Comptroller and Auditor General
Report on Value for Money Examination

Department of the Environment and Local Government

Special Housing Aid for the Elderly

Report for presentation to Dáil Éireann pursuant to Section 11 of the Comptroller and Auditor General (Amendment) Act, 1993 (No. 8 of 1993)

Report Number 36

November 2000

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ISBN 0-7076-9006-4

The report was prepared on the basis of information, documentation and explanations obtained from the bodies referred to in the report.

The draft report was sent to the Accounting Officer of the Department of the Environment and Local Government and to the Chief Executive Officers of the Health Boards and their comments were requested. Where appropriate, these comments were incorporated in the final version of the report.

Report of the Comptroller and Auditor General

Special Housing Aid for the Elderly

I have, in accordance with the provisions of Section 9 of the Comptroller and Auditor General (Amendment) Act, 1993, carried out a value for money examination of the administration of Special Housing Aid for the Elderly.

I hereby submit my report on the above examination for presentation to Dáil Éireann pursuant to Section 11 of the said Act.

John Purcell
Comptroller and Auditor General

3 November 2000

Table of Contents

Summary

Background

In the early 1980s, voluntary agencies reported a number of cases of elderly people who had died prematurely where the poor state of their housing was a contributory factor. It was apparent that these people had neither the personal nor the financial capacity to carry out the necessary repairs themselves.

In 1982, the Government responded by introducing a scheme called Special Housing Aid for the Elderly to enable emergency repairs in such cases to be carried out and funded by the State. The intention was to carry out the repairs without imposing any burden on the elderly person in need of assistance and to administer the scheme with the minimum of bureaucratic formality.

This examination is concerned with the operation of the scheme and its outcome to date, some eighteen years after its introduction. The examination assessed how the scheme is implemented and how the implementing agencies measure the impact of the scheme on those in need and the systems and procedures in place to evaluate the scheme's overall effectiveness.

Delivery and Outturn

The scheme is funded at national level by the Department of the Environment and Local Government. A total of £44m has been expended under the scheme since its inception in 1982. Funding of £6m was provided in 1999. From the beginning, the scheme has been overseen by a Task Force whose membership represents Government departments, local authorities, health boards and voluntary agencies.

Because of their contact with and knowledge of the conditions of elderly people, health boards were requested to operate the scheme at local level. The health boards agreed to do so provided they could adapt the scheme to suit conditions in their own areas. This combination of informality and flexibility is considered by the health boards to be one of the most important and successful attributes of the scheme.

The examination found that generally the scheme was being delivered across the health boards in three different ways

- use of FÁS trainees
- direct engagement of builders by boards
- payment of grants to applicants.

The grant-based approach was used in 38% of cases. While administratively efficient, this places an onus on the elderly applicant in terms of engaging a contractor and all that entails (and possibly obtaining planning permission) and may serve to discourage take-up of the scheme by those it was most designed to serve. The effect of the diversity of approach is that the ability of elderly people to avail of the scheme and the manner in which they benefit from it depends greatly on where they happen to live.

The cost of administering the scheme in health boards range from £34,000 to £314,000 per annum. The variations can be accounted for in part by differences in the administrative costs of the various means of scheme implementation.

Two-thirds of the work carried out relates to necessary repairs to make a dwelling habitable for the lifetime of the elderly occupant living alone. This emphasis is consistent with the original intention of the scheme.

An average of 2,300 repair and improvement jobs of varying size and complexity have been completed each year since 1982. The average cost per job in the three years 1997 to 1999 varied from £599 in one board to £2,258 in another.

There is a growing waiting list of applicants for work to be carried out. Depending on the health board area, an applicant could be waiting from six months up to four years. However, all boards have systems in place to prioritise the most needy cases, generally using health criteria.

Current Difficulties

It has been estimated that £17m would be needed to clear the backlog of cases. However, most health boards report that they would be unable to absorb more funding due to pressure on administrative resources and a shortage of building labour. In the past, health boards relied on local contractors and FÁS trainees but the building boom has decreased the interest of local contractors in small scale projects typical of the scheme and has also resulted in less trainees being available to FÁS. Given the circumstances of those in need, the resultant delay is likely to have quite an adverse impact. An innovative and concerted effort is required at local and national level to identify ways of dealing with impediments to ensure priority work is carried out.

Evaluation

Recent reports suggest that a significant number of elderly people may still be living in very poor housing conditions and that this is having a detrimental effect on their health and life expectancy. In addition to an absence of strategic planning, the scheme has never been the subject of a needs analysis and there are no systems in place to evaluate its effectiveness. Consequently, it tends to be operated in reaction to cases coming to attention, rather than as a pro-active effort to address the problem. The absence of

reliable information on need makes it very difficult to plan on a strategic basis or to articulate realistic and attainable objectives in the medium to long term. Given the length of time the scheme has been in existence and indications of unidentified need, there is a strong case for carrying out a comprehensive needs assessment at an early date.

Notwithstanding the problems identified, the scheme is implemented effectively by most health boards at local level and is valued by them as an effective tool in dealing with cases where an elderly person would otherwise need to be placed in an institution. Much of the credit for this effectiveness must go to health board staff who work to maximise the potential of the existing operation. However, their ability to impact on the problem would be appreciably improved if the scheme was reviewed and strengthened.

A significant proportion of elderly people are thought to require residential care due to poor housing conditions. In the light of the costs of hospital beds and long stay residential places, the scheme would appear to represent good value for money if it succeeds in creating conditions which facilitate elderly persons living in their own homes for as long as possible.

1 Introduction

Background

1.1 In July 1982, the Minister for the Environment and Local Government announced a new provision of £1 million by way of grant-in-aid to a Task Force on Special Housing Aid for the Elderly. The Task Force was set up to undertake an emergency programme to improve the living conditions of old people who lived in unsanitary or unfit accommodation, but who had neither the financial means to pay for the remedial works, nor the capacity to arrange them. The emergency programme has continued up to the present day.

1.2 The programme takes the form of a non-statutory scheme, known as the Special Housing Aid for the Elderly Scheme. It is operated by the eight health boards[1] on behalf of the Department of the Environment and Local Government which has overall responsibility for the scheme.

Objectives of the Scheme

1.3 When announcing its introduction and its purpose to the Dáil, the Minister for the Environment set out the scheme's objectives. Figure 1.1 gives a short extract from the text of his announcement which underlines the importance of the objectives of the scheme.

Figure 1.1 Extract from Dáil Speech

> It is clear that some elderly persons in the community are living alone in conditions that are not acceptable. They can be found in urban and rural areas alike. Many of these dwellings lack proper sanitary facilities, are often in a poor state of repair offering only minimal protection against the elements, offer no comfort to the occupants, and normal standards of cleanliness and hygiene are impossible to maintain.

Source: Parliamentary Debates, Column Number 971, 2 July 1982

1.4 The objective of the scheme is to improve the living conditions of old people living in unfit and unsanitary conditions. The objective was defined in more detail under guidelines on the operation of the scheme which stipulate that it should

- carry out fundamental repairs to a house in order to protect and contribute to the comfort of the occupant, particularly during bad weather
- be administered with flexibility to avoid rigid procedural and other requirements
- maximise the number of cases dealt with and ensure, as far as possible, that only deserving cases are assisted.

1 The Eastern Health Board has been reconstituted as the Eastern Regional Health Authority and as such, has overall responsibility for three new regional health boards with effect from January 2000. The scheme is operated on behalf of all three boards by a company called Eastern Community Works Ltd.(ECW Ltd.)

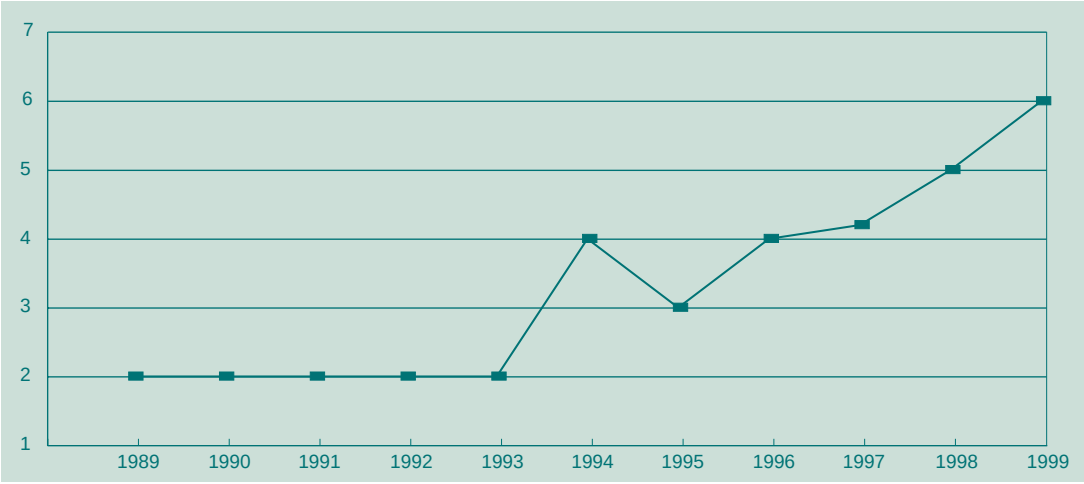
1.5 From the beginning, the intention was to maximise the use of the funding provided by harnessing the availability of spare labour capacity by using FÁS trainees to complete the necessary work.

