National Council for the Elderly

PROCEEDINGS OF CONFERENCE


ROYAL MARINE HOTEL, DUN LAOGHAIRE, CO. DUBLIN

24TH NOVEMBER 1995

DISPLAY ONLY
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.

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FOREWORD

The Department of Health’s strategy, Shaping a Healthier Future - A Strategy for Effective Healthcare in the 1990s stated that “to provide the firmest possible basis for the planning of services in the longer-term, the Department of Health will commission a study on the implications for the health services of the projected increase in the elderly population over the next ten years”.

As part of its mandate to advise the Minister for Health on all aspects of ageing and the welfare of the elderly, the National Council for the Elderly proposed, with the agreement of the Department of Health, to undertake this project. The Council commissioned Mr. Peter Connell of Trinity College Dublin to generate population projections for the period 1991-2011, and Dr. Tony Fahey of the Economic and Social Research Institute to produce a report based on these projections. In October 1995 the Council published this report entitled, Health and Social Care Implications of Population Ageing in Ireland, 1991-2011.

The Council then organised a Conference, Planning Health and Social Care Services for the Elderly: Implications of the Projected Increase in Our Elderly Population (1991-2011), in the Royal Marine Hotel, Dun Laoghaire on November 24th, 1995 to allow for a discussion of the report by concerned parties. Publication of the Council’s comments and recommendations was postponed until after the Conference.

The proceedings of the Conference and the Council’s comments and recommendations based on the report and the discussions at the Conference, are presented here.

We are very grateful to Mr. Michael Browne, a former Research Officer with the Council, for acting as rapporteur. On behalf of the Council, I would like to thank him for bringing together the papers presented at the Conference and for preparing his own report on the main points arising from the discussions. Though not pretending to record in detail everything said by invited speakers or from the floor, we are confident that this report provides a useful account of the main issues discussed. I would also like to express our thanks to the speakers for preparing such excellent papers and to the participants for their contributions at the Conference.

Michael White
Chairman
March 1996
Introduction

The following National Council for the Elderly comments and recommendations are based on the report, *Health and Social Care Implications of Population Ageing in Ireland, 1991-2011* prepared by Dr. Tony Fahey for the Council. They were presented in draft form at the Conference on this subject by Dr. John Murphy, a member of the National Council for the Elderly and Chairperson of the Consultative Committee established by the Council to oversee the preparation of this report and have been subsequently revised to take account of issues raised at the Conference.

Population Projections

1. The elderly population is projected to increase by 119,000 persons or 29.5 per cent in the period 1991-2011, due mainly to improvements in life expectancy. The greatest increases will occur within the sections of the older population which have traditionally consumed the largest share of health and social services. Firstly, there are projected to be 51,000 more persons aged 80 years or more. Secondly, the number of older persons living alone will rise by more than 41,000 persons. In geographical terms, the largest relative increases are projected for older people living in the Eastern Health Board region.

2. The Council welcomes the recent improvement in the life expectancy of Irish older people and hopes that the projected increases in life expectancy are actually realised. Ireland has traditionally had low life expectancy figures among older people compared to other European Union and OECD countries. The Connell projections in Dr. Fahey’s report assumes that men at 60 years of age will be living an extra 2.1 years, and females an extra 2.5 years by the year 2011. These improvements are overdue and it is to be hoped that the life expectancy of Irish older people will continue to increase after the year 2011.

3. The report highlights concerns over the accuracy of population projections. It is pointed out that previous projections made by the National Economic and Social Council and by the Central Statistics Office have been inaccurate, particularly when projecting the proportion of the general population that will be aged 65 years or...
more. Whilst accepting that the current projections are unlikely to be completely correct, the Council has confidence in their general thrust. Firstly, the size of the base population from which the elderly population in 2011 will be drawn is known. This age group is not prone to the fluctuations caused by emigration seen in younger populations. Secondly, population ageing is an established trend in the developed world. The main sources of inaccuracy in previous projections have been unexpected falls in the fertility rate and rises in the life expectancy of older people. These changes bring Ireland into line with trends in other developed countries however, and the Council feels that the likelihood of these trends reversing in the near future is low.

4. At a local level however, the population projections are likely to show some degree of inaccuracy. The county level projections are based on the disaggregation of national assumptions, as the information required to make assumptions about local population trends was not available. The local population projections will, therefore, reflect regional trends in life expectancy, fertility or marital rates. The Council recommends that future population projections incorporate assumptions based on local mortality, fertility, marital and migration rates. A systematic method for gathering this information should be developed where none currently exists.

5. The Council would also like to draw attention to the likely increases in the elderly population beyond 2011. The most striking demographic change that has occurred in Ireland over the last 10-15 years has been the increase in the number of middle aged people. The number of people aged between 35 and 44 years, for example, increased by 103,600 persons or 29 per cent between 1981 and 1991. This cohort of people will be aged between 65 and 74 years by the year 2021 and are likely to contribute to a greatly enlarged elderly population at this time. Both the Central Statistics Office (1995) and the Connell projections indicate that the elderly population will exceed 600,000 persons by the year 2021, with the CSO projecting an elderly population of almost 700,000 persons by the year 2026.

Health and Social Needs Projections

6. In order to project future service requirements, one must determine future levels of need for health and social care. In practical terms, need may be defined as the areas in an individual’s life that would benefit from an intervention by health or social service providers. Older people on average have poorer health and higher levels of dependency than younger adult age groups, and this leads to higher rates of health and social service utilisation. Within the older population, need, and particularly social need is also influenced by demographic variables such as advanced age (living to beyond 80 years), living circumstances, socio-economic status and available family support.

7. There can be no dispute that the aggregate level of need by older people will increase given that the older population grows as projected. Dr. Fahey argues however, that the average level of need by the elderly will decline in the near future with the result that total need will not increase at the same rate as population ageing. This argument is based on the assumption that the average health status of older people will improve due to better lifestyle in the coming decades. As health improves, the need for services will be pushed further into old age.

8. To deal with health need alone, the Council naturally welcomes any evidence that the health of Irish older people is set to improve, and that this will reduce the burden on service providers of an ageing population. There are important qualifications to this argument however. Firstly, one must acknowledge that health promotion and illness prevention require resources. The prevention of heart disease, for example, requires significant resources, including campaigns aimed at changing diet, exercise patterns and smoking, routine cholesterol and blood pressure measurement and the use of medications. The cost of such measures can only be expected to increase as the population ages and the number of people with pre-morbidity conditions increases. The Council would recommend that adequate resources are provided to promote the health of a growing older population, and that health promotion efforts are not relaxed as the life expectancy of older people improves.

Secondly, there is little evidence that the average mental health of older people is improving. It must be remembered that up to 20 per cent of older people suffer from depression, and a further five per cent from dementia at any one time. There is currently little attention paid to the prevention of mental illness in older people and it is hard to be optimistic about the likelihood of current morbidity levels falling. In addition, the life expectancy of persons with intellectual and other disabilities has significantly improved in recent times. It is likely that many persons with these disabilities will reach old age in the future, and will at that time pose a special challenge to providers of mental health services.

A third important influence on future health needs is the extent to which improvements in the health of older people will be cancelled
out by a growth in morbidity associated with senescence such as Alzheimer's disease and osteo-arthritis. The current evidence is mixed, suggesting that although those aged 65-75 years can expect to live healthier lives, people older than this will continue to develop the so-called diseases of old age. The population projections indicate that the number of persons aged 75 years or more will increase by more than 64,000 persons from 1991 to 2011. Health and social services should therefore begin to prepare for an increased level of need related to the disorders of advanced age on the basis of the population projections provided in the report.

Whilst the exact level of health need in the future is unclear, it seems easier to predict the level of social need that will arise from the ageing of the Irish population. Social services may be defined as those where the focus is on care rather than cure. The alleviation of social need has many facets. It can involve practical tasks such as shopping, cleaning around the house or transportation to hospital. It can also involve psychological support for older people who are lonely or depressed. Social services also have a significant health dimension of course, as the social services will often be the first to notice the risk of physical or mental disorder. On a larger scale, the provision of housing for persons with special requirements is also involved.

When considering the need for these services one must first remember that there is already a reservoir of unmet need in older people. This has been clearly established in previous Council publications and in other research. It must also be acknowledged that certain types of social care for the elderly are essential to ensure that reductions in health need will actually materialise. Older people living alone, for example, will still need to be monitored to ensure the early detection of physical and mental problems. Services such as chiropody, which can be provided at a relatively low cost, will still need to be provided to ensure that preventable health problems are not allowed to develop.

The social care services will also need to increase if they are to meet the policy on community care for persons aged 75 years or more. In the health strategy document, *Shaping a Healthier Future* a target of at least 90 per cent of persons aged 75 years or more living in their own homes is outlined. At the 1991 census, 22,277 persons (13.7 per cent) aged 75 years or more lived in non-private households. The community care services will need to be considerably strengthened therefore, if the policy objective is to be met with current population levels. This expansion must also take place in a context where it is widely accepted that current services are insufficient to maintain the quality of life of those who are currently dependent and living in the community. The invaluable role of informal care has been a constant theme of many Council reports.

According to the Connell projections however, the population aged 75 years or more is set to increase from 162,848 persons in 1991 to 226,901 persons in 2011. If the health strategy policy has been fulfilled at this point, there will be between 22,000 and 23,000 persons over 75 years in institutional care. This is the same level of institutional care that is currently provided. At the same time though, an extra 60,000 persons in this age group will be community residing if the population projections are accurate. Given this scenario, and given that the current levels of morbidity and dependency in the over-75s do not change, the community care services will require a massive expansion in order to function properly. The need for purpose built housing is also likely to increase as the number of community residing older people with some form of dependency grows. It must be stressed here that community care must do more than keep people out of institutions. In the health strategy, a goal of such services is explicitly stated as being "to maintain older people in dignity and independence at home" (p.66).

There is no easy alternative to this scenario. If the community care policy fails, the State must again look to the provision of institutional care which has already rejected as the first option for care on quality of life grounds. In the past it could be argued that the lack of a measurable outcome or target for community care services contributed to the lower priority placed upon it by service planners. Following the health strategy document, this is no longer the case and it is safe to say that a significant growth in the area of social care will be required to meet both current and future need if policy objectives regarding the quality of life of the elderly are to be met. For all these reasons, the Council would recommend that social care and housing services be developed at a rate that closely matches the growth in the elderly population.

**Future Resource Availability**

11. A crucial question arising from the report relates to the availability of funding for health and social care in the future. Essentially we need to know if a natural growth in the wealth of the country will provide the increased health care resources needed, or alternatively if future restrictions on resources will require our health budget to be distributed differently from at present.
12. The Council would welcome the scenario outlined in the report, that economic growth will provide for a 70 per cent growth in health expenditure between 1991 and 2011. There are good reasons however, for not allowing this prediction to reduce one’s vigilance at this time of great demographic change. Firstly, one can not be absolutely certain that this increase in resources will materialise given the uncertain nature of economic prediction. Secondly, one must remember that an ageing population will create demands on the exchequer much greater than those within the health budget. The recent National Pensions Board report (1993) has already shown that the cost of providing pensions and the other benefits currently enjoyed by older people will be of considerable cost to the exchequer. Thirdly, it is highly likely that the rising cost of providing health care will absorb much of the increase in resources. In health care particularly, advances in medical science are generally associated with increased costs for new medications and equipment. Additionally, the changing methods of delivering health care to older people are likely to lead to demands for increased resources. These pressures make it important that a concerted effort is made to ensure that increased resources are translated directly into increased levels of service provision in both the social and health care sectors.

Planning Services for the Future

13. The final and most important question raised in this report relates to the planning of services. On the basis of the projections and current State policy, it would be incorrect to maintain the current balance between health and social care services if we wish to meet the current target on community residence. There would also seem to be an argument for changing the distribution of resources for the care of the elderly across different geographical areas to match the changing age structures of these regions. It would be difficult to implement such changes within the current ad hoc system of resource allocation however. The most important challenge therefore, is to ensure that health and social care services respond to changes in demography and need in a flexible way that ensures any future growth in health resources is not wasted.

14. The Council recognises that the organisation of a system as large and as complex as the Irish health system has no easy solutions. The problems faced by Irish planners have not been resolved completely in other countries, although systematic resource allocation methods on the basis of need, or proxies of need, have been attempted.

One must be wary of planning methods that rely on utilisation rates or demand alone. Demand is not synonymous with need and is influenced by factors such as information and advice from health professionals and social attitudes towards health and social care. Demand is also influenced by supply, of course. An often repeated truism is that services will be used when available - sometimes whether needed or not. This in turn creates a momentum for expansion as it is perceived that the service is meeting a need. It has been argued that the growth in prescribed medication usage due to the availability of free medication is an example of this effect.

15. The Council recommends that a transparent formal mechanism for distributing health and social care resources in an equitable and flexible manner on the basis of need be developed. This mechanism should be based on information collected across local areas feeding directly into the decision making process. The first step towards developing such a system should be a clearer understanding of how resources are currently distributed. A study of the current process of allocating health and social care resources should be carried out. This study should describe the decision making process at all relevant administrative levels, and detail the information sources used when planning future services.

16. The Council recognises that any future system of resource allocation will be influenced by changes in State policy on health and social care. The Council would strongly recommend however that the implications for older people of policy decisions relating to the total health budget allocation are always calculated. Lyons (1995) has suggested for example that the political urge to reduce waiting lists for elective surgery in the last six to seven years was not necessarily to the benefit of older people. It may be argued that those benefiting most from these initiatives had been those best able to express their demands within the UK health system - traditionally the middle classes from younger age groups.

17. Ultimately any future system for allocating resources will only succeed if it is based on accurate information about need. The most important area for research on need in relation to the Irish elderly must be the relationship between morbidity and different socio-demographic variables. These variables include gender, income, district of care, marital status, social class and living circumstances. Types of morbidity must also be investigated. It is vital to know, for example, where morbidity leading to progressive dependency is most prevalent. Research on health needs is not sufficient on its own however, as morbidity is not the only determinant of quality of life. There is evidence that the type and level of social need can vary.
significantly across demographic variables. This information must also be documented if social care is to be planned effectively. The Council would recommend that research on morbidity, need and demography be urgently commissioned.

18. It is also imperative that outcomes following health and social care interventions are in some way assessed within a future resource allocation system. This will ensure that identified needs are met in the most equitable and efficient manner. The Council would warn against a reliance on measures of outcome which discriminate against older people, however. Certain measures (e.g. the Quality Adjusted Life Year or QALY) assess the average number of years lived after a particular intervention, adjusted for life quality. These measures are generally ageist, firstly because older people have a lower life expectancy and therefore do not experience the same improvements in mortality as younger populations following an intervention, and secondly because the measures of life quality (e.g. ability to return to work) are often more relevant to younger people and give the impression that older people have experienced little social gain. As an alternative, one might measure the number of people that have to receive a particular intervention (e.g. a total hip replacement) in order to prevent a relevant adverse event (e.g. a fall). As the risk for adverse events in the elderly is high compared to younger people, it requires comparatively fewer interventions to prevent an event. In this way, the true benefits to older people of particular services could be identified.

