


Perceptions of Ageism in Health and Social Services in Ireland

Report based on research undertaken by
Eileen McGlone and Fiona Fitzgerald, QE5

National Council on Ageing and Older People

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National Council on Ageing and Older People
22 Clanwilliam Square
Grand Canal Quay
Dublin 2

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Previous Council research on health and social care related issues indicated that the organisation and delivery of health and social care services in Ireland may create barriers that result in the marginalisation of older people (*A Framework for Quality in Long-Term Residential Care for Older People in Ireland*, 2001; *HeSSOP*, 2001,; *Care and Case Management for Older People in Ireland*, 2001; *Protecting Our Future* 2002; *The Role and Future Development of Day Services for Older People in Ireland*, 2003; *Healthy Ageing in Ireland: Policy, Practice and Evaluation*, 2003).

Therefore, the National Council on Ageing and Older People is pleased to present this study, *Perceptions of Ageism in Health and Social Services in Ireland*, the first examination of prejudice, stereotyping and discrimination on the basis of age in the Irish health service. The Council has long been concerned about the quality of care in various care settings and is of the opinion that negative attitudes towards old age have a direct impact on the amount and quality of care received by older people.

Very importantly, and consistent with the Council's *modus operandi* over recent years, older users of the health service were interviewed for this study. The consultation process was designed to allow older people to describe their own experiences of attitudes towards them and of discrimination against them within the health and social care sector, if it existed. Such consultation is consistent with the National Health Strategy (Department of Health and Children, 2001) recommendation that every opportunity should be used to consult older people with a view to improving service planning and delivery. In addition, in order to adopt a balanced approach to the research and its findings, health and social service providers were consulted to determine whether they felt that ageist practices existed within health and social care services, at both organisational and individual levels.

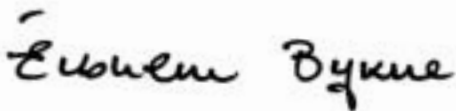
The Council considers this research as a first and necessary step in the identification and elimination of ageism from health and social services. The research findings provide evidence of direct and indirect discrimination against older people within these services

in Ireland. Direct discrimination was evidenced by upper age limits for breast screening and certain treatments; by a lack of referrals for some specialist services; and by prejudicial attitudes by some staff towards older people. Indirect discrimination was evidenced by shortages of certain services of particular importance to older people, which disproportionately affect them.

The Council hopes that the findings of this research will act as an impetus for all health and social service planners and providers to rethink their practices and to ensure that older people are placed at the heart of all care planning and delivery, in order to ensure that the right care is provided in the right place and at the right time.

On behalf of the Council, I would like to thank Eileen McGlone and Fiona Fitzgerald of QE5 for their commitment and dedication. I would also like to thank Dr Ruth Loane who chaired the Council Consultative Committee that assisted the progress of the research and oversaw the preparation of the report. Thanks are also due to members of the Committee: Mr James Conway; Mr John Kincaid; Ms Fiona Johnston; Ms Mary Nally; Ms Ann Ryan; Mr Jim Cousins; Dr Michael Loftus; Dr Ciaran Donegan; Ms Brenda Hannon; Ms Hilary Coates.

Finally, the Council would like to thank its Director, Mr Bob Carroll and Research Officer, Ms Sinead Quill, who steered the project on the Council's behalf. Special thanks are also due to Ms Gabrielle Jacob who prepared the report for publication and to the Council's administrative staff for their assistance throughout the course of the project.

A handwritten signature in black ink that reads "Eibhlin Byrne". The signature is written in a cursive style with a small flourish above the 'E'.


Cllr Éibhlin Byrne
Chairperson

Authors' Acknowledgements

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Council Comments and Recommendations

Council Comments and Recommendations

Findings of the Study

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Though it was beyond the scope of this study to ascertain the exact scale of ageism encountered by older people in Irish health and social services, the research provides concrete examples of prejudicial attitudes and discriminatory practices that have been experienced by older people or witnessed by health and social care providers. For example, participants (health and social service providers in particular) reported upper age limits for interventions, which directly discriminate against older people. They also identified examples of prejudicial attitudes among health and social service providers, for example, as manifested by the operation of implicit age limits for certain services and a lack of referrals of older people to specialist services, screenings and preventative health care programmes. The research also provided examples of policies and practices within and between health boards¹ that also indirectly discriminate against older people by offering care in such a way that older age groups are disproportionately affected.²

The research was intended to be an explorative and descriptive exercise, so generalisations of findings to the whole population of service providers and health and social services should therefore be avoided. The National Council on Ageing and Older People (NCAOP) is aware of the negative effect that sensationalist reporting of research on age discrimination would have and is concerned that any future response is conducted in a considered manner.

The Council acknowledges that the elimination of ageism from health and social services will not take place overnight and concerted long-term efforts must be made in this regard. The Council therefore proposes the following recommendations as the first steps in addressing this issue, which is so important to the welfare and quality of life of older people.

1. The health boards had not been restructured when the research was conducted (2004).
2. When services are limited, they affect the population in general. However, given that older people are greater users of health and social care services, service shortages indirectly discriminate against them because they are disproportionately affected.

Equal Status Legislation

The Equal Status Act 2000 prohibits discrimination in access to goods and services on the basis of age. **The Council recommends the development of guidelines that clarify the relevance of this legislation to access to health and social services. Furthermore, the Council endorses proposals made by the Equality Authority that this legislation be amended to place a 'positive duty' on service providers (including health and social service providers) to be proactive in the promotion of equality.**

Leadership in Tackling Age Discrimination

The Council recommends that future national policy statements, strategic plans and service plans relating to the health and social care of older people should publicly acknowledge the importance of eradicating ageism in health and social services. Such statements should make it clear that denying or delaying access to services on the basis of age alone is unacceptable.

The 2004 Say No to Ageism public awareness campaign, jointly organised by the NCAOP, the Equality Authority and the Health Boards Executive (HEBE), sought to draw public attention to the issue of ageism in general. Continued leadership and support is required from the Department of Health and Children (DoHC) and the Health Service Executive (HSE) to ensure that the issue of ageism in health and social care services is acknowledged. Public awareness campaigns to inform older people of their rights to equal access to health and social services and to inform providers of their responsibilities in facilitating equal access to services by older people should also be supported by the health authorities.

The Council recommends that the DoHC and the HSE provide leadership and guidance in identifying and eliminating ageism from Irish health and social services, much as the UK Department of Health and health authorities have done under the National Service Framework, Standard One, 'rooting out age discrimination'. Policies, procedures and guidelines to promote equal access to services should be developed.

More specifically, the Council recommends initiatives by the health authorities to:

- **raise awareness of ageism and age discrimination in health and social services**
- **provide guidance in relation to the recording and reporting of age discrimination**
- **develop intervention mechanisms and appropriate structures to deal with age discrimination in health and social services.**

The most recent National Health Strategy (DoHC, 2001) proposed that 'regional advisory panels/coordinating committees (including service providers and consumers) will be established in all health board areas for older consumers and their carers to provide them with a voice'. **The Council recommends that the HSE use these panels as a forum for consultation with older people and their carers in terms of their experiences of the health and social services and their rights in this regard.** In keeping with Objective 1: Goal 3 of the National Health Strategy ('responsive and appropriate care delivery'), the Council suggests the development of customer service strategies, the implementation of standardised customer care plans and the development of a statutory framework for complaints in order to place the consumer at the heart of service delivery and in a stronger position to assert their rights for equal treatment.

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Raising Awareness of Ageism

The Council recommends that the HSE devise an information booklet to assist health and social service providers to understand:

- **what constitutes ageism in health and social services**
- **the negative effects of discriminating against older people**
- **that the HSE wishes to promote equality of access for older people and is against ageism in any form**
- **proposals for eliminating ageism from Irish health and social services.**

Gathering the Evidence

This research provides an exploratory account of perceived ageist attitudes and behaviours in Irish health and social services. However, it is only when evidence of direct and indirect age discrimination is fully collated that effective strategies, supported by sufficient resources, can be introduced to address it. **In this regard, the Council proposes that a standardised approach to auditing age discrimination be adopted and recommends that the HSE offer clear guidance in this regard.**

The Council proposes that, as in the UK, national and local health policies should be scrutinised by the appropriate authorities to identify any discrimination on the basis of age that exist. In addition, future policies should be age-proofed. **The Council recommends the development of an instrument similar to the tool-kit developed by the King's Fund for the UK Department of Health to:**

- **scrutinise local health and social care policies**
- **detail how to gather and assess evidence of age discrimination**
- **detail who to involve in the collection of evidence of age discrimination**
- **detail the kinds of evidence to look for (with regard to both direct and indirect discrimination)**
- **detail where to look for evidence of age discrimination.**

This tool-kit should be amenable for use within community care, acute hospital and long-stay care services.

Intervention

The Council recommends that the justification for age-based approaches to health and social care service provision should be closely scrutinised and alternative ways of managing access to treatments or services be explored.

However, it is acknowledged that this scrutiny is more likely to detect instances of explicit age discrimination. **Therefore, the Council further recommends the development of benchmarking tools to detect implicit ageism (such as implicit**

age limits) by enabling comparison of patterns of referral, treatment, care and support achieved among comparable patient groups and localities.

Medical Groups

The Council recommends that all medical organisations, such as the Irish Medical Organisation (IMO) and the Irish Nurses' Organisation (INO), develop resolutions rejecting ageist practices.

A Health and Social Care Strategy for Older People

This research has highlighted cases of indirect discrimination arising from poor assessment of needs and preferences, as well as the unavailability of or ineligibility for services. **The Council believes that the elimination of indirect discrimination would be assisted by the development of a new health and social care strategy, underpinned by legislation and funding, that makes provision for the multi-disciplinary assessment of older people's needs and preferences, so that older people are entitled as of right to services.**

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References

Department of Health and Children, 2001. *Quality and Fairness: A Health System for You*. Dublin: Stationery Office.



