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Contents

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Page No.

- 1 Nursing Homes Support Scheme Bill 2008
- 3 Proposed new arrangements
- 3 Who qualifies for financial support
- 4 The means test
- 5 State support
- 8 Summary of paying for care

Nursing Homes Support Scheme Bill 2008

The Nursing Homes Support Scheme Bill 2008 has been published. This proposes to implement the *Fair Deal* nursing home scheme which was announced in December 2006. The Bill is going through the Oireachtas at present. The new arrangements are expected to be in place some time in 2009.

The main effects of the arrangements proposed in this Bill are:

- You will not be adversely affected by the changes if you are in a nursing home when the new scheme is put into effect; if you are in a public nursing home, you will continue to be charged under the current arrangements (the new scheme would not be to your advantage); if you are in a private nursing home, you may opt for the new scheme if it would be to your advantage (the new scheme is likely to be better for many current residents)
- State support (see below) may be provided to nursing home residents who are assessed as being in need of long-term residential care
- New residents of both public and private nursing homes or other long-stay residential facilities will be liable to pay 80% of their assessed means towards the costs of their stay; assets, including the family home and other property, will be taken into account in assessing means
- There will be a 3-year limit on the assessment of the family home, which means you are liable to pay a maximum of 15% of the value of your family home towards your nursing home costs
- Charges arising from the assessment of assets may be deferred until a specified event occurs such as the sale of the asset or your death or, in the case of the family home, the deaths of certain other family members

Current rules, p2; care needs assessment, p3; specified person, p4; ancillary State support, p5; choice of nursing home, p6; standards in nursing homes, p8

- **The means test for financial support for long-term residential care is broadly similar to the one currently used for the private nursing home subvention scheme**
- **There will be a legal distinction between acute care and long-term residential care and different charging arrangements will apply to each type of care**

The majority of people in long-term residential care are older people. However, the rules set out here are the same regardless of age. So, for example, younger adults living in residential institutions for people with disabilities will come under the same rules as older people in nursing homes. A small number of adults and those under the age of 18 will not be liable for charges under the new arrangements – see page 3.

At present, there are approximately 22,750 people in long-term residential care. About two-thirds of these are in private nursing homes. It is expected that the numbers of people in long-term residential care will increase to 44,000 in 2036 and 61,000 in 2056 – this assumes that the proportion of older people needing care will decrease from its current level of 4.6% to 4% of the population.

Current rules about nursing home support

The current rules about paying for nursing home care make a clear distinction between care provided in public nursing homes and that provided in private nursing homes. Public nursing homes are those which are owned and run by the Health Service Executive (HSE). They include welfare homes, continuing care units, geriatric hospitals and community nursing units – these are generally occupied by older people in need of care. These homes, and most of the institutions run by not-for-profit organisations for people with disabilities, have the same charging arrangements.

Current residents of public nursing homes

Most residents in long-stay public nursing homes have to pay long-stay maintenance charges. The long-stay charges apply when you have been receiving in-patient services for 30 days. They apply whether you are receiving those services in an acute hospital or in a long-stay institution.

The maximum charge at present is €120 a week for people in hospitals and homes with 24-hour nursing care and €90 a week in homes where 24-hour nursing care is not provided. These charges are being increased from 1 January 2009 to €151.44 and €113.50 respectively.

If you are in a public nursing home or equivalent at present, or if you take up residence before this Bill comes into effect, you will continue to pay under the present rules.

Current residents of private nursing homes

The legal position on subventions for residents of private nursing homes is governed by the Health (Nursing Homes) Amendment Act 2007. You may qualify for a subvention if you meet the means requirements. Your income and assets, including your house, are taken into account. There is a 3-year limit on the assessment of the family home, which means you are liable to pay a maximum of 15% of the value of your family home. It is not possible to defer the charges arising from the assessment of your home. The stated "maximum" subvention is €300 a week but an enhanced subvention may be paid in some cases.