1.6 As the primary health-care providers for the elderly, the health boards have developed specific strategies for an integrated spectrum of services for older people to improve their well-being and quality of life. The overall objective is to maintain older people in dignity and independence in their own homes for as long as possible. The Special Housing Aid for the Elderly Scheme is regarded by health boards as an important element in achieving this objective.

Scheme Expenditure

1.7 Since the inception of the scheme in 1982, expenditure by the health boards under the scheme has been in excess of £44 million, including £6 million in 1999. Figure 1.2 shows the amounts allocated to the health boards by the Department under the scheme since 1989.

Figure 1.2 Scheme Amounts Allocated to the Health Boards 1989-1999



Source: Department of the Environment and Local Government

Value For Money Issues

1.8 In common with most social programmes, consideration of value for money issues for the scheme requires both a quantitative and qualitative approach. Economy and efficiency may be evaluated in terms of the expenditure and administrative support for the scheme and the number and quality of jobs completed. The value of the scheme cannot be judged solely in money terms, but has to be viewed also in terms of its social importance.

1.9 The effectiveness of the scheme depends on looking at longer term trends in the penetration of the scheme to all areas covered by the health boards, the general quality of housing available to the elderly and the improvement in living conditions and mortality rates caused by the scheme. The scheme's primary purpose is concerned with improvement in the quality of well-being of the constituency being reached through remedial work on inadequate housing conditions and the prevention of a deterioration in life quality. This purpose is affected by a number of variables besides the quality of housing and does not easily lend itself to quantitative assessment.

1.10 The nature of the scheme and the expectations attached to its outcome suggest that effectiveness is the most important value for money issue.

Scope and Objectives of the Examination

1.11 As the scheme has been in operation for eighteen years on an emergency basis, it was considered timely to undertake a value for money examination of its operation. The objective of the examination was to evaluate how the scheme was being delivered and to review the arrangements for the evaluation of the effectiveness of the scheme.

1.12 Chapter two assesses the effort to implement the scheme by the Department, the Task Force and the health boards. The assessment covers expenditure, administrative arrangements, planning and needs assessment, the resources used and the work carried out under the scheme.

1.13 Chapter three examines the role of the principal parties involved and the systems, practices and procedures used to evaluate the effectiveness of the scheme.

Methodology

1.14 The examination was performed by staff of the Office of the Comptroller and Auditor General. The records and documentation, systems, procedures and practices of the Department and the health boards were reviewed during the course of the examination. The administration costs reported by the boards were also analysed.

1.15 Information relating to the scheme was also obtained by way of questionnaires to the health boards. The examination team subsequently visited and interviewed relevant personnel in the Department and in each health board.

2 Implementing the Scheme

2.1 This chapter is concerned with the scheme's administration and implementation. It examines the expenditure and resources used, the work undertaken and the implementation problems experienced.

Scheme Expenditure

2.2 Since 1982, over £44.5 million has been allocated to the health boards under the scheme. The amount allocated each year has been increasing steadily since 1995. During 1999, £6 million was allocated to the health boards, representing an increase of 20% over the amount allocated in 1998. An analysis of the amounts allocated and spent by health boards on the scheme for the three year period 1997 to 1999 is shown in Table 2.1.

Table 2.1 Allocations and Expenditure: 1997 to 1999

	Eastern £'000	Midland £'000	Midwest £'000	Northeast £'000	Northwest £'000	Southeast £'000	Southern £'000	Western £'000	Total £'000
1997									
Allocation	720	475	440	462	395	450	440	750	4,132
Expenditure	806	475	377	344	345	446	477	671	3,941
Surplus/(Shortfall)	(86)	-	63	118	50	4	(37)	79	191
% of Allocation	*(12%)*	-	*14%*	*26%*	*13%*	-	*(8%)*	*11%*	*5%*
Jobs Underway	134	168	42	31	216	181	187	317	1,276
1998									
Allocation	900	585	527	535	465	513	505	970	5,000
Expenditure	848	416	513	381	342	410	529	951	4,390
Surplus/(Shortfall)	52	169	14	154	123	103	(24)	19	610
% of Allocation	*6%*	*29%*	*2.6%*	*29%*	*26%*	*20%*	*(5%)*	*2%*	*12%*
Jobs Underway	319	157	28	221	193	212	211	439	1,780
1999									
Allocation	1,096	673	625	646	565	624	606	1,165	6,000
Expenditure	879	622	514	330	312	367	440	1,256	4,720
Surplus/(Shortfall)	217	51	111	316	253	257	166	(91)	1,280
% of Allocation	*20%*	*8%*	*18%*	*49%*	*45%*	*41%*	*27%*	*(8%)*	*21%*
Jobs Underway	540	154	75	98	204	303	190	449	2,014

Source: Analysis by the Office of the Comptroller and Auditor General

2.3 The table indicates that a substantial proportion of the annual allocation remains unspent at year end. However, this shortfall in expenditure is offset by the amount of expenditure committed on jobs underway but not completed at year end.

2.4 Some health boards regard the level of annual funding from the Task Force as inadequate to meet current demand. The Southern Health Board stated that, even though it received an allocation of £606,000 in 1999, it estimates that additional funding of approximately £300,000 per annum is needed "to enhance the service and meet the present demand". However, most health boards report that they are not in a position to absorb more funding and this appears to be borne out by the expenditure trends.

The Operation of the Scheme

2.5 When the scheme was introduced in 1982, its primary purpose was to make the houses of elderly people weatherproof and comfortable. In the intervening years this 'first aid' type of repair work has evolved into a more complex housing improvement scheme, including roofing, installation of showers, electrical works, and limited structural work such as chimneys and ceilings. In February 2000, additional funding was announced for the scheme to allow it to be extended to include the provision of appropriate heating systems.

2.6 The scheme's eligibility criteria specify that applicants must occupy the house needing repair and must be living alone, or with other elderly persons. The scheme does not apply to local authority houses or houses which are eligible for local authority housing grants.

2.7 At local level, applications are received directly from the elderly person, or from others acting on their behalf, such as relatives, neighbours, home helps, nurses, general practitioners, social workers and voluntary groups. All applications are examined by the health board staff, mainly by Environmental Health Officers[2], but sometimes by Public Health Nurses, administrative staff or Community Welfare Officers. They inspect the property and assess the degree of urgency of the required work.

2.8 The work is carried out by a variety of means which are discussed in detail in the following section. On completion, a health board maintenance foreman or an environmental health officer will visit the house to inspect work carried out. If they are satisfied with the completed work payment under the scheme, including grant payment, will be approved.

Scheme Resources

2.9 Besides funding, the resources needed to implement the scheme are building labour and the administrative resources allocated by the health boards. The economy of the scheme depends on minimising the cost of these resources without compromising the standard of jobs carried out.

2 The enforcement of housing and planning legislation and regulations is a key role of Environmental Health Officers (EHOs). Knowledge of buildings and housing related subjects is a requirement of their professional qualification and they receive training and practical experience in evaluating housing standards to enable them to fulfil that role.

Building Labour

2.10 The health boards use the following mechanisms to carry out work under the scheme

- FÁS - groups of trainees under the supervision of foremen
- Building contractor - The health board engages the building contractor directly to carry out the work
- Applicant contractor - the applicant enters into a contractual arrangement with a contractor and the board pays the applicant a grant, usually 90%, towards the cost
- Direct labour unit - employees of a subsidiary company, ECW Ltd., of the ERHA are used to carry out the work in the Authority's area
- Joint ventures, including co-funding between the health board and voluntary organisations.

2.11 The health boards employ labour to carry out work approved under the scheme from a number of sources and in different ways. Most of the work under the scheme is carried out by private building contractors. The contractors are either employed and paid directly by the health board, or are engaged by the applicant, who subsequently receives a grant from the health board towards all or most of the cost. Most health boards also use FÁS, but one health board uses direct labour, i.e. health board employees, to carry out the work. A small amount of work is carried out by one board through joint ventures. Table 2.2 shows the estimated breakdown in 1999.

