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Special Issue

Expanded, but not regulated: ambiguity in home-care policy in Ireland

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What is known about this topic

- Home-care services in Ireland have been heavily influenced by the (Catholic) principle of subsidiarity.
- The regulated institutional care sector in Ireland contrasts starkly with the unregulated home-care sector.
- There are differences in the focus and characteristics of public, private and non-profit providers of home care.

What this paper adds

- Home-care services were radically expanded in the absence of policies to define eligibility and standards.
- The forces that drive expanded provision are different from drivers of policy to govern home care.
- Weakness of governance structures and political advantages of the absence of regulation are the main reasons for the lack of standards and entitlement rules.

Abstract

This article argues that home-care policy in Ireland was ambiguous throughout the first decade of the 21st century: policy-makers expanded home care, but failed to develop policies to govern this expanded provision. As a result, home care became more widely available in the absence of a framework to govern access to services and to regulate care providers. We analysed official policy documents, statistics and policy critiques published between 2000 and 2010 in order to understand this incongruity between the expansion of home-care services and the failure to develop policies to govern access to and quality of services. The key factors that motivated home-care expansion in the Irish case were: (1) problems in the acute hospital sector and the perception of home care as a partial solution to these (political blame avoidance) and (2) significant GDP growth (until 2007) that provided politicians with the means to fund expansion in home-care services (political credit claiming). The key factors that inhibited the development of a policy framework to govern home-care services were: (1) weak governance structures in health services and decision-making at national level based on short-term political gain; (2) Ireland's adherence to the liberal welfare state model and concern about uncontrollable care costs in the face of population ageing; (3) until 2010, paucity of attention to home-care issues in the Irish media and (4) weak provider interest representation. The recent budgetary cutbacks in Ireland bring into sharp relief the political expediency of an unregulated domiciliary care sector and absence of entitlements to home care. We conclude that the forces that drive expanded provision are different from drivers of policy to govern home care and that weakness of governance structures and political advantages of the absence of regulation are the main reasons for the lack of standards and entitlement rules.

Keywords: governance, home care, Ireland, older people

Introduction

Ireland is generally categorised as a liberal welfare state (Esping-Andersen 1990, Castles & Mitchell 1993, Ferrera 1996, Korpi & Palme 1998). This obscures the pervasive influence of Catholic conservatism on the formal and informal welfare structures in Ireland (Fanning 2003). The influence of Catholicism is most apparent in the organisation of social care services. The Catholic principle of subsidiarity provided the ideological justification for a residual role of the state in areas deemed the preserve of the family, in particular the care of young children and older people. Subsidiarity underpinned the provision of social care either from within the informal family network or by the religious and voluntary sector, hence rendering the state's role in the provision or regulation of social care services minimal. Secularisation, modernisation, increased social liberalism and women's

emancipation have served to diminish the dominance of Catholicism and subsidiarity. The expectation that women are available and willing to provide long-term care to older family members is less realistic and endorsed only by a minority in present-day Ireland where over 55% of women participate in the labour market (McCashin & Payne 2006, CSO 2010).

At the start of the millennium, Ireland had a fragmented and unregulated domiciliary care system where public providers tended to focus on personal care, non-profit providers on assistance with domestic work ('home help') and a small number of private providers straddling both tasks (Timonen & Doyle 2007). Despite official policy commitments since the 1960s to enable older people to live in their own homes (Inter-Departmental Committee 1968, Department of Health and Children 2001), community and home-care services had evolved little by the year 2000. 'Current' government policy on care for older people in Ireland dates back to 1988 (Working Party on Services for the Elderly 1988) and has not been updated to accompany the significant social changes that have occurred in Ireland and the increase of funding to the domiciliary care sector since the new millennium began. Regulation of care services lags behind the development of policies to govern services in many contexts, and indeed, governance of care is a continuous process, with new regulatory instruments and rules governing eligibility being constantly added. Ireland constitutes an interesting and noteworthy case because the time lag and contrast between radical expansion of services and development of policy to govern this expansion is particularly striking. While this article is a case study, it does elucidate some of the reasons for the fact that policy often lags behind the introduction of new services, and as such our case study is of relevance for researchers seeking to understand disparity between expansion of services and reluctance to govern them in other countries.