If you are in a private nursing home when this new scheme comes into effect, you may continue with your present arrangements or you may opt into the new scheme. It is likely that many residents of private nursing homes will be better off under the new scheme.

Proposed new arrangements

The Bill proposes to introduce a legal distinction between acute hospital services and residential care services and provides for a new charging arrangement for residential care services. At present, the legislation deals with in-patient hospital services, which includes acute hospital care as well as long-term care in public nursing homes and other long-stay care facilities such as residential services for people with disabilities.

Long-term residential care services

The Bill proposes to define long-term residential care services as maintenance, health or personal care services, or any combination of these, provided to you while you are maintained in an approved nursing home or a facility that is publicly designated by the HSE as a facility predominantly for the care of older people and in which nursing care is provided on a 24-hour basis, for a period of not less than 30 consecutive days, or periods totalling not less than 30 days within a period of 12 consecutive months. However, if the HSE considers that you are going into the care facility permanently, then the 30-day requirement does not apply – that means that you can be charged from the start of your stay.

Long-term residential care services do not include:

- Medically acute care and treatment in an acute hospital
- Respite care
- Rehabilitative care for a period of less than 12 months
- Rehabilitative care for periods totalling less than 12 months in a period of 24 months
- Out-patient services

So, if you are getting acute care in a hospital, you are not receiving long-term residential care services. If you are getting acute care and you are in hospital for more than 30 days you may, as is the case at present, be liable for long-stay charges. Acute care is not defined in the legislation so the precise borderline between acute care and long-term residential care may not always be entirely clear.

Charges for residential care services

The Bill provides that the HSE may charge virtually all residents for residential care services which it provides. The maximum charge is the cost of such services. The following groups are exempted from paying the charges:

- People aged under 18
- Women in respect of motherhood
- People detained involuntarily under the mental health legislation
- People who contracted Hepatitis C in certain circumstances
- People receiving treatment for certain infectious diseases

If you are in an acute hospital and a doctor certifies that you do not need medically acute care and treatment you may be charged as if you were receiving long-term residential care services whether or not you have applied for State support. The maximum charge will be the average cost of long-stay care in facilities operated by the HSE and publicly designated in writing as facilities predominantly for the care of older people – that is, in public nursing homes.

Who qualifies for financial support

As already stated, the maximum charge for long-term residential care will be the cost of that care. The Bill provides for financial support for people who cannot meet the full cost of their care. The support scheme is called the Nursing Homes Support Scheme and it will be administered by the HSE.

In order to get support under the scheme you must:

- Have either applied for a care needs assessment under the scheme, been deemed to require long-term residential care services or be already provided with care services by or on behalf of the HSE or in an approved nursing home when the scheme comes into effect and
- Be ordinarily resident in Ireland

N.B. "Ordinary residence" is not defined in this Bill or in any other legislation dealing with health services. Guidelines issued by the Minister for Health and Children state that it means that you must be expected to live in the State for at least a year.

Care needs assessment

If you are applying for State support after this new scheme comes into effect, you must have a care needs assessment. Existing nursing home residents will not be obliged to have any further assessment of care needs. An application for a care needs assessment may be made by you or by a "specified person" (see below). The assessment will be carried out by or on behalf of the HSE and may involve examinations by a range of medical professionals including GPs, nurses, occupational therapists and physiotherapists.

It is expected that there will be a uniform national system of assessment. The assessment will involve an evaluation of:

- Your ability to carry out the activities of daily living, including your cognitive ability, extent of orientation, degree of mobility, ability to dress, bathe and eat without assistance, ability to communicate and degree of continence
- The family and community support that is available to you
- The medical, health and personal social services being provided to you or available to you
- Any other matter that affects your ability to care for yourself
- The likelihood of any material change in your circumstances

This is similar to the assessment which is carried out at present if you apply for a nursing home subvention.

On the basis of this assessment, the HSE will decide whether or not you need residential care services. If you do need care services, the HSE may also decide that it is unlikely that you will ever stop needing those services.

