ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Submission on Home Care

2 October 2017

The Royal College of Physicians of Ireland (RCPI), representing physicians, public health, occupational health, paediatrics, pathology, and obstetrics and gynaecology in Ireland, welcomes the opportunity to make a submission to the Department of Health and Children on home care, a core element of government policy. The template of questions and answers proposed on the website seemed unduly restrictive for such an important and complex subject, and RCPI elects to submit a narrative submission.

The submission is based on seven main themes:

1) **The centrality of the biopsychosocial model of care to modern healthcare** which views elements of rehabilitation and support as of equal importance with pharmacological and the technological factors in optimal health and well-being. It is now four decades since the biopsychosocial model was proposed[1], and this has been adopted at the heart of the International Classification of Functioning, Disability and Health by the WHO[2]. In this context, the RCPI considers community-based home care as central to maintaining health and well-being of people with relevant disabilities (including older people so affected) as their medications or other forms of therapies.

This is consistent with United Nations *Convention on the Rights of Persons with Disabilities* which aims to: "Promote, protect and ensure the full and equal enjoyment of all human rights (civil, cultural, political, social and economic) and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity, " and calls for: *"… appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain their maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life".*

2) **An understanding of the complexity of issues raised by home care of older people with a range of cognitive, physical and sensory limitations**. As gerontology is a relatively young science and as specialist services for older people have really only developed in recent years in Ireland, policy-makers, some healthcare providers and the lay public may still harbour simplistic notions of the complexity of care required in home care for older people with cognitive, physical and sensory disabilities sufficient to require home support. Consistent with the knowledge base that late life is the point of time at which people are likely not only to develop complex co-morbidity but also marked inter-individual variability, repeated studies have indicated the complexity of care needs of those who require such services[3], mandating an approach that incorporates multiple morbidities and cognitive impairment, as well as measurement systems which can support quality of care. In this, the earliest possible deployment of the Single Assessment Tool (the interRAI/MDS tool) in Irish home care must be seen as a high priority as this has been shown to be an effective instrument for measuring quality[4] as well as defining need, developing prompts for care planning, and linking to care in both hospitals and nursing homes in jurisdictions where it has been fully implemented.

3) **The need for adequate training, compensation and coordination of home care with other services to ensure not only retention and recruitment of a skilled and motivated workforce but also effective person-centred and gerontologically literate care**. One of the major and undebated changes in Irish health care has been the outsourcing of home care to private agencies and a retreat by the state in providing this care directly [5,6]. It is a feature of the international literature that home care workers feel unsupported, under-trained and under pressure[7]. It is a matter of some importance that policy for homecare workers in this demanding and complex aspect of health care should explicitly clarify adequate training, compensation, support and coordination with public health nurses, family doctors, integrated care teams and other elements of the health care system for home care staff, incorporating due elements of advance in gerontological, mental health and person-centred care. The coordination of home care should routinely be formally clarified, ideally through the person's public health nurse or a case/care manager for more complex cases (as specified in the National Dementia Strategy[8]).

4) **Listening to, and strengthening the voice of older people in choice in health care.** Older people's long-term care preferences resemble those of younger persons with disabilities, but the two groups are treated differently[9]. Younger persons with disabilities pursue the goal of social integration, whereas safety and efficiency receive undue emphasis and ageist differences prevail in the way older persons are served. Among the changes needed to help older consumers get what they want are; empowering older persons and their agents to make better decisions, including providing them with more structure and better consumer information; revising attitudes toward safety and protection; and developing more vigorous advocacy by and for older people. In addition, there needs to be a focus on emergent issues such as continuity of personnel[10,11,12] and appropriate cultural sensitivity and training in terms of both the global phenomenon of increasing proportions of international staff in care work forces[13], and movement of people to this country that can bring extra difficulties as they age, especially when they develop dementia and are culturally and linguistically at a loss.

5) **That quality assurance is just as important an aspect of this form of care as other complex care in the HSE, and adequate regulation is an important aspect of quality assurance**. As mentioned in paragraph 2, the further deployment of the Single Assessment Tool to the community will provide the opportunity for measuring quality of care provided at home. However, the sector in Ireland and in Europe is marked by a lack of scrutiny and regulation from outside the service funders and providers, a situation analogous to that which existed for nursing homes prior to the Leas Cross Review and the development of National Quality Standards and their overview by HIQA. The RCPI considers that a similar process should now take place with HIQA, complementing the monitoring of quality by the service funders and providers.

6) **Eligibility for home care should be on the same basis as access to other elements of health care, and should be age-neutral**. Despite some interpretations to the contrary in the popular media, a recent review by the Health Research Board of funding of community long-term care in four European countries confirms that the majority of funding for such care arises from public funding, either from central or local government or social/health insurance in countries with universal schemes of this nature[14]. Given pressures on health spending in many societies[15], older people should not be seen as a 'soft' target but rather any changes in terms of co-payment should be on a similar basis as other forms of healthcare such as medications, and public hospital and OPD charges.

7) **A more formal focus on research into home care should be promoted through the HRB, HSE and the Department of Health and Children, supported by professional bodies and advocacy.** Home care is a neglected area of research throughout the developed world[16], and yet is clearly an increasingly important element of health systems. The HRB, HSE and the Department of Health and Children should work together to develop research into home care as a substantive focus of research so as to inform future development of policy, guidelines and services, as well as developing critical mass in terms of critical insights and discourse on the optimal future direction for home care in Ireland.

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