National Council for the Elderly

PROCEEDINGS OF CONFERENCE

MEASURES TO PROMOTE THE HEALTH AND AUTONOMY OF OLDER PEOPLE IN IRELAND

CASTLE HOTEL, KILLINEY, CO. DUBLIN

30TH SEPTEMBER AND 1ST OCTOBER, 1993

PUBLICATION NO. 32
The National Council for the Elderly was established in January 1990 in succession to the National Council for the Aged which began in June, 1981. The terms of reference of the Council are:

To advise the Minister for Health on all aspects of ageing and the welfare of the elderly, either on its own initiative or at the request of the Minister, and in particular on

- measures to promote the health of the elderly,
- the implementation of the recommendations of the Report, The Years Ahead - A Policy for the Elderly,
- methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for the elderly,
- ways of encouraging greater partnership between statutory and voluntary bodies in providing services for the elderly,
- meeting the needs of the most vulnerable elderly,
- ways of encouraging positive attitudes to life after 65 years and the process of ageing,
- ways of encouraging greater participation by elderly people in the life of the community,
- models of good practice in the care of the elderly, and
- action, based on research, required to plan and develop services for the elderly

**MEMBERSHIP**

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<th>Lady Valerie Goulding</th>
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<td>Chairman</td>
<td>Mr. Michael White</td>
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FOREWORD

The National Council for the Elderly is an advisory body to the Minister for Health on all aspects of ageing and the welfare of the elderly. One part of the Council's work is to advise the Minister on measures to promote the health of the elderly.

In 1993, the European Year of Older People and Solidarity between Generations, the Council published *Measures to Promote Health and Autonomy for Older People: A Position Paper*, prepared by Professor Cecily Kelleher of the Department of Health Promotion, University College Galway.

The findings of this report were outlined at a conference at the Castle Hotel, Killiney, Co. Dublin on 30th September and 1st October 1993, the proceedings of which are presented here.

On behalf of the Council I would like to thank all those who contributed to the conference. I would also like to thank Ms Sally Pilkington for undertaking the task of compiling and editing these proceedings.

Michael White
Chairman
As President of the National Council for the Elderly it is my very great pleasure, Minister, to welcome you to our conference, *Measures to Promote the Health and Autonomy of Older People in Ireland*.

We are most grateful to you for kindly agreeing to open our conference despite your busy schedule and many commitments.

It is one of the Council's terms of reference to advise you, Minister, on measures to promote the health of the elderly. We are therefore delighted to have the opportunity to organise this conference which will be of great assistance in this regard.

We are of course most grateful to all our speakers, chairpersons and workshop rapporteurs for the contributions they will make to our deliberations here today. I have no doubt that the preparations they have made will be well rewarded.

We would not, of course, be able to realise our aim of progressing thought and reflection on how to improve the health and autonomy of older people in Ireland today without the presence and contribution of all of you who have come to Killiney to this conference. It is indeed gratifying to note the interest in this subject of people from so many different quarters. Issues of health and well-being are often complex and your contributions will be very valuable in identifying measures that we might take to promote better health and greater autonomy for older people in Ireland.

This conference represents one of the National Council for the Elderly's more important contributions to the *European Year of Older People and Solidarity between Generations*, which places such emphasis on changing our perspectives and combating fatalistic attitudes to ageing and older people at all levels. This emphasis is intrinsic to all efforts to promote the health and autonomy of older people and it must be maintained in the years to come.

The conference is also timed to coincide with the *International Day for the Elderly*, tomorrow, 1st October. This United Nations initiative in nominating a Day to commemorate older people world-wide arose from the Vienna International Plan of Action on Ageing. *The Years Ahead* report, which represents our national policy on health and welfare services for the elderly, quotes part of the plan which is particularly apposite to our deliberations here today. I would therefore like to read it to you in conclusion:

*The care of elderly persons should go beyond disease orientation and should involve their total well-being, taking into account the interdependence of the physical, mental, social, spiritual and environmental factors. Health care should therefore involve the health and social sectors and the family in improving the quality of life of older persons. Health efforts, in particular primary health care as a strategy,*
should be directed at enabling the elderly to lead independent lives in their own family and community for as long as possible instead of being excluded and cut off from all activities of society.

Finally, Minister, may we take this opportunity to present a copy of the Council's recent publication, *Measures to Promote Health and Autonomy for Older People*. This is a position paper prepared specially for this conference by Professor Cecily Kelleher of the Department of Health Promotion, University College Galway, to help us all address the questions of older people's health and autonomy in an ordered and meaningful way. I am very pleased to present this most useful report to you, Minister.
OPENING ADDRESS

Mr Brendan Howlin T.D.
Minister for Health

It gives me great pleasure to be here with you today to open this conference on Measures to Promote the Health and Autonomy of Older People in Ireland. This conference, which is being organised by the National Council for the Elderly is a significant event in the calendar of events to mark the European Year of Older People and Solidarity between Generations. It is also interesting to note that this conference also coincides with the United Nations International Day for the Elderly which takes place tomorrow.

1993 European Year of Older People

I am pleased to be addressing this conference in the European Year of Older People and Solidarity between Generations. During this year the community and the Member States are trying to heighten the awareness of the position of the elderly and of the challenges which an ageing population holds for society.

I am pleased that so much has been done in this country this year to highlight the position of older people and to encourage intergenerational solidarity. I would like to express my thanks to the 1993 Committee, chaired by Mr Larry Tuomey, for the role it has played in stimulating action and provoking reflection. In quantitative terms the Committee has approved grants to 170 groups and organisations, mostly voluntary, which are running suitable events to celebrate the aims and spirit of the Year.

The Year has stimulated many groups to examine the issue of ageing for the clients they work with. Conferences have been held on the implications for service providers of the ageing mentally handicapped population; on the care of the elderly in long stay hospitals and homes; on the need to expand dementia services; on how best our general hospitals should respond to the needs of our growing elderly population, to name but a few.

One innovation of the Year is the Come and Go Week which began yesterday. The aim of the week is to encourage older people in the Republic to travel north and older people in Northern Ireland to travel south. They may renew old acquaintances, share a common sporting or leisure activity or see a part of the country they have not seen before. The week, which is being organised by Co-operation North, has the support of the 1993 committees in both parts of the island. Concessions to those travelling during the week are available from the transport companies, hotels and guest houses and shops and leisure centres. With such an attractive offer, I regret that I am not old enough to avail of the opportunity to come and go myself!
The Greying of Europe

One of the great achievements of Western Society in this century has been the opportunity provided to the majority of citizens to live to old age.

While recognising that increased longevity usually brings more active years of life, we must also plan to meet the needs of the more dependent elderly. I am very fortunate, as Minister for Health, to have the National Council for the Elderly as an advisory body. Without the Council very few of the research projects, reports and seminars on a whole range of important topics pertaining to the elderly would have been undertaken. These reports have been very useful to my Department in determining policy and priorities for the elderly and in informing a wider public of the challenges of ageing and an ageing population.

The Council has highlighted through its work issues relating to the elderly, which previously received scant attention. For example, the reports on the role of the carers of elderly people had a remarkable effect in focusing public attention on the needs of this neglected group of people. Your work on nursing home care, housing for the elderly and co-ordination of services for the elderly has made a major contribution to thinking on these issues and to clarifying the issues to be tackled. May I also compliment you on the publications you have circulated this week to schools for use with primary and secondary pupils, which will help create more positive attitudes to older people and ageing among young people. I know that the report under discussion today on Measures to Promote Health and Autonomy for Older People will be equally well received and will prove a useful basis for policy developments.

Implications for Health Services

I have already mentioned that life expectancy is growing. What then are the economic and social consequences of everyone living longer? In the health services we have a particular responsibility to examine the implications of an ageing population because illness increases with age and because older people tend to avail of a share of health services which is disproportionate to the size of the elderly population. The good news is that most older people are in good health and are participating actively in the social and economic life of their communities. It would also appear that the proportion of health care consumed by the elderly in the 1970s, about four times as high as for persons under 65, declined slightly during the 1980s despite the rapid increase in the number of older people. This suggests that financing health care for the elderly may not be as great a problem as suggested some years ago.

However, the question of how one organises health care most effectively for the growing elderly population must also be addressed. This Government is committed to improving services for those most in need. One of the most vulnerable groups in our society is the dependent elderly. I was pleased, as part of the Government’s contribution to the European Year of Older People, to bring the Health (Nursing Homes) Act, 1990 into effect on 1st September last. The Act marks a major new development in providing nursing home care for our dependent elderly population. The expansion of facilities for hip replacements and cataract surgery as a result of the major Action Programme on hospital waiting lists will also be of benefit to the elderly. The Action Programme provides for an additional 1,117 hip replacement
operations and 2,145 cataract operations. A health charter for the elderly will also be published, building on the successful Patients' Charter launched last year. It is encouraging that in a recent survey of attitudes on the health services, undertaken by the Irish Independent, more people over 65 considered that the health services had improved in recent years than any other age group.

Changing Attitudes to Ageing

One of the features of our older years is that they present many life changes in very rapid sequences. The potential changes can be loss of a job, spouse, friends, separation from children and work associates, loss of health, income and job-related roles. In almost everything in life we make preparation. Why then do we not prepare for our old age and the resultant changes in lifestyle? Many problems which people commonly associate with age are due not to added years, but to a lack of fitness, a lowering of horizons or loss of status. Inactivity has a cumulative effect. If you are physically unfit you feel tired and lacking in energy. You become less mentally alert, more inactive and as a result feel older.

The success of health promotion for older people, as for any group, depends on their co-operation. Their co-operation in turn will depend on how well efforts to promote health reflect the aspirations and desires of older people themselves. In terms of promoting a healthy old age we can learn a great deal from those elderly people who can draw on their experience of ageing and wish to share their wisdom with others. Society in general is not well informed about ageing. One opportunity the elderly must seize is the opportunity to inform younger people about the challenges and opportunities of growing old.

The Conference

It is essential to realise that health promotion amongst the elderly should not merely concentrate on preventing illness and disability. Policies affecting housing, security, social cohesion, retirement and income are equally important in promoting and protecting the health and well-being of the elderly. The purpose of this conference is to provide a platform for discussion of a broad range of environmental, lifestyle, diagnostic and other issues which are central to reducing morbidity and increasing the health and well-being of older people in Ireland today. I am impressed by the range of experts who will be presenting papers on these themes over the next two days. The conference also has a European, indeed an international, dimension. It provides an opportunity to debate how best the health and autonomy of the elderly can be achieved throughout the European Community in solidarity with the other Member States.

I feel sure that the conference will stimulate improvements in the health and autonomy of our elderly population at national and European level, a goal which is shared by all of us, both in the caring professions and among those responsible for policy. I look forward to hearing the results of your analysis and discussions and your priorities for action.
Conclusion

May I conclude by wishing you well in your work. I hope that you will find the various papers and discussions informative and beneficial to your task of promoting a healthy old age.
A PROFILE OF HEALTH AND WELL-BEING AMONG THE OVER-65s:  
PRELIMINARY FINDINGS OF A NATIONAL SURVEY

Dr Tony Fahey

This presentation draws on preliminary results from the National Survey of the Over-65s (June-August 1993) and on other statistical sources to provide a general profile of self-reported physical health and mental well-being among the over-65s in Ireland (excluding those living in institutions). The presentation gives a brief overview of some of the initial findings of the research and is not intended as a finished or comprehensive analysis. (Figure 1)

The principal points of the presentation are:

1. The average age of the non-institutionalised over-65s in Ireland is approximately 73. As might be expected for such an age-group, there is a substantial level of illness: 47% report having a long-standing illness and 58% report having taken medicine on prescription in the previous twenty-four hours. At the same time, the majority are physically well and active - only 11% were prevented by illness from carrying out normal activities at any time in the previous four weeks and over two-thirds rate their health as good or very good. Morale is also reasonably high - almost three-quarters of the over-65s say they are as happy now as ever they were, though substantial minorities report feelings of loneliness and of having time on their hands. (Table 1)

2. Compared to most other western countries Ireland has a low proportion of over-65s in the population. This is the result of high emigration up to the 1960s, high fertility in the 1970s and 1980s and, to a lesser extent, some shortfall in life expectancy in Ireland compared to other countries. Unless a high proportion of the present youth population is lost to emigration in the years ahead, the elderly in Ireland will continue to have a strong support base in the population under 65 for the foreseeable future. (Figure 1A)

3. By European Community standards older people in Ireland do not have particularly good physical health in that life expectancy for both men and women in the older age-ranges is the lowest in the EC. (Figure 2)

4. By the mid-1980s basic physical health among older Irish men was little better than it was among their grandfathers earlier this century: from about the age of 50 onwards, life expectancy for Irish men in 1985-87 was only slightly longer - and for some ages was marginally shorter - than it was in 1926. (Figures 3, 5)

5. Older Irish women have had real increases in life expectancy since the 1920s, so that they now have a substantial and widening life expectancy advantage over older Irish men. (Figures 4, 5)

6. Paradoxically, though older women are generally healthier than older men in the sense that they live longer, for the most part they report higher levels of
sickness on a day-to-day basis. Over a number of indicators of physical illness - self-reported major illness, number of days in bed, taking of medicines and health service utilisation generally - women in most cases emerge as worse off than men. (Tables 2, 3)

7. Of the order of 40% of the sample reported at least some functional incapacity - i.e. difficulties with mobility, personal care, hearing or eyesight (even using hearing aids or glasses). Women in each age-group were slightly worse off than men, and for both men and women functional incapacity increased steadily with age. (Figures 6, 7)

8. While previous research in Ireland has shown some link between social class on the one hand and mortality and morbidity on the other, initial analysis of the present data did not show any strong connections between social class and indicators of physical health. However, further analysis of the data is needed to clarify this question.

9. Almost a quarter of the sample in the survey reported significant symptoms of psychological distress. Women were worse off in this area than men, the widowed were worse off than the married (and to a lesser extent the single) and distress increased with age. However, physical illness was the strongest single correlate of psychological distress and to some extent accounted for the higher incidence of psychological distress among women and among those in older age-groups (all of these have a higher incidence of physical illness). Factors strongly associated with psychological distress among those under 65, such as unemployment and poverty, are less significant for those over 65 (despite the presence of some poverty). As a result, the elderly are not dramatically worse off than the population as a whole in this area. (Figure 8)

10. General measures of life-satisfaction and contentment indicate a quite widespread, high level of morale among the over-65s. Substantial minorities, however, express problems of general unhappiness, loneliness, worry about becoming a burden to other people, and having a lot of time on their hands. Almost half express concerns about being unable to reciprocate the favours and help they receive from other people. Women generally are more affected by concerns of these kinds than men, but again, as with psychological distress, illness has a stronger influence on respondents’ feelings in these areas than gender. It is notable that the vast majority - almost 95% - report agreement with the statement that there are members of my family who care for me very much, so that a sense of complete abandonment by family is rare among the elderly. (Table 4)

Conclusions

The information on physical health and mental well-being among the over-65s presented here is too limited to tell us what health promotion measures are needed to improve these aspects of old people’s lives in the future. But it does remind us of the nature of the challenge health promotion has to address. Three aspects of that challenge are worth repeating here:
• The high levels of mortality among Irish people from late middle age on. The fact that for Irish men in particular there has been no improvement in this area in the last sixty years, despite massive increases in expenditure on therapeutic health care, emphasises very clearly the need for greater effort in preventive health care and health promotion.

• The complex, little understood interaction between gender and illness. Health promotion needs to be gender sensitive since men and women seem to relate quite differently to their illnesses and health problems. How such sensitivity should be reflected in health promotion programmes is not at all clear in our present state of knowledge.

• The close relationship between physical health and mental well-being. It is well known that ill health is psychologically, as well as physically, debilitating. Health promotion needs to give close attention to the psychological dimensions of health and to try to equip people with the psychological resources necessary to help them cope with the psychological consequences of illness.
Survey details: Non-weighted sample consisting of 911 non-institutionalised persons aged over 65, selected by screening from a random sample of 9,200 names drawn from the electoral registers. Fieldwork by personal interview, July-September 1993.
Table 1: Some measures of physical and mental well-being among over-65s

<table>
<thead>
<tr>
<th>Measure</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>73.2</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>73.7</td>
<td></td>
</tr>
<tr>
<td>Percentage who have long-term illness or disability</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Percentage who have taken medicine on prescription in previous 24 hours</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>Percentage having one or more disability days in previous 4 weeks</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Percentage rating health as very good or good</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>Percentage showing symptoms of psychological distress (i.e. above GHQ stress threshold)</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Percentage who feel generally as happy now as they ever did</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>Percentage feeling lonely (in winter time) more often now than when younger</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Percentage who feel they often have time on their hands</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Percentage who feel they have family members who care very much for them</td>
<td>93</td>
<td></td>
</tr>
</tbody>
</table>
Figure 1A: Age-sex pyramid, Ireland 1991-1992 (provisional data)

% of total population

Average for EC

Source: Demographic Statistics 1993 (Eurostat)
Figure 2: Life expectancy at 60 in EC countries, around 1991 (provisional data)

<table>
<thead>
<tr>
<th>Country</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>19.2</td>
<td>24.4</td>
</tr>
<tr>
<td>Italy</td>
<td>18.7</td>
<td>23.2</td>
</tr>
<tr>
<td>Spain</td>
<td>19</td>
<td>23.2</td>
</tr>
<tr>
<td>Netherlands</td>
<td>18.2</td>
<td>23.1</td>
</tr>
<tr>
<td>Belgium</td>
<td>18</td>
<td>22.8</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>18.2</td>
<td>22.7</td>
</tr>
<tr>
<td>Europe 12</td>
<td>18.2</td>
<td>22.5</td>
</tr>
<tr>
<td>Greece</td>
<td>19.4</td>
<td>22.4</td>
</tr>
<tr>
<td>Germany</td>
<td>17.6</td>
<td>21.9</td>
</tr>
<tr>
<td>UK</td>
<td>17.7</td>
<td>21.7</td>
</tr>
<tr>
<td>Denmark</td>
<td>17.8</td>
<td>21.7</td>
</tr>
<tr>
<td>Portugal</td>
<td>17.1</td>
<td>21.2</td>
</tr>
<tr>
<td>Ireland</td>
<td>16.9</td>
<td>20.8</td>
</tr>
</tbody>
</table>

Countries arranged in descending order of female life expectancy.
Source: Demographic Statistics 1993 (Eurostat)
Figure 3: Life expectancy for males at various ages, 1926-86
Figure 4: Life expectancy for females at various ages, 1926-86
Figure 5: Change in life expectancy, 1926-86

- Men
- Women
The Mortality - Morbidity Puzzle

Question: What is the relationship between mortality and morbidity (the incidence of illness) in populations?

Answer 1: The COMPRESSION OF MORBIDITY thesis: as life expectancy increases, morbidity becomes *compressed* into the later years of life so that the incidence of good health increases steadily in all except the oldest age-groups.

versus

Answer 2: The historical record: as life expectancy increases so too does the incidence of illness in all age-groups from mid-life on - morbidity *increases* with longer life expectancy. Likewise, some social groups with higher life expectancy (e.g. women) also have higher morbidity rates across most age-groups.
Table 2: Percentage of elderly who reported long-standing illness in 1977 and 1993, classified by age-group and sex

<table>
<thead>
<tr>
<th></th>
<th>65-69</th>
<th></th>
<th>70-79</th>
<th></th>
<th>80+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>1977</td>
<td>56</td>
<td>62</td>
<td>56</td>
<td>67</td>
<td>66</td>
</tr>
<tr>
<td>1993</td>
<td>48</td>
<td>39</td>
<td>43</td>
<td>48</td>
<td>50</td>
</tr>
</tbody>
</table>


Table 3: Gender differences in various measures of morbidity among 70-79 year olds in 1977 and 1993

<table>
<thead>
<tr>
<th></th>
<th>1977</th>
<th></th>
<th>1993</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Percentage whose most recent visit to the doctor was</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In past 4 weeks</td>
<td>41</td>
<td>49</td>
<td>43</td>
<td>53</td>
</tr>
<tr>
<td>A year or more ago</td>
<td>25</td>
<td>19</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Percentage who took pills or medicine in past 4 weeks</td>
<td>56</td>
<td>67</td>
<td>54</td>
<td>65</td>
</tr>
<tr>
<td>Average no. of visits to/from doctor in past 4 weeks</td>
<td>0.6</td>
<td>0.84</td>
<td>0.6</td>
<td>0.9</td>
</tr>
<tr>
<td>Average no. of days unable to carry out normal activities in past 4 weeks</td>
<td>1.53</td>
<td>1.77</td>
<td>1.5</td>
<td>1.1</td>
</tr>
<tr>
<td>Percentage stating health as good or very good</td>
<td>63</td>
<td>55</td>
<td>71</td>
<td>62</td>
</tr>
</tbody>
</table>

Source for 1977 data: as Table 2
Functional Capacities - 1993 Survey of Over-65s

*indicates item replicated from 1977 Survey of Elderly*

- Have all-over wash or bath
- Dress oneself
- Walk half a mile
- Get up and down stairs
- Get on a bus
- Hear easily (with hearing aid if necessary)
- Read a newspaper (with glasses if necessary)

Wash hands and face
Get to and use toilet
Cook a hot meal
Do heavy grocery shopping

Scoring: 0 - no difficulty
1 - some difficulty/cannot do at all

Functional Capacity Index (FCI) - sum of scores over first seven items - i.e. those replicated from 1977 Survey
Range of FCI: 0 = high capacity (no difficulty with any item),
7 = low capacity (difficulties with all seven items).
Figure 6: Distribution of sample by functional capacity index scores

<table>
<thead>
<tr>
<th>FCI score</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>56</td>
<td>66</td>
</tr>
<tr>
<td>1</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>2 or 3</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>4 or 5</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>6 or 7</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

Percentage

Legend:
- Women
- Men
Figure 7: Average functional capacity index scores by age-group and sex

Average FCI score

- Women
- Men

Age-group

65-69
70-79
80+

0
0.5
1
1.5
2
2.5
3

0.5
1
1.5
2
2.5
3
General Health Questionnaire (GHQ)
Measure of Psychological Distress

Have you recently ...