Table 2.2 Building Labour, 1999

Health Board	FÁS	Applicant Contractor (Grants)	Board Contractor	Direct Labour	Joint Venture
Eastern	62%	1%	27%	10%	-
Midland	-	1%	99%	-	-
Mid Western	50%	50%	-	-	-
North Eastern	34%	19%	46%	-	1%
North Western	3%	96%	1%	-	-
South Eastern	35%	65%	-	-	-
Southern	30%	69%	1%	-	-
Western	30%	5%	65%	-	-
Average %	31%	38%	30%	1%	-

Source: Analysis by the Office of the Comptroller and Auditor General of information supplied by the health boards

2.12 The examination found a mixed approach between health boards and between community care areas within boards. In some locations, only FÁS or building contractors engaged directly by the health board are used. Other areas use a mix of grants and building contractors or FÁS, depending on the individual case. In yet other areas, only grants are available under the scheme. The single most commonly used mechanism is direct engagement by the applicant of contractors on foot of grant approval. The extent of reliance on contractors directly engaged by the applicant is not in keeping with the scheme's intent to remove the burden of implementation from the elderly person.

2.13 All boards cite the difficulties in sourcing private contractors to carry out work as the main impediment to the scheme. The problem arises as a result of the current construction boom, which has also led to a decline in the number of small contractors prepared to take on the type of work covered by the scheme.

The Use of FÁS Trainees

2.14 The scheme guidelines issued by the Task Force suggest that health boards should use FÁS to carry out work under the scheme to the maximum extent possible. When these guidelines were first issued, the scheme was seen as a way of supporting FÁS operations. In addition, projects undertaken by FÁS cost less, because the labour costs of these projects are borne directly by FÁS and the health boards are responsible only for the cost of materials used.

2.15 From the outset, most health boards have been unable to use FÁS to the extent envisaged. This is mainly because FÁS schemes are predominantly urban based. In addition, it has been difficult to match the scheme's requirements with FÁS's training responsibilities. Some boards see difficulty in matching the skills available to FÁS and the skills needed to provide a worthwhile service to the elderly.

2.16 The level of FÁS activity in the scheme has been declining steadily in recent years. The buoyant state of the building industry has led to a reduction in the numbers of trainees and the availability of supervisory staff. In view of the current difficulties surrounding the provision of skilled labour to the scheme an assessment of the options available under the various State-sponsored training and employment schemes should be considered.

Grants

2.17 Most health boards offer grants under the scheme and Table 2.2 indicates that over one third of the expenditure on the scheme is spent in this way. The degree of reliance on this approach varies between health boards and even between community care areas within the same board. Some health boards and community care areas operate the scheme almost exclusively on a grant based approach. In others, only a small amount of projects are administered in this way.

2.18 With a grant, the onus is placed on the elderly applicant to find a suitable contractor and to enter into a contractual arrangement to have the work carried out. The amount of the grant is based on the approved cost of essential works, as estimated in advance by the health board. The cost of additional work considered by the health board not to be allowable under the scheme is borne by the grant applicant. The grant usually amounts to 90% of the approved cost, thus providing for an automatic contribution of 10% from the applicant. In cases of hardship, the health board forgoes the 10% contribution and pays grants of 100% of the approved costs of essential works.

2.19 The use of the grant based approach appears to conflict with the spirit of the scheme as outlined by the Minister when he announced its introduction and with the terms of the scheme detailed in the operational guidelines issued by the Task Force.

2.20 The advantage for the health board in this approach lies in reducing the administration costs of the scheme. It is also argued that this approach is more attractive to contractors as they are not required to comply with the health boards' financial procedures.

2.21 The economic gains of using grants may be offset by the risk of the approach acting as a barrier to entry for people who are otherwise eligible to avail of the scheme. If an elderly person happens to reside in an area where this approach is used exclusively, there is a risk that they will be incapable, for various reasons, of taking advantage of the grant. In addition, the risk of non-performance is borne by the applicant, many of whom are not in a position to pursue those responsible.

Impact of Different Approaches to Implementation of Scheme

2.22 The guidelines for the scheme state that it is to be administered "with flexibility and a minimum of formality" so as "to avoid rigid procedural and other requirements". The guidelines suggest the use of simple application forms. However, the application forms in use in some health boards, particularly those which provide grants, are more complex and run counter to the intention of the scheme. The complexity of these forms could act as a disincentive for elderly applicants in terms of the conditions they impose in regard to

- responsibility for obtaining planning permission
- contributions to the cost of the works
- responsibility for seeking of quotations and for employing contractors
- indemnities in favour of the health board against defective work and contractual claims.

2.23 The underlying thrust of the Task Force guidelines is that boards were to undertake all works on behalf of applicants and ensure their proper completion. To this end the boards would be required to

- obtain planning permission where necessary
- prepare specifications for the extent and quality of works
- obtain tenders and select a contractor or appoint FÁS or directly execute the works
- ensure completion of the works to the required standard

The imposition of such tasks on elderly applicants may be burdensome and stressful. In some community care areas, applicants are required to obtain quotations and to enter into direct contractual relationships with contractors.

2.24 The Task Force guidelines specify that it is desirable that applicants who can afford to do so should make contributions towards the cost of the works being undertaken. This requirement is being interpreted in a diverse manner by the health boards and by community care areas within the health boards. The Department has confirmed that it intends that work would be undertaken and paid for by the health boards initially, with applicants making contributions where feasible.

2.25 This approach is being used where work is carried out by the health board on behalf of the applicant. However, applicants who reside in health board areas where grants are used are at a financial disadvantage to those living in areas where the work is carried out by health board appointed contractors or by FÁS. This is due to the fact that the grant based approach involves the applicant paying for part of the work, usually 10% of the cost.

2.26 Although the guidelines require health boards to be responsible for ensuring that works are completed to an acceptable standard, some health boards disclaim responsibility in this regard. In one community care area, the examination found that applicants were required to enter into formal agreements indemnifying the board against defective or sub-standard work and against damage caused to applicants' properties in carrying out the work. Such arrangements may be unnecessarily burdensome given the role of the health boards in this area.

Administration of the Scheme

2.27 Significant costs are incurred by the health boards in administering the scheme. Most health boards meet some of these costs from the annual scheme allocation. However, the Department advises that it has not agreed this practice with the health boards.

2.28 Table 2.3 outlines the number of staff involved and the administrative costs incurred by the health boards during the operation of the scheme in 1999. This data is based on estimates provided by the health boards specifically for the purpose of this examination. The table reflects the difference in approach in terms of resources available to administer the scheme.

Table 2.3 Estimated Administration Costs 1999

Health Board	Administration Staff (Full Time Equivalents)	Administration Costs £000
Eastern	13.8[a]	251
Midland	4.0	40
Mid Western	2.0	46
North Eastern	1.3	34
North Western	5.0	86
South Eastern	3.5	95
Southern	7.5	173
Western	14.5	314
Total	**51.6**	**1,039**
Average	**6.4**	**130**

Note: [a] Includes 11.3 full time equivalent employees in respect of the Direct Labour Unit
Source: Estimates supplied by the health boards

2.29 There is little consistency between the boards in administration costs. It is the general policy of the health boards to minimise recoupment in order to leave the maximum amount available for scheme projects. One board absorbs all costs without recoupment. There are also different approaches adopted by the boards to recording and charging costs. For example, the administrative cost figure returned by the Midland Health Board represents 6% of the annual scheme allocation as it is the policy of this board to charge this amount to the scheme. ECW Ltd (Eastern Regional Health Authority) has 13 staff working on the scheme, but the administrative cost includes four works foremen whose costs are partly recouped by FÁS.

2.30 Health boards consider that there is insufficient administrative capacity in terms of staff resources to implement the scheme. Some boards use a percentage of their annual allocation for the scheme to provide additional administrative resources to deal with backlogs of scheme applications. This has the effect of speeding up the processing of applications but, in the absence of contractors or FÁS workers to carry out the repairs, it may move the backlog in performing the work to the contractor stage. However, the improved efficiency in processing applications has the advantage of allowing urgent cases to be identified more quickly.

2.31 From the examination it is evident that a review of the funding of administration costs should be undertaken by the Department in conjunction with the health boards and the Department of Health and Children.

Scheme Outputs

Nature of Work Completed

2.32 Table 2.4 analyses the number of jobs undertaken between 1997 and 1999 according to the nature of work performed.

2.33 The great majority of works carried out relates to the category 'Necessary Repairs'. This relates to any works which are considered to be urgently necessary to improve the living conditions of elderly persons living alone. The Task Force guidelines defines them as "necessary repairs to make a dwelling habitable for the lifetime of the occupant", for example, repairs to a roof, chimney or fireplace, or the provision of food storage facilities. The concentration on works of this nature is therefore in line with the original intention of the scheme and with the provisions of Task Force guidelines.