References


INTRODUCTION

Mr. Michael White
Chairman, National Council for the Elderly

Good morning, ladies and gentleman. On behalf of the National Council for the Elderly, I welcome you all here this morning to this Conference entitled Planning Health and Social Care Services for the Elderly: Implications of the Projected Increase in Our Elderly Population (1991-2011). It is very encouraging to see the interest shown in today's topic by such a wide variety of people and interest groups from all over Ireland. Many of you have gone to considerable trouble to be here this morning, so wherever you are from, you are indeed welcome.

We are living, ladies and gentleman, in very significant times. The Peace Process is now over a year old. The President of the US will visit our country in the next few days and on this very day the people of Ireland are deciding on a constitutional change, a decision which will affect the lives of many people for years to come. Our interest in the issues of the present, however important, should not deflect our concern for future issues and for timely planning to ensure that proper management of our resources will enable us to respond to future challenges, as they arise, and so prevent problems developing on a community or personal level.

One of the great challenges facing us as a community in the next twenty-five years is that arising from the great increase in the numbers of older people. As the day goes on you will hear in great detail that there will be an increase in every part of the country and among every older age group. This increase in the population of older people is going to have a significant influence on many aspects of Irish life. Public and private service providers will have to seriously consider the implications of the demographic shift in order to adequately respond to the challenge.

The demographic changes that are evident from the statistics will create a significant growth, in both the need and the demand for health and social care services over the next two decades. When one considers the level of current needs for services, particularly services in the community, as outlined in previous Council reports, the population projections are a source of considerable concern.

This is by no means an academic discussion because by and large when we talk about older people at the beginning of the next century we are talking about ourselves. This should give a sense of real concern to our discussion.
today. At the heart of the debate is the question: how can we allocate resources so that health and social needs are met in the most efficient way possible?

The Council is indebted to Mr. Peter Connell for preparing the population projections and to Dr. Tony Fahey, the author of the report, *Health and Social Care Implications of Population Ageing in Ireland, 1991-2011* for outlining in a clear manner the complex issues involved in this area. I would also like to express my gratitude to the members of the Consultative Committee set up by the Council to oversee the preparation of this report and to Dr. John Murphy who chaired this Committee.

FIRST SESSION: THE STUDY FINDINGS

Chair: Mr. Jerry O’Dwyer
Secretary, Department of Health
PRESENTATION OF POPULATION PROJECTIONS

Mr. Peter Connell
Trinity College, Dublin

1. Assumptions

1.1 The projections presented in the report are built around a series of assumptions relating to life expectancy, marital status, migration, fertility, household formation and the propensity to live alone.

1.2 Assumptions relating to life expectancy have the most direct impact on the projected numbers of elderly persons. Historic trends in Irish life expectancy have seen sustained improvements since the 1950s, with particularly marked advances in female life expectancy. During the second half of the 1980s male life expectancy rose from 71 to 72.3 years, while female life expectancy rose from 76.7 to 77.9 years. These trends are by no means exceptional in a European context. Indeed in the 1990s Irish life expectancy for both males and females remains low by European standards.

In the period 1991-2011 it is assumed that the gains in life expectancy experienced in the period 1986-1991 will continue at the same rate up to 2001, at half the rate in 2001-2006, and will level off in the period 2006-2011.

1.3 Projections relating to the marital status of the elderly population assume a significant increase in the proportion married. The assumptions relating to marital status are driven by two factors. Firstly, improved life expectancy will mean that more couples will survive into their 70s and 80s. Secondly, the rising marriage rate of the 1960s and 1970s will begin to feed through after 2001 to a much higher proportion of married elderly.

1.4 Regarding household composition, there is an historic trend suggesting an increasing propensity among the elderly to live alone. An increasing proportion of single and widowed elderly live in single person households. It is assumed that this trend will continue up to 2011 (Figure I).
2. Projections

2.1 The absolute number of those aged 65 and over is projected to increase from about 400,000 in 1991 to 520,000 in 2011, or by 30 per cent. The elderly, who represented 11.4 per cent of the population in 1991, are projected to rise to 14.1 per cent of the population by 2011 (Figure 2).

2.2 In terms of the changing age composition of the elderly, the most dramatic increase will occur in the 80+ age group. The number of those aged over 80 will increase by 79,000 and the over-80s will represent almost 25 per cent of the elderly as opposed to 19.5 per cent in 1991.

2.3 While the total number of elderly is projected to increase by 30 per cent, the number of married elderly will increase by 57 per cent reflecting the much higher marriage rates among those currently in their 50s together with improved life expectancy. The number of widowed is projected to increase by 27 per cent and the number of single elderly to fall by 13 per cent.

2.4 Despite a growing propensity for the single and widowed elderly to live alone, the actual proportion of elderly living alone will only rise from 24 per cent to 26 per cent in the period 1991-2011. The absolute increase in the numbers of elderly living alone will be from 96,500 in 1991 to 133,000 in 2011 (Figure 3).

2.5 Demographic trends across the eight health boards areas are quite uniform. The next 20 years will see an amplification of trends already evident. The Eastern Health Board currently has, in absolute terms, the highest concentration of elderly and this is projected to rise from 117,000 in 1991 to 176,000 in 2011. On the other hand, this health board will continue to have, proportionally, the youngest population. The North Western Health Board will continue to have the lowest number of elderly but by 2011 the over-65s will represent almost 17 per cent of the population in that area, the highest proportion in the State (Figure 4).

The period 1991-2011 will witness a quite dramatic increase in the number of over-80s in the Eastern Health Board, rising from 23,000 in 1991 to 42,000 in 2011 (Figure 5).

In summary, the number of elderly is projected to increase at about the same rate as through the 1970s and 1980s. Within the over-65s there will be a distinct shift towards the over-80s and towards more married elderly persons. Geographically, the Eastern Health Board will witness a virtual doubling in the number of elderly aged 80 and over.
Figure Two. Percentage change in age groups, 1991-2011.

Figure Three. Number of older people living alone, 1991-2011.
Figure Four. Distribution of over 65s by health board, 1991 and 2011.

Figure Five. Distribution of over 80s by health board, 1991 and 2011.
PRESENTATION OF STUDY FINDINGS

Health and Social Care Implications of Population Ageing in Ireland, 1991-2011

Dr. Tony Fahey
Author of Report
Economic and Social Research Institute

My task today is to consider the implications for health services and social care services of the population projections just outlined by Peter Connell. I will first consider the implications of population ageing for the overall size of the health and social care system, as indicated especially by possible future trends in overall health expenditures, and then I will look at the effects population ageing may have on future trends in the composition of the health and social care services.

My central contention is that population ageing is less important in determining overall health service expansion than is often assumed. It may have some effect on changes in the composition of the health and social care services, but it is difficult to identify what that effect is likely to be. The overall conclusion is that population trends in general provide little guidance on the likely future size or shape of the health services, though they may have some bearing on individual sectors.

To consider the impact of population ageing on overall health expenditures I would invite you to cast your minds back over the last two or three decades of health service consumption. In Ireland, real growth in consumption of health services per head of population was enormous in the 1960s and 1970s, equivalent to more than a doubling of consumption in each of those two decades. In response to the runaway growth of the 1970s, the 1980s were a decade of cutbacks in real per capita terms. Nevertheless, in 1990, health services consumption per capita in Ireland was about four times what it had been in 1960 (See Table 1).

A similar overall level of growth occurred throughout the OECD over the same period, though it was more evenly spread over time. Growth in health services consumption was lower on average in the OECD in the 1960s and 1970s than in Ireland, but it continued during the 1980s when Ireland was cutting back. By 1990, the OECD average increase since 1960 had more or less caught up with that of Ireland.

Did population ageing play a role in the growth of health spending per head in Ireland since 1960? Were people in 1990 consuming more health services because they were older on average than the population in 1960? The answer is no, since no significant population ageing had occurred in Ireland over the period. The percentages of the population in Ireland aged over 65 and over 80 were more or less the same in 1990 as in 1960. In fact, the population got younger on average during the 1960s and 1970s, when health services expansion was at its most rapid. Paradoxically, as the population began to get older in the 1980s, health services consumption declined. Thus, population ageing made no contribution to the overall growth in health service consumption over this period.

Was Ireland somehow anomalous in this lack of a relationship between growth in health services consumption and population ageing? Again, the answer is no. Analyses of health expenditure levels across OECD countries show that overall health expenditure has not been consistently linked to population ageing or to any other aspect of population structure. Nor have major sub-areas of health expenditure such as acute hospital care, ambulatory care or drug consumption been linked to population trends or structures. Over this period, many OECD countries experienced population ageing on a scale similar to that which is projected to occur in Ireland over the next two to three decades. These countries did not have notably higher rates of growth in health expenditures than Ireland.

How can we explain this lack of impact of population ageing on consumption of health services? Three explanations can be considered.

1. Population ageing does not of itself necessarily lead to a deterioration in average population health status or to an increase in health needs.

Increased life expectancy (one of the major contributors to population ageing) has been associated with increased disability-free life
expectancy. It has also been argued that intensive health services consumption among older people tends to arise in the last months of life, regardless of the age at which those months occur. Thus, as the average age at which people die rises, the average age at which they become chronically or acutely ill also rises.

As a result, increases in the population of older people are not always accompanied by parallel increases in the population of sick or dependent people and thus do not always lead to an increase in health needs.

By arbitrary convention, we have long defined the age 65 as the threshold of old age. As far as health status is concerned, it may be more realistic to view that threshold as a rising boundary which shifts upwards with improvements in life expectancy (we should also recall that such improvements in health status are an explicit goal of health policy). Thus, by 2011, the age threshold which could be validly compared with the age 65 in the early 1990s as far as health status is concerned might be 67, 68 or 69 rather than 65. If we were to take 67.5 as the age threshold in 2011 which would compare with 65 in 1991 from a health status point of view, the population for 'elderly' persons in 2011 would be made up of about 440,000 persons aged 67.5 and over rather than 512,000 persons aged 65 and over. This would imply an increase of 10 per cent in size of the 'elderly' population since 1991, in place of the increase of almost 30 per cent which is projected to occur in the elderly population on the basis of an unchanged chronological definition of old age.

Population ageing thus has a double effect on health needs - one, a negative effect arising from the increasing numbers of older people, and the other, a positive effect arising from improved average health status among older people. While it is impossible to predict where exactly the net balance of those effects will lie, it is likely to be a moderate, in-between balance rather than the wholly negative outcome which is often assumed, thus moderating the impact of population ageing on health service needs.

2. Resources, not need, determine demand for health care.

At a national level, demand for health services is determined less by health need than by the amount of money available for health spending. Nations spend more on health not as their populations become healthier or sicker but as their economies grow. For health spending, therefore, it matters little what effect population ageing has on average health status or health needs since these considerations have little bearing on health consumption trends. Health services have the character of a luxury good - the richer a population, the more it spends on health, irrespective of underlying health status. Over recent decades, health spending in western nations has come closer into line with what one might predict on the basis of their level of economic development.

There are some exceptions - especially the United States, which spends far more on health than its total national expenditure would lead one to expect - but otherwise the degree of international conformity to the expenditure norms associated with various levels of economic output is quite consistent and striking.

3. Supply rather than demand is the main influence on health service consumption.

To varying degrees, the factors which affect health service consumption - the determination of individuals' need for health care, the provision of resources, the determination of which kinds of services should be supplied - are shaped by the supply side of the system (doctors, governments, health bureaucracies, health insurers, drug companies, etc.) rather than by the consumers who make up the demand side. To a great extent, both supply and demand are the outcome of struggles between supply side actors - in particular, between those who have an interest in maximising consumption (doctors, hospitals, medical insurers, drug companies) and those who have an interest in containing it (usually the State, as chief funder of the health system). Consumers, in this view, constitute a vast, possibly unlimited, pool of potential demand. The segments of that potential which are converted into actual potential consumption, and the level at which that consumption takes place, are principally determined by the trajectory and balance of forces on the supply side.

Factors arising on the demand side proper, such as the expectations of consumers, may have some bearing on consumption patterns, but these are likely to be less significant than supply side influences.

From past experience in Ireland and other countries, therefore, there is little empirical evidence that population ageing has much effect on our health expenditure. There also seem to be plausible grounds for accepting that lack of effect as quite understandable. Thus there is no reason to expect that a demographic effect on overall health expenditures is likely to become significant in the foreseeable future.

If that is so, what about the effect of population ageing on the composition of the health services? Some such effects are likely. There may be some rebalancing of health expenditures away from younger age groups towards
the elderly. This is not to say that health expenditures for younger people will be cut but rather that they may get a smaller share of future growth in provision than older people. For policy reasons, there may also be some reallocation of provision for elderly people away from institutional care towards community care, including social care services for elderly people. Those aged over 75 years are projected to increase by about 20 per cent by the year 2011. One hopes that the risk of disability and dependency among those aged over 75 will decline over this period so that the increase in the numbers of dependants among the over-75s will be a good deal less than 40 per cent. Nevertheless, considerable upward pressure on the community care services is likely to result since, as is stated in recent policy documents such as Shaping a Healthier Future, the target is to reduce reliance on long-term institutional care as a means of catering for the needs of the frail or dependent elderly.

It is often suggested that demographic developments may have an impact not only on the numbers likely to be in need of such care but also on the sources of social care. Social care traditionally has been an informal family function and has been most often provided by spouses and children (especially daughters) of dependent older people. Demographic trends can have an influence on the capacity or willingness of families to provide that care. Today, emphasis is often placed on trends which tend to reduce such provision. The decline in family sizes, the rapid increase in the numbers of old people living alone and the increasing labour force participation rate among women (which means that women are not available to provide care to older relatives) are often referred to in this regard.

However, present demographic trends are not all working in the same direction as far as the supply of informal care is concerned. In Ireland, it is especially important to note that the single elderly as a proportion of all elderly are projected to decline substantially and that the growth in numbers of older people is projected to occur among the married. Since spouses are among the most important sources of informal care, the increased prevalence of marriage among older people indicates an increase in the supply of informal care. Furthermore, both the married and the widowed are likely to have children, where the single elderly are not, so that the decline in the proportion of single elderly reduces the incidence of those who have little or no informal care resources. We should also recall that the decline in marriage and fertility in the last two decades will free many non-elderly adults to devote more time to care for elderly parents. It is often assumed that increasing labour force participation rates among women reduce the supply of informal care. This in turn seems to reflect an assumption that a woman working full-time in the home, even if she has children to look after, is more available to care for an elderly parent than a woman with no children who is in a full-time job. This is an assumption which needs to be tested rather than adopted unquestioningly as a basis for thinking about future sources of care for older people.