Executive Summary

Executive Summary

About the Study

This study is an explorative and descriptive one that seeks to establish whether age discrimination occurs in Irish health and social services and, if so, in what forms.

Aims and Objectives of the Study

The overall aim of the study was to investigate whether older people experience ageism within the health and social services and, if so, to ascertain the impact of this experience.

The main objectives of the study were:

- to review published material to identify examples of ageist practices, both direct and indirect, with a view to drawing comparisons between experiences, policies and practices occurring in Ireland and those documented elsewhere
- to gather direct information, through consultation with staff and older people, regarding the concept and existence of ageism in health and social services; the effects of ageism on older people; and strategies for challenging and/or preventing ageism.

Defining Ageism

Ageism is broader than age discrimination. It refers to deeply rooted negative beliefs about older people and the ageing process, which may then give rise to age discrimination. Such beliefs are socially created and reinforced, embedded as they are in functions, institutions, rules and everyday social life (Hewstone, 1989).

Discriminatory practices cannot be fully understood and tackled without reference to these collective beliefs.

Robert Butler, the first director of the American National Institute on Aging, coined the term 'ageism' in 1969. The definition used to guide the assessment of the evidence base in this study is based on his 1969 definition:

Ageism is a process of systematic stereotyping, prejudicial attitudes and direct or indirect discrimination against people because they are old.

Butler (1969) proposed that ageism has three components:

- a *cognitive* component (beliefs and stereotypes about older people)
- an *affective* component (prejudicial attitudes towards older people)
- a *behavioural* component (direct and indirect discriminatory practices).

Why Ageism Occurs

Many theories have been proposed as to why ageism occurs at individual, societal and organisational levels.

- According to Butler (1969) and Lewis (1987), ageism allows the younger generation to see older people as different from themselves and thereby reduce their own fear and dread of ageing.
- A second factor contributing to ageism is the emphasis on youth culture in western society (Traxler, 1980). The media places an emphasis on youth, physical beauty and sexuality, while older adults are primarily ignored or portrayed negatively (Martel, 1968; Northcott, 1975).
- Thirdly, the emphasis in western culture on productivity contributes to ageism, where productivity is narrowly defined in terms of economic potential (Traxler, 1980).
- A fourth factor contributing to ageism is the manner in which ageing was originally researched (Traxler, 1980). In general, researchers visited long-term care institutions, so early research on ageing was based on unwell, institutionalised older individuals.

Ageism and Its Impacts

Ageism promotes the idea that older people are a burden and this can lead to neglect and social exclusion. It can also reduce older people's self-esteem, reduce their participation in society and restrict the types and quality of services available to them. Research by Sargeant (1999) reported that victims of ageist prejudices experience being discounted, ignored, treated with disdain and denied the opportunity to be recognised as individuals with civic rights and responsibilities.

Fatalism and low expectations about what services and interventions can achieve for older people can result in discrimination against the older population. Low expectations on the part of planners and providers tend to be self-fulfilling, while low expectations of older people's mental capacity can produce inappropriate and infantilising behaviours (Roberts, 2000).

Studying Ageism in Irish Health and Social Services

Broadly speaking, the aims of the research were to investigate whether older people experienced ageism within health and social services, to ascertain the impact of these experiences and to determine whether health and social services staff observed ageism at an organisational level, as well as in relation to accessibility and quality of services. The research took place in two phases as follows.

1. Literature Review

A review of relevant literature relating to ageist practices (both direct and indirect) was undertaken with a view to facilitating comparisons between experiences, policies and practices in Ireland and those documented elsewhere. Themes explored included:

- ageism as a concept within health and social services
- measuring experiences of ageism
- effects of ageism on older people
- legislation and policy developments
- strategies for challenging and preventing ageism.

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2. Consultation with Older People and Health and Social Services Staff

It was decided that consultations should be undertaken with older people who had been in recent contact with the health and social services sector and with staff from that sector who had spent a good proportion of their time working with older people. This dual approach was adopted in order to acquire evidence from different populations of interest and in the hope that it would better ascertain whether ageism exists in the Irish health service.

606 people participated in this study throughout all ten health board areas, comprising consultations with 456 older people (discussion groups and one-to-one interviews) and 150 staff (discussion groups).

All interviews and group discussions with older people and staff were transcribed in full by experienced note-takers. The qualitative data from the field notes was verified at the end of each session. Qualitative data analysis was conducted and the findings from the various strands were amalgamated with a view to painting a fuller picture of the incidences and experiences of ageism in the health and social services sector.

Study Findings

While the findings of this study should not be considered as being representative of the population as a whole, they do emanate from a substantial sample of older people and health and social service providers, and therefore provide indicators of areas for follow-up investigation.

Access to Services

There is evidence of age discrimination with respect to older people's access to services. Many of the older people consulted felt 'fobbed off' because of their age and reported experiencing differential treatment on the part of health and social service providers.

Staff also highlighted the fact that they believed that some older people were not being referred to specialist services because of their age. Individual service providers also appeared to be making negative value judgments about further treatment based on the age of their patients. There was also evidence of an organisational bias in favour of referrals for younger people rather than their older counterparts. Evidence of discrimination in favour of treating acutely rather than chronically ill people was also

provided, which disproportionately affects older people and is a further example of discrimination.

In addition, staff noted that eligibility criteria can act as barriers to access. They specifically highlighted age restrictions, geographic location, administrative complexities and possession of a medical card in this regard. Both staff and older people agreed that lack of transport, waiting lists and prolonged waiting times are significant barriers for older people attempting to access services. This implies both direct and indirect discrimination in operation, resulting in inequity in access to services throughout the country.

Service availability is also a problem for older people. Staff reported an acute shortage of staff and resources in the older care sector in general, and in the community support services sector in particular. Deficiencies in the community sector (particularly availability of Home Helps and Public Health Nurses) have knock-on effects in terms of putting pressure on the acute hospital and long-term care sectors.

Lack of community support services can also limit both the independence and the accommodation choices available to older people. As older people are the heaviest users of community support services, failure to resource these services adequately can be construed as ageist.

Quality of Care

Staff highlighted the fact that assessments of both physical and mental health needs of older people are not 'as good as they could be', mainly due to resource difficulties. Inadequate assessments lead to less-than-effective treatments and can have a detrimental effect on the health and well-being of older people.

Inappropriate referrals are also problematic, as they add unnecessarily to waiting lists and waiting times for treatment. It was argued that over-referring occurs because of a lack of training, a lack of understanding of available services and a fear of litigation on the part of service providers.

The tendency to practice poly-pharmacy is an issue that exercises both staff and older people themselves. It is an issue that must be addressed because it has major resource implications as well as detrimental effects on the health of individual older people.

According to staff, poor communication and information provision can lead to failed discharges. Conditions and illnesses must be explained better if treatment is to be successful. The older people consulted also highlighted problems with communication.

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They particularly resented the practice of staff consulting with family members about their condition while not consulting with them. Staff acknowledged that this does occur, but not to the same extent as in the past.

Many of the older people in the study reported negative experiences with staff in the acute sector. They felt that they were often ignored or not taken seriously. Some staff agreed that the quality of care in acute hospitals can be less than optimal, and cited lack of resources and limited staff complement as possible reasons for this.

Stereotyping of older people does exist in the health and social services, according to staff. The tendency to make generic assumptions about older people – that they are all frail, incapable of looking after themselves, are 'bed-blockers' etc. – has decreased in recent years, but has not been eradicated.

Policies and Practices in the Irish Health Service

If ageism is pervasive at national and societal levels, it tends to filter down through institutional policies and practices. It would appear from the discussions with staff that a level of discrimination is evident in some of the policies and practices of the Irish health and social services sector.

Due to a perception of a lack of national direction in policy, the majority of staff consulted believed that 'money goes into crisis management', without proper planning with service providers and recipients. Resourcing older people's services in a planned and permanent manner was viewed as more appropriate than 'short-term measures for long-term problems'.

Staff also identified a lack of national guidelines in a number of service areas. In the absence of such guidelines, there is an *ad hoc* approach to service delivery at local level. Where policies have been devised at local level, e.g. discharge policies, staff reported that there are insufficient community resources to implement the discharge plan, which often results in a failed discharge and re-admission of the patient to acute services.

Fragmentation of service delivery was another area that raised major concern. Staff emphasised a need for national standards in relation to resource allocation, care delivery and quality standards. In particular, they highlighted primary care initiatives, care and case management programmes, discharge planning and quality of care.

There was also a general conviction that there is a need to provide more choice to older people in relation to independent living, which should be in the nature of home support and supported accommodation. The care and case management model, and intermediate care scheme and subsidised good neighbour scheme initiatives were identified in this regard.

Health promotion and preventative care were viewed as significant issues, with varying approaches reported throughout the country and a clearly identified need to promote planning for old age. This is particularly relevant to future generations of older people and their health status, in terms of dealing with negative attitudes towards ageing and promoting both physical and mental health and well-being.

Staff recruitment, retention and training was deemed to be an area that needed to be addressed at national level. Particular difficulty in recruiting for community-based posts including Chiropodists, Home Helps and Occupational Therapists was noted. Training was seen by many staff in the nursing profession as being too academically based with insufficient emphasis placed on experience and practical services delivery. It was also felt that there was a need for national standards on accredited training for Care Assistants and Home Helps.

Conclusions

This study echoed the findings of the King's Fund (2001), that older people tend to be stereotyped by some service providers as a homogenous group characterised by passivity, failing physical and mental health, and dependency.

