fully burdened salary of a nurse employed in the public sector, including average premium and employers PRSI at €54,645. In addition to this the cost of employer pension contributions at approximately 23%, and which is included in the nursing homes funding, significantly widens nursing pay costs.

A comparable average fully burdened salary is not obtainable for nurses in the private sector. Therefore, while salary costs could contribute to the price differential more data is needed to determine the extent of its impact. While many private sector nursing homes pay allowances, these can vary greatly from one nursing home to another, which leads to difficulties in calculating average costs. In addition to this, Crowe Horwath found that approximately 35% of staff nurses in private nursing homes are in receipt of employer pension contributions.

The midpoint of the salary scale for a public sector health care assistant is €31,117, while the average salary for a health care assistant working in a private nursing home is €24,138.

3.4 Skill Mix

The Health Act 2007, (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, requires that "*the registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents*". Due to the varying care requirements, there are no regulatory ratios governing skill mix or number of staff. Therefore, this Review does not have a benchmark against which it can comment as to the appropriateness of the skill mix and ratios of direct care staff to residents. Instead, the data can be stated and compared within the sectors.

The HSE provided skill mix and staffing numbers for each public nursing home for April 2019. The figures displayed in Table 7 are for whole time equivalent (WTE) staff directly employed in older person's residential care centres, and therefore exclude agency staff. It should be noted that these staff may also be responsible for the short-stay beds not funded under the NHSS.

Table 7: Total Staff Directly Employed (WTE) in Public Residential Care Centres for Older People (excl. Agency Staff) April 2019

WTEs		
Nursing	**Patient & Client Care**	**Ratio of Nurses to Patient & Client Care**
2,944	3,753	1: 1.3

*Nursing includes Staff Nurse - General, Staff Nurse - Senior, CNM1, CNM2

*Patient and Client Care includes Health Care Assistant, Multitask Assistant etc

Source: *HSE*

[11] HSE, *Consolidated Salary Scales*, January 2019

According to Crowe Horwath there are approximately three times as many health care assistants for every nurse in private nursing homes; a figure that is significantly higher than in public nursing homes. Without a skill mix framework, and the ability to determine individual care needs, it is not possible to determine whether the ratios are too high in the public sector, too low in the private sector, or whether the appropriate level is somewhere in between.

It should be noted that the Department of Health is commencing Phase 3 of the *Framework for Safe Staffing and Skill Mix* with the focus of this phase on community settings, including residential care facilities. The Framework (Department of Health, 2018)[12] is a comprehensive evidenced based approach that identifies appropriate staffing and skill mix for different care areas. It is built around patient needs and not ratios.

The HSE have attempted to address staffing levels and skill mix via local agreements, focusing on nursing homes with a historic model of high clinical service with high nurse staffing levels. These attempts have been met with resistance from the relevant Unions. In March 2018, the Irish Nurses and Midwives Organisation (INMO) and the Services, Industrial, Professional and Technical Union (SIPTU) advised the HSE that in their view "*staffing within Older Persons Services can only be determined by a scientific exercise such as the staffing framework which is currently underway in medical and surgical wards*". Therefore, until the *Framework for Safe Staffing and Skill Mix* is introduced it is unlikely that any measures which would alter existing staffing levels can be negotiated.

3.5 Ratios of Nursing Staff and Healthcare Assistants to Residents

For the same reasons, as outlined in the previous section on skill mix, the use of prescribed ratios of direct care staff to beds or residents is discouraged due to the variances in individual care needs. While no commentary can be provided as to their appropriateness, for the purposes of this review comparing existing average ratios is useful to highlight the cost differential.

Table 8: Nurse and Health Care Assistant to Bed Ratios

	Public Nursing Homes[13]	**Private Nursing Homes**
Nurse : Bed Ratio	1 : 1.6	1 : 4.4
HCA : Bed Ratio	1 : 1.3	1 : 1.8

Table 8 shows that there are significantly more nurses, and slightly more health care assistants, in public nursing homes than in private nursing homes. Using these average ratios for illustrative purposes, a 50 bed public nursing home would have 31.3 nurses and 38.5 health care assistants, whereas a 50 bed private nursing home would have 11.3 nurses and 27.7 health care assistants.

[12] Department of Health, *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Setting in Adult Hospitals in Ireland*, 2018

[13] HSE, *Total Staff Directly Employed (WTE) in Public Residential Care Centres for Older People (excl. Agency Staff)*, April 2019

It should be noted that these ratios refer to the total number of staff working in a nursing home, not the number of staff working at any one time, and that the numbers of staff on-site may vary between shifts, resulting in varying ratios at different times.

It should also be noted that many public nursing homes are of older stock than private nursing homes. The HSE notes that the current environment and layout of many public nursing homes brings challenges to staffing levels due to the layout of rooms and wards in different buildings. Substantial capital funding has been committed to modernise or replace these centres. Once completed this may help to address staffing issues in some public units.

As pay costs are a large proportion of total costs in public nursing homes, staffing levels and skill mix appear to be the most significant reasons for the overall cost differential.

3.6 Staff Mobility

There was anecdotal evidence to suggest that staff mobility is an issue in public nursing homes and where occupancy/capacity is reduced; for example, following a Health Information and Quality Authority (HIQA) inspection, staffing levels remain static. Where there are significant reductions in the number of residents, or beds available, it would be assumed that there should be a corresponding reduction in staffing levels. It should be noted that HSE care staff are not contracted to a specific nursing home but instead to the Community Healthcare Organisation (CHO) area.

To validate whether this may be an issue impacting on the price differential the Department liaised with HIQA who provided data showing changes in bed registrations over the period January 2018 – May 2019. The HSE provided data showing the number of direct care staff (nursing and healthcare assistants) for the corresponding period.

An analysis of these data sets found that occupancy levels were relatively static for the period, as were staff complements. There were only six public nursing homes where occupancy levels differed by more than 10% over the period. These are listed in Table 9 below.

Table 9: Impact of Variations in Occupancy on Staffing Levels

	Jan-18			**May-19**					
Nursing Home	**Number of Residents**	**Nursing (WTEs)**	**HCA (WTEs)**	**Number of Residents**		**Nursing (WTEs)**		**HCA (WTEs)**	
A	35	13	16	48	**↑ 37%**	17	**↑ 25%**	21	**↑ 29%**
B	46	18	21	28	**↓ 39%**	16	**↓ 8%**	22	**↑ 4%**
C	51	27	33	43	**↓ 15%**	27	**↓ 1%**	33	**↑ 1%**
D	22	6	17	16	**↓ 27%**	7	**↑7%**	18	**↑ 7%**
E	70	52	51	57	**↓19%**	57	**↑ 10%**	56	**↑ 9%**
F	91	64	65	102	**↑ 12%**	57	**↓ 12%**	68	**↑ 5%**

Source: *HIQA*

Table 9 shows Nursing Homes D and E experienced a decrease in occupancy but an increase in the number of staff. Conversely, Nursing Home F had an increase the number of residents but a decrease in the number of nursing staff. This may be due to variations in care needs over the period but without supporting data a definitive conclusion cannot be reached. However, this analysis shows that the limited issues relating to staff mobility are unlikely to have any significant impact on the price differential.

3.7 Regulatory Compliance

In the absence of defined skill mix and staffing metrics, a comparison of compliance rates with Section 15 (Staffing) of the *Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013* was undertaken to highlight any differences between the sectors.

In Ireland, HIQA is legally responsible for the monitoring, inspection and registration of designated centres for older people, such as nursing homes. HIQA's Older Person's Inspection team carry out inspections to ensure that services meet the requirements set out by the *Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013* and National Standards[14] in order for the centre to be registered and allowed to operate. The types of inspections vary; they can be announced or unannounced, and some are thematic.

During an inspection, inspectors aim to meet as many people as possible, including residents and their families, members of staff, the person in charge and the person who represents the provider, in order to gain an insight into the running of the nursing home.

The nursing home is assessed for compliance with a number, but not all, of the assessable regulations. If a regulation is not assessed during an inspection but was previously deemed to be compliant, the previous assessment stands. The nursing home can be found to be either compliant, substantially compliant, or non-compliant with the assessable regulation.

In the subsequent inspection report, published on HIQA's website, a narrative accompanies each finding for an assessed regulation. HIQA urges caution in using the findings, without reference to the narrative, as the levels of compliance, or non-compliance, can vary substantially. Where a nursing home is deemed to be non-compliant with a particular regulation, it is not possible to determine how easily remedied the issue is without reference to the level of non-compliance. It should also be noted that, by their nature, inspection findings are a snapshot at a particular point in time.

It would be remiss not to use the HIQA findings, as the statutory body with responsibility for ensuring compliance with the Regulations, in a comparative analysis of this nature. However, it is not possible to sub-classify levels of compliance from the narrative provided.

Regulation 15 requires that "*The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents".*

From analysis of public accounts referenced earlier in the report a large proportion of the price differential appears to rest with pay costs. While there are compelling reasons for not prescribing minimum staff to resident ratios, the subjectivity of the Regulation does not facilitate a quantifiable comparison to be easily made.

[14] HIQA, *National Standards for Residential Care Settings for Older People in Ireland,* 2016

Table 10: Staffing Compliance Rates February 2018 – April 2019				
	Regulation 15 : Staffing Compliance Rates			
	Public Centres		**Private Centres**	
	Number	**%**	**Number**	**%**
Compliant	52	81.3%	181	79.7%
Substantially Compliant	5	7.8%	24	10.6%
Non-Compliant	7	10.9%	22	9.7%

Source: HIQA

Table 10 compares the rates of compliance with Regulation 15 in public and private nursing homes for the period February 2018 – April 2019. Compliance rates are broadly similar. 'Compliant' means that there were sufficient numbers of qualified staff on the premises to meet the care needs of the residents at the time of inspection. No distinction can be made as to whether the nursing home inspected had the minimum number to be deemed compliant or had excess levels of staff. From a sample analysis of HIQA Reports of compliant nursing homes, the narratives accompanying the determination do not make any reference to whether excessive staffing levels were observed. The legislation requires that the threshold of sufficient staffing be "*appropriate having regard to the needs of the residents,…the size and layout of the designated centre*".

Similarly, non-compliance does not necessarily mean that there were insufficient numbers of staff employed. Some public nursing homes deemed non-compliant had a higher than average number of staff employed. From a detailed analysis of these non-compliant HIQA inspection reports, the narratives raise issues related to rostering, where HIQA deemed that there were insufficient numbers of staff available at night-time. Another recurring issue among public nursing homes was the absence of an Activities Co-ordinator to address the social needs of residents.

3.8 Non-pay Costs

The HSE provided non-pay costs for 2018 for each public nursing home. Of these only Allowable Cost Components are charged to the NHSS. Non-NHSS expenditure on non-pay items are charged to other budgets such as the wider Older Persons budget, General Medical Services (GMS) etc.

Table 11 only shows the public nursing home costs charged to the NHSS budget.

As previously referenced, in accordance with legal advice, limited data was provided by the NTPF. Actual costs were provided on a regional basis; Dublin, Leinster (excluding Dublin), Munster and Connacht/Ulster.

Table 11: Comparison of Private and Public Nursing Home Non-Pay Costs 2019				
	Public		Private*	
Number of Nursing Homes	108		438	
Number of Occupied Beds	4,649		22,421	
	Total Cost (€)	**Cost Per Occupied Bed Per Week (€)**	**Total Cost (€)**	**Cost Per Occupied Bed Per Week (€)**
Medical Supplies	473,139	2	18,970,229	16
Food	7,979,011	33	48,829,590	42
Energy	8,167,482	34	24,185,195	21
Training	31,729	1	5,345,100	5
Repair & Maintenance	5,931,979	25	29,556,749	25
Other Eligible Costs	23,362,486	97	97,748,470	84

**Financial Statements containing cost data are only submitted to the NTPF during the price negotiation process. Most nursing homes would not have undergone this process in 2019 so the cost figures are from 2018 and earlier in many cases. Occupied beds figures include non-NHSS beds.*

Source: Public NHSS Accounts (Public), Aggregate Data 2015-2019, NTPF (Private)

The differences in line-item definitions cause difficulties when trying to compare the headline aggregate figures. There is a very narrow definition of medical supplies in the legislation that determines allowable NHSS costs for the public sector; basic clinical consumables and oxygen. Therefore, the cost of medical supplies is very low, but is likely to be only a small proportion of the actual medical supplies consumed. It is not possible to determine the real costs from the information available. The private sector is not confined to the same narrow definitions as the public sector.

Food costs per occupied bed per week were 27% higher in private nursing homes but it should be noted that the figure used for public nursing homes is the net cost. Total food costs were almost €9.4m in public nursing homes but this was partially offset by just over €1.4m in canteen receipts. Public nursing homes also enjoy the benefit of utilising the HSE's purchasing power for items such as food.

Repair and maintenance costs per occupied bed per week were the same in both sectors, while 'other costs' per occupied bed per week, which includes cleaning, equipment, bedding etc, were only marginally higher in public nursing homes.

Energy costs per occupied bed per week were 62% higher in public nursing homes. This is likely due to the public infrastructure generally being of older stock, and therefore less energy efficient. A capital refurbishment programme is currently underway which should result in reduced energy costs once all works have been completed.

The large variance in training costs per occupied bed per week is likely due to the provision of global staff training within the HSE i.e. training costs met from a central training budget, rather than charged to individual nursing homes

Ideally, a more detailed comparison of non-pay data would have been undertaken. However, without access to detailed private sector data, such a comparison was not possible.

3.9 Procurement

The comparable data necessary to carry out an analysis on procurement processes in nursing homes is not readily available. The Health Business Services (HBS)/HSE Procurement is responsible for procurement of non-pay items within the HSE. HBS/HSE Procurement runs large scale, health specific tender competitions ensuring VFM and also ensuring compliance with EU Procurement Directives. HBS/HSE Procurement is also responsible for stores/warehousing and logistics. HBS/HSE Procurement has a large National Distribution Centre fully equipped with state-of-the-art stock control/purchasing systems, based in Tullamore. This allows for the purchasing of large quantities of stock which is re-distributed in a cost-effective way to HSE Nursing Homes throughout the country. Savings are achieved by controlling stock, reducing stock holdings in the nursing homes, and purchasing products at the most economically advantageous price. However, data was not available to quantify the effect improved procurement processes has had on non-pay costs.

3.10 Additional Charges

The total operating cost of public nursing homes also includes other costs that fall outside of the 'cost of care' as defined for the purposes of the NHSS; this is also the case for private and voluntary nursing homes, which may provide other services outside long-term care that are funded separately to the NHSS (such as respite and day care), as well offering other services to long-term residents that are not included under the cost of care.

These non-allowable costs may be for items like social activities, newspapers and hairdressing, but may also include medical services such as therapies and medical equipment not included under the cost of care. Many such services are covered by other public schemes such as the medical card and are offered free of charge to eligible recipients whether they are in the community, in public care, or in private nursing homes. However, there is anecdotal evidence that residents in private homes may face longer waiting times in accessing such services or equipment, and therefore may choose to pay for them privately via additional charges in the nursing home.

There is also evidence that private homes are more likely to charge additional fees for social and recreational activities than public homes.

Ongoing work on additional charges is being taken forward by the Department of Health. The Programme for Government, 'Our Shared Future', page 51, published in 2020, contained the commitment to '*ensure that no Nursing Homes Support Scheme resident is charged for services they do not use*'. In 2019, the CCPC published '*Guidelines for contracts of care in nursing homes*' to assist nursing home providers in ensuring that contracts with residents are fair and legally compliant.

3.11 Conclusion

From the analysis undertaken, the significant variance in staffing levels, and associated costs, between the sectors appears to be the single biggest driver of the price/cost differential. There are no defined metrics available to assess whether staffing levels in some public nursing homes are excessive and are thus leading to costs above what is considered appropriate. The only information available shows that compliance with current staffing Regulations is broadly similar between the sectors. Therefore, until the Safe Staffing and Skill Mix Framework, referred to earlier in this chapter is agreed, it is unlikely that any meaningful effort can be made to more closely align staffing levels

between the sectors. If staffing levels were more closely aligned the price/cost differential would be significantly reduced.

The HSE notes that many Public Community Hospitals/Community Nursing Units were required to reduce bed numbers since 2009/2010 to comply with Residential Care Standards but it has been more difficult to achieve a similar reduction in fixed costs. A total of 405 long stay public beds have closed since 2011 primarily due to the requirements of health and safety related standards and HIQA compliance. The HSE further notes that it has an obligation to provide residential placements in areas which, for geographical reasons, are not unlikely to be profitable for the private sector to supply.

A lack of obtainable data hindered the ability to carry out detailed analysis on non-pay costs. From the information available, differences in non-pay costs appear to contribute to the differential, albeit on a much smaller scale than the variances observed in pay costs.

Chapter 4: Care Needs - Comparing Levels of Dependency between Sectors

4.1 Introduction

One of the enormous challenges faced by governments the world over is how to allocate finite health resources in a fair and equitable way in the provision of state-funded long-term care and in meeting the wide-ranging healthcare needs of older people who permanently reside within these services.

Acuity levels of long stay residents in Ireland across both public and private sectors are not routinely monitored or reported and currently in Ireland there is no standardised healthcare needs assessment in use nationally for older people in long-term care. This creates difficulty in discussing patient acuity and any attempts to ensure resources mirror acuity/frailty levels.

Within Irish long-term residential care services there is currently a lack of an acuity-based model of funding. Internationally, various casemix classification systems are often used in determining resource allocation for long-term care. Casemix systems group patients into clinically similar groups with homogeneous resource usage. This facilitates prospective revenue systems for healthcare facilities where a portion of the payment is directly set to patients' clinical characteristics or attributes (Costa *et al.* 2015).

In Ireland there is no standard assessment tool to assess the care needs of people in long-term residential care. The absence of a standard tool causes issues with comparability. In order to determine whether the price differential is partly due to the public sector having a higher cohort of high dependency patients, the Steering Committee commissioned a study to assess the care needs of all residents in receipt of NHSS support in a selected cohort of residential care centres, both public and private. The care needs were assessed using the interRAI assessment (international Resident Assessment Instrument), (formerly known as Single Assessment Tool (SAT) pilot).

However, due to both time and resource constraints, the sample size and total number residents assessed is very limited (<1% of total population of residents in long stay care in Ireland) and cannot be considered statistically relevant. Therefore, it must be kept in mind at all times that the data cannot be interpreted as being a representative sample of either a public or private provision.

Box 2: Sample Size Required to Undertake a Statistically Representative Study of Care Needs

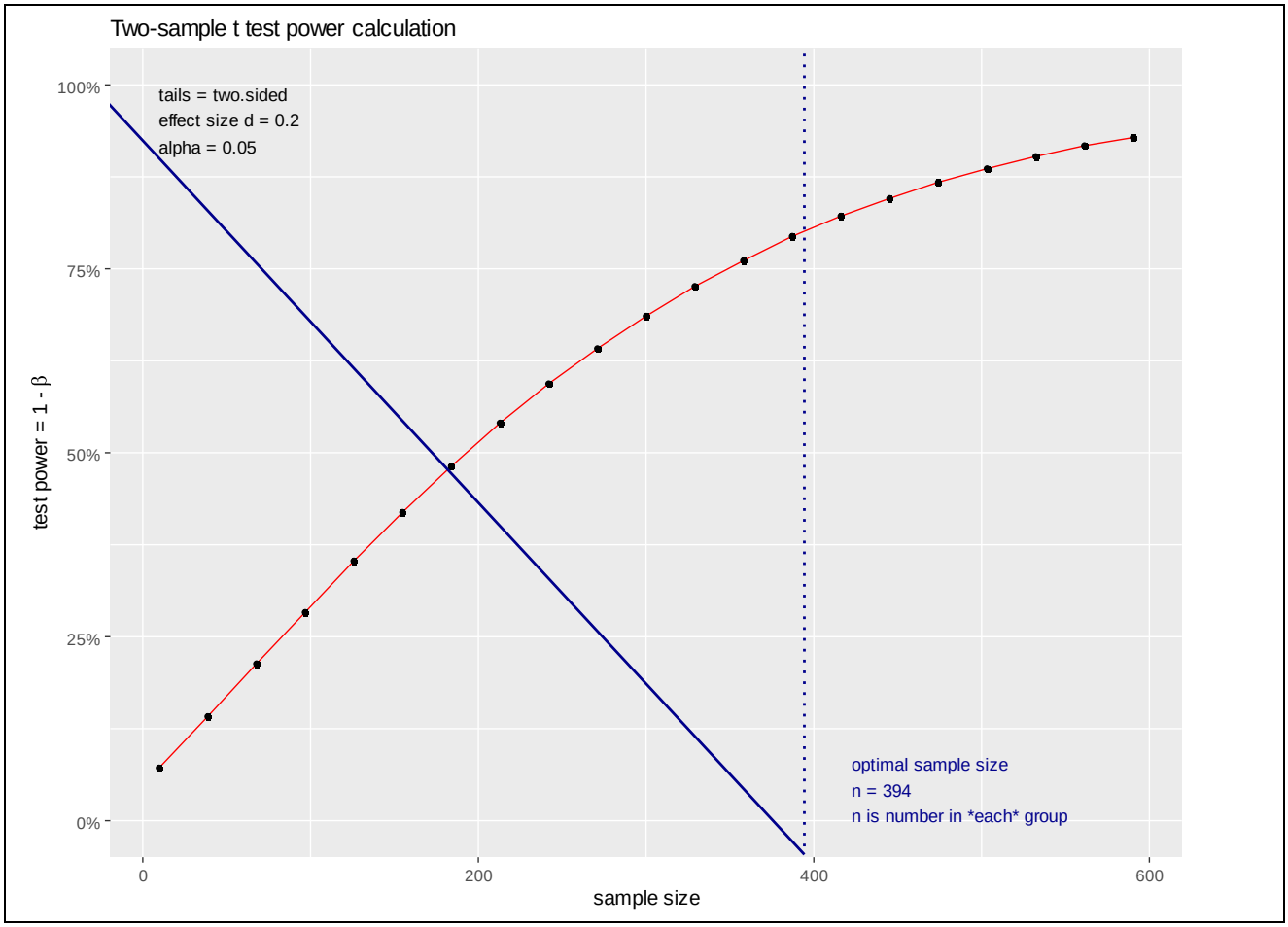
There are 573 nursing homes in the State, including nursing homes who do not participate in the NHSS. Of these, 80.1% are private or voluntary institutions, and 19.9% are HSE-funded, a 4:1 ratio. The analysis below presents the minimum number of survey units required to assess statistically significant differences for any metric which may be correlated with public or private/voluntary funding models.

Given the proposed approach is to survey every resident of homes (units) selected for inclusion, the statistical power analysis must be tailored to a one-stage cluster design. The standard statistical significance levels of 80% power with 95% confidence levels would require a minimum of 394 *individual* participants in *each* group, be it public or private/voluntary (see Figure 2 below). To preserve the 4:1 ratio of private/voluntary to public homes in the sample, and with the median

maximum occupancy of a nursing home set to fifty, a minimum of eight (394/50 = 7.8) HSE-funded units and 32 (8 x 4=32) private/voluntary units are required for the survey.

Therefore, clustered random sampling of a total 40 units (32 private/voluntary units and 8 public), having a median occupancy of fifty persons, would be sufficient to detect statistically significant differences on any metric between the unit types**.**

Figure 2 – Power calculation for one-stage cluster analysis



While it was acknowledged that the study would not be statistically representative, the Steering Committee were of the view that it would provide useful insight on a micro level into the care needs of residents in nursing homes, and whether any preliminary findings would highlight differences in care needs that would explain cost differentials.

In undertaking the study, six nursing homes of similar bed size were selected by the Department of Health to represent private and public nursing homes within geographically defined rural and urban locations.

Following ethical approval, all sites were invited to take part in the study. Five nursing homes participated in the study and all residents who were in receipt of NHSS support in these homes were invited to participate in the study and consent was sought, with an overall 75% response rate. Trained assessors assessed the care needs for all residents who had given consent. All data was anonymised, and the IT system generated interRAI assessment outputs which were aggregated and

analysed by the interRAI national team. At a high level, there are few differences emerging between the public and private cohort in terms of care needs assessment outcomes.

Box 3: What is the InterRAI assessment (formerly known as Single Assessment Tool)?

The interRAI (short for international Resident Assessment Instrument) suite of assessment instruments has been developed by the interRAI organisation and is in use in over 35 countries.

InterRAI is an international not-for profit organisation, made up of a collaborative network of researchers, clinicians, and service users in over 35 countries committed to improving care for persons who are disabled or medically complex. InterRAI promotes evidence-informed clinical practice and policy decision making through the collection and interpretation of high-quality data about the characteristics and assessment outcomes of persons served across a variety of health and social services setting.

The interRAI electronic tools employ a minimum data set, with assessment items that share a standardised language of assessment and common core concepts and measures. InterRAI assessments are IT based; an IT system is required to generate the interRAI algorithms which produce scales and outputs from individual assessments.

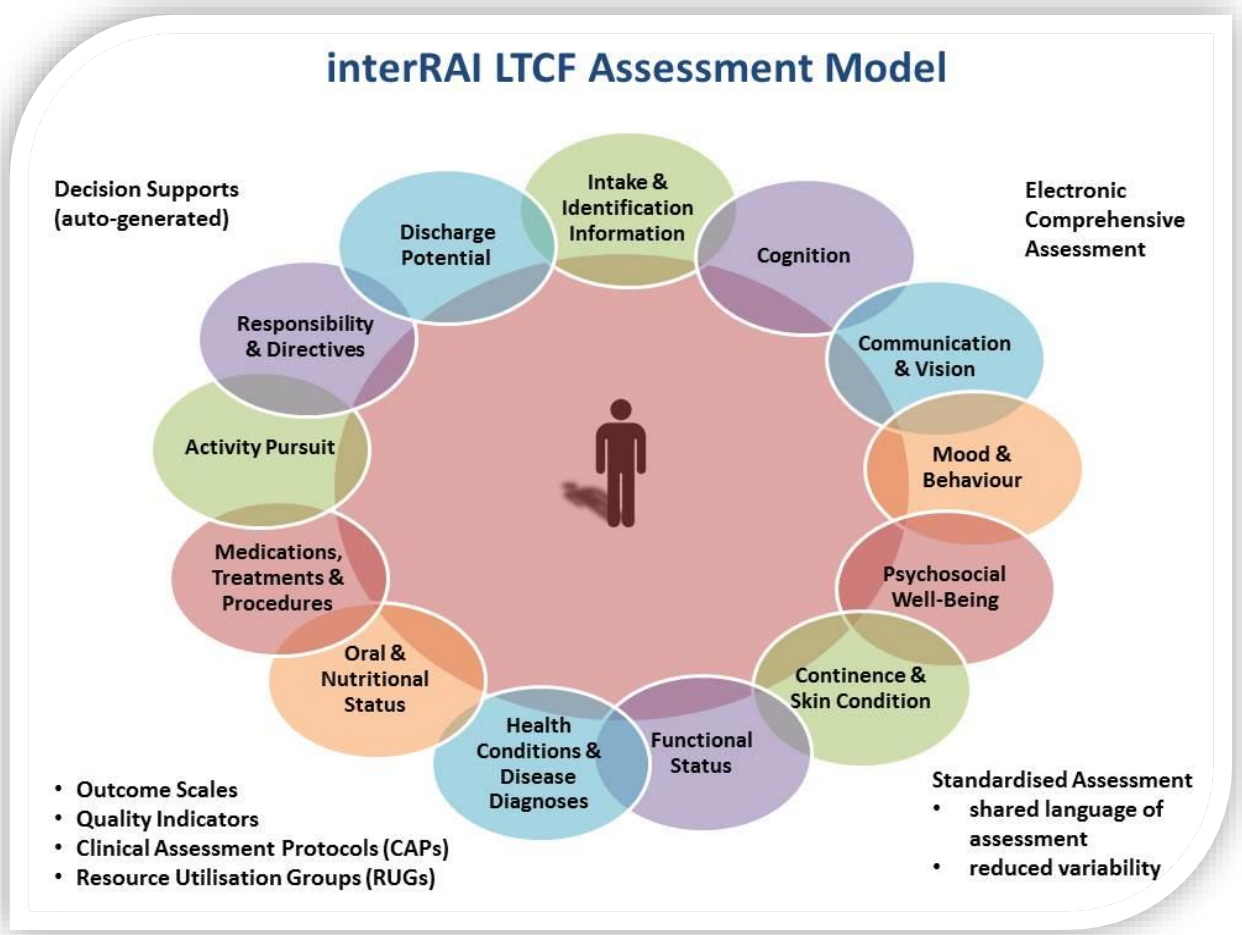
The interRAI assessments have undergone rigorous scientific development and have proven reliability and validity internationally.

There are currently 23 different assessments available for a range of settings as part of interRAI's integrated suite of tools. In Ireland, the HSE is currently implementing the interRAI Home Care (interRAI HC) in hospital and community settings.

The interRAI Long-Term Care Facility (interRAI LTCF) is specifically designed for older people located in nursing home settings and is suitable for use with people who have cognitive impairment. The interRAI LTCF Assessment and Care Planning system is a comprehensive standardised instrument for evaluating the health and social care needs, strengths, and preferences of those in long-term residential care.

The interRAI LTCF assessment model is presented in Figure 3 below. Further information on the areas of assessment covered by the instrument, the interRAI assessment outputs and scales which have been validated in several international studies is provided in Appendix 3.

Figure 3: interRAI LTCF Assessment Model



A central focus of this study was value for money and resources. One of the standardised outputs of interRAI is that of a casemix measure called RUGs (Resource Utilisation Groups). The Department of Health wished to examine the interRAI casemix classification system RUGs and its associated CMI (Casemix Index) measure.

The interRAI Resource Utilisation Groups (RUGs) Version III casemix classification system was originally designed in 1994 in order to group nursing home residents by *per diem* resource use.

RUGs-III group classifies patients into seven hierarchical and mutually exclusive groups:

- Special Rehabilitation
- Extensive Services
- Special Care
- Clinically Complex
- Impaired Cognition
- Behaviour Problems
- Reduced Physical Functions

Each of these major groups contains a number of secondary and tertiary splits or subgroups. Secondary splits are based on an Activities of Daily Living (ADL) Index that is calculated by measuring the level of dependence a person has in 4 categories:

- transferring
- toilet use
- eating
- bed mobility.

Tertiary splits are assigned in some of the hierarchical categories to further classify patients, such as in the provision of nursing rehabilitation or a person's depression status. Based on clinical characteristics, patients are grouped into one of the seven categories and associated subcategories. However, it is important to note, the criteria for inclusion in the Special Rehabilitation category is primarily based on the intensity of physiotherapy, occupational therapy, and speech and language therapies that patients receive. This will be discussed in further detail later in this chapter.

While developed in the US, this casemix classification system has been widely implemented in several countries for long-term care and post-acute services including New Zealand, Canada, France and the US. In the US, the systematic use of the interRAI LTCF is driven by the implementation of the RUGS as a payment system. The resultant Health Information System has led to the creation of a database that has proved of unprecedented value to clinical and business intelligence.

Internationally, the interRAI LTCF is being used to determine care needs, provide outcome information on Nursing Home residents, develop eligibility criteria, support monitoring of services delivery, construct quality measures, and to support a greater efficacy in resource allocation within this sector. If future work to examine and implement RUGS for an Irish context was to be considered it should be noted that significant work to attune to an Irish context is required.

4.2 Methodology

In undertaking this case study, six nursing homes of similar bed size were selected by the Department of Health to represent private and public nursing homes within geographically defined rural and urban locations. Following ethical approval, all sites were invited to take part in the study. The Person in Charge (PIC) and registered provider of each of the nursing homes were provided with the Research Proposal on the proposed study and an invitation was extended for their nursing home to participate in the research.

All older people who permanently resided in each of the nursing homes and receive support through the Nursing Homes Support Scheme (NHSS), were invited to participate in the study and were provided with verbal and written information on the study, and a consent form for their completion. Time was given for the person and their families to consider their participation in the study and they were advised that participation was optional. Consent was explicitly sought and gained by the PICs and/or Directors of Nursing in the nursing homes.

All interRAI LTCF assessments were conducted by trained interRAI assessors who hold a current registration with their respective professional bodies and who have extensive clinical expertise in undertaking healthcare needs assessments using the interRAI system of assessment.

All participants' personal data was fully anonymised for the purposes of this study. While consent for the processing of anonymised data is not a requirement under the General Data Protection Regulations, as per Health Research Regulations 2018, explicit informed consent was sought for cognitively intact participants, while process consent methods were used with cognitively impaired participants.

'Process consent' methods employ an on-going consensual process that involves the assessor, patient and carers/family members in mutual decision-making regarding study participation. As the interRAI LTCF assessment instrument is specifically designed for use with people who have cognitive impairment, it is essential to include these patients rather than exclude them. It is well documented that even where the capacity for informed consent no longer exists in a legal sense, many people with moderate to severe cognitive impairment retain the capacity to make choices about aspects of their day-to-day living. This is both recognised and used by healthcare professionals in the provision of care and in day-to-day interactions, to enable cognitively impaired patients to make life choices and to ensure their human rights are protected.