There are no time limits stipulated on the carrying out of the assessment or the making of the decision. Once the HSE has made a decision, you (or the person who applied on your behalf) must be notified in writing within 15 days. You must be given a copy of the assessment report and told the reasons for the decision. The care needs assessment may identify services which you need but this does not mean that the HSE must provide those services.

If the HSE decides that you do not need care services you may not make another application for 6 months after the decision was made unless there has been a material change in your health or circumstances and this is medically verified.

Specified person

- A specified person may be:
- Your spouse or cohabiting partner
- A relative who is 18 years of age or over
- An attorney appointed under an Enduring Power of Attorney
- A care representative appointed under this scheme (see below)
- The Registrar of Wards of Court if you are a Ward of Court or
- A doctor

If the application is made by a specified person, the HSE may refuse to deal with that person if it considers that he/she is not acting in your best interests.

The means test

If the HSE decides that you do need care services, you may then apply for financial support. You and your spouse or partner must provide the HSE with information about your income and assets.

Your weekly assessed means are your combined means assessed under the headings of income, cash assets and relevant assets.

The income and assets of each member of a couple will be assessed. As well as a married couple who are living together, a couple, for the purpose of the Bill, includes opposite-sex and same-sex cohabiting couples who have been living together for at least 3 years before applying for support or before the start of the provision of care services.

Regulations may be made to provide for the relief of undue hardship. This may include provisions that, in exceptional circumstances, the income and assets of the member of the couple who does not need care may not be taken into account.

The HSE will have the power to access relevant records for the purposes of the scheme. It will be required to publish a code of practice for accessing and processing such records.

Income

Income includes income from all sources including pensions. The following amounts are then deducted: income tax, PRSI contributions (these are not payable by people aged 66 and over), income levies (the health levy is not payable by people aged 70 and over but the proposed new income levy will be), mortgage interest or rent, health expenses and maintenance payments under a separation agreement. Regulations may be made to provide for other deductions.

If you are not part of a couple, your weekly assessed means are 80% of your total income after deductions. If you are part of a couple, your own weekly means are assessed as 40% of the net income of the couple. You must be allowed to keep 20% of the maximum rate of the State Pension (Non-Contributory). This is called the "minimum retained income threshold". A couple must be allowed to keep this amount plus the maximum rate of this pension. The effect is that the person going into care must have at least 20% of the State Pension (Non-Contributory) and the other person must have at least the full amount of the same pension available to live on.

Cash assets

"Cash assets" means money that you own and which is:

- Held in an account (or in cash by you)
- Lent to another person and is repayable
- Held in shares, stocks, bonds, securities, and other financial instruments (valued at market value on the date you apply for State support)

It also includes transferred cash assets (see below).

Relevant assets

"Relevant assets" means any property in which you have an interest, including property abroad and transferred assets. So, it includes the family home, any investment property, farms, shops and other commercial premises. The valuation is the market value on the day you apply for State support. Deductions are allowed for borrowings to buy or maintain the property.

You are considered to have transferred assets if, in the previous five years, you gave away any assets (including cash assets) or sold any assets for less than 75% of their market value.

This does not apply if the transfer of assets was done as a result of a maintenance claim by a child or other matrimonial proceedings. If the asset in question was transferred before 9 October 2008 (the day this Bill was published), you may ask that it not be taken into account because including it would involve undue hardship.

The first €36,000 of assets in the case of a single person, and €72,000 in the case of a couple, is not taken into account.

The rest of the cash and relevant assets that you own are then assessed at 5% of their value per year. So, if you have cash and relevant assets of €1 million above the disregarded amount, your means from your assets will be assessed as €50,000 a year. Each of a couple is considered to have half of the combined assessed assets of the couple.

Principal private residence

Your principal private residence will not be taken into account when you have been receiving care services for 3 years – these 3 years need not be continuous. This means that anyone who has been in a nursing home for 3 years before this legislation comes into effect will not have their principal private residence assessed in the means test.