What are the implications for planning? The central contention here is that demographic projections, which basically are concerned with the numbers of people in various age categories, have much less value for planning of future health than projections of people's behaviour - and here we have to consider the behaviour not just of health service consumers but also of the wide range of actors involved in health service provision. While changes in behaviour are difficult to predict, we do know of one central factor which influences changes in health behaviour among both consumers and suppliers - that is, the availability of resources. Health expenditure has become ever more closely linked to the level of economic development, so that trends in the latter provide the best available predictor of trends in the former. Assuming moderate economic growth rates in Ireland up to 2011, and assuming the persistence of the kind of link between economic growth and health expenditure which has become the norm in OECD countries, it would not be unrealistic to project a 70 per cent real increase in health service provision between 1991 and 2011. Such a scale of increase far outstrips anything required or dictated by demographic change alone.

The main planning task, therefore, is to look ahead at how to direct the distribution of that large real increase - across regions of the country (e.g. by health board area), across sectors of the health services (e.g. between hospital as opposed to community care within health boards), across illness categories, age categories, income categories and so on. It does not help planning that we know so little about how such distribution is determined at present. Little research has been conducted into the decision making process within the public sector health service - for example, with regard to the setting or distribution of expenditure budgets, either at national, health board or sub-health board levels. Much less do we know how supply side actors other than public sector planners have an impact on distribution - through price setting, development of new products or attempts to increase market share in health service markets. It would hinder rather than help health planning if a great deal of attention was paid to future demographic trends and as a result too little attention was paid to these other, more significant, influences on health service provision.
RESPONSE I
A National Economic and Social Council Perspective

Mr. Joe Larragy
Policy Analyst, National Economic and Social Council

1. Introduction

Essentially, in this paper, I will be presenting a somewhat critical view of the findings of the report. In saying this, I want to stress, that I found the report very stimulating and thought provoking and there is much in it with which I do agree. I will summarise the basic contentions of the study, then I will set out a response to the main points with which I have difficulty agreeing.

I hope that by the end of this paper you will agree with me that this report contains the opening shots in a new debate about health care planning and provision in Ireland. Of course, there are other issues not covered in the report, which are very important but about which I will have little to say either. I am thinking of issues such as a radical reorientation of the health services towards outcome, which is the stated objective of the new health care strategy. Perhaps in the work that will be done over the coming months and years, the inter-relationship between demography and the agenda set out in the strategy will be made more concrete and meaningful. Today's Conference hopefully will be an important contribution to that process.

2. The Study Findings

The key findings of the author of this study are as follows:

(i) Population projections are generally not very reliable.

(ii) Even if population projections were reliable, they are not a very good guide to health care utilisation or health care expenditure.

(iii) They are not a good guide because, regardless of age structure, there is a predictable relationship between national income per capita and national expenditure per capita on health care.

(iv) The study goes on to suggest possible mechanisms or explanations for the apparent absence of a relationship between ageing and health care and for the apparent presence of a high correlation between income per capita and expenditure per capita.

(v) Part of the explanation offered in the study is that health care expenditure is driven by demand rather than need. While demand reflects need to some extent, it is also subjective. Health care expenditure is compared in the study to luxury expenditure, which increases with income but at a faster rate.

(vi) Another possible explanation offered by the study for the correlation between income per capita and expenditure on health per capita is the dominance of supply side factors. Here neither need nor demand determine the increase, but the various interests ranging from drug companies to professionals which influence both private and public expenditure on health care.

(vii) A theoretical explanation is also offered for what is described in the study as the demographic 'non-effect'. Essentially the argument is that population ageing is not matched by a pro rata increase in health care need. The author appeals to the idea, sometimes referred to as 'morbidity compression', that the onset of illness is pushed ever deeper into old age with the result that increasing numbers of elderly people are not matched by a corresponding increase in the toll of illness and mortality.

(viii) The study goes on to criticise a report by Raftery published in 1983 by the National Economic and Social Council on the implications for the health services of demographic change. The author questions the relevance such a study may have had to policy makers and offers fairly scathing criticisms of the assumptions used in that study.

(ix) A final conclusion arrived at in the study is that, while medical care and health care may not be correlated with ageing, the same might not be said for social care. However, the author goes on to argue that such care might be provided by informal sources, and he suggests that we have little or no evidence of a conclusive kind to suggest that informal care resources will decline relative to the growing demand in the future.

I wish very briefly in my presentation to this Conference to present some alternative perspectives on the relationship between demography and health care as a constructive counterbalance to the line of argument offered in the study.
3. Unreliable Population Projections

I would contest the view that all projections of population are equally unreliable. The projections made by the NESC in the early 1980s and those of the CSO in the mid-1980s were inaccurate on a number of points. However, I believe that both for good theoretical reasons and on the basis of international evidence - the CSO’s latest projections, and indeed Peter Connell’s projections, produced in the last year, will prove more accurate. The key factor is fertility. Up to the early 1980s, for decades, the birth rate had been relatively stable. In the late 1980s, birth rates began to collapse rapidly. I believe that this is a shift rather than a swing, i.e. it is unlikely to swing back to former levels.

Other countries, which experienced a collapse in fertility earlier than Ireland, show little sign of a swing back. Some writers (Ermisch 1983), put forward plausible reasons for a shift as opposed to temporary fluctuations largely connected with rising income and married women’s rising labour force participation. People are not having families of four and five children now but families of one, two or three children. If we take account of this, we can readily see why the NESC and the CSO got it wrong in the 1980s, but the CSO and Connell have remodelled their assumptions around the fertility collapse in birth rates and, as a result, we can be much more confident about the new projections.

4. From Population Growth to Population Ageing

The 1980s, consequently, were a watershed. The demographic agenda has to be redefined as a result of the changes which have taken place during the 1980s. The most important change, for present purposes, is a shift in focus from an absolute growth in the size of the Irish population to a very definite change in the age structure of the population. From 1961 to 1986, Irish population grew by 25 per cent, a substantial rate of growth, particularly in view of the fact that Irish population had been declining over the 120 years prior to 1961. From 1986-2011, according to a middling pair of CSO assumptions, the Irish population will grow by 4.5 per cent approximately – less than one-quarter of this pace.

The two periods, 1961-1986 and 1986-2011, may be contrasted also in terms of changes in the age structure of the population. While absolute growth of population is no longer the driving force it has been, I would argue that the phenomenon of population ageing – not an important issue up to now – will become increasingly central to discussions of demography. The most notable change in age structure of the Irish population between 1961 and 1986 was the increase in the relative size of the young adult age group, that is aged 15-39 years. Over this period, the proportion accounted for by children (0-14 years) declined a little, while the proportion in the other age groups also declined.

Table 1: Population by Age, 1961-2026 (in Thousands)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>1961</th>
<th>1986</th>
<th>2011</th>
<th>2026</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14 'Children'</td>
<td>877.259</td>
<td>1,024.70</td>
<td>740.4</td>
<td>700.4</td>
<td>-25.5</td>
</tr>
<tr>
<td>15-39 'Young Worker'</td>
<td>856.796</td>
<td>1,348.39</td>
<td>1,333.50</td>
<td>1,241.60</td>
<td>-8.0</td>
</tr>
<tr>
<td>40-64 'Older Worker'</td>
<td>769.233</td>
<td>783.195</td>
<td>1,131.6</td>
<td>1,257.80</td>
<td>-48.4</td>
</tr>
<tr>
<td>65+ 'Elderly'</td>
<td>315.065</td>
<td>384.355</td>
<td>485.7</td>
<td>692.2</td>
<td>72.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2,818.34</td>
<td>3,540.64</td>
<td>3,691.1</td>
<td>3,892.20</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: CSO, various publications.

Children

Between 1986 and 2011 the number of children will decline fairly drastically from over one million to about 750,000. This represents a proportional decline from almost 29 per cent to just 20 per cent of population. After 2011 the decline will continue, but more gradually.

Young Workers

If we look next at the young worker age group (15-39 years), we see a very slight decline in numerical and proportional terms between 1986 and 2011, from 1.35 million to 1.33 million, or a decline from 38 per cent to 36 per
cent of population. However, in this age group there will be a more rapid decline after 2011, so that by 2026 this component of the population will amount to 32 per cent.

**Older workers**

The situation for older workers (40 - 64 years) and the elderly will change in the opposite direction. In the case of older workers, there will be a rapid increase between 1986 and 2011, from 780,000 to 1,25 million, representing an increase from 22 per cent to almost 31 per cent of population - an increase of 60 per cent. After 2011, the growth of this age group will continue but at a slower rate so that by 2026 it is projected to represent 32 per cent of population.

**Elderly**

Finally, the elderly population, which grew at roughly the same rate as the total population between 1961 and 1986, is set to increase in the coming decades. Up to about 2006, the increase will be fairly small but will begin to pick up thereafter and, from 2011, the increase will be major. Thus, the number aged 65 or over will increase from under 385,000 in 1986 to 486,000 in 2011, a rise of 26 per cent. and to 690,000 by 2026, a further rise of 42 per cent after 2011. In proportional terms, the elderly will comprise almost 18 per cent of the population in 2026 as against 11 per cent in 1986.

In Figure 2 we can see that between 1986 and 2011, the key is a reduction among children and an increase in the older worker age group, while from 2011 to 2026 the key is a reduction in the young worker age group and an increase in the over 65 age group.

**Figure 2: Population by Proportion in Each Age Group, 1961-2026**

5. **Per Capita National Income and Health Expenditure**

The present study argues that it is not demography, or population ageing, but changes in Gross National Product per capita, which influences health care spending. The study criticises the NESC study of 1983, by Raftery, which projected certain levels of expenditure and service utilisation under a number of important headings, such as acute care, GMS, etc. The critique, essentially, is that the study ignored the relationship between per capita income and per capita expenditure on health care. The NESC report is also criticised for assuming constant utilisation rates for health services, since of course such rates would change. The NESC study is also criticised for getting it wrong in the 1980s for want of an anticipation of the fiscal restraint which was to be imposed, curtailing health budgets. On the basis of that, Fahey argues, were the initial population projections correct - which of course, as we know, they were not - the NESC report on health care would have been even more erroneous. And finally, he wonders, what conceivable relevance or influence such a study might have had on policy making in the 1980s.

I believe that the critique is inaccurate both as to the content of the NESC study and the context in which it was written.

Firstly, in relation to the fiscal context, Raftery was clearly aware of the existence of a correlation in comparative analysis between per capita health spending and per capita income. Indeed, the author was well aware of Ireland's position in relation to other OECD countries and particularly Ireland's GNP, morbidity and health expenditure as a percentage of GNP, relative to Scotland, England and Wales and Northern Ireland.

OECD data on health care expenditure per capita show that during the 1970s and 1980s Ireland was out of line with international standards, that is in relation to the proportion of GDP a country of Ireland's average per capita income ought, by international standards, to be spending on health care.

By 1990, the fiscal situation had been considerably alleviated and recent OECD data for 1992 shows that Ireland was no longer above the regression line but below it (OECD, 1995). I would suggest that the purpose of the NESC (1983) study was to bring about health care reforms with the intention of facilitating this fiscal adjustment.

The NESC report highlighted in detail Ireland's failure to make the trend shift in health care expenditure as a percentage of GNP which other countries in the OECD had been making throughout the 1970s. Indeed, the NESC report offered very plausible explanations for Ireland's tendency to drift apart from the trend. These included our proximity to a very wealthy country, the UK, the added burden of importing most of the drugs.
expenditure the NESC study was attempting to capture different age-specific expenditure which almost mirrored the projected population increase. These points were added by Raftery to the general observation, which Fahey also makes, to the effect that rising GNP puts an upward pressure on the GNP ‘percentage spend’ on health.

Thus, the 1980s were exceptional in that Ireland made a belated fiscal adjustment, following the example of other OECD countries. Although the cutbacks of 1987 and 1988 stand out as the most memorable aspect of this adjustment, other changes, recommended by the NESC report were implemented more gradually. These included reducing the acute bed to population ratio and the geriatric bed to population ratio and changing the GMS remuneration system from a fee per item to a capitation basis.

I should say that the cuts in health spending in the 1980s did have bitter consequences for many elderly people. Fortunately, during the 1980s, the relative income position of older people had improved considerably since the mid-1970s. Consequently, some alleviation of the problems they faced during the 1980s arose out of their ability to resort to private health care. Private nursing home utilisation grew, as did VHI membership. While the proportion of elderly people with medical cards declined during the 1980s, this was partly driven by improvements in income. Nevertheless, perhaps because the cutbacks were postponed so long and could not be implemented in a phased or planned way, their effects on older people were more harmful, and manifested in such phenomena as growing waiting lists for public acute hospital care, particularly in the case of ‘elective’ procedures such as joint replacement or cataract surgery.

6. Population Growth and Health Service Level

We must also consider once again the demographic context in the early and mid-1980s. Irish population was expected to continue growing. The NESC projected an increase in total population of between 11.2 per cent and 13.6 per cent between 1979 and 1991 with a projected increase in health care expenditure which almost mirrored the projected population increase. Within these projections there was no expectation of significant population ageing during the 1980s.

By using age-specific utilisation rates to project health service utilisation and expenditure the NESC study was attempting to capture different age-specific utilisation profiles in different health service areas. So, the age profile for acute in-patient care was different from the age profile for utilisation of residential places for mentally handicapped people, and this in turn differed from the utilisation rates for psychiatric care. Raftery was attempting to show what might happen in these individual service areas if no policy changes were made. Thus, he provided a context for examining the kinds of changes that might be implemented in relation to acute hospital care, GMS, psychiatric care, or residential care of the mentally handicapped. For instance, mental handicap residential care provision was skewed towards the young, and psychiatric residential care towards the middle aged. Raftery used these known profiles as weighting factors to be applied to expenditure on the health services.

The purpose of the NESC study was to highlight the effects of demographic change (growth for the most part, but also any structural change) on volume and expenditure. The study did not build in assumptions about morbidity changes, efficiency changes, demand pressures, fiscal changes and restraint or other factors which inevitably exercise a key influence. But to have done so would have made no improvement on the study since some of these were imponderables while others were precisely what the study was seeking to influence - namely the policy variables. The study extrapolated current utilisation patterns and volume and expenditure changes to project the future expenditure, were no changes or improvements in these patterns to take place. He, therefore, cautioned that health spending would grow in line with population and this would not help to reduce the percentage of GNP spent on health care.

In-Patient Days

In this context, it is necessary to respond to a criticism contained in the Fahey study in relation to total acute in-patient days. Fahey points out that there was a 31 per cent reduction in public acute in-patient days between 1979 and 1991 when, according to the Raftery study, an increase of over 10 per cent was projected. In addition, Fahey makes the point that the population aged 65 and over increased faster than was projected by the NESC.