Through this method, it has been shown to safely include patients that might otherwise be excluded from research studies when relying solely on rational processes of informed consent. The method also makes use of on-going monitoring to ensure that the patient experiences no distress through any participation or inclusion. This is in keeping with the HSE National Consent Policy (2019)[15] and HIQA standards on healthcare assessments for individuals with cognitive impairment (2016)[16].

4.3 Result

Data from the baseline assessment for the entire study sample are reported. Multi-item summary scales embedded in the interRAI LTCF were used to measure resident's characteristics. As previously stated, all data was fully anonymised for the purposes of this study. Coded quantitative data was entered into Excel and analysed using non-parametric descriptive statistics. Data was analysed by the HSE interRAI Ireland national team.

One private nursing home decided not to participate. Assessments took place in the 5 nursing homes from 10/05/2019 to 14/08/2019. The total number of NHSS residents available for inclusion in the study was 300 (N=171 public, N=129 private). Seventy-six residents (N=39 public, N=37 private) decided not to participate.

[15] https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/national-consent-policy-hse-v1-3-june-2019.pdf
[16] https://www.hiqa.ie/sites/default/files/2017-01/Dementia_Care-Guidance.pdf

Table 12: Demographic and Health Characteristics of Respondents by Nursing Home type

Age Profile	49%	Residents aged 85 to 101 years	51%	Public Units	47%	Private Units
	48%	Residents aged 65 to 84 years	47%	Public Units	50%	Private Units
	3%	Residents aged 48 to 64 years	2%	Public Units	3%	Private Units
Gender	67%	Female Residents	66%	Public Units	68%	Private Units
	33%	Male Residents	34%	Public Units	32%	Private Units
Activities of Daily Living	74%	Residents requiring assistance with ADLs (ADLH >/=3)	73%	Public Units	74%	Private Units
Cognition	54%	Residents with cognitive impairment (CPS >/= 3)	53%	Public Units	54%	Private Units
Medication	66%	Residents in receipt of 10 or more prescribed medication	58%	Public Units	77%	Private Units
Therapies	43%	Residents in receipt of therapy (Physio, OT, SLT) in last 7 days	67%	Public Units	9%	Private Units
RUGs	54%	Residents in lowest RUGs category (Reduced Physical Function)	52%	Public Units	57%	Private Units

4.4 Response Rate

The overall response rate for the study was 75%.

Table 13: Response Rate Breakdown

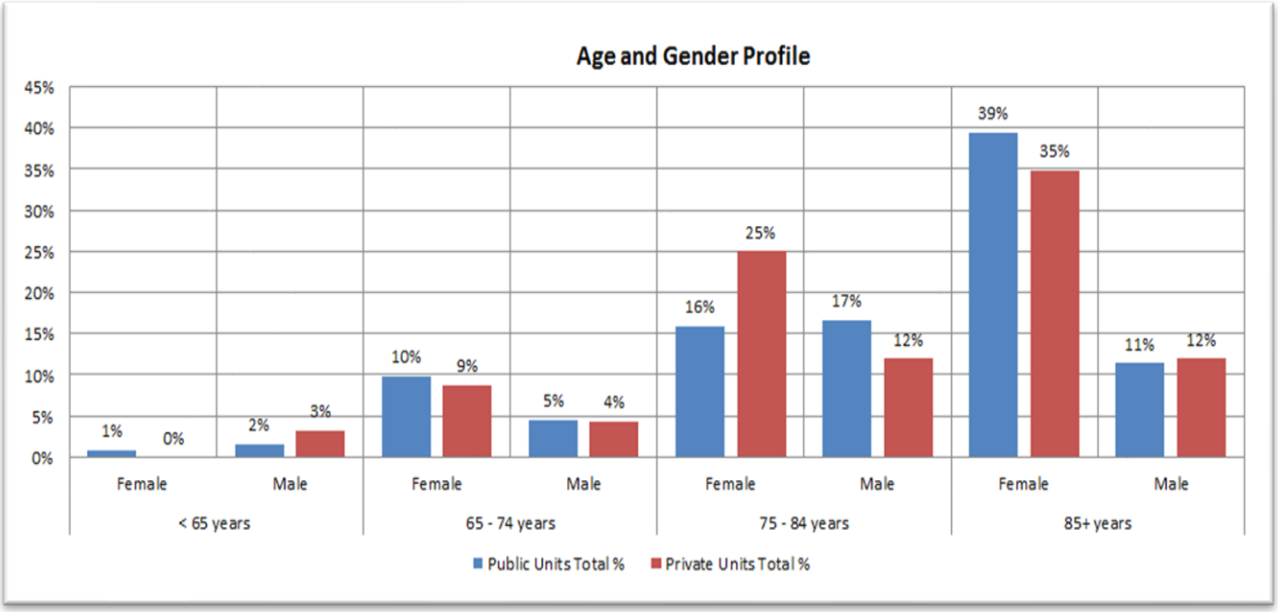
Unit	Total Beds	No. of NHSS beds / Residents	Vacant NHSS Bed	RIP	Resident admitted to hospital	Total available for inclusion in VFM study	No. refused consent / Family did not respond	No. consented & assessed	% Uptake
Total	**370**	**304**	**1**	**2**	**1**	**300**	**76**	**224**	**75%**
Public Unit 1	80	61	1			60	9	51	*85%*
Public Unit 2	46	34		2		32	5	27	84%
Public Unit 3	95	79				79	25	54	68%
Total Public	***221***	***174***	***1***	***2***		***171***	***39***	***132***	***77%***
Private Unit 1	89	83				83	23	60	72%
Private Unit 2	60	47			1	46	14	32	70%
Total Private	***149***	***130***			***1***	***129***	***37***	***92***	***71%***

As can be seen from the table above the response rates for both public and private nursing homes are similar with 77% and 71% respectively.

4.5 Age & Gender Profile

Analysis of the data revealed the majority of residents assessed were female (67%) and the average age was 83 years. Those aged 85-101 years represented the largest cohort across age groups. Similar age ranges were recorded across private and public nursing homes with the majority of residents being female. The results are displayed below:

Figure 4: Age & Gender Profile



4.6 Assessment Outcomes - interRAI Scales and Outputs

The table below displays a breakdown of the output scales, which are examined in more detail below.

Table 14: Residents Profile

Outcome Scales	**Scores**	**Total Cohort**	***Public Units***	***Private Units***
Cognitive Performance Scale (CPS) - Scores range 0-6	Relatively Intact (0-1)	**22%**	*20%*	*24%*
	Mild/moderate impairment (2-3)	**45%**	*43%*	*47%*
	Severe impairment (4-6)	**33%**	*36%*	*29%*
Activities of Daily Living Self-performance Hierarchy Scale (ADLH) - Scores range 0-6	Independent / limited assistance (0-2)	**26%**	*27%*	*26%*
	Extensive / maximal assistance (3-4)	**28%**	*28%*	*27%*
	Very / total dependence (5-6)	**46%**	*45%*	*47%*
Resource Utilisation Groups (RUGs) III – 7 groups	Reduced Physical Function	**54%**	*52%*	*57%*
	Behaviour Problems	**1%**	*0%*	*2%*
	Cognitive Impairment	**13%**	*10%*	*18%*
	Clinically Complex	**11%**	*10%*	*13%*
	Special Care	**6%**	*4%*	*9%*
	Extensive Care	**1%**	*2%*	*1%*

Outcome Scales	Scores	Total Cohort	*Public Units*	*Private Units*
	Rehabilitation	**14%**	*23%*	*0%*
Depression Rating Scale (DRS) - Scores range 0-14	No depressive symptoms (0)	**54%**	*53%*	*54%*
	Some depressive symptoms (1 or 2)	**24%**	*23%*	*26%*
	Possible depressive disorder (3 or more)	**22%**	*24%*	*20%*
Pain Scale - Scores range 0-4	No pain (0)	**58%**	*55%*	*61%*
	Less than daily pain / daily but not severe (1-2)	**39%**	*42%*	*35%*
	Daily severe / excruciating pain (3-4)	**4%**	*3%*	*4%*
Pressure Ulcer Risk Scale (PURS) - Scores range 0-8	Very low to low (0-2)	**50%**	*53%*	*45%*
	Moderate (3)	**24%**	*22%*	*27%*
	High to very high (4-8)	**26%**	*25%*	*28%*
Changes in Health, End-Stage Disease, Signs and Symptoms (CHESS) - Scores range 0-5	None / Low (0-2)	**93%**	*92%*	*95%*
	Moderate (3)	**4%**	*5%*	*3%*
	High instability (4-5)	**3%**	*3%*	*2%*
Aggressive Behaviour Scale (ABS) – Scores range 0-12	No aggressive behaviour (0)	**75%**	*73%*	*77%*
	Some Aggressive behaviour (1-2)	**9%**	*11%*	*5%*
	Severe Aggressive Behaviour (3-5)	**9%**	*10%*	*8%*
	Very Severe Aggressive Behaviour (6-12)	**7%**	*5%*	*10%*

4.7 Cognitive Performance Scale (CPS)

The Cognitive Performance Scale (CPS) is used to assess the cognitive status of the person.

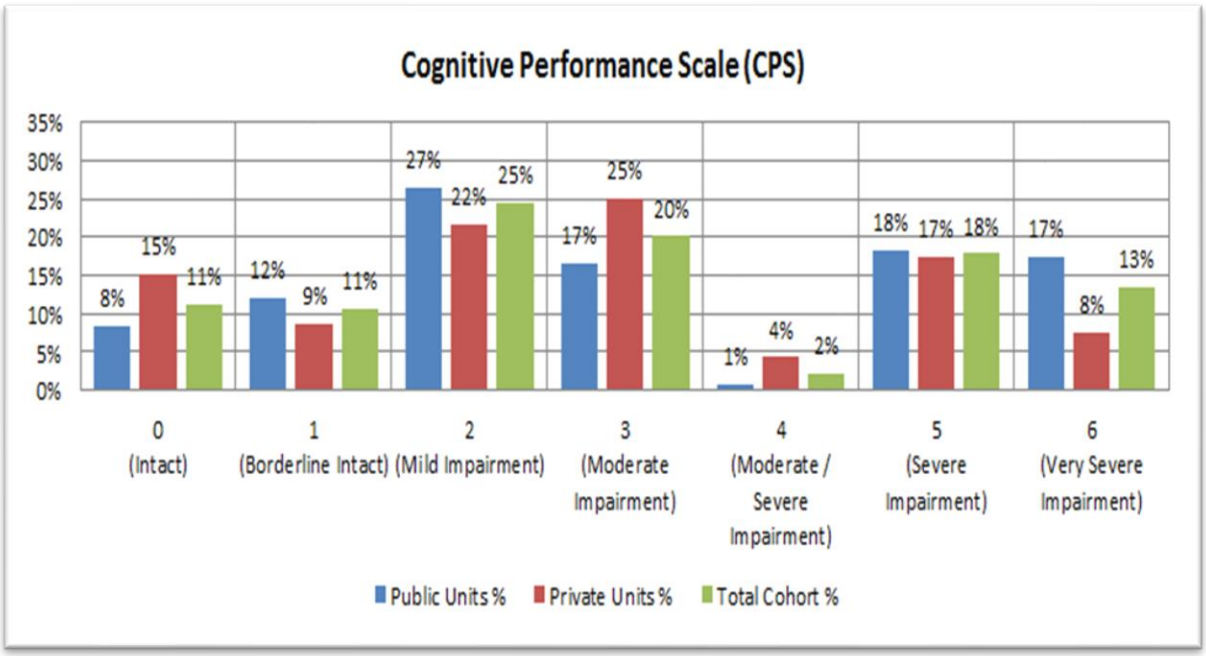
Scores range from 0 to 6 and higher scores indicate more severe cognitive impairment. The CPS has been validated against the Mini Mental State Examination (MMSE) and the Test for Severe Impairment (TSI). The table below displays scores and MMSE equivalent.

Table 15 – Cognitive Performance Scale/Mini Mental State Examination

CPS Score	Description	MMSE Equivalent Average
0	Intact	25
1	Borderline Intact	22
2	Mild Impairment	19
3	Moderate Impairment	15
4	Moderate / Severe Impairment	7
5	Severe Impairment	5
6	Very Severe Impairment	1

The graph below displays the breakdown of the CPS scale for the total cohort and further displays the public and private breakdown:

Figure 5 – Cognitive Performance Scale Breakdown

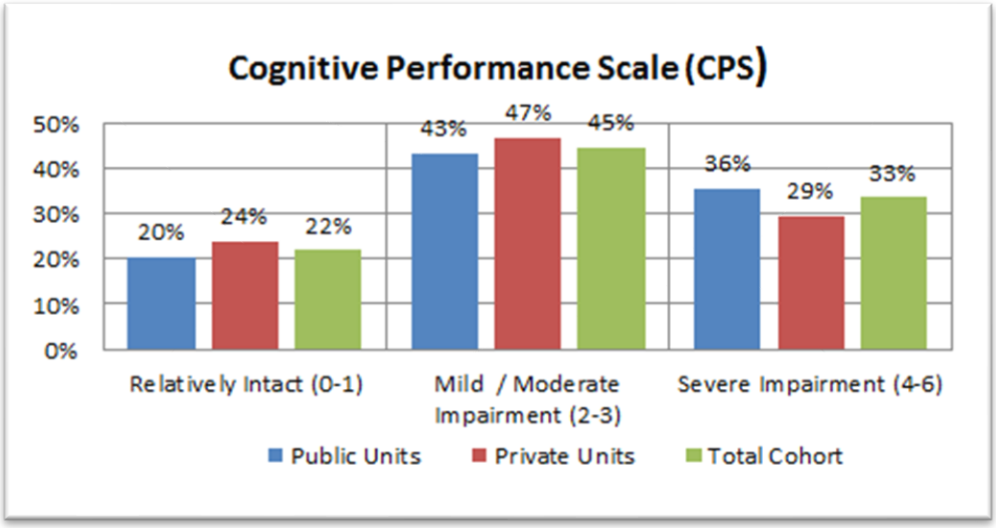


Cognitive impairment was categorised as follows:

- Intact/borderline intact (CPS score 0 to 1)
- Mild/moderate impairment (CPS score 2 to 3) and
- Severe/Very severe (CPS score ≥ 5)

The graph below displays the breakdown by % into the CPS categorisations for the total cohort and further displays the public and private breakdown:

Figure 6 – Cognitive Performance Scale Percentage



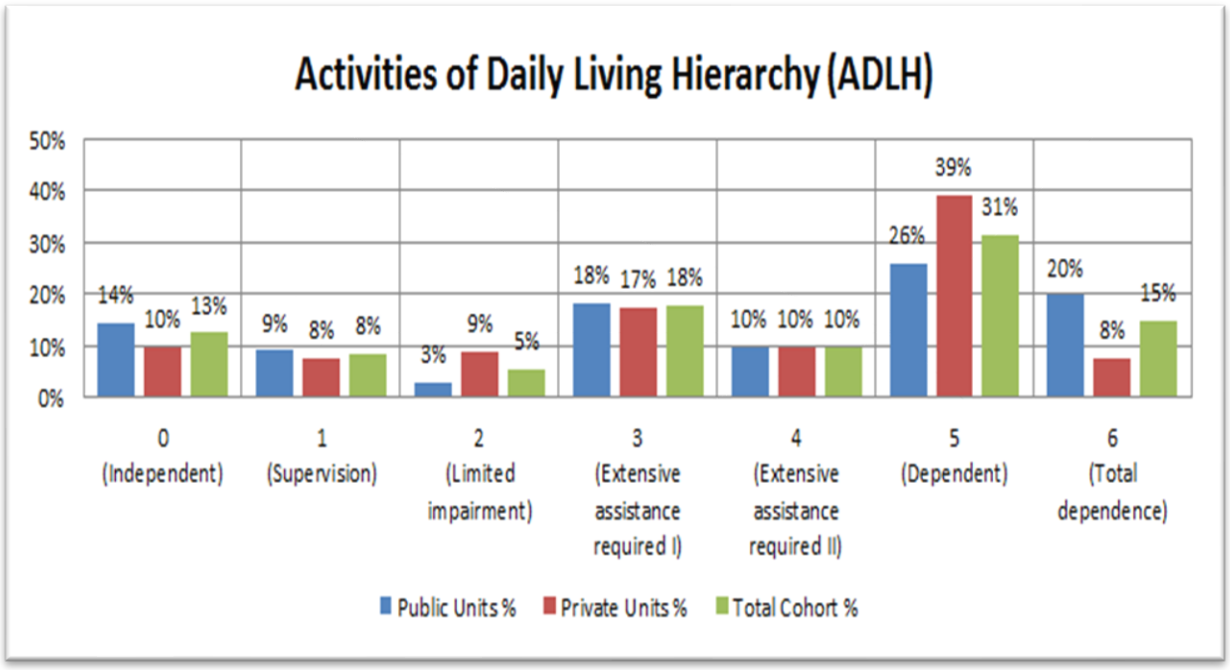
As can been seen from the graph above just 22% have little or no cognitive impairment. However, as the levels of impairment increase, some differences emerge. In the highest level of impairment (severe or very severely impaired) the public nursing homes record 36% of their sample as severe or very severely impaired whereas the private nursing homes record 29%.

4.8 Activities of Daily Living Hierarchy (ADLH)

To evaluate functional status, the Activities of Daily Living (ADL) Hierarchy scale was used. This scale reflects the disablement process by grouping ADL performance levels into discrete stages of loss (early loss: personal hygiene; middle loss: toileting and locomotion; late loss: eating). Early loss ADLs are assigned lower scores than late loss ADLs. The ADL Hierarchy Scale ranges from 0 (Independent) to 6 (Total dependence). The breakdown is as follows:

- 0 = Independent
- 1 = Supervision required
- 2 = Limited impairment (non-weight bearing support - guided movement of limbs by assistants e.g. for dressing)
- 3 = Extensive assistance (i) (weight-bearing support including lifting limbs by 1 or 2 assistants for personal hygiene or toilet use and non-weight bearing support in eating / locomotion, where person still performs 50% or more of sub tasks)
- 4 = Extensive assistance (ii) (weight bearing support of 1 or 2 assistants for locomotion or eating)
- 5 = Dependent (person fully dependent on others for eating or locomotion)
- 6 = Total dependence (person fully dependent on others for personal hygiene, toilet use, locomotion and eating.

Figure 7 - Activities of Daily Living Hierarchy Scores Breakdown

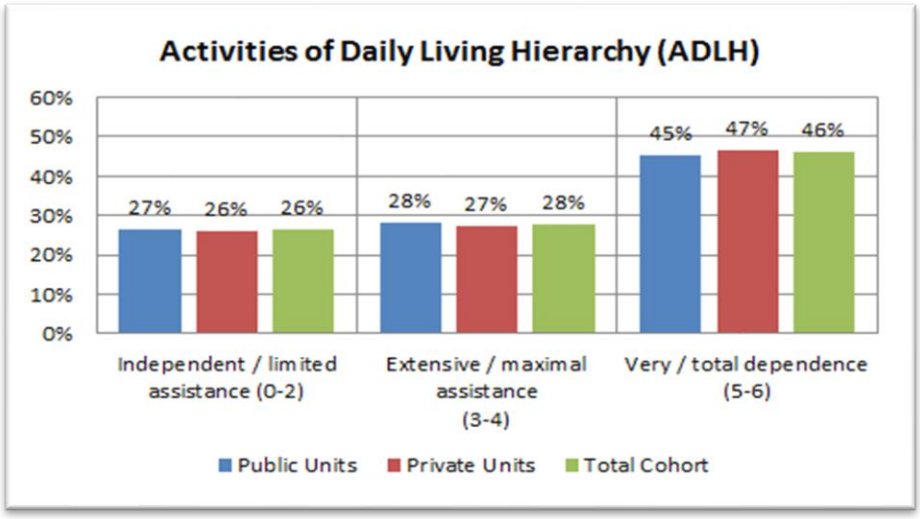


ADL impairment was categorised as follows:

- Independent/ limited assistance (ADL score 0-2)
- Extensive/maximal assistance (ADL score 3-4)
- Very/total dependence (ADL score 5-6).

Figure 8 below displays the breakdown by % into the ADL impairment categorisations for the total cohort and further displays the public and private breakdown:

Figure 8 – Activities of Daily Living Hierarchy Categories



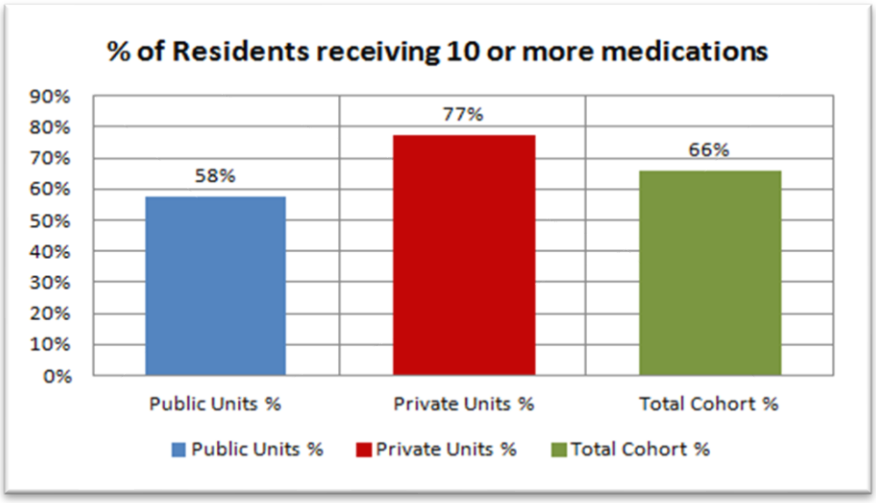
From the graph above it can be seen that the breakdown of ADL impairment is remarkably similar across both public and private units where the majority of residents are either very dependent or totally dependent in ADLs.

4.9 Medications

One of the items collected by interRAI LTCF assessments is the number of prescribed and over the counter medications a person received in the three days prior to assessment.

When looking at medications a cut-off point of residents with 10 or more prescribed/over the counter medications was analysed.

Figure 9 – Percentage of Residents Receiving 10 or More Medications



In the total sample, 66% of residents were on 10 or more different medications (with the maximum of 26 medications being recorded for 2 residents). Of these residents on 10 or more medication, 58% of the public sample fell into this category whereas 77% of private residents fell into this category.

4.10 Primary Diagnoses

The most common primary diagnoses among residents (almost half) were dementia (other than Alzheimer's), followed by stroke and Parkinson's disease, with comparable rates in both public and private nursing homes. A full list of primary diagnoses is listed in Appendix 6.

4.11 Resource Utilisation Groups (RUGs)

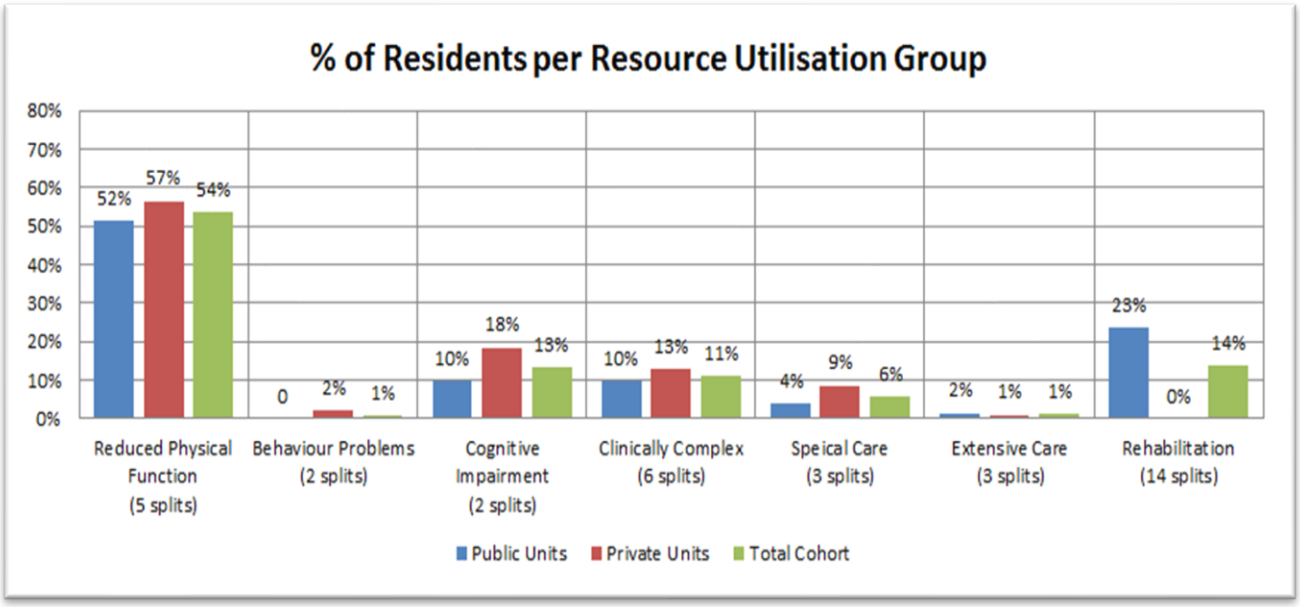
RUGs groups individuals into categories reflecting the relative costs of services and supports they are likely to use. RUG-III groups patients by relative *per diem* resource consumption and is currently being used internationally as part of the basis for prospective payment systems to ensure that facility reimbursement is commensurate with patient acuity.

RUGs algorithm produces seven categories. The system of seven clinical categories was devised as a hierarchy ranked by resource use. Residents can qualify for more than one group but are placed in the most resource intensive one. A resident failing to fulfil the criteria for the rehabilitation groups would be checked against criteria for extensive treatments; those failing to meet the criteria would be checked against special care and so on. The reduced physical function group contains those residents who fail to meet the criteria for any of the other groups.

The % breakdown for each of the seven RUGs categories are listed below, and is further broken down by public and private in the graph below:

- Rehabilitation 14%
- Extensive Services 1%
- Special Care 6%
- Clinically Complex 11%
- Impaired Cognition 13%
- Behaviour Problems 1%
- Reduced Physical Functions 54%

Figure 10 – Percentage of Residents Per Resource Utilisation Group



This breakdown is in line with international trends, where the largest group of residents are in the Reduced Physical Function RUG category, which includes persons with physical disabilities but few other medical complexities. The next most common levels are the Cognitive Impairment, Clinically Complex categories, and Rehabilitation (in Public Units).

As can be seen from the graph above, public, and private are generally similar with some variances in the Cognitive Impairment and Clinically Complex categories. However, the starkest difference emerges in the highest category of Rehabilitation. This warrants a more detailed explanation.

In order to fall into the category of Rehabilitation (and each of its 5 Rehab splits) a resident must qualify by virtue of receiving a minimum of 45 minutes of therapy (Physio, OT, SLT) for a minimum of 3 days over the look back period. The qualifications and criteria for each of the 7 Groups are detailed in Appendix 4.

Overall, Figure 10 shows that only 14% of the total cohort received the level of rehabilitation therapies required to place them in this Rehabilitation category. Residents are only assigned this RUG category if they have received the amount of rehabilitation therapies within the specified look back period (7 days prior to the assessment). In public nursing homes, 23% were assigned to the Rehabilitation group, whereas 0% of the private sample are in receipt of this level of therapy. The algorithm does not determine who needs rehabilitation it merely records the resources used in the provision of care to the cohort who receives them. These findings suggested that those in public

nursing homes were more likely to receive rehabilitation services than those located in private nursing homes.

Caution should be exercised in interpreting this level or absence of residents receiving therapy. Further investigation into staffing complements of therapists would be required to determine if access to therapies is equal across public and private nursing homes. It would be necessary to clarify if access to, and availability of therapies is equal across settings before any inferences to acuity and need are possible.

It must also be reiterated that this data cannot be interpreted as being a representative sample of either a public or private provision, as the sample included in this study is extremely small (<1%) and is not statistically relevant.

In addition to this complication of the Rehabilitation category of RUGs, any full understanding of the category is not possible without also examining the Casemix Index (CMI).

4.12 Casemix Index (CMI)

The CMI value for a category in the RUG classification system is a cost weight reflecting the relative intensity of resource use in that group compared with some base level of resource use (the overall average resource use for all 35 RUG groups combined).

The CMI for a RUG category represents the relative cost of caring for the average resident within that group compared with the average resident in a given population. The CMI for each category is obtained by dividing the resource use per day for that group by the average resource use per day across the population. The CMI is defined this way so that, if the CMI values are applied to the source data, the average resource use per day for the specified population will equal 1.0000. The resource use per day for each RUG category is calculated using health care provider wage rate information and staff time measurement data for that RUG category.

For example, since its original development in 1994, RUG-III casemix system has undergone a number of revisions (Fries *et al* 1994). In Canada, the wage rate information used for the RUG-III CMI values is derived from the annual Ontario Hospital Association Wage Rate Survey and the staff time measurement data is based on the Canadian Staff Time and Resource Intensity Verification Study (CAN- STRIVE) Project (Hirdes *et al.* 2010). This study revised the original casemix system and formed part of a joint United States / Canadian Study. The study was completed in the United States by the U.S. Centres for Medicare & Medicaid Services. In Canada, the most recent update to the RUG-III system 'RUG-III Plus' was launched by the Canadian Institute for Health Information (CIHI) in 2018 to better reflect the Canadian residential care population's resource utilisation[17].

The resource use for each group is the resource use per day multiplied by the patient days for that RUG category. The average resource use per day is calculated as the total resource use divided by the total patient days.

[17] https://www.cihi.ca/en/resource-utilization-groups-version-iii-plus

The CMI is not a direct measure of the cost of care. More accurately, the CMI provides a means of accounting for differences in the ways that resources are used by groups of residents with distinct therapeutic needs.

Each country needs to calculate their CMI values. This is a significant undertaking, requiring detailed financial information and a minimum of a years assessment data to align to RUGs grouping. However, for the purposes of this study we used the CMI values for Finland (for logistical reasons as the IT vendor was able to provide this analysis within the required timeframe necessary for the DoH study). As can be seen from the graph in Appendix 7, CMI values for Finland vary between and within groups and they are not linear. From this graph it can be seen that while residents may fall into the lowest RUGs category of Reduced Physical functions, the highest CMI weighting of this category (PEO) is actually higher than the lowest CMI weighting in the Clinically Complex category.

Additionally, the RUG category of Reduced Physical Function PEO grouping is similar in terms of CMI weighting to the RUA grouping in the highest RUG category (Rehabilitation). This means costs of care / resource use for these RUG groupings is similar in Finland.

This highlights the underlying need to view both the RUGS and CMI in tandem. Should policy decisions recommend further investigation into RUGS and CMI for resource allocation in long-term care in Ireland the current data using the Finnish CMI index as displayed in Appendix 7 may be useful starting point.

4.13 Conclusion

It must be kept in mind at all times, that this sample is extremely small and not statistically relevant. Therefore, the data cannot be interpreted as being a representative sample of either public or private provision. In order to obtain an accurate picture of the sector a statistically relevant study would have to be undertaken.

However, the study illustrates the potential the interRAI assessments has for identifying the resources required for meeting individual care needs. The value and range of data that can be produced from a standardised care needs assessment cannot be underestimated, and all of the data that is produced is not included in this chapter. While not the central focus of this study, the interRAI assessment generates data that can be used for both clinical care/care planning and service improvement. It can be used to benchmark and monitor care profiles around each of the outputs and can be used across services for older people for Dementia, Falls, etc.

In terms of the central question of this study in examining any significant differences in care need profiles between public and private, it appears at a high level there are few differences emerging between the public and private cohort.

On a micro level the study shows that higher costs are not necessarily a result of higher levels of dependency. The following table is a high-level comparison of two of the nursing homes that participated in the study. The private nursing home is paid €1,186 per occupied bed per week and the public nursing home costs €2,659 per occupied bed per week. The table shows that there are minimal differences in the care needs of residents in each home, and the cost differential in this case cannot be attributed to higher levels of dependencies. However, the data indicates that there are differences in the level of care provided. There are large differences in the level of therapies

provided and medication dispensed, which from a clinical perspective are traditional indicators of care outcomes.

Table 16: A High-Level Comparison of Care Needs in a Public and Private Nursing Home in Dublin, Compared to Study Average

Chapter 5: Stakeholder Engagement

5.1 Introduction

The Department, at the request of the Steering Committee, wrote to several key stakeholders to obtain their views on the Review and on its Terms of Reference. The following key stakeholders were identified and invited to make written submissions to the Steering Committee:

- Nursing Homes Ireland (NHI)
- Health Information and Quality Authority (HIQA)
- Health Service Executive (HSE)
- Irish Nurses & Midwives Organisation (INMO)
- Services Industrial Professional and Technical Union (SIPTU)

All the stakeholders contacted responded to the invitation. NHI, SIPTU and HIQA made written submissions. NHI requested a meeting with the chairman and to present its submission in person to the Steering Committee. The Chairman acceded to both requests. A bilateral meeting took place on 5th September 2018, and NHI gave a presentation of its submission at the third meeting of the Steering Committee.

