9 Trends in healthcare cover and healthcare use for older adults in Ireland during the austerity years of 2009 to 2016

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The Irish Longitudinal Study on Ageing

9 Trends in healthcare cover and healthcare use for older adults in Ireland during the austerity years of 2009 to 2016

Key Findings

Following the financial crash in 2008, Ireland entered a period of austerity. This report examines trends from 2009 to 2016 to explore potential effects of this period in healthcare cover and healthcare utilisation. Key trends are summarised here:

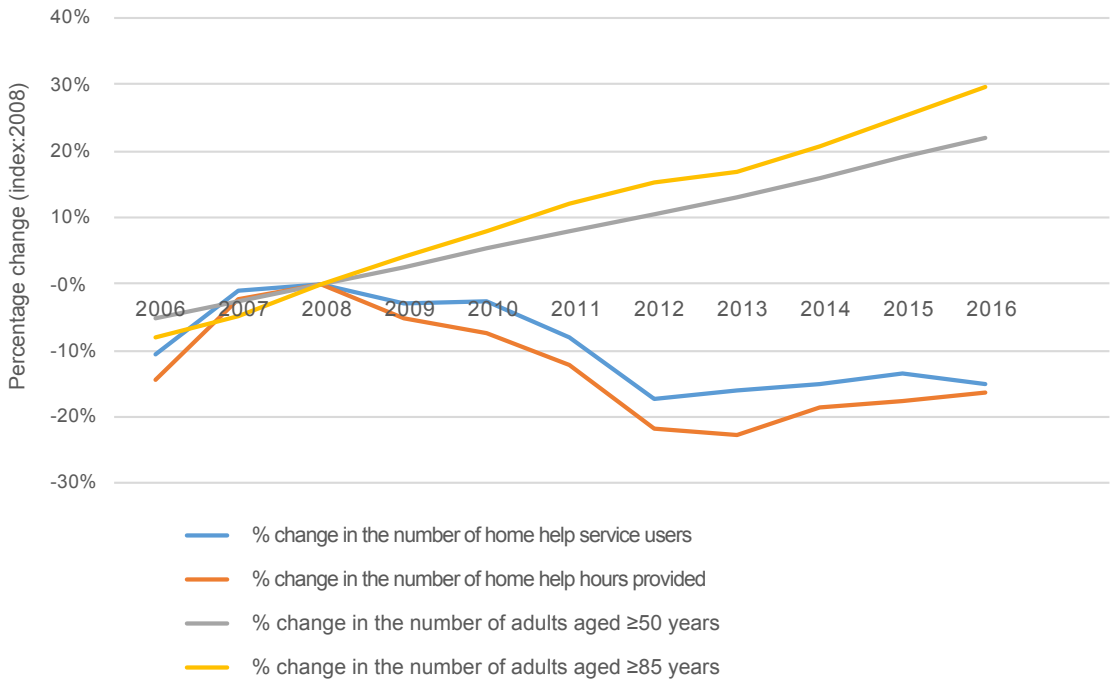
- The proportion with a medical card increased (from 45% to 53%) but, dropped in the over 70s (from 90% to 74%). A means testing system for medical card entitlement for the over 70s was introduced in January 2009 and the threshold decreased during subsequent Budgets.
- The proportion with a GP visit card increased (from 2% to 9%) and, within the over 70s, increased substantially (from 1% to 19%) between Waves 1 and 4. A universal GP visit card for the over 70s was introduced in 2015.
- We did not detect any changes in the rate of purchasing private health insurance among older adults in Ireland.
- We found an increase in the proportion of older adults in Ireland who visited a range of medical care services at least once in the previous year including visits to their General Practitioner (from 87% to 92%), the Emergency Department (15% to 18%) and hospital admissions (12% to 26%). We detected a marginal increase in the average number of nights spent in hospital (1.0 to 2.0 nights).
- For older adults with frailty, the proportion with at least one overnight hospital admission increased (from 23% to 31%) while the average number of nights spent in hospital more than doubled (from 2.7 nights to 6.5 nights). The proportion with at least one outpatient clinic visit fell (from 69% to 59%) and the average number of outpatient clinic visits decreased (from 3.1 visits to 2.1 visits).
- Dental care use reduced (from 11% to 9%); though the rate of decline was most notable for those who were classified as frail (from 17% to 11%).

- Community services (e.g. respite, day centre, meals on wheels, occupational therapy or community nursing) were accessed infrequently and we found minimal change in the utilisation of these services across the waves.
- Home help and personal care provision increased marginally (from 3% to 5%) however, the users of the home help service changed – 19% of users had concurrent limitations in activities of daily living (ADL) and instrumental activities of daily living (IADL) in 2010 compared to 41% in 2016. The HSE changed the objective of the home help service in 2012 from provision of 'domestic help' to provision of 'personal care.'
- Informal care (i.e. care from family or friend) use increased (5% to 9%), and particularly among older adults with frailty (27% to 36%) between Wave 1 and Wave 4.

9.1 Introduction

Older people's health service utilisation and healthcare cover is captured at each wave of TILDA, beginning with Wave 1 in 2009. By Wave 4, we have captured a seven year period allowing us to examine changes in these areas between 2009 and 2016. This was a period of significant change in Ireland – the so called 'austerity years' where public revenue for the health sector was substantially reduced and private incomes and employment fell. Government non-capital spending on health fell from €14.4 billion in 2009 to €13.1 billion[1] in 2015 while a public sector recruitment embargo and a voluntary redundancy scheme introduced in March 2009 resulted in the loss of over 8,000 whole time equivalent positions from the health service between 2008 and 2014 (1). At the same time, aggregate demand for healthcare increased, as more people became entitled to means-tested medical cards and the number of older adults, who are the main users of health services, increased. Figure 9.1 shows the percentage change in the number of older adults in the population, the number of home help users[2] and the number of home help hours provided relative to the values recorded in 2008, see Table 9.10 in the appendices for the aggregate data.