Table 2.4 Nature of Works Assisted 1997 to 1999

Type of work	1997	1998	1999	1997	1998	1999
Necessary Repairs	2,414	2,898	1,450	64%	73%	65%
Provision of Water Supply	159	99	73	4%	2%	3%
Provision of Toilet Facilities	324	265	174	9%	7%	8%
Provision of Bath/Shower	427	402	253	11%	10%	11%
Installation of Electricity	185	71	36	5%	2%	2%
Electrical Rewiring	73	76	85	2%	2%	4%
Provision of Hot Water	67	45	28	2%	1%	1%
Windows and Doors	100	100	127	3%	3%	6%
Other	4	2				
Total	**3,753**	**3,958**	**2,226**	**100%**	**100%**	**100%**

Note: The total number of projects detailed for 1999 is significantly lower than that for 1997 and 1998 because some health boards were not in a position to provide the information for 1999. The annual totals for 1998 and 1999 are greater than the total number of projects completed in those years because some projects include more than one category of works.
Source: Analysis by the Office of the Comptroller and Auditor General

Completed Projects per Health Board

2.34 The level of scheme activity in terms of jobs completed by each health board was reviewed for the three years 1997 to 1999. Table 2.5 details the number of projects completed for all boards in the period.

Table 2.5 Jobs Completed per Health Board

Board	1997	1998	1999	Total	1982 to 1999	% of Total	Average Annual Completions
Eastern	299	450	407	1,156	5,999	14.6%	333
Midland	258	234	243	735	3,064	7.4%	170
Mid-Western	251	282	318	851	3,701	8.9%	206
North-Eastern	671	651	441	1,763	9,922	23.9%	551
North-Western	160	307	363	830	3,648	9.0%	202
South-Eastern	355	378	340	1,073	4,088	9.7%	227
Southern	545	589	533	1,667	6,520	15.7%	362
Western	315	411	549	1,275	4,468	10.8%	248
Total	**2,854**	**3,302**	**3,194**	**9,350**	**41,410**	**100.0%**	**2,300**

Source: Analysis by Office of the Comptroller and Auditor General

2.35 While over 9,000 applicants have benefitted under the scheme in the past three years, there is a wide variation between boards in the number of annual completions. This is also the case at community care area level within health boards. For example, the North-Eastern Health Board has consistently achieved a high level of project completion between 1997 and 1999. However, within the board region one community care area has completed over 60% of these projects. A possible reason for this may be that the area is mainly urban based where, in general, the degree of complexity and the size of jobs undertaken is different from the more rural areas in the health board district. This could also apply to other health board areas.

Cost per Project

2.36 The expenditure incurred in completing these projects and the average job cost per health board is detailed in Table 2.6.

Table 2.6 Project Expenditure 1997 to 1999

Board	Expenditure £'000	Jobs Completed	Average Job Expenditure £
Eastern	2,533	1,156	2,191
Midland	1,513	735	2,058
Mid-Western	1,404	851	1,650
North-Eastern	1,056	1,763	599
North-Western	999	830	1,204
South-Eastern	1,222	1,073	1,139
Southern	1,446	1,667	867
Western	2,879	1,275	2,258
Total	**13,052**	**9,350**	**1,396**

Source: Analysis by the Office of the Comptroller and Auditor General

2.37 The analysis indicates that there is a wide variation in the average expenditure per job assisted by the scheme.

2.38 The averages used are those for the health boards as a whole. There can be wide variations between community care areas within the same health board. For example, while the lowest average is approximately £600 in the North-Eastern Health Board the averages for its constituent community care areas are

- Meath £1,054
- Louth £349
- Cavan/Monaghan £1,246

2.39 Health boards apply local approaches to implementing the scheme as part of the agreed flexibility and informality which is intended to characterise its operation. The content of a project or job and its associated costs can vary widely between cases and across community care areas, particularly in the "necessary repairs" category. The variation is related to the differing size of jobs and the availability of FÁS trainees. This limits the usefulness of cost comparisons. However, the extent of the cost variation does suggest the need for an in-depth assessment of whether the scheme could be delivered with better economy and efficiency, without impacting on the tailor-made nature of local approaches.

Backlog of Work

2.40 The health boards consider that the main factors which impact on their capacity to implement the scheme are

- the administrative capacity of the board to process applications, oversee work undertaken and process payments
- the availability of contractors or FÁS workers to carry out the work.

2.41 To work efficiently, the boards need the right balance between financial resources, administrative capacity and contractor availability. A change in any factor has an immediate impact on overall performance.

2.42 Figure 2.1 summarises the position of health boards on the average time taken from receipt of applications to completion of works.

Figure 2.1 Average Waiting Time

Health Board	Estimated Waiting Period
Eastern	4 years
Midland	3 years
Mid-Western	2 years
North-Eastern	2 years
North-Western	1 year
South-Eastern	1 year
Southern	6 months
Western	2 years

Source: Analysis by Office of the Comptroller and Auditor General of information provided by the health boards

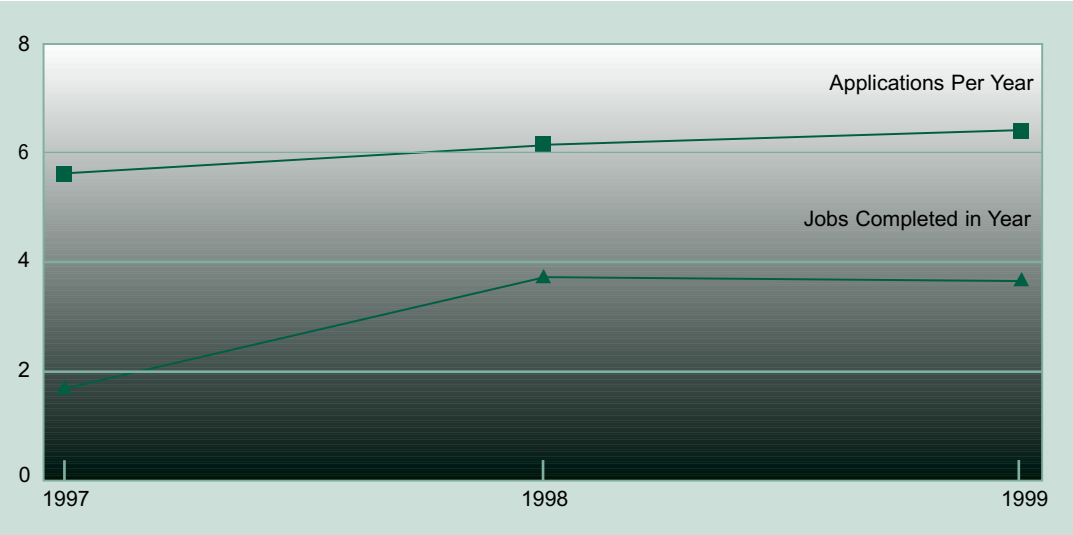
2.43 The four year waiting period for the Eastern Health Board, now ERHA, area is estimated on the basis of the number of applications on hands at 31 December 1999 (over 1,700) and the average annual job completions (400) by ECW Ltd. in the period 1997 to 1999. ECW Ltd. consider that this does not reflect the true position as it does not take account of the fact that applications are prioritised as either

- *Urgent* - works normally completed immediately or at most within a six month period. This category of fundamental repairs represents the original target group of the scheme and represents approximately 12 % of total applications.
- *Necessary but not urgent* - works normally completed within two years (58% of applications).
- *Minor repairs* - works completed as resources permit (30% of applications). ECW Ltd. also point out that the size of the waiting list reflects a 54% increase in applications in the period 1998/99.

2.44 There are significant delays in getting works completed under the scheme in all health boards. However, the boards have systems in place to ensure that needy cases are identified and prioritised by degree of urgency. The prioritisation systems are generally based on health criteria.

2.45 Health boards cite the difficulty in getting builders to carry out the work, given the current boom in the construction industry and, to a lesser extent, the lack of administrative capacity as the main reasons for increases in waiting times and the rising backlog. Some boards have allocated additional staff to the scheme in an attempt to clear the arrears situation. Figure 2.2 illustrates the situation in regard to applications and job completions between 1997 and 1999.