Common themes emerged during the analysis of submissions; the funding model, distribution of funding, clarity of funding, staffing and care needs. Below is a summary of the responses under these themes. Appendix 8 includes the full submissions. The views of the different stakeholders were of great benefit to the Steering Committee in coming to a better understanding of these issues.

Box 4: Why consult Stakeholders?

In the introduction to Guidelines on Consultation, 2016, the Department of Public Expenditure and Reform stated that public consultation "...*involves undertaking a systematic process of meaningful engagement and knowledge sharing with those outside the policy-making process who have a clear interest in a particular policy area, in order to better inform that process. By enabling the public to participate in policy development and in the design of public services, they will gain a greater sense of political efficacy, and potentially increase their confidence and trust in the political system. Meaningful participation increases the legitimacy of decision-making, improves the public's knowledge and awareness of complex policy challenges, helps decision-makers to make better decisions and can lead to improvements in the quality of service provision*".

5.2 Funding Model

HIQA raised concerns that the single fee payable by the NHSS "*does not provide funding based solely on the care needs of the older person*", which can result in situations where "*private providers, conscious of the cost of care for a resident who has higher dependency, select residents with lower dependency needs*". HIQA advocates the introduction of a "*funding model that is based on residential categories of care*", with a payment scale matched to care needs, to direct funding "*to those residents with the highest care needs, regardless of the geographical location of their chosen nursing home or the status of the provider*". HIQA would also like to see payments linked to regulatory compliance and conferred with an additional legislative remit to "*withhold consent for*

the admission of new or additional residents until the centre in question is deemed to be in compliance".

SIPTU contends that it is inaccurate to compare "a private profit driven model" with a State model "*to care for those who may not have the means and may require a high level of care albeit not in an acute setting*". They note that "*some locations within the public sector provide a service more akin to a small acute hospital*".

NHI believes that there is a need for a funding model that is more sophisticated than the model currently employed. It references several reports, including *An Irish National Survey of Dementia in Long-Term Residential Care*[18] and *Potential Measures to Encourage the Provision of Nursing Home and Community Nursing Unit Facilities*[19], in calling for a funding model which is more closely aligned with the cost of care.

5.3 Distribution of Funding

HIQA notes that affordability and the commitment that all persons receive "*the same level of State support regardless of whether they choose a public, voluntary or private nursing home*" are core principles of the NHSS, yet the NHSS is not providing the same level of financial support to private and public nursing homes.

NHI contends that there is "*gross inequality in the application of Fair Deal funding*" evidenced "*when €12 million, 55% of the additional Fair Deal 2018 budget allocation, was earmarked for HSE pay increases*". It also states that there is "*gross distortion*" in Fair Deal expenditure as "*2017 HSE accounts for one-third of the budget to fund the one-fifth of residents in HSE homes*".

NHI believes that "*non-transparency in public nursing home expenditure presents challenges in presenting specific cost differentials arising between public and private/voluntary homes*" and that the HSE's published cost of care does not show the real cost of care in public nursing homes. It argues that the HSE is "*in breach of the statutory scheme that is the NHSS*" by incurring costs "*external to the fee payable and the Fair Deal budget*". It refers to several substantial costs that private and voluntary nursing homes must meet within Fair Deal fees but which the HSE nursing homes do not. These include capital costs, commercial rates, land and maintenance costs, local authority charges, land costs, insurance premiums and education and training.

5.4 Clarity Surrounding Funding Entitlements

HIQA note that many residents and their families are not clear as to what they are entitled to under the NHSS, with additional fees a source of confusion. NHI argue that many private and voluntary nursing homes *"are tasked with providing services under regulatory requirements for the residents entrusted in their care that are excluded from their fees payable; whereas HSE nursing home residents retain access to such*".

[18] The Dementia Services Information and Development Centre (DSIDC), *An Irish National Survey of Dementia in Long-Term Residential Care*, 2015

[19] DKM Economic Consultants, *Potential Measures to Encourage the Provision of Nursing Home and Community Nursing Unit Facilities,* 2015

SIPTU argues that "*It is a gross aberration that private and voluntary nursing homes residents are paying additional fees to secure access for specialist care services that are vital to support their health and wellbeing*".

5.5 Staffing

NHI does not consider private sector pay rates for nursing and care staff to be substantially different to the public sector and reasons that the HSE "*needs to agree an appropriate model of residential care staffing and skill mix*". However, SIPTU contends that higher dependency in the public sector requires a higher nursing to support staff ratio which means that pay costs "*will be higher relative to a similar sized private home*". SIPTU is also of the view that qualification requirements are contributing to the cost differential in pay between the sectors, with a minimum of FETAC Level or equivalent a mandatory requirement for public nursing homes but not for some private nursing homes, leading to lower labour costs in the private sector.

5.6 Care needs

SIPTU states that public nursing homes cater for residents with a higher level of dependency and "*can typically be only cared for in public nursing homes*". However, NHI quotes the Dementia Services Information and Development Centre's (DSIDC) report *An Irish National Survey of Dementia in Long-Term Residential Care* where it states the HSE operated facilities which receive the highest payments from the NHSS are "*more inclined to refuse admission to those not independently mobile*". NHI states that the report claims the private sector "*is the main provider of specialist long-term care for people with dementia*".

SIPTU cites analyses that highlight how "...*the failure to appropriately fund the care provided to residents in private and voluntary nursing homes is impacting upon the capacity of such homes to meet care needs, capacity requirements and is leading to closure*".

Chapter 6: A Review of the International Literature to Examine Ownership Models and Efficiency in the Nursing Home Sector

6.1 Introduction

It is not possible to directly compare Ireland's cost of nursing home care with other similar jurisdictions. Systems of nursing home care have developed differently in countries and are influenced by economic, social, demographic, and cultural factors. As a result, the type of care provided, the funding mechanisms, and the regulatory process, are some of the variables that prevent a meaningful like-for-like comparison. Instead, this chapter draws on international evidence to examine the relationship between efficiency and ownership in the nursing home sector.

Nursing home expenditures have been growing steadily in spite of cost containment efforts[20]. Furthermore, population ageing and increasing expectations regarding the quality of care will likely result in a continued growth in public expenditure on nursing home care. As a consequence, long-term care, including nursing homes, is a policy priority in most countries with a focus on improving the cost effectiveness and cost efficiency of expenditure while ensuring accessibility of services and improvements in service quality and provision.

Traditionally, public nursing homes in Ireland were the dominant setting for long-term residential care in Ireland, but this has increasingly been replaced by privately owned and operated nursing homes. Between 1998-2011, the Government provided capital allowances to the nursing home market to stimulate private supply, predicated on achieving greater efficiencies, effectiveness, and responsiveness to consumer needs, than would have been obtained through direct government provision of nursing home services. The situation in Ireland mirrored recent trends in the UK, Europe, and Canada towards the marketisation and privatisation of nursing homes, similar to the long-standing trend in the US.

Marketisation refers to government efforts to encourage and enforce competitive markets with buyers and sellers within the private and public sectors[21]. Privatisation refers to shifts in ownership from government to private for-profit and not-for-profit companies[22]. A core factor behind this trend is tighter budget constraints and the expectation of achieving cost savings from the stronger incentives linked to private ownership and competition.

Marketisation has encouraged the growth in size and complexity of nursing homes, especially for-profit nursing homes and chains in the US, Canada, the UK, and other OECD countries. Some large nursing home chains are publicly traded companies and others are owned by private investors or private equity companies. For-profit chains aim to improve profitability through economies of scale, standardisation of services, brand name recognition and visibility, and survival in competitive

[20] Organisation for Economic Coordination and Development (OECD) (2011) Help Wanted? Providing and Paying for Long Term Care. Paris: OECD. Organisation for Economic Coordination and Development (OECD) (2014) OECD Health Statistics 2014. Paris: OECD http://www.oecd.org/els/health-sytems/health-data.htm. EuroFound, Care Homes for Older Europeans: Public, For-Profit and Non-Profit Providers, Publication Office of the European Union, Luxembourg, 2017.

[21] LaingBuisson (2013a) Domiciliary Care UK Market Report, London, UK. LaingBuisson (2013b) Laing & Buisson release latest in-depth analysis of the care home sector. Press Release, London, UK, January 17

[22] Herning, L. (2012) Konkurranseutsatte sykehjem i Norge, Notat 1, 2012. Stevenson, D.G., Bramson, J.S. and Grabowski, D.C., (2013) Nursing home ownership trends and their impacts on quality of care: A study using detailed ownership data from Texas. Journal of Aging and Social Policy, 25, 30-47

environments. It was found that nearly every large for-profit chain across five countries owned and operated a range of related long-term care companies[23]. This allows them to purchase services from their own related companies to enhance profit taking. Some provide physician services to the clients across their long-term care nursing home network. Other countries, particularly Norway and Sweden, were found to be expanding into preschools as well as mental health, developmental disabilities, substance abuse and refugee reception centres. Some of the large chains in the UK, Canada, and the US offer management services to their own nursing homes as well as other nursing homes.

Many for-profit nursing home chains have developed limited liability corporations or general limited-partnership structures to limit the risk of financial loss to the amount invested[24]. This is in contrast to partnerships, or sole owners, where the owners are personally responsible for all business liabilities.

A proposed taxonomy of different ownership types in the nursing home sector[25]:

- **Public ownership**: facilities owned by government or quasi-governmental bodies. Municipal governments, health regions, and Veteran Affairs are examples of public and quasi-public owners.
- **Not-for-profit ownership**: nongovernmental ownership by religious or community groups or agencies, in which the facilities they operate run as not-for-profit societies. A not-for-profit entity is constituted with the assumption that any revenue in excess of expenses will be used to benefit its clients.
- **For-profit ownership:** owned and operated by businesses. Here it is assumed that the revenue in excess of expenses can be directed to the owners- or in the case of shareholder-owned companies, to shareholders. They include small provider-owned facilities and large corporate chains whose headquarters are not necessarily in the province, or even in the country, where they operate.

This chapter, in the context of the evolving landscape in the nursing home sector and, aligned with the overall aim of this Value For Money Review, seeks to examine the international evidence base to see what relationships exist between nursing home ownership models and efficiency. In addition, it discusses the evidence on nursing home ownership models in a number of countries including US, Canada, England, Sweden and Norway and any evidence, that points directly or indirectly to efficiency, is reported, and discussed. In seeking to assess the performance differences between countries and/or between ownership models, it is important to understand the regulatory and financing arrangements which govern behaviours of both providers and consumers. It is also important to be cognisant of different roles that different groups of providers (public, not-for-profit and for-profit nursing homes) play within the sector as a whole, the available data is included in relation to variation in types of services provided, geographical location, scale, and resident profile.

[23] Harrington, C., Jacobsen, F.F. Panos, J., Pollock, A, Sutaria, S. and Szebehely, M. (2017) Marketisation in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains, Health Services Insight, 10(1): 1-23

[24] Harrington, C., Jacobsen, F.F. Panos, J., Pollock, A, Sutaria, S. and Szebehely, M. (2017) Marketisation in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains, Health Services Insight, 10(1): 1-23

[25] Ronald, L.A., McGregor, M, Harrongton, C., Pollock, A. and Lexchin, L. (2016), Observational evidence of for-profit delivery and inferior care: when is there enough evidence for policy change? PLoS Med, 13: 1-12)

Prior to examining the international evidence on ownership type and efficiency (Section 6.4), it is important to understand what in meant by "efficiency" in the context of the nursing home sector. Section 6.3 includes a discussion on these issues. The search strategy for this literature review is described in Section 6.2.

6.2 Search Strategy

The three most comprehensive electronic databases in economics, medicine and health were searched using keywords within titles and abstracts of articles: ECONLIT, PubMed (Medline), and Web of Science. Search terms used were: ("long-term care" OR "long-term care" OR LTC OR "nursing home" OR residential OR "care home") AND (owner* OR for-profit OR not-for-profit OR non-profit OR privat* OR market*) AND (efficien* OR productiv* OR performance OR inefficien*) OR (quality OR staff* OR skill-mix OR skillmix). The formal search was complemented with additional hand searches of the reference lists in included studies and a similar search was conducted in the grey literature. Only studies that have full text in English were included due to the time and resource limitations for translations of non-English publications.

6.3 What is meant by "Efficiency" in the nursing home sector?

Decision makers are increasingly faced with the challenge of reconciling growing demand for health care services with available funds. The achievement of (greater) efficiency from scarce resources is a major criterion for priority setting. Viewed through the lens of economic theory, health and healthcare is essentially a good or service that is produced. Production requires the use of resources, such as capital and labour, and is the process that transforms them into goods and services.

Productivity and efficiency are two related yet distinct concepts[26]. While the productivity of an organisation (e.g., a nursing home) refers to the ratio of outputs (products or services) to the inputs (resources), efficiency refers to the extent that the nursing home achieves the highest feasible productivity[27]. It is expressed as the proportion of the nursing home productivity to the maximum productivity of similar organisations. Efficiency is measured on a scale of 0 to 1 (or 0% to 100%), where a value of 1 indicates the nursing home has the highest possible productivity, and a value less than 1 indicates a lower productivity level (relative to the best), i.e., having some inefficiency. Outputs might include (number of) residents, services provided, and resident days. Typical inputs that a nursing home uses include the (number of) rooms (and/or beds), full-time-equivalent (FTE) staff hours (by categories), administration and supplies/consumables. The efficiency of a nursing home is affected by many factors, including resident dependency level, staffing mix, nursing home location, management and ownership structure, and operational objectives. Measuring efficiency and understanding the sources of inefficiencies (if any) can help nursing homes identify how well they are operating in relation to similar organisations and determine where to focus to improve their productivity[28].

Despite the importance of efficiency measurement in health care services, it is only relatively recently that the more advanced econometric and mathematical programming frontier techniques

[26] Jacobs, R., Smith, P.C. Street, A., *Measuring Efficiency in health Care: Analytic Techniques and Health Policy*; Cambridge University Press: Cambridge, UK, 2006

[27] O'Donnell, C.J. Productivity and Efficiency Analysis: An Economic Approach to Measuring and Explaining Managerial Performance; Springer: Singapore, 2018

[28] Ibid.

have been applied to measurement of efficiency in hospitals, nursing homes, health management organizations, and physician practices, among others[29]. There are two main methods of measuring efficiency: parametric and non-parametric approaches. The parametric approach involves the estimation of a production function using econometric techniques and Stochastic frontier analysis (SFA)is the dominant parametric method[30]. Data Envelopment Analysis (DEA) is the predominant non-parametric method. Depending on the data used, both methods can be used to calculate technical efficiency[31], scale efficiency, cost efficiency[32], and allocative efficiency[33]. When input and output quantities only are used, technical and scale efficiencies can be calculated. When price information is also available for individual input and outputs, one can calculate all four efficiency indicators[34].

A study[35] conducted a systematic review of the literature on efficiency measurement in nursing homes. The majority of studies in the nursing home sector estimate technical efficiency due to the unavailability of reliable price information for inputs and outputs of nursing homes. Most studies use an input orientation which assumes that nursing homes minimise the input or cost to achieve the desirable level of outputs (this is in contrast to an output orientation which assumes that nursing homes maximise outputs/revenue from their fixed resources). More than half the studies use data envelopment analysis. The most frequently used measure of physical capital input was number of beds. The most common measures of labour input were staff expenditures and/or the number of full-time equivalent (FTE) staff, which was broken down by skill categories, for example, registered nurses, licensed practical nurses, and nursing assistants. In studies where input prices were available, they often included labour prices, capital cost and material expenditure. The main output measures were "number of residential days", with or without casemix adjustment, and "number of residents".

Control variables in the efficiency analysis literature consist of all measures that are neither quantities nor prices of inputs or outputs but might affect productivity. It found that control variables used in efficiency analysis in the nursing home sector can be roughly categorised into two groups, nursing home characteristics and environmental factors[36]. Nursing home characteristics include for-profit status, chain affiliation, ownership, and occupancy rate. Environmental factors often included location (rural versus urban) and market competition.

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[29] Tan, A., Nguyen, K.H., Gray, L, Comans, T. (2019), A Systematic Literature Review of Efficiency Measurement in Nursing Homes, International Journal of Environmental Research and Public Health, 16, 2186; doi: 10.3390/ijerph16122186.

[30] Coelli, T., Rao, D.S.P., O'Donnell, C.J., Battese, G.E. An Introduction to Efficiency and Productivity Analysis, Springer: Boston, MA, USA, 2005

[31] Production is technically efficient if the most output possible is produced from a given set of inputs, or the fewest inputs possible are used to produce a given amount of output. Most studies in the nursing home sector have focused on technical efficiency because of the difficulty obtaining reliable information on the costs of inputs in this sector.

[32] Technical efficiency is only concerned with how many inputs are used in production, while *economic efficiency* is related to the cost of those inputs. Economic efficiency (often called cost efficiency) is achieved if the most output possible is produced for a given cost, or a given amount of output is produced at the lowest possible cost.

[33] Allocative efficiency reflects the ability of an organisation to use inputs in optimal proportions, given their respective prices and the available production technology. In other words, allocative efficiency is concerned with choosing between the different technically efficient combinations of inputs used to produce the maximum possible outputs.

[34] Coelli, T., Rao, D.S.P., O'Donnell, C.J., Battese, G.E. An Introduction to Efficiency and Productivity Analysis, Springer: Boston, MA, USA, 2005. Jacobs, R., Smith, P.C. Street, A., Measuring Efficiency in health Care: Analytic Techniques and Health Policy; Cambridge University Press: Cambridge, UK, 2006.

[35] Tan, A., Nguyen, K.H., Gray, L, Comans, T. (2019), A Systematic Literature Review of Efficiency Measurement in Nursing Homes, International Journal of Environmental Research and Public Health, 16, 2186; doi: 10.3390/ijerph16122186

[36] Tan, A., Nguyen, K.H., Gray, L, Comans, T. (2019), A Systematic Literature Review of Efficiency Measurement in Nursing Homes, International Journal of Environmental Research and Public Health, 16, 2186; doi: 10.3390/ijerph16122186.

It noted in the studies examined, large for-profit nursing homes with higher occupancy rates had higher efficiency scores than their counterparts. The authors speculated that this might be the effect of scope and scale economies and profit-oriented business models, which are often found in other efficiency literature such as hospital settings. Some studies observed a positive relationship between competition level and efficiency score, whereas some observed a negative effect or statistical non-significance. It concluded that it is important to have the correct incentives, such as competition based on value and not just on service.

Casemix reflects the fact that, the more complex the care needs of residents (physically and cognitively), the more likely it is that more inputs are required (more staff, different staff mix, more intensive care). This can be captured by measuring the number of residents over 85 years of age on the assumption that this group has a higher severity of illness. Others measure average length of stay to represent casemix. Other variables measured include indices of Activities of Daily Living (ADL), turnover of patients and the percentage of patients with cognitive difficulties. The importance of casemix is evidenced by the move to increasingly deploy structured assessment instruments such as interRAI[37].

In long-term care, both efficiency and quality are central concerns for policymakers. It is undesirable to improve efficiency by compromising quality of services because better health outcomes and improved wellbeing of the older adults are the ultimate goals of a good long-term care system. Therefore, measuring efficiency without proper adjustments for quality differences between nursing homes will not provide accurate information about their relative performances, thereby not facilitating true improvements[38].

The quality of care is multidimensional. Based on Donabedian's conceptual framework[39], which remains the foundation of quality assessment today, care quality entails the three dimensions of structure, processs, and outcome. "Structure" is defined as the settings, qualifications of providers, and administrative systems through which care takes place. "Process" refers to the components of care delivered, including both the health professional's activities (e.g., nursing care, diagnosis, treatment, or patient education) and the health care consumer's activities in seeking care and carrying it out (e.g., choice of treatment). "Outcome" refers to recovery, restoration of function and/or survival of the service recipients.

Measuring quality with a high level of precision, and identifying the determinants of quality, however, remain major challenges in both practice and research. Much of the evidence in this regard derives from observational studies rather than randomised controlled trials (RCT) (the principal advantage of the latter is their controlled nature *which* eliminates many of the biases that hamper the interpretation of *observational studies).* From the lens of healthy ageing in older adults,

[37] The interRAI instruments are a set of standardized and fully structured tools to assess characteristics of people having multiple chronic disorders and receiving long-term care services. Since 1989, the instrument is mandatory in US nursing homes with casemix application to improve the quality of care. Subsequently, a network of international clinicians and researchers set up interRAI™, as a not-for-profit collaborative organisation to apply the RAI to nursing home residents in other countries and to develop other structured, multi-disciplinary assessment tools to assess the wide-range of health and social care needs of older people with more than 35 countries involved as users (www.interRAI.org).

[38] WHO Regional Office for Europe, Health System Efficiency: How to Make Measurement Matter for Policy and Management, Cyclus, J., Papanicolas, I., Smith, P.C., Eds,: WHO Regional Office for Europe: Copenhagen, Denmark, 2016.

[39] Donabedian, A. (1988) The Quality of Care: How can it be assessed? JAMA, 260: 743-748. Donabedian, A. An Introduction to Quality Assurance in Health Care, Oxford University Press: Oxford, UK, 2003

quality in nursing homes involves both quality of care and quality of life. Both are important parts of clinical governance, accreditation and, increasingly, consumers' preferences. In a systematic review of efficiency measurement in the nursing homes sector, it was found that 74% of studies included at least one quality measure in their efficiency analyses[40]. The majority of studies used quality measures as control variables or as outputs.

There is often an assumption that there is a trade-off between quality and efficiency. Standard economic theory suggests a positive exponential relationship between quality and costs. To increase quality, costs must also increase and to achieve even higher quality, costs must increase at a higher rate[41]. All other things being equal, the more expenditure allocated to care the higher the expected quality. Increasing quality may require additional labour and costs whilst a tendency towards efficiency improvements and cost containment may lead to poorer performance in quality. But better quality can also be associated with better economic performance and lower production costs.

In a systematic review, it was noted that of those studies reporting the impact of quality on efficiency, the impacts were found to be mixed[42]. Four studies found that accounting for quality increased efficiency estimates of all nursing homes and four showed a negative impact of quality on the efficiency estimates. Notably, only one study accounted for quality of life of residents ("*degree of involvement in the provision of organised groups for its residents and their families*") and this was not a standardised quality-of-life measure that had been used widely or well-validated.

The authors concluded that it is important to account for quality when analysing performance but that there is a need for more precise measurements of quality for both outputs and inputs. Non-standardised quality measure will lead to mixed results of impact of quality on efficiency. A nursing home that increases the number of occupied beds or employs low-skill staff will inevitably reduce the operation costs while producing the same number of resident bed-days. If the bed-days are not quality adjusted, it is likely that the low-cost nursing homes that produce low quality services to residents will appear more efficient than their counterparts that invested in the nursing home and staffing skills to provide the best possible care to their residents. This will lead to misleading conclusions and make it difficult to distinguish between low-value and high-value care.

A concern expressed in the literature is that, due to the challenges outlined above, dimensions of quality may be non-contractible[43] when the State is procuring nursing home services[44]. This may lead to efforts by for-profit nursing homes to reduce costs instead of actions which improve quality. There is a presumption that not-for-profit nursing homes do not have this incentive and the mission-

[40] Tan, A., Nguyen, K.H., Gray, L, Comans, T. (2019), A Systematic Literature Review of Efficiency Measurement in Nursing Homes, International Journal of Environmental Research and Public Health, 16, 2186; doi: 10.3390/ijerph16122186

[41] Musa, M., Rosen, S. (1978) Monopoly and Product Quality, J Econ Theory, 18: 301. Donabedian, A. Explorations in Quality Assessment and Monitoring: The Definition of Quality and Approaches to Its Assessment. Vol. II. The Criteria and Standards of Quality. Ann Arbor, MI: Health Administration Press, 1982

[42] Tan, A., Nguyen, K.H., Gray, L, Comans, T. (2019), A Systematic Literature Review of Efficiency Measurement in Nursing Homes, International Journal of Environmental Research and Public Health, 16, 2186; doi: 10.3390/ijerph16122186

[43] Non-contractible refers to the challenge that derives from some quality dimensions being difficult to measure and verify, and therefore difficult to contract with and at risk of degradation when procuring a service.

[44] Bergman, Lundberg & Spagnolo, Public Procurement and Non-Contractible Quality- Evidence from Elderly Care, Umea Economics Studies 846. Umea University Department of Economics, 2012.

orientated purpose of caring for people may intrinsically motivate improved service delivery. However, not-for-profit nursing homes may also have other motivations.

For nursing homes, there is both a fixed and a variable cost element to quality. At a fixed cost level, increased quality can be achieved at higher fixed costs, for example through purpose-built nursing homes. Staffing has the potential to affect all three elements of care quality through structure, processes, and outcomes. As labour costs are the largest input for nursing home services, there are concerns that staffing levels will be reduced to deliver greater efficiency (reduction in cost) but this may impact on the quality of care services. Most studies that seek to explore the issue of efficiency, directly or indirectly, in nursing homes typically try to assess if any relationships exist between staffing levels, quality measures and efficiency scores. Issues around staff levels, vacancies, turnover and retention and skill-mix are typically measured in any analyses of efficiency or quality in nursing homes.

Over the past 25 years, over 150 studies conducted, primarily in the US but also in the UK, Canada, Germany, The Netherlands, Norway, and Sweden, have documented a strong positive impact of nurse staffing on both care processes and outcome measures[45]. This includes measures such as reduced resident time in bed, improved feeding assistance, improved incontinence care, increased exercise and repositioning, less use of physical and chemical restraints, lower rates of pressure ulcers, better pain management and quality of life, and fewer regulatory deficiencies. Longitudinal studies and studies that take into account the endogenous relationships between nurse staffing, resident acuity, and quality have generally shown strong positive relationships with staffing and quality of care[46].

The strongest positive relationships are found between Registered Nurses (RNs) (with two to four years of training) and quality. Total nurse staffing levels and Certified Nursing Assistants (CNAs) have also been associated positively with quality. This examination of staffing and quality is particularly relevant in any exploration of nursing home ownership models as it is typically assumed that profit-seeking companies have stronger incentives to strive for cost reductions that might lead to quality deterioration of services[47]. Some studies have suggested that a minimum threshold of staffing must

[45] Harrington, C., Kovner, C., Kayser-Jones, J., Burger, S., Mohler, M., Burke, R., Zimmerman, D. (2000), Experts recommend minimum nurse staffing standards for nursing facilities in the United States, Gerontologist, 40(1), 1-12;
Schnelle, J.F., Simmons, S.F., Harrington, CX., Cadogan, M., Garcia, E., B, M.B.J. (2004), Relationship of nursing home staffing to quality of care. Health Services Research, 39(2): 225-50;
Bostick, J.E., Rantz, M.J., Fiesner, M.K., Riggs, C.J. (2006) Systematic review of studies of staffing and quality in nursing homes. Journal of the American Medical Directors Association, 7: 366-376;
Castle, N. (2008) Nursing Home caregiver staffing levels and quality of care: A literature review, Journal of Applied Gerontology, 27: 375-405;
Comondore, V., Devereaux, P., Zhou, Q., Stone, S., Busse, J., Ravondran, N., Burns, K., Haines, T., Stringer, B., Cook, D., Walter, S., Sullivan, T., Berwanger, O., Bhandari, M., Banglawala, S., Lavis, J., Petrisor, B., Schunemann, H., Walsh, K., Bhatnagar, N and Guyatt, G. (2009) Quality of Care in For-Profit and Not-for profit Nursing Homes: Systematic Review and Meta-analysis. British Journal of Medicine, 339, b2732;
Spilsbury, K., Hewitt, C., Stirk, L. and Bowman, C. (2011) The relationship between nurse staffing and quality of care in nursing homes: a systematic review: International Journal of Nursing Studies, 48(6): 732-750;
Dellefield, M.E., Castle, N.G., McGilton, K.S., Spilsbury, K. (2015) The relationship between registered nurses and nursing home quality: an integrative review (2008-2014), Nurs Econ, 33(2): 95-1078, 116;
Backhaus, R., Van Rossum, E., Verbeek, H., Halfens, R.J.G., Tan, F.E.S., Capezutti, E and Hamers, J.P.J. (2016) Quantity of staff and quality of care in Dutch nursing homes: A cross-sectional study, The Journal of Nursing Home Research and Sciences, 2: 90-93.

[46] Harrington, C, Swan, J.H., Carrillo, H. (2007), Nurse Staffing Levels and Medicaid Reimbursement Rates in Nursing Facilities, Health Services Research, 42(3): 1105-29;
Konetzka, R.T, Stearns, S.C., Park, J. (2008) The Staffing-Outcomes Relationship in Nursing Homes, Health Services Research, 43(3): 1025-1042;
Castle, N.G., Anderson, R.A.(2011) Caregiver staffing in nursing homes and their influence on the quality of care, Med Care, 49(6): 545-552.

[47] Hart, O., Schleifer, A., Vishny, R.W. (1997) The proper scope of Government theory, Q J Econ, 112: 1127-61;
Schleifer, A. (1998), State versus private ownership, J Econ Perspect, 12: 133-50.

be reached before staffing levels show higher quality[48]. This has driven the development of guidance in most countries, and regulations in some countries, setting out minimum staffing standards in the nursing home sector.

6.4 Evidence examining ownership models and efficiency in the nursing home sector in other countries.

United States

Nursing homes in the US grew out of the almshouse system for the poor in the 1800s. Between the 1920s and the 1950s the number of nursing homes grew dramatically, and ownership changed from small, largely not-for-profit providers to mostly for-profit companies. After 1965, this growth in the direction of for-profit was further fuelled by a steady source of revenues after the enactment of the Medicare and Medicaid programs[49]. In 2014, for-profit ownership in the US was at 70%[50].

The Medicare programme in the US uses a prospective payment system to pay for daily rates, adjusting for resident casemix and for regional wages and benefits (US Centers for Medicare and Medicaid Services 2012). Once payments are received, nursing homes may use the funds as they choose as long as they produce annual cost reports which are not audited by government. Some authors have suggested that this methodology gives nursing homes a financial incentive to report that residents are in high casemix groups (up-coding)[51]. The state Medicaid programme pays for lower-income elderly and disabled people who meet each state's financial eligibility criteria and need criteria for nursing home care.

The US has federal standards for staff-patient ratios for nursing homes that provide Medicare and Medicaid services. These require 'adequate staffing levels to meet the needs of the residents to attain or maintain the highest practicable levels of physical, mental, and psychosocial well-being'[52] (Harrington C. C., 2012). The requirements are to have one Registered Nurse (RN) on duty for eight consecutive hours seven days a week, with one full-time Director of Nursing (DoN), one RN and one licensed nurse for the two remaining shifts. The Centers for Medicare and Medicaid Services (CMS) developed a method to determine the minimum nurse staffing levels needed for each US nursing home based on its resident acuity. The staffing star rating is based on two measures:

1. Total nursing hours per resident day (hprd): (RN + Licensed Vocational Nurse/ Licensed Practical Nurse + Certified Nursing Assistant hours) and
2. RN-specific hprd.

[48] Schnelle, J.F., Simmons, S.F., Harrington, CX., Cadogan, M., Garcia, E., B, M.B.J. (2004), Relationship of nursing home staffing to quality of care. Health Services Research, 39(2): 225-50.

[49] Kaffeberger, K.R. (2000) Nursing home ownership: an historical analysis. J Ageing Soc Policy, 12: 35-48.

[50] Harrington, C., Jacobsen, F.F. Panos, J., Pollock, A, Sutaria, S. and Szebehely, M. (2017) Marketisation in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains, Health Services Insight, 10(1): 1-23.

[51] Bowblis, J.R. & Brunt, C.S. (2014) Medicare skilled nursing facility reimbursement and up-coding, Health Economics, 23(7): 821-840.

[52] Harrington, C., Choiniere, J., Goldman, M., Jacobsen, F.F., McGregor, M., Stamatopoluos, V and Szebehely, M. (2012a) Nursing home staffing standards and staffing levels in six countries. Journal of Nursing Scholarship 44(1), 88-98.

CMS calculates the *expected hours* of care based on the casemix. It indicates that the average US nursing home should have 4.17 total nursing hprd, including 1.08 RN hprd.[53].

Some US States have additional requirements to those in federal law: either a minimum amount of licensed staff, or a minimum amount of staff providing direct care to residents, and this is referred to as Minimum Direct Care Staffing (MDCS) requirements. This is seen in Table 17 below.