Discrimination in the health and social services sector was evidenced by a lack of understanding of older people's needs, as well as by an element of fatalism and low expectations about what services and interventions can achieve for older people. Examples of this in the study included:

- a reluctance to refer older people to specialist services
- under-resourced community supports to facilitate older people to live independently
- under-resourced mental health service provision

- limited screening, health promotion and preventative care for older people
- a general absence of a multi-disciplinary approach to care of older people with complex needs.

The broad aim of health and social service provision for older people in Ireland is to maintain older people in dignity and independence in their own homes for as long as is possible or practicable (DoH, 1988). In order to maintain older people in their own homes in comfort, security and independence, a continuum of care is needed. This should involve appropriate services, which are easily accessible and timely. However, the findings of this research show that access to services can be uneven and barriers exist which have a significant impact on the quality of life of older people.

There are four key areas in which measures are required in order to address direct and indirect ageist discrimination in the health and social services sector. They are:

- policies and practices
- systems and structures
- resources and staffing
- health promotion and age awareness.



Chapter One

Introduction

Chapter One

Introduction

1.1 About the Study

This study is an explorative and descriptive one that seeks to establish whether age discrimination occurs in Irish health and social services and, if so, in what forms. From the outset it must be stated that the findings do not claim to represent the national experience. What is provided in this study is evidence from a sample of older people and staff working in the Irish health service of the existence of practices and policies that, on the basis of examples from international literature, could be perceived as being ageist and, in some cases, discriminatory.

1.1.1 Aims of the Study

The overall aim of the study was to investigate whether older people experience ageism within the health and social services and, if so, to ascertain the impact of this experience.

1.1.2 Objectives of the Study

The main objectives of the study were:

- to review published material to identify examples of ageist practices, both direct and indirect, with a view to drawing comparisons between experiences, policies and practices occurring in Ireland and those documented elsewhere
- to gather direct information, through consultation with staff and older people, regarding the concept and existence of ageism in health and social services; the effects of ageism on older people; and strategies for challenging and/or preventing ageism.

1.2 Defining Ageism

1.2.1 Towards a Definition of Ageism

Ageism is broader than age discrimination. It refers to deeply rooted negative beliefs about older people and the ageing process, which may then give rise to age discrimination. Such beliefs are socially created and reinforced, embedded as they are in functions, institutions, rules and everyday social life (Hewstone, 1989). Discriminatory practices cannot be fully understood and tackled without reference to these collective beliefs.

Robert Butler, the first director of the American National Institute on Aging, coined the term 'ageism' in 1969. He likened it to other forms of bigotry, such as racism and sexism, defining it as 'a process of systematic stereotyping and discrimination against people because of their chronological age'. He identified three distinguishable, yet interconnecting, aspects to ageism:

- prejudicial attitudes towards older people, old age and the ageing process, which includes attitudes held by older people themselves
- discriminatory practices against older people
- institutional practices and policies that fuel stereotypes about older people, reducing their opportunity for life satisfaction and undermining their personal dignity.

Butler (1969) proposed that ageism has three components:

- a *cognitive* component (beliefs and stereotypes about older people)
- an *affective* component (prejudicial attitudes towards older people)
- a *behavioural* component (direct and indirect discriminatory practices).

The definition that will guide the assessment of the evidence base in this study is based on Butler's 1969 definition:

Ageism is a process of systematic stereotyping, prejudicial attitudes and direct or indirect discrimination against people because they are old.

1.2.2 Concepts of Stereotyping, Prejudice and Discrimination

1.2.2.1 Stereotyping

Stereotyping occurs when a person is perceived to belong to a social group (for example, 'older people') with total disregard for individuality. Stereotypes provide us with role expectations, i.e. how we expect the other person (or social group) to relate to us and to other people. With stereotypes, everyone is believed to be the same, expected to behave in the same way and thus is treated the same.

For example, despite the fact that the majority of older people describe themselves as being in good health, older people tend to be stereotyped as a uniform group characterised by lack of activity, failing physical and mental health, and increased dependency (King's Fund, 2001).

Erdman Palmore, who has written extensively about ageism, outlined the stereotyping which forms the basis of ageism (1990). Ageist stereotypes exaggerate the importance of certain characteristics, often based on false assumptions rather than on facts. They tend to overlook positive characteristics and attempt to deny that certain negative traits also exist in the population at large. Stereotypes disregard the underlying causes of certain negative tendencies, assume that such tendencies are unlikely to change and leave little or no room for individual variation.

Some of the common ageist stereotypes referred to in the literature include:

- people in their 50's, 60's, 70's or 80's are homogenous
- older people are likely to be rigid, conservative, dependent, boring, repetitive, smelly, unattractive, asexual
- older people will become frail, disabled, disengaged,
- older people are inflexible in attitude, unlikely to learn new skills, and they use up scarce resources
- older people are largely lonely, isolated and miserable
- older people are confused and senile
- older people lack creativity and are poor problem solvers (Sargeant, 1999).

1.2.2.2 Prejudice

A prejudice is a pre-set attitude, typically negative and hostile, which is usually applied to members of a particular social group. Prejudicial attitudes, which are held towards older people, are usually based on stereotypes. However they may also be based on an individual experience with an older person. Ageist prejudicial attitudes in their mildest forms can lead to insulting and hurtful behaviour towards older people, while the most severe forms can lead to elder abuse (Hayes, 1993).

1.2.2.3 Discrimination

Age discrimination occurs 'when someone makes or sees a distinction because of another person's age and uses this as a basis for unfair treatment of that person' (Age Concern, 1998). Discrimination can be both direct and indirect.

Examples of direct discrimination include a law or policy that explicitly states that goods or services are unavailable to specific sections of the community, such as upper age limits on invitations to cancer screening or a 70 year old who has had a stroke but is not helped by the local stroke care team who restrict their services to people 65 years old and below (Age Concern, 2002; Robinson, 2002).

Indirect discrimination occurs when individual or organisational attitudes are used to inform decision-making and determine service provision. This can result, for example, in older people being given a low priority by service providers or experiencing a lower level quality of service (Age Concern, 2002). Indirect age discrimination also takes place when care is offered in such a way that particular age groups are disadvantaged. For example, policies to shorten lengths of stay in hospital and to maximise throughput in hospital beds can have adverse consequences for older patients who may take longer to recover from surgery or illness (Robinson, 2002).

Discrimination can occur at both individual and organisational levels. At individual level, for example, older people may not always be involved in planning their care, with family members making decisions with professional staff. This disempowers the older person.

An example of organisational discrimination is the shortage or absence of rehabilitation facilities or intermediate care. Low-level support can be particularly important in maintaining independence – failure to provide this discriminates against older people (Simey, 2002).

1.3 Why Ageism Occurs

Various theories are proposed as to why ageism occurs at individual, societal and organisational levels. According to Butler and Lewis (1987), ageism allows the younger generation to see older people as different from themselves. They cease to identify with their elders as human beings and thereby reduce their own fear and dread of ageing. Butler (1969) states that:

Ageism reflects a deep-seated uneasiness on the part of the young and middle-aged – a personal revulsion to and distaste for growing old, disease, disability, and a fear of powerlessness, 'uselessness', and death.

This represents the most commonly argued basis for ageism.

Traxler (1980) proposed four reasons for ageism in western society. The first was similar to the theory propounded by Butler and Lewis. The second reason he proposed was the emphasis on youth culture: the media places an emphasis on youth, physical beauty and sexuality, while older adults are primarily ignored or portrayed negatively (Martel, 1968; Northcott, 1975). The emphasis on youth not only affects how older individuals are perceived but also how older individuals perceive themselves. People who are dependent on physical appearance and youth for their identity are likely to experience loss of self-esteem with age (Block, Davidson and Grumbs; 1981).

Thirdly, according to Traxler, the emphasis in western culture on productivity contributes to ageism, where productivity is narrowly defined in terms of economic potential. Both ends of the life-cycle are viewed as unproductive and middle-aged people are perceived as carrying the burdens imposed by both groups. Children, however, are viewed as having future economic potential but older adults are perceived as a financial liability or burden. This contributes to negative perceptions about ageing and older people.

The fourth factor contributing to ageism in western society proposed by Traxler is the manner in which ageing was originally researched. In general, researchers visited long-term care institutions, so early research on ageing was based on unwell, institutionalised older individuals.

1.4 Ageism and its Impacts

Ageism promotes the idea that older people are a burden and this can lead to neglect and social exclusion. It can also reduce older people's self-esteem, reduce their participation in society and restrict the types and quality of services available to them.

Research by Sargeant (1999) has reported that victims of ageist prejudices experience being discounted, ignored, treated with disdain and denied the opportunity to be recognised as individuals with civic rights and responsibilities.

Internalisation of a negative image can result in the older person becoming prejudiced against him/herself, resulting in loss of self-esteem, self-hatred, shame, depression, and in extreme cases, suicide (Robinson, 1994). In this way, older people may unintentionally collude with the negative stereotypes carried by younger people, the media, health service professionals and service providers in the community (Palmore, 1990).

If ageist stereotypes extend into policies and services for older people, older people may be encouraged to adopt infantilising behaviours and become dependent. They may experience less opportunity to be in control or to make independent decisions. They may also be more likely to be restricted in choices (Sargeant, 1999).

1.4.1 Ageism in Health and Social Services

In general, notions of incapacity, non-adaptability and withdrawal are socially constructed around chronological age. Ageism in health and social services may occur because health problems in the older population are characterised as 'normal aspects of ageing'. There is little consensus over what level of physical limitation is in fact 'normal' in older age and the prevalence of disability has not remained fixed over time.