Figure 9.1: Percentage change in the number of home help users, hours of home help care provided, older adults aged ≥50 years & ≥85 years 2006–2016.



1 Later increasing to □14.6 billion in 2016
2 Not including users of home care packages

This HSE data shows that the number of home help hours provided declined relative to the levels provided in 2008 while the proportion of people in the older age groups increased, requiring the home help service to be shared among a greater number of people. The rules governing the allocation of the service also changed. Prior to 2012, the home help service prioritised the provision of 'domestic help' (e.g. household cleaning, shopping), but this was changed to prioritise the provision of 'personal care' (e.g. assistance into or out of bed, bathing); a more stringent test for allocating the home help service (2)[3] .

While greater efficiencies in hospital care were noted between 2008 and 2012 such as an increase in hospital day case activities[4] (4), 2012 was marked as a tipping point where the 'fat had been trimmed' and further budget cuts meant that the healthcare system was forced to do 'less with less' (5). From the end of 2012, through 2013 and 2014, inpatient activity decreased and day case activity levelled off despite increased demand, leading to even longer waiting lists for planned hospital care (5). At the end of 2013, health service managers reported that over 25% of their time was taken up with two activities - living within budget and managing change (6).

In addition to changes made to service provision, a substantial number of changes were made to healthcare cover, which is the protection that people have from being exposed to the full cost of healthcare. In the Irish healthcare system, any individual who is ordinarily a resident in Ireland is entitled to subsidised hospital care and prescribed medications financed through taxation (7). Those on low incomes are offered additional protection with the provision of a medical card[5], or a GP visit card[6]. Some people purchase private health insurance which is typically used for quicker access to hospital care. Between 2009 and 2016, healthcare cover changed substantially (Table 9.11).

In 2009, the universal 'over 70s' medical card was changed to a means-tested benefit and the income at which an individual could qualify for this benefit was lowered in subsequent budgets[7]. A charge on each item prescribed to those with a medical card, the 'prescription charge', was introduced in 2010 and this charge was increased incrementally. Entitlements to free dental and aural care were stopped as a medical card benefit.

3 "…Re-focusing home help services to prioritise personal care…There will be reductions of 4.5% nationally in the level of home help hours provided but this reduction will be compensated by a more rigorous approach to the allocation of these supports to ensure that the people most in need receive them by deprioritising non-personal care." (2 pg 7)
4 A 'day patient' is admitted to hospital for treatment on an elective (rather than an emergency) basis and is discharged alive, as scheduled, on the same day…Births are not included (3).
5 Provides access free at the point of use to GP care, hospital care, community care and subsidised medications.
6 Provides access free at the point of use to GP care only.
7 In July 2015, a universal GP-visit card was introduced for the over-70s who were no longer entitled to a medical card.

For those who did not have a medical card, the charges for public healthcare increased. The threshold for the Drugs Payment Scheme increased from €90 to €144, charges for an Emergency Department (ED) visit without a General Practitioner (GP) referral rose from €66 to €100 and charges for each night spent as an inpatient rose from €66 to €80 (capped at €800 per annum). Also the entitlements to dental and optical care were cut in 2010 and the entitlement to hearing aids was cut in 2012. Finally, the tax relief available to those who purchase private health insurance was lowered and in 2015, the Government introduced 'Lifetime Community Rating' which was a policy that incentivised people to purchase private health insurance. Within the population in Ireland, the proportion with private health insurance fell from 51% in 2008 to 43% in 2014 before increasing to 45% in 2017 (8).

Overall, the period 2009-2016 represents a period of significant change. A number of policy decisions were made that were driven by a financial imperative. The aim of this Chapter is to determine how entitlements to a medical card or a GP visit card, trends of purchasing private health insurance and health service utilisation changed over this period among the community-dwelling population aged 50 years and older. Data for this Chapter were obtained from the computer assisted personal interview (CAPI) conducted during four waves of TILDA.

Table 9.1: Timelines for data collection at each wave.

Wave	Data collection period
Wave 1	October 2009 – February 2011
Wave 2	February 2012 – March 2013
Wave 3	March 2014 – October 2015
Wave 4	January 2016 – December 2016

As our aim was to examine change at each time point, only those TILDA respondents who participated in all four waves were included in the analysis. Of the 8,175 participants in TILDA aged 50 years or more at baseline, 2,869 individuals who did not participate in all four waves were excluded, leaving us with an analytical sample of 5,306. We employed an attrition weight to deal with attrition bias and report on weighted means and proportions[8] at each wave. We recommend interpreting changes using the point estimates and confidence intervals.

8 As only participants who completed all four waves were included in this analysis, there may be small differences in the estimates reported for a wave compared to previous reports.

There are three parts to our analysis. Firstly, we examine participant's health cover at each wave, and categorised according to their age at the given wave.

Secondly, as we know that there is a relationship between frailty and service use (9), we examined the frailty status of service users to establish if there were changes in resource allocation on the basis of severity of need (i.e. frailty). Frailty occurs when people experience failure in multiple bodily systems leading to whole system breakdown. Frailty in older adults is viewed on a continuum and can change over time. Older adults classified as 'robust' may have health problems but these problems are being managed well. Older adults classified as 'pre-frail' are at an increased risk of adverse outcomes but are coping; and older adults classified as 'frail' are at highest risk of adverse health outcomes such as falls, disability, hospitalisation, nursing home admission and even death (10). Frailty was measured using a 'frailty index' which consists of 32 problems including chronic disease, functional measures and quality of life measures (Table 9.13). Participants were categorised as robust (0-3 health problems), pre-frail (4-7 health problems) or frail (8 or more health problems) at each wave.

Finally, we examined if the type and severity of disability of home help users changed over the waves in keeping with the policy change mentioned earlier. We measured disability with instrumental activities of daily living (IADL) and activities of daily living (ADL). IADLs are understood as higher order functional limitations (such as taking medications correctly, shopping, using the telephone, housekeeping, preparing meals and managing money) which align with the domestic management of the household (11). ADLs are the basic tasks of everyday life such as eating, bathing, dressing, toileting, and moving about (12). We examine the severity of an individual's functional limitations by reporting on the following categories: (1) "No ADL or IADL limitations"; (2) "one or more IADL limitations"; (3) "one or more ADL limitations"; (4) "one or more ADL and IADL limitations."