1. Been able to concentrate on whatever you're doing?
   Better than usual  Same as usual  Less than usual  Much less than usual
   1                2                3                4

2. Lost much sleep over worry?
   Not at all  No more than usual  Rather more than usual  Much more than usual
   1                2                3                4

3. Felt you were playing a useful part in things?
   More than usual  Same as usual  Less than usual  Much less than usual
   1                2                3                4

4. Felt capable of making decisions about things?

5. Felt constantly under strain?

6. Felt that you couldn't overcome your difficulties?

7. Been able to enjoy your normal day-to-day activities?

8. Been able to face up to your problems?

9. Been feeling unhappy or depressed?

10. Been losing confidence in yourself?

11. Been thinking of yourself as a worthless person?

12. Been feeling reasonably happy, all things considered?

The GHQ Stress Threshold: respondents who give stress-type responses (i.e. response codes 3 or 4) to THREE OR MORE items from the above list are classified as above the GHQ Stress Threshold. Otherwise they are classified as below the GHQ Stress Threshold. In large-scale tests of this measure in Britain and other countries, scores above the GHQ stress threshold have been found to correlate strongly with the presence of clinically diagnosed non-psychotic psychiatric conditions.
Figure 8: Percentages of over-65s exhibiting symptoms of psychological distress (i.e. above GHQ Stress Threshold) in 1987 and 1993

Source for 1987 data: ESRI 1987 Poverty Survey
Table 4: Percentages agreeing with various statements about well-being

<table>
<thead>
<tr>
<th>Statement</th>
<th>Male</th>
<th>Female</th>
<th>Ill</th>
<th>Not ill</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am generally as happy with life now as ever I have been</td>
<td>80</td>
<td>70</td>
<td>62</td>
<td>86</td>
</tr>
<tr>
<td>I worry a good deal that I am becoming a burden to other people</td>
<td>18</td>
<td>32</td>
<td>39</td>
<td>14</td>
</tr>
<tr>
<td>During the winter I feel lonely much more often now than I did when I was younger</td>
<td>33</td>
<td>50</td>
<td>52</td>
<td>34</td>
</tr>
<tr>
<td>There are members of my family who care for me very much</td>
<td>93</td>
<td>95</td>
<td>93</td>
<td>96</td>
</tr>
<tr>
<td>Often I am not able to return favours and help from people as much as I would like</td>
<td>42</td>
<td>49</td>
<td>59</td>
<td>34</td>
</tr>
<tr>
<td>My age generally has not caused people to treat me with any less respect</td>
<td>88</td>
<td>86</td>
<td>85</td>
<td>89</td>
</tr>
<tr>
<td>I often find I have time on my hands</td>
<td>47</td>
<td>49</td>
<td>59</td>
<td>38</td>
</tr>
<tr>
<td>I often have to depend on people I don't get on with very well for help with everyday things</td>
<td>7</td>
<td>8</td>
<td>11</td>
<td>5</td>
</tr>
</tbody>
</table>
HEALTH AND AUTONOMY FOR OLDER PEOPLE: DIRECTIONS FOR FUTURE POLICY

Professor Cecily Kelleher

(This paper is taken from a position paper Measures to Promote Health and Autonomy for Older People, available from the National Council for the Elderly.)

Introduction: Strategic Perspectives

It is important to differentiate the three different stages of health promotion strategies that have been discussed throughout this paper: short term, intermediate and long term. These will serve different needs.

(a) **Short term strategy** is based around the immediate needs of an already elderly population. Examples might include initiatives such as a review of housing and living conditions generally (Chapter 2), of existing health (Chapter 3) and educational services (Chapter 5) and how they might be improved. Where quality of life is concerned, the social needs that promote autonomy could be addressed (Chapters 2 and 4).

(b) **Intermediate approaches** include the preparation for old age of those now in early to late middle age (Chapter 5). This is where planning and education for retirement as part of health promotion at work can be envisaged and examples here will include attitudinal surveys in relation to beliefs about health and people’s own perceived capacity to change (Chapter 4). Within the health sector, screening programmes for the prevention of CHD and cancers could be considered (Chapter 5).

(c) **Longer term strategies** are our investment for ageing into the next century. This means a review of socio-demographic factors such as emigration, unemployment, the shift from the Western seaboard (Chapter 2). Innovation into living conditions such as housing will also be necessary. Here too allied issues such as pensions and retirement schemes for significant and sizable communities like farmers may have a bearing on health. Government policy initiatives will be taken for motives other than health policy of course, but it will form a part. It also includes education of the young (Chapters 4 and 5) with consideration of ageing and attitude shift of upcoming schoolchildren.

It can be argued that most of these issues have been considered in whole or in part in other reports on older people and that is true. Health promotion is not a magic formula for change. It is a refreshing way to build on the changes evolving in society; on the development of self-help and the criticism of prevailing social structures and attitudes. As Robert Anderson indicated in a recent paper (1992), health promotion for older people is a relatively recent concept, particularly in Europe. While the provision of information and the education of individuals continues to be an important focus and is advocated here, the newer health
promotion strategy is based around the process of changing ways and conditions of living.

If health promotion for older people is to be more comprehensive than cosmetic, we need to accept that the issue has to be tackled on more than one front to be effective and that preparation for ageing is merely one aspect of an ongoing process of living. Secondly, increases in support of older people will stand or fail in terms of the framework in which they are initiated. We must therefore ask whether that framework is covertly ageist or whether it enhances a genuinely positive approach to ageing?

We have a distressing tendency in modern society to believe that an issue is not satisfactorily resolved unless the solution is clear cut and simplistic. However, why should the human condition be reduced so summarily? What we can do is prioritise the issues identified, set them in context, and go about their resolution in different sectors using different methodologies. If therefore, I was advised to choose the single most obvious barrier to health promotion for older people, I would say this, those with different responsibilities and roles do not talk to each other enough. My advice? Take down the barriers and enjoy the real benefits of intersectoral cooperation.

A number of issues have been raised throughout this paper. Directions for policy might usefully be examined using the framework of the Ottawa Charter.

**Build Healthy Public Policy**

Public policy for older people must, of necessity, be intersectoral. The existing Cabinet Subcommittee on Health Promotion, chaired by the Minister for Health, is underutilised and should be re-emphasised by the present administration. *The Years Ahead* made specific reference to such an inter-departmental Cabinet subcommittee, chaired by the Minister for Health, established as part of a revised national structure for health promotion in 1987. This component of the revision was highly innovative, in line with the aspiration of the health promotion movement worldwide. It is to be hoped that it will be exploited more fully as a mechanism for addressing complex situations, where there is no real option but to involve all sectors and interests at policy level.

A similar mechanism is clearly needed at local level. This has been essayed in various ways by different health boards and local authorities. The varying experiences between areas described earlier would serve as a useful lesson for further development. A strategy task force appointed by the Minister could undertake this review and make recommendations for procedural change in a short period.

It will require real commitment to get beyond the understandable reluctance of different agencies and bodies to commit themselves beyond their remit and to put valid intersectoral structures in place at national and local level.

A recent International Conference under the auspices of Eurolink Age was held to discuss how European member states proposed to mark 1993 as Year of Older People. The general provisions of *The Years Ahead* were endorsed by the Irish group at that meeting and issues raised included the exploitation of this cabinet subcommittee as a policy forum.
The Health Promotion Unit in the Department of Health was established with the intention of influencing health policy generally, as well as the educational function previously undertaken by the Health Education Bureau. It also has the benefit, with the Minister, of advice from a National Advisory Council for Health Promotion. In this context, the Minister also has the advice of the National Council for the Elderly, whose terms of reference include advice on promoting the health of older people and action, based on research, to plan and develop services. Recent initiatives to network agencies providing services for older people and organisations of older people could also contribute a representative voice.

The Health Promotion Unit is relatively under-funded, both in relation to comparable agencies in other countries and as a proportion of our total national expenditure on the health sector. A number of important national policy documents are in preparation by the Health Promotion Unit at present, including ones on alcohol, nutrition and a more general one on a ten year strategic plan for health promotion. This latter policy document, like that in the United Kingdom, should specifically address how the World Health Organisation’s 32 Targets for Health for All of the European region are being addressed. These concern a number of aspects that have a bearing on the health of older people. Ultimately, many of the Health Promotion Unit’s operational health education functions could be devolved regionally to a much larger extent. This in turn depends on having properly trained professionals in place. It is in recognition of this need that my department has established a diploma/MA programme in health promotion to commence in Autumn, 1993. We are also preparing a register of training programmes in health education available at all levels.

Create Supportive Environments

Environmental planning in housing, roads, shopping services and urban planning must be seen as a priority for health promotion. Unless these fundamental structural issues are reviewed, the rest is cosmetic. This also includes the development of wide range of living options for older people. The range of long-stay homes available to old people at present does not allow for personal development in old age. The fact that a residential home is an institution does not mean that it has to be institutionalised. The same point has also been made in relation to sheltered housing. The need for a housing survey was mentioned earlier. The implementation of the Nursing Homes Act is also very important. That legislation should be understood in the spirit of its intention.

Many of the more serious threats to home autonomy for older people include threats to their personal safety. This is part of wider social changes in the fabric of Irish life generally. To the extent that ageist attitudes contribute to this, education may make some long-term impact. Meanwhile, Community Watch schemes and other forms of support could also serve to improve socialisation of elderly people.

Encourage Community Participation

The fundamental philosophy behind community participation is that it should be based on what communities themselves want. This applies even more critically in the case of older people because of paternalistic ageist attitudes of professionals at all levels and in all sectors.
The aspiration of community care, which seeks to maintain the older person in his or her own home, should be based around a total needs assessment of the person, including his or her preferred options. The community option is not necessarily cheaper, especially if informal care is taken into account. However, a quality of life assessment with validated economic indicators may well show that it is more cost effective. This approach will however require investment and re-organisation on the part of the health boards.

Enlightened state support for carers could form a health promotional activity: (a) by improved subsidy and other payment schemes, (b) by improved education and information provision and (c) by improved support services. Carers themselves endorse the need for further education; such programmes should include their own personal development. For example, the certificate/diploma programme in social care being offered through the Department of Health Promotion at University College, Galway, with the support of the E.C. NOW Programme is designed to meet the differing needs of carers and will ultimately contain a distance learning component. Cross-European collaboration is a specific element.

Community intervention projects provide a precedent for intervention that could be more specifically directed to older people. Several models exist at present in Ireland in varying stages of evaluation. These include: The Kilkenny Health Project, WHO Healthy Cities Project, the FORUM Connemara West Project and the pilot projects on coordinating services for the elderly at the local level, evaluated by the National Council for the Elderly. To incorporate their findings into local policy is an important issue.

Success of health promotion for older people, as for any group, is dependent on cooperation. This in turn will be based on how truly it reflects the aspirations and desires of clients themselves. One valid resource in this respect, from which all societies can learn, is literature and folklore. Ours is no exception.

A Patients' Charter is based on a 'citizenship' notion of participation in contemporary society. This assumes that it is an integral part of the dignity of inhabitants of democracies that they should both exercise control and choice over their circumstances, and be in a position to make appropriate contributions to those societies. Here, three elements appear to be crucial: the provision of a wide range of services; adequate information about these services; and opportunities for individuals to contribute to society rather than being treated only as passive recipients of aid. Policy-makers need practical methodologies to test areas of provision for their adequacy in these terms which start from characteristic predicaments of (a) elderly individuals; (b) carers or friends; (c) professional people attempting to assist elderly individuals. Given a particular predicament, are appropriate choices possible or easy? Indeed, the provision of information is a service in itself, considerably palliating the impression of helplessness which individuals feel in new, complex and difficult circumstances; this is not sufficiently taken into account in policy provision at the present time.

The advocacy of community participation and collaboration with voluntary agencies is precisely to avoid the situation for elderly people whereby state aid is paramount in social as well as financial terms. This is stated in recognition of the difficulties mentioned earlier with such models and is not intended to undermine the statutory duties of government.
Given that many people in Europe do not apparently welcome compulsory retirement, voluntary bodies might be encouraged to research into and channel the capacities for continued activity which elderly people have. Here, as elsewhere, it is important to ensure that the activities of voluntary organisations are adequately inter-connected, in both practical and informational terms, with state systems.

**Develop Personal Skills**

Personal choice for elderly people remains the hallmark of health promotion. We should recognise that one will want to continue what one enjoys. The principle is that social support should act as a client-oriented network that is activated only on requirement.

I have also advocated the development of adult education programmes in different contexts. In general, adult education on all aspects of ageing should be supported and improved. The models developed in other countries, particularly the United States, could be modified and piloted in this country. The work of groups like Age and Opportunity could be more strongly supported.

A further and related issue is the constructive and creative use of the media to promote messages. Use of the media to promote health should involve cooperation with mainstream entertainment schedules rather than exclusively didactic formats or advertising. This experiment has been successfully tried by Age Concern in the UK. The BBC for instance recognises the provision of entertainment programmes for an ageing audience profile as a client necessity.

Different attitudes toward older people may well exist in different sectors of the general population. We know something about this from existing research. However, this could benefit from better supported interview techniques, including contributions from older people themselves. In general, the provision of services for older people by older people is to be recommended and the concept of peer-counselling is part of upcoming changes in the United Kingdom. The importance of this cannot be too strongly stressed. If we do not know enough about peoples' attitudes, we cannot define policies appropriate for their needs.

If education both to promote health maintenance and to combat ageism among the young is to be taken seriously, then it will require a comprehensive review of teaching methods and materials. How are older people to be represented in such materials? The scope for health education in schools has been addressed by the recent Government Green Paper, which supports the health promoting school curriculum. This concept involves the integration of health education in all aspects of school life, including the physical structure of the building. It has traditionally been difficult for young people to empathise with their own health predicaments long-term, let alone of their parents and grandparents. In an integrated curriculum a spiral approach is used, so that one returns to concepts in increasing depth and complexity and in different contexts. Why not use this to reinforce our message? Consider for instance the poetry of Yeats 'That is no country for old men ...' or Kavanagh 'Every old man I see reminds me of my Father' or Maurice O'Sullivan's 'Fiche bhliain ag fás'. A programme for schools which focuses on two different age groups is being launched in 1993 by the National Council for the Elderly and is a welcome development.
In medical education negative attitudes to ageing are also pervasive. The policy document, *The Years Ahead*, has informed much of the discussion on future policy directions for older people in recent years. It advocated better training of health professionals, particularly of doctors, and more attention through the school education system to our attitudes to older people. More specific educational programmes for health professionals would improve their management of older people, particularly in taking a more holistic and less defeatist approach to their problems. This is particularly applicable to those destined for a career in primary care. The further development of geriatric medicine is similarly to be endorsed.

**Re-Orientiation of Health Services: Preventive Medicine**

Although the vast majority of elderly people are independent, health service utilisation by older people is relatively heavy, particularly for those who do have health needs and in the primary care sector.

What problems ought to be more closely targeted for rehabilitation? Although the emphasis of this paper is on wellness and positive approaches to health, it remains true that the prevention of dementia, osteoporosis, coronary heart disease and cancer would have major long term public health benefits. Established areas of success in previously studied cohorts include improved and sustained levels of exercise, an emphasis on a high fibre, nutritionally balanced diet, smoking cessation and early detection and management of hypertension. Cohort trials imply considerable differences in the incidence of these chronic diseases and cross-cultural studies imply that the changes are not necessarily inevitably associated with ageing. Basic epidemiological research to clarify these issues continues to be necessary and will be crucial to long-term planning. It is recognised that research on this scale cannot be confined to national cohorts, but it provides an ideal instance of collaborative work that might be undertaken.

There is certainly some benefit to be derived from lifestyle modification both as a primary and secondary prevention measure even after the clinical onset of conditions such coronary heart disease and stroke. There are also a range of surgical intervention procedures like hip replacement that are highly beneficial in terms of subsequent improvement of quality of life. Even the efforts to rationalise hospital resource allocation can be seen as health promoting, if for no other reason than the opportunity cost implications for the service as a whole of inefficiently directed curative care.

Other important considerations are an assessment of the health gains from treatment regimens involving chronic medication or recurrent outpatient assessment. The treatment of hypertension in older people has been a controversial one. Intervention, even in mild or systolic hypertension, has shown reduction in the risk of stroke, congestive cardiac failure, and probably myocardial infarction. If properly monitored, such treatment is likely to be of benefit. Other important, common, age related conditions demanding patient participation include diabetes mellitus. This is an example of the kind of service that can be examined from a multi-disciplinary perspective and evaluated relative to cooperative community-hospital clinics (Rohan et al. 1989).

More (a) basic research on and (b) facilities for people with Alzheimer's disease will be needed. This condition must be understood and better managed if at all possible. Although the severely mentally infirm are in quantitative terms a small
number, they constitute a major logistical burden for their families. What is needed is an adequate and seamless assessment and management service.

Because of the relatively higher proportion of ill health in the elderly, rationally planned, accessible and multidisciplinary services need to be developed. The importance of cooperation of a wide range of health professionals has to be stressed. Most major reports in recent years have endorsed this, and allied developments that allow for strategic services planning have an influence too. This means the development of clinical geriatric services, and a role for public health teams and community psychiatric services. The development of appropriate needs assessment models are a basic public health function.

The geriatric medicine teams, where developed in this country, have fostered a number of principles that are integral to health promotion. They are holistic in that they consider the needs of the patient as a whole and attempt to prioritise their treatment requirements. They do not accept ageing in itself as a diagnosis and continue to be proactive about aspects of health that can be improved upon. These services have also attempted to escape from the stranglehold of uptake of acute beds by patients with chronic problems. The mean age of the average general hospital patient is certainly over 60 and yet medical students, and to a rather lesser extent nurses, are still taught about disease processes rather than the life-context of the patient. Most health professionals are trained in hospitals rather than the community which necessarily encourages a compartmentalised, problem oriented approach.

Conclusion

What then can we say generally about health promotion in older people? The objective is to build constructively on what we have already. To recognise that there is no weakness in those trained in individual disciplines also calling on their experience as human beings to carry out their jobs. To remember, finally, that we all want to be lucky enough to get old. Former United States President, Richard Nixon apparently said recently that he used to hate the idea of being eighty, until he thought of the alternative. While the objective is not to be irreligious, we would like to retain our sense of humour, amongst other things, and our joie de vivre. Health promotion is, after all, a positive concept.
Dr Ruth Barrington began by presenting a framework of broad public policy concerns. Policy should aim to keep people well as long as possible, to facilitate the restoration of health and independence after illness and to maintain the autonomy of elderly people. Added years of life and health was the broad target, with respect for the dignity of elderly people and recognition of their heterogeneity as a group, thanks to differences based on gender, social class and lifetime experience. A realistic view of old age is needed in which positive adaptation opportunities are recognised alongside losses such as the increased prospect of ill health and the facing of death. The elderly are, in Dr Barrington's view, now on the policy agenda in ways in which they were not before.

In aiming to keep people well it is important to begin with the realisation that health is not to be equated with health services. Income is not perceived as a major issue at the present time, but this may change as expectations alter in the future. There are certain universal features of health promotion policy that apply to all age-groups. Personal security and stress is one area. This needs to be addressed at the community level. In relation to the elderly, this problem is being alleviated by encouraging the use of telecommunications aids. Accommodation is another area. Nowadays, standards are less often the issue than appropriateness. For the elderly this may mean problems with stairs or maintaining a garden. House adaptation is a practical means of addressing issues of appropriateness.

People need to be free of addictions if they are to maintain their health. Current cigarette messages are aimed at the young and consideration should be given to the needs of other audiences. A policy on alcohol is currently awaited. Appropriate messages on accidents need to be formulated for elderly people. Nutrition is another issue of universal relevance, but with particular requirements in the case of older people; similar considerations apply to physical fitness. It has been argued that public policy change should be subject to gender proofing or scrutiny from the point of view of its impact on women. Dr Barrington suggested that gero-proofing or scrutiny from the point of view of the impact on elderly people would be an appropriate aim in the present context.

Certain health promotion issues relate very specifically to elderly people. There is the reduction or loss of functional abilities such as hearing, vision or mobility. The problem of iatrogenesis arises out of the large amount of prescribed drugs taken by people in this age group. New ways are needed to address the problems of isolation or loneliness. The need for a preventive screening programme is being debated but, on present evidence, is hardly justified except where it is targeted at specific groups at higher risk. Fatalistic adaptation should be tackled by public policies which have the minimisation of disability as their goal.

In seeking to facilitate the restoration of health and independence after illness, a move away from institutionalisation and towards the harnessing of capacities for
rehabilitation is needed. The development of supportive primary health care services is of central importance in this regard.

In relation to the maintenance of autonomy there is the question of trying to determine how much scope for autonomy there actually is. Health service staff ought to be sensitive to elderly people's need for and aspiration to autonomy even where their incapacity appears great.