Table 17: Required Hours Per Resident Day (HPRD) for a facility with 100 beds *(Bowblis, 2011)*

US State	HPRD of MDCS	US State	HPRD of MDCS
Arkansas	*3.5*	*Minnesota*	*2.0*
California	*3.5*	*Mississippi*	*2.8*
Colorado	*2.0*	*Montana*	*1.78*
Connecticut	*2.6*	*North Carolina*	*2.1*
Delaware	*3.28*	*New Jersey*	*2.5*
Florida	*3.6*	*New Mexico*	*2.5*
Georgia	*2.0*	*Ohio*	*2.75*
Iowa	*2.0*	*Oklahoma*	*3.6*
Idaho	*2.4*	*Oregon*	*2.1*
Illinois	*2.5*	*Pennsylvania*	*2.7*
Kansas	*2.0*	*South Carolina*	*2.78*
Louisiana	*2.6*	*Tennessee*	*2.0*
Massachusetts	*2.0*	*Vermont*	*3.0*

One study[54] looked at the impact, in 1987, of the introduction of legislation that required nurse staffing standards and found that this improved quality indicators as measured by a decrease in pressure ulcers, physical restraints and urinary catheters. A number of studies examined California, which introduced higher nurse staffing than the federal requirements in 2001. They found this resulted in higher nurse staffing levels in nursing homes, lower resident mortality[55] and fewer deficiencies[56].

[53] Harrington, C., Choiniere, J., Goldman, M., Jacobsen, F.F., McGregor, M., Stamatopoluos, V and Szebehely, M. (2012a) Nursing home staffing standards and staffing levels in six countries. Journal of Nursing Scholarship 44(1), 88-98.

[54] Zhang, Z.X., Grabowski, D.C. (2004), Nursing home staffing and quality under the nursing home reform act, Gerontologist, 44: 13-23.

[55] Tong, P.K. (2011), The effects of California minimum nurse staffing levels on nurse labor and patient mortality in skilled nursing facilities, Health Econ, 20: 802-816.

[56] Kim, H., Harrington, C., Greene, W., Menzey, M. (2009) A panel data analysis of the relationships of nursing home staffing levels and standards to regulatory deficiencies, Journal of Gerontology: Social Sciences, 64B(2): 269-278.

In 2012, a study[57] examined nursing standards and actual nurse staffing levels in six countries including the US. At that time, 20 US states had higher requirements than the federal standards, 15 had the same and 16 had lower requirements. Ratios were required for direct care in 18 states, where the best standards were 1:5 direct care to resident ratio during the day, 1:10 in the evening and 1:15 at night. When actual levels were measured, staffing levels in 60% of nursing homes were below the recommended level required. Almost 80% of facilities had RN staffing levels below, 30% had Licensed Vocational Nurses (LVN) levels below, and 54% had CNA levels below the expected levels.

A number of authors have looked at nursing standards in terms of ownership models and reported that the ten largest US for-profit chains and other for-profit companies had lower registered nurse and total nurse staffing hours and 41% more serious violations of federal quality regulations compared to not-for-profit and government nursing homes, when controlling for other factors[58]. A gradient effect between profit margins and US nursing home inspection violations was reported[59].

In recent years, five of the largest chains in the US have been charged with fraudulent practices by the US Department of Justice and have either made large settlements or have pending cases. Using federal government data on nurse staffing and deficiencies for all US nursing homes, total nurse hours were lower than the national average in four of the five chains. When staffing hours were adjusted for Medicare patients (higher nursing and therapy hours required) the actual RN hours were significantly lower than expected in three of the five chains. All five chains had higher levels of deficiencies than the national average during 2009-2014[60]. In the US, to try to overcome some of these problems the Nursing Home Transparency and Improvement Act was passed as part of the Affordable Care Act in 2010. This included requirements for detailed ownership and financial reporting and stronger regulation.

A study[61] examined the relationship between quality of care and efficiency in a 10% random sample of nursing homes in the US to determine the characteristics of facilities that achieve high quality and high efficiency. With the exception of one quality indicator (bladder incontinence), and using data envelopment analysis (DEA), all other indicators showed higher quality of care in nursing homes that were categorised as efficient. Overall, a higher level of competition was related positively to the efficiency of nursing homes. In addition, the average efficiency score was higher in urban regions and marginally higher in not-for-profit and government nursing homes. The authors noted that this meant that high efficiency and high quality can co-exist, and they concluded that while different

[57] Harrington, C., Choiniere, J., Goldman, M., Jacobsen, F.F., McGregor, M., Stamatopoluos, V and Szebehely, M. (2012a) Nursing home staffing standards and staffing levels in six countries. Journal of Nursing Scholarship 44(1), 88-98.

[58] Harrington, C., Carillo, H., Blank, B., O'Brian, T. (2011a) Nursing facilities, staffing, residents and facility deficiencies, 2005-10, San Franciso, CA: University of California;
Harrington, C. Olney, B., Carillo, H. and Kang, T. (2012b) Nurse staffing and deficiencies in the largest for-profit chains and chains owned by private equity companies. Health Services Research, 47 (1), Part I: 106-128;
Harrington, C., Rosd, L., Mukatmel, D., and Rosenau, P. (2013) Improving the financial accountability of nursing facilities, Washington DC: Kaiser Commission on Medicaid and the Uninsured, June, http://kff.org/medicaid/report/improving-the-financial-accountability-of-nursing-facilities/;
Stevenson, D.G., Bramson, J.S. and Grabowski, D.C., (2013) Nursing home ownership trends and their impacts on quality of care: A study using detailed ownership data from Texas. Journal of Aging and Social Policy, 25, 30-47.

[59] O'Neill, C., Harrington, C., Kitchener, M. and Saliba, D. (2003), Quality of care in nursing homes: an analysis of relationships among profit, quality and ownership. Med Care, 41 (12): 1318-1330.

[60] Harrington, C., Jacobsen, F.F. Panos, J., Pollock, A, Sutaria, S. and Szebehely, M. (2017) Marketisation in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains, Health Services Insight, 10(1): 1-23.

[61] DeLellis, N., Ozcan, Y. (2013) Quality outcomes among efficient and inefficient nursing homes; a national study, Health Care Management Review, 38(2): 156.

stakeholders may be concerned primarily with one or the other, ultimately they should be concerned with both.

Other authors[62] who have sought to analyse efficiency in the nursing home sector in the US found for-profit homes to be more technically efficient than not-for-profit nursing homes. One found that not-for-profit nursing homes use about 6% more inputs per resident[63].

While it is unlikely that experimental evidence from randomised trials will ever be available to compare nursing home ownership and quality, two US studies have used a method (instrumental variable analysis) that mimics randomisation and can estimate causal relationships when it is not possible to conduct a Randomised Controlled Trial. Both studies examined a national cohort of newly admitted residents to 14,000 nursing homes. Data was gathered from the national standardised clinical dataset linked to Medicaid claims over an 18-month period. Both studies found higher rates of hospital admissions in for-profit nursing homes compared to not-for-profit nursing homes and one study demonstrated inferior outcomes for mobility, pain, and function measures among residents in for-profit nursing homes. The authors concluded that the observed effects could not be explained by unmeasured differences in casemix between nursing homes with different ownership structures[64].

One study[65] examined private equity (PE) nursing home models and compared them with other for-profit nursing homes. The hypothesis was that the stronger profit motive and aggressive use of debt financing of PE-owned nursing homes might result in a trade-off of quality for higher profits. To empirically address this policy concern, the authors constructed a panel dataset of all for-profit nursing homes in Ohio from 2005 to 2010 and linked it with detailed resident-level data. They compared the quality of care provided to long-stay residents at PE nursing homes and other for-profit (non-PE) nursing homes. The results concluded that PE ownership does not lead to lower quality for long-stay nursing home residents, at least in the medium term.

Canada

Home care and nursing home care in Canada is funded by government, operated at a provincial/territorial level. Previously, Canada had predominantly small owner-operated homes but this changed with the development of provincial government involvement in the licensing and payment for services. These changes encouraged the development of, and reliance on, for-profit nursing homes and chains because of economic restraints on government funding and government's limited role in the regulation and enforcement of quality[66]. This involved accepting

[62] Nyman, J. A. (1989). Excess demand, consumer rationality, and the quality of care in regulated nursing homes. *Health Services Research*, 24(1), 105–127;
Nyman, J. A., Bricker, D. L., & Link, D. (1990). Technical efficiency in nursing homes. *Medical Care*, 28(6), 541–551;
Fizel, J. L., & Nunnikhoven, T. S. (1993). The efficiency of nursing home chains. *Applied Economics*, 25(1), 49–55;
Chattopadhyay, S., Heffley, D. (1994) Are For-Profit Nursing Homes More Efficient? Data Envelopment Analysis with a Casemix Constraint," Eastern Economic Journal, Eastern Economic Association, vol. 20(2), pages 171-186, Spring;
Ozcan, Y. A., Wogen, S. E., & Mau, L. W. (1998). Efficiency evaluation of skilled nursing facilities. Journal of Medical Systems, 22(4), 211–224.

[63] Nyman, J. A., Bricker, D. L., & Link, D. (1990). Technical efficiency in nursing homes. Medical Care, 28(6), 541–551.

[64] Grabowski, D.C., Feng, Z., Hirth, R, Rahman, M, Mor, V. (2013) Effect of nursing home ownership on the quality of post-acute care: an instrumental variables approach. Journal of Health Economics, 32(1): 12-21.
Hirth, R.A., Grabowski, D.C, Feng, Z., Tahman, M., Mor, V. (2013) Effect of nursing home ownership on hospitalizations of long-stay residents: an instrumental variables approach. International Journal of Health Care Finance and Economics.

[65] Huang, S.S., Bowblis, J.R. (2018) Is the quality of nursing homes countercyclical: evidence from 2001 through 2015, Gerontologist, 2018.

[66] Baum, J.A.C. (1999) The rise of chain nursing homes in Ontario, 1971-1996. Soc Forces, 78: 543-583.

low bids for contracts, elimination of minimum staffing standards and a revised payment system that allowed companies to maintain their profits without a return to government[67].

Of the total nursing home beds in 2014, 43% were for-profit, 30% were not-for-profit and 27% were municipally owned. Of those that owned by for-profit companies, 30% were large chains (Canadian Institute for Health Information, 2014). Eligibility policies, staffing requirements, payment levels and quality regulations vary within and across provinces in Canada.

In Canada, staffing standards are the responsibility of provincial governments. Three provinces require a RN Director of Nursing and seven required an RN on duty 24 hours per day. Overall, the standards for 24 hour LN nursing are higher but the direct care standards (which ranged from 1.9 to 3.0 hprd) are generally lower than in the US. Ontario, the largest province, had a number of poor quality of care reports in the 2000s which led to the introduction of the Long-term Care Homes Act in 2007. Commentators argued that this was because the legislation did not set minimum staffing standards, and this has subsequently led to the establishment by government of a public reporting system for quality inspection data in 2010[68].

The few studies which have examined the impact of ownership models in Canada have focused on staffing levels and on quality indicators. For-profit nursing homes had higher hospitalisation rates for pneumonia, anaemia and dehydration and ED use[69]. In addition, for-profit chain nursing homes in Canada had significantly higher rates of resident complaints compared with not-for-profit and public nursing homes. A study[70] found that for-profit providers in Canada, especially chains, provided significantly fewer hours of registered nurse and registered practical nurse care, after controlling for resident acuity.

England

In England, following the establishment of the National Health Service (NHS), free universal healthcare is provided to the population in hospitals, primary care, and community health services. In the 1980s the government enacted policies which led to the closure of long-stay hospitals and the growth of the for-profit private nursing home sector. The NHS and Community Care Act of 1990 devolved the funding responsibility of long-term care to local authorities and continued to transfer previously free NHS care into means-tested social care.

The growth of the for-profit private nursing home sector happened mostly in the early 2000s and this growth was driven by mergers and acquisitions funded by debt, with private equity groups attracted by stable government funded income, increasing property prices of nursing homes and advantageous demographic changes. By 2012, 52% of care homes had for-profit ownership and by 2014 this had increased further to 86%[71]. The five largest chains accounted for 35% of available

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[67] Panos, J. Crisis in care: Ontario poinieers the privatisation of long term care. Briarpatch Magazine. November 1, 2011.

[68] Canada Long Term Care Home Quality Inspection Program (http://www.health.gov.on.ca/en/public/programs/ltc/31_pr_inspections.aspx).

[69] McGregor, M.J., Tate, R.B., McGrail, K.M., Ronald, L.A, Broemeling, A and Cohen, M. (2006) Care outcomes in long-term care facilities in British Columbia, Canada: Does ownership matter? Medical Care, 44(10): 929-935.
McGregor, M.J., Abu-Laban, R.B., Ronald, L.A., McGrail, K.M., Andrusieck, D., Baumbusch, J., Cox, M.B., Salomons, K., Schulzer, M., Kuramoto, L. (2014) Nursing home characteristics associated with resident transfers to emergency departments. Canadian Journal on Ageing, 33(1), 38-48.

[70] Hsu, A.T., Berta, W., Coyte, P.C. and Laporte, A. (2016) Staffing in Ontario's long-term care homes: differences by profit status and chain ownership. Can J Aging. 35:175-189.

[71] Harrington, C., Jacobsen, F.F. Panos, J., Pollock, A, Sutaria, S. and Szebehely, M. (2017) Marketisation in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains, Health Services Insight, 10(1): 1-23.

residential beds in 2015-2016[72]. After the 2008 global financial crisis, with the decrease in property prices and income, the focus shifted to diversification and restructuring. This, in turn, lead to the separation of operations and property ownership, with the selling of less profitable homes, leasing of the property from the property companies sometimes at artificially high rates and the development of new homes in more affluent areas[73]. These companies have diversified and expanded into independent living, day care, palliative care and other services.

Local authorities are responsible for determining a person's needs and for setting eligibility thresholds for state funded nursing home services. Local authorities have discretion in contracting practices and rate setting. Exact commissioning practices vary but generally involve the following[74]:

- Commissioners negotiate with care homes that are prepared to offer services in line with the council payment rate for that locality and other conditions.
- Local authority-supported placements are then made according to these terms for individual placements. In some cases, councils may block purchase places in advance. The contractual terms require that the home meets the minimum quality standards, but they generally do not involve any considerations for higher quality beyond that level. There are no restrictions that the care home needs to be within the council's boundaries.
- Payments tend to vary by the type of care provided (dementia care receives higher payments) and the area (e.g. the London area receives higher payments). The payment rates are calculated locally by using a cost model or through negotiating (tendering) process, but details on how payment rates are calculated by local government is not made available.
- With this decentralisation, there is no central system for collecting and tracking nursing home revenues, expenditures, and staffing data. There are no requirements to publish financial data.

Demand for care homes stems from two main sources: publicly supported residents where services are commissioned by local authorities on behalf of service users and self-payers (those who do not qualify for public support), with the latter making up 40-45% of demand. The publicly supported market is a quasi-market[75]. There is a wealth-based means-test whereby people with eligible assets (including housing assets for single person households) below a certain threshold receive council financial support. All of those above the threshold become self-payers[76]. Self-payers have more freedom to choose homes at their preferred price-location/type-quality point, but most homes currently operate with a mix of self-pay and local authority residents, with an increasing minority focusing on self-payers only. At March 2016, 47.5% of care home residents had their fees paid fully or partially by local authorities. Around 25% of care homes have over 75% of residents placed by local authorities[77].

[72] Ibid.

[73] Burns, D., Hyde, P.J., Killett, A. (2016), How financial cutbacks affect the quality of jobs and care for the elderly, Industrial and Labour Relations Review, 69(4): 991-106.

[74] LaingBuisson, (2012) Care of the Elderly People UK Market Survey: London, UK: LaingBuisson
LaingBuisson (2013a) Domiciliary Care UK Market Report, London, UK: LaingBuisson
LaingBuisson (2013b) Laing & Buisson release latest in-depth analysis of the care home sector. Press Release, London, UK, January 17
LaingBuisson, Care of Older People UK Market Report. 27th ed. London, England, LaingBuisson: 2016.

[75] Bartlett W., Propper C., Wilson D., Le Grand J., editors. Quasi-Markets in the Welfare State. SAUS Publications; Bristol: 1994.

[76] Wanless D., Forder J., Fernandez J.-L., Poole T., Beesley L., Henwood M., Moscone F. Securing Good Care for Older People: Taking a Long Term View, King's Fund; London: 2006.

[77] LaingBuisson, Care of Older People UK Market Report. 27th ed. London, England, LaingBuisson: 2016.

In 2017, the UK Government published a Care Homes Market Study[78], conducted by the Competition and Market Authority and they reported that the average fees paid by local authorities were 10% less than the total cost of providing care, amounting to a £200 million to £300 million shortfall in funding. To counteract this, care homes were charging self-funders around 40% more than they charge for UK council-funded placements[79]. The self-pay market is growing at a faster rate than the State-paid counterpart, a trend that is expected to continue, with local authority-funded operators increasingly repositioning their care homes to cater for private clients.

Multiple concerns regarding the standard of care homes owned by corporate chains arose after reports from the Southern Cross facility. This large nursing home chain became bankrupt, in part related to separating its operations from its property and, a lack of capitalisation. This led to a review by the National Audit Office in the UK of the five largest chains to ensure that there were a sufficient number of providers to ensure market stability.

Care homes are now regulated by the Care Quality Commission (CQC). This includes requirements for owners and managers of providers and sets out the fundamental standards which providers must adhere to and not fall below, including the financial position of the providers and statement of purpose. In 2016, the Care Quality Commission inspection reports found that 9% of homes provided inadequate care and 32% needed improvement[80].

The fundamental standards monitored by the CQC do not include specific requirements as to the minimum number of staff or ratio of skill mix. The UK Department of Health, however, has published some standards on staffing in nursing homes. It states that "*actual staffing numbers and skill-mix of qualified and unqualified staff must be appropriate to the assessed needs of the service users, the size, layout, and purpose of the home at all times*"[81]. These standards also require sufficient numbers of domestic staff to meet resident's needs for nutrition and cleanliness, with a minimum of 50% trained to total staff members. They state that the registered manager must be qualified with either a National Vocational Qualification at Level 4 or is a first-level RN with a management qualification, and must be registered with the National Care Standards Commission. Minimum hours of care or ratios of care are not specified in the national regulations. The UK Royal College of Nursing published guidelines for nursing homes with a staff to patient ratio of 1:5 for early shifts, 1:6 for late shifts and 1:10 for night shifts with an average of 35% RNs and 65% care assistants[82].

Until recently, the evidence as to the impact of staffing on quality in England is mostly descriptive. A UK Royal College of Nursing report surveyed nurses working in care homes and highlighted that (low) staffing levels and poor skill mix impacted on the level of quality[83]. The UK Royal College of Nursing[84] reported that nursing homes had 1 staff per 4.2 residents by day and 1 staff per 8.6 residents at night per resident (equivalent to 4.26 hprd) in 2009. In terms of actual staffing hours, RNs made up 25% of total nursing staff during the day in 2009, but this had declined from 34% in

[78] Care Homes Market Survey, Competition and Market Authority: UK Government (https://www.gov.uk/cma-cases/care-homes-market-study), 2017.
[79] Ibid.
[80] https://www.cqc.org.uk/
[81] UK Department of Health (2000), Care Standards Act 2000: National minimum standards for care homes for older people (pp31-36), London.
[82] UK Royal College of Nursing (2010), Guidance on safe nurse staffing levels in the UK, London.
[83] UK Royal College of Nursing (2012), Persistent Challenges to providing quality care, London (www.rcn.org.uk/about-us/policy-briefings/pol-0812).
[84] UK Royal College of Nursing (2010), Guidance on safe nurse staffing levels in the UK, London.

2007. In 2017, an empirical study[85] was undertaken on the impact of workforce composition on quality in English care homes. Quality was assessed using the CQC quality ratings and they examined a series of workforce characteristics including nurse staffing ratios. The findings suggested that local staffing characteristics did have a significant impact on quality. Interestingly, it did not find a significant relationship between staffing ratios and quality. However, it found that nursing homes with higher levels of job vacancies and those with lower levels of staff retention had significantly lower levels of quality.

In 2014 the impact of competition on quality and price in 10,000 nursing homes in England was studied[86]. Using Instrumental Variable estimates, they found that quality and price were reduced by greater competition. Further analysis suggested that the negative quality effect worked through the effect of price. In other words, higher competition reduced revenue, which in turn reduced quality. The authors did not analyse the results based on ownership type.

Sweden

In Sweden, a trend towards marketisation in long-term care occurred in two waves. Legislative change in 1992 made it possible for municipalities to contract out nursing home provision to private actors including for-profit companies[87]. This was followed in 2009 by the introduction of new legislation in more than half of Swedish municipalities. This was to facilitate the introduction of "choice models" where private but not public providers can offer top-up services (and pay half the price with their tax rebate). In both instances the expectation was that competition would reduce costs, improve quality, and stimulate the public sector.

Sweden is an interesting case in the sense that virtually all nursing home care is still provided through a publicly regulated and tax-funded system, even though actual services are carried out by a mixture of public, not-for-profit, and for-profit providers (some of which are private equity companies)[88]. In Sweden, nursing home care is provided by 290 local governing municipalities. Services are funded by the municipalities through local taxation. Sweden's care system is based on universality meaning that all citizens have access to publicly funded nursing home care services at heavily subsidised rates. User fees have a maximum ceiling and are tied to income.

Needs assessment is carried out by social workers from the municipal social service authorities. This means that private providers cannot themselves decide which users to accept, but are obliged to take all users placed by the municipality. It is also the municipality that decides where an elderly person is to receive their care, meaning that private operated homes have the same casemix as public homes, a condition rarely found in other countries. While the operation of nursing homes is contracted out, the nursing homes in most cases are still owned by the municipalities. Swedish law also stipulates that the staff employed at the nursing home must retain their employment for at least a year after a new provider takes over the operations. Contracts are typically 3-4 years in

[85] Allan S, Vadean F. The Impact of Workforce Composition and Characteristics on English Care Home Quality, Preliminary Results, PSSRU Discussion Paper DP2929, 2017.

[86] Forder, J., Allan, S. (2014) The impact of competition on quality and prices in the English care homes market, J Health Econ, 34: 73-83.

[87] Erlandsson, S., Storm, P., Stranz, A, Szebehely, M. and Trydegard, G.B. Chapter 2. Marketising trends in Swedish eldercare competition, choice and calls for stricter regulation. In Meagher, G and Szebehely, M. eds. Marketisation in Nordic Eldercare: A Research Report on Legislation, Oversight, Extent and Consequences (Stockholm Studies in Social Work 30). Stockholm, Sweden: Stockholm University: 2013.

[88] Winblad, U., Blomqvist, P. and Karlsson, A. (2017) Do public nursing home care providers deliver higher quality than private providers: Evidence from Sweden. BMC Health Services Research, 17:L 487.

duration, with the possibility of a single extension. In Sweden, there are no staffing standards for staffing ratios or for any specific skillmix[89].

In Sweden, the nursing home market is heavily consolidated. In 2012, four private equity companies controlled 52% of the private market, representing 11% of the total market[90]. Attendo is the largest care company in Sweden (and Finland) and developed from a home-care company in a Swedish municipality in 1985 to being owned by private equity companies between 2005 and 2015, and being listed on the stock market in 2016[91].

Nursing home chains increasingly evolved to building their own homes and selling beds back to various municipalities. For example, Attendo has built homes in cooperation with construction and real estate companies that own the properties, and lease the buildings to Attendo, normally for 10-15 years. Attendo contracts with the municipalities to provide nursing home care and the municipalities pay for the building costs. Prior to this, when privately provided residential care was outsourced after competitive tendering, it made it relatively easier for a municipality to end a contract if they were not satisfied with quality. Now if municipalities wish to end contracts with privately owned homes they must find new homes for residents, similar to situations in Canada, UK, and US. The more nursing homes that are built by private companies the more dependent the municipalities are on their contribution.

Overall, despite the increases in private provision of nursing homes in Scandinavian countries, it is still fairly small (40%). Notwithstanding this, it is a source of heated debate in Sweden, where a majority of the general public are against profit making in welfare services, with the view that firms that are primarily profit-driven will cut back on quality (especially when this is difficult to measure and monitor) and that they are more likely to reduce the staff-resident ratio or design the business to attract service users associated with lower costs[92]. This assertion, however, is strongly countered by private corporations who argue that private provision is necessary for choice, diversity, innovation, quality, and financial sustainability.

In Sweden, there is some evidence of cost saving from the first generation outsourcing (price competition) but not the later introduction of choice models. Bergman et al[93] examined the relationship between ownership and cost during the period 1990-2004 to see if introducing private provision of nursing home care as well as competition in the delivery of care had an effect. The authors used mortality, measured at the municipal level, to identify non-contractible quality to see what impact privatisation had on this variable. They found that opening to private provision increased non-contractible quality without an increase in the cost per resident.

The few studies that were conducted in Sweden looking at differences in performance between privately and publicly operated nursing homes have revealed a similar pattern to the US, particularly with regard to the staffing levels and other structural quality indicators such as staff education and

[89] Winblad, U., Blomqvist, P. and Karlsson, A. (2017) Do public nursing home care providers deliver higher quality than private providers: Evidence from Sweden. BMC Health Services Research, 17:L 487.

[90] Ibid.

[91] Szebehely, M. (2018) Nordic eldercare in the time of privatization; experiences from Sweden, March 2, Stockholm University.

[92] Szebehely, M. (2018) Nordic eldercare in the time of privatization; experiences from Sweden, March 2, Stockholm University.

[93] Bergman, M.A., Johansoon, P., Lundberg, S., Spagnolo, E. (2016) Privatization and Quality: Evidence from Elderly Care in Sweden, Journal of Health Economics, 49: 109-119.

full-time employment[94]. On the other hand, these studies found that private providers performed better than public counterparts on process-based quality indicators, for example the proportion of residents participating in the formulation of their care and the proportion of residents offered different food alternatives.

More recently, a research study[95] investigated the relationship between ownership and care quality in Sweden and found similar results. The results indicate that public nursing homes have higher quality than privately operated homes with regard to staffing levels (employees per resident) and individual accommodation. However, privately owned nursing homes tend to score higher on process-based quality indicators such as medication review and screening for falls and malnutrition. No significant differences were found between the different subcategories of privately operated nursing homes.

Some commentators have suggested that this better performance in process-based indicators is due to incentives that Sweden introduced for screening routines for risks such as fall prevention and pressure ulcers and the assumption that private owners may be more sensitive to such incentives. As well as some evidence of lower levels of staffing, training and permanent employment in for-profit care is also lower and this is lowest in the largest corporations. There are no differences in user satisfaction. The measures and findings are contested, and the author of this study concluded that ownership may play a role in nursing home care quality but the way in which it matters depends on the definition of quality.

Norway

Norway has a universal health care system that includes long-term care fully funded by the State. In 2014, Norway's municipalities owned and operated over 90% of nursing homes while 4% were operated by for-profit and 5% by not-for-profit companies[96]. The privatisation of nursing home services occurred in the late 1990s, inspired by new public management and the example of Sweden, as a way to increase competition. This resulted in competitive tendering by for-profit nursing homes which are operated by chains which are subsidiaries of large international corporations, and these are mostly located in the largest cities[97]. The municipalities have the autonomy to plan, spend and coordinate long-term care services but they are also influenced by national legislation, regulations, judicial decision and block-grant funding[98].

Municipalities differ widely in per capita income, age composition, geographic conditions and property taxes and block grant funding. Therefore, eligibility criteria, service benefits and obligations vary across municipalities. While some local authorities use fee-for-service

[94] Stolt, R, Blomqvist, P., Winblad, U., (2011), Privatisation of social services: quality differences in Swedish elderly care, Soc Sci Med, 72: 560-7. The National Board of Health and Welfare (NBHW), Public or private ownership, does it matter? A comparison of providers with eldercare, Stockholm, 2012.

[95] Winblad, U., Blomqvist, P. and Karlsson, A. (2017) Do public nursing home care providers deliver higher quality than private providers: Evidence from Sweden. BMC Health Services Research, 17:L 487.

[96] Statistics Norway, Nursing and Care Services, 2013, preliminary figures, Oslo, Norway, July 2014.

[97] Herning, L. (2012) Konkurranseutsatte sykehjem i Norge, Notat 1, 2012, ISBN 978-82-92, 515-11-1.
Vabo, M. Christensen, K., Traetteberg, H.D. and Jacobsen, F.F. (2013a) Marketisation in Norwegian Eldercare. Oslo: Nova Norwegian Social Research
Vabo, M., Christensen, K, Jacobsen, F.F. and Traetteberg, H.D. (2013b) Marketisation in Norwegian Eldercare: preconditions, trends and resistance. Chapter 5. In Meagher, G and Szebehely, M. (2013) Marketisation in Nordic Eldercare. A Research Report on Legislation, Oversight, Extent and Consequences. Stockholm Studies in Social Work No. 30. Stockholm: Stockholm University, 163-197.

[98] Vabo, M. Christensen, K., Traetteberg, H.D. and Jacobsen, F.F. (2013a) Marketisation in Norwegian Eldercare. Oslo: Nova Norwegian Social Research.

reimbursement and/or take resident casemix into account when paying the nursing homes, the majority do not[99]. Local authorities are obliged to use competitive tendering for services operated by for-profit providers but not for contracts with not-for-profit providers (based on EU law).

Payment data is not made available for any nursing homes as they are considered confidential and proprietary. There is little by way of formal standards for staffing levels or competence except that they are required to have a medical doctor and a registered nurse on hand 24/7 with "sufficient staffing"[100]. Some municipalities have unofficial standards. For example, in Bergen, the standard is a ratio of 0.94 FTE workers for each resident, including all nurses, domestic staff and managers. Nursing homes also unofficially require a Director of Nursing who is a registered nurse and a charge nurse to be responsible regardless of the size of the nursing home. Some studies that have sought to measure actual staffing levels have found 0.79 FTE per resident[101] and 54 FTE per 200 residents[102].

Norway has no national system for quality indicators, but municipalities are encouraged to map quality and to conduct surveys of residents, family, and staff. Of the small percentage of private nursing homes, there is constant debate and concerns about profit making. Since 2005, there has been a shift away from a dominance of private equity companies primarily because of nursing home scandals and rumours of stricter government regulations. Following these scandals in for-profit chains, the city governments of Oslo and Bergen, the two biggest cities in Norway, decided not to renew management contracts with for-profit chains in the care sector. Unlike in Sweden, municipalities own the nursing home buildings and material assets so operators, whether public or private do not have to pay rent, and this also makes it easier to end contracts.

Relevant literature from other countries

A study[103] was undertaken in 356 nursing homes in Switzerland in the period 1998-2002-wherein the authors conducted stochastic frontier analysis (SFA) and found that public nursing homes were the least efficient (where the output variable used was total patient days), followed by not-for-profit nursing homes and that for-profit nursing homes are the most efficient. However, in another study[104] from Switzerland, also using SFA, examined nursing home performance across varying institutional form and regulatory environments in operation across Swiss cantons in 1998. It assessed 835 nursing homes including 93 for-profit, 530 private, not-for-profit, and 212 public nursing homes. It found that public nursing homes are just as cost efficient as private nursing homes (it also used total patient days as the output variable).

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[99] Vabo, M. Christensen, K., Traetteberg, H.D. and Jacobsen, F.F. (2013a) Marketisation in Norwegian Eldercare. Oslo: Nova Norwegian Social Research

Vabo, M., Christensen, K, Jacobsen, F.F. and Traetteberg, H.D. (2013b) Marketisation in Norwegian Eldercare: preconditions, trends and resistance. Chapter 5. In Meagher, G and Szebehely, M. (2013) Marketisation in Nordic Eldercare. A Research Report on Legislation, Oversight, Extent and Consequences. Stockholm Studies in Social Work No. 30. Stockholm: Stockholm University, 163-197.

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[103] Farsi, M., Filippini, M., Lunati, D. (2008). Economies of scale and efficiency measurement in Switzerland's nursing homes, Swiss Journal of Economics and Statistics, 144(3): 359-378.

[104] Crivelli, L., Filippini, M., Lunati, D. (2002). Regulation, ownership and efficiency in the Swiss nursing home industry, International Journal of Health Care Finance and Economics, 2(2): 79-97.

In Italy, a study[105] investigated efficiency and quality of care in 6 public and 34 private nursing homes by means of data envelopment analysis (DEA). Efficiency of nursing homes that deliver their services in the north-western area of the Lombardy Region was assessed over a 3-year period (2005-2007). Lombardy is a very peculiar setting, since it is the only Region in Italy where the healthcare industry is organised as a quasi-market, in which the public authority encourages managed competition by purchasing health and nursing services from independent providers, establishing a reimbursement system for this purpose. The reimbursement of nursing homes in this region is defined in part on the basis of staff to resident ratios. The results of this study indicate that private nursing homes outperform public nursing homes on efficiency (the variables measured included casemix, extra nursing hours and out-of-pocket charges) but the results also suggest that the gap is closing. The authors suggest that the greater ability of private nursing homes to adjust their staff to resident ratios may explain their better performance noting that the public nursing homes are experiencing more difficulties because of the organisational inertia at changing and the negotiations with labour trade unions.