Hall's (1993) division of policy transformation into first-, second- or third-order change is a useful framework in analysing policy developments in home care in Ireland. *First-order changes* are alterations in the setting of policy instruments; the instruments themselves, the goals and the general logic of the policy remain unaltered. An example of alteration in policy instruments is an increase or a decrease in social contribution rates paid by employees or the increased allocation of finances to a particular area. *Second-order change* refers to the introduction of new policy instruments, such as a new regulatory system (Hall 1993) or new entitlement rules (Palier 2010). *Third-order change* involves 'paradigm shifts', that is changes to the goals of the system (Hall 1993).

If we apply these definitions to the Irish domiciliary care sector, it becomes apparent that policy change with respect to home care has been largely of the first and second order. We first outline the first- and second-order changes that have taken place. We then identify explanations for the incongruity between the rapid expansion of home-care services on the one hand and the lengthy delay in developing policies on access to services and minimum quality on the other hand.

Methods

Our argumentation is based on a review of legislation, policy documents and policy analysis pertaining to home care. The review included all qualitative and quantitative studies and reports where a primary focus was on legislation, service utilisation and policy analysis pertaining to home care published in Ireland between 2000 and 2010. The official policy documents were identified through a search of the publications of government departments and governmental organisations with a mandate to develop healthcare/home-care policy or to provide healthcare/home-care services. Table 1 provides a summary of the documents and how they were categorised. A detailed list of the documents is available on request. Because of the diversity of sources, a narrative approach to synthesise studies was undertaken (Mays *et al.* 2005). Authors conducted a preliminary analysis of sources independently and explored similarities and differences in their interpretations during research team meetings (that also involved on two occasions an independent health policy analyst) until a consensus over interpretation was reached.

Findings

Expansion in home-care services in the absence of a policy framework

The number of older people in receipt of formal home-care services in Ireland quadrupled during the first decade of the millennium, from 16 000 in 2000 to almost 63 000 in 2009 (Mercer 2002, Health Service Executive 2009a). This amounts to a remarkable increase from 3.8–12.7% of the 65+ population in Ireland being in receipt of home-care services in 2000 and in 2009, respectively, based on Population Estimates from the Central Statistics Office (2011).

Annual public expenditure on home-care services tripled from €102.3 million in 2001 (Timonen *et al.* 2006a) to €331 million in 2008 (PA Consulting 2009b). Ireland's National Development Plan for 2007–2013 allocated €4.7 billion towards community-based services for older people. A significant amount of this money was ring-fenced for additional home-care packages (a

Table 1 Classification and number of sources (all relate to the period of 2000–2010 unless otherwise specified)

Document type	Description	Number of documents
Relevant legislation	Primary and secondary legislation relating to home-care provision, enacted between 2000 and 2010	6
Official policy documents relating to home-care policy	Policy documents published by government departments or state agencies	6
Government commissioned research/evaluations on home care	Research and evaluations on home-care services commissioned by government	3
Statistics	Statistical sources relating to the provision of home care and informal care in Ireland	16
Reports on home and community care services commissioned by statutory agencies	Reports/critiques of policy on home care written/commissioned by state-funded agencies	18
Reports on home and community care services commissioned by non-statutory agencies	Reports/critiques of policy on home care written/commissioned by non-governmental agencies	4
Peer-reviewed policy analysis/critiques of home-care services	Peer-reviewed critiques of Ireland's home-care policies and provision.	20
Policy analysis of Irish home-care policy and provision in an international/comparative context	International policy analyses of home care in a comparative context	8
Official policy documents on health and social care policy	Policy documents written by government departments or state agencies, highlighting new developments within health and social care provision in Ireland	12
Background documents: analysis/critique of Irish health services and policy implementation, 1990–2010	Critiques and analyses of Ireland's health and social care policies and provision and some background information on the organisation of policy implementation channels related to the health sector in Ireland	14
Official policy documents on health and home care prior to 2000	Policy documents published by government departments or state agencies on health and home care, written prior to 2000	8