Fatalism and low expectations about what services and interventions can achieve for older people can result in discrimination against the older population. Low expectations on the part of planners and providers tend to be self-fulfilling, while low expectations of older people's mental capacity can produce inappropriate and infantilising behaviours (Roberts, 2000).

1.4.2 Ageism in Health and Social Services and its Impacts

A qualitative study of ageism in the Australian health services by Minichiello *et al.* (2002) provided details of a number of negative experiences with health professionals

reported by the older people interviewed. They spoke of incidents in which they were neglected or treated as unimportant patients. There were incidents where they were expected to tolerate and accept physical discomfort and pain. They also reported that they were not properly informed of the reasons why medical tests were conducted. The interviewees reported that these negative experiences resulted in the removal of personal autonomy because they were not consulted about major decisions regarding their health or life. The findings are consistent with the findings of other similar research (Betheway, 1995).

Minichiello's research demonstrated how ageism may vary in the intensity with which it is experienced, the older person's responses to it and the way in which older individuals construct their understanding of such experiences. While various forms of stereotyping and discrimination may impact on their lives, older people may not be able or wish to express these experiences as discrimination based on their age.

Older people may be reluctant to classify these experiences as ageism for various reasons. They may not perceive themselves as being old and may seek ways in which to dissociate themselves from ageist stereotypes and behaviours. Alternatively, they may internalise stereotypes of old age and come to accept discriminatory treatment, if it occurs, as 'normal'.

Some older people interviewed in the Minichiello study firmly believed that it was best to just accept what happens and get on with things. Although they may have encountered and recognised stereotyping and witnessed or experienced instances of discrimination, they accepted these with resignation and a sense of powerlessness to act or to prevent such situations from occurring. Minichiello proposed that older people believed that they did not have social power to change their situations so it was best to accept them and not make things worse for themselves by 'acting up'.

The combination of negative and stereotypical attitudes about ageing and older people can have the effect of marginalising older people, causing many to endure unacceptable limitations in their lives. Blackman *et al.* (2001), in their comparative study of social care and social exclusion of older people, found that, although social inclusion is usually defined in terms of income and employment status, the organisation and delivery of social care services can also create barriers to the social inclusion of older people. Convery (2001) discussed these barriers, including lack of entitlement, over-dependence on family care and problems with access to services.



Chapter Two

Literature Review

Chapter Two

Literature Review

2.1 Introduction

This chapter provides a review of relevant literature and identifies ageist practices (direct and indirect) with a view to facilitating comparisons between experiences, policies and practices in Ireland and those documented elsewhere.

Information was sourced from the Internet and medical library journal articles, covering many professions within the health and social care sector, as well as information published by the NCAOP. Themes explored include the following:

- ageism as a concept within health and social services
- measuring experiences of ageism
- effects of ageism on older people
- legislation and policy developments
- strategies for challenging and preventing ageism.

2.2 Service Rationing

The right to health care on the basis of need and clinical ability to benefit is a fundamental principle of health services. In the UK, for example, the General Medical Council's guidelines for doctors assert that:

a patient's lifestyle, culture, beliefs, race, colour, gender, sexuality, age, social status, or perceived economic worth [should not] prejudice the treatment you provide or arrange.

However, with limited resources allocated to public spending on the health service, it is inevitable that rationing or prioritisation takes place. In an over-stretched health service, older people are potentially vulnerable because of the proportion of total resources that they consume. Various rationing systems operate, such as gate-keeping and waiting lists in Canada and the UK, and cost control and out-of-pocket expenses in the USA.

For older people, priority systems, such as waiting lists, are linked to the explicit, or implicit, rationing of treatment. In the context of setting priorities, Daniels (1983) reported that older people are perceived by some as having a 'natural life-span' and hence are classified as low priority cases for health care treatment, relative to younger people. Harris (1995) similarly noted that older people (and particularly the oldest old), may be judged to have had a 'fair innings' and thus be 'less deserving' of limited health and social care resources.

In addition to developing priority systems, some European countries are developing cost-benefit analyses as a basis for policy. These analyses explore which interventions and treatments are the most effective in proportion to their costs. Various ways have been developed to measure cost-effectiveness in health care, such as Quality Adjusted Life Years (QALYs) and Disability Adjusted Life Years (DALYs).³ There are three primary ways in which such measurements discriminate against older people:

- because older people have lower remaining life expectancies, health interventions in older age groups generate fewer adjusted life years than interventions in younger age groups
- years lived in disability are given lower weight than years lived in full health. This discriminates against people with chronic disabilities and illnesses, many of whom are older people
- they do not analyse broader issues that may be especially important to older people such as independence, or the impact of an intervention on carers and family.

Research into public support for the rationing of services is mixed. Williams (1997) highlighted the fact that public attitudes surveys in the UK have found that many people would support a system that prioritised the young. Other studies have found that the public would support a system that prioritises people who are severely ill, regardless of the clinical outcomes (Bowling, 1993).

3. In cost-benefit analyses of health interventions, health problems of different degrees of severity are assigned numerical scores on a scale from zero to one. The scores are used to weight life years in calculations of Quality Adjusted Life Years (QALYs) and Disability Adjusted Life Years (DALYs).

2.3 Age Restrictions

Age limits governing access to screening and treatment may be found at all levels in health care systems. At a macro level, age limits may be found in legislation or regulations specifying the rights and entitlements of patients. Age limits may also be found in professional codes and guidelines or quasi-formal statements of rights and obligations, to complement or supplement legislation or regulations. At regional level, age restrictions may be applied in the protocols and guidelines of individual hospitals or clinics. Age restrictions are a form of direct discrimination against older people and can have a detrimental affect on their health.

2.3.1 Explicit Age Limits

Coronary and vascular diseases and various types of cancer have been identified as the leading causes of death in Europe. Despite this fact, older people are quite frequently excluded from screening, particularly cancer screening. The reasons for applying age restrictions are not always clearly indicated. Medical considerations play a role, but so do other considerations. For example, studies have been done in various countries regarding the effectiveness of breast cancer screening in older women (Henwood, 1990; Sutton, 1997). According to a study by Shapiro (1992), various arguments are presented to justify excluding women above a certain age (usually between 64 and 84 years):

- it is said to be too stressful for older women
- the high cost of screening relative to years of life saved.

The effectiveness of calling women over seventy for breast screening is difficult to assess although one estimate suggests that 1,500 lives could be saved annually if the programme was extended to all older women in the UK (Age Concern, 2000a).

2.3.2 Discretionary Age Limits

Some services operate upper age limits which may not be explicit but which nevertheless act as genuine barriers to treatment. A recent survey of a representative sample of GPs in the UK found that many reported being aware of discretionary upper age limits in a range of services including heart bypass operations, knee replacements and kidney dialysis (Age Concern, 2000b).

Some documented examples of the operation of discretionary upper age limits from international literature include the following:

- Hughes and Griffiths (1996) recorded a series of cardiac catheterisation case conferences in the UK at which cardiologists discussed potential candidates for surgery with the consultant cardio-thoracic surgeon. The researchers found that, in many case conferences, the age of the patient appeared to influence the outcome. Age was used tacitly to position patients on the waiting list, rather than explicitly to exclude or disadvantage patients. Decisions were rationalised in terms of technical feasibility. Age tended to be only explicitly acknowledged as an important factor in decision-making in cases where patients were young.
- a review of cardiac rehabilitation in the UK found that although there was no written policy regarding upper age limits, age was a factor in practice, in that it was again used to position patients on a waiting list (Whelan, 1998)
- in the UK, postoperative care in a High Dependency Unit (HDU) should be routinely considered for surgical patients aged 90 and over, according to the National Confidential Enquiry into Perioperative Deaths (1999). Despite this, in a detailed review of the cases of 944 very old patients who died following surgery, only 4 per cent had been admitted to a HDU (King's Fund, 2001). Furthermore, 28 surgeons reported that upper age limits existed for the high dependency or intensive care facilities in their hospitals.

2.4 Assessment

Stereotyping and prejudicial attitudes may result in older people being inadequately assessed and not receiving the services most appropriate to their needs.

A 2003 study published in the *Journal of the American Medical Association* found that between 25 per cent and 40 per cent of Americans aged 65 and over experience some level of hearing impairment.⁴ Despite these numbers, many of the respondents were not assessed or treated by physicians for hearing loss, even though hearing aids and other treatments could improve hearing for many (Yuen, 2003).

A study of 200,000 women aged 50 and over conducted by the American National Osteoporosis Foundation showed that 40 per cent of the women had brittle bones, 7 per cent had full-blown osteoporosis and 11 per cent had suffered fractures. In all cases,

4. At least enough to impact on their ability to work, drive, enjoy music, etc.

the women were unaware of their condition because their doctors never made it known to them. Only 10 per cent of the women interviewed aged 65 and over had received the recommended bone density mass test (CDC, 2003).

Several studies have suggested that mental health disorders in advanced age are under-diagnosed and the development of diagnostic and therapeutic skills for those treating older people has largely been neglected. Mental health promotions for older people have also been underdeveloped.

2.5 Accident and Emergency Care

A major survey conducted in 2000 of 12,000 patients admitted with injuries to Scottish A&E departments found that excess mortality in older patients was higher than expected (Grant, 2000). Older patients were much less likely than younger people with similar injuries to receive appropriate treatment. They were also less likely to be referred to intensive care or for specialist investigation. In addition, it was found that medical staff did not always recognise the significant threat of moderate injuries to older people.