Figure 2.2 Trends in Annual Applications and Job Completions



Source: Analysis by the Office of the Comptroller and Auditor General

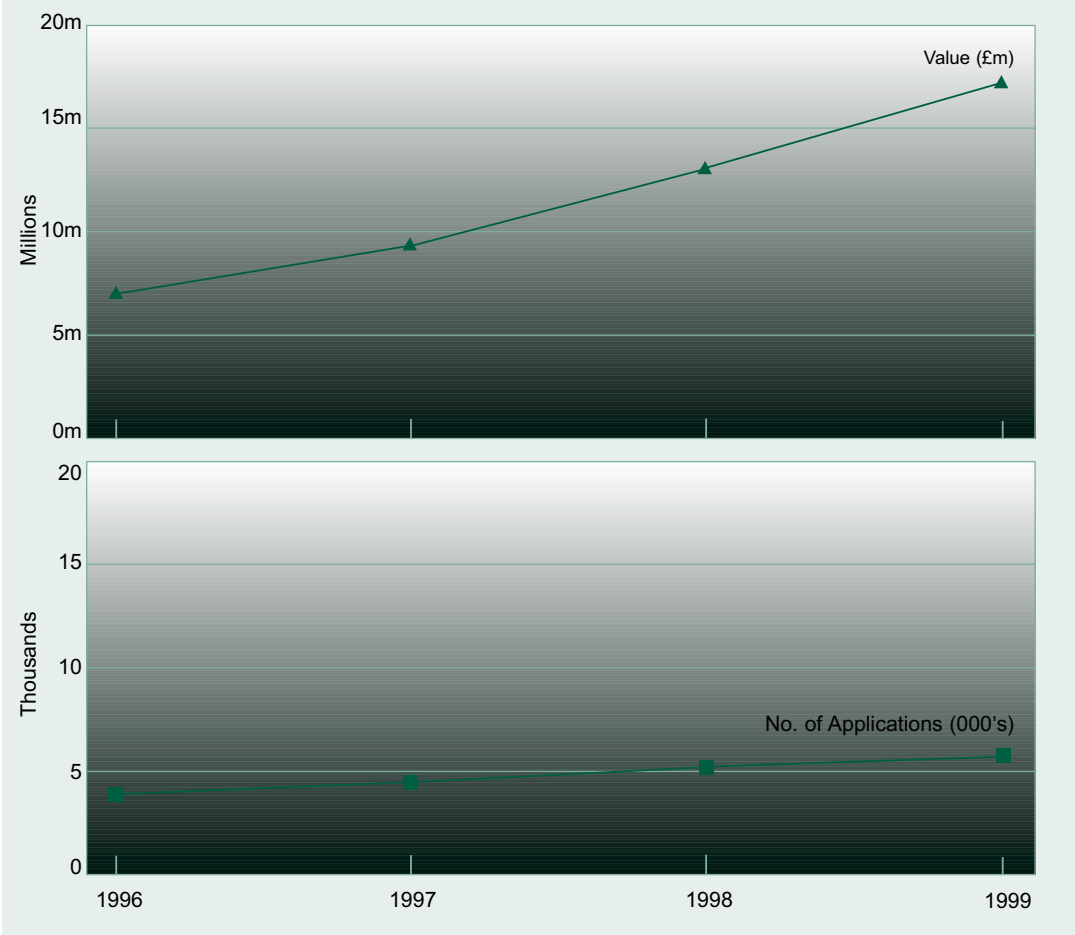
2.46 The boards with the shortest waiting time tend to be those which place most reliance on grants (Table 2.2). However, most benefits accrue to those who are capable of carrying out the repair work on their own initiative, not to those for whom the scheme was originally intended. The health boards also benefit as administering grants is less resource intensive than administering repair works.

2.47 Since 1997 the Department has been monitoring the estimated expenditure committed by the boards to applications on hands at year end. Departmental records indicate that the health boards would require approximately £17 million to clear the backlog of applications at 31 December 1999. However, health boards advise that, even if the funds were provided, they would be unable to eliminate the backlogs due to insufficient administrative capacity and non-availability of building contractors or FÁS workers.

2.48 On the basis of current waiting times, it is estimated that the backlog would take an average of two to three years to clear in all health boards. This does not take into account the resources and time required to deal with the ongoing receipt of current applications.

2.49 Notwithstanding the prioritisation of applications by health boards, delays have a significant impact on an elderly person's health and life expectancy. The backlog also results in cost increases, as building costs continue to rise. Figure 2.3 illustrates the growth in the backlog value across all health boards between 1996 and 1999, providing evidence of the general increase in building costs during this period and its potential future impact on the scheme.

Figure 2.3 Volume and Value of Backlog



Source: Analysis by the Office of the Comptroller and Auditor General

Conclusions

2.46 The main conclusions are as follows

- The wide variation in approaches, costs and project completions suggests the need for an in-depth assessment of the operation of the scheme.
- Obligatory contributions and reliance on a grant-based approach in some boards runs counter to the spirit of the scheme and the letter of the Task Force guidelines. There may also be an unequal burden of contribution across different health board areas. Health boards who wish to retain the option of grants should review their approach to ensure that it does not act as a barrier to scheme entry.
- The growing backlog of applications and the average time interval between receipt of applications and completion of works strongly suggests that action should be taken at national and at local level to address the problem.

3 Evaluating the Scheme

Introduction

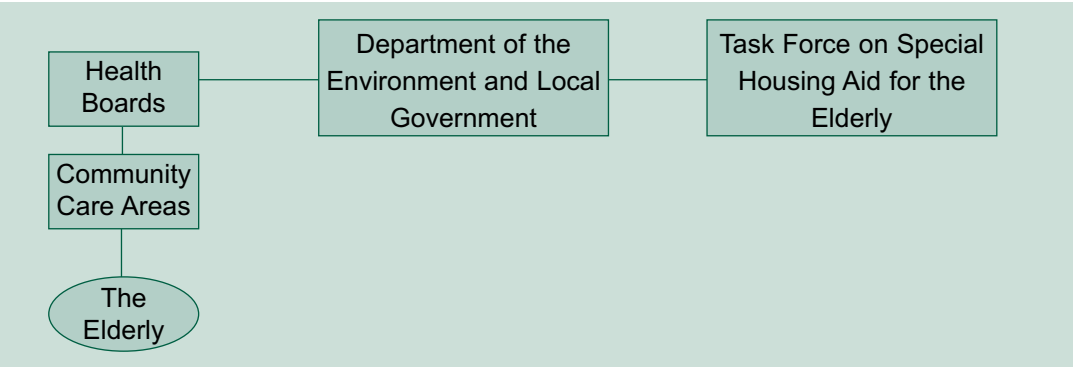
3.1 All health boards value the scheme highly. They consider that it provides a tangible benefit in the form of improved living conditions to the elderly and supports the preferred wish of elderly people to live in their own homes until they are no longer able to do so. However, recent reports indicate that a significant number of elderly people continue to live in unfit conditions, suggesting that the scheme has made insufficient progress in tackling the problem.

3.2 This chapter is concerned with the systems, practices and procedures used to evaluate the effectiveness of the scheme. The roles and responsibilities of the organisations involved in the scheme are first reviewed. Then the specific arrangements to consider the effectiveness of the scheme are considered, together with some cost effectiveness issues.

Roles and Responsibilities

3.3 Figure 3.1 outlines the administrative structure of the scheme. In cases where there is more than one body involved in implementing the scheme, there are significant implications for value for money in the effort focused on the scheme by each body and the degree of co-ordination between them in its administration.

Figure 3.1 Administrative Structure of the Scheme



Source: Analysis by the Office of the Comptroller and Auditor General

In particular the responsibilities for strategic management functions should be clear. These include the clarification of the objectives of the scheme, the performance of a needs analysis to support the adequacy of funding, the monitoring of the implementation of the scheme and the occasional evaluation of the impact of the scheme on the problems it seeks to resolve.

Department of the Environment and Local Government

3.4 The scheme is funded and administered at national level by the Department of the Environment and Local Government. The Department estimates the scheme's annual financial requirements on the basis of periodic reports received from the health boards. It allocates funding to the health boards, in the form of grants-in-aid, and monitors their expenditure regularly during the course of the year.

3.5 The Department provides administrative support for the twice yearly meetings of the Task Force. While the Department exercises budgetary control, it does not actively engage in co-ordinating and planning the scheme's operation. At £6 million in 1999, the scheme represents a tiny proportion of the Department's overall expenditure of £1.3 billion for that year.

Task Force on Special Housing Aid for the Elderly

3.6 The Task Force was established in 1982 by the Minister for the Environment to implement the scheme. It is a non-statutory body whose membership is drawn from the Department of the Environment and Local Government, the Department of Social, Community and Family Affairs, the Department of Health and Children, the Society of Saint Vincent de Paul, FÁS, ALONE and two local authorities.

3.7 The Task Force meets twice yearly to monitor the operation of the scheme, evaluate activity within the various health board areas and to agree financial allocations to the boards from the funding available. In determining the allocations due cognizance is given to returns furnished by the boards of activity under the scheme and the number of applications on hands within each area.