cash-for-care scheme first introduced in 2006, see Timonen *et al.* 2006b). By 2008, funding for this scheme had increased to €120 million and approximately 11 000 people were using home-care packages (compared with just 1100 in 2005) (Department of Health and Children 2009).

Policy-makers therefore enabled the radical expansion of home-care services through the provision of substantial additional funding. However, as the next section shows, this expansion was not accompanied by the development of policy instruments to govern access to services and quality of care.

Official policy documents and home care

In 2001, the government produced a new national health strategy titled *Quality and Fairness – A Health System for You* (Department of Health and Children 2001). This new strategy, which aimed *inter alia* to strengthen community-based services, was borne out of intense pressure on acute hospital services (Wren 2003) and shortcomings in the structure of existing health services provided through 11 regional health boards, with negligible central co-ordination (Wiley 2005). While the document made few references to detailed plans for the expansion of home-care services, it did acknowledge that services were fragmented and uneven and highlighted the government's intention to:

> reform the operation of existing schemes (…) in order to introduce an integrated care subvention scheme which maximises support for homecare.
>
> (Department of Health and Children 2001, p. 77)

The 2001 health strategy arguably acted as a catalyst for reform of home-care services over the next 10 years. Following the publication of the health strategy, however, the government's attention focused on resolving health and social care–related 'crises', including a significant and unanticipated rise in expenditure on subvention payments for older people living in residential care and the illegal charging of nursing home fees from residents who were entitled to free or subsidised care (O'Shea 2002, O'Dell 2006, Office of the Ombudsman 2010).

An important new element was also introduced to the Irish home-care system at the start of the millennium. Home-care packages (officially known as the Home Care Support Scheme) offer older people individually tailored support packages, incorporating services such as public health nursing, day care, occupational therapy, physiotherapy, home help services (household tasks), personal care and respite care whether drawn from the 'existing

pool of services' (i.e. public or non-profit sector provision) or 'additional resources' (in practice, private sector services) (NESF 2009). The Scheme was aimed primarily at older people who are at risk of (re)admission to long-term care following a hospital stay. It was rolled out nationally in 2006 with funding of €55 million, after being successfully piloted in a small number of locations between 2001 and 2004 (Timonen 2004, Timonen *et al.* 2006b). The Scheme operates across Ireland through the Health Service Executive's (HSE) 32 Local Health Offices (LHOs), set up to manage the delivery of community-based services. The HSE is the public body tasked with the provision of health and social care services to all those living in Ireland. Home-care packages have been heralded as a significant factor in enabling older people to remain living in their own homes (PA Consulting 2009b). It is noteworthy that the Scheme is an 'administrative' one, and therefore, older people do not have a right to a home-care package (as is also the case with existing home help services, i.e. assistance with housekeeping).

However, it was not until 2005/2006 that the government began to develop formal policy proposals in relation to home care for older people. An Interdepartmental Working Group was set up in 2005 to identify the policy options for a financially sustainable system of long-term care (Interdepartmental Working Group on Long Term Care 2006). The group's work focused on reforming the financing of residential care, but it also outlined the aim of improving home-care services through the continuation of home help services and through increased provision of home-care packages (Interdepartmental Working Group on Long Term Care 2006). The Working Group recommended that guidelines on the quality of home care and eligibility criteria be drawn up to ensure that home-care packages are provided uniformly throughout the country.