Temporality has been investigated in some studies by examining conversions between ownership types. Longitudinal research from the US[106] and Sweden[107] found that nursing homes converting to, for-profit ownership demonstrated a subsequent decline in some quality measures. Nursing homes converting from, for-profit to not-for-profit status, generally exhibit improvement before and after conversion. A challenge in drawing conclusions from this research, however, is the potentially confounding effect of unmeasured differences in nursing homes that choose to convert compared to those who do not.

Relevant literature from Ireland

Available evidence from Ireland focuses on the 2008-2009 period with data taken from a survey of nursing homes across Ireland[108]. The authors set out to estimate the technical efficiency of 39 public and 73 private nursing homes in Ireland using data envelopment analysis (where they measured ownership type, casemix, location, quality, total patient days, staffing and number of beds). In general, they reported that Irish nursing homes are less technically efficient and more scale efficient than reports from other countries. Their analysis concluded that the efficiency determinants included type of ownership (private nursing homes were less efficient than public) and the size of the nursing home (positive effect). In proposing explanations for their result that public nursing homes were more technically efficient than private nursing homes, the authors put forward three possible explanations (1) that the state subsidy for the provision of contract beds, which was in operation at the time, protected the nursing homes from the need to minimise costs and produce efficiency (2) that the Government policy of introducing capital allowances to stimulate private delivery could have led to the self-selection of "inefficient" homes into the private nursing home

[105] Garavaglia, G., Lettieri, E., Agasisti, T., Lopez, S. (2011). Efficiency and quality of care in nursing homes: an Italian case study, Health Care Management Science, 14(1): 22-35.

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[108] Luasa, S.N., Dineen, D., Zieba, M. (2018) Technical and scale efficiency in public and private Irish nursing homes: a bootstrap DEA approach. Health Care Management Science, 21(3): 326-347.

sector and (3) that the private sectors substitution of nursing staff for non-medical staff may in fact lower efficiency.

6.5 Conclusion

Marketisation and privatisation of nursing home care has been the choice of many countries to address their long-term care needs. These countries are at different points along the continuum of privatisation, with different approaches to the delivery, financing, and oversight of nursing home care.

The extensive use of markets and private providers, often with a high degree of public funding, are characteristics of the nursing home industry in many countries. Despite this, there is a relatively small pool of literature investigating whether markets in long-term care 'work', and whether promoting competition is a beneficial policy. The research tends to paint a mixed picture.

There is some evidence internationally that when health care providers face fixed reimbursement rates from State sources, they may adjust staffing to deliver care within a given cost structure. The assumption that ownership type may exert influence on quality in nursing home care is supported by research in the field. Research on nursing home quality has so far been undertaken primarily in the US. There are, however, a small number of studies conducted in Sweden which have compared performances between privately and publicly operated nursing homes. The results of these indicate a similar pattern as that in the US, namely that not-for-profit nursing homes have higher staffing levels, lower staff turnover and better trained staff compared to for-profit providers. They also have better quality outcomes, such as lower prevalence of pressure ulcers, less use of physical restraints, less hospitalisation, and fewer deficiencies in governmental regulatory assessments.

Three systematic reviews concluded that for-profit nursing homes had poorer quality than not-for-profit-owned nursing homes. One large meta-analysis found that two outcomes were significantly better in not-for-profit owned nursing homes, higher quality staffing and lower pressure ulcer prevalence. Results for two other outcomes were non-significant, deficiencies in government regulatory assessments and lower physical restraint use.[109]

While the prevailing evidence suggests that changes in nursing home markets have resulted in negative consequences in relation to quality of care, there is contradictory evidence on whether this has led to reduced overall costs.

Although much of the focus has been on the differences between for-profit and not-for-profit nursing homes, this simple distinction has become less useful in recent years as companies have employed more complicated ownership and management structures. As large nursing home chains and companies grow in dominance in the marketplace and political arena, governments have less control over the amount, type, and quality of nursing home and related long-term care services. Due to municipal ownership of nursing home properties, Norway is currently able to limit the growth

[109] Comondore, V., Devereaux, P., Zhou, Q., Stone, S., Busse, J., Ravondran, N., Burns, K., Haines, T., Stringer, B., Cook, D., Walter, S., Sullivan, T., Berwanger, O., Bhandari, M., Banglawala, S., Lavis, J., Petrisor, B., Schunemann, H., Walsh, K., Bhatnagar, N and Guyatt, G. (2009) Quality of Care in For-Profit and Not-for profit Nursing Homes: Systematic Review and Meta-analysis. British Journal of Medicine, 339, b2732.
Hillmer, M.P., Wodchis, W.P., Gill,. S.S., Anderson, G.M. and Rochon, P.A. (2005) Nursing Home profit status and quality of care: is there evidence of an association? Med Care Res Rev, 62 (2):139-166.
Xu, D, Kane, R.L., Shamliyan, T.A. (2013), Effect of nursing home characteristics on resident's quality of life: a systematic review. Archives of Gerontology and Geriatrics, 57(2): 127-142.

of for-profit chains and control its contracts for nursing home services. As governments become more dependent on large nursing home chains for services, they are less able to terminate contracts, remove residents from poorly performing nursing homes, ensure that standards are maintained, and control the costs of care.

A comprehensive or robust evidence base to demonstrate the effectiveness of minimum staffing standards is lacking. While most countries have noted the importance of staffing and skillmix and acknowledge that it should be based on the needs of clients, nursing standards, actual staffing hours, levels of education and training are not readily available in the case of most nursing homes. Given the growing evidence that nurse staffing levels make a difference to care quality in nursing homes, this lack of basic information is a matter of growing concern. Most countries do not take acuity into account in their guidelines or regulations and the research shows that actual staffing levels is often lower than recommended and not aligned with client needs. Therefore, data should ideally be collected on resident acuity and their individual needs along with facility size and type. More cost-effectiveness studies and simulation studies are necessary to better inform nursing homes of different options of staffing mix and level and their financial impacts.

As a result of differing results between studies and between countries, it is important to aggregate and review studies systematically at national and European level to gain more definitive conclusions about differences in the accessibility, quality, and efficiency of services.

Overall, a lack of government information on the ownership, costs, and the quality of services provided by nursing homes make it challenging to conduct robust studies exploring causal links between ownership models and efficiency. To better monitor the extent of public and private provision, it is essential to have clear common definitions that allow gathering data on the different types of long-term care services and providers. Definitions and data about public, for-profit and non-profit provision should consider the legal status, ownership, and economic activity of providers. Studies that document differences between the types of providers should document whether improvements in one area come at the expense of others.

A core driver behind changes in the nursing home market is, tighter budget constraints, and the hope of achieving cost savings from the stronger incentives linked to private ownership and competition. However, it is because of these incentives, it can be hard to achieve and maintain appropriate quality levels and this is particularly true where it is hard to define, measure and verify quality dimensions of the services contracted. One potential solution to improve the reliability of efficiency measurements in nursing homes is to establish a minimum list of quality indices that cover the quality-of-care domains and quality of life of residents, and ensure that these are regularly collected as part of nursing administration processes. It should be noted that the Expert Panel has recommended the development of an Outcomes Framework for Nursing Homes considering the Nursing Metrics and the Hospital Patient Safety Incidents Reporting. Early scoping work for a policy project on this topic has commenced.[110]

If competition is pushing prices down, such that providers are producing services at minimum quality, but this quality is acceptable to policy makers, then greater competition might be

[110] COVID-19 Nursing Homes Expert Panel Final Report, August 2020, Department of Health

interpreted as beneficial. However, such an interpretation can only be sustained if there is confidence that the (non-market) actions of the regulator are sufficient to maintain minimum quality levels. Without robust regulation, and a change in public commissioning behaviour, quality could deteriorate below acceptable levels.

While DEA has been the most popular method (as it easily accommodates multiple outputs and inputs), its drawbacks lie in its deterministic nature (i.e., no statistical error term) and its inability to account for the potential effects of other variables on the production process (i.e., the position of the production frontier).

Stochastic Frontier Analysis can deal with these limitations, but it is more limited in the inclusions of multiple inputs and outputs, unless a distance function approach is applied. It is therefore important that researchers use both methods and conduct extensive sensitivity analyses around the assumptions of functional form and statistical error, and, ideally, different definitions and measurement of inputs, outputs, and quality. For instance, efficiency scores and ranking resulting from estimation with and without quality measurement can be compared and contrasted to highlight the domains where quality can be improved. This method will allow for an in-depth understanding of the source of true inefficiency versus statistical and measurement errors. Only when this practice is applied consistently and widely in efficiency analyses of nursing homes will performance scores and ranking become relevant to business managers and policy makers in the aged care sector.

Chapter 7: Conclusions and Recommendations

7.1 Introduction

As outlined in Chapter 1 this VFM Review is not a review of the NHSS per se, but rather an analysis of the price/cost differential that exists between the public and private nursing home sectors. Overall, the Review Team found that additional data is required before a conclusive determination can be made as to whether the price/cost differential is justified. Some of the data required is either not currently obtainable, such as private sector financial data; or does not currently exist, as is the case of levels of dependency of residents.

Therefore, the recommendations in this chapter are largely formulated with the intention of putting in place mechanisms that will provide greater clarity and transparency around the components of nursing home care costs and enable the allocation of NHSS resources to best meet care needs.

7.2 Recommendations

Recommendation 1: An inter-agency project team, with the range of expertise required, should be established to drive the delivery of the recommendations.

The Steering Committee has brought forward a range of recommendations that are substantial and would likely require primary legislation and substantial redevelopment of the NHSS. The first recommendation proposes the establishment of an inter-agency project team, with the range of expertise required, in order to drive the delivery of the other recommendations. The work arising from these recommendations would involve significant research, policy analysis and development work, and a wide-ranging mix of clinical, economic, and legal input.

Recommendation 2: The NTPF and Department of Health should explore a potential change to the Deed of Agreement between the NTPF and private operators to allow for the sharing of the information collected by the NTPF with the Department. It is likely that a change in the legislation would be required to facilitate this. A clearly defined process would need to be agreed to provide reassurance to the sector with regards to the purpose, use and availability of the data transferred, with safeguards in place to protect any commercially sensitive information.

Rationale: The Review's remit of comparing the cost differential was hampered by the lack of comparable private sector financial data. While the NTPF collect this information during price negotiations, it was not releasable to the Department on the basis that the Deed of Agreement between private operators and the NTPF makes no provision for this. The NTPF obtained legal advice that to do so may be considered breach of contact. However, it is reasonable that the Department, as the funders of the Scheme and the body with responsibility for policy making, should have sight of all relevant information.

Recommendation 3: The interRAI Single Assessment Tool should be rolled out nationally, along with a set of national operational policy and guidelines, to determine the care needs of the applicants to the NHSS. Within a defined period of time (determined by the Department) care needs assessments used to determine funding under the NHSS should be undertaken using the interRAI Single Assessment Tool.

Rationale: It has long been assumed that public nursing homes have a larger cohort of higher dependency/high complexity residents than their private sector counterparts. This assumption is based on anecdotal evidence only as there is no single assessment tool used to determine the individual care needs of residents in nursing homes. The study, undertaken as part of this Review attempted to test this assumption, found no discernible difference in care needs between the sectors. However, as this study involved only around 1% of the total cohort of residents participating in the NHSS it cannot be considered in any way representative. The study does however illustrate that the InterRAI tool, if used in a much larger representative study, or national roll out, would help to determine if differences in care needs exist on a sectoral basis.

Recommendation 4: A programme of work should be established to examine and develop, as appropriate, a model for the allocation of resources through the use of Resource Utilisation Groups to align resources/payments to care needs. This should include an examination of international evidence and best practice and should include a comprehensive capture of data using the interRAI assessment tool for a minimum period to determine a baseline profile of care needs in residential care settings. Work on such resource allocation models should fully align with development work being undertaken with regard to the development of the statutory home support scheme.

Rationale: The use of a standard tool would better allow the Department to align resources more closely to individual care needs. The interRAI Single Assessment Tool is currently being piloted in a number of acute hospitals to determine the care needs of patients who are unable to be discharged without some level of support. Periodic use of the tool in a residential setting would provide a platform for measuring care outcomes, which this Review has not been able to sufficiently address due to lack of existing data. Periodic assessment will highlight changes in levels of dependency/acuity and provide for realignment of resources where necessary.

Ideally, payments should be structured to reflect the costs associated with meeting individual care needs. The Resource Utilisation Group function of the interRAI Single Assessment Tool allows for the creation of multiple price bands linked to care needs. However, in order to effectively create these price bands, a detailed understanding of care needs must be established. Therefore, it is likely that at least two years of periodic SAT assessments would be required in order to build a meaningful profile of costs.

Recommendation 5: The Safe Staffing and Skill Mix Framework for Residential Care should be agreed as a priority.

Rationale: Based on the information available, the biggest drivers of the cost differential are staffing levels and skill mix. Public nursing homes, on average, have approximately 2.5 times as many nurses to residents as private nursing homes. While HIQA have a responsibility for ensuring that staffing levels are sufficient, there is no national framework currently in place that illustrates the appropriate number of staff, and skillmix. While the Safe Staffing and Skillmix Framework for Residential Care will rightly focus on the quality of care delivered, it will also be a valuable tool from a value for money perspective in ensuring that staff resources are closely aligned with the needs of residents.

Recommendation 6: An extensive review and audit process be established as a matter of urgency to examine the operation, costs, staffing, rostering, use of agency staff and cost assignment in public nursing units prioritising the most expensive nursing homes. The process should be supported by external expertise as required. Cost improvement measures should be a key outcome along with recommendations for future use and/or alternative service models where costs improvement measures cannot be achieved.

Rationale: The international evidence offers compelling reasons for the continued provision of public nursing homes. However, the cost of care in public nursing homes can vary widely. Even with higher costs of care, some public nursing homes are incurring costs significantly higher than the maximum cost of care they can charge to the NHSS. Largely following the Pareto 80/20 rule, the 20% most expensive public nursing homes account for approximately 80% of the variance (83% of net overspend, 73% of gross overspend). Therefore, a focus on reducing the cost overruns in the most expensive nursing homes via an audit process, would aim to address the majority of the overall overspend in public nursing homes. Ideally an audit should include a number of public nursing homes that operate within their maximum cost of care to allow for comparison and possible benchmarking.

Recommendation 7: The published cost of care for public nursing homes should be explicit whereby the cost of care referred to is the maximum cost of care that can be charged to the NHSS. For the purposes of transparency, a list showing the actual eligible costs incurred by each nursing home, highlighting any variances against the maximum cost of care, should be published shortly after the end of each financial year.

Rationale: While it is appropriate that the HSE, at a national level, sets the maximum cost of care as it deems reasonable for each public nursing home, the majority of public nursing homes are incurring costs greater than this. The published cost of care, which shows the maximum costs chargeable to the NHSS, could be misconstrued as a reflection of the actual costs public nursing homes are incurring per resident per bed per week. For the purposes of transparency, a separate list which clearly shows the cost variances should be published shortly after the end of each financial year.

Recommendation 8: The Department of Health and the HSE should examine if a cohort of existing long-term care residents supported under the NHSS could have remained at home for longer had the right package of supports been available.

Rationale: There is a general consensus that a cohort of people who are supported by the NHSS for their long-term residential care needs, may, with the right level and arrangement of supports, have been able to remain at home for a longer period. The HSE and the Department, in the context of a future Statutory Home Support Scheme, should examine if this situation can be substantiated. Ideally, the cohort should be residents recently admitted to a nursing home. From there, establish what type and level of support would have been required to keep this cohort at home and determine if a value for money case exists.

Recommendation 9: The recommendations of this review should be implemented having regard to the recommendations of the final report published by the COVID-19 Nursing Homes Expert Panel on 19 August 2020.

Rationale: The Expert Panel's report, which was published on 19 August 2020, contained a range of recommendations in line with lessons learned from the response to the COVID-19 pandemic and international best practice, aimed to safeguard the residents in nursing homes over the next 12-18 months and into the longer term. The recommendations of this VFM Review should be considered in tandem with those of the Expert Panel.[111]

[111] Appendix 9

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Appendix 1: Membership of the Steering Committee

Tom Ferris	Senior Economist, Dept of Transport (retired) **Chair**
Kevin Colman	Vote Management, Department of Heath
Matthew Hornsby	Older Persons Services, Department of Health
Deirdre Collins	Health Vote, Department of Public Expenditure and Reform
Joe Carroll	Financial Controller, National Treatment Purchase Fund
Janette Dwyer	Assistant National Director, Older People and Palliative Care Strategy, Health Service Executive
Dr Sheelagh Connolly	Research Officer, Economic and Social Research Institute
Eoin Halpin	Financial Performance Unit, Department of Health

Previous members

Judith Meirmans	Health Vote, Department of Public Expenditure and Reform
Karl Duff	Older Persons Services, Department of Health
Michael Fitzgerald	Assistant National Director, Older People and Palliative Care Strategy, Health Service Executive
Jessica Lawless	Health Vote, Department of Public Expenditure and Reform

Appendix 2: Cost Components in Respect of Care Service (Public Nursing Homes)

Nursing Homes Support Scheme Act 2009
Cost Components in respect of Care Services (Public Nursing Homes)
In accordance with section 33(2) of the Nursing Homes Support Scheme Act 2009 (No. 15 of 2009), I, Mary Harney, Minister for Health and Children, following consultation with the HSE, hereby lay before the Houses of the Oireachtas details of the goods and services which constitute care services within the meaning of paragraph (a)(i) of the definition of "long-term residential care services".
Care services within the meaning of paragraph (a)(i) of the definition of "long-term residential care services" in section 3 of the Nursing Homes Support Scheme Act 2009 shall encompass the following:

Pay Related Services

- Management/ Administration Staff directly involved in running the relevant facility
- Nursing Staff directly involved in managing and providing health and personal care services within the relevant facility
- Health Care Assistants, Attendants and equivalent grades directly involved in providing health and personal care services within the relevant facility
- Porters, Catering, Laundry and Housekeeping Staff directly involved in maintaining the relevant facility and its residents
- Maintenance/ Technical Staff directly involved in maintaining the relevant facility

The staff costs listed above shall include pay, including any overtime and allowances, and Employer's PRSI.

Non-Pay Related Goods and Services

- Basic clinical consumables, including: basic bandages; basic, non-medicated dressings; swabs; aseptic packs; syringes and needles; sterile gloves, wipes, aprons etc.; hip protectors and disposable underwear; sharps box; catheters; drainage bags and leg bags; tubing for oxygen, feeding pumps etc.
- Oxygen
- Catering
- Heat, Power and Light
- Cleaning and Washing
- Upkeep of Furniture, Equipment, Crockery and Hardware

Costs under this heading are capped at a maximum of €7,000 per annum.

- Bedding and Clothing
- General Maintenance

This item encompasses only regular maintenance works and service contracts with an annual value of €7,000 or under.

- Education and Training directly related to health and long-term care and undertaken by staff directly involved in the provision of care within the relevant facility.

This item excludes pre-registration training. It is also capped at a maximum of 4% of the gross cost of direct salaries for the relevant facility.

- Insurance (public liability, employer's liability and property)
- Audit
- Office Expenses Rent / Rates directly attributable to the relevant facility

Costs under this heading are capped at a maximum of €7,000 per annum.

- Miscellaneous

This cost category is capped at a maximum of 2% of the overall non-pay expenditure per annum in accordance with existing HSE accounting principles

Appendix 3: InterRAI Assessment Domains, Outputs and Scales

interRAI LTCF Assessment Domains	
A. Identification B. Intake and Initial History C. Cognition D. Communication/Vision E. Mood and Behaviour F. Psychosocial Well-being G. Functional Status H. Continence I. Disease Diagnoses	J. Health Conditions K. Oral and Nutritional Status L. Skin Condition M. Activity Pursuit N. Medications O. Treatments and Procedures P. Responsibility and Directives Q. Discharge Potential R. Discharge S. Assessment Information

interRAI Outputs - Status and Risk measures	
AGE BMI Cognitive Performance Scale (CPS) Depression Rating Scale (DRS) Changes in Health, End-stage Signs and Symptoms (CHESS)	Pressure Ulcer Risk Scale (PURS) Aggressive Behaviour Scale Activities of Daily Living (ADL) Long Form ADL Self-Performance Hierarchy Scale (ADLH) Pain Scale RUGS

Description of interRAI Validated Scales			
Abbreviation	**Scale Name**	**Purpose**	**Score Range**
ADLH (Morris *et al.* 2013)	Activities of Daily Living Self-Performance Hierarchy	Categorises ADL loss according to the disablement process. Early loss ADL e.g. dressing are assigned lower scores that late loss ADL e.g. eating.	0=Independent 1=Supervision required 2=Limited impairment 3=Extensive assistance (i) 4=Extensive assistance (ii) 5=Dependent 6=Total dependence ≥3 weight bearing assistance required.
CHESS (Hirdes *et al.* 2003; Hirdes *et al.* 2014)	Changes in Health, End-Stage Disease, Signs and Symptoms	Measure of health instability and frailty. Identifies individuals at risk of: health decline, hospitalisation, pain, caregiver distress, and death.	0=No health instability 1=Minimal health instability 2=Low health instability 3=Moderate health instability 4=High health instability 5=Very high health instability
CPS (Morris *et al.* 1994)	Cognitive Performance Scale	Assesses cognitive functioning	0=Intact 1=Borderline intact 2=Mild impairment

Description of interRAI Validated Scales			
Abbreviation	**Scale Name**	**Purpose**	**Score Range**
	(validated against the Mini-Mental State Examination (MMSE)		3=Moderate impairment 4=Moderate-severe impairment 5=Severe impairment 6=Very severe impairment
DRS (Martin *et al.* 2008)	Depression Rating Scale (validated against the Hamilton Depression Rating Scale and Cornell Scale for Depression)	Measures the signs and symptoms of depression	0 (no depressive symptoms) to 14 (all depressive symptoms present). >3 indicates minor-major depressive disorders.

Appendix 4: Resource Utilisation Group Categories

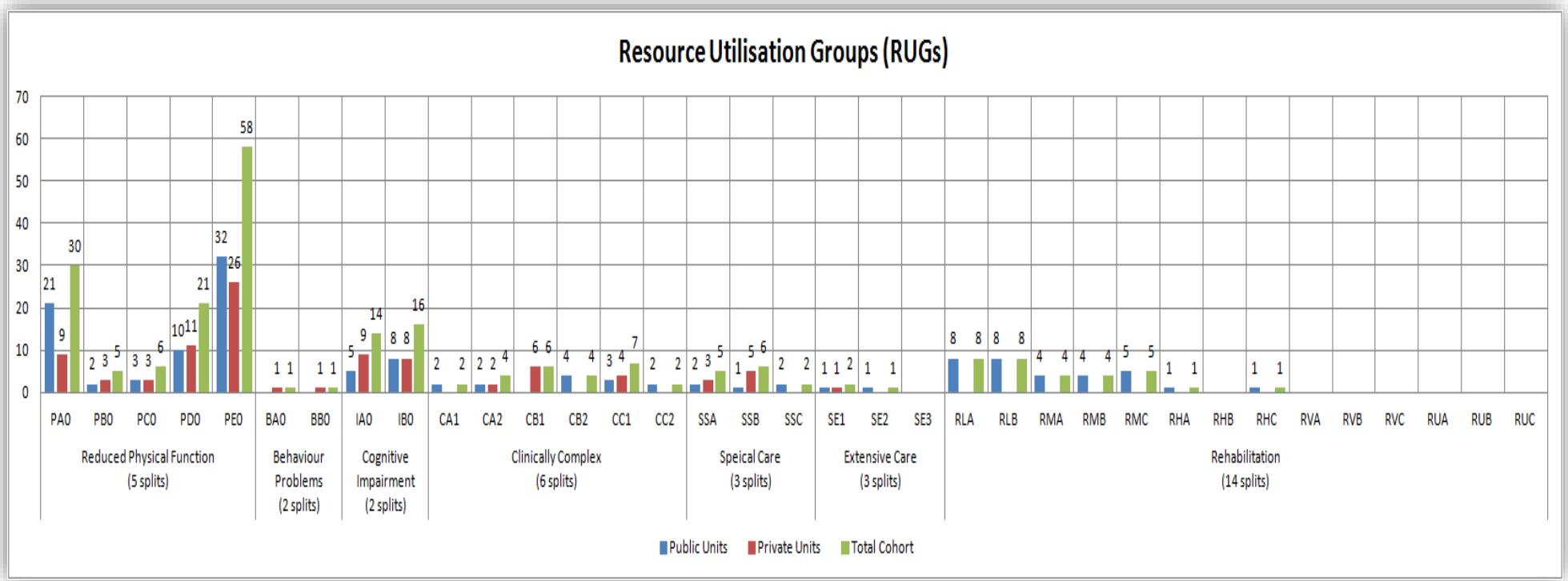
RUG-III Categories	
Group	**Qualifications**
Rehabilitation	Resident qualifies for **Ultra High Intensity Rehab** 1. 720+ minutes received across all types (Physio, OT, SLT) AND 2. 5+ days received for 1 type of therapy (Physio or OT or SLT) AND 3. (3) 3+ days received for a second type of therapy (Physio or OT or SLT) Resident qualifies for **Very High Intensity Rehab** 1. 500+ minutes received across all types (Physio, OT, SLT) AND 2. (2) 5+ days received for 1 type of therapy (Physio or OT or SLT) Resident qualifies for **High Intensity Rehab** 1. 325+ minutes received across all types (Physio, OT, SLT) AND 2. (2) 5+ days received for 1 type of therapy (Physio or OT or SLT) Resident qualifies for **Medium Rehab** 1. 150+ minutes received across all types (Physio, OT, SLT) AND 2. (2) 5+ days received across all types of therapy (Physio, OT, SLT) Resident qualifies for **Low Intensity Rehab** 1. 45+ minutes received across all types (Physio, OT, SLT) AND 2. 3+ days received across all types of therapy (Physio, OT, SLT)
Extensive Care	Resident qualifies for **Extensive Care** category on the basis of clinical indicators. 1. Parenteral/IV feedings OR IV medication OR 2. Suctioning OR tracheostomy care OR 3. Ventilator or respirator
Special Care	Resident qualifies for **Special Care** category on the basis of clinical indicators (any one sufficient) 1. Stage 3 or 4 pressure ulcer AND turning and positioning. 2. Feeding tube WITH parenteral/enteral intake AND aphasia. 3. Major skin problems or Skin tears or cuts with wound care. 4. Respiratory therapy for 7 days. 5. Cerebral palsy AND ADL score of 10 or more. 6. Fever AND vomiting OR weight loss OR tube feeding WITH high parenteral/enteral intake OR pneumonia OR dehydrated. 7. Multiple sclerosis AND ADL score of 10 or more. 8. Quadriplegia AND ADL score of 10 or more. 9. Radiation therapy.
Clinically Complex	Resident qualifies for **Clinically Complex** category on the basis of clinical indicators (any one sufficient): 1. Feeding tube WITH high parenteral/enteral. 2. Comatose AND not awake AND ADL dependent. 3. Septicaemia. 4. Burns-second or third degree (not available separately). 5. Dehydration. 6. Hemiplegia/hemiparesis and ADL score of 10 or more. 7. Internal bleeding.

	8. Pneumonia. 9. End stage disease. 10. Chemotherapy. 11. Dialysis. 12. Physician order changes on 4 or more days AND physician visits on 1 or more days. 13. Physician order changes on 2 or more days AND physician visits on 2 or more days. 14. Diabetes AND physician order changes on 2 or more days. 15. Transfusions. 16. Oxygen therapy. 17. Foot problems that limit/prevent walking. *(Depression variable used for Clinically Complex category splits)*
Cognitive Impairment	Resident qualifies for **Cognitive Impairment** category if Cognitive Performance Scale is 3 or more.
Behaviour Problems	Resident qualifies for **Behaviour Problems** category on the basis of behavioural indicators (any one sufficient) 1. Wandering occurred on 4 or more days. 2. Verbally abusive behaviour occurred on 4 or more days. 3. Physically abusive behaviour occurred on 4 or more days. 4. Socially inappropriate/disruptive behaviour occurred on 4 or more days. 5. Resident resisted care on 4 or more days. 6. Sexually Inappropriate Behaviour 4 or more days. 7. Hallucinations. 8. Delusions.
Reduced Physical Function	Resident is classified as reduced **Physical Function** if a previous hierarchical classification has not been made (Residents whose needs are primarily for activities of daily living and general supervision.)

Criteria for allocation to main RUG-III categories

Rehabilitation	↓	**Very High intensity multidisciplinary rehabilitation:** 450 minutes or more of rehabilitation therapy per week; and at least five days a week of one type of therapy; and at least two of the three therapies provided. **High Intensity rehabilitation:** 300 minutes or more of rehabilitation therapy per week; and at least five days per week of one type of therapy. **Medium intensity:** 150 minutes or more of rehabilitation therapy per week; and at least five days per week of rehabilitation therapy. **Low intensity:** 45 minutes or more of rehabilitation therapy per week; and at least three days per week of rehabilitation therapy; and at least two types of rehabilitation nursing, each provided five days per week. **Note:** Rehabilitation therapy is any combination of physical, occupational or speech therapy. Rehabilitation nursing includes: Amputation care, active/passive range of motion, splint/brace assistance; training in locomotion/mobility; dressing/grooming; eating/swallowing; transfer.
Extensive services	↓	**If the resident fails to fulfil these criteria, the next category is considered** ADL index score of at least seven and meet the following criteria: Parenteral feeding, suctioning, tracheotomy, ventilator/respirator.
Special care	↓	**If the resident fails to fulfil these criteria, the next category is considered** ADL index score of at least seven and meet at least one of the following criteria: Burns; coma; fever with vomiting, weight loss, pneumonia or dehydration; Multiple Sclerosis; pressure ulcer of stage 3 or 4; quadriplegia; septicaemia; IV medications; radiation treatment; tube feeding.
Clinically complex	↓	**If the resident fails to fulfil these criteria, the next category is considered** Meet at least one of the following criteria: Aphasia, aspiration, cerebral palsy, dehydration, hemiplegia, internal bleeding, pneumonia, stasis ulcer, terminal illness, urinary tract infection, chemotherapy, dialysis, four or more physician visits per month, respiratory therapy, transfusions, wound care other than ulcer care including active foot care dressing.
Impaired Cognition	↓	**If the resident fails to fulfil these criteria, the next category is considered** ADL score of 4 – 10 and cognition impairment in all three of the following: Decision making, orientation (recall), short term memory.
Behavioural Problems	↓	**If the resident fails to fulfil these criteria, the next category is considered** ADL scores of 4 – 10 and residents who display daily problems with the following: Inappropriate behaviour, physical abuse, verbal abuse, wandering, hallucinations.