I would query the use of total in-patient days as an adequate measure of in-patient care. ‘In-patient days’ can be decomposed into number of discharges by average length of stay. However, reduced average length of stay is quite compatible with maintaining and improving the real quantity and quality of in-patient health care. It was in this context, as we have already seen above, that Raftery made certain recommendations such as reducing the total acute bed to population ratio. This is the kind of productive efficiency that has proved indispensable to health care development throughout the developed world. If, instead of in-patient days, therefore, we compare the numbers of patients discharged annually over this period, we find that, far from declining by 31 per cent, service output was almost static.
Not only did the length of stay in acute care decline but there was an increase in consultant out-patient care. Like the falling length of stay, the increased provision of out-patient care is a progressive feature of health service reform. Taken together, these data suggest that demographic change was not running in the opposite direction to acute health service provision but there continued to be some meaningful correspondence between the two.

Despite the achievement of such acute care efficiencies, and indeed partly because of these changes, pressure on long-stay facilities increased, requiring further reforms. Given the fiscal context, the provision of new long-stay beds in the public sector was not possible but it was also argued, on demographic grounds, that some parts of the country at least were over-provided with public long-stay care facilities. Increasing attention was therefore paid to reducing the number of low dependent and not so elderly patients in the public long-stay sector. Insofar as much public long-stay accommodation was of a ‘welfare’ nature, improved income and housing among the elderly, together with increasing provision of community care services, enabled more people to continue living in the community. Nevertheless, there was an increase in the number and proportion of elderly people resorting to private nursing home care. Within nursing homes too, the average age of patients increased over the decade. In addition, the whole nursing home financing system was riddled with anomalies which were only sorted out with the introduction of the Health (Nursing Homes) Act, 1990 which was finally implemented in 1993. The purpose of the Act is to direct the statutory subvention of non-statutory long-stay care towards the more dependent elderly with limited means. Finally, the 1980s saw growing concern about the position of unpaid informal carers.

Overall, therefore, despite the ‘fiscal correction’ of health care spending, patterns of health care provision were influenced by demographic and social changes. To the extent that bottlenecks and unmet need continued to exist, the health services could be said not to have satisfactorily adapted to need. However, it is quite apparent that an effort was made to adjust the health care system to need, despite the restraint which was exercised on public expenditure throughout the 1980s.

7. Increasing Centrality of Ageing for Health Care Planning

I now wish to suggest that ageing is the most important demographic change on the agenda, and that ageing has important implications for health care planning in the coming 15 years. One reason, already identified, is that population ageing as opposed to population growth, is what the future holds, and that this is a shift not a swing. Secondly, Ireland has now made its major fiscal adjustment and, so long as Ireland can remain on the correct side of the line as regards the ratio of health spending to GNP per capita, the fiscal agenda may not any longer dominate the health care planning agenda to the same extent. Fiscal restrictions will continue, of course, under the Maastricht criteria which limit public sector borrowing and, consequently, public sector borrowing. Also, fiscal factors will arise due to technologically driven need and demand.

I would argue that population ageing is now a much more important factor with much more direct implications for health care planning and provision than at any time in the past. When Care of the Aged was published in 1968, the elderly population was expected to decline. What were the issues then? Poverty among the elderly was a key one. Another was the task of providing a basic level of universal health care in line with the welfare state approach of other countries. When The Years Ahead was published in 1988, 20 years later, though it refers to population ageing and projections, the real issue it was focusing on was how, in the context of extreme fiscal pressures, to reorientate our health and social services towards the elderly population in order to achieve greater efficiency, greater equity, more community care and higher quality of outcome. Hence, the focus in The Years Ahead was on issues such as health promotion, service co-ordination, partnership between the voluntary and statutory sector, the development of community care and the reduction of inappropriate long-stay admission.

The OECD (1995) state that ageing is but one among several demand-side factors, and in addition to these are supply-side factors. Nevertheless, the OECD acknowledges a consistent if minor ageing effect up to 1990 in developed countries. From 1990 to 2000, it projects an increasing age effect, and from 2000 to 2020, projects an even stronger ageing effect. This change in the importance of ageing in determining health care spending reflects the changing demographic agenda - from growth to ageing - to which I have referred above.

Morbidity Compression - But How Much?

Fahey is sceptical about the impact of ageing on health care need because he is doubtful about the likelihood of a corresponding rise in treatable morbidity. I have argued that the extent of population ageing in the decades ahead is unprecedented. However, not only that, but such demographic ageing is important because the degree of morbidity compression which can be expected is difficult to establish and the indications are that it could be quite limited for some time to come. Though there is some truth in the morbidity compression thesis, we should not be seduced by this. Depression is everything here. Here is some evidence to provoke discussion:
Randomly distributed illness: Tuberculosis

A major development of 20th Century society has been the decline of acute infectious diseases, which tended to be randomly distributed throughout populations. For example, in 1944, very similar and large numbers of people (about 1.3 per thousand among females) died in Ireland as a result of tuberculosis and cancers of all kinds. In the case of tuberculosis, morbidity was high in all age groups, but highest among the young adult age groups. Today, happily, TB is almost negligible in its effects on mortality. The few remaining deaths from TB arise mainly in the elderly. The case of TB is indicative of an important shift that has taken place in the 20th Century in all developed countries, and in the underdeveloped world to a lesser extent, due to the control or eradication of many other acute infectious diseases. This has resulted in a concentration of illness and death in the older or elderly population.

Circulatory disease

It might be argued that even in the case of diseases which are clearly related to age, such as diseases of the circulation and heart there is evidence of an overall improvement in all age groups, including the elderly, in mortality rates due to these causes. However, even accepting that, there are marked differences in the relative improvement in age-specific mortality due to circulatory diseases. Between 1972 and 1983 in Ireland, there was an overall improvement of 20 per cent in mortality from circulatory diseases. However, in the elderly and very elderly, the improvement was less than 20 per cent, compared to improvements of around 40 per cent for those aged 45-54.

Cancer

Cancer mortality, which was once matched by TB mortality, has increased in importance among the whole population. The greatest increase has been experienced in the elderly, both in the 65-74 and 75+ age groups. Thus, both relatively and in absolute terms, cancer mortality has increased in the elderly population.

The Limitations of Morbidity Compression

What conclusions should be drawn from the evidence presented here? I would suggest the following:

- The relationship between broad age group and morbidity has been strengthened, not weakened, throughout this century, in large part due to the control or eradication of acute infectious diseases.
- In the last few decades, there has been an increasing focus on reducing premature mortality, that is mortality before age 65 due to diseases which are associated with lifestyle or conditions of living.
- Although there is evidence of the postponement or compression of morbidity in old age, for example in relation to heart disease, the relative share of heart and circulatory diseases is higher in the elderly, while both the absolute level and relative share of cancer in the elderly has risen (at least up to 1983).
- It is much easier to reduce mortality and morbidity in the younger age groups than it is in the elderly, or, to put it another way, morbidity can be deferred into old age more readily than into very old age.
- Not only will the problems of illness remain closely related to age in a population, but, whereas younger people tend to suffer from one or two diseases at most, which may be prevented or treated, many elderly people suffer from several diseases at one time, and this complicates the treatment of any one of them.
- The postponement or compression of morbidity in old age comes at a cost, in terms of health care utilisation and health care expenditure. There is a suggestion in the report that morbidity compression will reduce the need for services. I would rather suggest that the focused orientation of services to those in need - and need is related to age - is a key factor in the compression of morbidity.
- Finally, the incidence of diseases such as Alzheimer's disease and other forms of dementia, osteoporosis and osteo-arthritis has increased as more people reach very old age. The implications of these types of morbidity for health care, research, treatment and long-term care, are enormous. Alzheimer's disease affects at least one-fifth of people over the age of 80 and can last for several years.

8. Ageing and Service Utilisation

The report suggests that service utilisation is influenced by as much demand as need, if not more so. I would contest this view. After all, most countries have predominantly publicly financed health care systems. The United States is one notable exception. Thus, most countries have a mechanism for effectively taxing those with sufficiently high incomes and using the money to pay for services for those in need. Ireland falls into this category. Ireland does not have a universal health care system in the fully fledged sense, but provides many services on a universal basis. One obvious exception is free general practitioner services, which are available only to about 35 per cent of...
the population, and approximately 70-80 per cent of the elderly, who satisfy a means test.

This suggests a certain stability, and a certain relationship between health service utilisation and age. The study, despite highlighting the possible effect of morbidity compression and the effect of demand over and above need in determining health service utilisation, provides little or no data in support of this argument.

Figure 3 presents some evidence of the relationship between age and service utilisation in respect of public acute in-patient bed days. For example, children under one year of age were 2.3 times as likely as the average person to spend some time in hospital in 1979. In 1994, this rate had not changed very much. In fact, none of the rates changed all that much over this 15 year period and what gradual change there was points towards a rising relative utilisation among the elderly as compared with the young. This is very valuable information because in the present context we are projecting health service utilisation between now and 2011, that is a period of approximately 15 years. The age distribution of health care utilisation over a 15 year period between 1979 and 1994 shows a shift towards relatively more services for the elderly. In 1979 the young elderly were about three times and the old elderly almost five times as likely to use in-patient care as the average person and, by 1994, there was an increase in both of these ratios.

Figure 3: Public Acute In-Patient Days Shown as the Ratio of Age Group Utilisation Rates to Average Utilisation Rates, in 1979 and 1994

Source: Department of Health

This suggests a certain stability, and a certain relationship between health service utilisation and age. The study, despite highlighting the possible effect of morbidity compression and the effect of demand over and above need in determining health service utilisation, provides little or no data in support of this argument.

The sheer quantitative implications of population ageing, as already referred to, when combined with these utilisation rates, even if the ratios were to change in the direction of morbidity compression, would be of major significance for the planning and provision of health services in the future.

9. Social Care

The report suggests that, while the implications for health care arising from demographic ageing might not be all that predictable or important, nevertheless ageing and social care requirements are related. The report, nevertheless, suggests that social care is provided, in large part, through informal sources, particularly family members, and to a lesser extent neighbours and friends. It also suggests that the implications for formal social service provision arising from increasing numbers of elderly might be less than proportional because we cannot predict what amount of informal care will be available in the future. The report certainly leans towards the view that there is no hard evidence to suggest that the reservoirs of informal care will diminish, even going so far as to suggest that they might grow.

I agree that the growth of the elderly population has important social care implications. However, I do not agree that the sources of informal care are as likely to remain the same or increase as they are to decline. Firstly, in addition to the actual increase in the numbers of elderly people, a greater percentage will live in the community, particularly in the not so very elderly groups. In addition to this, there has been and will continue to be a rising proportion of elderly people living alone. Furthermore, there has also been a decline in the number of elderly people living with non-elderly adults (children, children-in-law etc.). The changes in patterns of residence have thus reduced the extent of multi-person households.

When we put these trends with the finding of O'Connor et al. (1988a and 1988b) on the huge differences in the level of informal care which may be provided by carers who reside within the elderly persons' household and carers who reside elsewhere, there is every reason to suspect that demographic and socio-demographic trends will conspire to increase the extent of the elderly at risk and reduce the resources available to provide the heavy care which many carers provide at present. Other pressures, particularly changing labour force participation rates among married women, will impact negatively on informal care resources.

Therefore, I think that we would be remiss in not anticipating an increase in formal service provision to buttress and support informal carers, or to substitute for them in their absence. Indeed, the growing political awareness of carers will inevitably create pressures for financial recompense, and we
have already seen some response to this. However, it may be preferable in the long-run that a more balanced array of financial and non-financial supports for the caring relationship be devised.

10. Conclusions

In contrast to Tony Fahey, I believe that ageing is important. It has direct implications for need and the utilisation of health care services in the future. Although the required change in health service provision will not, of course, be pro-rata, I would not take too much solace from the morbidity compression thesis just yet. The study is extremely critical of demographic projections and their use, but not proportionately critical in the way it makes use of non-demographic concepts and arguments. I have suggested that current population projections might be more reliable than those of the early 1980s. I have also tried in my response to connect some of these issues together. In a short presentation like this, of course, it is impossible to do justice to all of the complexities of the issues involved. However, in the points that I have raised, I hope that I have made a start, indeed along with Tony, in provoking further debate, and hopefully further research, on the issues not covered in the report.

This is not the place for a litany of research headings that need to be filled in, but we do need more work on the relationship between income, demographic ageing, and the workings - that is the arrangements for financing and providing health services (in the method of budgeting and allocating resources etc.) of the health care system in Ireland. I would see demography as of key importance, but would not counter-pose this to any of the non-demographic issues which Tony has raised. Rather, I hope that the presentations today will bring about a more active engagement of demographic and non-demographic factors affecting health service planning and provision. Finally, I welcome the report, even though I have taken a different position to the author, and, as stated at the outset, I have not concentrated here on the areas where I am in agreement with the study.

References


This report is one of the most valuable and interesting pieces of commissioned work I have come across in Ireland for quite some time and I should like to compliment Dr. Fahey and all who collaborated with him on a job well done. Indeed, it would be a great pity if it were to be typecast and classified as a report likely to be of interest only to persons concerned with the planning and delivery of services for the elderly. It is likely to be of interest and value to everyone with responsibilities for service planning and delivery right across the health service.

It is pointed out (p.65) that “demographic trends seem to have little or no effect on overall health expenditure, which seems mainly to be determined by national income and a range of institutional factors, including Government controls over health spending. By comparison with these factors, population ageing seems to have at best a marginal influence. As a result, it is easy to over-estimate the value of population projections for future health service planning” and it goes on to suggest (p.81) that “rather than look to demographic trends as a determinant of health service requirements, it might be more useful for policy making to refer to demographic indications as a measure of the effectiveness of health policy”.

The report points out (p.47) that “health spending per person is related to the national income per person to an extraordinarily close degree”. The good performance of the Irish economy in recent years, the projections in this report and those by Dr. Garret Fitzgerald in a recent Irish Times article, suggest that the tendency to refer to the problem which will be caused by the growing elderly population is misguided and that in fact the dependency ratio will improve in the course of the years covered by these reports.

The number of elderly people is projected to increase at about the same rate as has prevailed in Ireland since the 1970s. The most dramatic change is expected to occur in the over 80 age category.

The health strategy document, Shaping a Healthier Future aims to be robust against all possible futures by emphasising (p.12), that it “will be clear throughout the health strategy that a central element in the planned reshaping of the services is the emphasis which will in future be placed on achieving the greatest possible benefit from whatever resources are available”.