National guidelines on the home help service (assistance with housekeeping) have not yet been finalised; national guidelines for the standardised implementation of the home-care packages were not finalised until 2010, 5 years after the establishment of the Working Group (Health Service Executive 2010b), and are being implemented gradually during 2011 (Personal Communication 2011). This is intended to result in uniform eligibility criteria, care needs assessment and application process for the home-care packages throughout the country. Owing to the delay in introducing national eligibility criteria, the provision of home care has been extremely uneven throughout the country and standards of care have been shown to vary dramatically (National Economic and Social Forum 2009) because in the absence of a standardised national approach, each LHO has been delivering the Scheme differently (National Economic and Social Forum 2009).

Outcomes

Irish policy-makers therefore made significant efforts between 2000 and 2010 to increase the provision of home-care services for older people. The tripling of expenditure on home care over the decade was remarkable and led to a fourfold increase in the number of people in receipt of home-care services. However, there is still no official policy framework for an integrated home-care service system. No legislation has been passed to govern the area of home care, and home care in Ireland remains unregulated. Home care is financed through annual budget allocations, limiting opportunities for strategic planning and increasing the risk of cutbacks. The implications of these developments for service provision are discussed in more detail below.

Unevenness of provision across country

There is no entitlement (right) to home-care services and the level of provision varies throughout the country. 'Out-of-hours' and respite services remain particularly limited in many areas (O'Shea 2006, NESF 2009). Expenditure on home-care services also varies significantly by geographical area, which creates egregious inequity in the availability of home care. For example, the average weekly expenditure on a home-care package ranges from €128.99 in one area to €497.40 in another (NESF 2009). Access to services is, to a greater extent, determined by geographical location than by need; for every 1000 people over 65 years of age in one regional district, there were 52 home-care package beneficiaries in 2008, compared with just eight in another similarly sized and populated district (NESF 2009).

Absence of a regulatory framework

Home care in Ireland is minimally regulated. Service-level agreements (between the LHO that funds the services and the various providers) that govern the standards of care and training and supervision of staff are not in place in all parts of the country, and monitoring by the HSE is erratic. This means that service provision takes place in the absence of uniform external standards and rules. According to the 2009 report on home-care packages (NESF 2009), national quality guidelines for home-care support services were drafted by the HSE Advisory Group on Services for the Older People Expert Group in October 2008 (Health Service Executive 2008b). However, according to the NESF (2009, p. xvi), 'these guidelines will need to progress through several more stages before being implemented'. There are still no regulations governing home care, although it is anticipated that Quality Guidelines for Home Care Services will be submitted to the Department of Health by the HSE in late 2011 (Personal Communication 2011).

Shifting balance between provider sectors

Home-care services in Ireland are provided through the public, non-profit and private sectors (Timonen & Doyle 2007). The public sector is the largest provider of home-care services, with a 'market share' of €237.95 million (PA Consulting 2009a). In 2009, approximately 126 private home-care providers operated in Ireland (PA Consulting 2009a). The private sector in 2009 received €13.9 million via the state-funded home-care packages, which constituted the majority of private sector operators' revenue. The non-profit sector remains larger than the private sector, as it is in receipt of €79.15 million in state funding. However, the non-profit sector's share has declined as a result of a significant expansion of the private sector. The expansion of the private sector is partly because of the fact that it provides out-of-hours and weekend services, while the public and non-profit sectors have focused on service provision during 'office hours'. The introduction of home-care packages has arguably led to the substitution of some public and non-profit sector provision with private sector provision (Timonen & Doyle 2007).

Explaining ambiguity and attendant outcomes

Based on the evidence outlined above, we argue that home care in Ireland is characterised by ambiguity, created by the contrast between the enthusiasm for expanding funding and provision on the one hand and the failure to put in place a policy framework to govern home care on the other hand. We will now turn to analysing the factors that produced this ambiguity, first by examining the factors that drove home-care expansion and second by outlining the factors that inhibited the development of home-care policy.

Factors that drove home-care expansion

We have identified two key factors that drove home-care expansion in the Irish case, namely (1) problems in the acute hospital sector that called for more effective discharge of hospital patients and (2) GDP growth that had the corollary of increased spending across all areas of public expenditure.