Appendix 5: Resource Utilisation Groups Study Results



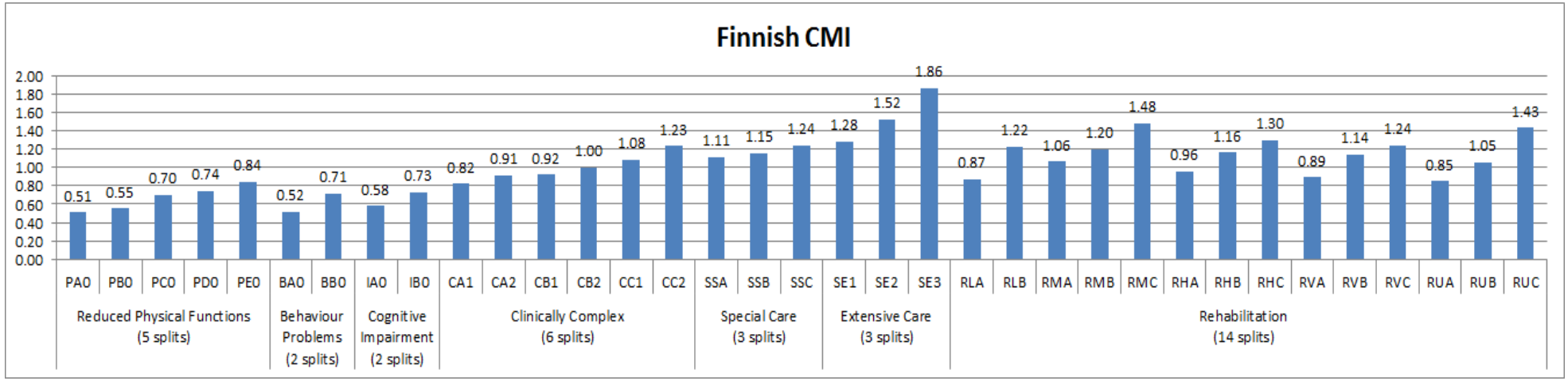
Appendix 6: Primary Diagnoses

Primary Disease Diagnoses			
Primary Disease Diagnoses	**Total Cohort**	**Public**	**Private**
Dementia other than Alzheimer's	116	63	53
Stroke / CVA	37	20	17
Parkinson's disease	24	13	11
Alzheimer's disease	21	12	9
Depression	16	12	4
Hemiplegia	11	5	6
Schizophrenia and delusional disorders	11	9	2
Problem related to life-management difficulty	11	10	1
Chronic Obstructive Pulmonary Disease	6	3	3
Diabetes mellitus	6	5	1
Intellectual Disability	5	3	2
Congestive Heart Failure	4	3	1
Degenerative disorders of the nervous system	4	2	2
Leg amputation	4	2	2
Multiple sclerosis	4	2	2
Urinary tract infection in last 30 days	4	2	2
Anxiety disorder	3	2	1
Bipolar disorder	3	2	1
Quadriplegia	3	2	1
Spinal stenosis	3	2	1
Alcohol Dependence syndrome	2	2	
Cervical disc disorders	2	1	1
Chronic renal failure	2	1	1
Fibromyalgia	2	2	
Hip Replacement	2	1	1
Osteoporosis	2	1	1

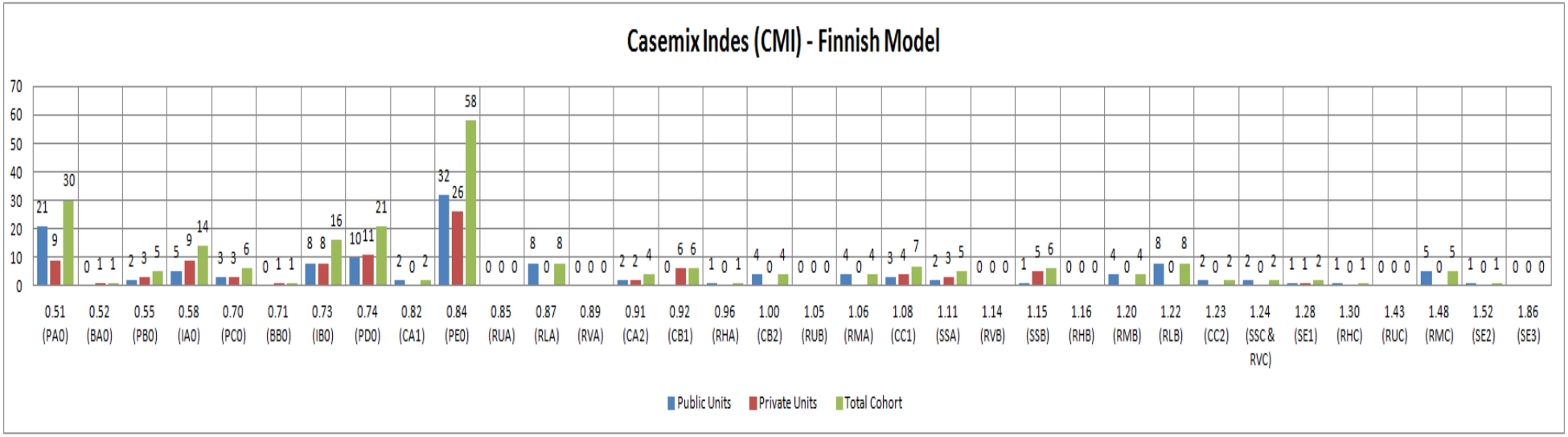
Primary Disease Diagnoses			
Primary Disease Diagnoses	**Total Cohort**	**Public**	**Private**
Paraplegia	2	2	
Cancer	1	1	
Deep Vein Thrombosis	1	1	
Encephalitis due to herpes	1	1	
Dissociative disorders	1		1
Fracture of femur	1	1	
Low back pain	1		1
Macular degeneration (Kuhnt-Junius)	1	1	
Other fracture during last 30 days	1	1	
Recurrent falls	1	1	
Reduced mobility	1	1	
Epidural haemorrhage	1		1
Septicaemia	1		1
TOTAL	**322**	**192**	**130**

Appendix 7: Finnish Casemix Index

Finnish CMI / RUGs



VFM Data / CMI / RUGs



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Health Division

27th February 2019

Eoin Halpin

System Financing and Value Unit

Dept. of Health

Block 1

Miesian Plaza

50-58 Baggot Street

Dublin 2

Re: Public/Private Nursing Home Care Review - (SIPTU Submission)

Dear Tom and Eoin,

This submission is presented on behalf of the SIPTU trade union. In the context of the review, we wish to make several points by way of submission to the review to provide our perspective on why there is a significant differential between the operating costs of public and private nursing homes.

The Department of Health will be aware SIPTU represents a significant percentage of staff in the sector across nursing, healthcare assistant, admin, health and social care professional and general support grades.

Profile of care in Public and Private Nursing Home:

The profile of patients within public and private NH is critical in explaining the differential in terms of the cost base for public and private facilities. Across the scale of dependency among patients, those with greatest dependency can typically be only cared for in public nursing homes. Comparable facilities on such scale typically do not exist in the private NH sector.

In addition, there is a far higher concentration of long stay beds across public nursing homes. The DKM, RDJ, Aecom 2015 report on the nursing home sector found that some 26% of all beds in public nursing homes were long stay, relative to just 8% in the private nursing homes.

Given that the total volume of nursing home beds has changed marginally from the date of the source data for the 2015 report, which was derived in 2014 and 2015 and the latest available data on total nursing home beds which appears to be 2017, it is likely that this composition will have changed little in the period 2015 to 2017.[112]

It is therefore logical that greater dependency levels among the patient profile and a greater concentration of long stay beds implies a greater cost base for public nursing homes.

Staffing profile:

Two issues arise here. Typically, higher dependency cases require a higher nursing to support staff ratio. Given the greater share of high dependency cases in public nursing homes, it is to be expected the ratios of nurses to support staff are higher in public NH. By extension, the paybill for that facility will be higher relative to a similar sized private home.

As you are aware, the wage differential between nurses and support staff can be significant. Furthermore, it is our understanding and local knowledge that the FETAC level 5 training level is not a mandatory requirement for recruitment into some private NH. In contrast, it tends to be mandatory for public NH. This situation would give rise to lower labour costs in those private NH and a potential difference in measurable standards which may be more evidenced when compared with the common service user needs in both categories.

Building type:

[112] HIQA 2017 review of HIQA regulation of the social care and healthcare service suggests that the total number of beds in the sector was 30,732.

The bulk of the new nursing home beds that have come into the sector over the past 15 years have been in the private sector. Government policy had been to incentivise new nursing home bed delivery by the private sector by way of capital allowance tax relief. As a result, much of the private nursing home stock is more recently constructed, when compared to public nursing homes and therefore requires lower maintenance and upgrade costs compared to older buildings.

Finally, we wish to highlight that the overall funding allocation for the nursing home sector remains inadequate to meeting current and future demand. Successive reports such as the one produced in 2015 or the more recent ESRI research on future health service needs points to a very dramatic requirement for older person services over the next decade and more. In that context, your review must consider this increase in demand, the appropriate allocation and most importantly, how we can ensure a standardisation of service according to dependency level across all nursing homes, irrespective of whether they are public or private.

SIPTU contend that any assessment must be based fairly on a like for like analysis. It is inaccurate to adjudge two systems which are not designed for the same constituency per se or indeed the same social demands. One in effect is a private, profit driven model while the other is provided by the State to care for those who may not have the means and may require a high level of care albeit not in an acute setting.

It is also important to note that different needs for residents/service users arise and not all public locations provide the same service. There is no doubt that some locations within this sector provide service more akin to a small acute hospital, while others provide essential services to our citizens so that they can be provided with a safe home and care as needed.

We would welcome any further engagement in the review process and ultimately look forward to a comprehensive report.

Yours Sincerely,

Yours,

_____

Kevin Figgis,

Sectoral Organiser

Executive Summary

Submission to the Department of Health Value for Money Review

January 2019

The State has engaged in a policy of procrastination and obscurity with regard to public nursing home costs over many years. The appropriate scrutiny of expenditure within HSE nursing homes has never been applied. This is unacceptable given it amounts to €300m+ spend per annum from our health budget. As stated by the Oireachtas Public Accounts Committee (PAC) within its recently published (December 2018) periodic report for the period May to July 2018: "It is not clear that the cost of care in public nursing homes is providing value for money to the taxpayer."

Our submission informs:

- Non-transparency in public nursing home expenditure presents challenges in presenting specific cost differentials arising between public and private/voluntary nursing homes. This review needs to provide long overdue public transparency and scrutiny of expenditure that is being incurred within HSE nursing homes.
- HSE nursing homes are paid fees that are a national average 60% above those payable to private and voluntary counterparts (based on latest published HSE fees: February 2017).
- There is a gross distortion in Fair Deal expenditure. The 2017 HSE accounts inform one-third of the budget was to fund the one-fifth of residents in HSE homes.
- The indicative average contribution was circa €69,000 per resident in a HSE home over the course of the year by comparison with average €35,000 per resident in a private or voluntary home.
- The *Elderly Care Services HSE Midlands – Information Document,* published 2012, presents serious questions regarding the reality of the "cost of care" fees published by the HSE.
- The Department of Health review of Fair Deal, published July 2015, recommended: "In the medium term (within 18 months) the NTPF should review the present pricing system [Fair Deal] and submit proposals to the Minister for Health." 42 months on, the review remains outstanding.
- The HSE itself has acknowledged pay rates to staff between its nursing homes and private and voluntary are not substantially different and it needs to agree an appropriate model of residential care staffing and skill mix.
- Gross inequality in the application of Fair Deal funding was evident when €12 million, 55% of the additional Fair Deal 2018 budget allocation, was earmarked for HSE pay increases.
- Private and voluntary nursing homes must encompass a myriad of substantial costs within their Fair Deal fees which are not applicable for HSE nursing homes. These include, but are not limited to (not an exhaustive list):
    - Capital costs o Commercial rates o Land and maintenance costs o Local authority charges
    - Land costs o Insurance premiums o Education and training
- The definition of "long-term residential care services" for HSE nursing homes is intended to mirror care services as per private and private providers under the NTPF Deed of

Agreement. However, the reality is the costs entailed for the provision of a myriad of services are incurred by the HSE external of the fee payable and the Fair Deal budget. This is arguably in breach of the statutory Scheme that is the NHSS (Fair Deal).

- Private and voluntary nursing homes are tasked with providing services under regulatory requirements for the residents entrusted in their care that are excluded from their fees payable; whereas HSE nursing home residents retain access to such. HIQA informs with regard to inadequate access to care services such as therapies: "This reflects a wider funding and access issue in the sector and is an issue in particular for some private centres who are not able to access HSE services such as those listed above as they fall outside of the Fair Deal Scheme".

- HIQA states within its report *Overview of HIQA Regulation of Social Care & Healthcare Services 2017*: "There are examples of certain smaller nursing homes – which provide a more homely environment – closing voluntarily due to concerns over the financial viability of running such services."

- Within its report *An analysis of inspection findings during the first 15 months of inspections,* HIQA states funding issues for private nursing homes lead to issues in accessing HSE therapy services.

- Within its report *Who Cares? An Investigation into the Right to Nursing Home Care in Ireland,* the Office of the Ombudsman highlights "care packages" provided for in the NTPF "agreements are not consistent with the obligations placed on private nursing homes" under the Health Act and Regulations.

- The Dementia Services Information and Development Centre (DSIDC) states in its report *An Irish National Survey of Dementia in Long-Term Residential Care,* HSE operated facilities which receive the highest payments under Fair Deal are "more inclined to refuse admission to those not independently mobile" than private providers, who are "the main provider of specialist long-term care for people with dementia".

- It further states: "The complex and high dependency needs of persons with dementia in specialist care units now need to be more realistically reflected in fairer resource allocation, in recognition of the skill mix of staff employed in specialist care units, their training needs and the level of care expected to be delivered to residents with dementia. A new funding model is required if the private sector is to be further incentivised, with more funding allocated to private nursing homes in recognition of the specialist services needed to support PWD [persons with dementia] including those with behaviours that challenge."

- The Department of Health commissioned DKM Economic Consultants report *Potential Measures to Encourage the Provision of Nursing Home and Community Nursing Unit Facilities* states Fair Deal's failure to address differing levels of dependency "increases risks for operators with respect to deterioration of residents subsequent to their admittance and discourages some of the more sophisticated financing options". It states there is "no standard objective assessment basis for setting the price…in the final analysis the rate for each nursing home is a matter for ad hoc negotiation. The most important factors appear to be the "going rate" in the particular county… In short, it is untenable that the State quality regulator can assess differentiated dependency levels and in doing so impose costs on

nursing homes, while the State regulator claims it is unable to reflect the same factor in its pricing decisions."

- The Oireachtas Joint Committee on Health and Children advances within *Report on End of Life and Palliative Care in Ireland* necessity for "evidence-based cost of care model" to determine "real cost of residential nursing home care in Ireland".
- The aforementioned DKM report states: "While the scheme has delivered many benefits and is a significant advance on what was in place heretofore, its current pricing model operates in an ad hoc manner, lacks rationale, consistency and fairness, only applies to the private sector, and in the long run is unsustainable."
- Bank of Ireland has warned a change in Fair Deal rates and policy direction is required to deter a shortfall of nursing home beds.
- AIB states "the financial model underpinning smaller homes is becoming increasingly difficult to sustain", adding 20 private nursing homes with 535 beds have closes the past five years.
- We must be cognisant of the crisis presenting for care of the older person in the UK. The large growth in requirement for nursing home care and funding pressures are presenting a national emergency in healthcare delivery 'across the water'. Our submission presents numerous analyses state the current model of funding is leading to the closure of care homes, threatening their sustainability, not reflecting the reality of costs, having a negative impact upon care provision, and resulting in people's care needs going unmet.

Half of residents in our nursing homes are aged 85+. The CSO projects the number will increase by 53% over the next ten years, from 73,000 in 2018 to 112,000 in 2028. We are at a critical juncture in care of the older person.

This VFM needs to provide overdue public transparency and scrutiny of expenditure that is being incurred within HSE nursing homes. The fees payable HSE nursing home and expenditure they incur exclusive of Fair Deal is devoid of negotiation, analysis, transparency and accountability. The complete lack of independent oversight with regard to HSE nursing home expenditure emphasises the critical importance of this VFM review and vital importance for it to undertake a comprehensive and independent assessment of expenditure within public nursing homes. We must ensure spend within our health services is transparent, achieves value and is optimised.

What is the true expenditure being incurred for the provision of care in HSE nursing homes? The breakdown of costs are not published to inform regarding the expenditure being incurred. Accenture has highlighted non-transparency with regard to public nursing home costs and highlighted irregularities with regard to utilisation of its budget. It stated there is requirement for visibility, transparency and oversight re public nursing home spend. A HSE information document presenting expenditure within Midlands nursing homes highlighted huge levels of expenditure being incurred that could not be incurred within income. The published "cost per bed" far exceeded the "cost of care" fees that had been published by the Executive. What is the true reality re cost of care in HSE nursing homes? This VFM provides vital opportunity to deliver the recommended visibility, transparency and recommended oversight.

Nursing homes provide high quality care and this must be sustained as requirement for it increases in tandem with our ageing population. This review presents vital opportunity to present a critical analysis regarding the funding of this specialist care and to advance the necessity for greater fairness and transparency with regard to how the State supports people who require nursing home care.

ENDS

Submission to the Department of Health Value for Money Review

January 2019

Introduction

Nursing Homes Ireland welcomes opportunity to submit to this important review.

The State has engaged in a policy of procrastination and obscurity over many years with regard to public nursing home costs.

When the Nursing Home Support Scheme (Fair Deal) came into operation in 2009, a commitment was made it would be reviewed after three years. The review was delayed to 2015 and when published it effectively 'kicked for touch' with regard to public nursing home costs, stating: "A Value for Money and Policy (VFM) review will be carried out on public facilities which will recommend actions and timelines to address any cost distorting factors that cannot be attributed to inherent differences in resident profile or unavoidable costs as between the public and private sectors." Two years later in March 2017, the Department informed the Public Accounts Committee it had yet to commence the review but anticipated it would be undertaken and completed by that year-end[i].

We note the Oireachtas Pubic Accounts Committee's (PAC) statement within its December 2018 published *Periodic Report No 4, May - July 2018*: "The Department of Health commenced a Value for Money review of the cost of care in public nursing homes in 2017 and hopes to complete the review by the end of March 2019. Given the significant sum of public funds involved, the Committee recommends that the Department ensures the report is delivered and published within this timeframe." Given the unacceptable procrastination with regard to assessing Fair Deal expenditure and how the scheme is operating, it is imperative this critical review of the scheme is expedited.

The appropriate scrutiny of expenditure within HSE nursing homes has never been applied. This is unacceptable given it amounts to €300m+ spend per annum from our health budget. As stated within the PAC report: "It is not clear that the cost of care in public nursing homes is providing value for money to the taxpayer."

Within our sector the State, through the NTPF, has a dominant position as a monopolistic purchaser of care. Private and voluntary nursing homes operate in a constrained economic environment, where their income is fixed and set by the State. Their expenditure is scrutinised and independent analyses inform fees payable are not commensurate with care costs. It is a damning indictement of our health services that the Fair Deal budget of €1 billion – to support residents approved for nursing home care across HSE, private and voluntary providers - is applied in a discriminatory manner to the benefit of State nursing homes. It is unacceptable and reprehensible that particular care providers – private and voluntary – do not have the reality of costs incurred to provide nursing home care encompassed within their fees. Fair resourcing of residents in private and voluntary nursing homes under Fair Deal can ensure the reality of resident care costs are appropriately recognised. Furthermore, it can place such homes on a sustainable footing, ensuring care is provided in community settings in line with Government policy and the wishes of residents, and bring further employment and economic benefits to the relevant urban or rural community.

The reality of such is presented in the closure of private and voluntary providers. HIQA, the independent regulator, states within its *Overview of HIQA Regulation of Social Care & Healthcare Services 2017* report: "There are examples of certain smaller nursing homes – which provide a more homely environment – closing voluntarily due to concerns over the financial viability of running such services." Analysis of the sector undertaken by AIB informs 20 private and voluntary nursing homes have closed the past five years.

The complete lack of independent oversight with regard to HSE nursing home expenditure since Fair Deal commenced emphasises the critical importance of this VFM review. It is vital it undertake a comprehensive and independent assessment of expenditure within public nursing homes and the review is expedited. The issues it highlights must be acted upon. The discriminatory practice and non-accountability presently in effect with regard to public nursing home spend must be addressed with immediacy.

We are at a critical juncture in care of the older person. Half those availing of nursing home care are aged 85+[ii]. The CSO projects the number will increase by 53% over the next ten years, from 73,000 in 2018 to 112,000 in 2028[iii]. We must ensure spend within our health services is transparent, achieves value and is optimised. The excellence synonymous with nursing home care must be sustained through an appropriate and fair funding structure.

As a society, we must ensure people presenting for nursing home care are supported by a fit-for purpose funding model that is appropriately resourced to ensure we meet the increasingly high dependency, clinical care needs of persons who require nursing home care. This review presents landmark opportunity to assess State expenditure of €1 billion to fund the care needs of circa 24,000 people availing of nursing home care.

We should heed the stark warnings from the crisis presenting for care of the older person in the UK. The large growth in requirement for nursing home care and funding pressures are presenting a national emergency in the UK in healthcare delivery.

This review presents decisive opportunity to provide transparency regarding public nursing home care spend. We acknowledge your commitment to meet with NHI post submission.

We have in our submission responded as per Terms of Reference presented by the Department of Health.

TOR 1: Having regard to the overall objectives in provision of long stay care supported by the Nursing Home Support Scheme, identify the cost differentials between residents in the private/voluntary and public sectors.

Person's approved for State support under Fair Deal are all required to undertake a comprehensive, multi-step process. It entails assessment by a multidisciplinary team of HSE healthcare professionals to determine if nursing home care is most appropriate to the person's care needs.

All nursing homes – public, private and voluntary – must comply with the Health Act 2007 (Care and
Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland. The Standards are nondiscriminatory and implicitly state the obligations upon all nursing home providers to respect the rights of residents and ensure their health, social and personal care needs are fulfilled. That said, it should be noted, in 2015 the Government announced the requirement for HSE nursing homes to comply with HIQA's physical environment standards deadline would be extended by six years to 2021 by legislation in the Care and Welfare Regulations. It was an act of political interference in a regulatory process and further discriminatory action against the private and voluntary sector who had incurred significant capital expenditure in compliance with the Care and Welfare Regulations.

The Dementia Services Information and Development Centre (DSIDC) report *An Irish National Survey of Dementia in Long-Term Residential Care*[iv], the first national survey to map the provision of specialist long-term care for people with dementia, informs "the private sector is the main provider of specialist long-term care to persons with dementia". It states: "Curiously, HSE operated facilities, which receive the highest payments for care from the Nursing Home Support Scheme because they are said to accommodate those with highest dependency needs were more restrictive than other providers in relation to admission criteria and were more inclined to refuse admission to those not independently mobile."

To inform this submission, NHI undertook a snapshot survey with 123 random private and voluntary nursing homes. Of the 7,159 residents within those nursing homes, 63% had maximum or high dependency care needs (4,531 residents). The predominant validated tool used to measure was the Barthel Index. This measures the physical dependency needs of residents. It should be noted, there is no such tool to capture cognitive dependencies. 177 fewer people entered Fair Deal in year 2017 by comparison with year 2013[v]. The average length of stay of residents supported by the scheme halved over the period 2009, the year of its commencement, to 2014, from four years to 1.9, according to the Department review of the scheme. These trends reflect increasingly people are only availing of nursing home care if they have maximum to high dependency care needs.

The most recently published fees for HSE nursing homes – February 2018[vi] – informed such homes were being paid fees per resident that were a national average 60% above those payable to private and voluntary. The gross chasm and inequality in fees payable across the country is presented in Appendix 1. The VFM should recommend the HSE publish its Fair Deal fees on a minimum quarterly basis, to provide appropriate transparency for residents and the wider public.

Private and voluntary nursing homes operate within a constrained economic environment under a monopoly purchaser of care. In year 2017, one-third of the Fair Deal budget spend was allocated to fund one-fifth of those supported by the scheme[vii]. At year-end, 4,713 people funded by the scheme were availing of care in HSE nursing homes, whereas 18,236 were funded in private and voluntary. The indicative average HSE contribution under Fair Deal was circa €69,000 per resident in a HSE home over the course of the year by contrast with an average €35,000 per resident in a private or voluntary home.

The cost differential presented is exorbitant. And are the fees published by the HSE the true cost of care? In 2012, the HSE published an information document during a consultation process regarding the potential closure of nursing homes in the Midlands. It informed the cost to provide care on a weekly basis was €2,472 in Shaen and €2,340 in Longford Community Nursing Units. However, it had previously informed in its "cost of care" fees published in March 2011 the weekly cost of care in Shaen was €1,633 and €1,246 in Longford. The published costs in 2012 were 51% and 88% more than those stated twelve months previously. What is the reality of HSE costs and expenditure surrounding nursing home care? The above presents the "cost of care" fees published by the HSE are no way reflective of the reality of cost of care in HSE nursing homes and, as outlined above, the HSE figures cannot be trusted.

The *Elderly Care Services HSE Midlands – Information Document*[viii] informed the 2012 budget for pay costs for nine HSE nursing homes was €373,382 above anticipated Fair Deal income and income from patient charges[ix]. It informed total income budgeted for nine HSE nursing homes was €9,276,823 and the total budget for pay costs was €9,650,205. Furthermore, non-direct pay costs were budgeted for €1,486,024 and indirect pay costs for €188,432. Therefore, the budgeted expenditure exclusive of income derived was a further €2 million. This would amount to average €222,222 per nursing home per annum. Where is this budget coming from? Is this in breach of the provisions of the statutory Scheme that is the Nursing Home Support Scheme (Fair Deal)?

The breakdown of costs such as these presented within the *Information Document* should be published on a consistent basis to inform regarding the expenditure being incurred within HSE nursing homes. Yet they are not divulged, with the outcome being non-transparency with regard to HSE nursing home expenditure. It is imperative this review provides a breakdown regarding expenditure within individual HSE nursing homes. The HSE have a duty as a public body to ensure transparency and to ensure residents funded under the Fair Deal are in possession of the full accurate information to make an informed choice.

The HSE acknowledges pay rates to staff between its nursing homes and private and voluntary are not substantially different. It acknowledged such within its December 2016 submission to the Public Accounts Committee[x] in response to issues presented before the Committee by NHI, but further stated public service conditions of employment apply additional costs. Its 2019 Service Plan informed of a reliance on agency staff in residential care services to maintain the required

workforce and skillset. It stated a priority for 2019 is a requirement to agree an appropriate model of residential care staffing and skill mix.

Private and voluntary providers are tasked with absorbing pay costs and other substantial costs, further detailed below, within the fees payable that are a national average 60% below those payable to HSE nursing homes.

The gross inequality in the application of funding under Fair Deal was further evident within the budgeting for the scheme for year 2018. Within the provision of €21.7 million of 'additional' funding, €12 million – 55% of the additional allocation – was earmarked for HSE pay levels in public nursing homes[xi]. With 4,713 supported by Fair Deal in HSE nursing homes at the end of 2017, this equated to circa an additional €2,546 being allocated per resident within such homes for the year. The equivalent contribution required for private and voluntary nursing homes, funding 18,236 people year-end 2017, would have amounted to €45.1 million.

Increases in public sector pay levels, particularly those within health services, have a direct impact upon wage levels in private and voluntary nursing homes. Yet, such increases are not recognised within the budget allocation. The non-recognition presents very significant challenges for private and voluntary nursing homes in the recruitment and retention of staff, with them tasked with operating in an economic environment that is discriminatory.

The Department of Public Expenditure and Reform staff paper *Nursing Homes Support Scheme Trends and Figures* (October 2017)[xii], presents the escalating pressures upon private nursing homes with regard to staffing costs. It states: "And with the general economy approaching full employment, recruitment in the private nursing home sector is becoming more challenging, possible resulting in higher pay rates." Yet the Fair Deal budget allocation for 2018 was specifically cognisant of increasing staffing costs for HSE nursing homes and ignored private and voluntary cost pressures.

The monopoly applied to private and voluntary nursing homes with regard to fees payable for provision of care compounds the inequality and the financial pressures that have resulted in closures of homes.

Compounding the gross distortion in utilisation of the Fair Deal budget is the fact private / voluntary nursing homes must encompass a myriad of substantial costs within their Fair Deal fees which are not applicable for HSE nursing homes. These include, but are not limited to:

- Capital costs
- Commercial rates
- Land and maintenance costs
- Local authority charges
- Land costs
- Insurance premiums
- Education and training

A 2017 NHI survey of private and voluntary nursing homes where revaluations had occurred presented increases in commercial rates had averaged 116% and had risen up to 277%. The average increase was the equivalent of €614 per resident, per annum, equating to an average increase of €35,000 over the course of a year for a 60-bed nursing home.

152 private and voluntary nursing homes informed NHI annual survey published in 2015 the total capital expenditure they had incurred in capital costs to meet HIQA compliance requirements was an average €1,136,942 per home. The average capital expenditure incurred over the previous 36month period was €579,430. Failure to encompass such costs within fees payable under Fair Deal led to closure of nursing homes. The survey states: "Given the large cost of compliance with the Standards, it is perhaps unsurprising that some operators, unable to achieve a satisfactory Fair Deal rate, were unable to fund the necessary expenditure and were forced to take the decision to close their homes."

In contrast, the Government has committed €385 million for capital investment in 90 HSE nursing homes – an equivalent of €4.3 million expenditure per nursing home. Furthermore, in an act of gross political interference with independent regulation and of discriminatory behaviour, in 2015 the Government changed the regulations to extend the period for compliance with HIQA's physical environment standards by six years to 2021. Private and voluntary nursing homes had incurred enormous expenses and considerable financial pressures to meet the deadline. An inability to meet the standards and non-flexibility from the regulator had led to the closure of some nursing homes. The change to the regulations represented abuse by the State of its powers to act on behalf of State-run HSE nursing homes. It presented flagrant discriminatory practice in care of the older person.

The fees payable to public nursing homes do not include the capital costs, further significantly understating the published weekly cost per resident in HSE nursing homes. NHI questions has there been a thorough cost benefit analysis by the State of continuing to operate and maintain ageing buildings to ensure HIQA compliance.

Report on the Cost of Employer and Public Liability Insurance[xiii], the Cost of Insurance Working Group report published January 2018, presented insurance costs are likely to have increased by 57% for businesses from January 2011 to July 2016. Given the high dependency care needs of residents in private and voluntary nursing homes, premiums for such homes are likely to have increased substantially more.

The requirement to upskill and educate staff in the provision of care is a continuous requirement for private and voluntary nursing homes. Residents present with high dependency, acute clinical care requirements and the necessity for staff to continuously engage in education and training is imperative. Ensuring staff are appropriately skilled is a key regulatory requirement. NHI's annual survey informed circa 2.7% of private and voluntary nursing home turnover encompasses training. Such costs are not recognised under the Fair Deal fees.

TOR 2: Quantify and analyse the reasons for the cost differentials between the private / voluntary and public sectors

The NTPF Deed of Agreement explicitly defines the costs covered under Fair Deal fees. It states:

> **"Long-term Residential Care Services"** shall have the meaning assigned to it by the Act and shall, without prejudice to the generality of the foregoing, include:
>
> - Bed and board;

- Nursing and personal care appropriate to the level of care needs of the person;
- Bedding; o Laundry service; and
- Basic aids and appliances necessary to assist a person with the activities of daily living.

For the avoidance of doubt, Long-term Residential Care Services shall not include: *inter alia*

- Daily delivery of newspapers; o Social programmes; o All therapies; o Incontinence wear o Chiropody; o Dry cleaning;
- Ophthalmic and dental services; o Transport (including care assistant costs); o Specialised wheelchairs; and o Hairdressing and other similar services

The definition of "long-term residential care services" for HSE nursing homes is intended to mirror care services as per private and private providers under the NTPF Deed of Agreement. However, the reality is the costs entailed for the provision of a myriad of services are incurred by the HSE external of the fee payable and the Fair Deal budget. This is arguably in breach of the statutory Scheme that is the NHSS (Fair Deal).

The anomaly was highlighted in Accenture's *Funding Fair Deal – High Level Issue Analysis* report that was presented to the Minister for Health in November 2011. The report highlighted to the Minister: "The key point is that the current system for public beds has not been transparent in relation to cost and activity". It highlighted the treatment of ancillary services for HSE nursing homes. "There is an important distinction between the calculation of the cost of care and the inclusion of ancillary services in the subhead," it stated. "Both the Department and the HSE agreed that ancillary services are excluded from the cost of care calculation. The costs to be included under Fair Deal were considered in detail prior to the Scheme and cost components lodged with the
Oireachtas. The central issue therefore has been how ancillary services are treated in the subhead.

Both the Department and the HSE calculated the 2011 subhead requirement excluding ancillary services. It is clear from a review of the Departments files that the Department's explicit intent was that ancillary services should be excluded from the subhead. This was also the understanding of some HSE personnel who engaged with the Department in establishing the scheme. However, it was not the consistent view taken by the HSE. Ancillary services will be funded through subheads B1 to B4 in 2012."

Yet, funding for long-term residential care is from subhead B12 of the HSE's Vote (Vote 39), effectively the Nursing Homes Support Scheme. It is explicit services within the definition of "long-term residential care services" defined for HSE nursing homes are not funded from the Fair Deal budget allocation.

Accenture further stated: “The HSE needs to have full visibility and transparency around public beds at national as well as regional level to implement Fair Deal. A critical related factor has been the quality of management information on Fair Deal. The level of oversight on Fair Deal was constrained by lack of real-time information available to managers on activity levels and pressure points.” The report highlighted Fair Deal funding for public beds “is effectively treated as a historically-based block budget” and recommended “revising how public beds are funded and managed from a historic block funding basis to a model where the money follows the patient.”

(The relevant Statutory Instrument is presented in Appendix 3).

Private and voluntary nursing homes are tasked with providing services to residents under regulatory requirements that are excluded from their fees payable by NTPF under the Fair Deal; whereas residents in HSE nursing homes retain access to such.

Non-transparency in public nursing home expenditure presents challenges in presenting specific cost differentials arising between public and private/voluntary nursing homes. This review needs to provide long overdue public transparency and scrutiny of expenditure that is being incurred within HSE nursing homes. This examination should encompass a breakdown informing of:

- Salaries expenditure
- Indirect staffing / administration and agency staff costs
- Pension contribution expenditure
- Day-to-day costs such as food and beverage, heating and electricity
- Cost of maintenance
- Insurance costs
- Rates • Capital costs
- Spend on:
    - Therapies,
    - Activities (staff and other cost), o GP services / medical cover
- Medication expenditure
- Expenditure on furnishings and ‘household’ equipment
- Shared services:
    - HR
    - Accounts/Finance o Auditing o IT support o Admin support

Note, the list is not exhaustive.