These findings are alarming because a high proportion of emergency admissions to A&E departments are older people. Although there are national standards in the UK guiding waiting times for treatment in A&E departments (DoHUK, 1992), some staff were concerned that they were unable to provide older patients with the standard of care appropriate for their specific needs and that standard waiting times did not take sufficient account of their frailty (Cherry and Reid, 2001). Timely assessment and prompt care would help to minimise the risks associated with the vulnerability and multiple pathology of older people. As a result, the Health Advisory Service (1999) argues for a change in patient management to reduce lengthy trolley waits, unnecessary delays in patient admission and the associated clinical risks.

2.6 Independent Living

Many European countries assign priority to enabling older people to live independently for as long as possible and to delaying or avoiding admission to a residential care unit or nursing home. However, inadequate assessment, service rationing and delayed treatment can mean that older people become unnecessarily dependent on outside help and, in extreme cases, require long-stay care.

2.7 Staff Recruitment, Retention and Training

Policies on staff training, recruitment and retention can also contribute to discrimination against older people.

In the USA, a report published by the Alliance for Aging Research (2003) cited serious shortcomings in medical training for health care professionals in the 'care of older people'. The authors pointed out that staff did not receive enough training in this area. The report also highlighted that work with older people was not attractive to staff and that pay levels tended to be very low for care workers and assistants. The proportion of qualified staff also tended to be lower than with other patient groups. Career prospects, e.g. in nurse consultant positions, tended to be associated with high-technology specialties such as intensive care medicine. Gilhooly (2001) also found that geriatric medicine and nursing was frequently referred to as a 'Cinderella' service; a low-status specialty unable to attract well-qualified and highly motivated staff.

For some time in Britain, it has been difficult to recruit clinical psychologists and other health professionals to work with older people. A study by Kristina Lee (2003) explored this issue with clinical psychologists in training. The trainees were asked to comment on why it might be difficult to recruit to the older adult specialty and how recruitment could be increased. Many trainees believed that clinical psychology had less to offer older people than other age groups, suggesting that they had negative preconceptions about the efficacy of clinical psychology for older people. This can be construed as evidence of ageism.

To increase recruitment into the older adult specialty of clinical psychology, the trainees recommended the following:

- good quality placements and teaching during training

- improved marketing by clinical psychologists working in the specialty
- improved support, terms and conditions.

Research undertaken in Australia by Stevens and Herbert (1997) identified how the nursing profession was likely to have negative stereotypes about ageing reinforced. They maintained that there are many forms of ageism in nursing and nursing academia including jokes, words and patronising gestures when addressing and describing older people. Registered nurses tended to see working with older people as the least desirable career choice as it has a lower status and is not technically orientated. It was also found that nurses and doctors avoided older people in their charge who are heavily dependent and whose health problems stimulate little medical interest.

2.8 Quality of Health Care for Older People

Research has found that attitudes towards older patients may significantly influence nursing practice and the quality of patient care. Helmuth *et al.* (1995) demonstrated that those who reported holding negative attitudes towards older patients (i.e. who stereotyped them) held positive attitudes towards restraint use. Nurses who placed a high degree of importance on talking to patients held more positive attitudes to older people than those who placed a high degree of importance on general nursing care (e.g. bathing, toileting). The literature recognises that effective communication and information provision are essential principles of quality health care (Bull, 1994; Stevenson *et al.*, 2000), but also highlights that these principles are often neglected (Henwood *et al.*, 1998).

In 1998, an independent investigation in the UK into acute hospital care found evidence of negative attitudes towards older people and inadequacies in the care provided on some general acute wards (HAS, 2000). The investigation found that in certain instances, hospitals were failing to meet even basic standards of nutrition or personal hygiene for older patients, causing great distress to patients and their relatives, and resulting in adverse outcomes.

These examples show how stereotyping and prejudicial attitudes can result in discrimination against older people. Negative attitudes may have a significant impact on the quality of care that older patients receive. For example, when older patients are perceived as 'cantankerous' and 'complaining', then their requests to nurses may not be

taken seriously, impacting on the care they receive, length of hospitalisation and recovery chances (Courtney *et al.*, 2000).

2.9 Tackling Ageism at Strategic Level

It is clear from the international literature that a lack of strategic direction can result in deficits in policy and planning in the care of older people, which can lead to age discrimination in health and social care practice.

Age Concern (2002), highlights the need for a focus on culture and attitudinal change, and improvements in services and opportunities for older people, underpinned by targeted legislation and funding. Legislation should prohibit the use of age as a proxy for other characteristics such as health or competence and hence, protect older people against discrimination.

The UK National Service Framework for Older People (NSF) set out eight standards (DoHUK, 2001). Standard One, 'Rooting out age discrimination', states that NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria to restrict access to available services.

The NSF recognised that:

- there are many examples of age-based discrimination in access to and availability of services (particularly in cardiac care and palliative care services)
- decisions about treatment and care should be made on the basis of need, not age
- quality of care is affected by negative staff attitudes
- older people from black and minority ethnic groups can be particularly disadvantaged
- social care strategies are not sufficiently flexible to take account of individual needs
- there are specific concerns about resuscitation policies.

The response to these findings was a policy review leading to a rolling programme of action. The review involved critical examination of the justification for an age-based approach, exploration of alternative ways of managing access to services and the proposal of changes where necessary. The review check-list for the NHS is as follows:

- identify all relevant policies and scrutinise for references to age⁵
- set up a scrutiny group, involving at least one non-executive director, representatives of patients and carers, clinicians, practitioners and managers
- scrutiny group carries out a thorough review of the evidence and make recommendations to the board
- the board agrees a plan of action
- details of the policy reviews, programme of action and results are published in the annual report.

2.10 Tackling Ageism at Local Level

It is important to understand how and why stereotyping occurs. While assumptions can be made that stereotypes are simply learned generalisations, research suggests that stereotyping is part of the everyday process that enables people to cope with the large volume of information they must process in their interactions with others (Gilhooly, 2001). If this is a major factor, it will be difficult to prevent stereotyping.

Education and raising awareness are essential in tackling ageist stereotypes among providers of health and social services. Helping staff to understand the origins of stereotypes and the types of presumptions and inferences underpinning them (Forgas, 1985) would assist in reducing prejudicial attitudes towards old people (Gilhooly, 2001).

In 2003, the British Medical Association launched an online guide for health professionals and the public on how the body ages. The guide is intended to address concerns about ageism in the NHS by providing clear information on health and ageing. It looked at a range of areas, including counteracting the physical changes that come with ageing, mental health, degenerative brain diseases, cardiovascular health, stroke,

5. Recommendation 5.3: initially this audit should cover all written clinical, managerial and financial policies and protocols, service level agreements and contracts that specify an age limit for access to treatment, medications or access to services.

cancer and diabetes. Educational initiatives such as this can play an invaluable role in counteracting negative stereotypes of ageing and older people.

2.11 Ageism Research in the Irish Context

As part of the literature review, studies specifically relating to the Irish experience of ageism were also analysed.

There is evidence in Ireland that some staff working in acute hospitals have negative attitudes towards older people. In *Your Views About Health – Report on Consultation for the Health Strategy* (DoHC, 2002), the highest percentage of negative experiences reported by patients was of A&E departments (83 per cent) followed by services for older people (76 per cent). Poor attitudes to older people in acute in-patient services were mentioned repeatedly, as were the terms 'respect', 'dignity' and 'courtesy'. The 'caring' delivered by health and social services for older people was identified as deficient on two levels: being 'cared for' in terms of adequate provision of appropriate services and being 'cared about' as a person with equal rights and value as a human being (NCAOP, 2002).

Coordination in Ireland between the acute care setting and community setting has proved to be very difficult to achieve. While many studies have shown that the majority of older people wish to be cared for in their own homes, community care services are poorly developed to meet their expectations and needs (Garavan *et al.*, 2001; McGlone and Fitzgerald, 2002). Older people are particularly disadvantaged by poorly coordinated services. For example, lack of appropriate community-based services can cause delayed discharges from acute hospitals. A lack of appropriate facilities can also put older people at risk if they are discharged too quickly to facilities that are not suited to their needs (Robinson, 2002).

In an Irish study by Stokes *et al.* (2003), 543 older people completed a survey to explore the degree to which community-dwelling older people throughout Ireland experience ageism. The study found that 46 per cent did not experience any of the forms of ageism listed in the survey. Of those who did (54 per cent), 40 per cent of the incidents were reported to have occurred 'more than once'.

In 2003, the ESRI conducted a survey on attitudes to older people and their treatment in the Republic of Ireland on behalf of the Northern Ireland Social and Political Archive (ARK). This survey found that there was a common perception that older people are

treated less favourably in the Republic of Ireland because of their age. Key findings of the report included:

- 42 per cent of respondents thought that age impacted on the care provided in terms of the attitudes of providers and the treatment offered, with 46 per cent considering that age had an impact when it came to waiting lists for tests and operations
- 11 per cent of interviewees aged 50 years and over reported feeling that they had been treated 'with less dignity and respect' by health and social care professionals because of their age, while 8 per cent thought that they had not been offered treatment that might have helped them because of their age
- 24 per cent of all respondents reported feeling that a friend or relative had been treated with less dignity and respect as a result of their age, and 18 per cent thought a friend or relative had not been offered treatment which might have helped them because of their age.



Chapter Three

Methodology Overview

Chapter Three

Methodology Overview

... without an evidence base for the nature and extent of ageism, it is difficult, if not impossible, to target resources efficiently and effectively to tackle age discrimination in the Health and Social Services.

(Gilhooly, 2001)

3.1 Introduction

Broadly speaking, the aims of the research were to investigate whether older people experienced ageism within health and social services, to ascertain the impact of these experiences and to determine whether health and social services staff observed ageism at an organisational level, as well as in relation to accessibility and quality of services.