In all other cases it will be taken into account for 3 years of your stay in residential care. So, the maximum charge to be calculated on the value of your house is 15% in the case of a single person and 7½% in the case of a member of a couple.

State support

The amount of financial support you get from the State depends on your weekly assessed means (that is, your income and assets as assessed in accordance with the rules described above) and the cost of your nursing home care. If your weekly assessed means are equal to or greater than the cost of your care, then you get no financial support. If they are less, then you get the difference between your means and the cost of your care.

If you are receiving State support, you or your representative must give notice to the HSE of any material change in circumstances within 14 days of that change.

The HSE may stop paying State support if you do not pay your allocated amount to the care facility. The HSE may also stop paying support if the care services you are receiving are not appropriate for your needs.

Nursing homes and other long-term care facilities will be obliged to inform the HSE within 48 hours when a person who has been receiving State support dies or leaves the facility. If they propose to discharge a person who is receiving State support they must give at least 10 working days' notice to the HSE.

Ancillary State support

The Bill distinguishes between "State support" and "ancillary State support". State support is a payment by the HSE to help you meet the costs of your long-term residential care. You do not have to repay it at any stage. Ancillary State support is the money that the HSE will pay on your behalf if you defer payments based on your relevant assets (that is, property) until a specified event occurs, such as the sale of the asset or your death or the subsequent death of your partner.

You must apply separately for ancillary State support. You may apply even if you do not qualify for State support. Ancillary State support can be based on relevant assets only – not cash assets. In effect, there has to be a property over which a charge can be taken.

So, for example, if the cost of your care is €1,000 a week, your weekly assessed means are €500 a week, and you have no house or other relevant assets, then you will have to pay €500 a week towards your care and you will qualify for State support of €500 a week.

If your weekly assessed means includes €100 a week which is based on your assets, then your State support is still €500 a week, you have to pay €400 a week and you can apply for ancillary State support in respect of the €100 which is attributable to your assets. (You may choose to pay that €100 if you can manage to do so.) If you apply for and get ancillary State support, then the accumulated charge will be payable when a specified event occurs.

If you receive ancillary State support, the amount of that support will be registered as a charge against your assets. In simple terms, the effect is the same as taking out a mortgage on your house. The Bill deals in detail with the legal consequences for joint tenants of such a charge.

When you die (or another specified event occurs), that charge is redeemable. That means that the charge must be paid off before your estate is distributed among your heirs. The charge is a debt that you owe, and all debts must be paid before any of your money or assets can be distributed to your heirs. Your personal representative will be obliged to give notice to the HSE of the intention to distribute the estate not less than 3 months before the actual distribution.

The amount of the charge at that stage will be the actual amount received by way of ancillary State support together with interest (this will be based on the Consumer Price Index). If you decide to sell or transfer the asset on which this support is based, then you must repay the ancillary State support due when you do this sale or transfer. You must inform the HSE within 14 days if you have sold or transferred the asset in question.

Further postponement of payment

The ancillary State support which you received will, in general, be repayable on your death. If the asset on which this support was based is your principal private residence, then a further postponement of the repayment may be arranged. If the asset is the principal private residence of your spouse or partner, then he/she may apply for a further postponement until after his/her death. This request must be made within 3 months of the death (the HSE may allow a later request provided it is not later than 6 months after the death). Such a request may also be made by a "connected person". This is a person who has been living in the house concerned for not less than 3 years immediately before you applied for ancillary State support (in effect, for 3 years before you went into a nursing home) and that person does not have any other residence or any interest in other residential property. A connected person may be:

- Your child who is under the age of 21
- A relative who is getting Disability Allowance, Blind Pension, Disability Benefit, Invalidity Pension or State Pension (Non-Contributory) or the equivalent of one of these from outside Ireland or whose total income is not more than the maximum rate of State Pension (Contributory).
- A relative of the person who is the owner of a building to which the principal residence is attached.