It must be implicit with regard to the expenditure that is incurred within the Fair Deal budget by HSE nursing homes and inform of separate spend for items and services excluded from the scheme.

TOR3: Define outputs and inputs associated with activity in the private/voluntary and public sectors and identify the level and trend of these outputs and inputs.

Private and voluntary nursing homes are the significant majority providers of nursing home care in Ireland. At the end of September 2018, 79% of the 22,742 residents funded by Fair Deal were availing of care in private and voluntary nursing homes[xiv].

Analysis of Fair Deal expenditure for the year 2017 informs the indicative contribution per resident is €35,000 per annum. The indicative contribution per HSE resident is €69,000. Over the 16-month period October 2016 to February 2018, Fair Deal fees payable to HSE residents increased by an average 11%. Over the corresponding period, average fees for residents in private and voluntary nursing homes increased by 3.9%. The Department's review of the Fair Deal scheme, undertaken by Deloitte, informed Fair Deal fees were not keeping pace with inflation. It said "in the period 2010 to 2013…the increase in prices negotiated (1.71%) has been lower than the increase in the CPI over the same period (3.79%)". It should be noted CPI is not the appropriate index to reflect rising costs of medical inflation. We previously informed of a specific €12 million increase in the Fair Deal 2018 budget to increase salaries in HSE nursing homes. The huge disparity in Fair Deal budget spend has been highlighted as a concern by the Public Accounts Committee.

As presented within TOR 2, the DSIDC analysis of provision of specialist dementia care informs the private sector is the main provider of specialist dementia care.

The Department of Health commissioned DKM Economic Consultants report *Potential Measures to Encourage the Provision of Nursing Home and Community Nursing Unit Facilities* starkly highlights the shortcomings of the present funding model and its impact upon private and voluntary providers. It states the scheme's failure to address differing levels of dependency in patient care "increases risks for operators with respect to deterioration of residents subsequent to their admittance and discourages some of the more sophisticated financing options". It adds: "There is no standard objective assessment basis for setting the price, related to either efficient capital and operating costs or the level of dependency of residents; while the NTPF does use some benchmarks, in the final analysis the rate for each nursing home is a matter for ad hoc negotiation. The most important factors appear to be the "going rate" in the particular county."

It warns: "In short, it is untenable that the State quality regulator can assess differentiated dependency levels and in doing so impose costs on nursing homes, while the State regulator claims it is unable to reflect the same factor in its pricing decisions."

Private and voluntary nursing homes are required to function under a funding model that DKM states fails to acknowledge the dependency levels of nursing home residents and "operates in an ad hoc manner, lacks rationale, consistency and fairness, only applies to the private sector, and in the long run is unsustainable". Against this backdrop, current health expenditure for HSE long-term residential facilities increased by 18.5% over the period 2011 to 2016[xv].

It is a gross aberration that private and voluntary nursing homes residents are paying additional fees to secure access for specialist care services that are vital to support their health and wellbeing.. These include services such GP care, therapies such as OT / physio, specialised equipment and therapeutic activities. Such services are provided within HSE nursing homes but private and voluntary residents are required to pay for many services that they are entitled to and should be provided to residents under GMS entitlement. Obligations are placed upon providers or residents to pay for such services to ensure residents can secure access to life-changing therapies and care.

The issue of access to therapies has been highlighted by HIQA and the Office of the Ombudsman. Within its report *An analysis of inspection findings during the first 15 months of inspections*, HIQA highlights "inadequate access to all care services, i.e. physiotherapy, chiropody, occupational therapy, or any other services as required by the resident" as being one of the most common breaches of regulation. It adds: "This reflects a wider funding and access issue in the sector and is an issue in particular for some private centres who are not able to access HSE services such as those listed above as they fall outside of the Fair Deal Scheme".

In its report *Who Cares? An Investigation into the Right to Nursing Home Care in Ireland*, the Office of the Ombudsman states: "The exclusion from the care package of therapies and social programmes appeared to be at odds with what (in the words of the Department) "is commonly understood as long-term nursing home care. Furthermore, it appeared that the care packages provided for in the NTPF agreements are not consistent with the obligations placed on private nursing homes under the Health (Nursing Homes) Act 1990 (as amended) and the Health Act 2007. The Ombudsman was concerned that, in many individual cases, the NTPF agreed care packages were not adequate to meet the actual care needs of that individual and that, in this event, the agreements made by the NTPF were falling short of the level of care apparently envisaged under the NHSS Act. However, a careful reading of the NHSS Act suggests that the narrow care packages agreed by the NTPF may not necessarily be at odds with the provisions of the Act." This informs the scheme, in its operation, exclude essential care services for private and voluntary nursing home residents.

The PAC effectively confirmed denial of access to such within its aforementioned periodic report. It stated the HSE'S Assistant National Director for Older People and Palliative Care Strategy informed the Committee "a person residing in a public, private or voluntary nursing home with 24-hour care is considered less of a risk than a person who might be residing alone in their home". "As medical card services are a scarce resource, there may not be sufficient capacity to provide the services for everyone, and the Assistant National Director indicated that some prioritisation must take place," the report states.

Private and voluntary nursing home residents must retain equal access to primary care services. The review must examine the cost outlay by HSE nursing homes to facilitate the access to primary care services / therapies, GP services and specialised equipment. Discriminatory practice in the provision of care services between HSE and private and voluntary nursing homes must be highlighted and addressed.

As presented within TOR 1, private and voluntary nursing homes must also absorb substantial operational and development costs that are not encompassed within fees payable to HSE homes: commercial rates, capital costs, land and maintenance costs, local authority charges, land costs, insurance premiums, education and training.

It is a damning inditement of our health services that the Fair Deal budget of €1 billion – to support the residents requiring nursing home care across HSE, private and voluntary providers - is applied in a discriminatory manner to the benefit of State nursing homes. It is scandalous that particular care providers – private and voluntary – do not have the reality of costs incurred to provide nursing home care encompassed within their fees. Such nursing homes are under severe financial pressure and as presented by the regulator HIQA and AIB – within this submission,

smaller nursing homes are closing their doors because of failure by the funding model to meet the reality of care costs.

TOR 4: Examine the extent to which the objectives of the Nursing Home Support Scheme have been achieved, and comment on the effectiveness with which they have been achieved.

Fair Deal has largely fulfilled its stated objective by then Minister for Health Mary Harney in 2006 of making nursing home care "accessible and affordable and 'anxiety-free'". However, the scheme has been in operation for ten years and the necessity to review its pricing mechanism – central to the effective / non- effective operation of the scheme – has been procrastinated by State agencies.

Residents presenting for nursing home care have increasingly high dependency, specialised care needs. It is incumbent upon the State to bring into effect an effective, fit-for-purpose funding model to meet the care needs of nursing home residents.

The requirement was recognised in the Department of Health review of Fair Deal[xvi]. Published in July 2015, 42 months ago, it recommended: "In the medium term (within 18 months) the NTPF should review the present pricing system and submit proposals to the Minister for Health." The review remains outstanding.

As presented, gross distortion within health spending is facilitated under the Scheme. Analysis of it by independent organisations (statutory and non-statutory), inform it is not fit for purpose and requires redress. This includes:

- Within its *Overview of HIQA Regulation of Social Care & Healthcare Services 2017* report, HIQA states: "There are examples of certain smaller nursing homes – which provide a more homely environment – closing voluntarily due to concerns over the financial viability of running such services."
- The independent regulator highlighting breaches of regulations arising with regard to accessing therapies which reflect "a wider funding and access issue in the sector and is an issue in particular for some private centres who are not able to access HSE services…as they fall outside of the Fair Deal Scheme".
- The Office of the Ombudsman stating "care packages" provided for in the NTPF "agreements are not consistent with the obligations placed on private nursing homes" under the Health Act and Regulations.
- DSIDC advancing "the complex and high dependency needs of persons with dementia in specialist care units now need to be more realistically reflected in fairer resource allocation, in recognition of the skill mix of staff employed in specialist care units, their training needs and the level of care expected to be delivered to residents with dementia. A new funding model is required if the private sector is to be further incentivised, with more funding allocated to private nursing homes in recognition of the specialist services needed to support PWD [persons with dementia] including those with behaviours that challenge."
- The *Sunday Business Post*, 19th August 2018, stated with regard to Minister Jim Daly in an article headlined 'Dementia villages' needed to prevent 'next housing crisis': "Daly said there was a need to examine these rates [Fair Deal] for care providers who were "making strides to provide top-quality care for dementia patients"."

- The Oireachtas Joint Committee on Health and Children recommends in its *Report on End of Life and Palliative Care in Ireland*: "In reviewing the current Fair Deal scheme, an evidence based cost of care model could be used in assessing the real cost of residential nursing home care in Ireland."
- The aforementioned DKM report states: "The nursing home sector in Ireland is a very substantial sector of the economy. Through the Fair Deal scheme the State procures several hundred million euros worth of services annually from private nursing homes. While the scheme has delivered many benefits and is a significant advance on what was in place heretofore, its current pricing model operates in an ad hoc manner, lacks rationale, consistency and fairness, only applies to the private sector, and in the long run is unsustainable."
- The report, commissioned by the Department of Health, also states Fair Deal fees "do not reflect the degree of dependency of residents", adding: "In short, it is untenable that the State quality regulator can assess differentiated dependency levels and in doing so impose costs on nursing homes, while the State price regulator claims it is unable to reflect the same in its pricing decisions."
- These fundamental failings of the scheme are compounded by lack of independent recourse for providers during the negotiation process. Failure to agree a fee with the NTPF will effectively lead to the closure of a nursing home. Yet no right of independent appeal is available to a provider if they cannot agree a fee with the NTPF.
- Economist Jim Power warned within NHI Budget 2018 submission, *Cost Pressures in the Private Voluntary Nursing Home Sector*: "While cognisant of the requirement to achieve value for spend, the State must be mindful of the very serious economic and social implications of a failure to appropriately resource long-term residential care. Failure to resource providers and ensure that costs encompassed in delivering care within a labour-intensive 24/7, 365 days a year health setting are taken into account, will have broader cost implications for State spending and will also have serious social implications. Failure to take cost realities into account will prove counterproductive and come at enormous expense to the exchequer."
- Bank of Ireland has undertaken an assessment of nursing home bed requirements to year 2026. In an interview with the *Irish Times,* published 9th October[xvii], its Head of Health Sector warned nursing home beds might not materialise where they are needed "because the capital value of greenfield nursing homes, once operational, may, as a result of those rates [Fair Deal] and increased staff costs, be lower than the actual development costs". "In reality it may require a change in policy direction and possibly Fair Deal rates to promote a more balanced regional development to ensure that capital investment is directed towards the regions where bed stocks will be most needed and people can actually age in their communities."
- Within its *Nursing Homes – Outlook* report, published November 2018[xviii], AIB Health of Healthcare states: "As cost pressures continue to build, the financial model underpinning smaller homes is becoming increasingly more difficult to sustain, especially where investment is required to ensure regulatory compliance into the future. Twenty private and voluntary nursing homes with 535 beds in total have closed over the past five years and all

had less than 40 beds. There is evidence that smaller homes have lower Fair Deal rates, almost 80% of homes with less than 40 beds have Fair Deal rates below the county average rate. The national average Fair Deal rate for these homes was €910, €52 below the national average rate of €962 in August 2018."

TOR 5: Identify, examine and compare the cost differential and how it is dealt with for Residential Care Centres in other jurisdictions.

We must be cognisant of the crisis presenting for care of the older person in the UK. The large growth in requirement for nursing home care and funding pressures are presenting a national emergency in healthcare delivery in the UK.

The Competition and Markets Authority (CMA) is an independent non-ministerial department that was enacted by the UK Government's Department for Business, Innovation and Skills. Its remit is to promote competition for the benefit of consumers. Within its *Care Homes* market study report published November 2017[xix], it presents the sustainability of care homes in the UK is threatened "due primarily to the low fee rates being paid for state-funded residents. It warns the fees being paid by local authorities to providers for provision of care are "below the full costs involved in serving these residents". The report states: "The current model of service provision cannot be sustained without additional public funding; the parts of the industry that supply primarily local authority funded residents are unlikely to be sustainable at the current rates local authorities pay. Significant reforms are needed to enable the sector to grow to meet the expected substantial increase in care needs… Our assessment is that if LAs [local authorities] were to pay the full cost of care for all residents they fund, the additional cost to them of these higher fees would be £0.9 to £1.1 billion a year."

The CMA warns: "Many care homes, particularly those that are most reliant on LA-funded residents, are not currently in a sustainable position. Our analysis shows that while many can cover their day-to-day operating costs, they are not able to cover any additional investment costs. This means that while they might be able to stay in business in the near term, they will not be able to maintain and modernise facilities, and eventually will find themselves having to close, or move away from the LA-funded segment of the market."

It recommends accurate and informed planning regarding future care needs is required and subsequently "necessary commissioning steps" should be taken on the basis of those plans. "For capacity to be in place to meet the future increase in demand, these decisions need to be made in good time," it adds. The VFM should be cognisant of such warnings and the recommendations emanating.

The UK National Audits Office states between 2010-11 and 2016-17 local authority spending on adult social care services reduced by 5.3% in real terms[xx].

The Public Accounts Committee in the UK Parliament published a report in May 2018 titled *The adult social care workforce in England*[xxi]. The report states: "We are also concerned about the short-term funding fixes aimed at adult social care which are not sustainable…There are, however, clear and obvious signs of significant financial stress in the sector now with levels of unmet need high and rising… The Department [of Health and Social Care] should establish quickly the funding local authorities need to commission care at fair prices, to support a workforce of the right size and shape to deliver a sustainable care sector in the long-term."

The King's Fund is an independent charity working to improve health and care in England. In February 2018 it published a paper titled *Approaches to social care funding – Social care funding options*[xxii]. It states: "It is widely accepted that the system for funding social care is in urgent need of reform. Faced with shrinking budgets, local authorities are struggling to meet the growing demand for care, linked to increasing complexity in need and an ageing population. As a result, the number of older people receiving publicly funded social care has declined. While in practice, much of this shortfall has been met by private spending and informal care; it is also likely that many people's care needs are going unmet."

The Care Quality Commission, the independent regulator of health and social care services in England, has warned social care is approaching "tipping point" and what is required is a long-term sustainable solution for future funding and quality of adult social care. Within its report, *The State of Health Care and Adult Social Care in England 2016/2017*[xxiii], it describes the future of care of older people as "one of the greatest unresolved public policy issues of our time". It states: "Care providers need to be able to plan provision of services for populations with the right resources, so good funding and commissioning structures and decision making should be in place to help boost the ability of health and social care services to improve. Funding challenges of recent years are well known, and in June 2018 the government announced an extra £20.5 billion funding for the NHS by 2023/24. However, at the time of writing, there is no similar long-term funding solution for adult social care."

Within its report published May 2018, *Fixing the care crisis*[xxiv], Alzheimer's Society UK states: "In England, the amount after which someone pays for care – assets above £23,350 – has not changed in eight years. The combination of expensive care, and no limit on what someone can spend, means some people spend nearly everything they have. At the same time, the number of local authorities offering an increased rate to providers to reflect the extra cost of dementia support has dropped. This has meant increased demands for top-up fees from families, poor quality care from providers operating on a shoestring budget, and providers even refusing to accept people with dementia."

As per Ireland, unsustainable financial pressures have severe implications. The Association of Directors of Adult Social Services' Budget Survey 2018[xxv] found "continued evidence" of failure in the adult social care provider market. In the six months to May 2018, at least 66% (69% in 2017) of councils surveyed reported that they had either had providers close or cease trading, or had had care contracts handed back, affecting thousands of individuals as a consequence.

TOR 6: Evaluate the degree to which the objectives warrant the allocation of public funding on a current and ongoing basis and suggest recommendations for improving the value for money obtained by the State.

When then Minister for Health Mary Harney announced the commencement of Fair Deal, she stated it would place residents firmly at the heart of the service. However, it is evident Fair Deal is operating in a discriminatory manner and there is gross inequality in the funding of residents in HSE nursing homes as opposed to those in private and voluntary homes. It is a grotesque abuse of public funds that HSE providers are paid fees that are, on paper, a national average 60% above those payable in respect of residents in private and voluntary counterparts. Furthermore, all nursing homes must comply with the same regulations and standards and all residents undertake the same assessment to determine if nursing home care is most appropriate to their care needs.

As presented within this submission, independent analyses have highlighted the severe unfairness of Fair Deal funding. It is stark that the analyses have highlighted the failure to appropriately fund the care provided to residents in private and voluntary nursing homes is impacting upon the capacity of such homes to meet care needs, capacity requirements and is leading to closures. The analyses independent of NHI have included:

- The review of Fair Deal stating geography and history are the predeterminants with regard to fees payable under the Fair Deal scheme.
- Accenture stating ancillary services provided in HSE nursing homes are paid for outside of the Fair Deal budget and there is requirement for visibility, transparency and oversight with regard to public nursing home spend.
- HIQA, the independent regulator, informing smaller nursing homes have closed due to concerns over financial viability and it is concerned regarding the viability of similar homes.
- PAC stating concerns that public nursing homes do not provide value within a €1 billion budget.
- Oireachtas Joint Committee on Health and Children advancing necessity for "evidence based cost of care model" to determine "real cost of residential nursing home care in Ireland".
- DSIDC stating the complexity and dependency care needs of nursing home residents "need to be more realistically reflected in fairer resource allocation" and presenting case for "a new funding model".
- HIQA stating inadequate access to care services is breaching regulations and it is reflective of a wider funding issue for private nursing homes.
- Office of the Ombudsman highlighting care defined under Fair Deal is not consistent with obligations placed on private nursing homes.
- DKM Economic Consultants analysis, on behalf of the Department of Health, stating Fair Deal's failure to address the differing dependency levels of residents is presenting risks for the residents and nursing home providers. The analysis – now four years completed – states Fair Deal fees are not cognisant of regulatory requirements.
- Bank of Ireland stating there will be regional shortage of beds because Fair Deal rates will negate required development in regions.
- AIB informing of closure of 20 nursing homes and asserting "the financial model underpinning smaller nursing homes is becoming increasingly more difficult to sustain".

ENDS

Nursing Homes Support Scheme Average Fee Per Resident Per Week

The fees are based upon assessment of latest published HSE fees, February 2018, by comparison with fees payable for private and voluntary nursing homes in same period.

County	Average weekly cost of care HSE nursing homes	Average private / voluntary nursing homes	% Differential - average cost public v average fee private/voluntary
Westmeath	€2,229 (2 nursing homes)	€846 (11 nursing homes)	163%
Laois	€2,078 (3 nursing homes)	€935 (4 nursing homes)	122%
Longford	€1,912 (1 nursing home)	€887 (3 nursing homes)	115%
Offaly	€1,661 (3 nursing homes)	€846 (7 nursing homes)	96%
Monaghan	€1,679 (1 nursing home)	€918 (5 nursing homes)	83%
Cavan	€1,673 (4 nursing homes)	€917 (7 nursing homes)	82%
Limerick	€1,549 (2 nursing homes)	€853 (22 nursing homes)	81%
Clare	€1,526 (4 nursing homes)	€851 (11 nursing homes)	79%
Donegal	€1,465 (11 nursing homes)	€822 (12 nursing homes)	78%
Kilkenny	€1,596 (1 nursing home)	€901 (8 nursing homes)	77%
Kerry	€1,495 (6 nursing homes)	€859 (17 nursing homes)	74%
Roscommon	€1,464 (3 nursing homes)	€844 (11 nursing homes)	73%
Wexford	€1,477 (2 nursing homes)	€858 (13 nursing homes)	72%
Galway	€1,444 (7 nursing homes)	€849 (35 nursing homes)	70%
Mayo	€1,443 (6 nursing homes)	€860 (17 nursing homes)	68%
Meath	€1,636 (2 nursing homes)	€982 (18 nursing homes)	66%
Louth	€1,614 (4 nursing homes)	€978 (8 nursing homes)	65%
Tipperary	€1,411 (4 nursing homes)	€852 (25 nursing homes)	65%
Carlow	€1,366 (1 nursing home)	€871 (6 nursing homes)	57%
Kildare	€1,594 (2 nursing homes)	€1022 (21 nursing homes)	56%
Wicklow	€1,597 (2 nursing homes)	€1032 (19 nursing homes)	54%
Waterford*	€1,396 (2 nursing homes)	€915 (8 nursing homes)	53%
Cork	€1,438 (19 nursing homes)	€958 (48 nursing homes)	50%
Sligo	€1,448 (1 nursing home)	€963 (6 nursing homes)	50%
Leitrim	€1,296 (4 nursing homes)	€880 (2 nursing homes)	47%
Dublin	€1,605 (17 nursing homes)	€1145 (87 nursing homes)	40%

*Waterford also contains Dunabbey House, HSE nursing home (€370 perweek), which is a low dependency centre

Extract from NTPF Deed of Agreement – definition of Long-term Residential Care Services, NHSS (Fair Deal)

"Long-term Residential Care Services" shall have the meaning assigned to it by the Act and shall, without prejudice to the generality of the foregoing, include:

- Bed and board;
- Nursing and personal care appropriate to the level of care needs of the person;
- Bedding; o Laundry service; and
- Basic aids and appliances necessary to assist a person with the activities of daily living.

For the avoidance of doubt, Long-term Residential Care Services shall not include: *inter alia*

- Daily delivery of newspapers; o Social programmes; o All therapies; o Incontinence wear o Chiropody; o Dry cleaning;
- Ophthalmic and dental services; o Transport (including care assistant costs); o Specialised wheelchairs; and o Hairdressing and other similar services

Nursing Homes Support Scheme Act 2009
Cost Components in respect of Care Services (Public Nursing Homes)

In accordance with section 33(2) of the Nursing Homes Support Scheme Act 2009 (No. 15 of 2009), I, Mary Harney, Minister for Health and Children, following consultation with the HSE, hereby lay before the Houses of the Oireachtas details of the goods and services which constitute care services within the meaning of paragraph (a)(i) of the definition of "long-term residential care services".

Care services within the meaning of paragraph (a)(i) of the definition of "long-term residential care services" in section 3 of the Nursing Homes Support Scheme Act 2009 shall encompass the following:

Pay Related Services

- Management/ Administration Staff directly involved in running the relevant facility
- Nursing Staff directly involved in managing and providing health and personal care services within the relevant facility
- Health Care Assistants, Attendants and equivalent grades directly involved in providing health and personal care services within the relevant facility
- Porters, Catering, Laundry and Housekeeping Staff directly involved in maintaining the relevant facility and its residents
- Maintenance/ Technical Staff directly involved in maintaining the relevant facility

The staff costs listed above shall include pay, including any overtime and allowances, and Employer's PRSI.

Non-Pay Related Goods and Services

- Basic clinical consumables, including: basic bandages; basic, non-medicated dressings; swabs; aseptic packs; syringes and needles; sterile gloves, wipes, aprons etc.; hip protectors and disposable underwear; sharps box; catheters; drainage bags and leg bags; tubing for oxygen, feeding pumps etc.
- Oxygen
- Catering
- Heat, Power and Light
- Cleaning and Washing
- Upkeep of Furniture, Equipment, Crockery and Hardware
  Costs under this heading are capped at a maximum of €7,000 per annum.

- Bedding and Clothing

- General Maintenance
  This item encompasses only regular maintenance works and service contracts with an annual value of €7,000 or under.

- Education and Training directly related to health and long-term care and undertaken by staff directly involved in the provision of care within the relevant facility.
  This item excludes pre-registration training. It is also capped at a maximum of 4% of the gross cost of direct salaries for the relevant facility.

- Insurance (public liability, employer's liability and property)

- Audit

- Office Expenses Rent / Rates directly attributable to the relevant facility
  Costs under this heading are capped at a maximum of €7,000 per annum.

- Miscellaneous
  This cost category is capped at a maximum of 2% of the overall non-pay expenditure per annum in accordance with existing HSE accounting principles

References

[i] Oireachtas Public Accounts Committee meeting 9th March 2017, Greg Dempsey, Assistant Secretary at the Department of Health: "It [Value for Money review] will be undertaken by the Department [of Health]. We have not actually started yet. In the next couple of months we will scope it out… I think our expectation is that we would get it completed in 2017."

[ii] Health in Ireland Key Trends 2018, 49.5% of nursing home residents year-end 2017 aged 85+ [iii] CSO Population and Labour Force Projections

[iv] Dementia Services Information and Development Centre, *An Irish National Survey of Dementia in Long-Term Residential Care,* February 2015 [v] NHI analysis based upon HSE data. In year 2017, 8,073 people 'entered' Fair Deal. In year 2013, 8,250 entered the scheme. [vi] https://www2.hse.ie/file-library/fair-deal/cost-of-care-in-public-nursing-homes.pdf [vii]HSE Annual Report and Financial Statements 2017 viii

https://www.hse.ie/eng/services/publications/olderpeople/older%20person%20services%20consultation%20and%20in formation%20document.pdf [ix] Elderly Care Services HSE Midlands – Information Document informed total income budgeted for nine HSE nursing homes was €9,276,823. The budget for total pay costs was €9,650,205.

[x]

https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_of_public_accounts/submissions/2017/2017-01-19_correspondence-hse-nursing-homes-ireland_en.pdf [xi] HSE Service Plan 2018 xii

http://www.budget.gov.ie/Budgets/2018/Documents/7.Nursing%20Homes%20Support%20Scheme%20%E2%80%93%20Trends%20and%20Figures.pdf

[xiii] https://www.finance.gov.ie/wp-content/uploads/2018/01/180125-Report-on-the-Cost-of-Employer-and-PublicLiability-Insurance.pdf

[xiv] HSE Performance Report September 2017

[xv] Department of Health, Health in Ireland Key Trends 2018 [xvi] https://health.gov.ie/wp-content/uploads/2015/07/Review-of-Nursing-Homes-Support-Scheme.pdf [xvii] https://www.irishtimes.com/news/ireland/irish-news/rural-ireland-facing-shortage-of-nursing-home-beds-1.3628058 [xviii] https://business.aib.ie/content/dam/aib/business/docs/help-and-guidance/nursing-homes-outlook-nov-2018.pdf [xix] https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homesmarket-study-summary-of-final-report

[xx] https://www.nao.org.uk/naoblog/adult-social-care-at-a-glance/ [xxi] https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/690/690.pdf [xxii] https://www.kingsfund.org.uk/publications/approaches-social-care-funding xxiii

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663529/NEW_CQ C_SoC2017_Web_accessible.pdf

[xxiv] https://www.alzheimers.org.uk/sites/default/files/2018-05/Dementia%20the%20true%20cost%20-%20Alzheimers%20Society%20report.pdf

[xxv] https://www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

HIQA submission to the Department of Health's Value for Money Review on Nursing Home Care Costs

January 2019

The Health Information and Quality Authority (HIQA) is the independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit and welfare of the public.

HIQA is responsible for the development and monitoring of standards in health and social care services, the registration and inspection of designated services, and the conduct of a wide range of health technology assessments (HTA). We also play a major role in facilitating and advising on Ireland's eHealth infrastructure.

All of these functions are focused on making services safer and better, providing assurance to the public as to the quality of services and ensuring that the findings of our work are reflected in decision-making at local and national levels. Putting the needs and the voices of the people who use health and social care services to the fore is the essence of everything we do.The Office of the Chief Inspector located in HIQA began regulating residential services for older people in 2009. Our Older Persons' Team is legally responsible for the monitoring, inspection and registration of designated centres for older people, which include nursing homes. This team oversees almost 600 registered nursing homes with nearly 32,000 registered beds. In order to be registered to operate, services must meet the requirements set out in the Health Act 2007, in the associated regulations, and in the National Standards for Residential Care Settings for Older People in Ireland 2016.The Office of the Chief Inspector has an important role in protecting and safeguarding people who may be vulnerable, particularly those in long-term care. Based on our experience of regulating the sector for almost ten years, we welcome the opportunity to share our views on how the Nursing Home Support Scheme (NHSS) and this Value for Money Review on Nursing Home Care Costs could drive improvements in care for this vulnerable group of citizens.

The Nursing Home Support Scheme

In accordance with the Nursing Homes Support Scheme Act 2009, the National Treatment Purchase Fund (NTPF) negotiates payment rates with private and voluntary nursing homes on behalf of the State[113]. A deed of agreement is signed between the NTPF and each nursing home which specifies the maximum price the nursing home can charge a resident for long-term care. When negotiating payment rates with a nursing home provider, the following are taken into account:

- costs reasonably and prudently incurred by the nursing home and evidence of value for money,
- the price previously charged,
- the local market price
- any budgetary constraints
- the obligation of 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.

The impact of discrepancies in the provision of NHSS rates

[113] http://www.ntpf.ie/home/nhss.htm

HSE data indicates that agreed funding is influenced by geographical location and whether the provider is public[114] or private[115]. Figures released for 2018 show that the NHSS maximum agreed price with private and voluntary nursing homes averaged €967.50 per bed per week[116]. This contrasts with an average cost of €1,525.81 per bed per week in a public nursing home[117].

Naturally, in order to continue operating, private providers must be able to balance the books and maintain a viable financial model. As the NHSS model does not provide funding based solely on the care needs of the older person, some private providers, whether consciously or otherwise, may overlook potential residents who require more complex, and therefore expensive, care. As a consequence, older people may be limited in their choice of nursing home.

HIQA is concerned that the higher rates paid by the NHSS for beds in public nursing homes may lead to situations where private providers, conscious of the cost of care for a resident who has a higher dependency, select residents with lower dependency needs.

The differences in funding outlined above are also frequently cited as a one reason justifying the weekly charges levied on residents of private nursing homes. In contrast, residents accommodated in public facilities do not usually have to pay such charges. In essence, the higher NHSS payments to public nursing homes appear to cover the entire cost of care, including activities and aids. In contrast, the residents of private nursing homes must often pay for such services out of their own pockets.

As a consequence, older people who cannot afford additional weekly charges may have no choice but to take up residence in the multi-occupancy, ward-type environments that still prevail in many of Ireland's public nursing homes, rather than avail of more person-centred accommodation in the form of a single/twin room in a private nursing home.

The Nursing Home Support Scheme — driving improvements

Linking payments to regulatory compliance

The NHSS provides financial support for residents accommodated in registered designated centres only. This infers that the funded service is safe by virtue of its registration (with HIQA) and implied regulatory compliance. However, there is currently no formal link between regulatory compliance and payment of the NHSS.

Where the Office of the Chief Inspector finds poor regulatory compliance it may take enforcement action — ranging from the application of restrictive conditions to the registration of the centre, up to and including court proceedings — to close the designated centre. Throughout this often protracted process, the registered provider will continue to avail of funding from the NHSS although it has failed to deliver care to the required standard.

In this context, the NHSS has the potential to indirectly drive significant improvements to the quality of care for residents were it to be conferred with the legislative remit to withhold consent

[114] https://www2.hse.ie/file-library/fair-deal/cost-of-care-in-public-nursing-homes-2018.pdf
[115] https://www2.hse.ie/file-library/fair-deal/cost-of-voluntary-and-private-nursing-homes.pdf
[116] Figures correct on 12/12/2018 see https://www2.hse.ie/file-library/fair-deal/cost-of-voluntary-and-private-nursing-homes.pdf
[117] Figures effective from 01 February 2018 see https://www2.hse.ie/file-library/fair-deal/cost-of-care-in-public-nursing-homes-2018.pdf

for the admission of new or additional residents until the centre in question is deemed to be in compliance.

HIQA believes that this places a further incentive on the provider to maintain compliance with the regulations and National Standards. In such a situation, the Office of the Chief Inspector would be required to share information pertinent to regulatory enforcement with the NHSS. This approach is currently used in Northern Ireland to good effect.

Defining categories of care

As outlined above, currently the two key determinants of the rate payable to a registered provider of a nursing home are the geographical location of the nursing home and whether the provider is public, voluntary or private. This review provides an ideal opportunity to reconsider what determines the cost of care and to develop a funding model that is based on residential categories of care.

For example, there is scope to consider a payment scale, starting at the low level of care required by a frail, elderly person; escalating to the care required by a resident who may have advanced dementia. As an individual resident's condition and needs change, so too would the required funding.

In this way, funding could be directed to those residents with the highest care needs regardless of the geographical location of their chosen nursing home or the status of the provider. This approach is endorsed by the recently published Report of the Independent Review Group established to examine the role of voluntary organisations in publicly funded health and personal social services[118].

In this report, the review group outlines an approach whereby "essential services to be funded by the State at a nationally agreed price would support a move towards funding services based on the assessed needs of the individual. This list of essential services could form the basis for commissioning those services from non-State providers based on an assessment of their ability to provide services which meet national standards of safety and quality. This would of course not preclude any organisation, whether voluntary, public or private, from providing additional services but these would not automatically be funded by the State."