Two broad problems were identified as affecting current implementation of policies for elderly people. The first is the complexities arising out of the need to co-ordinate the initiatives and actions of different agencies. The second is the existence of competing priorities when it comes to the allocation of scarce resources.

In discussion The Years Ahead report was praised, but implementation of its recommendations was seen as patchy. The question of defining mandatory core obligations for responsible agencies, rather than leaving matters to their discretion, was discussed. There were calls for a monitoring body, for advocacy on behalf of elderly people, for audit to ensure that policy goals were translated into quality services and for common cause to be made with other age-groups (e.g. on an issue such as making roads easier to cross in safety). There were calls for recognition to be given and training to be provided to carers, who should be supported by better respite care provision in the health services. User management, whereby elderly people would articulate their own needs in terms of services at the local level, was also advocated. Attention was drawn to the existence of positive innovations on the ground which have not been documented. A rise in friction between age-groups over the distribution of resources was predicted as the age structure of the population changes; the view was also expressed that publicly-funded provision for the elderly represents a set of entitlements paid for by years of contributions.
SELF-HELP AND COMMUNITY ACTION TO PROMOTE THE HEALTH AND AUTONOMY OF THE ELDERLY

Mr Patrick Madden

Introduction

Health promotion policies in Ireland have a very broad perspective that could be summed up as attempting to cover three priority areas for action:

To add life to years.
To add health to life.
To add years to life.

The report *The Years Ahead*, published in 1988, recognised health promotion as a process that would enable more people reach old age, reduce the incidence of disease and increase the number who are healthy and active. The report considered strategies, including education, that would support self-care, self-help, mutual aid and motivation to maintain healthy lifestyles. Many of the gaps identified in that report still remain.

Information and education were identified as key elements to improve health, but the traditional education initiative targeted at individuals has been superseded or complemented by strategies for improving health through changing people's way and conditions of living. This health promotion approach also attempts to change the factors which influence the individual's capacity for decision making and behaviour related to health.

WHO documents have laid emphasis on community participation and intersectoral collaboration. The Ottawa Charter has identified action areas that have the objective of healthier old age through healthy public policy, community action, supportive environments, personal skills and reorientation of the health services.

Health and Older People

The Irish population is ageing, admittedly relatively slowly compared to the United States and some other EC states. Just over 0.5 million people, or 15% of the population, are aged 60 years and over. This figure is projected to increase by about 8% over the next 30 years. We are facing significant demographic changes in Ireland, for example, the number of people aged 75 years and over is expected to increase by almost one third between 1991 and 2021.

The incidence of health problems and disability increases with age, resulting in an associated use of services. The proportion of the population with chronic illness has been rising over the last ten years. However, most older people are relatively fit and healthy, a majority report their health for their age as good, very good or excellent, although their number falls below 50% among those aged 75 and over.
A 1989 report from Canada shows that older people do score high on indices of positive health behaviour, as the health and preventive practices of older people are generally equal to or better than those of younger people. Those aged 65 and over were less likely to smoke or drink alcohol to excess. However, they were not familiar with cardiopulmonary resuscitation and had no recent first aid training.

This study also found that various levels of health among the older population showed consistent variation with income and education. Strategies for health promotion must recognise that there is a correlation between poor health and lower socio-economic status, particularly in the older elderly and among women, which requires different methods and priorities to be developed according to the needs and interests of older people from varying social and economic backgrounds.

Projects, Progress and Policies

In Ireland there is a growing movement in self-care and self-help. This is manifested in the plethora of more or less organised exercise classes, arthritis and stroke self-help groups, home safety organisations and environmental improvement actions.

This growth in individual initiative, which has also led to increased voluntary activity, needs to be part of a well-defined national health promotion policy that would support health improvement among older people. I am hopeful that this Conference will result in the formulation and publication of a health promotion policy for the elderly.

Any such policy would have to be based on the epidemiology of health problems and should be grounded in knowledge of local health/illness status with local people closely involved in the identification and achievement of local priorities.

There are four main areas of particular importance to older people within the framework of health promotion: fitness and exercise; nutrition; accident and injury control and improved use of medicines.

Any programmes established in these areas should have a two-fold objective:

1. To increase the control older people have over their health (through awareness, social support or the availability of services).

2. To offer opportunities to people to improve their health.

Community Self-help

The growth of agricultural co-operatives at the beginning of the 20th century marked the emergence of community-based endeavours at local level. In 1931 a further initiative in community self-help presented itself in the establishment of Muintir na Tire. It has been suggested that the tradition of community self-help, encapsulated in organisations like Muintir na Tire, provided a background for the many community-based voluntary services in existence today. There are over 1,200 voluntary organisations providing services to the elderly in Ireland. The 1989 Report of the Working Party on Services for the Elderly, *The Years Ahead*, made many recommendations, with the objective of maintaining elderly people in
their own homes as far as possible and mobilising all the resources in the community to achieve this.

Many shortcomings in the relationship of voluntary and statutory organisations were identified. Of particular importance in promoting and protecting the health of the elderly, are policies affecting housing, security, air quality, road safety, retirement and income. The implementation of policies in these areas requires the development of an effective working relationship between the voluntary and statutory sectors. There is mention in many policy documents that community projects that facilitate multidisciplinary and intersectoral co-operation are integral to the health needs of older people. One of the priorities of a health promotion policy should be to take down the barriers to co-operation and partnership.

To date there has been only a limited effort to educate the elderly about staying healthy, as other age groups were deemed to have a higher priority. The aim of a health education policy for the elderly should be to raise individual ability to understand and manage health problems and discuss processes. As far as possible, health education should be integrated with the social activities of elderly people in clubs, community and parish centres.

The recent National Council for the Elderly report, Voluntary-Statutory Partnership in Community Care of the Elderly, attempted to identify the nature of voluntary organisations providing services for the elderly. Very few of the organisations had the goal of helping older people in neighbourhoods to provide services for themselves.

If health promotion policy is to succeed it will be necessary to identify and alleviate obstacles that prevent community action. One way of going about this was to develop a Health Empowerment Model which would:

(i) **Create awareness of an area's strengths and needs on the part of its residents.**
   - This would involve local residents being involved in gathering data on help-giving and help-receiving in the area. This would lead to an inventory of local agencies and services.

(ii) **Strengthen the area's helping network.**
   - This would help residents acquire confidence in their abilities to deal with professional agencies so that they would be able to interact with professionals as partners.

(iii) **Strengthen the professional helping network.**
   - This would bring together the fragmented and uncoordinated professional helping system in the local area.

(iv) **Form linkages between local residents and professionals.**
   - This would follow on once the previous objectives have been achieved.

(v) **Link the network established above with the macro-system.**
   - The community could focus on the larger forces that affect it. Information would be gathered on local plans, local sources of funding; linkage could be made with local funding organisations.
This model sees the professional acting in an advisory capacity to local groups rather than the more usual process of community groups being advisors to professionals and their agendas. Possible projects that could develop out of this include a directory of services for the elderly, self-help groups for widowed individuals, perhaps a hotline (freefone), staffed predominantly by elderly volunteers and an elderly advocacy group.

This is only one model of community action that would increase the capacity of the older person to solve their own problems and increase their ability to promote their own health.

The concept of self-help and community action implies that old age is to be perceived and experienced in a positive manner and is a period in which the individual exercises choice about his or her activities and circumstances. Is this the reality?

Negative attitudes to older people are common among the general public, health professionals and older people themselves. These attitudes are one barrier to older people participating in leisure, educational and other activities.

Healthy ageing is a new target identified by the World Health Organisation in its Health for All Programme. The European Community has created an EC Action Plan on healthy ageing which identifies four key areas around which action for health can be created. Strengthening self-help and local community action is one of these key areas, for which the Action Plan proposes the following objectives:

1. Acknowledge the right of, and create opportunities for, every older person to take decisions on the issues that affect his/her health and well-being.

2. Recognise and promote the key role of local community action and self-help initiatives, including the contribution of families and social networks.

3. Provide information and technical, organisational and social support encouraging self-help to both individuals and groups of older people, taking into account the needs of the most disadvantaged.

4. Create partnerships between government, for-profit and non-profit sectors at local, national and European level for practical and financial support of self-help and local community action initiatives.

Health promotion must seek to prevent ill-health in such a way as simultaneously to enhance positive health; it must also attempt to develop positive health with an eye on prevention.

Each one of us should consider carefully the full range of our potential contribution. We all have a part to play in health promotion and should work together towards achieving this goal.
1. Presentation

The main speaker in the workshop was Patrick Madden, Programme Manager in the Southern Health Board, who referred to the importance of health promotion policies which are enshrined in World Health Organisation (WHO) documents and in the key policy document on the elderly in Ireland, namely, *The Years Ahead: A Policy For the Elderly*, published in 1988.

The health of elderly persons is affected not just by health policies, he said; of particular importance in promoting and protecting the health of the elderly, are policies affecting housing, security, air quality, road safety, retirement and income.

Health promotion involves co-operation between the statutory and voluntary sectors within each local area, including:

(i) creating awareness of help-giving and help-receiving in each area,
(ii) strengthening the voluntary and informal helping network in each area,
(iii) strengthening the professional helping network in each area,
(iv) forming linkages between local residents and professionals,
(v) linking these local networks to larger networks.

According to Patrick Madden, this model sees the professional acting in an advisory capacity to local groups rather than the more usual process of community groups being advisors to professionals and their agendas. Possible projects that could develop out of this include a directory of services for the elderly, self-help groups for widowed individuals, perhaps a hotline (freefone), staffed predominantly by elderly volunteers and an elderly advocacy group.

2. Discussion

The discussion which followed this presentation focused on three questions:

- what factors inhibit the promotion of health among the elderly in the community?
- what factors promote health among the elderly in the community?
- what can the Department of Health and the health boards do to promote health among the elderly in the community?

2a What factors inhibit the promotion of health among the elderly in the community?

Attitudes to ageing and the elderly inhibit the promotion of health among the elderly. These attitudes, which are to be found throughout society, include the following:
(i) attitudes of the elderly themselves which reduce their level of activity and their sense of well-being,
(ii) attitudes in society which do not encourage the elderly to participate in activities,
(iii) some of these attitudes are reflected in the occasional tendency to associate the term elderly with the term ill,
(iv) attitudes in television which, notwithstanding the excellent RTE programme *Live at Three*, could encourage elderly persons to do appropriate physical exercises,
(v) attitudes of health boards and voluntary bodies, some of whose day centres for the elderly do not have a varied and interesting menu of activities.

Public policies outside the health area, in the strict sense, also inhibit the promotion of health among the elderly in the community. A notable example of this is the massive investment by the European Community (EC) and Ireland in roads which result in air pollution, noise pollution, traffic congestion and reduce safety on the roads. This infrastructural policy effectively reduces the opportunities for many elderly people to walk and take exercise. Referring to this situation, one speaker stated that EC and Irish money is promoting poor health.

2b What factors promote health among the elderly in the community?

One of the main factors promoting health among elderly persons in the community is the Home Help Service. This is a thoroughly community-based service and often a women-based service. Many persons involved in delivering this service are elderly themselves. It was suggested that home helps could play a more active role in disseminating information and awareness on health promotion among the elderly if they themselves were to receive training in this area.

It has been estimated that there are approximately 1,200 voluntary organisations throughout Ireland providing services for the elderly. Examples of these were cited in the discussion including: the Irish Countrywomen's Association, the Active Retirement Associations, Senior Citizens' Groups, Irish Association of Older People, Age and Opportunity, etc. These organisations, and many others, provide a range of services for the elderly including trips, outings, card games, talks on health and related matters, visits to hospitals, reminiscing, etc.

The informal community sector also promotes health among the elderly by organising activities which bring the different generations together. Examples of this intergenerational solidarity were cited, such as informal gatherings of people in a rural area of Kilkenny; the Share concept where fifth year pupils in secondary school adopt an elderly person and visit them regularly as part of their school activities; programmes where young and old quiz each other on their tastes in music, notions of love, etc.

2c What can the Department of Health and the health boards do to promote health among the elderly in the community?

Community activity throughout the country is promoting health among the elderly and this needs to be given more support by the Department of Health and the health boards. According to one speaker, the bottom-up approach needs to be matched by a top-down approach. Local groups need to be consulted more by
the health boards as to the needs of elderly persons and the support networks that are available to them. In this context the Community Care Model which operates in the health boards was described as inadequate because it is informed by a medical model and has the unnecessary requirement that only a medical doctor can be a Director of Community Care/Medical Officer of Health. Examples of good practice were cited from Connemara and Kilkenny, where the health boards are involved in consultation and support with the local community, from which the Department of Health and the health boards could learn.
QUALITY HEALTH CARE FOR OLDER PEOPLE:
REORIENTATING SERVICES

Dr David Clinch

In this workshop we are charged with contemplating the best way to actually provide health care for older people. As a geriatrician involved in the delivery of acute hospital medicine for the rehabilitation of the elderly and the supervision of continuing care I look forward to learning from the broader perspective of other participants. Perhaps we can work out practical proposals which can be readily implemented for the good of older people. Needless to say any developments suggested should be subject to the informed opinion of representative groups of older people such as the Irish Association of Older People. Such representative groups were not always around, but now those of us who basically are employed by the elderly have no excuse not to strive to meet their wishes.

The delivery of specific medical care for the elderly has taken enormous leaps in this part of Ireland in the last two decades. This time twenty years ago the number of medical specialists trained specifically for the elderly was three. Even then illness in the elderly was widely perceived as being chronic and hopeless. If they did not respond to traditional acute hospital medicine, and quickly, some sort of institutionalisation was often deemed to be the only solution. So what’s new? When you actually look at the progress of recent years, there has not been a specific milestone such as a way of reversing physiological changes of ageing. The difference is the growing medical recognition of two basic factors.

1. Firstly, acute illnesses can occur in multiples in the older person. This compares starkly with the medical tradition, which still holds true in younger adults, of trying to seek a single unifying diagnosis. By contrast, multiplicity and complexity of interaction between illnesses is almost the norm in the older patient. An example would be gout resulting from the treatment of heart failure with kidney failure lurking in the background and tending to make both worse. Diagnosis and treatment are more difficult and finely balanced in such a setting. Furthermore, the older patient would not be able to undergo all the usual tests that would be performed if the diseases were occurring singly in younger adults.

2. Atypical presentation. Illness in older adults can present very differently from the situation in younger persons. The examples are many: the heart attack without chest pain, the pneumonia without fever, the peptic ulcer without indigestion.

So while there are only two basic differences between illness in older and younger adults they are enough to throw conventional medical and nursing approaches into disarray.

The answer that has evolved over these last few decades is to have medical and nursing staff with the specific expertise and interest in the elderly. Equally important is that they should have no other priority. The past tendency to neglect the time-consuming problems of the elderly has tended to result, not from poor staff
attitudes, but from their understandably being preoccupied by other medical priorities. In a ward setting the recovering older person who needs to be mobilised before going home will have less immediacy than the critically ill young overdose in the next bed. When you reflect that illness in the elderly is often set against backgrounds of social isolation and economic deprivation you will conclude that it is all the more important to have doctors, nurses and other staff with the time and the interest to go into all of these in detail. It is no good having medical or nursing brilliance if one does not have time to go into the setting into which the patient is to be discharged. So the setting up of units specifically geared towards the elderly is a recognition of the need to provide conditions for staff to look after the elderly properly. They should have no other priorities but the elderly.

One such 14-bed acute hospital unit has yearly results like this:

- Admissions: 657.
- Average stay: 8.6 days.
- Discharged home: 70%.
- Long-stay hospital care: 6%.
- Number going to nursing home: 6%.
- Number going to convalesce with relatives away from their own home: 8%.
- Mortality: 10%.

The death rate may seem high, but it shows that when dealing with acute major illness in the elderly a proportion like this will die. The overall message is if you intervene early and appropriately with ill elderly people the great majority will return home. If necessary they will be willingly supported by relatives who will tend to have faith in the hospital system and referral mechanisms by general practitioners and public health nurses. These will have been sympathetic to their position, not just by arranging prompt admission in the early stages, but also in the timing and notice of discharges. These medical wards for the elderly are well established as being capable of delivering good medical care. They are enshrined as Government Policy since 1988 when *The Years Ahead* was accepted. This advised that a norm of 2.5 acute hospital beds be provided per 1,000 elderly persons in the catchment population.

Over five years later some great advances have been made, but sadly there are often some changes that have been mere tokens. Despite the elderly constituting about half of all admissions to acute hospitals many hospitals have only small show units for the elderly. They are not offering a central common pathway into which most elderly admissions go before reaching any other medical specialities they may need. This failure to change with the times inevitably leads to a large number of older patients who cannot go home. Complaints then arise of so-called bed-blocking as if it were the older person’s fault. As outlined above, in specific units for the elderly which are properly set up the numbers needing long-stay care will be very small, whereas in the more traditional hospital medical wards the numbers will tend to be higher.

Surely five years after the publication of *The Years Ahead* report reallocation of beds specifically for the elderly is the answer at acute hospital level? At community level, in areas such as home nursing, there must be similar imperatives for reallocation of resources.

To work in these medical units for the elderly and their associated rehabilitation units is a privilege and people who visit them speak of the high morale there.
To work in these medical units for the elderly and their associated rehabilitation units is a privilege and people who visit them speak of the high morale there. Geriatric Medicine or Medicine for the Elderly used to be a Cinderella specialty, but it now attracts the best and the brightest of young doctors as their number one career choice. So, in the medical world at least, the specialty has succeeded and is expanding. Despite this optimistic and self-congratulatory medical view it might be worthwhile for this workshop to report whether this satisfaction is shared by people with other perspectives. In general the views of general practitioners have been demonstrated to be very supportive of the new specialised departments of Medicine for the Elderly.

Away from acute care of the elderly there are wider organisational aspects to be considered. We in this country appear to have a great ability to sectorise our processes. With regard to the health of the elderly we have the acute hospital sector, the community services sector, the private nursing home sector and so on. All of these may be excellent in their own right, but crossing the barriers may be a huge problem for the older person whose powers of advocacy will often be limited. He or she needs structures of service and facilities which flow according to need rather than a series of barriers. For example, the hospital sector might be able to safely discharge an old person if the family were assured of two hours nursing care in the morning and evening. But, such an assurance may not be forthcoming, even if the resource is available, until the patient passes from the hospital sector to the community. This will tend to delay discharge or even prevent it altogether. So a sectoral barrier is present.

Conversely, a public health nurse or voluntary worker may come across a family who do their very best to keep their mother in their home with them but due to various pressures they need help. For example, say one of the children is doing the Leaving Certificate examination and the house is tense. For the family and the long-term good of the older person the nurse wants to arrange an immediate respite bed, but because of the formalities which have to be gone through, such as contacting the general practitioner to arrange an assessment by the consultant - it all takes too long. During this delay there is a big argument in the family and the patient ends up in the Casualty Department with the family saying they cannot take her home ever again. The cost as well as the human consequences of such intersectoral barriers must be high. This system overall suffers a loss of confidence as a result. These two cases are examples of where reorientation of health services is needed, not just within the medical specialties, but within the whole structure dealing with health and social welfare.

To summarise, we can say that reorientation of health services recognising the needs of an increasingly elderly population is underway. With all its benefits reorientation has also highlighted intersectoral barriers in our health services. Ways in which these might be remedied are equally important issues to gatherings such as this where the contribution of health services towards health promotion is being considered.
QUALITY HEALTH CARE FOR OLDER PEOPLE:
REORIENTATING SERVICES

Dr Mary Hynes

Dr Clinch, in his opening remarks, set the context of the workshop within the framework of the Ottawa Charter which has reorientation of health services as one of its five basic principles. He outlined the development of Medicine for the Elderly as a specialty. Following his address and the subsequent discussion the following points emerged.

1. The question was asked as to whether the health services are reorientating to cater for older people. The development of a specialist service with older people as a priority, expertise in caring for the elderly and community links is to be welcomed. However, dissatisfaction with the degree of reorientation was expressed. Many large hospitals have disproportionately small departments of medicine for the elderly. There is a danger of tokenism in the development of the service. While norms of acute, rehabilitation and day hospital bed provision have been accepted these have not been implemented.

2. The need for, and benefits of, early intervention were highlighted. This is important both at hospital level where adequate acute beds and day hospital places are essential and at community level where the general practitioner, public health nurse, home help or voluntary worker can have a key role in early recognition of problems. These two levels of care are interdependent. The community carers need prompt access to secondary levels of care. Similarly, hospital units need supportive communities into which patients may be discharged.

3. The question was also raised as to what extent we are dictating to older people in the health services rather than serving them. The voice of the older person is often not heard. Older counsellors may have a role in helping older people consider their options when the initial assessment and treatment has been completed by health care workers. An advocate for the older person is particularly important in the case of mental illness or dementia. It was suggested that the voluntary sector has an important role to play in this regard.

4. The need for co-ordination and communication between different health care providers, including the voluntary sector, and between different sectors which influence health, e.g. health, environment, justice, social welfare, education, was stressed again and again. The effects of social circumstances including housing was referred to by many contributors. Integration at both national and regional/local level is necessary, as is outlined in The Years Ahead. While the development of care teams for the elderly, liaison public health nursing services and general practitioner units is welcomed, there is room for improvement in many areas.
5. The patchy distribution of services for older people was highlighted and the need for equity stressed. In many cases the response of those caring for the elderly is constrained by lack of services.

6. While the discussion focused mainly on secondary and tertiary prevention, the importance of primary prevention was also acknowledged. Local radio was suggested as being one important avenue for the dissemination of health information to older people.