The ancillary State support then becomes repayable when the spouse/partner dies or the house is sold or transferred or the connected person no longer meets the requirements. So, for example, if an 18-year-old child was the connected person, the repayment would be due when he/she reaches 21.

You may, of course, repay the ancillary State support at any time before it becomes legally due.

The repayable amount will be collected by the Revenue Commissioners. They will have the power to do so for 12 years after the amount becomes due.

Care representative

The Bill introduces an arrangement whereby a care representative can be appointed to deal with issues relating to ancillary State support if you do not have full mental capacity. There is a presumption that everyone does have full mental capacity until the contrary is established.

A care representative will be able to:

- Make an application for ancillary State support
- Consent to the creation of a charge over the asset in question
- Take other necessary actions in relation to ancillary State support

A care representative may not be appointed in certain cases. These are cases where there is already a person entitled to make the necessary decisions and take the necessary actions. They are:

- Where the person is a Ward of Court
- Where there is an attorney appointed under an Enduring Power of Attorney and there are no restrictions on the attorney taking any of the necessary decisions or actions and the power is being implemented
- Where there is another person permitted by law to act on behalf of the person in question (for example, a parent is generally entitled to act on behalf of a minor child)

The following may apply to the Circuit Court to be appointed as a care representative (and in the following order of priority):

- A spouse or cohabiting partner
- A parent
- A child
- A brother or sister (including half-siblings)
- A niece or nephew
- An aunt or uncle
- A doctor or other such health practitioner (other than the owner of a nursing home in which the person lives or is likely to live) as appears to the court to be a fit and proper person to make the application

A person with greater priority may consent in writing to an application by a person with lower priority. So, for example, a spouse could consent to having a child appointed as the care representative.

When deciding on an application to be a care representative, the court must have reports from two doctors who have examined you and certified that you do not have the mental capacity to make the decisions in question.

You will not be considered to have the capacity to make a relevant decision if you are unable to:

- Understand the information relevant to the decision
- Retain that information
- Use or weigh that information as part of the process of making the decision, or
- Communicate your decision

The care representative must be aged 18 or over and must be a fit and proper person to be a care representative. There are certain disqualifications including bankruptcy, convictions for fraud and a conviction for an offence against the person in care.

The court may apply certain conditions to the order. The care representative will be obliged to act in your best interests and to keep proper records and accounts.

Choice of nursing home

In order to avail of the scheme, you must go into an approved nursing home. You will have some choice in which nursing home you go to. Clearly that choice will be limited by availability and by your particular needs. Both public and private nursing homes will take part in the scheme.

Approved nursing homes

Private nursing homes are currently required to be registered under the Health (Nursing Homes) Act 1990. There is no registration requirement for public nursing homes. It is proposed that both private and public nursing homes will be registered when the relevant parts of the Health Act 2007 come into effect. (The Health Act 2007 established the Health Information and Quality Authority and, among other things, provides that the Office of the Chief Inspector of Social Services will be responsible for registration and monitoring of designated centres, including nursing homes – see *Relate*, January 2007 and May 2007.)

An approved nursing home is one which:

- Is registered in accordance with the legislation and
- Has an agreement with the National Treatment Purchase Fund to provide services for people who are getting State support and
- Has a tax clearance certificate

Reviews and appeals

The HSE may review the support being provided at any time. If it does, and it decides that your means are higher than in the previous assessment or that you qualify for less ancillary State support, that decision may not be implemented for a time – up to a maximum of 60 days. In general, you may look for a review a year after the previous assessment but earlier if there has been a material change in your circumstances.

Appeals

You will be entitled to appeal against the following decisions of the HSE:

- A decision, following a care needs assessment, that you do or do not need care and a decision that you are likely to need care for the rest of your life

- A decision to refuse to consider an application for State support for various reasons, for example, because you have not provided enough information
- A decision about State support
- A decision taken after a review of your State support
- A refusal to consider an application not to assess assets which were transferred before 9 October 2008
- A decision on the issue of assessing such transferred assets

You must appeal within 60 days of getting the decision. The HSE must appoint an independent person to hear appeals. The appeals officer may confirm or revoke the decision and/or may substitute another decision or may refer it back to the HSE for re-consideration.