Providing clarity on residents' entitlements

The Nursing Home Support Scheme (NHSS) provides financial support towards the cost of long-term residential care[119]. The services which fall within the scope of long-term residential care which are covered by the agreed cost are:

- nursing and personal care appropriate to the needs of the person,
- basic aids and appliances necessary to assist a person with the activities of daily living,
- bed and board, and
- laundry services.

[118] Report of the Independent Review Group established to examine the role of voluntary organisations in publicly funded health and personal social services (January 2019)
[119] https://health.gov.ie/wp-content/uploads/2014/04/Information-Sheet-on-Payment-of-Fees.pdf

However, in our experience the system is a source of confusion for many residents and their families, particularly in understanding what they are entitled to and any additional fees that will be levied.

The provider of a nursing home is required to communicate clearly with each resident, setting out the services that they can expect to receive and any additional fees that will apply. This is set out in a contract of care, agreed with the resident, and providers can only charge for additional services listed therein.

Residents should not be charged additional fees over and above the agreed cost, except where he or she chooses to avail of additional services not covered by the NHSS, for example, hairdressing, the delivery of daily newspapers, or therapeutic or recreational activities.

In order to ensure clarity, transparency and consistency, we recommend that the NHSS should publish precise information on:

- how much residents are entitled to claim
- the criteria which define the level of nursing care
- the criteria which define the level of personal care
- the items included under the definition of basic aids and appliances
- what is covered under 'laundry services'.

A resident's eligibility for other schemes, such as the Drugs Payment Scheme or the medical card, is unaffected by the NHSS. However, HIQA is aware of multiple instances whereby services and aids availed of by an older person become unavailable once this person takes up residence in a nursing home. For example:

- nursing home residents may be required to pay for services such as physiotherapy and speech and language therapy because they cannot access the free, statutory service
- nursing home residents may be required to pay for specialised equipment such as chairs that would be available free of charge through the General Medical Services Scheme if they still lived in their own home.

Naturally, this causes unnecessary distress to the resident and their loved ones, and a process must be put in place to ensure that such errors do not occur.

The Nursing Hose Support Scheme — future implications

Homecare and alternative models of care

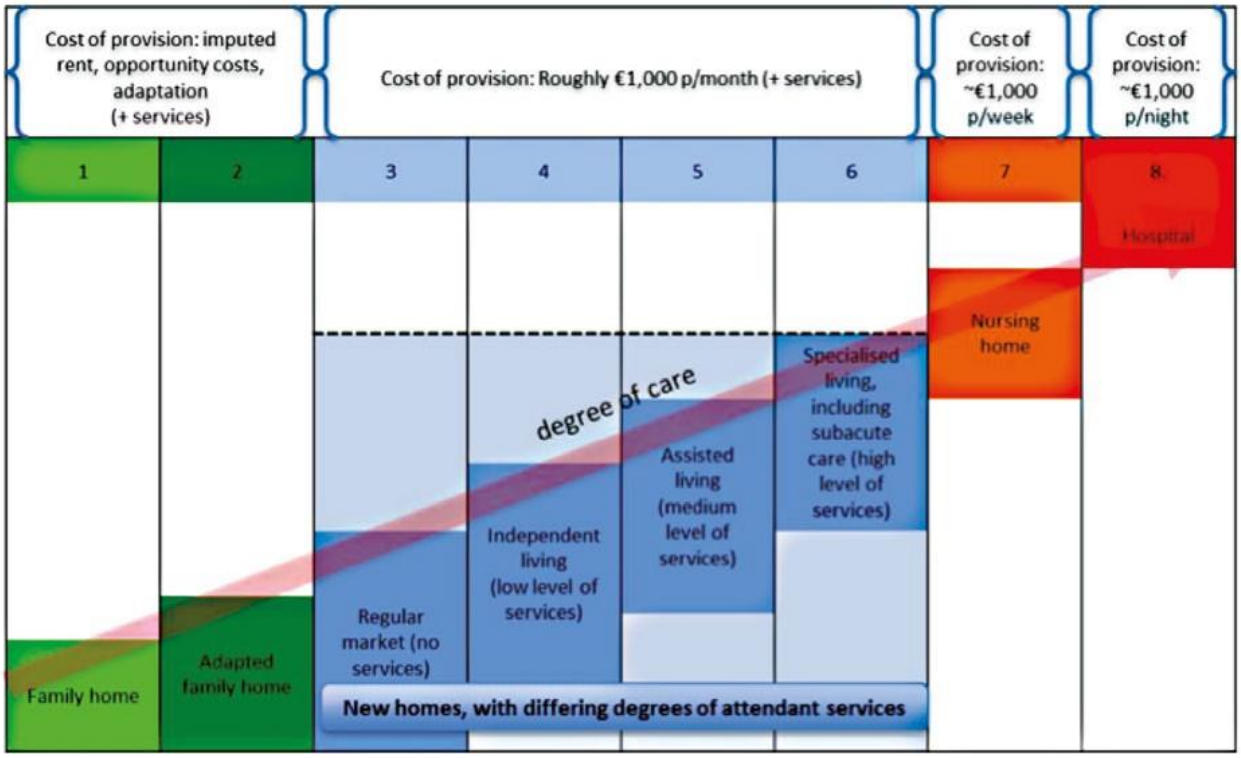
A review of various government health strategies[120] and policy documents since the 1960s have recommended that the best way of maintaining the physical and mental wellbeing of the majority of older people is to facilitate them to remain in their homes for as long as possible.

However, in Ireland we have created a system which is skewed towards residential care. Research published by the Centre for Ageing Research and Development in Ireland (CARDI) in 2011 showed that 7% of over 65s lived in nursing homes in the Republic of Ireland, while the figure was just 4%

[120] Browne, Dr M. Responding to the Support & Care Needs of our Older Population - Shaping an Agenda for Future Action. Dublin: Sage; 2016. Available from: http://www.thirdageireland.ie/assets/site/files/pr/Report_of_Forum_on_LTC_for_Older_People_FINAL.pdf.

in Northern Ireland. In fact, Ireland has the second-highest rate of nursing-home and or hospital residency for over 65s in the EU[121].

A report published in 2016[122] focused on housing and care needs for older people. This research, commissioned by the Housing Agency and the Ireland Smart Ageing Exchange, looked at the available literature on the subject and also interviewed hundreds of older people. Of relevance to this paper, the report proffered eight stages of housing and care needs for older people in Ireland. These stages are outlined in the graph below.



The preference for providing care in nursing home settings has led to the development of a funding model in the form of the NHSS which places a disproportionate emphasis on residential care to the detriment of homecare and other care services. Without the financial assistance from the State, many older persons are precluded from choosing alternative, yet perhaps more suitable, support services.

Currently there are a large number of services providing care in the community which are not covered by the NHSS. These services also do not come under the banner of a 'designated service', and therefore remain unregulated by an independent authority such as HIQA. Some examples include:

- homecare services — the provision of 'home help' or 'home care' packages to people in their own homes

[121][121] Centre for Ageing Research and Development in Ireland. Focus on Models of Care. Dublin: Centre for Ageing Research and Development in Ireland; 2011. Available from: http://www.cardi.ie/userfiles/Focus%20on%20Models%20of%20Care%20Aug%202011.pdf.
[122] Housing For Older People – Thinking Ahead. Available online https://www.housingagency.ie/Housing/media/Media/About%20Us/Report-Housing-for-Older-People-Thinking-Ahead-(2016).pdf

- sheltered housing/assisted living — the provision of accommodation in purpose-built dwellings with additional on-site services. This service is generally provided by voluntary organisations

- respite care — temporary services that are sometimes, but not exclusively, provided by nursing homes

- short stay/convalescence or step-down units — temporary arrangements which facilitate the care of persons recovering from illness

- day services — usually provided during day-time hours to older people who receive care in other settings

- hospice/palliative care — normally provided by the voluntary sector.

In conducting a review of the NHSS funding model, consideration must be given to alternative community services, that is, those services which are not considered designated services. Any future scheme of financial support must be fully future proofed to encompass new and emerging models of care. One means of doing so would be to define what is meant by 'care'. There is currently no definition in the Health Act 2007 or its associated regulations. A revised definition of 'care' would provide a benchmark against which any new service models could be measured.

CONCLUSION

The purpose of the NHSS is to provide financial support for people who require nursing home care. The scheme is founded on the core principles that long-term care should be affordable and that a person should receive the same level of State support regardless of whether they choose a public, voluntary or private nursing home[123]. However, in its present form the NHSS is not providing the same level of financial support to private and public nursing homes.

The NHSS has the potential to instigate meaningful improvements in care should the system change to link nursing home payments to the achievement of regulatory compliance. Furthermore, we believe that there is scope to develop a system whereby services would be funded according to the assessed needs of the individual.

HIQA welcomes the Government's commitment to placing homecare services on a statutory footing and is of the view that in doing so, homecare could become a viable alternative for many people who wish to remain in their own homes for as long as possible. However, in order for this to become a reality, homecare services must not only be consistently available across the country, but an appropriate, fit-for-purpose funding model must be established, whether within the NHSS, or closely associated with it. In addition, any plans to bring other models of care within the remit of regulation must also be included in any review of the supporting financial model.

[123] https://health.gov.ie/future-health/older-people/nursing-homes-support-scheme-a-fair-deal/

HIQA welcomes the opportunity to participate in this review of nursing home care costs and looks forward to further engagement with the Department of Health in this regard.

ENDS

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Appendix 9: Recommendations of the Covid-19 Nursing Homes Expert Panel

#	Recommendation	Suggested Lead Agency	Suggested Timeframe
1. Public Health Measures			
1.1.	Continue the enhanced public health measures for COVID-19 Disease Management in Long-term Residential Care (LTRC) adopted by NPHET at its meetings of 31st March 2020 and 3rd April 2020, including PPE supply to nursing homes; staff accommodation; contingency staffing teams; preparedness planning etc. (see appendix 2)	HSE, HIQA, Each Nursing Home Provider as relevant	Ongoing
1.2.	HSE COVID-19 Response Teams have been a critical initiative. These teams must remain in place. These teams should be standardised in terms of operation and composition and must be overseen jointly by HSE CHOs and Hospital Groups, who should have joint responsibility and accountability for their operation.	HSE and Hospital Groups	Immediately and ongoing
1.3.	It is critical that regional public health departments are provided with sufficient resources to have a staff complement and skill mix of team members in place to provide local support. The Crowe Howarth recommended implementation process should continue on a timely basis.	HSE	Immediately Ongoing
2. Infection Prevention and Control (IPC)			
2.1.	Develop an integrated infection prevention and control strategy in the community with particular focus on all nursing homes, public, private or voluntary.	HSE	Within 1 month of publication of this report
2.2.	Each nursing home should adopt a clear IPC strategy, including deep clean protocols, for itself which should be incorporated into its preparedness plan. It should be reviewed regularly to ensure consistency with the HSE's community IPC strategy.	Each Nursing Home Provider	Within 1 month of publication of this report
2.3.	In line with public health and ECDC guidance, nursing home residents should continue to be prioritised for testing with rapid reporting of results.	HSE (HPSC)	Immediate and ongoing
2.4.	A plan for and monitoring of a programme of periodic testing for healthcare workers in nursing homes should be continued. Associated protocols should identify the periods.	HSE (HPSC)	Within 1 month of publication of this report – monitoring and review ongoing
2.5.	Ensure there is rapid turnaround capacity in testing and contact tracing system.	HSE (HPSC)	Ongoing

#	Recommendation	Suggested Lead Agency	Suggested Timeframe
2.6.	It is essential that in-house staff who can undertake sample swabbing and reliable labelling are available, and that there is proximal access to a laboratory with Laboratory Information Management Systems (LIMS) follow up for contact tracing for both residents and staff.	Each Nursing Home Provider	Ongoing
2.7.	(a) Infection control training should be mandatory for all grades of nursing home staff. (b) Nursing home staff should have access to 'train the trainers infection control' training programme approved by the HSE. (c) Commitment required by healthcare agencies to formally confirm evidence of IPC, including PPE training prior to allocating staff to nursing homes. Nursing home providers should not contract an agency staff without evidence of IPC/PPE training. Each provider should have documentary assurance from the agency that the staff member has had the requisite training. HIQA should undertake compliance checks. (d) Every nursing home requires onsite access to a trained infection control lead on each shift. That lead will ensure IPC protocols are implemented and will support staff to do so.	(a) Each Nursing Home Provider (b) Each Nursing Home Provider and HSE (c) Staff Agencies and each Nursing Home Provider (d) Each Nursing Home Provider	Immediate and ongoing
2.8.	A user-friendly, consistent protocol for ordering and for the ongoing supply of additional COVID-19 related PPE to nursing homes by the HSE needs to be refined. Similar protocols must be put in place for the ordering and supply of other essential COVID-19 management related equipment. These protocols should be kept under review during the pandemic. Each nursing home is responsible for and should have an emergency supply of PPE and other COVID-19 related equipment in the event of a cluster. This should be included in preparedness plans.	HSE Each Nursing Home Provider	Ongoing
2.9.	Influenza vaccine should be prioritised for all residents unless medically contraindicated of all nursing homes once it becomes available and consider making it mandatory for staff.	HSE and Department of Health	Planning should commence immediately
2.10.	Management of entry and exit: Examine options for zoning within care homes so different entrances/exits can be used for different parts of the home. This examination should be documented with results and actions incorporated into preparedness plans.	Each Nursing Home Provider	Within 3 months

#	Recommendation	Suggested Lead Agency	Suggested Timeframe
3. Outbreak Management			
	COVID-19 is highly contagious and has atypical presentations in older adults. There needs to be a strong clinical index of suspicion. Nursing homes need an immediate action plan for when COVID-19 cases are suspected and must include the following elements, in accordance with HSE protocols:		
3.1.	Access to rapid testing with fast tracked results, as above.	HSE	Ongoing
3.2.	PPE to be readily available and staff training with onsite supervision on every shift to ensure PPE being used correctly. Training should be documented and records available for inspection by HIQA.	Each Nursing Home Provider HIQA (compliance oversight)	Ongoing and all staff should be trained within 2 months
3.3.	Sustain protocols for self-isolation, quarantine, cohorting and referral to GP Lead.	Each Nursing Home Provider	Ongoing
3.4.	Suspect cases and close contacts need to be isolated pending the results of rapid testing.	Each Nursing Home Provider	Ongoing
3.5.	Facilities must have ability and space to isolate and cohort residents and a clear plan on how this will happen. This plan should be incorporated into preparedness plans.	Each Nursing Home Provider	Ongoing
3.6.	Access to safe staffing levels at all times and to include required skill set on every shift.	Each Nursing Home Provider	Ongoing
3.7.	Social distancing facilities for residents and staff should be in place and maintained.	Each Nursing Home Provider	Ongoing
3.8.	Each provider should incorporate written plans on each of the above into their preparedness plan for review by HIQA.	Each Nursing Home Provider HIQA (compliance oversight)	Ongoing
4. Future admissions to Nursing homes			
4.1.	Ensure all new residents coming from the community or proposed transfers from hospital are tested for COVID-19 prior to admission.	Each Nursing Home Provider and HSE	Ongoing
4.2.	Admissions should only be made to nursing homes who can demonstrate their infection control measures are of sufficient standard to ensure there is no risk of onward infection. HIQA should maintain a register of those nursing homes it deems to have demonstrated sufficient infection control standard reached, to support informed decisions on admissions in this regard.	Each Nursing Home Provider, HSE and HIQA	Ongoing
4.3.	New Residents must be isolated according to HPSC protocol.	Each Nursing Home Provider	Ongoing

#	Recommendation	Suggested Lead Agency	Suggested Timeframe
5. Nursing Home Management			
5.1.	Log of all persons/staff entering nursing homes should be maintained by each nursing home and available for inspection by HIQA.	Each Nursing Home Provider HIQA (compliance oversight)	Ongoing
5.2.	Nursing homes should have a clear written back-up plan when regular staff cannot work or fail to turn up for work. This should be incorporated into the nursing home's preparedness plan for review by HIQA.	Each Nursing Home Provider HIQA (compliance oversight)	Immediate
5.3.	All Healthcare Assistants (HCAs) should have a relevant QQI Level 5 qualification or be working towards achieving it. A phased pathway towards achieving this should be in place. The requirement's inclusion in the regulatory framework should be considered.	Each Nursing Home Provider Department of Health (if regulation required)	An education plan for each healthcare assistant should be in place by each provider within 18 months of the publication of this Report
5.4.	Framework for Safe Staffing and Skill mix (published 2018) should be prioritised and urgently developed to apply in nursing homes - public and private, nationally.	Department of Health	Within 18 months of publication of this Report
5.5.	While Phase 3 of the Safe Staffing Framework is developed, in the interim, evidence and learnings from earlier phases of the Framework should be examined and used to inform interim changes to staffing in nursing homes. These learnings should also be used to develop guidance on staffing levels and skillmix in surge situations arising from COVID-19. These changes should be readjusted as Phase 3 develops and is rolled out.	Department of Health	2020
5.6.	For the next 18 months or until the declaration of the end of the Global pandemic by WHO, staff employed by a nursing home should be precluded from working across multiple sites and adequate single-site employment contracts should be put in place to support this.	Each Nursing Home Provider (employment) Department of Health (if regulation required) HIQA (compliance oversight)	Planning should commence immediately

#	Recommendation	Suggested Lead Agency	Suggested Timeframe
5.7.	A review of employment terms and conditions of nurse and healthcare assistant staffing grades in nursing homes should be undertaken with a view to ensuring future capacity and the supply of qualified staff.	Department of Enterprise, Trade and Employment	Within 18 months
5.8.	Occupational health and HR support, including psychological supports, for all staff is necessary and access should be put into place.	Each Nursing Home Provider	Immediately
5.9.	Increased integration of private and voluntary nursing homes into the wider health and social care systems requires enhanced transparency of operation, funding and finances of these nursing homes. The funding and expenditure (public and private monies) utilisation by private and voluntary providers in providing and improving services should be clearly transparent and measures should be considered to ensure this.	Department of Health, NTPF, HSE	Planning should commence immediately
6. Data Analysis			
6.1.	Improve linkage amongst different datasets such as CIDR with HIQA and GRO datasets. This may include updating the CIDR outbreak file data fields to include a HIQA ID.	HSE (HPSC) and HIQA	Planning should commence immediately with a view to completing linkages in 2020
6.2.	Implementation of Individual Health Identifier (IHI) as a matter of priority to enable tracking of patients between community and acute hospital sectors.	HSE and Department of Health	Progress should be made without delay
6.3.	Develop and introduce an integrated IT system for older persons services including residential, home support, day care, needs assessment and care planning, so as to support the provision, management, delivery and reporting of services, and especially for planning alternative service provision and planned capacity development in the event of evolving public health measures.	HSE	Introduce within 18 months or sooner
6.4.	Realignment of geography used in CIDR to Regional Health Areas (RHAs), counties or other, in line with current health system structures as they evolve.	HSE (HPSC)	Planning should commence immediately
6.5.	Introduction of the ability to link and track contacts into CIDR or using another data programme.	HSE (HPSC)	Planning should commence immediately
6.6.	Having regard to improved data linkages (6.1), the HSE (HPSC) should produce a detailed report on the management and outcomes of the multiple clusters that occurred during the COVID-19 pandemic with learnings on causal factors and preparedness for infection prevention and control.	HSE (HPSC)	Within 9 months of the publication of this Report
6.7.	HPSC, HSE and HIQA should produce a detailed epidemiological analysis comparing both risk and protection factors associated with having an outbreak or not at all in HIQA regulated facilities.	HSE (HPSC) and HIQA	Within 3 months of the publication of this Report

#	Recommendation	Suggested Lead Agency	Suggested Timeframe
7. Community Support Teams			
7.1.	Establish new integrated Community Support Teams with clearly defined joint leadership and responsibility across each CHO and hospital group area on a permanent basis, in line with the discussion in this chapter. In the interim, the existing COVID-19 Response Teams should remain in place.	HSE and Hospital Groups	Planning to commence immediately
7.2.	In the event of a COVID-19 surge, a designated member of the future Community Support Team should always have 24/7 availability for the nursing homes in the catchment area.	HSE and Hospital Groups	Immediately
8. Clinical – General Practitioner lead roles on Community Support Teams and in Nursing Homes			
8.1.	A GP will be a key member of each Community Support Team (and in the interim each COVID-19 Response Team).	HSE	Within 3 months of publication of this Report
8.2.	One of the GPs, already caring for their patients in a nursing home, will be appointed to the additional role as a nursing home's GP Lead, and working with the Person in Charge and other senior nursing home staff will contribute to the nursing home's general oversight and governance. The Person in Charge has overall responsibility for clinical governance.	Each Nursing Home Provider and GPs	Within 18 months of publication of this Report
8.3.	The sessional commitment and remuneration for the post will be specified in a contract between the nursing home and GP lead; functions would include promoting the use of instruments like the InterRAI Single Assessment Tool and the Clinical Frailty Score and optimising medication management, ensuring full compliance with e.g. influenza vaccine uptake for residents and staff in the nursing home and close liaison with community services and outreach services of acute Hospital Groups.	Each Nursing Home Provider and GPs	Within 18 months of publication of this Report
8.4.	A national framework describing the role and responsibilities of the GP lead, including the elements outlined above, should be developed, so that providers can operate within a consistent and clear set of requirements.	Department of Health and HSE	Within 18 months of publication of this Report
8.5.	The Department of Health with support from HIQA should explore, whether the particulars of this framework should be incorporated into the regulatory framework.	Department of Health	Within 18 months of publication of this Report

#	Recommendation	Suggested Lead Agency	Suggested Timeframe
8.6.	A clinical governance oversight committee should be established in all nursing homes and its inclusion in the regulatory framework should be considered – in the interim guidance on the role and composition should be developed. In time, one of the functions of this oversight committee should be to review quality indicator/resident safety reports and action appropriate follow up (see recommendation 9.4).	Each Nursing Home Provider HSE (Guidance) Department of Health (Regulation if required) HIQA (compliance oversight)	Within 9 months of publication of this Report. Within 6 months of publication of this Report. Within 18 months of publication of this Report.
9. Nursing Home Staffing/Workforce			
9.1.	HIQA should carry out and publish a detailed audit of existing staffing levels (nursing and care assistant) and qualifications in all nursing homes – public, voluntary and private.	HIQA	Within 6 months of publication of this Report
9.2.	It is essential to have strong informed nursing leadership on site in all nursing homes with a documented contingency plan for when leaders are absent. These plans should be incorporated into preparedness plans. They should be available for inspection by HIQA.	Each Nursing Home Provider. HIQA (compliance oversight)	Ongoing
9.3.	There should be national criteria on roles and responsibilities of the Person in Charge and registered nursing staff in nursing homes. This should be incorporated into the regulatory framework.	Department of Health	Within 9 months of publication of this Report
9.4.	Considering the nursing metrics and the HPSIR, a quality indicators and outcomes/resident safety model should be developed for nursing homes, requiring each nursing home to publish regular reports and to provide copies to HIQA. HIQA should establish a public register of all such reports provided by nursing homes, and oversight and validation checks should be incorporated into the regulatory framework.	Department of Health (model) Each Nursing Home Provider (Implementation) HIQA (compliance oversight)	Planning for and the development of a model and process should commence immediately with a system developed within 9 months and operational within 18 months
9.5.	The development, in the medium-term, of clinical governance models in the community should be explored further by the Department of Health in conjunction with the HSE, supported by an international evidence review of models of clinical governance in nursing home settings.	Department of Health and HSE	Within 12 months

#	Recommendation	Suggested Lead Agency	Suggested Timeframe
10. Education-Discipline-Specific and Inter-disciplinary			
10.1.	HSE training programmes, such as e.g. HSELanD, should continue to be made available to private nursing homes and an appropriate governance structure established.	HSE	Ongoing
10.2.	To promote the wider implementation of advanced healthcare directives (AHDs), education programmes, including some virtual, should be put in place and providers should facilitate greater staff participation.	The Decision Support Service and HSE Each Nursing Home Provider (facilitating staff participation)	Planning should commence immediately
10.3.	Implement relevant aspects of the Assisted Decision Making (Capacity) Act 2015, once enacted, in areas such as capacity assessment, recognising each resident's will and the wider use of advanced healthcare directives.	Department of Justice and Equality in consultation with the Department of Health	Within 6 months of publication of this Report
10.4.	Staff training and career development programme with a requirement that senior nursing staff will have undertaken post-graduate gerontological training and show general evidence of training competency. A phased pathway towards achieving this should be in place with clear targets set, and regulatory oversight provided to ensure that targets are met.	Each Nursing Home Provider Department of Health and HIQA (Regulation if required) HIQA (Compliance oversight)	Phased pathway and targets should be developed within 9 months (provider, with regulation developed as required (Department of Health). Each Nursing Home Provider should have a compliance plan within 3 months thereafter

#	Recommendation	Suggested Lead Agency	Suggested Timeframe
10.5.	Mandatory continuing education for all staff in areas such as infection control, palliative care & end of life and dementia should be introduced and a phased pathway towards achieving this should be in place with clear targets set, and regulatory oversight provided to ensure that targets are met.	Department of Health (Regulation if required) HIQA (Compliance oversight) Each Nursing Home Provider (compliance plan and pathway for all staff)	Phased pathway and targets should be developed within 9 months with regulation as required (Department of Health regulatory and HIQA compliance oversight). Each Nursing Home Provider should have a compliance plan within 3 months thereafter
11. Palliative Care			
11.1.	Every nursing home should be linked with the Community Palliative Care Team in their catchment area.	HSE and Each Nursing Home Provider	Within 2 months
11.2.	Visitor guidelines – individual assessments should be under-taken and documented, and compassionate visiting should be followed as recommended by the HSE and in line with HPSC visiting guidance. They should be available for inspection by HIQA.	Each Nursing Home Provider HIQA (Compliance oversight)	Immediately and ongoing
11.3.	Initiate a joint HSE-IHF collaborative national programme on palliative, end-of-life and bereavement care for the nursing home sector that engages all stakeholders and improves quality of care across the sector. This initiative would be established along the same lines as the HSE-IHF Hospice Friendly Hospitals Programme (2017 to date).	HSE and Irish Hospice Foundation	Planning should commence immediately
12. Visitors to Nursing Homes			
12.1.	HPSC should proactively/regularly review visiting guidelines in order to achieve a balance between individual freedoms and protective public health measures, in line with the Department of Health ethical guidance.	HSE (HPSC)	Ongoing
12.2.	Infrastructural adaptations may be needed including visiting rooms that can facilitate visits from friends and family.	Each Nursing Home Provider	Immediately
12.3.	End of life visiting must be arranged on compassionate grounds based on clinical judgement and take account of public health measures.	Each Nursing Home Provider	Ongoing

#	Recommendation	Suggested Lead Agency	Suggested Timeframe
13. Communication			
	Support and communication for residents and their families are a continuing priority.		
13.1.	Meaningful communications with residents and families should take place regularly in relation to visiting protocols, changes in processes and explanations relating to same.	Each Nursing Home Provider	Ongoing
13.2.	Clear communication plans with residents to provide information on the ongoing situation should be developed and documented regularly. HIQA should examine these as part of the inspection process. Providers should provide regular updates about residents to the families.	Each Nursing Home Provider HIQA (Compliance oversight)	Ongoing
13.3.	Phone lines must be maintained and additional reception / communications staff planned for at busy periods. Purchase tablet computers if relevant and review IT solutions for use by individual residents to assist with family and friend communication and review of facilities to ensure all have access to Wi-Fi facilities. Each provider should document its review and action plan in this regard and make it available to residents, families and HIQA.	Each Nursing Home Provider	Within 3 months of publication of this report
13.4.	Dedicated staff should be assigned/appointed to facilitate social activities and communication with family. Assignments / appointments should be documented with clear activity and communication plans and records in place, and available for inspection by HIQA.	Each Nursing Home Provider HIQA (Compliance oversight)	Within 3 months of publication of this report
14. Regulatory Recommendations			
14.1.	A clear document outlining the roles and responsibilities of key stakeholders should be developed to include a clear overview of the roles and responsibilities of NPHET, the Department of Health, HSE, HIQA, and individual providers. This should take into account the recommendations in this Report. The ongoing approach to nursing homes should be coordinated in line with this. Official guidelines, key updates and important news relating to COVID-19 should be coordinated and distributed to providers from one statutory source to avoid duplication and confusion. Requests for information from providers should be coordinated similarly subject to existing legal requirements.	Department of Health in consultation with HSE and HIQA	Document should be developed Within 1 month of publication of this report and HIQA or the HSE should be designated as sector communications coordinator HSE and HIQA should agree a written protocol on communication within 1 month thereafter

#	Recommendation	Suggested Lead Agency	Suggested Timeframe
14.2.	HIQA itself identified a deficit in infection control and risk management expertise in this sector. Mandatory training records including infection control should be included consistently in the inspection process.	HIQA	Planning should commence immediately
14.3.	There are currently 22 inspectors overseeing approximately 576 facilities with a visit frequency of 18 months. While onsite inspections are labour intensive, the frequency of these should be increased.	HIQA	Immediately
14.4.	The legislation underpinning nursing homes registration and operation and empowering HIQA is in place, but the current regulations need to be modernised and enhanced with additional powers and requirements. These regulations should be reviewed, including to give full effect to the recommendations of this report.	Department of Health with input from HIQA	Within 6 months of publication of this report
14.5.	Assessment of compliance with the regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak should be part of the inspection process.	HIQA	Immediately and ongoing
14.6.	Provision should be made for regular mandatory reporting to HIQA of key operational data by each nursing home provider including data on staff numbers and grades, qualifications, occupancy levels. This data should be available to health agencies including the Department of Health to inform ongoing planning for residential care services. HIQA should ensure streamlined processes are in place for the collection, collation and reporting of such data.	Department of Health (Regulation if required) HIQA (operational processes) Each Nursing Home Provider (submission of data)	Within 6 months of publication of this Report
15. A broader range of statutory care supports for Older People			
15.1.	Integration of private nursing homes into the wider framework of public health and social care should be advanced. This should be prioritised in the short-term with the implementation of the recommendations in this Report, and longer-term reform should be pursued as a key component of the intended Commission on Care.	HSE and Each Nursing Home Provider in the short term Government, HSE, Department of Health (long-term reform)	In line with timelines for relevant recommendations in this report. Planning should commence in line with the Commission on Care process
15.2.	The Department of Health and HIQA should explore introducing a requirement that all nursing home providers promote, facilitate and engage meaningfully with independent advocacy services.	Department of Health and HIQA	Within 6 months of publication of this Report

#	Recommendation	Suggested Lead Agency	Suggested Timeframe
15.3.	The Department of Health should explore a suitable structure and process for external oversight of individual care concerns arising in nursing homes, once internal processes have been exhausted without satisfaction.	Department of Health	Within 12 to 18 months of publication of this Report
15.4.	HIQA and each nursing home provider should continue to highlight and promote independent advocacy services available to residents.	HIQA and Each Nursing Home Provider	Ongoing
15.5.	Provide nursing home residents with full medical card eligibility equality of access to services available to community-based peers.	HSE	Immediately and ongoing
15.6.	Access to home support should be expanded and prioritised.	HSE and Department of Health	Immediately
15.7.	Standardised care needs assessment should be developed and rolled out. Consideration of a person's suitability for rehabilitation and/or reablement services should be mandatory prior to ad-mission to nursing home and an opportunity for access to such services should be available. The consideration and outcome should be documented.	HSE, Overseen by the Department of Health	Develop models and pathways within 9 months of publication of this Report. Ensure longer term integration within 24 months of publication of this Report
15.8.	Incentives, including financial, must be explored to help provide a wider range of service and ownership models for both care in the home and in smaller congregated units/ settings. This would acknowledge and reflect most people's preferred wishes.	Government, Department of Finance, Department of Public Expenditure and Reform, in consultation with Department of Health	Within 18 months of publication of this Report
15.9.	Review and as appropriate following review develop policy and underpinning legislation, as necessary, for the introduction of a single integrated system of long-term support and care, spanning all care situations with a single source of funding.	Government and Department of Health	Planning for the review should commence in line with the Commission on Care process
15.10.	This choice model would be payable to the beneficiary for use either to support further care in their own home, in alternative home-based supportive care or in residential care.	Government and Department of Health	Planning for the review should commence in line with the Commission on Care process
#	Recommendation	Suggested Lead Agency	Suggested Timeframe

15.11.	To support this policy initiative, and in line with 15.7 national integrated care needs assessment and care planning policy and structures should be developed for older persons services. Examination of the role of resource allocation models should be undertaken including an international evidence review.	Department of Health and HSE	Policy development and commence roll out within 9 months of publication of this Report
			Review of Re-source Allocation Modelling within 18 months of publication of this Report
15.12.	The National Care Experience Programme expansion to nursing home residents should be progressed at pace.	HIQA	Within 18 months of publication of this Report