7. Finally, it was agreed that there should be a move away from the current separatist approach to the provision of health care for older people and a move towards providing a service to meet the needs of the older person using available resources efficiently.
This conference on Measures to Promote the Health and Autonomy of Older People in Ireland will deal with a range of topics relevant to health promotion. Thus it covers a much broader set of issues than simply the provision of information, given that health promotion may be defined as the process of enabling people to increase control over and to improve their health. Health promotion addresses the ability to realise aspirations and satisfy needs and to change or cope with the environment.

The parallel workshops will be dealing with the other main areas of health promotion, namely public policies, self-help and community action, the reorientation of health services and the creation of an environment supportive of health. It is only within the broader context of health promotion that health education can be effective.

Health education is communication with a view to altering health behaviours. Thus for any given topic it is necessary to consider the group or subgroup with which one is working and the desired or desirable behaviour change. The appropriate methods of communication should be used and the overall programme tested.

Some topics which come to mind, of relevance to health education with older people in Ireland, are the maintenance of safe and warm accommodation, healthy eating, taking physical exercise and getting mental stimulation, the maintenance of social interaction and support, and other aspects of healthy lifestyles relating to tobacco, alcohol and the avoidance of obesity.

However, the essence of effective communication for health is an approach from the perspective of the consumer. When older people in Northern Ireland were asked which health education topics were of interest to them, they requested further information on heart disease, cancers, accidents, diet and arthritis (Dr. Jane Wilde, personal communication). By definition, those who are older in our community have maintained their health to the extent that they have not succumbed to the premature killers in our society. It is not surprising that older people in Northern Ireland expressed a wish to learn more about the diseases which have a high prevalence among older people. The purpose of such health education would be to help people reduce the impact of existing diseases and to delay the emergence of further disabilities.

In our workshop we should consider, as the title suggests, the provision of information at different levels of complexity. Thus we can consider access to and the dissemination of information on services and entitlements, or the teaching of skills relating to shopping and cooking where we may be building on existing knowledge, or the more complex issue of encouraging participation in leisure activities.
Different channels of communication or groups of media are effective in different situations. Thus, leaflets, posters, newspapers, television and radio may be effective to communicate information about entitlements to services or the availability of grants. Newspapers and television may also be suitable to provide information about more complex topics, for example, nutrition. However, in order to encourage people to change their habits, more interaction may be required. Thus, learning skills and development of the motivation to change may require videos, cookery classes, visits to shops, etc. Food producers use special techniques to encourage us to take those first steps towards becoming regular consumers of their products, by in-store demonstrations of how to cook and serve the food and by providing an opportunity to taste it. They may try to maintain our custom with special offers, competitions, etc.

Communication to change health behaviour should consider the following in relation to the individual or group:

* **Awareness** of the importance of the topic.
* **Knowledge** about the topic.
* The **skills** which are necessary to undertake the healthy behaviour.
* The provision of an opportunity for **action**.
* The skills and environment to support **maintenance** of the changed behaviour.

All those involved in health education need to be aware of the difficulties which people experience in changing behaviour. This may apply even more in the case of older people where lifelong habits may be more ingrained. We must consider the readiness of people to change at a particular time.

It is particularly relevant that the title of the workshop includes the word *networking*. It is hypothesised that people learn through their social networks. They gain not just knowledge about activities and services, but learn from their peers what is possible, acceptable or desirable. We learn particularly from the opinion leaders in our society. Those who are the first to take up new activities are called early innovators. Behaviours spread to the early majority, followed by the late majority. Those who hold out against what have become commonplace behaviours have been referred to as laggards.

These concepts reinforce introductory comments that health education must be considered in the context of the environment. This means that the physical environment must make it feasible to practice the desirable behaviours and that the social and cultural environment must also be supportive. This explains why those involved in health education are also concerned about community development.

Health education programmes must always be well planned. Thus it is not good enough to produce attractive coloured leaflets and distribute them. We need to know what the programme is setting out to achieve. We need to know how many people currently practice the desired behaviour and what are the perceived barriers to changing to more healthy behaviours. The information which we gather as we plan a programme is called *formative* research. When the programme is being carried out we should collect information on the number of attendances at meetings, the distribution of materials, etc. This *process* evaluation feeds back into the planning system, to continuously improve the programme. *Outcome* evaluation measures the extent to which the initial objectives were achieved, measuring not
just the benefits but also any observed harmful effects. Again, findings help to improve future programmes.

The position paper for this conference starts with a quotation from T. S. Eliot that *Old men ought to be explorers*. This reminds me of two important considerations for this workshop. Firstly, that most of our older people are women, reflecting the higher mortality rates among men in middle age. Secondly, that attitudes are probably the single most important consideration for this conference. With supportive attitudes the achievement of change is facilitated. This relates not just to the attitudes of older people but also to the attitudes of families, neighbours, voluntary and community organisations, commercial and state institutions and society generally.

This conference and the work of the National Council for the Elderly will contribute to the necessary changes in attitudes that will enable older people in our society to be explorers while remaining safe, well and happy.
HEALTH EDUCATION, INFORMATION AND NETWORKING

Dr Mary Hurley

Attitudes to Ageing

There is a need to educate the general public, elderly people themselves and carers - voluntary, statutory and family members - on the ageing process. There is also a need to educate older people on coping with ageing, particularly in relation to mental health. This can best be done through mass media campaigns, documentaries and local radio programmes for older people by older people.

Untapped Resource

It is important to listen to older people to ascertain what are their aspirations and perceived needs. These needs may be small, such as in the case of one lady who was simply dying to take a trip on the DART, they may relate to aspects of health on which information is required, or to the rights of older people in making decisions on their own lives.

From there it follows that older people must also be consulted, both as individuals and as groups, on the development of programmes to meet these needs.

Co-ordination of Groups

There is a greater need for groups of elderly people, voluntary groups and statutory agencies to work together. Together they would have greater power to act as advocates on behalf of the elderly with politicians and policy makers, and with commercial groups and organisations who provide services and products, to ensure that the needs of the elderly are taken into account.

Networking

While it was stated that in general the elderly do not form groups and therefore there is no constituency of older people to address, there are, however, many groups in Ireland working in this area and Age Action Ireland is endeavouring to bring these together under an umbrella group. Older people should be encouraged to join groups as these can give voice to their aspirations and needs.

There are, however, many people who either by choice or circumstance do not belong to groups and these must also be reached. This could be done by using groups of schoolchildren or groups of unemployed people, who could perform individual tasks to improve the health and autonomy of the older person and at the same time add to the aspiration of solidarity between generations and confer on the unemployed a sense of usefulness.
Technology

Finally, it was noted that technology has a role to play, such as in the use of alarm systems which can contribute both to the physical and mental health of the people to whom they are supplied.
The purpose of this short paper is to give direction to the workshop discussion and to facilitate identification of four or five priorities for action in creating a supportive physical environment for older people.

The last comprehensive review of policy for the elderly was *The Years Ahead - A Policy for the Elderly*. (1) This was the report of a working party appointed by the Minister for Health, published in October 1988. I will be using their main recommendations as a starting point for our discussions. I will also give you some of the results of the recent ESRI survey which relate to housing, safety and transport.

I will start with some relevant background information. The 1991 Census of Population showed that there were 403,000 people aged 65 or over. (2) Of these 9% were living in institutions, 24% were living alone and 67% were living with other people. Women were much more likely to be living alone than men. Of those women aged 65 or over living in private households, 31% were living alone.

One of the six basic considerations which *The Years Ahead* adopted was that the dignity and independence of the elderly can best be achieved by enabling them to continue to live at home with, if necessary, support services provided by the State. *The Years Ahead* gave the proportion of the elderly at any one time leading independent lives as 78%, being cared for by their families as 17% and in long-term care as 5%. A supportive physical environment can play a significant role in helping older people to remain independent and in facilitating families in looking after older relatives. Studies suggest that this is what the older people themselves want. It is also likely to be by far the most economical approach.

How can the elderly best be facilitated to live at home? The suitability of the house itself is likely to be the most important factor and that is the area to which I suggest we devote most of our attention. However, easy access to shops, health services and other facilities are also important. This relates to planning and the siting of suitable houses close to such facilities and/or to the availability of transport to them. Another area which one would expect to be increasingly important is the question of security or personal safety. The high number of elderly women living alone would tend to reinforce this.

**The Years Ahead: Recommendations on Transport and Housing**

**Transport**

The Departments of Transport and Environment should examine ways of coordinating transport in rural areas and improving transport for the elderly.
The design of public transport vehicles should be improved to provide for easier entry and exit by the elderly.

Each health board should ensure that adequate transport exists to give elderly people access to day care, day hospitals, and out-patient departments.

The emphasis in the recommendations was on public transport on the basis that car ownership among the elderly is low so the elderly depend more than other age-groups on public transport. Interestingly, a National Council for the Aged study in 1986 found that 70% of the elderly in a surveyed rural area had never used their free travel pass. (3)

Housing

There were about twenty recommendations relating to housing. The main emphasis in housing policy for the elderly was to be on enabling elderly people to choose between adapting their homes or moving to accommodation more suited to their needs. Priority was to be given to improving the accommodation of the elderly lacking the basic amenities of an indoor toilet, hot and cold water and a bath or shower. A national survey of the housing conditions of the elderly was called for, as was an assessment of the need for both new housing and for housing repairs and adaptations. A comprehensive and flexible repairs and adaptations scheme for housing for the elderly and disabled was recommended. The role of voluntary housing organisations in meeting the housing needs of the elderly was to be expanded. Ways of enabling elderly people to make greater use of the financial asset that their home represents, in order to improve their housing conditions, were to be examined.

Main House Building and Improvement Schemes

(a) Local Authority housing for the elderly.
(b) Special Task Force on Housing Conditions for the Elderly.
(c) The House Improvement Grant for Disabled Persons Scheme. 1,740 grants in 1992.
(d) Essential Repairs Scheme. 2,100 grants in 1992.
(e) Improvement works in lieu of rehousing scheme.
(f) Voluntary housing capital assistance scheme.

The 1991 Local Authority housing need assessment indicated a need for 2,379 houses for the elderly of which 1,905 were single person households.

ESRI Survey 1993 - Results Relating to Housing, Safety, Transport

The survey has been carried out by Dr Tony Fahey of the ESRI for the National Council for the Elderly. It relates to a random sample of 1,000 people aged 65 or over. The results below are based on preliminary tables kindly provided by Dr Fahey.
Housing

Ninety per cent of respondents own or are purchasing their present accommodation.

Eighty-eight per cent of respondents have been living at their present address for more than 10 years and 77% for more than 20 years.

Seventy-seven per cent of households are two persons or less.

Seventy-six per cent of dwellings contain 3 or more bedrooms.

Eighty-four per cent consider their accommodation about the right size and just 11% consider it rather too big.

Ninety-three per cent are very or fairly satisfied with their accommodation.

Ninety-one per cent would not move house given the opportunity. Only 3% would or might move to a smaller house.

Ninety-one per cent of respondents can avail of a bath or shower compared to just 62% of households in 1984 where the household head was aged 65 or over. (4)

Ninety-four per cent can avail of an internal toilet compared to 69% in 1984. (4)

Eighty-one per cent can avail of a telephone compared to 24% in 1984. (4)

Ninety-five per cent have a dry, damp-free dwelling.

Forty-two per cent of respondents live in rural areas but only about 4% are very isolated.

Twelve per cent of dwellings are described as poor quality - small, cramped, old, in bad repair or in a bad location and less than £15,000 in value.

Safety in the Neighbourhood

Questions were asked on safety in the neighbourhood. The percentage considering it no problem at all and very much a problem are shown below for the different types of safety.

<table>
<thead>
<tr>
<th>Type of safety</th>
<th>Very much a problem</th>
<th>No problem at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burglary</td>
<td>7</td>
<td>55</td>
</tr>
<tr>
<td>Vandalism</td>
<td>4</td>
<td>61</td>
</tr>
<tr>
<td>Personal safety</td>
<td>2</td>
<td>70</td>
</tr>
<tr>
<td>Danger from traffic</td>
<td>8</td>
<td>64</td>
</tr>
</tbody>
</table>
Transport

Forty-nine per cent of respondents' households owned or had continuous use of a car. Of those who did not have use of a car only 13% would have liked one but could not afford it. The remainder did not want or need one or could not drive.

Thirty-six per cent of respondents used public transport for most of their journeys, 39% did not use it even though available and for 25% it was not available.

Eighty-three per cent were very or fairly satisfied with public transport.

Summary

The survey shows considerable improvement in the housing stock in recent years, good satisfaction with housing and public transport and surprisingly low levels of concern about safety. However, the answers of the respondents should not necessarily be taken at face value. For instance, only 11% consider their dwelling rather too big when, objectively, the dwellings are large relative to household size. Similarly, few express an interest in changing accommodation, but this may well reflect the lack of availability of suitable housing in the area or cost factors involved in any house change. In addition the overall data hide subsets where no doubt the picture is far more gloomy. The data will hopefully be comprehensively analysed in the coming months and years.

Conclusion

I hope I have not overwhelmed you with statistics but I feel the survey, at least on the surface, shows rapidly changing housing conditions for the elderly and interesting attitudes to which we should have regard in drawing up our list of priorities. I do not personally claim great expertise in this area and I look forward now to your discussions.

References


There was a strong consensus amongst workshop participants that the environment has a central role in maintaining and promoting health and well-being.

What is often forgotten, however, is that the environment and objects in it can be designed to help compensate for impairments (e.g., ramps versus steps) and to help enhance performance (e.g., elevators versus stairs). The latter two roles of the environment are of particular significance in helping to maintain ageing in place.

The supportive role of the environment was firstly examined in relation to the home and secondly in relation to the neighbourhood and the environment beyond the home.

The following are the main points which emerged from the discussion.

**Home as a Supportive Environment for Older People - Priorities for Action**

* There was general agreement that most older people prefer to remain in their own homes for as long as possible. This is often longer than people in their formal and informal support network think appropriate. It was recognised that the wishes of elderly people have to be respected in this regard.

* In view of the desire of older people to remain in their own homes, the issue of adapting housing to meet changing needs is of great importance. It was recognised that grants for home improvement play a key role in supporting ageing in place, but that these grants need to be expanded.

* The role of a range of technologies, devices, consumer products, etc. in supporting independent living was recognised. However, it was felt that there is a lack of information on what products are available and where and how they may be obtained.

* There was a general agreement that there is an urgent need for a number of innovative financial schemes which would allow older people who own their homes to realise part of this asset in their lifetime.

* The issue of emotional attachment to home and neighbourhood was considered important to all members of society and to older people in particular. It was felt that older people who have to leave their own homes for sheltered or nursing home accommodation should have the option of bringing with them items of furniture, ornaments, etc. and be generally encouraged to personalise their new environment.

* In situations where remaining at home is no longer possible or desired, a range of alternative living arrangements should be provided to suit the
Supportive Neighbourhoods and Environments - Priorities for Action

It was recognised that the neighbourhood is an important context for fulfilling a range of day-to-day needs (e.g. shopping, meeting people, accessing health, economic and social services, etc.) and has an important role to play in helping older people remain independent. The following recommendations were made.

* It was felt that the following services play a key role in maintaining the health and well-being of older people. Innovative approaches to providing these services in the context of a variety of housing arrangements need to be considered. The following comments were made in relation to services.

  - **Home Help:** payment to home help workers is inadequate and needs to be increased; more training opportunities for home help workers need to be provided.
  - **Day Centres:** day centres can play a major role in supporting the physical, social and recreational needs of older people living in the community; accessible and suitable premises need to be provided for such facilities.
  - **Social Work Service:** there is a need to provide social work services for all older people who wish to avail of them.
  - **Warden Service:** given the fears regarding security which a number of older people experience, it was recommended that a live-in warden service be provided in sheltered housing schemes where possible; clarification of the role of warden was also required.
  - **Personal Alert Systems (PAS):** it was felt that PAS/alarms should be provided to all older people who wish to avail of them.

* Many of the existing facilities for institutionalised psychogeriatric persons were considered inadequate and non-therapeutic. There is a need to upgrade existing environments and to provide a greater variety of housing/service options to meet different client needs (e.g. small groups of clients living in houses in the community).

* It was felt that older people and their carers should have an active input into the design and planning of housing and environments to ensure that such environments are responsive to their needs. Mechanisms need to be developed to incorporate user input into environmental design and planning (e.g. formulation of user briefs) and architects and planners educated to make optimum use of user input.

Supportive Neighbourhoods and Environments - Priorities for Action

It was recognised that the neighbourhood is an important context for fulfilling a range of day-to-day needs (e.g. shopping, meeting people, accessing health, economic and social services, etc.) and has an important role to play in helping older people remain independent. The following recommendations were made.

* It was generally agreed that land use planning which involves rigid separation of land uses, results in unsafe environments and problems in accessing facilities, particularly for those who do not have access to private transport. Mixed land use in residential areas was recommended as better serving the needs of all age-groups and helping to ensure environmental safety.
Use of the environment by older people would be facilitated by:
- The provision of seating along frequently traversed routes, i.e. on the way to shops, church, etc.
- The availability of mobile Personal Alert Systems which would allow the older person to summon help in an emergency when outside their home range.
- Regular maintenance of footpaths to ensure safety of pedestrians.
- Incorporation of the requirements of older people into the design and management of roads, intersections, footpaths, traffic lights, etc. which would help maintain mobility as pedestrians and drivers.
- The availability of accessible and reliable public transport which plays an important role in supporting independence in the environment - this is of particular significance in rural areas where the lack of public transport is often a precursor to institutionalisation.

In some rural areas it is difficult to deliver health and social services to older people due to the poor condition of side roads leading to housing. In such cases road improvement works are a precondition for efficient service delivery.

It was felt that Community Alert and Neighbourhood Watch schemes were of value in promoting physical and psychological security and that these should continue to be supported.
1. Introduction

To start with a neat example of the challenge that we are facing:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Telegrams</th>
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<tbody>
<tr>
<td>1953</td>
<td>251</td>
</tr>
<tr>
<td>1991</td>
<td>4,300</td>
</tr>
<tr>
<td>2000</td>
<td>50,000</td>
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These figures represent the numbers of telegrams sent in the UK by the Queen to those who reach the age of 100. It is predicted that by the year 2000, in just seven years time, the monarch will be sending 50,000 telegrams.

People are living longer than ever before; our challenge is to ensure that *longer* lives are *healthier* lives - that we add life to the years which are added to life.

Below are the top 20 oldest countries in the world, and it is befitting to put the issue in a world context on the eve of the *International Day for the Elderly*. But, staggeringly, of the top 20 the first 18 countries are European. Ireland, the only EC Member State which is not on this list, nevertheless faces many of the same challenges as the rest of Europe in terms of the *ageing* of its population.
The World's Oldest Countries: 1991
Percentage of population aged 60 and over

Sweden: 22.8%
Norway: 20.9%
Belgium: 20.8%
Italy: 20.8%
United Kingdom: 20.7%
Germany: 20.6%
Austria: 20.5%
Greece: 20.5%
Denmark: 20.4%
Switzerland: 19.7%
France: 19.4%
Luxembourg: 19.3%
Bulgaria: 19.2%
Hungary: 19.1%
Spain: 19.0%
Finland: 18.7%
Portugal: 18.5%
Netherlands: 17.6%
Japan: 17.2%
United States: 16.9%

Source: US Department of Commerce
I would like to set the discussion in a European and, specifically, an EC context and provide a broader framework for some of the issues we have been discussing today.

### Ageing Well

1. The current European context
2. The EC Action Plan on Healthy Ageing
3. The way forward - an EC health policy for older people

### 2. The European Context

Any discussion on the health of older people starts with two basic assumptions (among many others, of course):

(i) Good health in later life is a key factor in promoting individual well-being and personal growth. An improvement in the health of the older population is essential to enable older people to contribute socially and economically. Both maximising the contribution that older people can make and minimising calls on health services could help to offset the escalating costs associated with an ageing population. The attitude of society towards older people is a major factor in the maintenance of psychological and physical good health.

(ii) A broad range of policies have implications for the health of older people. These include suitable housing, public transport, nutrition, consumer protection, policies on income, energy, the environment.

With regard to the demographic challenge, Europe has the highest proportion of older people in the world. There are 100 million older people (50+) in the EC today. Declining mortality rates in the very young and older populations have led to an unprecedented increase in life expectancy. The total population of Europe will increase between 1970 and 2000 by 17.5%; the number of people aged over 60 will increase in the same time by 30.7% and those over 80 by 62.4%.

Older people are not only a significant proportion of the EC population in terms of numbers, but also as consumers of health products and services. Increases in medical costs (put at 0.5% per annum in France) and in consumption of prescription pharmaceuticals are directly related to increases in the number of older people (new drugs for elderly people accounted for 96% of the increase in consumption of prescribed medicines in the UK between 1980 and 1990).

There is no doubt that this is a European challenge, a challenge common to all Member States and a challenge which demands a European as well as a national response.
What has been the European Community response so far? With regard to the emergence of an EC policy on ageing, little EC legislation specifically addresses the needs of older citizens; the EC focus has been on economic issues, excluding those citizens outside the workplace.

**EC Policy on Ageing: Milestones**

- 1984 First EC budget line for elderly people
- 1984 EEC Directive on equal treatment for men and women in social security schemes
- 1989 EC recommendations for European Seniors Pass
- 1990 Communication on Ageing
- 1991 EC Programme for Older People
- 1993 European Year of Older People and Solidarity between Generations

However, there have been a number of key developments over the past ten years. Most notable is the European Year of Older People, which this has played an important role in raising awareness at both national and European level on issues affecting older people. It has influenced the thinking of European politicians and policy makers alike. But what of specific measures affecting the health of older people? There have been no direct measures, indeed, no co-ordinated health policy as yet. However, a wide range of EC policies have been developed which do have implications for the health of older people.