This report points out (p.81) that life expectancy among older men in Ireland was lower in 1986 than in 1926 and goes on to claim that by the yardstick of health gain, health policy for older people in Ireland has been spectacularly ineffective for decades. It is an exaggeration, I believe, to attribute that situation to the failure of health policy alone. Industrial policy, social welfare, housing, agriculture policies, are just some of the others that need to be evaluated in that context also. However, I do accept that in the past the emphasis has been on health services and measuring inputs and outputs rather than on health.

What impresses me most about the health strategy is that it places the emphasis on health rather than on health services and that judgements will be based on health outcomes. I am impressed too that the strategy does not espouse commercial sector values and practices uncritically. Having said that, I am all in favour of adopting from any source, good practices for improving efficiency and eliminating waste. There are however, fundamental differences between commercial and private sector organisations. Commercial organisations are always most sharply focused on their bottom line, which is invariably profit. They exist to generate a profit for their shareholders. It is just as unacceptable to gloss over the fact that commercial organisations exist to make profit as it is to fail to question why public service organisations exist since it is clearly not to make profit. They exist, I suggest, to produce social rather than financial returns. Their management can be judged by the social results they produce.

What then is the difference between profit and social result? The difference is essentially that profit is the financial return on private investment, whereas, social return is the benefit to the public of the investment of public money. The health strategy adopts the investment for social result concept and applies it to health in the forms of health gain and social gain. These are relatively new and interesting concepts, but in practice how are they going to influence the outlook and behaviour of the health boards and their staffs? It is not yet possible to answer that question.

In the Midland Health Board and in the Mid-Western Health Board, we have adopted a set of values which we consider to be the hallmarks of a successful organisation in health gain and social gain terms. The eight values are:

Equity: persons with similar needs should receive the same standard of treatment and care regardless of where they live, where they are treated, their income, or what their religious beliefs may be.
Accessibility: everyone should have ready access to the services they need, when they need them. In particular, services should be equally accessible to both public and private patients.

Effectiveness: each person should get the best possible result from his or her contact with services.

Appropriateness: services and service delivery should meet local needs and should reflect a policy of appropriate care in the appropriate setting. The aim should be to avoid developing unnecessary dependency on services or institutions and be flexible enough to cope with the need to change.

Responsiveness: services should reflect the needs and entitlements of users.

Dignity: services should reflect the standards of courtesy, confidentiality, and respect for the privacy and dignity of the individual that society expects of the caring service.

Farsightedness: services should be capable of identifying, and pursuing through prevention and promotion programmes, opportunities to contribute to improvements in the health of the population in the area.

We are now developing ways of checking whether or not existing or new services qualify to have these hallmarks attached to them.

We frequently claim that our integrated health and personal social services delivery system has many advantages over the more fragmented delivery systems of other countries. But, do we extract the advantages our system offers by adopting holistic approaches in treatment and care settings, or by managing the whole as distinct from the component parts? In the past, we have not. By being focused, in future, on 'investment for social result', managing for social return', and 'managing the whole', we can bring about measurable improvements. Another aspect of this is that our level of expenditure appears high compared to other countries as mentioned in this report (p.50). Comparative data on health systems is very difficult to obtain. In our case, allowance is not always made for the significant spend here on, for example, services for the mentally handicapped, child protection and other personal social services. This report recognises this in, for example, the reference to the Child Care Act (p.52) and the difficulty of defining the boundary between social care and medical treatment.

This report does the health strategy document less than justice by attributing the objectives in the section in the strategy document, titled Ill and Dependent Elderly as the overall objectives which guide present health and social services provision for older people. I would suggest that the action plans on health promotion, general practitioner services, dental services, women's health, acute hospital services, palliative care, people with mental illness and people with physical or sensory handicap will contain generic provisions which will benefit the elderly among others and will need to contain elements specifically catering for the needs of elderly people.

In my opinion, health promotion will become a vitally important vehicle for pursuing health gains and social gains for the elderly. Programmes directed at people in middle age on how they can reduce the incidence of eye disease, dental caries and teeth loss, brittle bones and, for example, late onset diabetes, have the potential to produce major long-term benefits. The adequacy of orthopaedic services, ophthalmic services, dental services, protocols for the management of, for example, diabetes and asthma all need to be considered.

Measurable social gains can be produced by reducing and ideally eliminating waiting lists for hip replacements, removal of cataracts and preventing the complications diabetes can give rise to. In addition to improving the quality of life of the recipients, ready availability of the services I have mentioned, by way of example, can literally mean the difference between being able to lead an independent life or becoming a dependent person.

The health strategy document concludes (p.10) that "many of the services are not sufficiently focused towards specific goals or targets, and it is therefore difficult to assess their effectiveness: the information which would support this focusing is frequently unavailable or, if available, under-utilised". I wouldn't dispute that conclusion, but I would argue that lack of information or under-utilisation of available information are two of a much larger number of reasons. For example, the strategy document also concludes (p.10) that "community based services are not as yet developed to the extent that they can appropriately complement and substitute for institutional care, or provide adequately for those in the community who are dependent on support".

The largest investment in services for the elderly in recent years has been in implementing the Nursing Homes Act. I hold the view that a greater social return on that investment could have been obtained by investing the bulk of that money in developing domiciliary services. I understand fully the way the political imperative to enact and implement the Nursing Homes Act evolved. Many nursing homes were unable to command rates commensurate with the return on investment they expected to obtain or to compensate for the level of service they were providing.

The net result in many cases has been that the direct costs to residents and their families are not appreciably different today than they were before the
The following objectives and targets have been chosen:

**Objective 1:** The board will assess the needs of the elderly, and will provide appropriate services to meet the needs identified. The public will participate in needs assessment.

**Objective 2:** In order to maximise health and social gain, structures and mechanisms will be put in place to improve information and communication, to co-ordinate services and ensure that services are of high quality, appropriate, responsive, accessible and effective.

**Objective 3:** The elderly can themselves add significantly to their quality of life and health status by adopting a healthier lifestyle; by eating better; by refraining from smoking and excessive alcohol; by exercising regularly and by managing stress. The board will strive to encourage this improved lifestyle through its health promotion programme.

**Objective 4:** To improve health and social gain for the elderly, the board will ensure that the elderly will have access to an appropriate range of quality services in the home. In addition, carers will have access to respite care, information and education, stress counselling and sitting services.

**Objective 5:** The board will achieve health and social gain through promoting a range of appropriate services in the community for the elderly.

**Objective 6:** To improve health and social gain, the board will strive on a needs basis to improve housing conditions so that the elderly can continue to reside in the community.

**Objective 7:** To maximise health and social gain for the elderly, the board will provide an appropriate range of services for the elderly in acute hospitals.

**Objective 8:** To maximise health and social gain for the elderly, appropriate care will be made available in care centres for the elderly including private nursing homes and psychiatric hospitals.

You may argue that the targets are not specific enough. It is acceptable, in my view, to set non-specific targets while we develop the capability and
expertise necessary to develop the sharpness of focus that will be required in the future.

Let me conclude with another quotation from the strategy document (p.35) "In a complex and costly service, such as health, one of the best guarantees of the good use of resources is a commitment to investigate how well the job is being done and to apply throughout the system, the lessons learned from both good and poor practice".

The report I am responding to today greatly enriches the literature available to those willing to learn.
The Allocation of Health and Social Care Resources: Protecting the Interests of a Growing Elderly Population

Dr. Ronan Lyons
Consultant in Public Health Medicine, West Glamorgan Health Authorities and West Wales Centre for Public Health

The papers presented by Peter Connell, *Demographic Projections* and Tony Fahey, *Health and Social Care Implications of Population Ageing in Ireland, 1991-2011* indicate the extent of the increase in the elderly population which will occur in Ireland over the next 17 years and provide an estimate of the likely impact of the supply and demand of health and social care services. The purpose of this paper is not to comment in detail on either paper but to consider the factors involved in the allocation of health and social care resources and to consider how the interests of a growing elderly population can be protected.

Needs Assessment

Historically, the allocation of resources to health and social care has always been a rather ad hoc affair. There is very little evidence that the allocation was based on the needs of the population, rather it seems to have been based on what the country felt it could afford to spend in this area against the demands of all other areas. However, recently there has been a reorientation of thinking on how health and social care services are provided and organised with the emphasis placed firmly on an assessment of the population’s need. This movement was initiated by the World Health Organisation’s Health For All 2000 movement which influenced the thinking of many governments. Wales was an early innovator with its health strategy document *The Strategic Intent and Direction for the NHS in Wales* in 1989, which proceeded the *Health of the Nation* strategy in England (1992) and the *Shaping a Healthier Future* strategy document for Ireland (1994). What all of these strategies have in common is a reorientation towards basing health and social care service provision on the needs of the population.

What does a needs based service imply? Need can be defined as the ability to benefit. The assessment of health and social care needs involves measuring the incidence, prevalence, and severity of health conditions, and for every level of severity assessing the effectiveness of all the preventive and therapeutic strategies available, as well as all their costs. Some people talk of comprehensive health needs assessments but this is never going to be achieved in reality.
Since there are more than 1,000 different diseases, more than 2,300 therapeutic operations, and more than 10,000 different medical treatments, when severity and other factors are taken into account there are hundreds of thousands or millions of illness/treatment combinations which could be assessed.

The reality is that topics for health and social care needs assessments are prioritised. Prioritisation is guided by several factors including evidence from the literature on the potential for health gain, or the potential for releasing resources, as well as factors which may be centrally determined or of local importance. Health and social care needs assessments are often carried out by applying original work carried out elsewhere to the local population or by initiating local studies. However, it is quite clear that there is nothing like local information for stimulating local action. The result of a health or social care needs assessment is an assessment of the magnitude of a problem within a population, the effectiveness of the available therapies, and the costs of implementing those therapies. The comparison of several health needs assessments could facilitate a cost effectiveness approach to the provision of health and social services. However, whilst cost effectiveness is dear to everyone’s heart as an abstract concept it rarely exerts much influence in decisions between competing priorities. The reason for this is that cost effectiveness is subject to at least four higher rules:

1. the Rule of Rescue which states that human life, particularly that of a child, must be protected at all costs;
2. the Rule of Litigation which states that following a successful medical litigation case medical practice will change irrespective of the costs involved;
3. the Rule of Inquiry which states that the best way to improve a service is to have a disaster followed by a public or judicial inquiry, which will inevitably prescribe a Rolls Royce solution irrespective of the costs or the effect on any other service;
4. The Rule of Democracy which states that politicians make the rules in a democracy and are free to change them at will, irrespective of previous decisions.

A needs based health and social service must be able to adapt to the real world. If needs are not measured then it is unlikely that, given the number of competing priorities, such needs will be ever met. To ensure that the needs of the elderly are met it may be important that assessing the needs of the elderly becomes a priority with the new health authorities. Bodies concerned with promoting the interests of the elderly should lobby for such assessments to be made.

Waiting list initiatives are a real danger to a needs based service and the interests of the elderly. In Britain the vast majority of health authority management time is spent in ensuring that waiting list guarantees in the Patient’s Charter are not breached. Whilst reduced waiting times do benefit the population the problem is that the guarantees are not based on clinical severity and frequently prioritise the trivial at the expense of the important.

There is a tendency to invest all spare money in reducing waiting lists. Since there are no waiting lists in community care one can see how the disabled elderly lose out by such initiatives. Bodies with the elderly's interests at heart should consider lobbying against too much resources being spent on waiting list initiatives.

The concept of cost effectiveness is sometimes referred to in choosing from alternative packages of care. Cost effectiveness in a health economics perspective often involves the calculation of Quality Adjusted Life Years (QALYs) and investing in interventions which maximise the number of QALYs per pound spent. There are many theoretical objections to the use of QALYS in priority setting within the health service.

However, from the elderly’s point of view the biggest problem is that QALYS involve calculating benefits in relation to life expectancy and since elderly people have shorter life expectancies the use of QALYS in prioritising nearly always discriminates against the elderly. The move to evidence based medicine has stimulated a debate on measure of effectiveness. Currently, one measure of effectiveness, the number needed to treat (NNT) to prevent one adverse event is extremely popular. The good news about the increased interest in NNTs is that they generally favour the elderly. The number of people needed to treat to prevent an adverse event depends on the effectiveness of the treatment and the baseline risk of an adverse event. Many treatments are equally effective in the young and elderly so that the risk of an adverse event happening is reduced by the same amount in all age groups. However, the baseline risk of an adverse event happening generally increases with age. It follows that to prevent one adverse event it is necessary to treat fewer elderly people than younger people and that the cost of preventing one event is lowest for the elderly.

Examples of Needs Assessments Studies

I am now going to look at some examples of assessments of need involving the elderly to see if the needs of the elderly are currently being met. There are many examples from which I could choose but I have decided to concentrate on studies with which I am familiar. The first is a study of psychological distress in carers of dementia sufferers in North Dublin, which was carried out by the Old Age Psychiatry Unit in Blanchardstown. The level of stress
in carers of dementia sufferers was measured using the General Health Questionnaire in a group attending the service and a matched group not referred but known to the public health nurses. There was no overall difference between the groups but overall 65 per cent of carers suffered significant levels of psychological distress. Stress was not related to the degree of cognitive impairment but to the level of physical disability and was commoner in younger carers and females. Obviously our services are failing such people.

The second study which I mention is an assessment of health and social care needs of the elderly which I carried out in North West Dublin in 1991 when working for the Eastern Health Board. The study involved a structured interview with 208 elderly persons randomly chosen from the GMS list.

Standardised assessment tools were used and objectives levels of need predefined. There was a considerable level of unmet need in the group. It was estimated that to meet the needs of the population day centre places should expand by 109 per cent, chiropody by 77 per cent, home help services by 57 per cent, and meals-on-wheels by 12 per cent. Public health nurses visited 69 per cent of the over-75s living alone and 80 per cent of those with a physical disability. Studies which assess needs based on those already in contact with services will always underestimate the true level of need.

The third study which I am going to mention is the Tipping The Balance (TTB) study of health and social care needs of the elderly across Europe. The Tipping The Balance network is a group of health districts across Europe committed to redressing the balance between the primary and secondary sectors along the lines envisaged by the Health For All 2000 movement. The network currently involves 10 districts from eight countries. The purpose of the TTB elderly study is not only to provide an assessment of the elderly's needs in each district for local uses, but also to provide comparative information on how well the different ways of organising services meet the needs of the elderly. It is hoped to identify models of good service provision which can be copied across districts.

The TTB study involves two parts, an assessment of individual needs and utilisation, and an assessment of service provision using the World Health Organisation's Functional Reference Model. The assessment of individual need is based on structured interviews with persons aged 70 and over (and their carers where appropriate) randomly chosen from the population. The assessment covers a large number of topics including quality of housing and satisfaction with housing, health status, disability, cognitive function, mental health, adequacy of help for disabled people, and use of health and social services.