When examining a participant's health cover or patterns of service use stratified by their age, frailty status or disability status, it is important to note that we are reporting their status at each wave. As these characteristics will change over time, the corresponding numbers within each category will change at each wave. For example, a person who is classified as pre-frail in Wave 1, might be frail by Wave 3.

A description of the analytical sample

As the same participants took part in each wave, it is important to note the effects of cohort ageing. In Wave 1, the sample was aged a minimum of 50 years and this increased to 52 years and older in Wave 2, 54 years and older in Wave 3, and 56 years and older in Wave 4. This ageing of the sample is linked to the increasing proportion of the sample who were classified as frail or pre-frail over time in Chapter 7 (frail: 12.7% to 19.0% between Waves 1 and 4; pre-frail: 30.9% to 39.2% between Waves 1 and 4).

9.2 Health care cover

Healthcare cover refers to the protection that people have from being exposed to the full cost of healthcare. We describe healthcare cover from three different perspectives. Firstly, by examining the proportion of older adults in Ireland with additional public cover from a medical card or a GP visit card. Secondly, by examining the proportion with additional private cover from having purchased private health insurance. Thirdly, by examining the distribution of additional public or private healthcare cover across five categories: (1) 'None' indicates no medical card, GP visit card or private health insurance; (2) 'Medical card' indicates having a medical card only; (3) 'PHI' indicates having private health insurance only; (4) 'GP visit card' indicates having a GP visit card only and (5) 'Dual cover' indicates adults with either a medical card or GP visit card in addition to having private health insurance. These patterns are likely driven by the ageing of the cohort as the means-test thresholds for medical cards change as people age. Therefore, we examine the distribution of public and private healthcare cover by age group at each wave. Age has been categorised into three groups (50-65 years, 66-69 years, 70 years or more) that match those of public entitlements to a medical card or GP visit card (13, 14) to aid interpretation.

9.2.1 Additional public cover: Medical card or a GP visit card

Between 2009 and 2016, the proportion of people who had a medical card increased from 45% to 53% while the proportion with a GP visit card increased – from 2% to 9%, (Table 9.2). At each wave, approximately a third of 50 to 65 year olds had public healthcare cover indicating a persistent proportion of people pre-retirement on low household incomes. Approximately half of 66 to 69 year olds had public healthcare cover. The higher rate of public cover in this age group is likely explained by the combination of a drop in income following retirement and the slightly lower means-test threshold for additional public entitlements for this age group.

The majority of those aged 70 years or older had public cover at each wave, however the proportion with a medical card fell from 90% to 74% between 2009 and 2016 while the proportion with a GP visit card was 19% in 2016. This reflects the changing thresholds for the medical card and the policy decision to introduce a universal GP visit card for the over 70s in 2015.

Table 9.2: Proportion of older adults with additional public health cover between 2009 and 2016 by age group.

	No Medical/GP Visit Card		Medical Card		GP Visit Card		Total	Number in sample
	%	95% CI	%	95% CI	%	95% CI		
50-65 years								
Wave 1	68	(66-71)	29	(27-32)	2	(2-3)	100	3479
Wave 2	65	(62-67)	33	(31-36)	2	(2-3)	100	3071
Wave 3	65	(62-67)	33	(31-35)	3	(2-3)	100	2593
Wave 4	64	(61-67)	34	(31-37)	2	(1-3)	100	2148
66-69 years								
Wave 1	52	(48-56)	46	(41-50)	2	(1-4)	100	620
Wave 2	50	(46-55)	46	(42-51)	3	(2-6)	100	733
Wave 3	51	(46-55)	46	(41-50)	4	(3-6)	100	818
Wave 4	52	(48-56)	45	(41-49)	3	(2-5)	100	833
70 years or more								
Wave 1	9	(8-12)	90	(88-92)	0	(0-1)	100	1200
Wave 2	12	(10-14)	88	(86-89)	1	(0-1)	100	1482
Wave 3	16	(14-18)	79	(77-81)	5	(4-7)	100	1886
Wave 4	8	(7-9)	74	(71-76)	19	(17-21)	100	2315
Total								
Wave 1	53	(51-55)	45	(43-47)	2	(1-2)	100	5299
Wave 2	48	(46-50)	50	(48-52)	2	(2-2)	100	5286
Wave 3	45	(43-47)	51	(49-53)	4	(3-4)	100	5297
Wave 4	38	(36-40)	53	(51-54)	9	(8-10)	100	5296

9.2.2 Private health insurance

The proportion of older adults in Ireland purchasing private health insurance was consistent across the waves ranging from 54% to 57% (Table 9.3). At each wave, the rate of purchasing private health insurance was marginally lower for older adults aged 70 years and older compared to younger adults, suggesting important interactions between the public and private system where some older adults who become eligible for public cover cease to maintain their private cover.

Table 9.3: Proportion of older adults who purchased private health insurance between 2009 and 2016 by age group.

	No Private Health Insurance		Private Health Insurance		Total	Number in sample
	%	95% CI	%	95% CI		
50-65 years						
Wave 1	41	(39-44)	59	(56-61)	100	3483
Wave 2	44	(41-46)	56	(54-59)	100	3085
Wave 3	46	(43-49)	54	(51-57)	100	2595
Wave 4	45	(42-48)	55	(52-58)	100	2155
66-69 years						
Wave 1	37	(33-42)	63	(58-67)	100	619
Wave 2	40	(36-44)	60	(56-64)	100	735
Wave 3	42	(38-47)	58	(53-62)	100	820
Wave 4	44	(40-48)	56	(52-60)	100	833
70 years or more						
Wave 1	52	(48-55)	48	(45-52)	100	1202
Wave 2	50	(46-53)	50	(47-54)	100	1482
Wave 3	49	(46-52)	51	(48-54)	100	1887
Wave 4	48	(45-51)	52	(49-55)	100	2315
Total						
Wave 1	43	(41-45)	57	(55-59)	100	5304
Wave 2	45	(43-47)	55	(53-57)	100	5302
Wave 3	46	(44-49)	54	(51-56)	100	5302
Wave 4	46	(44-48)	54	(52-56)	100	5303

9.2.3 The distribution of public and private healthcare cover

With respect to the distribution of public and private cover, the proportion of those with no additional cover or with private health insurance only decreased while those with a medical card only or dual cover increased between the waves (Table 9.4).