It was decided that the views of older people who had been in recent contact with the health and social services sector and the views of staff from that sector who had spent a good proportion of their time working with older people should be sought. This dual approach was decided upon in order to acquire evidence from different populations of interest and in the hope that it would better ascertain whether ageism exists in the Irish health service.

The research was carried out in three stages:

- Stage One – consultation with older people
- Stage Two – consultation with health service staff
- Stage Three – data analysis and reporting.

3.2 Stage One – Consultation with Older People

3.2.1 Sample Selection

3.2.1.1 Target Population

The target population for this component of the study was older people who had been in contact with health and social services in the preceding year.

3.2.1.2 Sampling Strategy

The research team contacted Directors/Managers of Services for Older People in each health board area with a view to securing lists of names of older people who were in contact with the health services in the preceding year. This included those who were admitted to hospital, out-patient clinics, primary care, day care and community care services. A random sample of older people was then selected from these lists.

3.2.2 Ethics and Access Negotiation

All participants in this part of the research took part voluntarily. Individuals were informed by letter of the purpose of the research and given assurances of confidentiality and anonymity (Appendix 2).

To ensure protection of client privacy, consent forms were drawn up for use in each health board area to explain the purpose of the study to the older people involved and secure their permission to release their contact information to the researchers (Appendix 3). Potential candidates were only contacted when the researchers had obtained their informed consent.

Where difficulties were reported in securing completed consent forms, it was agreed that researchers would visit day centre/day hospital venues within health board areas to supplement numbers.

3.2.3 Method of Consultation

The consent forms indicated which was the preferred option for consultation, i.e. discussion group attendance or individual interview. This was to ensure that older people were given a real choice in order to maximise the number of participants consulted.

3.2.3.1 Discussion Groups

The discussion groups were held in day centres in each health board area. This facilitated the older people, ensured an even urban/rural split and maximised attendance. Up to four different centres were visited in each board area with between 6 and 15 people attending the discussion groups. A total of 143 older people attended discussion groups from a total sample population of n=456.

3.2.3.2 One-to-One Interviews

Individual interviews were offered to older people in the form of face-to-face or telephone interviews. In total, 313 older people opted for this method of consultation. Of this number, 233 older people were consulted through face-to-face interviews. Face-to-face interviews were conducted in day centres, day hospitals, rehabilitation units and acute hospitals. 80 older people were interviewed by telephone. The telephone interviews were organised separately from the face-to-face interviews and scheduled over a two-week period.

3.2.4 Design of Data Collection Instrument

The interviews and group discussions were semi-structured and based on themes uncovered in the literature review. In addition, a standard form was used with all older people to record information on demographics, health, and usage of health and social care services (Appendix 2).

The following themes were addressed in both interview and discussion group settings:

- access – have you had any difficulties in accessing services from the health board?
- quality – have you had any difficulties with the quality of care received?
- differential treatment – do you find as a result of getting older you are treated differently? How?

3.3 Stage Two – Consultation with Health Service Staff

3.3.1 Sample Selection

3.3.1.1 Target Population

The target population for this component of the study was any member of staff who, through their work came into contact with older people on a regular basis.

3.3.1.2 Sampling Strategy

A process of consultation with health board CEOs and subsequently with Directors/Managers of Services for Older People in each health board area was initiated to obtain personnel details of staff.

The desired sample size was 250 health and social service providers from a selection base of 2,250. This was stratified according to health board area and employment grouping on the basis of published employment figures from the DoHC 2002 personnel census (Table 3.1, p.42).

3.3.2 Ethics and Access Negotiation

To protect employee privacy, only the employee name, grade and workplace address was requested from the health boards. This ensured that the data protection rights of each employee were not compromised. A covering letter to explain the purpose of the study and to clarify this point was sent to all potential participants (Appendix 1). All participants in this component of the research took part voluntarily.

3.3.3 Method of Consultation

It was decided to convene discussion groups with health and social service staff in order to investigate themes and examples of ageism in the sector. The advantages of this methodology were that:

- it facilitated forming common impressions quickly and reliably
- it allowed for an in-depth investigation of predetermined themes, while providing staff with the opportunity to discuss other issues that they considered relevant.

Table 3.1: Numbers employed in the health service, 2002

	Grade/Category							Total
	General support staff	Health and social care professionals	Management /admin	Medical dental	Nursing	Other patient/client care		
Eastern Region	5,360	5,964	6,448	2,963	12,752	5,202		38,689
<i>Northern Area</i>	2,466	2,743	2,966	1,363	5,866	2,393		17,797
<i>South West Area</i>	1,769	1,968	2,128	978	4,208	1,717		12,767
<i>East Coast</i>	1,126	1,252	1,354	622	2,678	1,092		8,125
Midland	294	662	812	313	1,790	1,379		5,251
Mid-Western	651	824	1,254	458	2,746	1,430		7,364
North-Eastern	423	684	1,216	451	2,193	1,407		6,374
North-Western	1,428	631	1,218	389	2,312	746		6,722
South-Eastern	1,928	990	1,180	613	3,213	654		8,579
Southern	2,520	1,696	1,993	920	4,785	1,117		13,031
Western	1,125	1,126	1,569	668	3,605	1,577		9,669
Total	13,729	12,577	15,690	6,775	33,395	13,513		95,679

3.3.3.1 Sample Frame

The sample frame for the research included professional staff in the acute hospital sector, the community hospital sector and the primary care/community sector (Table 3.2, p.44). Departments such as Children's Services, Gynaecology and Obstetrics were deemed ineligible for inclusion given their infrequent contact with older people.⁶ Of the 95,679 health service providers included in the 2002 personnel census, it was estimated that 70 per cent came into contact with older people on a regular basis.⁷ Therefore, the target population was n=66,975 approximately.

To assist health boards in the selection process, each employment group was further stratified against specific grades based on the level of employee numbers within each group as published in the census. This identified the main positions within the employment groups in terms of number of persons employed.

This additional stratification was designed to support the health boards in selecting staff from their personnel database (P-PARS).⁸ In this way, for example, the NWHB, in identifying 54 employees within nursing, was able to break this down further to identify 24 Staff Nurses, four Clinical Nurse Managers (Level 2), four Psychiatric Staff Nurses and so on.

Because of difficulties in obtaining staff details from some boards, including the three health board areas in the Eastern Regional Health Authority (ERHA), that do not use P-PARS, the researchers negotiated reduced numbers against the original stratified quota sample originally requested.

3.3.3.2 Final Sample Frame

On the basis of information returned to the research team from the Directors/Managers of Services for Older People, 1,182 health service staff formed the sample frame for the study (Table 3.3, on p.45).

6. This is not to say that Gynaecology services do not have contact with older people. However, their level of contact is much lower than other services and due to time and budget constraints it was decided to sample from those services that had much more frequent contact with older people.
7. Based on the assumption that, on average, 30 per cent of the workforce are not employed or directly in contact with older people in the course of their everyday work.
8. Not all health boards use the P-PARS personnel management system. Those who do not have this system do use similar stratification approaches within personnel departments.

Table 3.2: Target numbers requested from health boards for sample frame

	Grade/Category						Total
	General support staff	Health and social care professionals	Management /admin	Medical dental	Nursing	Other patient/client care	
Northern Area	58	65	70	32	138	56	419
South West Area	42	46	50	23	99	40	300
East Coast	26	29	32	15	63	26	191
Midland	7	16	19	7	42	32	123
Mid-Western	15	19	29	11	65	34	173
North-Eastern	10	16	29	11	52	33	151
North-Western	34	15	29	9	54	18	159
South-Eastern	44	23	28	14	76	15	200
Southern	59	40	47	22	113	26	307
Western	26	26	37	16	85	37	227
Total	321	295	370	160	787	317	2,250

Table 3.3: Sample frame based on information supplied by health boards

	Grade/Category						Total
	General support staff	Health and social care professionals	Management /admin	Medical dental	Nursing	Other patient/client care	
Northern Area	3	11	4	-	36	16	70
South West Area	-	8	6	4	5	1	37
East Coast	-	6	1	-	10	4	21
Midland	16	14	19	11	40	27	127
Mid-Western	15	12	29	14	63	31	164
North-Eastern	7	10	27	8	43	17	112
North-Western	3	27	11	12	43	22	118
South-Eastern	-	11	4	12	45	9	81
Southern	13	49	7	42	108	20	239
Western	23	21	36	18	81	34	213
Total	80	169	144	121	474	181	1,182

3.3.3.3 Discussion Groups

A total of 250 staff were invited to attend round table discussions, with two discussion groups held in two different locations within each board area.⁹

Attendance at each discussion group ranged from 6 to 19 multi-disciplinary staff. The total attendance at round table discussions was 150, of the sample frame of n=250 (Appendix 4).

Response rates were poor in many health board areas due to difficulties in releasing staff and absences through annual leave and/or sickness. If a member of staff was unable or unwilling to attend, the Managers were asked to send a replacement of the same grade and from the same location.

3.3.4 Design of Data Collection Instrument

The discussions were semi-structured and based on the following themes.

Access

- Do older people get access to health care as quickly as other patients? (Topics included screening services, referral to specialist services, discretionary age limits, cardiac care, primary and community health care, cancer care and accident and emergency care.)

Quality

- Do older people receive the same quality of care as younger patients?
- How are older people spoken to by staff?
- Are the needs of older people (e.g. toileting, nutrition) met with dignity and respect?
- Are older people perceived and/or treated differently to younger patients?
- Are older people's views taken into account in treatment decisions?

9. With the exception of the SHB area, where a single discussion group in one location was requested, and the EHRA area, where a bespoke workshop was held with medical students, house officers and registrars in Beaumont Hospital, Dublin.