3.8 The Task Force issued guidelines on the operation of the scheme in 1987 and updated them in 1996. A copy of the 1996 guidelines is reproduced at Appendix C. The guidelines set out the eligibility criteria to be applied to the scheme. They suggest the type of work that might be carried out and advise that the scheme should be administered with flexibility and minimum formality.

3.9 Although the Task Force was established to implement the scheme, the examination has found that, other than the Minister's Dáil statement in 1982 announcing the establishment of the scheme (Figure 1.1), formal terms of reference for the Task Force have never been drawn up.

Department of Health and Children

3.10 The Department of Health and Children is the agency with primary responsibility for the health of elderly people. The Department has overall control of the services provided by the health authorities throughout the country. In addition, it reviews existing services and initiates proposals for new services. However, other than being represented on the Task Force, the Department of Health and Children is not involved in the Housing Aid for the Elderly scheme.

The Health Boards

3.11 Since its inception, the scheme has been implemented at local level by the health boards through their community care areas.

3.12 Initially, the health boards had considerable reservations about their role in the scheme. They argued that, not being housing agencies, they were not equipped to take on this type of work and that it would be more appropriate to local authorities with statutory responsibility for housing. As public health nurses, social workers and occupational therapists are in regular contact with elderly people in need of health care, the health boards were thought to have the best knowledge of the living conditions of the elderly and, therefore, to be the most appropriate bodies to administer the scheme.

3.13 Following discussions with the Department, the health boards agreed to implement the scheme, on the understanding that it would be administered with the minimum of formality and with the primary aim of rendering the homes of the elderly weatherproof and comfortable for the occupants.

3.14 Although most health boards now value the scheme as part of their framework of support for the elderly, it is still considered to be outside their regular mandate and is treated as an adjunct to their main work. Figure 3.2 lists the typical services which are available to support the older person at home.

Figure 3.2 Supporting the Older Person at Home

- General Practitioner
- Carer
- Speech and Language Therapist
- Social Worker
- Physiotherapist
- Care Attendant
- Registered General Nurse
- Occupational Therapist
- Home Help
- Nutritionist
- Chiropodist
- Voluntary Groups and Organisations
- Public Health Nurse
- Community Hospital
- Community Nursing Unit
- Community Welfare Officer
- Day Care Centres
- Respite Care

3.15 It is the policy of all health boards to maintain the elderly in dignity and independence in their own homes for as long as possible. The work undertaken to implement this policy, including house repairs under the scheme, is planned and monitored by way of the health boards' annual service plans and management information systems.

Co-ordination and Strategy

3.16 Local authorities also operate a scheme for repairs to the housing of elderly people. The objective of the Essential Repairs Grant Scheme is to maintain such housing in a habitable condition as an alternative to placing the occupant on the local authority housing list. The scheme differs from the Housing Aid for the Elderly Scheme in that it is wholly grant based. The Department of Social, Community and Family Affairs provides grant assistance to voluntary agencies which are involved, *inter alia*, in providing housing repair services.

3.17 All health boards rely on voluntary bodies to some extent to implement the scheme. Their assistance ranges from bringing individual cases to attention to advising on the housing needs of the elderly in general. The involvement of voluntary bodies in the operation of the scheme is significant in the case of two boards, the Southern Health Board and the North-Eastern Health Board. The wages of the works supervisors are administered by voluntary bodies in one board, while the other board makes funding available to voluntary bodies who carry out agreed work on the Health Board's behalf.

3.18 There is informal liaison between the health boards, local authorities and voluntary agencies on operating the scheme at local level. However, the only formal co-ordination occurs at Task Force level where these bodies and the departments are represented.

3.19 This scheme represents the only point of contact between the health boards and the Department of the Environment and Local Government. The health boards report to the Department of Health and Children on all other matters.

3.20 Strategic planning specifically for the scheme is not undertaken by health boards. Some boards consider that this work is the responsibility of the Department of the Environment and Local Government and the Task Force. They point out that the scheme, introduced as an emergency provision in 1982, still does not have a statutory basis and continues to be funded from year to year. If the scheme was put on a permanent footing with guaranteed funding, health boards consider that they would be in a better position to engage in longer term planning.

3.21 Like the health boards, the approach of the Task Force and the Department of the Environment and Local Government tends to be focused on day to day operational requirements. Neither the Department nor the Task Force has produced a strategic plan for the scheme. As a result, the scheme's long term expected outcome or the actions and strategies needed to realise that outcome have not been articulated.

3.22 The focus on operational rather than strategic matters may have arisen as a result of uncertainty about the role of the Task Force and the ongoing temporary status of the scheme.

3.23 Formal terms of reference need to be drawn up for the Task Force, setting out its role and responsibilities and establishing a mandate and reporting arrangements for effective strategic management and co-ordination of the scheme.

Needs Assessment

3.24 Health boards consider that they have a good knowledge of the condition of housing for the elderly in their own area. Their knowledge is drawn from long experience in operating the scheme, the information contained in applications and the extensive local knowledge of the many health board employees in regular contact with the elderly.

3.25 If an elderly person is unable or unwilling to highlight their plight, local representatives, voluntary groups or health practitioners will usually bring the case to attention. While this approach is proving practicable and efficient, health boards admit that, despite these arrangements, there is a risk that some elderly people in need are not being brought to their attention.

3.26 The Department, the Task Force or the health boards have not carried out or commissioned a formal analysis of the housing needs of elderly people. Such an assessment would provide accurate information on the nature and extent of the problem which the scheme was set up to address. While they recognise its value, the health boards state that this information is not available to them from any other source and they themselves do not have the resources or the administrative capacity to carry out such an assessment.

3.27 The examination sought to establish if there was a relationship between the size of the elderly population residing in the different health board areas and the proportion of scheme allocations received by those boards. Table 3.1 compares elderly population levels in the health board areas according to the 1996 Census with the proportion of scheme allocations received in the period 1996 to 1999. The table shows that there is little correlation in some areas, particularly the Eastern Health Board (now ERHA) area. Factors which might influence this include regional disparities in economic conditions, in the standard of housing and in the proportion of elderly people living alone.

Table 3.1 Allocations and Elderly Population by Health Board

Board	Population aged over 65	% of Total Population aged over 65	Average Annual Allocations 1996 to 1999 £'000	% of Total Allocations
Eastern	125,271	30	854	18
Midland	25,019	6	541	11
Mid-Western	37,480	9	498	10
North-Eastern	34,812	8	526	11
North-Western	29,395	7	451	9
South-Eastern	46,590	11	507	11
Southern	66,127	16	513	11
Western	49,188	12	894	19
Total	**413,882**	**100**	**4,784**	**100**

Source: Central Statistics Office, Census 1996 and Department of the Environment and Local Government

3.28 In the absence of an up to date needs assessment, the Department is completely reliant on the volume of approved applications in each health board to decide on the amount to be allocated.

3.29 The absence of up to date information on the extent and nature of needs makes it difficult to plan strategically, to develop appropriate responses to problems and difficulties at the point of implementation, or to collect the type of information necessary to support a case for additional resources. As the scheme has been in existence for a considerable length of time, it would be appropriate to arrange for a nationwide needs analysis to be carried out. This could be arranged in co-operation with local authorities, local development bodies and voluntary groups.

Public Awareness

3.30 All boards state that they are satisfied with the level of awareness of the scheme among the board officials in regular contact with the elderly and among local politicians and voluntary bodies. Health boards promote the scheme through their own literature and by way of local media. The extent of promotion of the scheme varies considerably between the health boards.

3.31 Most health boards are unwilling to publicise the scheme widely. They fear that the resulting increase in applications would overwhelm their limited administrative capacity by obliging them to process more applications, including more speculative applications. They also fear an increase in their already long waiting lists, which would raise expectations without any realistic chance of work being carried out quickly. The reluctance of health boards to publicise the scheme widely is based on their confidence that existing systems bring most needy cases to their attention and their anxiety to avoid any increase in the rate of applications. But it increases the risk that cases in genuine need will remain undetected.

3.32 Adequate and appropriate promotion of the scheme is essential for the scheme to be effective and equitable for those whom it is designed to serve. The Department or the Task Force should occasionally review the adequacy of the ways in which the scheme is promoted.

Monitoring and Evaluation

3.33 The Department and the Task Force monitor the scheme on the basis of regular health board returns. These returns provide information and statistics on applications received, projects completed and in progress, nature of works carried out, expenditure incurred and estimates of work on hands. However, the absence of plans and targets against which performance can be measured minimises the effectiveness of the monitoring system.