We did not find any significant change in the distribution of public and private cover over time among adults aged 50 to 65 years. This age group had the highest proportion of people with no additional cover or private health insurance only and the lowest proportion of people with dual cover in comparison to other age groups. Among older adults aged 66 to 69 years, the proportion with dual cover decreased from 19% in Wave 1 to 13% in Wave 4. Among those aged 70 years or more, the proportion with private health insurance only fell from 9% in Wave 1 to 7% in Wave 4. Very few adults aged 70 years or more had no additional cover or a GP visit card only, it was more common to have either a medical card only or dual cover. This reflects the higher income limits available for the medical card for people aged 70 years or older.

Table 9.4: Proportion of older adults with public or private healthcare coverage between 2009 and 2016 by age group.

	No additional cover		Medical card only		Private Health Insurance only		Dual cover		GP visit card only		Total	Number in sample
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI		
50-65 years												
Wave 1	16	(15-18)	24	(22-26)	52	(50-55)	7	(6-8)	1	(1-2)	100	3478
Wave 2	16	(14-17)	27	(25-29)	49	(46-51)	7	(6-8)	1	(1-2)	100	3070
Wave 3	16	(14-18)	28	(26-31)	49	(46-51)	5	(5-6)	2	(1-2)	100	2593
Wave 4	16	(14-18)	28	(25-31)	48	(45-51)	7	(5-8)	1	(1-2)	100	2148
66-69 years												
Wave 1	8	(6-10)	28	(24-33)	44	(40-49)	19	(16-23)	1	(0-3)	100	619
Wave 2	7	(5-9)	32	(28-36)	44	(39-48)	16	(13-20)	1	(1-3)	100	732
Wave 3	7	(6-10)	33	(29-37)	43	(39-47)	15	(12-17)	2	(1-3)	100	818
Wave 4	8	(6-11)	34	(30-39)	43	(39-48)	13	(10-15)	1	(1-2)	100	833
70 years or more												
Wave 1	1	(0-2)	51	(47-55)	9	(7-11)	40	(36-43)	0	(0-1)	100	1200
Wave 2	1	(0-1)	49	(45-52)	11	(9-13)	39	(36-42)	0	(0-1)	100	1481
Wave 3	2	(1-2)	47	(44-50)	14	(12-16)	37	(34-39)	0	(0-1)	100	1884
Wave 4	1	(0-1)	46	(43-49)	7	(6-8)	45	(42-48)	1	(1-2)	100	2313
Total												
Wave 1	12	(11-13)	31	(29-32)	41	(39-43)	16	(14-17)	1	(1-1)	100	5297
Wave 2	10	(9-11)	34	(32-36)	38	(36-39)	17	(16-19)	1	(1-1)	100	5283
Wave 3	10	(8-11)	36	(34-38)	36	(34-38)	18	(16-19)	1	(1-2)	100	5295
Wave 4	8	(7-9)	37	(35-39)	30	(28-32)	24	(23-26)	1	(1-2)	100	5294

9.3 Utilisation of medical care

At each wave, TILDA participants were asked about the number of times they visited a range of medical services including the General Practitioner (GP), an outpatient clinic and the Emergency Department (ED), the number of overnight hospital admissions and the number of nights spent in hospital over the previous 12 months.

We examine both the proportion of older adults in Ireland who had at least one visit to these medical services, and the average number of visits to each service. We distinguished between planned hospital care where a visit is determined by a medical referral (e.g. an outpatient clinic visit) and an unplanned visit which is determined by a medical crisis (e.g. an ED visit, overnight hospital admission and nights spent in hospital).

We found a higher proportion of older adults who were classified as frail visit each of the services in comparison to the robust or pre-frail at each time point. However, a higher proportion of older adults classified as frail report overnight hospital admissions, while a lower proportion report outpatient clinic visits in Wave 4 versus Wave 1.

Table 9.5: Proportion of older adults visiting each service in the previous year between 2009 and 2016 by their frailty status.

	ED admissions		Visit to a GP		Outpatients clinic visits		Overnight hospital admissions		Number in sample
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	
Robust									
Wave 1	10	(9-11)	80	(78-81)	29	(27-31)	7	(6-8)	3072
Wave 2	10	(9-12)	85	(84-86)	33	(31-35)	7	(6-8)	2880
Wave 3	12	(10-13)	88	(86-89)	33	(31-35)	8	(7-9)	2733
Wave 4	10	(9-12)	86	(84-87)	32	(30-35)	9	(7-10)	2300
Pre-frail									
Wave 1	19	(17-21)	94	(93-95)	52	(49-54)	17	(15-19)	1631
Wave 2	17	(16-20)	94	(92-95)	53	(50-55)	15	(14-17)	1743
Wave 3	19	(17-21)	95	(94-96)	53	(51-56)	15	(13-17)	1826
Wave 4	19	(17-21)	95	(94-96)	49	(47-52)	17	(16-19)	2105
Frail									
Wave 1	26	(22-30)	99	(97-99)	69	(65-74)	23	(20-27)	603
Wave 2	29	(26-33)	98	(96-99)	69	(65-72)	29	(25-33)	682
Wave 3	33	(30-37)	97	(96-98)	62	(58-65)	29	(25-33)	747
Wave 4	31	(28-35)	99	(97-99)	59	(56-63)	31	(27-35)	901
Total									
Wave 1	15	(14-16)	87	(86-88)	41	(39-43)	12	(11-13)	5306
Wave 2	15	(14-17)	90	(89-91)	45	(43-46)	13	(12-14)	5306
Wave 3	17	(16-19)	92	(91-93)	44	(43-46)	14	(13-15)	5306
Wave 4	18	(17-19)	92	(91-93)	44	(43-46)	16	(15-17)	5306

The average number of nights spent in hospital increased from 1 to 2 nights between 2009 and 2016 (Table 9.6). This was mostly driven by the fact that the number of nights that older adults classified as frail spent in hospital had doubled between 2009 and 2016 (2.7 nights to 6.5 nights). By comparison, the average number of visits to the outpatient clinic (3.1 visits to 2.1 visits) had fallen among older adults classified as frail.