### 2.1 EC Legal Framework

*The Treaty of Rome*

The original Treaty of Rome of 1956 did not mention health although Article 177 states that Member States agreed upon the need to promote improved working conditions and improved standard of living for workers. Article 118 gives competence for close co-operation between Member States in the social field, particularly in matters relating to prevention of occupational accidents and diseases; occupational hygiene.
The Euratom Treaty
The Euratom Treaty, signed at the same time as the Treaty of Rome, does contain articles relating to the health of workers in the atomic energy industry and to the general public in relation to radiation.

The European Coal and Steel Community
The European Coal and Steel Community (1951) has also provided a legal base for work related to the health and safety of workers.

The Single European Act
The Single European Act of 1986 strengthens the Treaty of Rome and provides for a high level of protection concerning health, safety, environmental protection and consumer protection.

Most recently, the Treaty on European Union (Maastricht) will give a new and direct EC competence in the health field and lay the foundation for an EC policy on health. This will be discussed towards the end of the paper.

Within the scope up to now, nevertheless, the Community has so far undertaken a wide variety of actions in the health field. The lack of specific competence has resulted in a fragmentary approach. This in turn has had the result, for instance, that EC action to discourage smoking on the one hand (including campaigns against cancer) is more than offset by subsidies to EC tobacco growers on the other. But, even so, a wide range of legislation and initiatives have emerged of relevance to the health of older people.

2.2 EC Legislation and Programmes in the Field of Health with Implications for Older People

1. Health care products: pharmaceutical policy - as part of the single market legislation - is aiming towards the free movement of goods and a single market in pharmaceutical products. Older people are the largest consumer group for pharmaceuticals.

   - There is difficulty in obtaining medicines, whether over the counter (OTC) or on prescription when moving within the EC (due to availability or different pricing policies).

   - There are adverse reactions from a combination of drugs.

   - There is overconsumption or inappropriate consumption of medicinal products.

2. Research programmes to date have included:

   - biomedical research,
   - technological research,
   - health resources,
   - drug research,
   - nutritional research.
There is a need for an orientation of all such research towards the health of older people.

3. Health professionals

- Freedom of movement of services and people in the light of widespread shortages of doctors in the field of geriatrics.

4. Health care services

- Access to insurance and health care should be a right of all EC citizens (at the moment only entitled to emergency care).
- Single market for health care.

2.3 A wide range of other policies affect the health of older people as outlined in the figure below.

<table>
<thead>
<tr>
<th>EC Social and Related Policies with a Health Impact for Older People</th>
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<tbody>
<tr>
<td>1 EC Programme for Older People (1991-93)</td>
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<tr>
<td>2 Disability - Helios programme</td>
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<tr>
<td>3 Employment policy - health and safety at work</td>
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<td>4 Anti-poverty programmes</td>
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<td>5 Housing</td>
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<td>6 Transport</td>
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<td>7 Environment policy</td>
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<td>8 Consumer policy</td>
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3. EC Action Plan on Healthy Ageing

Eurolink Age is an EC pressure group founded in 1982, which works with partners in all the EC Member States (in Ireland the National Council for the Elderly is our Council Member). Eurolink Age aims to influence EC policy makers and politicians working with all the EC institutions: the Commission, the European Parliament, etc. It monitors EC policies affecting older people and their implications, and seeks to promote and develop these on the EC political agenda.

Eurolink Age's Ageing Well programme is an initiative to propose a framework for EC policy. The Ageing Well conference which took place in November 1992 was attended by 200 delegates, representing all EC Member States and all partners. The aim of the conference was to develop an EC action plan on healthy ageing and locate responsibility in each Member State for the different points.

Healthy ageing is the shared responsibility of individuals, non-governmental and voluntary organisations, health professionals, academics and researchers, health service institutions, industry, the media, and of governments at local, national and international levels.

Five core areas have been identified, based on the WHO Ottawa Charter framework.
The Action Plan is targeted at EC Member States, the EC, the Council of Europe, the WHO and aims to stimulate debate and provide a framework for action. It also aims to highlight and reinforce existing policies and programmes.

Specific progress has been made in this regard in different countries.

In Ireland this conference here today is debating the relevance of these priorities in a national context. France has set up a programme, with a core working group of conference delegates and other colleagues. In Greece the EC Action Plan has been circulated to all members of the Gerontology Association. In Britain, Government and commercial funding has been obtained for a network of pilot projects promoting senior health mentoring or peer health counselling, where trained older volunteers act as health mentors. The Netherlands has set up similar projects and Luxembourg is running a small project on accident prevention.

So, different countries have made different responses, but at European level Eurolink Age has also taken these priorities:

(i) Public policy - to influence EC policy using a campaign framework, helping to ensure consideration of ageing as a core to future development of health policy: We have been working to promote these issues to the European Commission and to members of the European Parliament. In October 1993 we were involved in a joint meeting between the Intergroup on Ageing and Intergroup on Health.

(ii) Information and networking: We have sought to keep the issue alive through facilitating contact and exchange at European level and two follow up meetings to the Ageing Well Conference.

(iii) Self-help and community action: Eurolink Age has established a European programme, the aim of which is to identify projects across Europe, exchange experience between countries and promote the idea of twinning and tripling of projects in this field.
4. An EC health policy for older people?

The way forward

Article 129 of the European Treaty on Political Union (the Maastricht Treaty) gives the Community new competence in public health. For the first time the Community will gain competence in three specific areas, each of which provides distinct possibilities to consider health issues affecting older people:

- disease prevention and research,
- health information and education,
- making health protection requirements a constituent part of the Community's other policies.

There is ample evidence of what constitutes threats to the health of all older people: what have been referred to as the geriatric giants of immobility, instability, incontinence and intellectual impairment. These are often the result of disabling diseases such as cardiovascular and cerebrovascular diseases, arthritis, osteoporosis, Alzheimer's and other mental diseases, particularly depression.

There is as yet no precise definition of major health scourge as mentioned in the new Treaty, but cardiovascular disease is generally taken to be covered. If the EC is to improve the living and working conditions of all its citizens, it is important that its policies address the major scourges affecting all segments of the population, including older people. This means focusing on diseases affecting morbidity as well as mortality. Because mortality data are more readily available, there is a tendency to underestimate the importance of diseases that, while not leading to a rapid end to life, severely impair the quality of the remaining life of their victims, a large majority of whom are older people.

There is a clear role for the EC in the stimulation and co-ordination of research into accident and disease prevention, health information and education, and in the collection and dissemination of materials on good practice. Eurolink Age believes that a multi-year campaign, Europe for Healthy Ageing, should be implemented to promote health education and disease prevention for older people. The EC could take a lead by supporting the development of grass roots health education programmes, such as Health Mentor schemes, whereby senior volunteers are trained to act as peer health counsellors.

Eurolink Age is continuously lobbying both the European Commission and the European Parliament to encourage consideration of these issues. Work like this conference can help to raise awareness of the importance of these issues in a national context and of the importance of the European dimension.

The European Year is now coming to an end; it has played a central role in promoting issues of ageing at EC level. It is important that this momentum is not lost, that we see an immediate follow up to the first EC programme for older people:

- It is hoped that the Commission will publish proposals early next year before the next Parliament.
A bigger, more extensive and real action plan is needed that will take the EC up to the end of the century and 1999, now nominated the *International Year of Older People*.

This should contain four key elements:

- research,
- pilot projects,
- evaluation,
- consultation.

Finally, issues of ageing are of central importance to all EC Member States, both socially and economically. There is now recognition at EC level of this fact. We believe, however, that there is now scope and that the time is ripe for the EC to move towards a more co-ordinated approach to healthy ageing. Even if there are variations of culture, lifestyle, nutrition and economic development, and health education must be appropriately designed and targeted at regional or local level, the challenges are common to Member States.

Older people have a *right* to be impatient to see a co-ordinated health policy developed at EC level - it is in the interests of us all, now and in our futures.

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**Author's note**

Since the conference there have been the following developments:

(i) The Treaty on European Union has now been fully ratified and has entered into force.

(ii) The European Council of Ministers has agreed a *Declaration of Principles to mark the end of the European Year of Older People and Solidarity between Generations (1993)* which mentions preventive health measures as an area for future collaboration.

(iii) The Commissioner for Social Affairs, Mr. P. Flynn, has announced his intention to publish proposals for a future action programme for older people. It is hoped this will start some time in 1995.

Karen Chapman
21 January, 1994

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I am very pleased to have this opportunity to address your conference today, International Day for the Elderly.

This is a day that should be marked. It is the high-point of 1993 - European Year of Older People and Solidarity between Generations. Throughout the world governments and leaders at all levels are today publicly renewing their commitment to respect, to protect and to cherish the older generation.

Throughout Europe, given the European Year, the initiative is very much with older people themselves on this day; most of the major events that are taking place are being managed by older people's own organisations across the Community and beyond, from Graz (in Austria) to Dublin and from Copenhagen to Lisbon.

But first let me go back, for a moment, to what I said at the launch of European Year 1993, in Brussels, in January of this year. Many of you were present on that occasion.

I said that the New Europe must be a good place in which to grow old. If it is not, then we who are responsible for the shaping of this Europe will have failed. We will have failed not just the older generations, but all generations. For living is ageing - and the society that does not age well can hardly be said to live well.

Since the launch of the European Year last January, the response has been overwhelming. Taking the superficial measure of quantity, at the last count, the number of activities being organised across the Community to mark the European Year was approaching five thousand.

At a more qualitative level, reading the list of topics covered by these activities shows that elderly issues and politics have come a long way; pensions and services feature strongly, as would be expected, but great concern has also been evident about the needs of, for example, the older consumer, the older motorist, the ageing migrant, the often negative portrayal of older people in the media.

More heartening still has been the response by the various partners. The European Year has been carried forward, not by official bodies and bureaucrats, but by older people themselves, their organisations and the agencies at a local and national level. These are the organisations that are primarily responsible for the well-being of older people.

Let me say that we can all be very proud, and I am particularly proud, of Ireland's response to the call to work together to make 1993 truly special. Comparisons can be odious so I am not going to make any. But just as in any movement there are leaders and there are followers, let me say that, in the organisation and management of events for this European Year, Ireland has been amongst the leaders. Great credit is due to everyone responsible. Especially to the Ministers for Health and Social Welfare for creating and funding the European Year office in Dublin, to
Catherine Rose and her team for their boundless energy, and especially the older generation for its commitment and very active participation in making it all happen.

However, declaring a special European Year will not of itself make Europe or Ireland a good place in which to grow old. No matter how good the take-up or how great the enthusiasm, 1993 has been acclaimed - universally, I think - as the right gesture, the right signal to give. But is that all that it is to be, merely a gesture, a monument to the goodwill and energy of hundreds of thousands of people? Or will 1993 be the beginning of a movement that will carry on into years to come?

As the year enters its last quarter, and while we are awaiting the results of the independent evaluation that is under way, it is important that we keep the flame burning and benefit from the views of all the main players on where we should go from here.

The key questions at this stage concern the scope and nature of any further programme and the issues which should be addressed as priorities.

The European Year had the widest scope possible, as befitted a first, somewhat experimental step. No topic was excluded if it related in any way to the lives of older citizens. The result, as you have seen, is an increased consciousness of the ageing component across a very wide range of policy areas.

My personal view is that, for the next phase, we should target a relatively small number of priority areas. Areas that can realistically expect to go beyond the awareness-raising stage and actually bring about measurable change. Change that will make a difference.

What should these priority areas be? The potential list is long and we would need to choose with considerable care. At Community level, we should take only those measures which are most effective at that (EC) level; this is the gist of the oft-mentioned principle of subsidiarity. Amongst the priorities emerging strongly from the first phase of our work is, for example, the situation of older workers. This is giving rise to concern in all Member States; investment in skills maintenance is necessary, yet the more usual course is redundancy or early retirement. And, if you think that older workers have difficulties you should talk to some older, unemployed job-seekers.

We have already taken a step at European level this year by launching a transnational network in the field of older people in training and education generally. One can learn - and teach - at any age.

Another area that would be appropriate to the next phase of activity at EC level - and one that is, I think, of particular interest to you here today - is health and health promotion. Ratification of the Maastricht Treaty will open up new possibilities for co-ordinated action across the Community to protect and promote citizens' health. I emphasise the terms protect and promote since the emphasis, at EC level, will clearly have to be on disease prevention and not on medicine, treatment or provision of services.

What can we say about the health needs of elderly people? It is sometimes assumed that by the time we reach the age of 60 our previous bad habits, together with our genetic make-up, dictate the state of our health. There is the notion that
eating a better diet or taking exercise will not improve the length or quality of our life. But this is not true; there is now evidence that older people stand to benefit substantially from preventive measures, many of the measures that are identical to those that have been shown to be of value in younger age-groups. I believe that this fact represents a challenge to politicians which is relevant to the older generation in new and positive ways.

Our aim must be not only to prevent illness and disability, but also to improve the quality of life for those who, despite our efforts, unfortunately do suffer from ill health. Elderly people in retirement can do much to improve their own health. It is only too easy to eat the wrong things, to become overweight, to eat too much fat and too little fibre, and not to take enough exercise, justifying this by pretending that it will no longer make much difference. The key message which we should try to get across is that the effects of this unhealthy behaviour will be as bad for elderly people as it is for younger people.

Some elderly people are also more prone to accidents. A study in the UK has shown that 84 out of every 100 people over 65 suffer from some form of accident, often a fall at home. These accidents, even minor ones, often result in long-term problems, limiting mobility and consequently influencing quality of life and independence.

There are also less tangible risks to health and quality of life. Things like keeping people mentally aware and mentally alive. Continued participation in physical, mental and social activity maintains the integration of older people in the mainstream of life and helps to avoid the psychologically damaging effects of isolation and apathy.

And so I come back to the key question: will the new Europe be a good place in which to grow old? The answer, I know, is Yes, if - if that is what we want and if we refuse to settle for less. I will very much welcome your views on the themes that you believe should be central to our next European Programme. I will conclude with an old Irish saying 'Ni neart go cur le cheile', which with some poetic licence I will loosely translate as 'together we can be strong'.

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On this International Day for the Elderly we woke to news of the earthquake tragedy in India. The pictures remind us of the many - and the rapidly growing numbers of - older people in the so-called developing countries. In addition to poverty and poor living conditions many of these older people suffer from preventable and remediable conditions of eyes, feet, infectious disease and inadequate nutrition. Measures to promote the health and autonomy of older people are not about luxury additions, but about basic and essential opportunities to improve health by paying attention to the factors or conditions which contribute to undermining good health and quality of life.

This paper will be research-based and will return to the regions of the European Community and North America which have probably more immediate implications for developments in Ireland. Following an overview of the health situation of older people in the EC, there will be a brief review of initiatives to promote the health of older people and of their family carers. The paper concludes by identifying some areas for future action.

The Health of Older People

A link between advancing age and lessening good health is relatively well established, but the vast majority of older people should be considered as relatively fit and able to care for themselves. The EC Observatory report estimates that less than 10% of over-65s are frail to the extent that they require long-term care and other regular support. The ill health of older people often gives rise to multiple needs, especially with the chronic conditions of cardiovascular disease, arthritis and respiratory diseases. These may be accompanied by less serious disorders of sight and hearing, which nevertheless disrupt everyday life.

A UK survey reported an average of 3.5 serious conditions for elderly people living outside hospitals and 6.0 for those in hospital; the report for Germany to the EC Observatory pointed to a survey of hospital in-patients in which those aged 55-64 had an average of two chronic illnesses, but this figure rose to three among patients aged 85 and over.

Although the life expectancy of women is greater, they tend at all ages to report higher numbers of illnesses and higher levels of disability. Life expectancy at birth has increased throughout this century for both men and women, so that, in 1989, women in the EC were living to an average of 79.2 years and men to 72.8 years. This gender inequality was weakest in Greece (5.0) and strongest in France (8.2). The difference declines with increasing age, so that, for example, it is a little over three years at the age of 60 and between two and three years at the age of 75. A World Health Organisation (WHO) expert group has suggested that this sex difference is largely a consequence of behavioural differences (presumably with men being more reckless, violent, drinking heavily and so on); but they argue that
behavioural differences aside, there are biological and environmental reasons to believe that women will continue to live longer than men.

The issues of disability and dependency are at the centre of the policy debate about meeting the needs of older people. The UK report to the EC Observatory shows how the prevalence of severe incapacity increases rapidly after the age of 70, and it appears that very severe disability is, among those aged 75 and over, more than three times as likely among women as among men of the same age. The numbers of older people who are actually bedridden at home are small, probably not more than 3% of those aged 70 and over, but again this may affect substantially more women than men.

In general, the research done in countries of Central and Northern Europe (the former West Germany, Belgium, France, Ireland, UK) indicates that a majority of those aged 75 and over (50-60%) have no significant incapacity and could be considered as independent. Among people aged 80 and over, independence falls below 50%; the report of the Observatory estimates that in this age-group every third person now needs some assistance with daily care.

Many professionals have an exaggerated and over-pessimistic view of age-associated changes in mental capacity. The majority of elderly people are not suffering from mental illnesses and are in good health. However, one condition - senile dementia - appears to be of growing prevalence, and is associated with increasing life expectancy. There is, at present, no treatment that is regarded as effective for this disease. However, the diagnosis, treatment and monitoring of other mental health conditions may be beneficial and there is a need to be cautious about unwarranted inaction, resigned to an association between ageing and mental deterioration.

The extension of life expectancy may be regarded as a double-edged sword, considering the links between advanced age and dependency and isolation. In WHO terms there is a need to consider improvements in life to years and health to life as well as years to life. Some believe that the majority of older people are fitter, more active and healthier than previous generations. A study in the Paris region found that the proportion of older people unable to lead a normal life had fallen from 50% to 29% in 15 years, as a result of a decline in the numbers suffering from serious disabilities. Other studies in Belgium, Italy, The Netherlands and Ireland similarly indicate that the health of the older population is improving.

**Promoting Health**

The debates continue about the contribution of health services to lengthening life expectancy or to improving health in old age, compared to the role of healthier lifestyles and improved economic conditions for older people. Several studies indicate high levels of positive health behaviour among older people. Recent data from Canada, for example, show that the health and preventive practices of older citizens are generally equal to or better than those of younger people. Those aged 65 and over were less likely to smoke or drink alcohol to excess - although lower income may be a factor in this. However, the proportions using sleeping pills and tranquillisers increased strikingly with age, especially among women. Increasing attention is being paid world-wide to the potential for health promotion among
older people, even if this is still poorly developed in the primary care services of nearly all EC countries.

Screening and early disease detection have become more targeted over the last two decades as researchers have sought to evaluate what is worthy of attention. Recommendations by various bodies emphasise the value of checking hearing and vision, providing foot care, and attending to problems such as depression and incontinence. Older people have been exposed to these initiatives by professionals and service providers, and have participated in a growing movement in self-care and self-help.

Alongside this growth of individual initiatives and those sponsored by the voluntary sector, there are several countries, e.g. Australia, Canada and the United States, with relatively well-defined national health promotion policies, including specific elements to support health improvement among older people. In the United States the potential for action among older adults was stimulated by the Report of the Surgeon General (1979), which included a chapter on Health Promotion for older people. Priorities were developed based upon knowledge or assumptions about the epidemiology of health problems, concentrating upon the issues of smoking, alcohol use, nutrition, stress, safety and accident prevention. There was a preference for projects to be grounded in knowledge of the epidemiology of health (illness) in local areas, and for local people to be closely involved in the identification and achievement of local priorities. This emphasis on community-based activity was carried forward into the development of initiatives specifically for older people. The National Health Promotion Initiative for Older People focused upon four areas of particular importance to older people within the general framework of health promotion: fitness and exercise; nutrition; accident and injury control; and improved use of medicines.

During the 1980s a relatively large number of community-based health promotion programmes became well established in the United States and in Europe. The diversity of programmes is so great, a statement is needed about what the programmes have in common - they are all intended to increase the control older people have over their health (through increased awareness, social support or the availability of services) and to offer opportunities to people to improve their health. It is perhaps notable how many go beyond concern with risk factors for specific diseases (the prevention of which does raise many doubts about effectiveness); and how many go beyond medical interventions as a means of improving health.

Promoting the Health of Family Carers

Promoting the health of carers has been discussed as a fourth level of prevention - preventing disease in, or breakdown of, the primary carer by responding to or avoiding the predictable sequelae of becoming a carer. The needs of carers for advice, help and support are not a mystery; many, not only the carers but their professional supporters, understand what needs to be done. Studies of family carers point to a set of needs which are rather similar for people even in quite different circumstances. In practice carers are looking firstly for recognition that they are doing a difficult job, not that they should be rewarded, but that they should be acknowledged and asked how they feel and what their needs and preferences are. And it is important that this is done on a continuing basis, as the needs of carer and dependent person change over time. Secondly, many carers
need a break, a period of genuine respite from the tasks and responsibilities of caring. Thirdly, a majority of carers are not well informed about the information and services which are available. All too often it appears that these needs come close to recognition and action only in circumstances of crisis or breakdown. Yet services need to be available systematically and consistently over time if they are to consider the carer’s health and quality of life; and not only the threat of having to make alternative institutional arrangements.