In terms of results the European results are not yet available but I can show some of the results relating to my own district, West Glamorgan:

- Just over 10 per cent live in sheltered housing or nursing homes, with the remainder in their own homes or with relatives.
- About one in seven houses lack central heating, a serious deficiency considering the high levels of excess deaths which occur in this part of the world every winter.
- Almost a quarter of houses lack a fire alarm.
- The private rented sector provides the worst quality of housing.
- Almost as many seriously disabled people live on their own or with relatives as live in nursing homes.
- More than 80 per cent of their care is provided by relatives and friends and the minority are provided for by statutory bodies.
- The services provided are well targeted but there are considerable levels of underprovision.
- There are high levels of untreated depression.
- There is a low provision of hearing aids.

I will now look at some assessments of needs taken from the literature. The first area I will look at is treatment for hypertension. Blood pressure increases with age to peak in middle age in men and in old age in women. The risk of developing a stroke or heart attack increases with age. Effective treatment of high blood pressure reduces the risk of stroke by about 40 per cent and of a heart attack by about 15 per cent. Older people respond to therapy as well as younger people. However, because older people have a higher baseline risk of developing a stroke or heart attack the number of older people it is necessary to treat (NNT) to prevent a stroke or heart attack is far fewer than in younger groups. Thus, treating high blood pressure in elderly people is more cost effective than treating younger people. Paradoxically older people with high blood pressure are less likely to receive treatment partially due to the misperception that increasing blood pressure is a normal aspect of ageing.

Another area which I will briefly turn to is the acceptance of elderly people onto renal dialysis programmes. A population based study of renal failure carried out in Devon in 1993 demonstrated a rate of renal failure which was twice that reported by studies based on renal units. Seventy two per cent of
cases occurred in those aged 70 and over. The difference between the studies can be attributed to the fact that many elderly people who develop renal failure are not referred for treatment, particularly those living furthest from renal units. In my own district a study of the effect of distance and age on the uptake of renal replacement therapy showed that elderly people from throughout the county were referred and accepted for therapy. However, there is a fall off in uptake with distance in elderly people in a neighbouring county.

A third area which is worth looking at is the level of unmet need for knee replacements. Tennant et al. carried out a population based study of indications for knee replacement in those over 55 years in Yorkshire in 1995. The proportion who might benefit from knee replacement increased from 1.3 per cent in men aged 55-64 to 2.0 per cent in those aged 75 and over and from 1.3 per cent to 4.3 per cent in women. However, two-thirds of those identified in the 55-64 year old group were currently attending a specialist compared with less than a quarter of those aged 75 and over.

Monitoring of Service Utilisation

Taken together all the studies in the above section indicate that the level of underprovision of services to the elderly is substantial. Those bodies charged with promoting the interests of the elderly might wish to enquire of the health authorities about age-specific uptake rates of selected services in their areas. Of particular interest would be the uptake of selected elective procedures such as hip and knee replacements and coronary bypass surgery, as well as certain acute procedures such as admissions to coronary care units and uptake of renal replacement therapy.

An indicator of the overall level of equity in the system might be the ratio of elective to emergency episodes. In my district the ratio of elective to emergency episodes falls with increasing levels of deprivation. This is in keeping with the fact that demand exists only for elective care and the well healed middle classes are better at vocalising their needs and having them met. Emergency admissions are an indicator of need but not demand whereas elective admissions indicate a mixture of need and demand. Curiously, whilst hospital utilisation for both elective and emergency care increases with age, the ratio of elective to emergency care also diminishes with age. We are interested in carrying out further work in this area to test the validity of this promising indicator of equity.

Population Projections

The population projections produced by Peter Connell indicate that the numbers of those aged 65 and over will increase by 29.5 per cent between 1991-2011, and that the biggest increase will be in the over-80s (65 per cent increase). Tony Fahey has discussed the assumptions used in projecting populations and has mentioned that population projections are not population predictions and tend to be inaccurate to a certain degree because the assumptions on which the projections are based change with time. I am not going to comment on the precision or accuracy of the projections except for one point: the effect of changes in the smoking epidemic on the numbers and gender distribution of the elderly. People often forget how devastating smoking really is. Recent work by Richard Peto and others demonstrates that 50 per cent of persistent smokers will die at a younger age directly as a result of their smoking. In 1995 the tobacco companies will kill two million people worldwide, with 6,000 deaths in Ireland.

Those who are killed by smoking in middle age will lose on average 21 years of life and those killed by smoking after the age of 70 will lose average of eight years of life. The increasing proportion of the population who do not smoke, and the increasing proportion of the population who have given up in recent years means that life expectancy in Ireland will continue to increase. I am not sure whether the effects of the changing smoking epidemic in Ireland are fully reflected in the population projections. Also the changing ratios of male and female smokers are likely to reduce the gap in life expectancy between women and men.

Whilst I am on the topic of smoking it is worth mentioning that not only does smoking kill people but there is growing evidence that smoking accelerates ageing in those not yet killed by the habit. In a study of health status and its determinants in my own district in 1993, ever smokers had equivalent levels of physical function as never smokers some 6.6 years older, smokers also rated themselves at the same level of health as those 15.6 years older. This has important implications because the need for and use of health services is more closely related to functional ageing than chronological ageing.

Will More Elderly People Result in an Increased Need for Health and Social Services?

This is the question which interests most people. However, I do not believe that we have sufficient information on which to answer the question. The evidence from the literature is unclear with some authors arguing for a compression of morbidity into the last few years or months of life and others arguing against this theory, and for a viewpoint which states that as life
expectancy increases so will morbidity and the need for services. The problem is that the cohort effects of ageing are not well studied. Certainly, as people age their need for treatments increase but what is not well studied is whether as successive generations of people live longer their quality of life will increase in proportion to their quantity of life. People live longer because they are healthier. Functional ageing needs to be separated from chronological ageing. The decline in many functions which occurs with ageing varies considerably from individual to individual and is influenced by many factors.

Whilst it is not possible to predict the future with too high a degree of precision it would seem likely that generations which are born with better health, are free from many childhood illnesses due to better nutrition, immunisation and a better environment, and who are less exposed to cigarette smoke and other adverse factors will maintain a higher level of health into their old age. In such a scenario an increasingly elderly population will not necessarily have higher needs. What will undoubtedly change is that the demand for health and social care will increase due to the increasing consumerisation of society. Given the levels of underprovision of health and social services for the elderly which the examples in this paper have demonstrated, it is clear that the increase in services required to meet their needs far outweighs any increase which might be required as a result of an increasing proportion of the population who are elderly. Whether such services are provided depends to some extent on the power of the elderly lobby.

This talk is about how to protect the interests of a growing elderly population. There are many ways in which this task could be approached but from a health point of view the following suggestions are likely to yield the most benefits:

1. **Eradicate smoking**

   Nothing will ensure that the elderly population continues to grow as much as the eradication of smoking amongst that section of the population which still smokes. The key to success lies with government policies on taxation, advertising, access, and the availability of nicotine replacement therapy which is the most effective aid to smoking cessation.

2. **Assess the needs of the elderly**

   Ensure that population based health and social care assessments are carried out by all health boards. There is nothing like local information to stimulate local action. If the needs of the elderly are not clearly identified they will lose out to more vocal groups.

3. **Monitor service uptake**

   Ensure that age-related service uptake profiles are available for selected elective and emergency procedures. Compare the utilisation data with the information on needs and insist that any deficiencies are remedied.

4. **Avoid waiting list initiatives**

   Since one of the greatest needs of disabled elderly people is for good quality community care the investment of large amounts of money into waiting list initiatives for elective surgical procedures generally discriminates against the elderly.

5. **Use appropriate effectiveness measures**

   When competing priorities are being assessed ensure that ageism QALYs are not used and that more elderly friendly NNTs are used.

6. **Support carers**

   Informal carers provide most of the care for the disabled elderly people at considerable cost in health and personal terms to themselves. Any health and social care strategy which did not recognise the contribution of informal carers and prioritise their needs would be clearly deficient.
PARALLEL SESSIONS
Implications of the Projected Increase in the Elderly Population in Ireland for the General Hospital Section

Chair: Mr. Tony McNamara  
General Manager, Cork City Hospitals

Speaker: Dr. Desmond O’Neill MD  
Consultant Physician in Geriatric Medicine, Meath Hospital, Dublin

If you design for the old, you include the young; if you design for the young, you exclude the old.  
Bernard Isaacs

In macro-economic terms, non-health issues may be a more major influence than an ageing population in determining that the health budget remains a relatively constant proportion of national earnings (Fahey 1995). However, as older people are the core group of users of the general hospital, the relative proportion of resources used by the elderly is high, and there is little evidence to suggest that their needs will not be increased by the increase in the numbers of older people. Figures for 1995 for an urban general hospital demonstrate how the over-65s use the service to a much greater extent than their demographic representation might imply (Table 1). The report by Fahey suggests a two-thirds increase in the number of over-85s (p.37); as can be seen from Table 1, this could be expected to have significant implications for general hospitals.

Table 1: General Hospital Usage by the Elderly in 1995

<table>
<thead>
<tr>
<th>Category</th>
<th>%</th>
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<tbody>
<tr>
<td>All over-65s in EHB in 1991</td>
<td>9</td>
</tr>
<tr>
<td>All over-65s as proportion of discharges</td>
<td>64</td>
</tr>
<tr>
<td>All over-65s as proportion of bed days</td>
<td>57 (factor of 6.5)</td>
</tr>
<tr>
<td>Over-85s in EHB in 1991</td>
<td>0.7</td>
</tr>
<tr>
<td>Over-85s as proportion of bed days</td>
<td>10.3 (factor of 14.7)</td>
</tr>
</tbody>
</table>
Services in general hospitals are often categorised as 'high tech', the services represent two main types; interdisciplinary services with a high cognitive content (e.g. stroke rehabilitation) and usually monodisciplinary services with a high technology and high cognitive content, e.g. laparoscopic surgery. The care of older people requires a mixture of both types of service, and there is increasing evidence that the interdisciplinary, high cognitive approach is central to treating older people in the general hospital. Initiatives of this type in acute geriatric medicine (Landeefeld, Palmer et al. 1995), post-operative care (Gustafson, Brannstrom et al. 1991), stroke care and ortho-geriatrics have all shown improved health status and reduced bed stays.

The interdisciplinary high-cognitive approach requires several factors to work successfully:

(i) a dedicated multi-disciplinary team with appropriate training in the assessment, treatment and rehabilitation of older people;
(ii) access to the patient from the day of admission;
(iii) regular interdisciplinary case conferences;
(iv) on-going team training;
(v) attention to discharge planning and good liaison with community services.

Several factors militate against this form of interdisciplinary high-cognitive approach:

(i) ageism or discrimination against older people (Currie 1987). There are at least three levels of ageism:
- restricted access to services such as coronary care units (despite evidence that this resource is more effective in older people than in younger people) (Dudley and Burns 1992), cancer therapy (Fentiman, Tirelli et al. 1990) and renal dialysis (Aaron and Schwartz 1981).
- negative and discriminatory attitudes are very widely held within the health care professions and are easily passed onto students (O'Neill, Daly et al. 1990). Many patients and their carers suffer from unconscious ageism, suffering stoically from conditions causing disability while ascribing them to 'old age'. If a 40 year old woman could not get out of her chair unaided, it is unlikely that she or her family would accept a diagnosis of 'middle ageing' and accept the provision of a hoist, meals-on-wheels and a home help. Geriatricians must try to combat a nihilistic approach to disability in later life among the general population.

(ii) non-detection and/or non-prioritisation of disability. Disability levels are at their highest among the elderly (Hunt 1978) and are the key underlying factors in the increased morbidity and length of stay in older people in the general hospital. Any disability or loss of function is nearly always a sign of a disease which, acute or chronic, can always be treated or managed. However, the narrow focus of an over-socialised medical model of health is such as to place a low priority on the assessment (not to mention remediation) of disability among older patients. Studies of the detection of disability among older patients in general medical and surgical wards have shown very low pick-up rates; for example, in an Irish study only 9 per cent of disability was noticed by doctors and 27 per cent by nurses (Ryall, Connolly et al. 1994).An undetected disability cannot be remediated.

(iii) an incomplete understanding of the basis of rehabilitation of older people:
- Rehabilitation is a sophisticated process, with a relatively high requirement of trained staff (an investment which pays back in terms of improved survival, quality of life and earlier discharge). For example, adequately staffed assessment/rehabilitation units in Ireland have much higher staffing than most general or teaching hospitals. Many existing departments do not have the minimum team required to function properly.
- Rehabilitation needs to start from the first day of admission to hospital. A lack of understanding of this aspect of rehabilitation is typified by the use of phrases 'step down' and secondary rehabilitation. 'Step-down' is a phrase from the North American literature exclusively, and the step-down institutions referred to operate with a rehabilitation staffing far superior to anything seen in Ireland; 'step-up' should be the appropriate phrase adopted by general hospital health care staff, and should ideally take place on the general hospital site.
- Rehabilitation needs to be interdisciplinary and holistic. Not only do patients with stroke need careful assessment with regard to cause, remediable factors and strategies for secondary and tertiary prevention, but they tend to have multiple other illnesses which may complicate rehabilitation and which need to be treated appropriately. Finally, a specialist medical input to
stroke rehabilitation detects more of the medical complications of stroke, which occur in 66 per cent of cases. Yet a 'stroke care service' is planned for one health board without any reference to geriatricians or rehabilitation physicians and without any planned involvement of specialist medical input.

(iv) a costing system which is based on a North American case-mix with emphasis on surgical cases. The diagnostic-related grouping system (DRG) is a software programme which compresses diagnoses into a restricted range of categories. These are being used to assign a proportion of hospital allocations (Wiley 1995). The main problem is that they pay little attention to functional disabilities or significant co-morbidity which affect length of stay. There is also no account taken of a hospital's access to long term care for the minority of patients who cannot return home. In the Meath Hospital in 1994, 6.8 per cent of the admissions spent 6.4 per cent of the available hospital bed days while awaiting long-term care. The average wait was 50 days after listing for long-term care.

There is compelling evidence from the United States that advanced age should also be factored into DRG costings. The use of other rating measures, such as the resource-utilisation groups (RUGs) (Fries, Schneider et al. 1994) may prove to be more accurate in determining the resource implications of complex medical and rehabilitation needs of older patients in the general hospital.

Illness Trends

Although it is tempting to hope that secular trends may soften the load of age-related illnesses among this population (Fahey p. 74) there is as yet no evidence that this is the case (Williams and Evans 1993). Several illnesses show a trend to increase.

Cardiac disease

Three quarters of those dying from coronary heart disease are aged 65 years and older. Older people not only have a more significant response to 'clot-busting drugs' such as streptokinase, but also represent both an absolute increase and an increasing proportion of patients presenting for cardiac surgery.