Table 9.6: Average number of times each older adult visited a service in the previous year between 2009 and 2016 by their frailty status.

	GP visits	Nights spent in hospital	Overnight hospital admissions	Outpatient clinic visits	ED admissions	Number in sample
	Mean (95% CI)	Mean (95% CI)	Mean (95% CI)	Mean (95% CI)	Mean (95% CI)	
Robust						
Wave 1	2.5 (2.3,2.6)	0.4 (0.3,0.5)	0.1 (0.1,0.1)	0.7 (0.6,0.8)	0.1 (0.1,0.2)	3070
Wave 2	2.6 (2.5,2.8)	0.4 (0.3,0.5)	0.1 (0.1,0.1)	0.9 (0.7,1.0)	0.1(0.1,0.2)	2880
Wave 3	2.7 (2.4,3.0)	0.7 (0.2,1.1)	0.1 (0.1,0.2)	0.8 (0.7,0.9)	0.1 (0.1,0.1)	2731
Wave 4	2.6 (2.5,2.8)	0.7 (0.4,1.0)	0.1 (0.1,0.1)	0.9 (0.7,1.0)	0.1 (0.1,0.1)	2613
Pre-frail						
Wave 1	4.6 (4.3,4.8)	1.3 (0.9,1.7)	0.2 (0.2,0.3)	2.0 (1.7,2.3)	0.3 (0.2,0.4)	1630
Wave 2	4.5 (4.3,4.8)	1.2 (1.0,1.4)	0.2 (0.2,0.3)	1.9 (1.6,2.2)	0.3 (0.2,0.3)	1742
Wave 3	4.4 (4.2,4.5)	1.6 (1.2,2.0)	0.2 (0.2,0.3)	1.8 (1.7,2.0)	0.2 (0.2,0.3)	1825
Wave 4	4.3 (4.0,4.5)	1.5 (1.2,1.8)	0.3 (0.2,0.3)	1.9 (1.6,2.2)	0.3 (0.2,0.3)	1865
Frail						
Wave 1	8.0 (7.2,8.9)	2.7 (2.0,3.4)	0.4 (0.3,0.5)	3.1 (2.6,3.6)	0.4 (0.3,0.5)	601
Wave 2	7.1 (6.4,7.8)	3.6 (2.6,4.5)	0.7 (0.5,0.9)	3.1 (2.6,3.6)	0.5 (0.4,0.6)	681
Wave 3	6.9 (6.3,7.6)	4.2 (3.1,5.2)	0.5 (0.4,0.6)	2.4 (2.1,2.8)	0.5 (0.4,0.6)	746
Wave 4	6.7 (6.2,7.3)	6.5 (4.7,8.2)	0.6 (0.5,0.7)	2.1 (1.9,2.4)	0.5 (0.4,0.6)	824
Total						
Wave 1	3.8 (3.6,4.0)	1.0 (0.8,1.1)	0.2 (0.2,0.2)	1.4 (1.3,1.5)	0.2 (0.2,0.3)	5301
Wave 2	3.9 (3.7,4.1)	1.1 (0.9,1.2)	0.2 (0.2,0.2)	1.5 (1.4,1.7)	0.2 (0.2,0.3)	5304
Wave 3	3.9 (3.7,4.1)	1.5 (1.2,1.8)	0.2 (0.2,0.3)	1.4 (1.3,1.5)	0.2 (0.2,0.2)	5302
Wave 4	3.9 (3.8,4.1)	2.0 (1.6,2.3)	0.2 (0.2,0.3)	1.5 (1.3,1.6)	0.2 (0.2,0.3)	5302

9.4 Utilisation of public allied healthcare

We also examined care services other than those provided by GPs and hospitals. At each wave, participants were asked if they had utilised any of the allied healthcare services in the preceding twelve months - excluding any services for which they had paid anything other than a token or nominal amount. This included any state provided physiotherapy, dietician, hearing, dental, optician, psychological and social work services (Table 9.7).

Unlike utilisation of medical care which increased between 2009 and 2016, at an aggregate level the proportion of older adults who accessed public allied healthcare did not change substantially. The proportion who utilised the hearing increased from 2% in 2009 to 3% in 2016, while the proportion utilising dental care decreased from 11% in 2009 to 9% in 2016.

Being an older adult classified as frail in comparison to robust or pre-frail was associated with an increased use of most services across all waves. However, in older adults with frailty, we found a decreased use of dental services (17% to 11%) and dietician services (5% to 2%) between Waves 1 and 4. Older adults classified as robust or pre-frail were associated with a decreased use of dental, optician services and physiotherapy services between Waves 1 and 4.

Table 9.7: Proportion of older adults visiting each service in the previous year between 2009 and 2016 by their frailty status.