There are substantial examples across Northern Europe and North America of initiatives to maintain the health of carers, and also consequently the health of the dependent elderly relative. These include the development of mutual aid and carers’ support groups, distribution of information packages, and organisation of respite care. Such actions are diverse, but it may be helpful to consider the Ottawa Charter as offering a helpful framework: healthy public policy (e.g., income or tax policies, transport); supportive environments (e.g., housing for disabled, workplace elder care policies); community action (e.g., self-help groups, community development); personal skills (e.g., training in personal care, coping with emotional consequences of chronic illness); and health services (orientated to communication, co-ordination and continuity of care).

**Conclusion**

The action of the Ottawa Charter underlines the significant contribution that many sectors and groups can make to health promotion. However, identification of opportunities alone will not lead to effective initiatives any more than urging the need for comprehensive and integrated approaches has led to co-ordinated action. Planning and allocation of responsibility should be part of a more systematic, structured and strategic approach to realising the potential for health promotion, specifically in the older population. There is a growing base of information on what is being done, albeit scattered across an international field. However, there appear to be relatively few training programmes for either health or social services professionals which incorporate modules on health promotion for older people.

Some of the apparent lack of commitment in this field may be ascribed to generalised feelings that little can be done for older people. Attitudes to older people and to ageing tend to the negative, with old age viewed as a period separate from productive life, associated with loss and decline, decreased social worth and failing health. Not only are options for health narrowed in the eyes of professionals, but the cultural prevalence of this image diminishes the expectations older people have for themselves. This attitude is being challenged during this European Year of Older People and Solidarity between Generations, but the momentum must be maintained. New opportunities for health promotion are opening up, in part through initiatives and networks established in this European Year, but importantly through the potential afforded by the European Union’s new competence in public health matters. The Maastricht Treaty Article 129 emphasises the promotion of health education and information. The focus is upon disease prevention and the combating of major health problems, specifically those such as arthritis and mental illness with a high impact on the quality of life. Health promotion for older people should be high on this agenda for action.
Our purpose today is to endeavour to identify strategies which may be applied in respect of those who are already elderly to help support ageing as a positive phenomenon, to improve the quality of life of the older members of our society. Age discrimination with compulsory retirement at 65 is a feature of many occupations and professions, but only 46% of the labour force is covered by occupational pension schemes, so for many individuals there is a very considerable drop in income on retirement. It is well recognised that the lower the income the poorer the functional capacity and the lower the socio-economic status the greater the morbidity and probably the greater the eventual dependence on carers whether family, society or social services.

This loss of independence may be minimised to some extent by appropriate housing and environmental supports. Recent surveys of rural medical card holders have demonstrated that many older people lack the basic household amenities and are highly dependent on state pensions or allowances. A significant number had high levels of illness, serious mobility problems and long distances to travel to shops and other amenities.

According to public health nursing records physical dependency was less than 33% of a sample of over-75s in the west of Ireland, but social dependency was of the order of 50%, mainly owing to living alone. The public health nurses and community welfare officers carry a very heavy workload, but are not sufficient in number to cope with the increasing demands of their clients. There is no central co-ordination of information on the living conditions of older people, particularly in relation to housing, which may be a key factor in determining their degree of independence. It should be possible to prolong independence by enabling an individual to make informed choices regarding housing options, by making an assessment of an older person's needs and capabilities and by providing information on, and assistance with, possible aids and adaptations to housing. Where this is not possible sheltered housing or residential accommodation with space for personal furniture and possessions should be available.

In Ireland although we have smaller absolute numbers of ageing people there is a high level of unmarried senior citizens. There are also high levels of social support owing to large families and a traditionally low number of women in the workforce. This is changing, but there are currently many individuals, predominantly of lower socio-economic status, caring for elderly relatives, 29% being children of an older person and 29% the children-in-law.

Many of these older dependent persons cared for at home are females over the age of 80 with many health problems or are part of the 10% of the population over 65 who have significant mental impairment commonly owing to atherosclerosis, stroke or Alzheimer's disease and some may be terminally ill with cancer etc.
The carers have sacrificed financial gain from employment and therefore, it could be argued, are entitled to financial recompense, or at least to information regarding the professional, voluntary and respite services which are available to provide assistance. It has been shown that the carers, many of whom are themselves older people, are unaware of, and therefore under-utilise, available services. A successful social policy which supports informal carers must be flexible, sensitive and provide alternatives.

We should endeavour as far as possible to address the health needs of our older citizens under three main headings:

1. **Health promotion**: to prevent disease and disability and encourage good mental and social function, i.e. find a means to communicate the need for behavioural change, market this within society and provide an organisational framework to continue the spread of information, fostering public participation, strengthening community health services and co-ordinating public policy.

2. **Case finding or anticipatory care**: this could easily be performed by general practitioners at routine check-ups. There should be a careful assessment of needs and good rehabilitation available. Many problems encountered by older people, such as undernutrition, impaired hearing, minor falls and osteoporosis, are easily remedied.

3. **Appropriate and timely intervention for the acutely ill to avoid loss of personal autonomy**. The health service should be client directed, user friendly and geared to the individual. There has been no systematic and significant input as regards their needs on the part of older people themselves and no statement of patients' rights within the community in the form of a patients' charter as in the hospital sector.

We have a conventional organisation of the health services by programme. Improved community surveillance, taking account of socio-demographic health status and health requirements, supported by an organisational structure that can ensure effective service delivery would seem necessary at community care level. Older people, the voluntary sector, carers and GPs, as well as the statutory agencies, should be involved in the planning in order to develop client-orientated services.

Unfortunately at present just as we have no co-ordinated national data on housing we also need research into the nutritional status of the elderly, morbidity trends and needs assessment. Given appropriate funding and resources general practitioners, in association with the health boards, would be in the best position to provide this information. Such research would supply the requisite information to plan an effective health policy on a health board, regional and national basis enabling policy decisions and mission statements to be formulated.

So far I have addressed the needs of the dependent older person, but a very large number of older citizens are fit, well and capable of self-care and complete autonomy. They are entitled to and should be facilitated in their personal development by continuing employment opportunities and adult education programmes specifically geared to the older person, whether on self-care, academic programmes, nutrition, home improvement, assertiveness or hobbies. They should
be assisted in maintaining their independence, protected from the fear of personal violence at home or in the streets and supported by health and social services as far as possible.

So, to summarise the main concerns about the already elderly: are they receiving adequate nutrition? Are they suitably housed? Is health maintenance being addressed and is the delivery and organisation of services appropriate to their needs? Can we counter age discrimination in the workplace, in education and in society as a whole and how can we develop and maintain information sources on all these aspects?
The focus of the workshop was to identify strategies which may be applied in respect of those who are already elderly to help support ageing as a positive phenomenon and to improve the quality of life of the older members of our society.

Our speaker, Dr Eileen Caulfield, identified a number of key factors in her presentation and these were taken up in the ensuing discussion.

The areas addressed were:

1. Housing
2. Carers of the Elderly
3. Education/Research
4. Co-ordination

1. Housing

With regard to housing, recent surveys of rural medical card holders revealed that many of the older people surveyed lacked even basic household amenities such as running water, toilets and bathrooms. Appropriate housing and environmental supports are essential and would minimise the loss of independence among the elderly. The present at risk register was not considered sufficient to identify the elderly and an age/sex register should be compiled in each area.

The need for sheltered housing was also acknowledged and housing which catered for various disabilities. Specific reference was made to a project in Holland, where houses were built in courtyard style to cater for elderly people with problems regarding mental capabilities. There they could live in a sheltered environment having complete autonomy and control over their own living circumstances. The present welfare homes in Ireland were not considered particularly suited to those with dementia and the EMI homes in Northern Ireland were noted as a good model.

2. Carers of the Elderly

A lot of discussion centred around the carers of the elderly. The contribution of informal carers was noted. Many have sacrificed financial gain from employment and it could be argued that they are entitled to some financial support from the State. It was recognised overall that home helps do tremendous work; they are undervalued and underpaid. One public health nurse said it was embarrassing for her to offer a paltry sum of £2 per hour to a home help. The role of the public health nurse as carer was also highlighted. Public health nurses, while largely working at a curative level, have a large contribution to make to health promotion. In recent years their workload has increased enormously; there are too few public
health nurses on the ground, they have additional clerical work to carry out and, with early discharges from hospitals, more and more people are coming back into the community for care. Public health nurses also indicated that there is a lot of drug non-compliance among the elderly. Many elderly people are confused leaving hospital with huge prescriptions. With regard to long-stay and acute hospitals, the role of the primary nurse was acknowledged since she is the one to co-ordinate all aspects of the patient's care. Given that health promotion takes a more comprehensive and holistic approach to health, the pastoral care and spiritual well-being of the elderly was also noted. For many, church activities play a central role in their lives and pastoral programmes need to take account of this.

3. Education/Research

The need to have a model of education that is participatory and that promotes the autonomy of older people was reflected by workshop participants. The VEC employs adult education organisers in each county and these were considered key people in providing adult education for the already elderly. Courses such as stress management, assertiveness, healthy lifestyles and coping with loss could be specifically targeted at the elderly. If the elderly are empowered to take responsibility for their own health and if they are given some in-service training and support, they themselves could facilitate health education programmes for their peers. Health education and in-service training for health professionals was also identified as a priority. Public health nurses, home helps and other health professionals who care for the elderly need basic counselling skills, they need to be able to promote healthy lifestyles and also have ongoing support for themselves. Reference was made to GPs saying that they need to be informed of the various services in the community. It was also stated that since many GPs are already overworked GP facilitators should be employed.

A food scientist from Moorepark, who participated in this workshop, reported on research carried out to examine the nutritional status of older people. A nutrient-dense food for the elderly has been developed and is currently being piloted in the Eastern Health Board and funded by IRD, Duhallow, Cork.

4. Co-ordination

There was overall agreement that co-ordination on a formal basis is essential between statutory and voluntary bodies as too many groups are working in isolation. It was also noted that at least one health board in the country had no co-ordinator appointed for the elderly. It was announced that a directory on all elderly services in Ireland will be published shortly by Age Action Ireland.
MEDIUM-TERM STRATEGY - ADDING HEALTH TO LIFE:
PREPARING THE MIDDLE-AGED FOR AN ACTIVE, INDEPENDENT AND
HEALTHY OLD AGE

Mr Noel Usher

Introduction

In keeping with the World Health Organisation’s Health for All targets, health promotion policies aim to add life to years by enabling people remain healthy and active for as long as possible. They also aim to add health to life by reducing the incidence of preventable illness and accidents. Finally they aim to add years to life by increasing average life expectancy.

The focus of this workshop is Adding Health to Life. I hope to show how the Health Promotion Unit, in collaboration with other statutory and voluntary bodies, works towards achieving the WHO targets in relation to the needs of the middle-aged as they head into the later years of life.

Today’s Illnesses

Although more people are living longer today there are still high premature mortality and morbidity rates due to avoidable ill health. Coronary heart disease and stroke, together with cancer and road accidents, are major contributors to premature death and disability in Ireland.

Many of these conditions result from unhealthy lifestyles - smoking, excessive consumption of alcohol, not varying the diet and lack of exercise. The environment may affect the health of older people. For example, if houses are cold, draughty or damp this can lead to ill health. If social surroundings are unpleasant, with poor transport facilities or poor access to shops or friends, older people may suffer from isolation, loneliness or fear. The aim of an effective health promotion strategy is to maximise health potential at every stage and to add health to life. Early intervention is the key to effective outcomes.

Medium-term Strategies

Important medium-term strategies for preparing the middle-aged for an active, independent and healthy old age revolve around reducing the toll of physical illness, particularly heart disease, cancer, osteoporosis and also promoting good mental and social function.
Heart Disease

Coronary heart disease continues to be the leading cause of premature ill health and death in Ireland. In the 30-69 age-group, almost 3,000 deaths - one third of all deaths in that age-group - relate to coronary heart disease and stroke. While death rates have been showing a downward trend, particularly in the late 1980s, Ireland still has the fifth highest death rate from this cause in the 30-69 age-group. This effectively means that many people never see their later years at all or do so with a chronic disability. Health promotion interventions in middle age, and indeed earlier, aim to support and facilitate a lifestyle that reduces the risk of coronary heart disease - a lifestyle that involves not smoking, drinking in moderation, eating a balanced diet and taking regular exercise. Incidentally, this type of lifestyle, together with some additional precautions, also helps to reduce the risk of some cancers. Because we recognise the importance of healthy lifestyle habits the Health Promotion Unit has put in place a number of initiatives in this area.

Smoking is the largest single dimensional issue on which the Health Promotion Unit organises public education and health promotion programmes. These programmes form part of my Department's comprehensive anti-tobacco strategy, which also includes legislative and fiscal measures. The most recent piece of legislation, the Tobacco (Health Promotion and Protection) Act 1988, prohibits and restricts smoking in designated public places. Last year the Department sought to extend protection against smoking to workers generally by means of a Voluntary Code of Practice against Smoking in the Workplace. This Code has been widely disseminated by the Health Promotion Unit in a booklet entitled Clean Air at Work.

Earlier this year the Health Promotion Unit launched a major new multimedia anti-smoking campaign. Entitled I'm One Less, the Campaign seeks to enlist the aid of friends and peers of smokers in encouraging them to stop and so become one less smoker. A freephone operated during the first phase of the campaign and usage of it exceeded all expectations, with 75,000 calls received during the five-week period. A second phase of the campaign started on World No Tobacco Day, 31 May, and a third phase is planned for later in the year.

Most of the healthy lifestyle habits we seek to encourage are applicable across all age-groups - what differs in many cases is the most effective setting for delivering the message. For example, schools are an obvious setting for young people. For young adults and middle-aged people the workplace offers special advantages, particularly from the point of view of the amount of time spent there. For this reason the Health Promotion Unit has provided support for the Happy Heart at Work programme launched recently by the Irish Heart Foundation. The objective of this programme is to promote in the workplace the development of positive attitudes and behaviour towards healthy eating, smoking, exercise and stress control.

In addition to providing funding and general guidance for the Happy Heart at Work programme the Unit has been actively involved in developing the healthy eating component of Happy Heart at Work. The Healthy Eating Co-ordinators Guide was developed and pilot tested by the Unit. We will be actively involved in its implementation in the workplace by supporting catering assessments by dietitians in companies and organisations. Needless to say, all the health messages
in the *Happy Heart at Work* programme, including the health eating component, support and complement our own health messages and healthy eating guidelines.

If the issue of heart disease in Ireland is to be addressed effectively, it is important that we have an adequate research base that will guide us in devising and implementing the most effective strategies and permit assessment of our efforts through the monitoring of risk factors and trends in morbidity and mortality. For this reason the Health Promotion Unit has just recently established a *Cardiovascular Disease and Health Promotion Research Project* based in the Department of Epidemiology at the Royal College of Surgeons in Ireland. It is envisaged that this project will link closely to policy planning, implementation and review in the area of coronary heart disease over the next few years.

**Cancer**

Cancer is another major cause of death and disability in middle age leading to about 2,000 deaths annually in those under 65 years. Many cancers, particularly lung cancer, are avoidable through pursuing a healthy lifestyle. In that context the Health Promotion Unit is supporting a workplace initiative being undertaken by the Department of Health Promotion in University College Galway. This programme entitled *Lifestyle and Cancer* is a three-stage health promotion programme in the workplace designed specifically towards the needs of women, and lower paid women in particular.

This is, in fact, one of a number of projects receiving EC support under the *Europe against Cancer* programme. The aim of the programme which started in the late 1980s is to reduce cancer deaths in Europe by 15% by the year 2000. The programme in Ireland started with the widespread dissemination of a ten-point Cancer Code - recommendations on lifestyle that would help to reduce the risk of cancer. In more recent years we have developed more detailed specific projects on various aspects of the Code, e.g. nutrition, smoking, screening, palliative care and training of health professionals. Several of the projects are collaborative ones between statutory bodies such as the Health Promotion Unit or health boards and voluntary organisations, in particular the Irish Cancer Society. Indeed one of the major widely acknowledged benefits of the *Europe against Cancer* programme is the fact that it has, through the National Co-ordinating Committee established by the Minister for Health in 1988, acted as a catalyst for increased co-operation between the various agencies involved in the cancer area.

**Osteoporosis**

Fractures are a common source of morbidity in older people. Osteoporosis is a major cause of bone fracture and is a complex and multifunctional disorder. Building of substantial bone mass in youth and early middle age through balanced diet - particularly one that provides adequate calcium - and regular exercise, is regarded as a valuable preventive measure. The Health Promotion Unit is currently preparing educational materials for women on the subject and these will be available soon.
The Menopause

The menopause, with which the risk of osteoporosis increases, is one of the important transitions in a woman's life which can have health implications. Successfully negotiating this transition can enable a woman to look ahead to later life with a sense of confidence and well-being. It is probably true to say that up to recently the menopause did not receive the attention from health professionals that women themselves may have considered it deserved. Information is one of the factors which can help women at this time in their lives. The Health Promotion Unit has available, without charge, a booklet on the menopause. Earlier this year the Unit provided financial support to Family Planning Services Ltd. for the production of the first Irish video on the topic. An Irish Menopause Society has also recently been established. This has as its main objective the education of health professionals and the advancement of research in the area. To coincide with its inaugural meeting, the Society, with financial support from the Health Promotion Unit, is producing a booklet for professionals entitled The Menopause - a Guide for Primary Care.

Mental and Social Functions

Adding health to life implies more than a concentration solely on physical health. Health promotion should also be concerned with good mental and social function, aspects which can be critical to a sense of well-being in later life. We in the Unit were pleased to be in a position to fund the reproduction of the Mental Health Association's series of information pamphlets dealing with some major causes of stress, including one titled Coping with Growing Older.

Public attitudes towards older people and towards ageing in general are important to the integration of older people in the community.

It is important that old age is not associated in the public mind with disease and immobility. Since the publication of The Years Ahead a report of the Working Party on Services for the Elderly in 1988, significant progress has been made in addressing this issue. For example, school books, magazines and newspapers are more careful not to stereotype older people as feeble and inactive. In order that young people build up a rapport with the older generation, competitions have been introduced this year on intergenerational themes, aimed at primary and post-primary school children and co-ordinated by the National Committee for the European Year of Older People.

Many factors are involved in people having good mental and social function in later life - involvement with family and friends, with hobbies and interests, capacity for coping with change and perhaps their sense of a meaning in life and in their own life in particular. Health promotion programmes for those in middle age, particularly those in late middle age and coming towards retirement, should provide an opportunity for people to address these issues in a flexible way.

Pre-retirement Courses

For those at work who are moving closer to retirement, pre-retirement courses can provide an additional opportunity to address some of the lifestyle issues mentioned
above. Ideally such courses should begin five years before retirement date to allow time to prepare for change, as it is not always easy to shift lifestyle patterns that are firmly established. For example, giving up smoking at any age is beneficial. After a period of a few years lung function can improve. At a nutritional level fibre intake can improve bowel action. Exercise programmes - walking, swimming, cycling - pursued in moderation can improve flexibility, stamina and strength, help reduce the risk of coronary heart disease and improve sleeping patterns. Another health-related element of a pre-retirement course should be guidelines on safety in the home such as hints on fire safety and cutting down the risk of tripping on slippery surfaces or over loose-hanging wires.

LifeWise

While I have mentioned the workplace as having advantages as a setting for health promotion for middle-aged people, we also need to remember the needs of those who are not in employment. For these people and for others who do not have the benefit of being offered such courses, statutory and voluntary agencies should collaborate in the development of programmes in health board areas which would assist people assess their overall health levels and guide them towards making changes for the better. One such programme which contains modules on smoking, nutrition, exercise, and rest and relaxation is LifeWise, which was successfully piloted a few years ago in the Mid-Western Health Board with the support of the Health Promotion Unit. This programme is now being used by a number of health boards and, indeed, by ICA groups, with trained leaders who guide the group through the course modules. The course is also useful for carers, who may themselves be middle-aged and who have not previously had the opportunity to examine their own health status. One of the advantages of this programme is its flexibility for use in different settings and with different target groups - from young third level students to the elderly.

Adult Education

Adult education has great potential for adding health to life. The growth in adult education has been enormous with health boards being prominent in such initiatives. The Western Health Board, for example, has sponsored health education courses in conjunction with local voluntary groups for a decade. Areas covered on these courses include nutrition, assertiveness and practical home maintenance. Further courses along these lines could be initiated country-wide, using established community groups to encourage those who would benefit from such courses to attend.

Networking

There is no doubt that the most effective communication occurs at local level. The Health Promotion Unit hopes that through its links with public health nurses, general practitioners and voluntary organisations, it can support the delivery of the health promotion message country-wide. As summarised in a Heartbeat Wales report in 1985 there is a need:
1. to teach, i.e. to give information relating to healthy lifestyle behaviour change,
2. to reach the community through appropriate community based channels,
3. to sustain the momentum of such initiatives by an appropriate organisational framework.

This approach would guarantee the effective delivery of health promotion programmes relating to such areas as heart disease, cancer and osteoporosis. Professor Cecily Kelleher in her report for the National Council for the Elderly Measures to Promote Health and Autonomy for Older People, notes that three-quarters of the population over 75 years of age are on medication of some form. Successful health promotion strategies for the young and middle-aged would prove to be an investment for healthy ageing, cutting down on medication and allowing people to have a better quality of life in the later years, with a reduction in lifestyle-related illnesses.