3.34 Health boards monitor the scheme's operation at local level through their standard reporting and management information systems. Plans and targets under the scheme are included in the boards' overall service plan and target achievement is monitored under the boards' monthly and annual management reporting systems. Each project is assessed at completion to ensure that the work agreed has been carried out. However, post-completion evaluations are not carried out systematically to assess whether the work is having the intended effect on the quality of life of elderly people or if it contributes towards the scheme's intended outcome.

3.35 The monitoring system at local and national level allows quantum outputs under the scheme to be monitored, but does not allow an in-depth assessment of the scheme's impact as a whole.

3.36 The scheme is not subject to formal evaluation at local or national level. The examination found that

- effectiveness evaluation criteria relating to the outcome of the scheme in terms of impact on the elderly people targeted, are not stated
- assessments of the scheme's impact on the target population are not conducted and the outcome of the scheme has not been formally reviewed since its inception
- performance measures and indicators relevant to the scheme are not stated
- output targets and specified time periods are not stated.

3.37 Some health boards have carried out internal reviews of the scheme and others receive and consider regular activity reports on the scheme at board meetings. Those charged with operating the scheme at local level usually have a clear view of the required impact of the scheme within their own areas. However, the expected outcome of the scheme at board level needs to be stated and supported by targets. Health boards should develop formal evaluation mechanisms and systems for getting feedback in a systematic way and for analysing it to assess if the expected outcome of the scheme as a whole is being achieved. These need not be elaborate.

3.38 Practical indicators of effectiveness are already available to health boards, on a case by case basis, and require little additional administrative resources to operate and record.

- Health visitors attending an elderly person on a regular basis are in a position to provide feedback on the improvement in the person's health and well-being as a result of the work.
- Health board staff who visit a site after the work has been completed to approve payment are in a position to note and record jobs which need to be redone or improved and the reason why.

- A system for recording complaints from elderly people about any aspect of the scheme would afford them a voice about a service directly affecting their well-being and provide useful feedback to the health board on its practical effectiveness.

3.39 In addition to monitoring the scheme, the Department and the Task Force should review its operation to establish formal mechanisms and criteria to allow for regular evaluation of the scheme at national level.

3.40 Health boards are anxious to retain the present flexibility and informality of approach to the scheme which, they consider, has facilitated the development of tailor-made solutions to match local circumstances, thereby increasing efficiency and effectiveness. Board staff are aware of what is happening in other areas, but this information is informal and limited and there is no system for communicating new local initiatives to the benefit of all boards.

3.41 The Department and the health boards need to develop systems for assessing the value, effectiveness and impact of the various local approaches and to ensure that information on the best of these initiatives is circulated to and used by all health boards.

Cost Effectiveness

3.42 The health boards consider that the scheme represents value for money in terms of reducing the necessity for the elderly to have recourse to hospital beds or long stay homes. There is evidence that a significant number of elderly require residential care due to poor housing conditions.

3.43 In 1996, the Department of Health and Children reported that 15.6% of all patients in residence in long stay institutions at that time were there for social reasons and that it was fair to assume that these reasons included poor or unsuitable housing conditions.

3.44 If the average cost of a project under the scheme is expressed in terms of the number of bed nights it would fund in residential care it is clear that the return on expenditure under the scheme is very reasonable.

3.45 For example, the average scheme expenditure on a project in the Southern Health Board in 1999 was £825. The average cost per day of maintaining a patient in an acute hospital such as Cork University Hospital is £300. In the case of a Community Hospital the cost is £63. Therefore, the average project cost would fund three days in an acute hospital and 13 days in a Community Hospital. If, on average, the improvement in living conditions brought about by the scheme reduces the dependency on residential care by even a small number of days it has paid for itself. If it reduces the dependency by more than this there is clearly a substantial value for money gain.

3.46 A recent report entitled "*Homes for the 21st Century*" was published on foot of research to establish the extent of the remedial work required to upgrade the existing housing stock of Ireland to meet the energy conservation standards of the 1997 Building Regulations. The report stated that "Ireland has thousands of relatively poor older people, often living alone, whose houses and flats are so cold that many die prematurely, and thousands of others struggle on in discomfort and distress".

3.47 The report estimated that, with upgraded housing

- about half the excess winter hospitalisation cases in Ireland from cardiovascular and respiratory disease, and half the winter drugs expenditure on these two diseases, would be avoided.
- 44% of excess winter deaths in Ireland, which in turn represents 6% of total winter mortality, could be prevented.
- Most of the lives saved would be amongst the lowest socio-economic groups, with the majority (87%) also being over 65.

The main findings of the report are outlined at Appendix B.

Conclusions

3.48 The main conclusions are as follows

- Although the informal and flexible approaches to the scheme at local level are considered to be a major factor in its efficiency and effectiveness, there is now a need to assess the value of local initiatives in order to apply the best approaches across all health boards.
- The Department and the Task Force need to review the value of continuing the scheme on a temporary footing. The health boards consider that the inability to guarantee funding from year to year has inhibited the scheme in reaching its full potential.
- The Department, Task Force and health boards need to introduce strategic planning for the scheme at local and national level. The introduction of strategic planning should ensure that the scheme retains its strengths at local level, i.e. the flexibility and informality in approach and the close integration into the health boards' day to day operations.
- There is an urgent need to introduce a system of formal needs analysis to identify the full extent and nature of the problem of elderly people living in substandard accommodation and to allow an effective response to be planned and evaluated.

- Although the scheme has been used to assist 40,000 projects since its inception, independent reports indicate that the problem of elderly people living in sub-standard conditions is still significant. The effectiveness of the scheme in terms of achieving its objectives has not been evaluated either by the Department, the Task Force or the health boards. At present, there is an absence of systems, practices and procedures to allow such an evaluation. Other than the value placed on the scheme by the health boards in general, it is impossible to quantify its impact on the elderly population since its inception in 1982. The reports reviewed in this examination indicate that such an evaluation is overdue.

- Expenditure under the scheme represents good value for money when set against the potential alternative of having to provide for badly housed elderly people in residential care.

Appendices

Appendix A Current Status of Housing for the Elderly

The scheme has been in operation for 18 years. In the past three years it has been used for more than 9,000 projects. Given the level of activity under the scheme it would be reasonable to expect that it has had a significant impact on the living conditions of the elderly. The examination reviewed a number of reports relating to the condition of the housing stock occupied by the elderly.

The 1991 Census found that 33% of older people lived in houses built before 1919, although only 20.5% of all private dwellings in Ireland were built before 1919. Only 26.1% of older people lived in houses built since 1961, although 52% of the total Irish housing stock was built since 1961. The statistics indicate that, broadly speaking, a higher proportion of elderly people live in older houses. It can be reasonably assumed that these houses tend to need the most attention in terms of repairs and maintenance.

A report on research commissioned by the National Council on Ageing and Older People (NCAOP) entitled *Income, Deprivation and Well Being Among Older People* was published in 1999. It indicated that 10% of elderly headed households are considered poor in terms of low income and material deprivation. Women, rural women in particular, are over-represented in poverty terms. The NCAOP advises the Minister for Health and Children on all aspects of the welfare of the elderly. The report's summary of the housing status of the elderly is outlined in Figure A.1

Figure A.1 Housing Status of the Elderly

First of all, the elderly tend to have lived in their houses for longer and thus the stock of housing will be of worse quality in this group. Second, where houses need renovation or modernisation the elderly may be more 'risk averse' than younger householders and cautious about major structural changes. For instance it may well be that the elderly are significantly more sensitive than the rest of the population to the bother and hassle involved in improving the quality of their homes. Lastly, as their houses tend to be older and in need of more work, this tends to increase the average cost of repairs to the elderly thus making it more unlikely that they will be carried out.

Source: Income, Deprivation and Well Being Among Older People 1999

The NCAOP quoted data from the 1997 Living in Ireland Survey which confirmed that the elderly occupied poorer quality housing. This survey set out to indicate the extent to which people had problems with heating their homes and with dampness, leaking roofs and rotting doors and windows. The results are outlined in Table A.1 and reveal that significantly more elderly people have problems with their houses than those householders who are under 65.

Table A.1 Proportion having problems with Housing by age of Head of Household

Type of Problem	% Having a Housing Problem	
	Households with Head Aged <65 years	Households with Head Aged >65 years
Lack of Adequate Heating	6.5	7.8
Dampness	7.0	11.5
Rot in Windows, Floors, Doors	6.1	8.3
Leaking Roof	2.7	4.5

Source: Living in Ireland Survey 1997

Appendix B Extracts from "Homes for the 21st Century"

A report entitled "*Homes for the 21st Century - The Costs and Benefits of Comfortable Housing in Ireland*" published recently by Energy Action Limited (ISBN 0-9537424-0-7, 1999) provides important insights into the condition of the current housing stock occupied by the elderly. The report is the result of research carried out by UCD's Energy Research Group and Environmental Institute. The purpose of the research was to establish the extent of the remedial work required to upgrade the existing housing stock of Ireland to meet the energy conservation standards of the 1997 Building Regulations. The following are some of the key findings of the report.