There is a further right of appeal to the High Court on a point of law.

Acting on behalf of a person needing care

The Bill provides that another person may act on your behalf in respect of most aspects of the scheme, including applying for financial support and appealing decisions. However, as outlined above, an application for a care needs assessment may be submitted only by you or by a “specified person”. Decisions and acts in relation to ancillary State support may be carried out only by you, by specifically authorised people such as attorneys appointed under an Enduring Power of Attorney or by a care representative as provided for in this Bill.

Costs and numbers

The new scheme will have a specific budget each year. This means it will be “resource capped”. So, there could be a waiting list to avail of it. The HSE is establishing a central Nursing Homes Support Scheme Unit to manage funding for the scheme and to maintain a national waiting list, if and as necessary.

Of the approximately 15,000 people in private nursing homes at present, 8,700 are getting a subvention; 5,000 of these are getting an enhanced subvention. There are 3,000 people in contracted beds. In 2007, the cost of private nursing home subventions was almost €205 million.

The Minister for Older People has given the following estimates of the costs involved in the first year of the scheme: the total cost of long-term residential care will be €1,252 million and residents will contribute €230 million of that cost. It is expected that €92 million will be deferred but this is a very tentative estimate.

The Citizens Information Board is the statutory body which supports the provision of information, advice and advocacy on the broad range of social and civil services to the public. It provides the Citizens Information website and supports the voluntary network of Citizens Information Services and the Citizens Information Phone Service.

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About a quarter of the people who go into nursing homes are there for less than three months. The Long-Stay Activity Statistics 2006 show the following distribution of long-stay patients by length of stay:

Less than 3 months	24.5%
3 to 6 months	12.7%
6 to 12 months	13.6%
1 to 2 years	15.8%
2 to 4 years	17%
4 to 6 years	8.2%
6 to 10 years	5.8%
Over 10 years	2.4%

Standards in nursing homes

The present standards for nursing homes are set out in the 1993 Care and Welfare Regulations and the HSE inspects private nursing homes on the basis of these standards.

The Health Act 2007 provides that the Chief Inspector of Social Services in the Health Information and Quality Authority (HIQA) will have statutory responsibility for inspecting and registering all residential centres for older people including private and public nursing homes. HIQA has published the *National Quality Standards for Residential Care Settings for Older People* – these are described in the April 2008 issue of *Relate*. They will come into effect when they get the approval of the Minister for Health and Children under section 10(2) of the Health Act 2007. It is expected that this will happen when the new scheme comes into operation.

Summary of paying for care

When this Bill becomes law, this is how you will pay for hospital and long-stay care:

Public ward of an acute hospital

Acute care will be free to medical card holders and a number of other groups; others will have to pay €75 a day up to a maximum of €750 a year.

If you are in hospital for 30 days or more and getting acute care, you will be liable to pay long-stay charges – the maximum charge from 1 January 2009 will be €151.44 a week. This applies to everyone, including medical card holders.

If you are in hospital for more than 30 days **and a doctor certifies that you do not need medically acute care and treatment** you may be charged as if you were receiving long-term residential care services – this means that you are liable to pay the cost of your care or 80% of your assessed means, whichever is lower. This applies to virtually everyone including medical card holders.

Private bed and private hospital

You pay the costs as set by the Government in the case of public hospitals or by the hospital itself in the case of private hospitals.

Public nursing home

If you are already resident when this Bill becomes law, you pay up to a maximum of €151.44 a week.

If you become a resident after the Bill becomes law you are liable to pay the cost of your care or 80% of your assessed means, whichever is lower. This applies to everyone including medical card holders.

Private nursing home

If you are already resident when this Bill becomes law, you may continue with your existing arrangements or you may avail of the new arrangements. The new arrangements mean that you are liable to pay the cost of your care or 80% of your assessed means, whichever is lower.

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