Research

Professor Kelleher, in her position paper, has also repeatedly mentioned the importance of research if an appropriate social environment is to evolve to support ageing as a positive phenomenon. In this context I am pleased to say that the Health Promotion Unit was in a position to provide financial support for a research document compiled last year by the National Council for the Elderly on Health Promotion in the Elderly. I am aware that there is much that we still need to learn about how people in later middle years feel they can best be supported as they move towards the years ahead.

Resources

A wide range of printed and audio-visual resources are available from the Health Promotion Unit, in the Department of Health. Such titles as Foot Care, Nutrition in the Later Years, Be Nifty at Fifty, which looks at exercise and fitness, Hysterectomy, Menopause, Drugs and Alcohol and AIDS, give useful information on health-related issues. For people heading into the later years with chronic conditions such as diabetes or asthma, information and advice is also available.

Conclusion

The scope for health promotion is wide ranging and can involve any activity which is within the control of the individual, groups or society. However, in keeping with the recommendations of the Ottawa Charter of the WHO, which declared that health promotion should be a process of enabling people to increase control over and to improve their health, we must make a more concerted effort to collaborate in offering people in their middle years the chance to maximise their health potential in their later years. Agencies such as the Retirement Planning Council, Age and Opportunity and countless clubs and associations can be part of this process of assisting people to get the best out of life.
You may be aware that the Minister for Health has already announced his intention to publish a comprehensive *National Health Strategy* later this year. This will have a dedicated component on health promotion which we in the Unit have been working on for some time. We recognised that much of the work being done by the Unit was in separate one-dimensional programmes and seldom as part of an integrated, structured, clearly-defined programme of work. This deficiency will be addressed by the publication of the *Strategy* and I think we can anticipate that it will give a clearer sense of direction and an impetus for better co-ordination of our efforts, both in the statutory and voluntary sector, to help those in middle age move to an active, independent and healthy old age.
Ms Catherine Rose

Noel Usher gave a succinct account of the work of the Health Promotion Unit, which, he said, is working within the World Health Organisation framework, in collaboration with statutory and voluntary agencies, to achieve the Health to Life targets.

He described Health Promotion Unit initiatives to reduce the levels of illnesses such as heart disease, cancer and osteoporosis. He also referred to the Unit's strategies to promote mental, emotional and physical health in middle-aged and older people and made particular reference to health implications at important transitional periods such as menopause for women and retirement for those in the workforce.

Ability to cope with change, continued involvement with family and friends and leisure interests are factors in retaining health in older age according to Noel Usher.

Lively discussion focused on the following topics:

- Pre-retirement training.
- Retraining for older workers.
- Men's attitudes to work.
- Lack of security at work and fear of redundancy.
- Phased retirement and post-retirement education.
- Barriers to a healthy lifestyle in older age.

**Pre-retirement Training**

Participants called for improvements in retirement training and agreed that such training should begin at the age of 40 for those in the workforce. It was agreed that those who are not in the workforce should also be offered pre-retirement courses, particularly the unemployed and women at home. As one participant quipped: a woman finds herself with twice the husband and half the money when he retires.

**Retraining for Older Workers**

Participants called for retraining for middle-aged and older workers. It was agreed that older workers can adapt to and successfully utilise new technology and that it is offensive to suggest otherwise.

**Men's Attitudes to Work**

It was considered that men need to change their attitudes to work and find a way to replace the status which they receive at work with a meaningful role in retirement.
Lack of Security and Redundancy

Middle-aged workers are suffering from stress-related illnesses through lack of security and fear of redundancy and unemployment. Actual redundancy and unemployment if it arrives was cited as a further stress leading to illness.

Phased Retirement

It was agreed that phased retirement, a period during which the working week is gradually lessened, is preferable to the present sharp shock method.

Post-retirement

Cookery classes for older people should have an input from a dietitian. Older carers are often so worn out from their caring role that their own health breaks down.

Barriers to a Healthy Lifestyle

Participants were of the opinion that older people very much want to remain healthy, but that there are serious barriers to retaining an active and independent lifestyle in older age. Older pedestrians in urban areas see widened roads, busy intersections and speeding cars as a hazard and a deterrent to staying involved and taking up leisure time activities. Older people in rural areas cite lack of public transport as a major deterrent to staying active and involved. Older people fear for their safety at home and do not feel safe outside the house after dark.

Older people want to walk for health reasons, but walking has become unsafe in urban areas. Walking clubs and public areas with secure warden-patrolled areas were suggested.

The first five issues relate to the middle age aspect of the workshop title while the final two issues relate to active independent and healthy living for those who are currently in older age.

Participants call on the following government departments:

- Health,
- Social Welfare,
- Justice,
- Education,
- Labour,
- Environment,

to co-operate in addressing the issues raised.
Introduction

In many European Community countries the debate on health and social security issues has been dominated for some time by concerns about the impact of ageing on the economic and social fabric of society. Ireland has not been overly concerned with this issue, mainly because its elderly population is not expected to increase significantly until the second decade of the next century. This lag in population ageing in Ireland means that policy makers have some breathing space in which to formulate a long-term strategy for older people - a strategy that would both extend and improve the quality of their lives. The objective of this short paper is to highlight a number of key strategies for adding years to life and to set out the major elements of planning for ageing in the next century.

Health Promotion and Public Policy

The ability to live independently depends crucially on the health of individuals. The choices that people make throughout their lives have a major bearing on the health stock that they carry into old age. At the limit, poor choices at an earlier stage of the life cycle may mean that many people do not reach old age at all. Public policy has an important role to play in improving the health decision making of people at all stages of the life cycle. In particular, the practice of healthy eating, a sensible approach to alcohol, non-smoking, and reduced stress levels can all be enhanced by an investment in health promotion programmes. However, for public policy to influence healthy choices in a major way it must be seen as much wider than simply giving advice in these areas. Attitudes to health maintenance among older people are influenced by disposable income, social class and education. It is in these very areas that major inequalities exist in Irish society. If policies to promote independent and healthy living are to be successful then a prerequisite is to address some of the basic inequalities that continue to exist (and have even increased) in the country; inequalities that result in some social groups having higher mortality rates than others and therefore not surviving into old age. Clearly, healthy public policy for ageing well is multisectoral, multidimensional and is closely related to the broader social policy objectives of reducing poverty and ensuring less inequality in income, wealth and education.

Income Maintenance

There is general agreement that the incomes of older people have improved significantly over the past two decades. During the 1970s in particular, a disproportionate share of state subsidies, both cash and in-kind, have gone to older people. Improved, and more widely available, occupational pension schemes have also raised incomes. The result has been a substantial reduction in the risk of poverty for older people.
There has not been much concern in Ireland about differences in income among older people. However, we do know that redundancies and ill health, linked to social class, increases the risk of deprivation among older people. The risk of poverty is also likely to increase for elderly people living alone, especially for women and the very old. Both of these categories are much less likely to be receiving income from occupational pensions or to be covered by social insurance and, therefore, tend to rely on social assistance for the bulk of their income. Some old people are, therefore, clearly better off than others. This should not be surprising since people carry with them into old age the advantages and disadvantages that they have accumulated during their life. Life experience is, therefore, likely to be a significant factor influencing the quality of life in old age.

Policy makers have tended to focus on old people as a homogenous group rather than concentrating on particular subgroups within the sector. Consequently, there have not been any recent policy initiatives seeking to improve the position of one group relative to another. Older pensioners do receive an additional allowance, but that has been in place since 1972. Similarly, an additional allowance for pensioners living alone has operated since 1977. The worry is that the needs of those old people (admittedly a minority) who continue to live in absolute poverty may be overlooked in light of the common perception that old people are now relatively well-off. In the report of the Working Party on Services for the Elderly (1988) particular attention is paid to the need to bring about an increase in the incomes of old people living in absolute poverty. This should be the main focus of social welfare changes for older people in the coming decades.

Housing

The provision of suitable housing for older people is a necessary condition to ensure the independent living of older people in the community. While a major improvement in housing conditions has taken place in recent years, there are still some old people living in very poor accommodation. The extent of the problem cannot be fully ascertained without a comprehensive survey of the housing conditions of the elderly. A survey of this kind would be an important first step in an overall strategy to improve the housing conditions of vulnerable elderly people. Old people living in rented accommodation, although small in number, are a particularly disadvantaged group, while the most at risk of all old people are those who are homeless. Specific intervention by government in these two areas would be a major investment in healthy ageing for those people currently living in very difficult circumstances.

This year (1993) has seen an improvement in the provision of social housing. The agreement for government between the two coalition partners made provision for an additional 3,500 local authority houses during the year, with special attention promised for the elderly and for people with disability. Increased spending in this area will help to offset the public housing cutbacks of recent years. Investment in public housing will assume even higher priority in the upcoming decades as increases in the elderly population put more pressure on existing provision.

Voluntary housing groups, supported by the exchequer, now play a major role in meeting the housing needs of old people. This is a welcome development, since voluntary groups are well placed to respond to local housing needs in a flexible and innovative way. If the voluntary sector is to expand further then statutory
funding for the maintenance and repair of buildings will have to be provided. In addition, resources will have to be made available, where appropriate, for the infrastructural and community care support which will sometimes be necessary to ensure that old people can continue to live in their own homes as they become more frail. It is important to avoid a caring system whereby dependent elderly persons have to be kept on the move to get the care they need. That is why most emphasis in the next decade should be placed on barrier free, user friendly, normal housing in the community.

Sheltered housing also has a role to play in the accommodation of specific categories of older people. Establishing the optimal number of units is a difficult task, but all the indications suggest that the current provision of sheltered accommodation is considerably below what might be considered adequate, let alone optimal. The provision of additional sheltered housing should be a priority for government in the coming decades.

Family Role and Social Networks

Patterns of social contact have been subject to modification as a result of changes in living patterns and household forms. Older people are particularly vulnerable to these changes because, in addition to the decline of the extended family, they are at a stage in life when, typically, the children have left home and spouses and friends may be lost through bereavement. In that context, it is heartening to report that older people in Ireland continue to have very high levels of contact with their families (Eurobarometer Survey, 1993); over 50% had daily contact and a further one-third had contact at least once a week. Unfortunately, we do not have the extensive micro-data that would allow us to make a judgement on the degree to which old people are satisfied with the quantity and quality of family contacts. In general, the effect of contact on morale and well-being is dependent on dimensions of contact other than its quantity. Moreover, social contact must be analysed in conjunction with other variables such as class, income, housing, health and life events, many of which are influenced either directly or indirectly by government behaviour. One of the challenges of public policy will be to improve the social contact and well-being of older people.

There are those who would argue that public policy can only be expected to have a weak influence on the development of a more socially aware and integrated society. After all one cannot force individuals to behave in a communitarian way. However, incorporating moral and ethical dimensions into economic and social discourse and decision making can influence the shape and direction of human interaction, even with families. The virtues of truth, ethical behaviour, commitment, fairness and equity are important for both constructive competition in capitalist societies and in family life. Certainly a society dedicated solely to individualism, self-interest and the pursuit of economic growth is unlikely to foster healthy levels of social integration, especially for vulnerable social groups deemed to be outside the productive process.

Nowhere is public policy more important than in the encouragement and support it provides to the carers of dependent old people. Families play a crucial role in the care of dependent old people, often at great personal cost in terms of opportunity cost foregone. Concerns that families may be less willing to care is contradicted by the data on the high level of care currently being provided. Yet it would be wise
not to become too complacent with regard to the availability of such care in the future. Caretaker potential is set to decline in the next century as demographic and labour force participation rates for women combine to reduce the stock of available female carers. Public policy interventions may be necessary to encourage and reward caring within families.

The vast majority of carers express a desire for direct payment for caring. Yet current payment rates through the Carer's Allowance Scheme, are restricted and often derisory in comparison to the efforts expected of carers. Support from statutory sources in the form of more and better services, respite care and advice is also inadequate. Evidence from elsewhere suggests that carers can often be kept happy in their work for quite small amounts of exchequer expenditure. A great number of carers enjoy what they do, receiving many intangible benefits and great fulfilment. It would be a pity if the natural willingness of so many people to care for their kin was eroded by the parsimonious response of the state to their material needs.

**Effecting the Transfer of Resources to Community Care**

One of the key elements of an investment strategy for ageing in the next century is the allocation of more resources to community care. The closing of long-stay beds has put severe pressure on community care resources in Ireland. That pressure will not recede without a transfer of resources to the sector. More practical support will have to be given to carers to ensure the continuation of family care in a complementary sense, rather than having statutory intervention only when family care is absent or breaks down. There is evidence that access to home helps, public health nursing, paramedical services, day care and meals-on-wheels is limited and variable within and among health boards. This situation reflects both an under-provision and an inequitable distribution of community services. This situation can only be redressed by an increase in the community budget and by the establishment of uniform service targets and eligibility criteria for core services within and among health boards. The latter requires the setting of more explicit policy objectives by the Department of Health; only then will it be possible to match the rhetoric of community care with real progress on the allocation of resources.

Of crucial importance in the long-term care of old people is the integration of public, private and voluntary provisions. The first step in this process would be for the statutory authorities to give more formal recognition to the voluntary sector as a partner in care. There are also advantages in developing closer links between the public long-stay sector and the regulated private nursing home market. This would widen the choice available to health boards when decisions about the placement of older people have to be made. A complementary approach to care provision involving home care, community services and in-patient care would also improve the situation of old people in need of care. If this is to happen, services on the ground will have to be more formally co-ordinated than they are at present, while greater co-operation will also be required across the various government departments responsible for the setting of overall policy goals.
The Labour Market

Exit from the labour market for older workers is no longer regulated solely by public retirement systems. Instead, redundancy, disability and voluntary early retirement are increasingly determining the labour force status of older workers. Age discrimination in the labour market is not an issue that has received much attention in Ireland. Consequently, it is not surprising that older workers receive no special protection or rights under the law. Yet, it is clear, that the decline in the activity rates of older workers, their longer spells of unemployment and the tacit encouragement they often receive to leave the labour force points to some element of discrimination. The recent Eurobarometer Survey showed that almost three-quarters of the population believe that older workers are discriminated against with regard to job recruitment. Furthermore, a majority of the population also believe that discrimination exists with regard to job promotion and training.

Neither the government, the unions nor the employers have done much to offset age discrimination in the labour market. There seems to be tacit agreement among the social partners that older workers should bear a disproportionate share of the burden of unemployment in a labour surplus economy. The first step towards improving the situation for older workers would be the introduction of specific legislation to prohibit age discrimination. It should also be possible to include more older workers on state-sponsored training programmes. Until this happens it will be hard to convince older people that their contribution to economic and social progress is as highly valued as that of younger workers.

There is no evidence of widespread support for any earlier retirement than 65 years of age. Most people enjoy work. Even the observed voluntary nature of retirement before that age is open to question. Individuals may be left with no choice if employers give a clear signal that they want workers to leave. Policies which would support a voluntary phasing out of work and phasing in of retirement pensions, so that workers could leave the labour force at their own pace and in their own time would be an important first step towards extending the range of choices for older people. This might have implications for the financing of pensions if more workers sought early retirement. Bringing forward the payment of pensions (public and occupational) could impose substantial cost on the exchequer as well as on employer and company profits. Nevertheless, allowing people a genuine retirement choice may be a better policy than paying people for involuntary idleness.

Conclusion

Investment in healthy ageing should focus on policies that enhance the independent living of older people in their own homes. The fundamental objective of policy should be to ensure that individual choice is both respected and protected as people grow older. Public policy can bring about an improvement for older people in the following areas: health promotion, income maintenance, housing, community care and employment. Healthy ageing is only possible and meaningful if older people are able to participate fully in all aspects of economic and social life. That participation is conditional on more power and greater choice being available to older people, thereby allowing them the normal freedom and responsibilities associated with full citizenship.
LONG-TERM STRATEGY - ADDING YEARS TO LIFE: PLANNING FOR AGEING IN THE NEXT CENTURY

Ms Janet Gaynor

When invited several months ago by Bob Carroll to act as Rapporteur to a workshop on the elderly I thought he had made a mistake. I work with schools and with young people, and could see no obvious links. This conference, however, has been a process of looking at my own tunnel vision and prejudice, and has provided me with ideas which I hope will enrich the experience of young people in the schools where I work. So thank you for the invitation.

1. Introduction

Mr Eamon O'Shea opened the discussion by identifying key areas for long-term planning. He said that we are fortunate in that our population is relatively young and we expect to experience a surge in ageing only after the year 2000. This gives us the opportunity to address issues in a planned way, drawing on the experience of other societies which have already passed through or are more advanced in terms of the demographic ageing process.

He also said that the value system of our society needs to be questioned, for example, in relation to the value placed on people arising from their occupational or work role. We tend to emphasise payment for work. This can generate negative attitudes towards those who might be perceived as unproductive - such as those who are retired or elderly.

He said that promoting health and autonomy in the elderly in the long term involves policies affecting the whole life span, or social policy generally. He discussed the concept of community care which is outlined in The Years Ahead. Policy has only been partly implemented as yet, unfortunately. Fuller and more even implementation of policy is essential.

Work and retirement policies will affect the experience of old age profoundly. Little has been said or written on discrimination but it is widespread. Legislation in this area, as was achieved in relation to sex discrimination, will have to be addressed. Attitudes too will need to change.

Housing policy needs to provide choice and maximum continuity. More attention to people's preferences will be needed.

Individual autonomy as citizens is a key to maintaining autonomy in old age in economic, social and cultural matters. Social integration in the labour market, and in society generally, is an issue that must be addressed.
2. Discussion

Ours was a very philosophical group, where most of our discussion centred around the type of society we want to live in, and how we begin to ask the questions that help to examine our values, and also direct us towards a healthy, caring environment for all.

We found it difficult to make a distinction between short-, medium- and long-term strategies.

We need to look at our policy and planning under a number of headings, including Planning for Ageing, Population Projections, Health Promotion, Income Maintenance, Housing and Supportive Environment, Social Integration, Community Care, and Work and Retirement.

Two important questions we need to keep asking are (a) how do we equalise life chances for all? and (b) how do we get more people to old age?

We discussed the importance of integration. It was felt that older people in Irish society are well thought of and do not suffer from intergenerational conflict. For this positive attitude towards our elderly to continue we need to reflect and discuss how we want our society to evolve, and as part of that, how we can encourage social integration.

As policy makers and service providers, nevertheless, when we examine ideas of social integration, and strategies for the health of the elderly, we have often been guilty of not asking the elderly for their ideas, or translating their ideas into policy.

A number of points were made from the floor concerning work and retirement. There is continued pressure to exclude older workers from the labour force but little or no emphasis on their right to continue in employment. Unemployment levels are sometimes allowed to sway the argument against introducing legislation against age discrimination. Mandatory retirement age was a form of discrimination based on age.

On the issue of intergenerational conflict there was a range of views. The future of the welfare state, which is based on assumptions about a social contract between the generations, is a matter of concern. At EC level there are changes being considered which could have far-reaching implications for the elderly. The EC has higher unemployment levels than the USA and contributors were concerned that policies to address this could impact negatively on the elderly.

In Ireland and elsewhere a productive role for the elderly needs to be fostered. As yet we have seen small beginnings only. But the potential exists for more progress in this area.

3. Individual Autonomy

How can we encourage independence, which is a key to active healthy living? The rights and needs of the elderly should be clearly identified and their involvement encouraged. Old people should have the right to make their own
decisions regarding their own lifestyles, their own housing and their own ideas about work.

Some thought was given to the merits or demerits of organisations of older people which do not view their role as partners and participants in society. In some countries there is some evidence that stridency among the emerging older people's lobby could lead to the alienation of younger generations - particularly if older people are perceived as being better off than young people.

The concept of partnership is increasingly being used to address the greater integration of the elderly and other parts of society. Under the PESP certain commitments were made to the elderly - though they were not directly represented. In Germany a social insurance scheme for sick pay has been curtailed in order to pay towards the cost of long-term care of the elderly.

4. Co-ordination at Local Level

The issue of community care was also taken up. Co-ordination is a necessity as existing service delivery can be patchy. We heard of one pilot study of effective co-ordination in the Dun Laoghaire area where a Co-ordinator of Services for the Elderly has since been appointed. This process can allow real co-operation to develop for all the various groups to know what is happening and to work together to provide a planned service. It can provide a focus for all the local activity. Having a person responsible for co-ordination is essential.

Local level planning and provision is essential if community care is to be successful. Targeting needs, e.g. for sheltered housing, nursing and home help, transport, etc., is best achieved at this level. Voluntary and self-help initiative operates best at the local level too.

5. National, Local and International Debate

We need to acknowledge that, at national and local level, society is changing, and to take on board the issues that will promote a positive view of the aged and make a positive experience of ageing.

The next ten years provide us with the opportunity to think, plan and act towards providing in the years ahead a worthwhile life for all.

National and local debate must take account of (a) the European and international dimensions of ageing and (b) the greater economic and political integration of social systems around the world.
In one sense I wish Alexandre Sidorenko of the UN Ageing Unit could have been here, because of his specialised knowledge on the subject of ageing, and more detailed knowledge of UN activities and mechanisms. I am honoured to attend in his place.

At the beginning of the 1980s it was already recognised by the world community that the unprecedented demographic phenomenon of population ageing would have to be addressed as a matter of urgency. The UN was designated to lead the international community in meeting the challenges of ageing.

The UN Charter of 1945 and the Universal Declaration on Human Rights of 1948 refer again and again to the right of all people to fully realised life and work no matter what age, sex, race or religion.

In 1982 one thousand delegates from 124 Member States gathered at the World Assembly on Ageing. It adopted the *International Plan of Action on Ageing* which was adopted by the General Assembly in resolution 37/51 of December 1982.