Problems in the acute hospital sector

Throughout the 1980s and 1990s, pressure on the acute health-care system was immense; the number of acute beds per 1000 in the population was significantly below the EU-15 average (Tussing & Wren 2006). Because of the lack of community supports available to facilitate their transfer home, many older people had longer than average hospital stays (Burke 2009), creating considerable negative publicity and the need for politicians to be seen to address the problem. Investment in care services for older people was seen as a way of alleviating the crisis in acute care and helped politicians to avoid the blame for hospital overcrowding. Thus, although residential care continued to be the priority area of spending on services for older people (€979 million of the €1.3 billion budget on services for older people in 2010 was spent on residential care – Health Service Executive 2010a), the tripling of annual public expenditure on home-care services outlined above is explained in part by the desire to free up acute care beds.

Economic growth

In the 1980s, Ireland's labour market was one of the worst performing in Europe. Unemployment rose from 7% in 1979 to 17% in 1986. During the so-called Celtic Tiger years that followed, GDP per capita increased from about 60% to about 120% of the EU-15 average, and by 2007, average incomes in Ireland were amongst the highest in the world (Fahey *et al.* 2007). In tandem with this growth in GDP, spending on health-care increased significantly between 2000 and 2010, allowing politicians to claim the credit for this expansion. Total public health expenditure rose from €3.6 billion in 1997 to over €12.3 billion in 2006, an increase of 240% (Department of Health and Children 2007), which was in turn reflected in the increased spending on home care. The recent recession in Ireland has resulted in significant budgetary cutbacks in public services, including health-care. The 2010 health budget was a 5% reduction on 2009, the first cut in spending on health-care in two decades (Burke 2010). Figures published by the HSE indicate that home-care provision is not expected to fall with immediate effect (Health Service Executive 2010a). However, in practice, Local Health Managers have started to impose restrictions on the service as a result of the overall decline in their budgets (Donnellan 2010).

Factors that inhibited home-care policy development

We will now turn to examining the key factors that *inhibited* home-care policy development in Ireland, namely (1) governance structures, including the relationship between central government and the administrative units in charge of holding and allocating budgets at local level (LHOs); (2) the liberal welfare state model and concerns about uncontrollable care costs in the face of population ageing; (3) lack of significant media attention to home-care issues (until 2010) and (4) weakness of interest organisation in the area of home care.

Governance structures

Several commentators have criticised the weak governance structures in Ireland, suggesting that policy-making often happens in the absence of any guiding principles (Taylor 2005, Nolan 2008, OECD, 2008) and in

the interests of short-term political gain (Taylor 2005). While short-term political gain arguably influences political decision-making to at least some extent in all countries, commentators have argued that the electoral system in Ireland gives members of the parliament (Dáil) very strong incentives to engage in short-term, local and clientelistic practices in garnering votes by 'looking after' members of their constituency. Ireland uses a proportional representation single-transferable vote system (PRSTV). In this system, voters' choices are based on ranking candidates. This means that parties do not have the ability to guarantee victory to a particular candidate – there are no 'safe seats' under PRSTV. Each candidate must maintain his or her own personal appeal to the voters within the constituency. Collins & O'Shea (2003) state that Ireland has a 'political system in which the central government is captured by provincial or special interests', effectively hampering decision-making in the national (as opposed to local) interest.

This has also affected health and social care provision. As noted earlier, the 2001 national health strategy (Department of Health and Children 2001) outlined a programme of investment and reform for the health system. It was the first significant reform of the health services strategy, structure, funding and delivery in 30 years (Wiley 2005). One of the main purposes of the programme was to reform the delivery of primary-care services at local level, and also to remove the influence of local politicians (councillors), who sat on the boards of local health services and thus had input into where services would be located and fought over funding to be channelled into their constituencies (Wren 2003). The reform programme involved significant restructuring of existing healthcare structures, replacing ten autonomous, regional health boards with one national service provider (the HSE) in order to centralise decision-making.