- Fuel poverty in Ireland, i.e. the inability to heat one's home to a safe and comfortable standard, is among the highest in Europe, owing primarily to low income and poor energy-efficiency housing standards.
- Irish housing standards are amongst the lowest in Northern Europe from the point of view of thermal efficiency.
- The least well off tend to live in the worst of these houses.
- Excess morbidity and mortality in Ireland, due to poor housing standards, is amongst the highest in Europe.

The report examines the costs and gains (health, employment, energy and environmental) of adopting and implementing a household energy strategy. It states that the gain in health is substantial and makes the following general assessment of the health implications arising from the present housing conditions of the elderly.

> "Ireland has thousands of relatively poor older people, often living alone, whose houses and flats are so cold that many die prematurely, and thousands of others struggle on in discomfort and distress."

Ireland (along with many other countries) experiences a statistically significant surplus number of deaths during the winter months, denoted 'excess winter mortality'. The latest figure for excess winter mortality is 1,429, using as yet unpublished 1996 CSO Vital Statistics. This figure seems in line with previous years where the average number of excess winter deaths tends to be approximately 1,500. Most of these deaths (approximately 85%) can be attributed to either cardiovascular disease (CVD) or respiratory disease (RD).

It is also worth noting at this stage that over 85% of the excess CVD-related mortality occurs in the over 65 age group, while the corresponding percentage for RD-related mortality is over 90%.

Seasonal variations in mortality are, in fact, among the highest in Ireland compared with other countries with similar or indeed considerably colder winters. Table B.1 illustrates this by a cross-country comparison.

Table B.1 Seasonal mortality variations

Country	Mean External Temperature January (°C)	Seasonal Coefficient of Mortality Variation
Ireland	5.0	.15
Wales	4.7	.13
Northern Ireland	4.5	.12
England	4.1	.13
Scotland	3.7	.12
France	3.3	.07
Holland	2.2	.10
West Germany	0.5	.09
Denmark	0.0	.07
Norway	-1.1	.05
Austria	-2.7	.11
Sweden	-2.7	.07
Finland	-3.0	.05
Canada	-7.8	.07

Thus, Ireland has a relatively mild winter, yet a strikingly high excess winter mortality rate.

Conclusion

The report concluded that a programme to bring the thermal standards of Irish housing up to those specified in the 1997 Building Regulations would reduce the level of sickness (morbidity) and would allow people to live longer and more comfortably. It estimated that about half the excess winter hospitalisation cases in Ireland from cardiovascular and respiratory disease, and half the winter drugs expenditure on these two diseases, would be avoided. The report also estimated that 652 lives could be spared premature death over the life of the programme. This represents 44% of excess winter deaths in Ireland, which in turn represents 6% of total winter mortality. Most of the lives saved would be amongst the lowest socio-economic groups, with the majority (87%) also being over 65.

Appendix C Guidelines for Health Boards on the Operation of the Special Housing Aid for the Elderly Scheme

Background

The Task Force on Special Housing Aid for the Elderly was set up in 1982 to undertake an emergency programme to improve the housing conditions of elderly persons living alone in unfit or insanitary accommodation. The scheme is funded in full by the Exchequer and is operated on the ground by the Community Care Departments of Health Boards. Work to houses is generally carried out by contract or by FÁS trainees working under the supervision of Health Board Foremen. Labour costs are met in full by FÁS in the latter case.

Guidelines

In the interests of elderly persons, whose housing conditions are improved under the scheme, it has, since its inception, been administered with flexibility and a minimum of formality. For these reasons it has been an objective to avoid rigid procedural and other requirements but health boards are asked to have regard to the following guidelines when operating the scheme:

(1) Aid may be provided for any works that are considered to be urgently necessary to improve the living conditions of elderly persons living alone in unfit or insanitary accommodation. Typically, aid may be made available for necessary repairs to make a dwelling habitable for the lifetime of the occupant, repairs to a chimney or fireplace, the provision of water and sanitary facilities, the provision of food storage facilities etc.

(2) Personnel directly involved on the ground should have the flexibility to implement the programme in their particular areas with due regard to the most urgent cases (as reported on locally) and the available labour resources for carrying out, supervising and inspecting etc., the relevant works. However, the top priority of the scheme must continue to be the carrying out of fundamental repairs to a house in order to protect and contribute to the comfort of the occupant during, in particular, bad weather.

(3) Where necessary, aid may be provided towards the provision of water and sewerage facilities. The provision of such facilities may be expensive so appropriate steps should be taken to minimise costs, e.g. the most practical arrangement for the provision of a toilet may be to partition off an area of the existing house. On cost grounds, the building of extensions should only be undertaken where there are no other options available. Problems which may arise regarding the location of septic tanks etc. should be considered in consultation with the local planning authority. The co-operation of

local authorities should be sought where connections to a public water supply are available, with a view to minimising costs, delays etc.

(4) Electrical rewiring is permissible under the scheme where such works are considered, by the health board, to be necessary. The following summary of the methods used by various boards may be helpful when dealing with houses in need of rewiring or electrical works

- use of suitably qualified and insured electrical contractors who provide a certificate to show completed works comply with E.S.B. requirements,
- use of outside contractors who employ qualified electricians to carry out electrical works and who produce certificates to show completed works comply with E. S. B. requirements,
- contribution of funds or materials where the house owner/occupier is arranging for the works to be carried out,
- work is carried out by FÁS and certified by a suitably qualified electrical contractor that the completed works comply with E.S. B. requirements.

The contribution method above may be particularly useful in cases where health boards notice electrical works which require attention and which the board may not be in a position to carry out.

(5) Certain protective measures can be undertaken under the scheme in so far as elderly people are concerned. The fitting of locks etc., to make dwellings more secure (in association with the carrying out of any works or where works have already been carried out) can be regarded as works coming within the scope of the scheme; indeed, in the case of any elderly persons who would normally qualify for aid under the scheme, works to make dwellings more secure can be carried out, as considered necessary, irrespective as to whether any other works are being undertaken. This will, of course, particularly apply where doors and windows of the houses of elderly people need particular attention to help to guard against attacks. Work of this nature generally can be given priority where considered necessary.

(6) It should be noted that local authorities operate a number of schemes, viz, disabled persons, essential repairs, repairs in lieu of re-housing and also advance certain loans, which may be more appropriate to some applicants.

(7) The involvement of FÁS, who provide a valuable training service especially for those with most difficulties in the labour market, including long-term unemployed and early school leavers, should be maximised by health boards in all appropriate cases.

(8) It is desirable that applicants who can afford to do so should make contributions towards the cost of works being undertaken by the boards. Such contributions should

not, however, be a condition of eligibility and should never exceed what the applicant agrees he/she can afford.

(9) Boards should aim to maximise the number of cases dealt with under the scheme and to ensure, insofar as possible, that only deserving cases are assisted. It is considered reasonable, given the purpose of the scheme and the limited funding available under it, that boards should seek to recoup some of their costs from a beneficiary of the scheme where the house involved is sold within a short period (say 3 years) of the completion of the works and the beneficiary has profited because of the works. However, boards should avoid involving themselves in what could be costly procedures to try and recoup such costs.

(10) Boards should ensure that relevant tax clearance procedures relating to payment (including contributions of funds or materials) by public authorities are adhered to and that any insurances necessary to cover any liabilities which may arise are in place. Beneficiaries of the scheme should not be required to accept liability for any bad workmanship, etc., that would more properly be the responsibility of the board or the contractor.

(11) The general housing conditions of the elderly can differ substantially from one community care area to another within the same region and it accordingly follows that health boards, when deciding the annual provision for each community care area, should have regard to the degree of need rather than population alone.

(12) Boards should take whatever steps are necessary to ensure that the public are aware of the scheme and should have a simple application form on which applicants (or someone on their behalf) can apply for assistance under the scheme. Such forms should be easily completed and contain the minimum of information required to help the board decide on the applicants eligibility.

(13) Boards should have adequate procedures in place to enable quick and accurate responses to requests for information/statistics on the operation of the scheme in their individual areas. Such procedures are necessary to enable the Task Force to monitor the effectiveness of the scheme and to direct funding where it is most needed.

November, 1996.

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Pn. 9192

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Dublin
Published by the Stationery Office
To be purchased directly from the
Government Publications Sales Office,
Sun Alliance House, Molesworth Street, Dublin 2
or by mail order from
Government Publications, Postal Trade Section,
4-5 Harcourt Road, Dublin 2
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