- Are older people offered the same level and quality of information in relation to their care and treatment as younger people?

Organisational Factors

- What policies and practices affect the care of older people?
- Are there written health board policies in local work areas that affect older people in either a positive or negative manner (including policies on referral to specialist services, restraints and resuscitation)?
- Are there unwritten practices in operation in the health board or local work area that affect older people in either a positive or negative manner (e.g. cut-off age limits for referral to specialist services, admission/discharge procedures or allocation of resources)?
- What training is available for staff in the care of older people?
- Are there deficits in professional training for the care of older people?
- Does skill mix and staff ratio affect the care of older people in local work areas?

3.4 Stage Three – Data Handling and Analysis

All interviews and group discussions with older people and staff were transcribed in full by experienced note-takers. The qualitative data from the field notes was verified at the end of each session.

The transcripts were read through carefully and divided into analytical units on the basis of the predetermined themes. The data was coded for correspondence to these themes. Validation of the thematics involved tabulation of the frequency with which certain themes were supported by the data. Researchers adopted a system of *a priori* coding that was complemented by inductive coding if interesting new themes emerged.

3.5 Overall Response Outcome

In total, 606 people participated in the study; 456 older people and 150 staff (Table 3.4).

Table 3.4: Participation levels

	Older people			Staff	
	Individual interviews	Numbers attending discussion groups	Total	Numbers attending discussion groups	Overall total
Northern Area	51	32	83	9	92
South West Area	19	–	19	–	19
East Coast Area	12	–	12	–	12
Midland	30	20	50	26	76
Mid-Western	33	23	56	26	82
North-Eastern	35	12	47	23	70
North-Western	36	15	51	24	75
South-Eastern	36	20	56	20	76
Southern	30	–	30	5	35
Western	31	21	52	17	69
Total	313	143	456	150	606

3.5.1 Participant Population Overview

A detailed profile of each participant group is included in Appendix 4, with some key features highlighted as follows.

3.5.1.1 Older People

- Those interviewed ranged in age from those in their 60's to those in their 90's, with half (50.2 per cent) aged between 76 and 85 years of age. Almost one in three (32 per cent) were aged under 75.
- Over half of all older people consulted (53 per cent) were widowed. Of these, the majority were female (70 per cent). More than nine in ten of those widowed (93 per cent) were aged over 70.
- While one in five of the older people consulted were married (19 per cent), one in six (12.5 per cent) of these were not living with their spouse because s/he was in long-term residential care.
- Almost half (49 per cent) of the older people consulted lived alone. More than two in five (43 per cent) lived with a spouse, child or other relative. Fewer than one in ten lived in either residential care (8 per cent) or supported accommodation (1 per cent).
- Only one in twenty (5 per cent) had progressed to college or university. The older men consulted were almost four times more likely to have studied at college or university than their female counterparts. A significant number of older people (13 per cent) consulted made it known that they were unable to read or write.
- All of the older people interviewed suffer with and/or are being treated for a health problem or condition, with the most commonly noted being arthritis (57 per cent), blood pressure (49 per cent), mobility problems (38 per cent) and heart problems (25 per cent).
- The older people consulted suffered with anything from one to thirteen different health problems or conditions, with an overall average of 3.5 conditions.¹⁰ There was a direct relationship between age and total number of health problems/conditions with increasing levels of conditions with increasing age.
- More than one in ten (11 per cent) stated they were on tablets, but they were unclear as to what the tablets were or the specific condition for which they were prescribed.

10. Mean 3.5; Std Dev 1.6

- Over three quarters of the respondents (78 per cent) had visited their GP within the previous year.
- Four out of five of the older people (81 per cent) consulted had stayed in either a hospital or a nursing home during the previous year, with over half being admitted to a general hospital. Just under a quarter (23 per cent, had visited an A&E department. A third more older men than women were admitted to a general hospital.
- Of those older people consulted who were living alone, more than three quarters (78 per cent) were admitted to a hospital or nursing home during the previous year, while three in four (75 per cent) attended day centres.
- Only two in three of the older people (67 per cent) consulted received any health and/or social services at home, with Public Health Nurses and Home Helps being the most commonly noted (although both were evidenced in only one third of cases). More than one in five (22 per cent) stated that their GP came to their home to visit them.

3.5.1.2 Health and Social Services Staff

- Staff involved in the study represented all fields and disciplines of health and social service delivery: general support services (3 per cent); health and social care professionals (16 per cent); management and administration (13 per cent); medical and dental (12 per cent); nursing (41 per cent); and other patient care (16 per cent).
- Over two thirds of the staff consulted (69 per cent) were based in a hospital or residential setting (including acute and community hospitals) with 30 per cent based in the community or in a centre including health centres, day centres and community outreach facilities.
- More than two in three of the staff consulted (68 per cent) spent over half their average week working with people aged 65 and over. Those staff aged 61 and over spent the least amount of time working with older people, with only one in three (33 per cent) of staff in this category spending half or more of their working week with older people.
- Almost half (46 per cent) those participating had been working in their chosen profession for more than twenty years.



Chapter Four

Access to Services for Older People

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4.1 Introduction

From the outset, it must be stated that this is an exploratory study and the findings of this research should be interpreted with caution. However, the qualitative nature of the research, consisting as it does of discussions with older people and health service staff, does provide insights into ageist practices in the health and social services sector. In many cases, the accounts given by older people were corroborated by a number of health service staff. As a result, the qualitative findings provide a sound evidence base with regard to areas for further investigation.

All the older people who took part in this study were in contact with health and social services during the previous twelve months. Therefore, the experiences they recounted are recent. The majority of older people consulted said that they had experienced difficulties in accessing health and social services in their respective health board areas. Staff consulted also identified differential treatment in relation to older people accessing services in comparison with their younger counterparts.

This chapter documents the feedback from older people in relation to their experiences of accessing services. The views of health and social services professional staff are also relayed in order to provide a fuller picture of health and social service access issues throughout the country.

4.2 Referrals to Specialist Services

With regard to referrals to specialist services, a substantial number of older people reported that they felt directly discriminated against because of their age.

I am 83 and I like to think I am active and have a good quality of life. I have been attending my GP for years, on a private basis. When I was younger and visited his surgery he checked me out, BP [blood pressure], the works, now he doesn't bother. I have chest pain on exertion and it is affecting my life quite badly. He told me it was my age and hasn't referred me to anyone. I am far from happy. I think I have a right to be treated. Who is he to make such value judgements?

(Female, 83)

I'm in constant pain and taking eight painkillers a day... They [doctors] say you're bound to expect suffering at my age, but they wouldn't say it if it was you at your age. [referring to 31 year old interviewer]

(Female, 68)

We are always told that there wouldn't be any point in doing this operation or that operation 'at your age'. They are acting as judges regarding our health ... and whether we are 'value for money.'

(Male, 88)

I think that because I'm getting older they don't want to do anything for me ... The pain I am in is shocking.

(Female, 89)

I think they prioritise young people first.

(Male, 75)

Referrals are much harder now, I've no VHI cover and BUPA won't take me because I'm too old.

(Male, 82)

Many staff in the discussion groups echoed this perception. They reported that older people were being prevented from receiving treatment on the basis of their age. Comments made by staff in relation to older people accessing specialist services included:

Older people are not prioritised for treatment as much as younger [people].

(Clinical Nurse Manager 2)

Some GPs do base decisions on age... [and] can act as gate-keepers in terms of referring older people to specialist services.

(Radiotherapist)

Many GPs won't refer older people, they see complaints as part of ageing process.

(Public Health Nurse)

You nearly feel you have to really prepare a good case for older people to get services. That never happens with young people. (Public Health Nurse)

There is definite discrimination – ageism. Older people are referred down the line and left waiting much longer. (Staff Nurse)

There is some evidence of value judgements being made by individuals based on the age of the person in relation to suitability for referral to specialist services. At organisational level, underestimation of later life potential is evident in the prioritisation of 'younger' referrals for specialist treatment.

4.3 Condition Prioritisation

Acute cases (those that can be 'healed') were reported by staff as having priority over chronic cases (those requiring maintenance and relief of symptoms). This places the older person in the Irish health service at a distinct disadvantage because chronic conditions are more commonly associated with older age. This can be considered a form of indirect discrimination.

At 80 years of age, they [GP's] go for symptom management rather than treatment. (Cardiac Rehabilitation Coordinator)

... most [staff] want to see progress rather than maintenance. (Occupational Therapist)

4.4 Barriers to Access

4.4.1 Barriers to Access: Eligibility Criteria

Staff referred to the use of different eligibility criteria for services that potentially discriminate against older people. These took different forms and are reported under the following themes, which were derived from the frequency of their reporting in round table discussions:

- age limits
- geographic location
- administrative requirements
- possession of a medical card.

4.4.1.1 Age Limits

Staff identified established age limits for health and social services, both explicit and implicit. In some instances, these age limits varied from one health board area to another:

- breast cancer screening – 65 years is the national cut-off point for this service
- stroke rehabilitation – some health board areas won't take anyone aged 65 or over, while in other areas patients must be aged over 65 to access such services
- cardiac services – in one health board area, 82 years was identified as the age limit, while in other health board areas staff referred to an unwritten policy regarding cardiac care and older people though a specific cut-off point was not known
- intensive care – staff in certain health boards reported that an unwritten policy of prioritisation of younger people existed
- oncology services – in one health board, it was stated that there is no aggressive treatment for older people with cancer. Conversely, staff from another health board area stated that there was no upper age limit and that treatment would normally be based on ability of the patient to tolerate aggressive treatment and on patient preference, regardless of age.