	Physiotherapy		Dietitian		Hearing Service		Dental		Optician		Psychological		Social Work		Number in sample
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	
Robust															
Wave 1	2	(2-3)	0	(0-1)	1	(0-1)	9	(8-10)	8	(7-9)	1	(1-1)	0	(0-0)	3072
Wave 2	2	(2-3)	1	(0-1)	1	(1-2)	8	(6-9)	8	(7-9)	1	(0-1)	0	(0-0)	2880
Wave 3	2	(2-3)	0	(0-1)	1	(0-1)	5	(4-6)	6	(5-7)	1	(0-1)	0	(.-.)	2733
Wave 4	1	(1-2)	0	(0-1)	1	(1-1)	6	(5-7)	5	(4-6)	0	(0-1)	0	(.-.)	2298
Pre-frail															
Wave 1	7	(6-8)	2	(1-2)	2	(2-3)	13	(12-16)	17	(15-19)	1	(0-2)	0	(0-1)	1631
Wave 2	7	(6-8)	1	(1-2)	4	(3-5)	10	(9-12)	17	(15-19)	1	(1-2)	1	(0-1)	1743
Wave 3	7	(6-8)	1	(1-2)	3	(2-4)	9	(8-10)	13	(11-15)	1	(0-1)	0	(0-0)	1826
Wave 4	5	(4-6)	1	(1-2)	3	(2-4)	10	(9-12)	13	(12-15)	1	(0-1)	0	(0-1)	2098
Frail															
Wave 1	15	(12-18)	5	(3-7)	4	(3-7)	17	(14-20)	22	(19-26)	2	(1-4)	1	(0-2)	603
Wave 2	15	(12-19)	4	(2-5)	7	(5-9)	17	(14-20)	29	(25-33)	2	(1-4)	0	(0-1)	682
Wave 3	14	(11-16)	3	(2-4)	6	(5-9)	9	(7-11)	18	(15-21)	1	(0-2)	0	(0-2)	747
Wave 4	13	(11-15)	2	(1-3)	7	(6-10)	11	(9-14)	20	(18-24)	1	(1-3)	0	(0-1)	882
Total															
Wave 1	5	(4-6)	1	(1-2)	2	(1-2)	11	(10-13)	12	(11-13)	1	(1-1)	0	(0-0)	5306
Wave 2	6	(5-7)	1	(1-2)	3	(2-3)	10	(9-11)	14	(13-15)	1	(1-1)	0	(0-1)	5306
Wave 3	5	(5-6)	1	(1-1)	2	(2-3)	7	(6-8)	10	(9-11)	1	(0-1)	0	(0-0)	5306
Wave 4	5	(4-5)	1	(1-1)	3	(3-4)	9	(8-10)	11	(10-12)	1	(1-1)	0	(0-0)	5278

9.5 Utilisation of public home care

Public home care reflects services which are provided by the State to support older adults to live independently at home and include; the home help and personal care service[9], community nursing[10], meals on wheels, day centre care, occupational therapy and respite care.

Data were not collected on the use of home care packages[11] until Wave 3 so it is not possible to look at use of this service in this Report. As informal carers (or family carers) are an important part of the overall care provided to older adults in Ireland we also examined respondents who reported having an informal carer at each wave (Table 9.8).

Overall, it was uncommon for adults aged 50 years and over in Ireland to use public home care services. Informal carers are the most common type of home based care provided, followed by community nursing and the home help or personal care service. During the study period, use of informal care nearly doubled (5% to 9%) as did the home help or personal care service (3% to 5%) while the use of community nursing remained the same (5/6%). An increase in the proportion of older adults classified as frail also reported having an informal carer at Wave 4 compared to Wave 1 (36% versus 27%). This may indicate that the burden of care was transferred from the State to families during this period.

9 Home Help services are provided to assist people to maximise their independence; remain in their own home; support their informal carers; avoid where possible going into long-term care. The service provides a number of hours' assistance each week to successful applicants to deliver: personal care (washing, changing, oral hygiene, help at mealtimes); essential domestic duties related only to the individual client (lighting a fire / bringing in fuel, essential cleaning of the person's personal space) (15)

10 In TILDA this includes Public Health Nurses, Community Registered General Nurses, Community Mental Health Nurses, Clinical Nurse Specialists and Advanced Nurse Practitioners

11 The Home Care Packages scheme aims to help people with medium-to-high support needs to continue to live at home independently. There are two types of Home Care Packages provided by the HSE: Standard HCP - inclusive of the Delayed Discharge Initiative (DDI); Intensive packages – prioritises delayed discharges and acute hospital pressures providing higher levels of resources than standard HCPs. The services are provided to clients in their own homes and support is primarily aimed at older people who are: (I) living in the community or (II) who are in-patients in acute hospitals and are at risk of admission to long-term care, or (III) who are in long-term care, but who, with support, could return to limited independent living. (15)

Table 9.8: Proportion of older adults visiting each service in the previous year between 2009 and 2016 by their frailty status.

	Informal/ Family Carer		Respite		Day centre		Meals on wheels		Occupational therapy		Either home help or personal care		Community Nursing		Number in sample
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	
Non-frail															
Wave 1	1	(0-1)	0	(0-0)	0	(0-1)	0	(0-1)	0	(0-0)	1	(0-1)	2	(1-2)	3072
Wave 2	0	(0-1)	0	(0-0)	0	(0-1)	0	(0-1)	0	(0-0)	1	(0-1)	1	(1-2)	2880
Wave 3	1	(0-1)	0	(.-.)	0	(0-0)	0	(0-1)	0	(0-0)	1	(0-1)	1	(1-1)	2733
Wave 4	1	(0-1)	0	(.-.)	0	(.-.)	0	(0-1)	0	(0-0)	1	(0-1)	1	(1-2)	2298
Pre-frail															
Wave 1	4	(3-5)	0	(0-1)	1	(0-1)	1	(0-1)	1	(1-2)	2	(1-3)	5	(4-7)	1631
Wave 2	5	(4-6)	0	(0-1)	1	(1-2)	1	(0-2)	1	(0-1)	3	(2-4)	5	(4-6)	1743
Wave 3	4	(3-6)	0	(0-1)	1	(0-1)	1	(0-1)	1	(1-2)	2	(2-3)	4	(3-5)	1826
Wave 4	5	(4-7)	0	(0-1)	1	(0-1)	1	(0-1)	1	(0-1)	3	(3-5)	5	(4-6)	2098
Frail															
Wave 1	27	(23-31)	2	(1-4)	4	(2-6)	2	(1-5)	7	(5-10)	13	(10-17)	19	(16-23)	603
Wave 2	28	(24-32)	1	(0-2)	4	(2-6)	3	(1-5)	6	(4-8)	13	(11-17)	16	(13-20)	682
Wave 3	33	(29-37)	2	(1-4)	5	(3-7)	3	(2-5)	4	(3-6)	17	(14-20)	15	(13-19)	747
Wave 4	36	(33-40)	2	(1-3)	3	(2-4)	3	(2-5)	4	(3-6)	20	(17-24)	17	(14-20)	882
Total year on year															
Wave 1	5	(4-6)	0	(0-1)	1	(1-1)	1	(0-1)	1	(1-2)	3	(2-3)	5	(4-6)	5306
Wave 2	6	(5-7)	0	(0-1)	1	(1-1)	1	(0-1)	1	(1-2)	3	(3-4)	4	(4-5)	5306
Wave 3	7	(6-8)	0	(0-1)	1	(1-1)	1	(1-1)	1	(1-2)	4	(3-4)	4	(4-5)	5306
Wave 4	9	(8-10)	1	(0-1)	1	(1-1)	1	(1-1)	1	(1-2)	5	(4-6)	6	(5-6)	5278