Table 2: Age Profile of Cardiac Surgery, 1983 - 1992

<table>
<thead>
<tr>
<th>Year</th>
<th>&lt;65</th>
<th>&gt;65</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983</td>
<td>508</td>
<td>153</td>
</tr>
<tr>
<td>1992</td>
<td>846</td>
<td>770</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>+66%</th>
<th>+403%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983</td>
<td>77%</td>
<td>23%</td>
</tr>
<tr>
<td>1992</td>
<td>52%</td>
<td>48%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>-32%</th>
<th>+108%</th>
</tr>
</thead>
</table>

Table 3: Day Case Profile of the Elderly in the General Hospital, 1995

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All over-65s in EHB in 1991</td>
<td>9%</td>
</tr>
<tr>
<td>All over-65s as proportion of day cases</td>
<td>14%</td>
</tr>
<tr>
<td>All over-65s as proportion of non-day case discharges</td>
<td>64%</td>
</tr>
</tbody>
</table>

Hip fracture

Hip fracture occurs at an incidence of 1/1000 at age 50 and 30/1000 at age 85 for women and 15/1000 for males. There has been an increase in age-specific incidence over the last three decades in England and Wales with a doubling of age-specific fracture rates 1955-75. Although interventions for both falling and osteoporosis (major risk factors) have been investigated, the effect has so far been minimal.
Stroke

Stroke is a disease of ageing, and although the death-rate from stroke has decreased over the last 50 years, there is considerable doubt as to whether the incidence has fallen in the last 20 years.

Cancer

Cancer is primarily a disease of the elderly. More than half of all the cases, particularly of the breast, colon, lung and prostate occur after the age of 65. Sixty per cent of all cancer mortality is reported in this age group. Future cohorts of older people may be less tolerant of ageism in access to suitably aggressive therapy.

Planning Priorities for the General Hospital

- development of fully resourced interdisciplinary departments of geriatric medicine in each general hospital;
- development locally of best models of collaborative care between geriatricians and orthopaedic and general surgeons, as well as reviews of delivery of acute medical care, particularly stroke;
- undergraduate and postgraduate teaching of specialised elderly care and the principles of interdisciplinary working in each discipline; (only one chair in geriatric medicine, and two postgraduate courses in elder care nursing in the Republic of Ireland);
- encouragement of special interest groups in elder-care and rehabilitation among disciplines (as exists in occupational therapy and physiotherapy);
- development of functional screening as part of the assessment process, with appropriate referral arrangements;
- development of an audit of commonly undertreated conditions of older patients, e.g. pressure sores, incontinence;
- develop a positive and meaningful response to the shortcomings of the DRG system;
- develop close links with the community services;
- ensure that access to all technology and treatment is not based on age.

References


Cunningham, C., F. Horgan et al., In press. 'Detection of Disability by Different Members of an Interdisciplinary Team in a Geriatric Rehabilitation Setting'. Clinical Rehabilitation.


Landefeld, C.S., R.M. Palmer et al., 1995. 'A Randomized Trial of Care in a Hospital Medical Unit Especially Designed to Improve the Functional Outcomes of Acutely Ill Older Patients', N. Engl. J. Med., 332: 1338-44.
The main issues which emerged in the discussion were:

1. It should be taken as given that population changes in the coming years will have cost implications for acute hospitals.

2. There is a need to develop and expand the multi-disciplinary team approach to caring for the elderly. General practitioners should be more involved in this team approach.

3. There should be more integration between hospital-based and community-based services. Hospital services are not stand-alone services and should have a stronger outreach dimension than that which currently exists.

4. There is a deficiency in the number of Consultant Physicians in Geriatric Medicine and an inequity in their distribution around the country.

5. Rehabilitation should be regarded as a step up rather than a step down facility and provision should be made for intensive rehabilitation programmes, including both physiotherapy and occupational therapy. This will not be a cheap option.
Living at home decreases the likelihood of a dependent old person being able to continue long-term care. Old people without close kin are, for instance, statistically over-represented among nursing home residents. Living alone clearly depends on providing long-term care services to functionally disabled old people in long-stay care. Informal care by family and friends is currently the dominant mode, by far, of providing long-term care services to functionally disabled old people in the community. Family care plays a pivotal role in keeping old people out of long-term care. Old people without close kin are, for instance, statistically over-represented among nursing home residents. Living alone clearly decreases the likelihood of a dependent old person being able to continue living at home. If family care were to decline in the future, then many more old people would have no alternative but to seek admission to long-stay care.

If family care were to decline in the future, then many more old people would have no alternative but to seek admission to long-stay care. Of course, everything will not stay the same and the ceteris paribus assumption is unlikely to hold. An ageing elderly population will almost certainly add additional demands on places in long-stay institutional care. However, many things may happen which will either exacerbate or alleviate the pressure on the long-stay sector. Primary among these influences is the role of government, particularly in the area of community care. If additional money is made available to fund community care services then more health nurses, more home helps, additional day care places and increased day hospital provision will reduce the number of old people seeking admission to long-stay care.

Informal care by family and friends is currently the dominant mode, by far, of providing long-term care services to functionally disabled old people in the country. Family care plays a pivotal role in keeping old people out of long-term care. Old people without close kin are, for instance, statistically over-represented among nursing home residents. Living alone clearly decreases the likelihood of a dependent old person being able to continue living at home. If family care were to decline in the future, then many more old people would have no alternative but to seek admission to long-stay care.

Government policy can promote family care by judicious intervention to support carers through the provision of complementary support services, particularly in the areas of income maintenance, respite care and information. The future of family care depends as much on government intervention to support carers as on any structural changes in the labour market affecting the willingness of female family members to care.

Both demographic pressures and concerns about cost are likely to put strains on the current system of long-term care financing in the coming years. Marginal changes to the current tax-based, but selective, system is the pragmatic approach most likely to find favour with policy makers. However, the potential also exists for a small but significant expansion of private long-term care insurance, providing coverage for people who can afford what will inevitably, because of fears about moral hazard and adverse selection, be expensive care. Changes in the financing system may alter the balance between community care and institutional care, leading to changes in the mix of care on offer. It is important, therefore, that even marginal changes are properly planned in order to ensure the realization of given objectives with respect to care of the elderly. The most basic objective is that old people are supported in their own home for as long as is possible and practicable. Supporting and equalising old people's preferences with respect to how and where they want to live will ensure optimality with respect to the provider-mix between institutional care and community living.

Procedures for admission to long-stay care have become more rational, less ad hoc in recent years. Placement decision making can be made even more efficient by the increased involvement of geriatrician-led multidisciplinary teams in the admissions process. Currently, differences exist across regions with respect to admission procedures leading to differences in the mix of dependency in long-stay institutions. Best practice suggests an increased use of pre-admission assessment and rehabilitation as a means of reducing impatient stays. For this to happen more resources will have to be directed towards increasing the number of geriatricians and paramedical staff working with old people in long-stay institutions.

Finally, demographic data can be used to assist in the allocation of resources to old people across the regions. The age structure of local populations should be an important influence on the resource allocation process. Along with other important related variables such as overall population density, dependency levels, morbidity rates and average income, age structure is an important indicator of need. Not enough is known about resource allocation decision-making with respect to care of the elderly. Much of the allocation process is governed by historical, sometimes idiosyncratic processes, resulting in inequities in the provision of services. This is unacceptable in such a small country and should be addressed through the development of a population-based approach to resource allocation across the country.
Workshop 2
Discussion

The main points arising out of the discussion were:

1. The focus should be on the here and now and on the adequacy of current levels of provision rather than looking too much into the future. For example, the question must be asked to what extent have the recommendations of The Years Ahead been applied throughout the country?

2. The concept of long-term care needs to be defined more precisely. Does it, for example, refer only to extended nursing care?

3. There should be one assessment for all services - community care, private nursing homes and health board institutions.

4. Funding should be available to support all care options and not just private nursing homes as is currently the case.

5. There is a shortage of facilities for extended nursing care in the Eastern Health Board area. This has a knock-on effect on acute hospital places.

6. There will be a need for increased provision in the years to come to meet the needs of elderly people with dementia.

7. The concept of integrated planning involving all agencies and personnel, including users of services, needs to be applied throughout the system and not just stated as an aspiration.

Workshop 3
Implications of the Projected Increase in the Elderly Population in Ireland for Community Care and Housing Provision for the Elderly

Chair: Dr. Ambrose McLoughlin
Deputy Chief Executive Officer and Programme Manager, Community Care Services, North Eastern Health Board

Speaker: Dr. Davida de la Harpe
Acting Director of Community Care, Wicklow Community Care Area, Eastern Health Board

While there are inevitably caveats in any population projection, techniques are gradually improving and the value of such projections cannot be dismissed. But the influence of other factors on our health service needs, demands and provision must also be borne in mind.

Whether or not we accept some or all of the assumptions on which the projections are based, it is evident that barring some unforeseen events the population structure in Ireland will change in the future and it is possible to be fairly sure about possible changes. The population will age relatively slowly and the old dependency ratio will increase compared to the dependency ratio of children.

It is evident from the various policy documents in recent years that there is a continuing emphasis on community care in the future provision of services for the elderly. What is less clear, however, is the influence that changing demography will have on future demand for health care among the elderly population.

It is well documented that older people are more likely to use health care services. It is likely also that changes in service availability and delivery systems have changed how elderly people interact with health care systems. The relationship between national income per person per year and health expenditure and the prediction of a continuing increase in both (which can be disputed) may also have implications for the demand of health care among the elderly population. Can we assume that current policy documents, which are based on equity and the recognition that being in one's own home with dignity and independence should underpin our service, will continue to be the basis for our community care and social policies? As the numbers of elderly and their proportion in the population increases, will this inevitably be reflected in our public policies as people themselves make
Just a question of providing specific health care remedies. The question, of options, considered. It is evident that the approach is a multi-sectoral one and that in common with most precipitatory causes of disability the care of people is not knowledge required to choose healthy lifestyles and making certain that medication, treatment, appliances, home care and other care must be specific medication, hormone replacement therapy, encouraging exercise, elderly females. It leads to pain, fractures, loss of mobility and loss of independence. Tackling the problem, however, ranges from providing opportunity for exercise, improving diet, giving people the knowledge required to choose healthy lifestyles and making certain that people have adequate financial resources to take up all or some of the above options. If the disease occurs despite attempts to prevent it, the provision of medication, treatment, appliances, home care and other care must be considered. It is evident that the approach is a multi-sectoral one and that in common with most precipitatory causes of disability the care of people is not just a question of providing specific health care remedies. The question, of course, is whether it is possible to reconcile the long-term and difficult to measure gains of a health promotional approach versus the traditional reactive service provision model. As community care providers, can we develop and facilitate the multi-sectoral framework required for true community care and use the reactive provision approach as just part of the total spectrum of community care?

One of the basic tenets of the policy documents on services for the elderly is that elderly people should remain in their own homes in dignity and independence for as long as possible. In Ireland a high proportion of people own their own homes.

Over the last twenty years, figures show that the elderly have an increasing propensity to live alone. In the future there is also likely to be an increasing number of elderly married couples living together in independent households. The right to own and remain in one’s own house is important and again the approach of maintaining health status is one which will allow people to do this. The provision of community care staff such as public health nurses, occupational therapists and physiotherapists has been an investment which has paid excellent returns. The provision of home helps and home care is of paramount importance in some cases. Also, in some instances grants are provided to allow people to make specific modifications to their own homes so that they can manage at home with many disabilities.

Increasingly, also, sheltered housing is being provided in many cases. Of particular significance is the role of voluntary groups in providing such sheltered accommodation and it is encouraging that many such enterprises are in fact combined projects between voluntary and statutory agencies. This is an essential part of community care and both voluntary and statutory groups have much to gain from such co-operation in the future. In other European countries the provision of smaller housing units and apartments has been a feature of the development of housing stock. In Ireland, while there is a move towards apartments and smaller housing units, it may be some time before this is as common as elsewhere.

It is difficult to predict exactly what the effect of the projected eventual decline in people living alone and the increase in married couples will mean for the provision of care. It may well be that increased emphasis on day care will provide a solution for elderly couples where one or both are becoming dependent. Already, day care is being developed using different models throughout the country. This may be an area in which the voluntary and private sectors may enter into co-operative ventures with the statutory services to a much greater degree in the future.

In order to provide what people want the opinions of everyone must be given a forum for expression. Health care services must be provided on the basis...
The key points which emerged in the discussion were:

1. There is a need for a pro-active inclusive strategic planning approach at all levels of the system. This should include mechanisms for community and user involvement in planning and designing services.

2. More efforts are required in order to maximise the potential of the family as a care-giving system, including education, counselling, mechanisms for converting assets, housing design and income tax relief.

3. There should be an expanded role for care workers and home helps in the provision of high quality care for people in their own homes. Appropriate pay, working conditions and accreditation should be put in place accordingly.

4. The carer’s allowance should be more flexible to support a range of family caring situations.

5. There should be a wider and more imaginative use of technology in supporting the elderly living at home.

6. All caring options should be grant-aided and not just private nursing home care as is currently the case.
WORKSHOP 4

Adding Life to Years: Developing a Healthy Ageing Strategy for an Ageing Population

Chair: Ms. Mary Aylward
Principal Officer, Health Promotion Unit, Department of Health

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

This paper aims to contribute to the discussion on the development of a health promotion strategy for the over-65s. Programmes are most likely to achieve health and social gain if they are focused on the desired end points. Thus, the objective is to seek to identify priority areas for development and action, so as to promote health and delay the development of illness and disability.

In developing health promotion programmes for any age group it is important to remember that the focus is not just on behaviour change by the individual, it is also necessary to ensure that public policies are conducive to health, that the environment supports healthy choices, that there are sufficient opportunities for community participation and that the health services play their role. Given that it may be difficult for older people to change the behaviours of a lifetime, it is important to ensure that all the components of a health promotion programme are in place when implementing programmes for older people.

It is recognised nowadays that economic well-being is fundamental to the maintenance of health. Fahey and Murray (1994) found that, while most elderly people had sufficient money to buy food and to pay for everyday necessities, almost 10 per cent were lacking basic housing amenities. They also identified the need to provide elderly people with a telephone, and emergency alert system and transport; these are particularly important for those living alone in rural areas. Programmes such as Community Alert and Neighbourhood Watch should be evaluated to assess their effectiveness in supporting elderly people.

Supportive environments, allied to community programmes, could also promote a reduction in accidental injury in the home, for example, by checking houses for hazards, such as loose carpets and long flexes which increase risk. Houses should be checked for fire risks and for the presence of functioning fire alarms. Footpaths and pedestrian crossings should be improved and traffic regulations should be rigorously applied so as to minimise hazards for all pedestrians, including those who are elderly.