However, the health service reform programme has been criticised by several commentators. First, the fact that there were no redundancies for administrative staff has resulted in a top-heavy and confused system (Wren 2003). Second, each of the HSE's 32 LHOs is overseen by a Local Health Manager, who has the autonomy to implement national policies in a way that best fits in with local practices (NESF 2009). It has since been acknowledged by the HSE that this autonomy has hampered it in resolving the problem of disorganisation inherent in the former system (Health Service Executive 2008a). This is further compounded by the fact that the CEO of the HSE is legally responsible for keeping the HSE within budget (Tussing & Wren 2006). As a result, while the level of political interference in decision-making has fallen, decisions are now often based on short-term financial affordability considerations, rather than being driven by the needs of health service users. Third, the geographical boundaries set by the HSE for the LHOs do not conform to the vast majority of administrative boundaries in the Republic of Ireland. This has led to many anomalies and confusions, including for resource allocation (Vega *et al.* 2010). For instance, funding for each LHO on a per capita basis varies widely (Walshe 2007). Although the HSE was therefore effectively 'de-politicised', it is possible that remnants of the clientelistic system of politicians making representations on behalf of constituents in need of services (and hence boosting their election prospects) may still be impeding the development of an overarching vision of care for older people.

Liberal welfare state and concern about escalating care costs

Because the home-care package budget does not meet all needs for home care, each LHO has to ration home care by employing localised eligibility criteria. This has led to inconsistencies in implementation (NESF 2009). Ireland's liberal 'low tax-low spend' regime, which provides a relatively low level of social protection, is predicated on means-testing, i.e. allocating services to the lowest-income groups (McCashin & Payne 2006). Adhering to this principle would mean applying a standardised means-test to home care. The National Economic and Social Forum (NESF 2009) suggests that the reason for the absence of national eligibility criteria (until 2011) lies in the lack of legislation on charges for home-care packages and in the sensitivity around charging older people for health-care. The Forum (NESF 2009) also suggested that the use of annualised budgets hinders the development of a medium- to long-term strategic plan for home-care services. The discretionary system, where eligibility criteria were ad hoc and based on the judgement of care providers (who were in some cases subject to lobbying by politicians on behalf of their constituents), therefore served the purposes of elected representatives better than the introduction of an alternative, more transparent system, based on clearly spelled-out criteria for means-testing. This provides further evidence that the delay in implementing policies on home care may be linked to politicians' desire for short-term political gain (avoiding blame for the introduction of means-testing and garnering credit for 'looking after' voters within their constituency).

Role of the media

The media can play an important role in interpreting government policy and in agenda-setting (Dahlgren 1981, Iyengar & Kinder 1987, Thompson 2000). As is the case elsewhere, Irish politicians are mindful of the extent and slant of the media's coverage of policy issues (Devereux & Breen 2004, Taylor 2005). Scott & Brown (2010) note that the media in Ireland offer a

mechanism for applying pressure to government departments and agencies through the process of 'naming and shaming'. However, the Irish media have paid relatively little attention to home-care services. A search on the LexisNexis database shows that, between 2005 and 2010, twice as many articles focused on residential care services than on home care. This focus may relate to the (perceived) higher risks of elder abuse in residential care, an issue that has received considerable attention since the broadcasting of a documentary showing abuse of residents in one Irish nursing home, Leas Cross, in 2006. This media attention was a significant contributing factor to the extensive reform of the regulation and inspection system for residential care in Ireland (Government of Ireland 2009).