We were particularly interested in identifying any change in the characteristics of those receiving the home help service, specifically, if the re-prioritisation of the home help service in 2012 from 'domestic help' to 'personal care' was borne out in the data. We examine this by looking at the home help user's disability status at each wave (Table 9.9).

The proportion of home help users with both difficulties in ADLs and IADLs doubled (20% at Wave 2 to 41% at Wave 4) indicating a trend of targeting the service to those with a more severe burden of disability after 2012.

Table 9.9: Proportion of the home help service allocated to older adults with different levels and types of disabilities between 2009 and 2016.

Home Help service only	No disability		IADL disability only		ADL disability only		IADL and ADL disability		Total (%)	Number in sample
	%	95% CI	%	95% CI	%	95% CI	%	95% CI		
Wave 1	50	(40-61)	21	(13-31)	10	(5-19)	19	(12-28)	100	101
Wave 2	48	(39-57)	26	(18-35)	6	(2-14)	20	(14-29)	100	119
Wave 3	50	(41-59)	15	(10-22)	2	(1-6)	33	(25-43)	100	138
Wave 4	38	(30-46)	15	(10-22)	6	(3-12)	41	(33-49)	100	175

9.6 Discussion

Between 2009 and 2016, public healthcare entitlements and dual healthcare cover increased among older adults aged 50 years and over in Ireland. This is likely a result of the safety net of the social welfare system and the effect of cohort ageing. For example, a 69-year old might not have been entitled to a medical card but might be the following year on turning 70 due to the different medical card income thresholds. However, approximately 1 in 4 of the cohort aged 70 years or more in 2016 did not have a medical card and its associated benefits including access to publicly provided allied health and community services.

Private health insurance cover was consistent between 2009 and 2016 suggesting that this cohort prioritised payment for private health insurance during this period. This also suggests the small increase in private insurance coverage noted by the Health Insurance Authority was likely driven by younger people who were responding to the Governments community rating policy.

Between 2009 and 2016 there was an increase in the proportion of older adults aged 75

years or more with ADL or IADL limitations (Chapter 3), an increase in the prevalence of cardiovascular diseases.[12] In terms of cardiovascular disease, there was an increased prevalence of hypertension (35% to 38%), diabetes (8% to 11%), heart attack (4% to 6%), stroke (1% to 2%), and transient ischaemic attack (2% to 4%) between Waves 1 and 4. In terms of non-cardiovascular disease, there was an increased prevalence of arthritis (26% to 39%), osteoporosis (9% to 17%), cataracts (9% to 14%) and lung disease (4% to 5%) from Wave 1 to 4 (Chapter 6) and an increase in the prevalence of frailty (Chapter 7). These epidemiological patterns are an important context with which to frame our discussion on patterns in healthcare provision.

Overall, our preliminary findings point to an increase in unplanned hospital care utilisation (ED visits, hospital admissions, length of stay), a decrease in planned hospital care utilisation (outpatient clinic visits), while the proportion of older adults utilising services such as community nursing, physiotherapy and occupational therapy remained the same.

Our evidence suggests that the cut to public dental benefits (for both medical card and non-medical card holders) may have contributed to a decline in the use of dental care services within this cohort between 2009 and 2016.

We found an increased use of the home help service between 2009 and 2016 which contrasts with an overall pattern of decreased provision noted in the HSE data (Table 9.10). There are two possible explanations for this. Firstly, the HSE estimates include home help users of all ages, while this report only reports on users aged 50 years and older. Secondly, our estimates are likely to include participants who received a home help as part of their home care package which are recorded separately by the HSE.

With respect to hospital care, our data suggest that significant change occurred in Irish hospitals during the course of the recession, notably that use of planned hospital care (e.g. outpatient clinics) decreased from 69% to 59% among older adults classified as frail between 2009 and 2016 while unplanned hospital care (e.g. overnight hospital admissions and ED admissions) increased from 23% to 31% among the same group during the same period. This is consistent with previous findings about the impact of austerity on the Irish healthcare system (5) but also reflects the increasing age and care needs

12 In terms of cardiovascular disease, there was an increased prevalence of hypertension (35% to 38%), diabetes (8% to 11%), heart attack (4% to 6%), stroke (1% to 2%), and transient ischaemic attack (2% to 4%) between Waves 1 and 4.