Thus there would appear to be potential for a major health promotion programme to create environments which support health in older people, through the expansion of existing policies in relation to housing, communications and transport, and the implementation of such policies by local authorities with support from community groups. Education programmes for groups and individual elderly people may also be necessary so that they may gain from these initiatives.

Fahey and Murray found that the majority of respondents described themselves as being in good general health. Psychological distress was related to the onset of functional incapacity, rather than to age per se. Thus programmes which delay the onset of physical illness are likely to also support the maintenance of psychological well-being.

Programmes to reduce risk factors for cardiovascular disease and cancer in the elderly would represent an extension of proposed programmes for the under-65s. The success of programmes in younger age groups would mean that those reaching the age of 65 would be healthier in future. Within the ‘settings’ approach being adopted in the national promotion strategy, priority should be given to the development and evaluation of workplace education programmes for those approaching retirement. Community based programmes should also be developed, perhaps by adaptation for older people of the ‘Lifewise’ programme currently available in some health boards for younger people. Such programmes should place emphasis on leisure activities and on the maintenance of social networks, perhaps by encouraging groups to continue to meet on a regular basis.

The health services have a special role to play in the early detection of disease and disability in elderly people. Implementation of many aspects of the national health strategy would support health maintenance in elderly people. The integration of services, with improved communication between acute hospitals and community services, would facilitate the rehabilitation of elderly people after acute illness. Protocols are required for the assessment and follow-up of older people with chronic conditions, such as poor vision, hearing loss or diabetes. Creative approaches are required in the provision of services, for example, through hospital consultants providing clinics in general practitioners’ surgeries. The expansion of community-based services, for example, chiropody and physiotherapy services, would be expected to result in health and social gain for older people.

It is now widely recognised that expansion of care in the community will require more support, both formal and informal, to maintain the health of
The health promotion initiatives outlined above point to the need for improvements in the environment, with support from local authorities, other State agencies, the community and the health services. The importance of health education programmes is also recognised. However, fundamental to the success of health promotion programmes for elderly people will be the creation of positive attitudes about ageing in all sectors of society, not least among those who work in the health services and among older people themselves.

The key points arising from the discussion were:

1. Health promotion should be an integral part of all public policies - environment, education, health and housing. While health services have a vital role to play other policies are also central to bringing about a healthier society.

2. There is a need to create a more supportive environment for older people in regard to housing, transport, communications, pavement and road design. This would both give older people greater independence and also reduce the risks of accidental injuries.

3. There are still negative attitudes to ageing and to the elderly both among the general population and among personnel in the health, nursing and caring services. Negative images of ageing continue to be portrayed in some promotional material.

4. The development of a positive attitude to old age is a life long process for each individual, as is the adoption of a healthy lifestyle. People in old age inevitably have difficulty in changing the habits of a lifetime.

5. Health promotion requires a multisectoral approach which embraces a range of factors which contribute to health, well-being and a positive attitude to old age.
FINAL SESSION

Chair: Mr. Eamonn Hannan
Chief Executive Officer, Western Health Board and Member, National Council for the Elderly
The Policy Research Centre is carrying out a review of *The Years Ahead* on behalf of the National Council for the Elderly.

The principal aims of the review are:

(a) to inform the Council, policy makers, service planners and providers at national, regional and local levels on progress on the implementation of the recommendations of *The Years Ahead* report, in a factual account of which of the recommendations have been implemented, which are in process of implementation and which have not been implemented;

(b) to comment on the effects of recommendations implemented from the perspective of service providers and service users;

(c) to comment on gaps in the implementation of the recommendations and to interpret reasons advanced for such gaps;

(d) to assist in the formulation of recommendations for future policy on the elderly based on the review of findings and relevant developments since 1988.

It is envisaged that the review will examine a range of policy areas including health strategies, co-ordination of services, care of the elderly at home and in institutions, the elderly mentally infirm and partnership issues.

There would appear to be mixed messages coming through about the degree to which the recommendations of *The Years Ahead* have been implemented. For example, the health strategy document points to increased provision in a number of areas while other studies, e.g. Lundström and McKeown (1994), are less optimistic in stating that the recommendations of *The Years Ahead* have not been implemented widely. What appears to have happened is that health boards have adopted and implemented their own models of service provision. This may point to basic difficulties in operating according to the types of norms set out for various services in *The Years Ahead* report.

It is reasonable to assume that current aspirations for service provision are broadly similar to those which were there in 1988 and that elderly people require more services than are presently available. There is, indeed, much to...
suggest that demand for services will increase and little to indicate that the opposite will be the case. We must not loose sight of today's problems in consideration of tomorrow's.

The study will be based on a review of relevant Irish literature since 1988. It will also be based on:

- the views of policy making and service providing agencies and disciplines named in the report;
- the views of voluntary organisations and other implementing bodies mentioned in the report;
- the views of those who represent the interests of the elderly or have a special expertise in areas of relevance to the welfare of the elderly.

With regard to the health boards, the collection of factual data will be carried out in close collaboration with the Chief Executive Officers who will be asked to designate the most appropriate persons to provide the relevant data in different areas.

Person-to-person interviews and group discussions will be employed to collect data on perceptions of:

- the effects of recommendations implemented from the perspective of both service providers and service users;
- the reasons for non-implementation where recommendations have not yet been acted upon.

RAPPORTEUR'S REPORT
Mr. Michael Browne

1. Conference Deliberations

1.1 Population Ageing

The key issue considered at the Conference was the nature and extent of the impact of an ageing population on health and social care expenditure over the next fifteen years. Two broad views were postulated in this regard. The first by Dr. Tony Fahey suggested that population ageing is less important in determining overall health service expenditure than is often assumed. The other view, argued by Mr. Joe Larragy, is that there is a relationship between ageing and illness and between ageing and health and social care utilisation. Dr. Ronan Lyons suggested that we do not currently have sufficient information to determine if more elderly people in the population will result in an increased need for health and social services.

The central tenet of Fahey's argument is that population trends in general provide little guidance on the likely future size and shape of the health services though they may have some bearing on individual sectors. He bases his argument on five premises as follows:

1. The accuracy and reliability of population projections must be called into question and, specifically, the inaccuracy of previous projections by the National Economic and Social Council in 1982 and by the Central Statistics Office in 1988 should be noted.

2. Population ageing does not of itself necessarily lead to a deterioration in average health status and to an increase in health needs.


4. Supply rather than demand is the main influence on health service consumption.

5. The supply of informal care in the community may not decline to the extent that is frequently predicted.

Larragy, in his paper argues that there is a relationship between demography and health care and suggests that current population projections are more likely to be accurate than previous ones.
The relationship between demography and health care is illustrated by the following considerations.

1. The phenomenon of population ageing in Ireland is likely to become increasingly central in demographic considerations.

2. There is a relationship between ageing and illness, with some illnesses continuing to be more prevalent in the older population than in other age groups.

3. There is also a relationship between ageing and health and social service utilisation.

4. The growth in the elderly population has important social care implications and the current services of informal care already under strain, cannot be assumed to remain the same or to increase.

5. Current population projections are more likely to be accurate than previous ones due mainly to the fact that the fertility rate will be likely to remain stable in future years.

1.2 Assessment of Need Among Older People

Lyons in his presentation referred to the growing trend in many countries of reorientating health and social care service provision to the actual needs of the population.

Needs assessment is a complex process which has to take into account the magnitude of a problem within a population, the effectiveness of the available therapies and the costs of implementing these therapies. To ensure that the needs of the elderly are met it may be important that the assessment of the needs of the elderly becomes a priority. There are a number of reasons for this:

1. The concept of cost effectiveness in a health economics perspective tends to discriminate against older people and their needs.

2. Waiting lists may be dysfunctional to a needs based service and the interests of the elderly.

3. Studies which assess needs based on those already in contact with services will always underestimate the true level of need.

Some of the speakers (Larragy, O’Neill) point to the fact that some diseases are more prevalent among older people e.g. cardiovascular disease, cancer, hip fractures. O’Neill states that as the numbers and population of older people grows, their need for surgical intervention will grow.

1.3 Current Levels of Provision

In the course of the Conference the issue of the health needs and related health and social care expenditure of an ageing population was located clearly in the context of current provision for older people.

Some speakers referred to the current prevalence of unmet need among the elderly population. Lyons cited a number of studies, including two in Ireland and in the UK, where instances of unmet need were clearly identified. His conclusion was that, taken together all the studies referred to indicated that the current level of underprovision of services for the elderly is substantial. O’Neill referred to the non-detection and/or non-prioritisation of disability among the elderly.

Another issue raised by a number of speakers related to the current level of provision in the community, in general hospitals, and in respect of long-stay accommodation. O’Neill referred to the presence of ageism and discrimination against older people in the health services and to what he terms an incomplete understanding of the basis of rehabilitation of older people. The adequacy of current community care provision was questioned by a number of speakers with particular reference to housing, housing amenities and domiciliary services. De le Harpe argued that the future of community care cannot be simply an expansion based on increased numbers of older people but must take into account the nature and quality of that care. Doherty emphasised the need to focus attention on quality of outcomes and to target provision accordingly.

1.4 Impact of a Health Promotion Approach

A number of speakers stated that the question of the health and social care needs of the elderly population in the future must be addressed in the context of current lifestyles and current health promotion strategies. “Illness and disabilities for which older people require treatment often have their origins in lifestyles and behaviours which are changing with time” (de la Harpe).

Lyons suggested that generations born with better health, receiving better nutrition, living in a better environment and having a healthier lifestyle are likely to maintain a higher level of health into old age. Doherty argued that preventative programmes and healthier lifestyles have the potential to
produce major long-term benefits. Healthier lifestyles include eating better, refraining from smoking and excessive alcohol, exercising regularly and managing stress. Shelly pointed to the importance of the environmental context in promoting and developing healthier lifestyles and thus delaying the onset of illness and disability. A central environmental support was the availability of suitable and appropriate housing, a point emphasised also by Doherty and by de la Harpe.

The challenge facing us, according to de la Harpe, is to reconcile the long-term and difficult to measure, gains of a health promotional approach with the traditional reactive service provision model.

An important aspect of a comprehensive health promotion approach is to change the attitudes to illness and disability in old age among health and social care professionals. Many illnesses and disabilities among older people can be successfully treated with resources, time and positive attitudes.

2. Key Points

There was little general discussion at the Conference on the issue of the reliability of population projections. There appeared to be a general consensus that there would be a significant ageing of the population over the next fifteen years and that this would have implications for health and social care expenditure. The following are some considerations which were regarded as impinging on the question of health and social care expenditure in the context of an ageing population.

(1) There is currently a significant level of unmet need among the elderly population. There are obvious cost implications in identifying, assessing and responding to this unmet need. Demand is not synonymous with need.

(2) Theoretically, health promotion strategies should bring about healthier lifestyles and consequent better health in old age. The extent to which this will happen remains to be seen. Health promotion also needs resources.

(3) It may be that there will be some balancing out between greater numbers of older people on the one hand and better overall health in old age on the other.

(4) As the proportion of older people in society grows it may be that they will exercise greater power through the democratic process and consequently exert a shift in health and social care expenditure.

(5) The demand for health and social care is likely to increase due to the increasing consumerisation of society.

(6) The current emphasis on quality of outcomes in terms of health gain and social gain, if applied to the elderly population, should bring about some re-orientation of resources towards the treatment, rehabilitation and care of older people. This will, however, need to be planned for in a systematic manner.

(7) Dealing with the current level of underprovision of health and social services for the elderly may be more significant in terms of costs than the actual increase in the older population.

(8) The adoption of a more holistic approach to health and social care in terms of management and provision would almost certainly improve the quality of care. However, the cost implications would require further consideration.

3. Overview

The Conference papers and discussions set out the broad parameters of the issue of population ageing and health and social care expenditure. However, the exact contribution of many of the relevant variables referred to remains unknown. The best that can be achieved in such a context is the postulation of a range of possible scenarios that are likely to occur and how these might be influenced by various factors, including population ageing. The Conference provided a good basis and a useful context for considering these various scenarios and should be of benefit to those engaged in the provision and development of services.

What is clear from the discussions is that we are dealing with complex social realities which are difficult to disentangle. There are a range of concepts and factors involved which require to be operationalised further. This process should involve social scientists, welfare economists and administrators in the construction of a composite set of measurable variables in respect of concepts such as health gain, social gain, health promotion, disease prevention and morbidity compression. These concepts should also be considered in their demographic context with particular reference to developing individually-tailored packages of care for older people. This latter emphasis would provide a valuable framework for considering the various scenarios which have been postulated.
NATIONAL COUNCIL FOR THE ELDERLY PUBLICATIONS

1. Day Hospital Care, April 1982
3. First Annual Report, December 1982
4. Community Services for the Elderly, September 1983
5. Retirement Age: Fixed or Flexible (Seminar Proceedings), October 1983
6. The World of the Elderly: The Rural Experience, May 1984
8. Report on the 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
15. The Elderly in the Community: Transport and Access to Services in Rural Areas, 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 Care at Home and in the Community, June 1988
20. Sheltered Housing in Ireland: Its Role and Contribution in the Care of the Elderly, May 1989
22. The Role and Future Development of Nursing Homes in Ireland, September 1991
23(a) Co-ordinating Services for the Elderly at the Local Level: Swimming Against the Tide, A Report on Two Pilot Projects, September 1992
23(b) Co-ordinating Services for the Elderly at the Local Level: Swimming Against the Tide, Summary of an Evaluation Report on Two Pilot Projects, September 1992
24. The Impact of Social and Economic Policies on Older People in Ireland, January 1993
25. Voluntary-Statutory Partnership in Community Care of the Elderly, January 1993
26. Measures to Promote Health and Autonomy for Older People: A Position Paper, August 1993
27. Co-ordination of Services for the Elderly at the Local Level, (Seminar Proceedings) September 1993
29. Dementia Services Information and Development, (Seminar Proceedings) September 1993
30. Bearing Fruit, A Manual for Primary Schools, September 1993
31. In Due Season, A Manual for Post Primary Schools, September 1993
32. Measures to Promote the Health and Autonomy of Older People in Ireland, (Conference Proceedings) February 1994
33. Theories of Ageing and Attitudes to Ageing in Ireland, (Round Table Proceedings) May 1994
34. Third Term of Office Report, July 1994
35. The Economics and Financing of Long-Term Care of the Elderly in Ireland, August 1994
36. Home Help Services for Elderly People in Ireland, November 1994
37. Older People in Ireland: Social Problem or Human Resource, A Submission to the National Economic and Social Forum, November 1994
38. The Economics and Financing of Long-Term Care of the Elderly in Ireland, (Seminar Proceedings) November 1994
39. Health and Autonomy Among the Over-65s in Ireland, December 1994
40. Support Services for Carers of Elderly People Living at Home, December 1994