As a result units, agencies, bodies and activities were set up by the UN. These included:

- The Ageing Unit in Vienna/now New York, which has responsibility for monitoring the Plan. This Unit is part of the Social Development Division of the Centre for Social Development and Humanitarian Affairs.

- The UN Trust Fund for Ageing was set up to assist Member States in their programmes.

- The International Institute on Ageing was set up in Malta to carry out research.

- The UN Medium-term Plan 1990-1995 was set up to look at research and policy analysis.

- Annual resolutions at the General Assembly on the Aged (many of these arise from national contributions), so each individual and group can make a contribution.

The eight Global Targets adopted by the UN General Assembly are as follows:

1. *To support countries in setting national targets on ageing:*
   - assessing their ageing situation,
getting up-to-date quantifiable information,
identifying priorities,
transferring aid and technologies to other countries.

2. To generate support for countries' plans and programmes:
   - by providing expert advice and assistance.

3. To generate support for community-based programmes of care and participation.

4. To improve cross-national research on ageing.

5. To encourage inclusion of an item on ageing in international events and meetings.

6. To establish a global network of senior volunteers for social and economic development.

7. To facilitate closer co-operation among non-governmental organisations on ageing.

8. To facilitate closer co-operation among inter-governmental organisations.

The UN Principles on ageing, set out below, emerged in 1992 and were adopted by the General Assembly as a result of lobbying by NGOs for guidance and direction.

1. Independence

   Older persons should:
   - have the opportunity to work,
   - be able to participate in determining when withdrawal from the workforce takes place,
   - have access to educational programmes,
   - be able to reside at home for as long as possible.
2. Participation

Older persons should:
- remain integrated in society and not be marginalised,
- be able to contribute to and serve the community, to do voluntary work, etc.

3. Care

Older persons should:
- have the best family or community care,
- have access to the best health care etc.

4. Dignity

Older persons should:
- be free of exploitation or abuse,
- be treated fairly.

5. Self-fulfilment

Older persons should:
- be able to make a difference at all levels.

The UN Principles acknowledge the diversity in the situation of older people in different countries and between individuals themselves.

Boutros-Ghali said:

*In the passage of time, in age, in personal acceptance of age, we have something full of promise - promise for everyone: the benefit of experience, of maturity and of knowledge and wisdom.*
NOTES ON CONTRIBUTORS

SPEAKERS

Mr Robert Anderson

Mr Robert Anderson is Research Manager at the European Foundation for the Improvement of Living and Working Conditions in Dublin.

Dr Ruth Barrington

Dr Ruth Barrington is Principal Officer in the Department of Health with responsibility for services for the elderly as part of her brief.

Mr Eoghan Brangan

Mr Eoghan Brangan is a civil engineer and chartered town planner at the Environmental Research Institute.

Ms Nora Brennan

Ms Nora Brennan is Health Education Officer in the South Eastern Health Board.

Dr Eileen Caulfield

Dr Eileen Caulfield is President of the Irish College of General Practitioners and GP Unit Medical Officer in the North Western Health Board.

Ms Karen Chapman

Ms Karen Chapman is Executive Secretary of Eurolink Age, an EC-wide network concerned with older people and issues of ageing.

Dr David Clinch

Dr David Clinch is a Consultant Physician in the Department of Medicine for the Elderly at the Regional Hospital, Limerick.

Dr Tony Fahey

Dr Tony Fahey is a Research Officer in the Economic and Social Research Institute, Dublin. He is currently conducting research on the health and well-being of the elderly population in Ireland, on behalf of the National Council for the Elderly.
Commissioner Padraig Flynn

Commissioner Padraig Flynn is a member of the European Commission with responsibility for Social Affairs and Employment.

Ms Janet Gaynor

Ms Janet Gaynor is Health Education Officer in the North Western Health Board.

Lady Valerie Goulding

Lady Valerie Goulding is President of the National Council for the Elderly.

Mr Brendan Howlin T.D.

Mr Brendan Howlin is Minister for Health.

Dr Mary Hurley

Dr Mary Hurley is the Co-ordinator of Services for the Elderly in Area 3 of the Eastern Health Board.

Dr Mary Hynes

Dr Mary Hynes is a specialist in public health medicine and a Director of Community Care in the Eastern Health Board.

Professor Cecily Kelleher

Professor Cecily Kelleher is Director of the Centre for Health Promotion Studies in University College Galway. She is author of the Report *Measures to Promote Health and Autonomy for Older People: A Position Paper*, published by the National Council for the Elderly.

Ms June Lambert

Ms June Lambert is the President of the Irish United Nations Association.

Mr Patrick Madden

Mr Patrick Madden is Programme Manager of the Community Care Programme in the Southern Health Board.
Mr Kieran Mc Keown

Mr Kieran Mc Keown is Director of Kieran Mc Keown Ltd., Social and Economic Research Consultants.

Ms Rosalyn Moran

Ms Rosalyn Moran, an Environmental Psychologist, works for the Health Research Board.

Dr Peter Murray

Dr Peter Murray is a Research Officer with the Economic and Social Research Institute, Dublin. He is currently completing a study of healthy lifestyle promotion strategies and contributing to a health and well-being profile of Ireland's elderly population, commissioned by the National Council for the Elderly.

Mr Eamon O'Shea

Mr Eamon O'Shea is a Lecturer in Economics at University College Galway and a member of the EC Observatory on Ageing and Older People.

Ms Catherine Rose

Ms Catherine Rose is National Co-ordinator of the European Year of Older People and Solidarity between Generations.

Dr Emer Shelley

Dr Emer Shelley is Director, Department of Epidemiology, Royal College of Surgeons in Ireland.

Dr Alexandre Sidorenko

Dr Alexandre Sidorenko is Officer-in-Charge, Ageing Unit, Department of Policy Co-ordination and Sustainable Development in the United Nations, New York.

Mr Noel Usher

Mr Noel Usher is Principal Officer at the Health Promotion Unit in the Department of Health.
Mr Michael White

Mr Michael White is Chairman of the National Council for the Elderly, having been appointed to the first Council in 1981.

CHAIRPERSONS

Professor Davis Coakley

Professor Davis Coakley is Dean of the Faculty of Health Sciences and Professor of Geriatric Medicine at Trinity College Dublin. He is also Director, Mercer's Institute for Research on Ageing and Consultant Physician in Geriatric Medicine at St James' Hospital.

Dr Rosaleen Corcoran

Dr Rosaleen Corcoran is Director of Community Care in the Eastern Health Board and a member of the National Council for the Elderly.

Dr Finbarr Corkery

Dr Finbarr Corkery is a General Practitioner in Cork and a member of the National Council for the Elderly.

Dr Harry Crawley

Dr Harry Crawley is a Consultant in Health Education and Health Promotion.

Mr Brian Gallagher

Mr Brian Gallagher is Chairman of the Retirement Planning Council of Ireland.

Mr Kieran Hickey

Mr Kieran Hickey is Chief Executive Officer of the Eastern Health Board.

Mr Dermot McCarthy

Mr Dermot McCarthy is Assistant Secretary in the Department of the Taoiseach.

Mrs Mamo McDonald

Mrs Mamo McDonald is Chairperson of Age and Opportunity and a member of the National Council for the Elderly.
Mr Thomas Mooney

Mr Thomas Mooney is Principal-in-Charge in the Department of Health.

Mr Patrick Morrissey

Mr Patrick Morrissey is a former Assistant City Manager of Dublin Corporation and a member of the National Council for the Elderly.

Mr L.J. Tuomey

Mr L.J. Tuomey is Chairman of the 1993 Co-ordinating Committee for the *European Year of Older People and Solidarity between Generations*. 
Programme
Thursday, 30th September

9.30 REGISTRATION
Coffee

OPENING OF THE CONFERENCE

10.30 WELCOME
Lady Valerie Goulding, President,
National Council for the Elderly

OPENING ADDRESS
Mr. Brendan Howlin, T.D., Minister for Health

THE HEALTH AND AUTONOMY OF OUR ELDERLY POPULATION
Chair: Mr. Kieran Hickey
Chief Executive Officer, Eastern Health Board

11.00 A Profile of the Wellbeing of our Elderly Population:
Preliminary Findings of a Recent Survey
Dr. Tony Fahey, The Economic and Social Research Institute

11.45 Health and Autonomy for Older People: The Challenges
Professor Cecily Kelleher, Department of Health Promotion
Studies, University College Galway

12.30 DISCUSSION

1.00 Lunch

2.30 WORKSHOPS

1. The Health and Autonomy of the Elderly in Ireland:
Priorities for Public Policies
Chair: Dr. Rosaleen Corcoran, Director of Community
Care, Eastern Health Board
Speaker: Dr. Ruth Barrington, Principal Officer,
Department of Health
Rapporteur: Dr. Peter Murray, The Economic and Social
Research Institute

2. Self Help and Community Action to Promote the Health and
Autonomy of the Elderly
Chair: Mrs. Mamo McDonald, Chairperson, Age and
Opportunity
Speaker: Mr. Patrick Madden, Programme Manager,
Southern Health Board
Rapporteur: Dr. Kieran McKeown, Social and Economic
Research Consultant
3. Quality Health Care for Older People: Re-orientating Services
   Chair: Dr. Finbarr Corkery, General Practitioner, Cork
   Speaker: Dr. David Clinch, Consultant Physician, Dept. of Medicine for the Elderly, Regional General Hospital, Limerick
   Rapporteur: Dr. Mary Hynes, Director of Community Care and Medical Officer of Health, Eastern Health Board

4. Health Education, Information and Networking
   Chair: Dr. Harry Crawley, Consultant, Health Education and Health Promotion
   Speaker: Dr. Emer Shelley, Director, Department of Epidemiology, Royal College of Surgeons in Ireland
   Rapporteur: Dr. Mary Hurley, Coordinator of Services for the Elderly, Area 3, Eastern Health Board

5. A Supportive Environment for Older People: Priorities for Action
   Chair: Mr. Paddy Morrissey, Former Assistant City Manager of Dublin Corporation
   Speaker: Mr. Eoghan Brangan, Environmental Research Institute
   Rapporteur: Ms. Ros Moran, Research Consultant, Health Research Board

4.00 Coffee

AGEING WELL
   Chair: Professor Davis Coakley
   Dean, Faculty of Health Sciences and Professor of Geriatric Medicine, TCD and Director, Mercer’s Institute for Research of Ageing

4.30 WORKSHOPS REPORT

5.00 European Community Action Plan on Healthy Ageing
   Ms. Karen Chapman, Executive Secretary, Eurolink Age, London

5.45 DISCUSSION

6.00 End
Programme
Friday 1st October
INTERNATIONAL DAY FOR OLDER PEOPLE
STRATEGIES FOR HEALTHY AGEING
Chair: Mr. Tom Mooney
Department of Health

10.00  The Status of Older People in the New Europe
Commissioner Padraig Flynn, Member of the Commission of the
European Communities

10.45  Strategies for the Promotion of the Health and Autonomy of
the Elderly in Different Countries
Mr. Robert Anderson, European Foundation for the
Improvement of Living and Working Conditions

11.15  DISCUSSION

11.30  Coffee

12.00  WORKSHOPS: STRATEGIES FOR IRELAND

6.  Short Term Strategy - Adding Life to Years:
Addressing the Needs of the Already Elderly
Chair:  Dr. Rosaleen Corcoran, Director of Community
Care, Eastern Health Board
Speaker:  Dr. Eileen Caulfield, President, Irish College
of General Practitioners
Rapporteur:  Ms. Nora Brennan, Health Education Officer,
South Eastern Health Board

7.  Medium Term Strategy - Adding Health to Life:
Preparing the Middle Aged for an Active, Independent
and Healthy Old Age
Chair:  Mr. Brian Gallagher, Chairman of
Retirement Planning Council of Ireland
Speaker:  Mr. Noel P. Usher, Health Promotion Unit,
Department of Health
Rapporteur:  Ms. Catherine Rose, Director, European
Year of Older People
8. Long Term Strategy - *Adding Years to Life: Planning for Ageing in the Next Century*

Chair: **Mr. Dermot McCarthy**, Director, National Economic and Social Council

Speaker: **Mr. Eamon O'Shea**, Dept. of Economics, UCG and EC Observatory on Ageing and Older People

Rapporteur: **Ms. Janet Gaynor**, Health Education Officer, North Western Health Board

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**1.15**   **Lunch**

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**INTERNATIONAL DAY FOR OLDER PEOPLE**

Chair: **Mr. L.J. Tuomey**

Chairman, 1993 Co-ordinating Committee

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**2.30**   **WORKSHOPS REPORTS: Strategies for Healthy Ageing in Ireland**

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**3.00**   **United Nations Programme on Ageing: Streamlining the Action**

**Ms. June Lambert**, President, Irish United Nations Association

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**3.30**   **DISCUSSION**

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**3.45**   **CLOSING ADDRESS:**

*Conference Conclusions and Summing Up*

**Mr. Michael White**, Chairman, National Council for the Elderly

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**4.00**   **Coffee**

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**END**
APPENDIX

As the United Nations Ageing Unit was in the process of moving office from Vienna to New York, Ms June Lambert kindly spoke to the Conference at short notice in place of Dr Alexandre Sidorenko, who, however, provided the text of his paper which is included here.
I feel greatly honoured by your invitation to participate in this conference and to address it on the occasion of the United Nations International Day for the Elderly. I would particularly like to express my warm gratitude to the organisers of the meeting, the National Council for the Elderly, for giving me the privilege of speaking to this audience of distinguished specialists in the field of ageing.

I am here today to represent and to speak on behalf of the Ageing Unit of the United Nations Department for Policy Co-ordination and Sustainable Development. The Ageing Unit is the nucleus within the United Nations Secretariat for all activities relating to ageing. Until recently our office was located in Vienna as part of the Centre for Social Development and Humanitarian Affairs. In the past weeks we have been in the process of physically relocating the office to headquarters in New York.

International Day for the Elderly

This meeting is being held on a very special day for older persons around the world. Three years ago the General Assembly designated 1st October as the International Day for the Elderly. Today we are celebrating it for the third time.

Two themes have been proposed by the United Nations for the observance of International Day for the Elderly this year: Human rights of older people (following the recent World Conference on Human Rights in July) and Indigenous knowledge and skills of older people (to mark the International Year of Indigenous People).

The 1st October, International Day for the Elderly, serves as a day for assessing the issues of ageing in the community, nation and world. It serves as a day for the elderly to make known their views and activities on radio, television and in the press. It can be a day for advance planning by youth, and a day for promoting family and community care-giving. It can serve as an occasion for the professional and scientific community to explain their work (as I now have the pleasure of doing), and it can be an opportunity for policy makers to announce and share ideas on ageing.

United Nations Programme on Ageing

At the beginning of the 1980s it was already recognised by the world community that the unprecedented demographic phenomenon of population ageing would have inevitable economic, social and political consequences. It was also felt that these consequences must be examined and a policy response be prescribed, as a matter of urgency. The United Nations, as a universal organisation uniquely
equipped to deal with global issues, was to lead the international community in meeting the challenge of ageing.

More than ten years ago, one thousand delegates representing 124 Member States of the United Nations, inter-governmental and non-governmental organisations, as well as bodies and organisations of the United Nations system, gathered at the World Assembly on Ageing in the Austrian capital, Vienna. The participants at the World Assembly adopted the *International Plan of Action on Ageing*, which was endorsed later the same year by the General Assembly. Since 1982 the United Nations Office at Vienna, entrusted by the General Assembly with the responsibility to monitor the implementation of the International Plan, has been a global focal point on ageing within the United Nations system. Throughout this period the Vienna office has performed its focal point's functions in co-operation with various entities around the world.

In all eleven years since the adoption of the Plan of Action, over one hundred million older people have been added to the global population. Nearly 70% of these live in countries in the less developed world. In the decade ahead one million persons a month, on average, will become 60 years of age. By 2001 there will be another one hundred and twenty-five million plus older persons. The increase in those aged 80 and over will be the most striking - from 1980 to 2001 their numbers will increase by 54%. The United Nations recognises that the ageing of the world's population is not only a demographic phenomenon, but also has a range of social, economic and developmental consequences. As such, it is potentially one of the most serious socio-economic issues of the decade 1992-2001.

Ireland, with 14% of its older population in the 60 years and above category, has already passed through its demographic transition. By the year 2025, according to United Nations demographic projections, 18.4% of the Irish population will be aged 60 and above. In the recent decade Ireland has established a comprehensive policy and programme response to its ageing population. The Vienna *International Plan of Action on Ageing* has hopefully contributed to this. I look forward to learning more about the Irish experience during this conference.

In the arena of international ageing, eleven years experience in monitoring the implementation of the Vienna Plan shows considerable progress in reaching its objectives, although the Plan has been unevenly implemented across the world: levels of awareness, infrastructure and programme development vary greatly.

Different factors have contributed to limiting progress in the implementation of the International Plan. The most obvious one in many developing and some other countries has been a contraction of the material basis for development, caused by a variety of reasons, political, economic and social. Among other reasons suggested is the failure to realise how society can benefit from population ageing and from the vast collective experience and expertise of its older members. Or, conversely, an unwillingness to confront the cost of empowering its older members, the cost of adjustment from a youthful to a mature population. A failure to incur the costs of adjustment to population ageing not only runs the risk of losing the valuable contribution of older members of society, but could also endanger the solidarity between the generations.

The pace at which populations are ageing in developed countries and are beginning to age in developing countries underscores the urgency of action now
and in the decade ahead. Experience from the first ten years of the Plan of Action pointed to a need for a practical strategy to catalyse implementation of the Plan in the second decade (1992-2001). A core element of the practical strategy is the selection of Targets on ageing.

**Targets**

Such a strategy was developed, through a two-year process of wide ranging consultations, and adopted by the General Assembly at its 47th session in 1992, the tenth anniversary of the *International Plan of Action on Ageing*. Aimed to streamline the implementation of the Plan in its second decade, the strategy identifies eight Global Targets on ageing, together with enabling steps for their achievement in the decade 1992-2001.

The eight Global Targets adopted by the General Assembly are as follows:

1. **Support Countries in Setting National Targets on Ageing.** By setting targets, countries would simultaneously assess their national ageing situation, identify priorities and facilitate international co-operation and the transfer of aid, skills and technologies.

2. **Generate Support for Integrating Ageing into National and International Development Plans and Programmes.** The objective of this target is to ensure that the expert advice and assistance of international development agencies can be provided to the countries wishing to adjust their national development plans and resources to population ageing.

3. **Generate Support for Community-Based Programmes of Care and Participation of Older Persons.** Here the objective is to secure international support for developing and implementing the programmes on ageing at their primary site of action.

4. **Improve Cross-National Research on Ageing Including Harmonisation of Terminology and Methodology.** Being ongoing in nature, this target strives to provide national co-ordinating mechanisms on ageing with the reliable instruments for assessment and planning.

5. **Include an Item on Ageing in International Events and Meetings of Relevance.** The ultimate goal of this target is to raise awareness of ageing issues in relevant economic, social, political and other sectors.

6. **Establish a Global Network of Senior Volunteers for Social and Economic Development.** This target calls for using the accumulated wisdom and skills of older persons in support of United Nations development, environment, and peace programmes.

7. **Facilitate Closer Co-operation Among Non-Governmental Organisations on Ageing.**
8. FACILITATE CLOSER CO-OPERATION AMONG INTER-GOVERNMENTAL ORGANISATIONS ON AGEING.

Reaching the Targets will require an innovative and practical approach, multisectoral co-operation and a variety of national and local initiatives. A unifying leadership should be provided by the United Nations. Such a leadership should, at the same time, be accompanied by actions aimed at establishing a procedure for sharing responsibilities, for partnership, for independent initiatives as well as for concerted action.

One of the most important guarantees of the success in implementing policies and programmes on ageing is the willingness of community, from local to international, to view ageing as both challenge and opportunity. This, in turn, requires changing attitudes towards the elderly in order to recognise their potential to participate and contribute.

Addressing the special plenary meeting of the General Assembly on the occasion of the tenth anniversary of the International Plan of Action on Ageing, the Secretary-General of the United Nations, Mr. Boutros Boutros-Ghali noted:

In the passage of time, in age, in personal acceptance of age, we have something full of promise - promise for everyone: the benefit of experience, of maturity and of knowledge and wisdom.

Thank you.
NATIONAL COUNCIL FOR THE ELDERLY PUBLICATIONS

1. *Day Hospital Care*, April 1982
4. *Community Services for the Elderly*, September 1983
5. *Retirement Age: Fixed or Flexible* (Seminar Proceedings), October 1983
7. *Incomes of the Elderly in Ireland: An Analysis of the State's Contribution*, May 1984
8. *Report on its Three Year Term of Office*, June 1984
10. *Housing of the Elderly in Ireland*, December 1985
11. *Institutional Care of the Elderly in Ireland*, December 1985
12. *This is Our World: Perspectives of Some Elderly People on Life in Suburban Dublin*, September 1986
14. *"It's Our Home": The Quality of Life in Private and Voluntary Nursing Homes in Ireland*, September 1986
17. *Choices in Community Care: Day Centres for the Elderly in the Eastern Health Board*, September 1987
18. *Caring for the Elderly. Part I. A Study of Carers at Home and in the Community*, June 1988

National Council for the Elderly Fact Sheets

- **Fact Sheet 1**: Caring for the Elderly at Home
- **Fact Sheet 2**: Carers You Matter Too!
- **Fact Sheet 3**: Ageing in Ireland: Some Basic Facts
- **Fact Sheet 4**: Voluntary Sector Services in the Community