By examining the characteristics of users of hospital care, we found that frailty was driving utilisation and that hospital admissions and lengths of stay increased. In unpicking why this occurred, firstly, it is possible that the volume of older people with frailty presenting to the ED and admitted to hospital, could have crowded out the capacity of Irish hospitals to deliver its planned elective care. Secondly, the increase in the average number of nights that an older person with frailty spent in hospital is potentially a result of pressures in the community sector where provision of services was not increased to match increased need. Thirdly, the increased use of the home help service in those with higher levels of disability could be a result of strategies such as the delayed discharge initiative which relied on the home help service among others, to support safe hospital discharges and alleviate some of the pressure on the hospital system.

9.7 Conclusion

In conclusion, despite increases in the prevalence of chronic disease, frailty and disability, healthcare provision did not increase suggesting that policy changes made during this period influenced healthcare cover and may have made it more difficult for older adults to access services that they required. This preliminary analysis will be progressed with more sophisticated statistical modelling allowing us to unpick the effects of these policies in more detail.

9.8 References

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Appendices

Table 9.10: Aggregate number of home help clients, home help hours, older adults aged 50 years and older and older adults aged 85 years and older between 2006 and 2016.

	Annual estimated number of home help clients recorded by the Health Service Executive[1]	Annual estimated number of home help hours recorded by the Health Service Executive[1]	Annual estimated number of adults in Ireland aged 50 years and older[2]	Annual estimated number of adults in Ireland aged 85 years and older[2]
2006	49,578	10,800,000	1,112,400	47,800
2007	54,736	12,351,088	1,142,900	49,400
2008	55,366	12,631,602	1,174,200	51,900
2009	53,791	11,970,323	1,204,600	54,000
2010	54,011	11,690,515	1,236,000	56,100
2011	50,986	11,090,000	1,265,800	58,200
2012	45,705	9,880,000	1,296,000	59,800
2013	46,454	9,740,000	1,326,300	60,700
2014	47,061	10,300,000	1,360,800	62,700
2015	47,915	10,400,000	1,396,900	64,900
2016	46,948	10,547,393	1,433,000	67,300

1. Health Service Estimates (HSE) estimates of home help clients can be found in the annual report for each respective year found at: https://www.hse.ie/eng/services/publications/corporate/annualrpts.html
Note: HSE estimate of users of the home help service include individuals of any age

2 Annual population estimates for 2006 to 2016 come from the Central Statistics Office Statbank Table (PEA01)

Table 9.11: Changes in healthcare coverage between 2009 and 2018 (Source: authors own based on a previous version (16).

		2009-2010	2011-2012	2013-2014	2015-2016	2017-2018
MEDICAL CARD HOLDERS	*Medical card entitlement*	Over 70s medical card means-tested 2009: € per week Single: €700.00 Couple: €1400.00		Increased to €1.50 per prescribed item up to €19.50 per month per family (2013)		
	GP services	No charge	No charge	No charge	No charge	No charge
	Prescribed medications	Introduction of a €0.50 per prescribed item up to €10.00 per month per family (2010)		Increased to €1.50 per prescribed item up to €19.50 per month per family (2013) Increased to €2.50 per prescribed item up to €25.00 per month per family (2014)		Decreased to €2.00 per prescribed item up to €20.00 per month per family (2018)
	Public inpatient hospital care	No charge	No charge	No charge	No charge	No charge
	Public hospital outpatient care	No charge	No charge	No charge	No charge	No charge
	Other	Dental Treatment Services Scheme: dental entitlements cut (2010)				

Table 9.11: Changes in healthcare coverage between 2009 and 2018 (Source: authors own based on a previous version.

NON MEDICAL CARD HOLDERS		2009-2010	2011-2012	2013-2014	2015-2016	2017-2018
	GP services	Pay full charge	Pay full charge	Pay full charge	Pay full charge	Pay full charge
	Prescribed medications	Drugs Payment Scheme: threshold increased from €90.00 to €100.00 per month (2009) Increased to €120.00 per month (2010)	Drugs Payment Scheme threshold increased to €132.00 per month (2012)	Increased to €1.50 per prescribed item up to €19.50 per month per family (2013) Increased to €2.50 per prescribed item up to €25.00 per month per family (2014)	Drugs Payment Scheme threshold increased to €144.00 per month (2013)	Drugs Payment Scheme threshold decreased to €134.00 per month (2018)
	Public inpatient hospital care	Inpatient charges increased from €66.00 to €75.00 per night (2009) ED attendance without a referral charge increased from €66.00 to €100.00 (2009)	No charge	Inpatient charges increased to €80.00 per night (2013)	No charge	No charge
	Public hospital outpatient care	No charge	No charge	No charge	No charge	No charge
	Other	Tax relief on medical expenses restricted to the standard rate (20%) (2009) Treatment Benefit Scheme: dental and ophthalmic entitlements cut (2009) Health levy doubled and income threshold lowered for higher rate (2009)	Treatment Benefit Scheme: aural statutory entitlements cut (2012) Government abolishes the health levy and replaces it with a (non-earmarked) universal social charge (USC) (2012)	Tax relief on private health insurance contributions reduced to €1000.00 for adults and €500.00 for children (2013)		Treatment Benefit Scheme: €42.00 payment towards annual scale and polish; biannual entitlement to free sight test and €42.00 towards cost of glasses (2017)

Table 9.12: The 32 items which formed the Frailty Index used in this Chapter.

Frailty Index items in the 32-item measure	
Difficulty walking 100m	Polypharmacy
Difficulty rising from chair	Knee pain
Difficulty climbing stairs	Hypertension
Difficulty stooping, kneeling or crouching	Angina
Difficulty reaching above shoulder height	Heart attack
Difficulty pushing/pulling large objects	Diabetes
Difficult lifting/carrying weights ≥10lb	Stroke or Transient ischemic attack
Difficulty picking up coin from table	High cholesterol
Difficulty following a conversation	Irregular heart rhythm
Feeling lonely	Other Cardiovascular disease
Absentmindedness	Cataracts
Poor self-rated physical health	Glaucoma or age related macular degeneration
Poor self-rated vision	Arthritis
Poor self-rated hearing	Osteoporosis
Poor self-rated memory	Cancer
Daytime sleepiness	Varicose ulcer