Weak interest organisation

Many commentators have been critical of the ability of private providers to influence official government policy in Ireland (OECD 2001, Collins 2010, Scott & Brown 2010). However, this relies on private interests having a political platform. As private home-care providers only gained a presence in Ireland over the last 10 years, it is perhaps unsurprising that their influence has been weak. The Home Care Association (formerly the Irish Private Home Care Association) is the trade association representing private home-care providers in Ireland. Although a recent report (PA Consulting 2009a) estimated that there were approximately 128 private home-care providers operating in Ireland in 2009, the Home Care Association has just 11 members. This compares unfavourably with Nursing Homes Ireland (NHI), the representative body for private and voluntary residential care settings in Ireland, which has 334 members, representing approximately 70% of all providers. The NHI arguably has made a considerable effort since it was established in 2008 to improve the reputation of private nursing homes in the wake of abuse scandals (O'Neill 2006) and unfavourable analyses of the sector (cf. Mangan 2002).

The Home Care Association commissioned a report in 2009 (PA Consulting 2009a), which called for greater transparency in the purchasing decisions of the HSE and for regulations safeguarding home-care customers. Such recommendations portray private providers as consumer-centred and, if implemented, might have the effect of reducing competition for private providers, as many non-profit providers may not be able to raise their standards to the same extent in the short term (PA Consulting 2009b). However, given the recent establishment and low coverage of the Home Care Association, the ability of private home-care providers to influence policy-makers has been limited over the last 10 years.

Discussion and conclusions

This article has shown that significant progress has been made in Ireland in the provision of home care to older people over the last 10 years. The overall proportion of older people in receipt of home-care services has risen significantly, even in the context of an increase in the older population over the last decade. The government has also responded to a rise in the demand for home-care services by facilitating the expansion of the private sector (through the home-care packages). However, we argue that the absence of a formal home-care policy has inhibited progress in many ways. The sector remains unregulated in terms of the quality of service provision. The lack of clear eligibility and implementation guidelines has resulted in uneven provision and hence glaring inequity in access to services throughout the country.

Using Hall's (1993) terminology introduced above, increased funding towards domiciliary care services constitutes first-order policy change, and the new cash-for-care scheme (home-care packages) amounts to second-order change. Plans to introduce a new regulatory system have not yet been realised, but if implemented, would constitute a second-order change. These reforms, however, do not amount to a change in the overall goals of the system; a reliance on family care on the one hand and unpredictable access to formal care of varying quality on the other hand persist. Funding for care services for older people remains disproportionally channelled into residential care rather than home care, and there is no legal obligation on the state to provide home-care services. The availability of home-care services is dependent on annual budgets, and citizens do not have a statutory entitlement to care services. Eligibility criteria, an essential component of any new policy instrument, remains undefined in relation to home help services and was not defined in relation to home-care packages until 2010/2011, meaning that second-order policy change in the form of the new home-care packages was inconsistently implemented. Change in Irish home-care policy has therefore been largely confined to first-order and incomplete second-order changes. The continuing absence of legislation, which would provide citizens with a statutory entitlement to domiciliary care services based on care needs, evinces a lack of aspirations to shift the allocation of resources from institutional care to domiciliary care and thereby to bring about a paradigm shift, or third-order change to use Hall's terminology.

Instead of a thorough reform incorporating regulation and uniform criteria, policy-makers in Ireland have preferred to impose incremental modifications to the domiciliary care system. In the light of

Ireland's current straightened financial circumstances, the absence of far-reaching reforms to the domiciliary sector is both politically and financially expedient for the administration. As Alber (1995, p. 137) notes, 'cutbacks are most easily administered in those policy fields where binding norms regulating the standard of services are absent'. If the achievements made in home-care provision during the first decade of the 21st century can be characterised as 'the seeds of a new beginning', it is unfortunately becoming increasingly unlikely that these seeds will blossom over the coming decades in the light of the straightened financial circumstances now facing Ireland. More generally, we argue that the forces that drive expanded care services provision are different from drivers of policy to govern care. Weakness of governance structures and political advantages of the absence of regulation are the main reasons for the lack of standards and entitlement rules. Applicability of these arguments to other systemic contexts calls for further investigation into the dynamics of expansion of care services and development of policy to govern such expansion.

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