4.4.1.2 Geographic Location

It was felt by staff that access to services based on location discriminates against some older people. Differences between various health boards, as well as differences within health boards create inequities for older people. Issues identified included:

- community physiotherapy being available to one older person but not to another living a few miles away because of a health board boundary

- chiropody services being available in one regional hospital and not in another within the same health board area¹¹
- older people receiving physiotherapy if they are at home but not if they are in a community hospital in certain health board areas
- dental treatment being provided to children within community hospital settings but not to older people in one health board area
- mental health services only being available in a designated catchment area within a health board area
- a temporary embargo on home help services within a health board area, leaving older people assessed as needing these services being forced to do without.

4.4.1.3 Administrative Requirements

With regard to accessing services, staff made reference to an excessive level of bureaucracy inherent in the health service structure.

Community services are virtually impossible to access – there are so many different levels to go through and no clarity or information available. Then there’s so much red tape and bureaucracy before finding out if the older person’s eligible. (Public Health Nurse)

There isn’t enough knowledge on the criteria for admission or acceptance to services, leaving the power in the medical court not the clients’. (Occupational Therapist)

Many older people reported being confused by health service structures, terminology and procedures, which often made services very difficult for older people to access.

They pass you from department to department and fob you off because you’re old. You have to fill out forms for everything and they are not geared for older people. (Male, 78)

[When you look for services] you just get a phone number and a Christian name. You get passed through all these departments, then you can’t remember who you’ve been speaking to. (Female, 68)

11. However, it was later acknowledged that the lack of trained chiropodists is a national problem, which is currently being addressed by a working group.

First they give you these complicated forms that pry into everything, then when you get all that done they say the forms have gone missing. (Male, 74)

These structures can be interpreted as a form of indirect discrimination, as they place the older individual at a disadvantage.

4.4.1.4 Possession of a Medical Card

Another form of discrimination identified by some older people arose from having a medical card as opposed to paying for treatment.¹² This was the subject of heated debate at some group discussions.

I have a medical card but I'm still paying out constantly. Half the tablets I'm on aren't even covered. (Female, 80)

Unless I was dying I wouldn't get in with the medical card. (Female, 79)

Some older people opted not to use their medical card as they perceived that it limited their medical access. However, this must be balanced against those older people consulted who felt that the card has brought them 'great benefits'.

Staff consulted expressed disquiet in relation to differential access to services depending on 'the level of VHI cover' of the individual or whether they possessed a medical card.

It's a two tier health service – the haves and the have-nots.
(Respiratory Nurse Specialist)

Difference between public and private ... favouritism regardless of age.
(Staff Nurse)

It appears from consultations with staff that negative discrimination towards medical card holders occurs regardless of age. However, it must be acknowledged that some older people consulted perceived they were unfairly disadvantaged because of its possession; this is ultimately ageist as they qualified for entitlement based on their age.

12. Everyone normally resident in Ireland aged 70 and over is entitled to a medical card regardless of means. Medical card holders are entitled to free GP services; prescribed drugs and medicines (with some exceptions); in-patient public hospital services; out-patient services; dental, optical and aural services; and medical appliances.

4.4.2 Barriers to Access: Transport

Older people highlighted transport as a significant barrier to accessing services. This was particularly (though not exclusively) the case for older people based in rural areas.

I have appointments near every week, and there used to be an ambulance came out for me from the health board but they stopped that. There's no bus comes here and I can't be asking my family to take me all the time for they work. [When asked how she gets to her appointments in these circumstances] ... I have to hitchhike or else I have to miss them. The staff at the hospital found out that I'd hitchhiked to the hospital one day and made me get a taxi home. That cost me €20, so that would mean I'd be paying €40 a time just to get to an appointment, so now I don't tell them. (Female, 78)

I have to cancel appointments because I can't get transport. (Female, 83)

The cutbacks in ambulances and health board transport directly affects older people like me who doesn't have anyone to take me to the hospital. Everyone I have about me works and I can't be asking them to take time off all the time to take me everywhere. (Female, 89)

Given that the majority of older people rely on public transport, inadequate transport facilities could be interpreted as a form of indirect age discrimination.

4.4.3 Barriers to Access: Waiting Lists

When questioned about waiting lists, examples were given of older people being told they would have to wait at least 10 months for ophthalmology services, 18 months for physiotherapy services, between 12 and 18 months to be seen as an out-patient by orthopaedic services, one year for audiology and three years for community occupational therapy. Both staff and older people regarded this as ageist as such delays disproportionately affect this client group.

As described in Chapter Two, this can be perceived as a form of indirect age discrimination, where insufficient resources create gate-keeping practices which disadvantage older people.

4.4.4 Barriers to Access: Waits in A&E Departments and Out-Patient Clinics

Older people talked of lengthy waits in A&E departments and out-patient clinics before being seen.

You go in for a 10 o'clock appointment and you're still sitting there hours later.

(Male, 78)

[On why older people are made to wait] ... because they think we are old that we've got nothing else to do with our time and can sit there all day.

(Male, 70)

Instances were reported of waits in A&E departments of between 6 and 18 hours before initial consultation, often with limited contact from staff.

I had a stroke in January and was made to spend 26 hours in A&E ... on a stretcher. It was two days after I went into A&E before I got a scan or knew that I actually did have a stroke.

(Male, 73)

You go into A&E and you're put in chairs. You're afraid to go to the toilet in case you lose your chair and you're there for hours.

(Female, 78)

While it could be argued that this situation is applicable to all age groups it was perceived by many older people consulted who had used this service that they were disproportionately affected because of their complex needs and the effect the lengthy wait had on their health.

4.5 Availability of Services

4.5.1 Staffing and Resources

While the use of eligibility criteria was identified as potentially discriminating against older people, staff also pointed out that the limited availability of services *per se* is a serious issue. In many instances, older people may well be eligible for services under the criteria laid down but these services are simply not available. Often this is due to staffing and resource difficulties.

Staff reported major shortages of social workers for older people throughout the health board regions. Other services which are experiencing resource problems (effectively making them unavailable to older people in some areas), were identified as occupational therapy, speech and language therapy, chiropody and physiotherapy. The lack of chiropody services is viewed as a serious gap in service provision, as it has a major impact on the quality of life of the older individual.

It was felt by a number of staff that there are specific problems in relation to screening and preventative services, mental health services, and ophthalmic and audiology services for older people.

Screening is way down the list. There's no screening/routine checks for old people. (Management)

No referrals whatsoever for psychological assessment ... (Staff Nurse, Community Hospital)

Another major gap is that of ophthalmic and audiology services. There's no screening of older people here and huge waiting lists. (Orthoptist)

Constraints on personnel also affect the availability of equipment. Staff across a range of grades discussed a lack of Occupational Therapists to carry out home assessments for basic aids, as well as little access to equipment for older people after operations such as hip replacements.

You have Public Health Nurses and care in the community staff ordering equipment for older people that are not specifically designed for their needs, but you can't get out yourself to do the assessment. (Occupational Therapist)

A number of older people reported difficulties in getting mobility aids, with many reporting that they had to buy their own walking aids, rails and wheelchairs. This was also identified as a problem for older people who require adaptations to their homes.

I have had one hip replacement and now the other one's bad. I need sticks to get around. I have no mains water and no toilet or bath. The man across the road brings me over water and I have a barrel outside to catch rainwater. I applied three years ago to get water and a shower and toilet but I am still waiting. I have to use a commode and it's very hard to manage emptying this with needing the sticks as well. (Female, 65)

Staff in three of the health board areas referred to it being 'easier' to access equipment if an older person is under the care of the disability services rather than older people's services, which suggests inequity between these services.

While there are issues affecting staffing levels and resources that are pertinent to all user groups within the health care system, it is the specific shortfalls within older people's services that are of note here.

4.5.2 Community Services and Supports

Without exception, staff across all health board areas spoke of deficiencies in community supports as a major gap in services for older people. These deficiencies were identified as key factors in older people being admitted to acute hospitals and in them being kept in acute beds for longer than necessary. This is a form of indirect discrimination as older people as a client group are disproportionately affected by inadequate community supports.

There's a lack of community specialists, so once older people leave the acute setting there's no support or access. There's nothing either to cross the divide between acute and community services. [referring to convalescent/rehabilitation facilities]
(Staff Nurse, Acute Hospital)

In a substantial number of instances, older people spoke of having to cook, clean, dress and bathe with very limited mobility, or having to rely on the generosity of neighbours and/or friends to supplement whatever community supports they received from their health board.

The only community staff are Public Health Nurses and Home Helps.
(Management)

4.5.2.1 Home Helps and Public Health Nurses

Staff identified the home help service in the majority of health board areas as 'the saviour of care in the community'. There was a widespread belief among staff that this is a service that is very beneficial to older people but does not receive the appropriate level of investment.

Where the service is provided, many older people felt the amount of time provided was very limited.

I have no Home Help at weekends and it is very hard to cope. I live on bread and milk from a Friday to a Monday. (Female, 84)

My Home Help was cut back – they didn't consult with me and they didn't ask me how I'd manage. (Male, 85)

I had a Home Help for four hours a week, then they cut it back to two. I can do nothing myself. How am I supposed to manage with just two hours Home Help? (Female, 69)

While some of the older people consulted said that they were visited by their Public Health Nurse (PHN) either regularly or annually, a considerable number had not seen their PHN in over a year. There was a degree of dissatisfaction with PHN support, which seemed particularly evident in those who were discharged from a lengthy hospital stay or those in pain.

My husband had a heart attack and we were left on our own for a fortnight – no-one to check if we were alright. (Female, 80)

It was three weeks after I was discharged ... after a month in hospital before the Nurse even called to see if I was okay. (Female, 69)

The Nurse passes my door to call with my neighbours but has never once called to see me. (Female, 89)

The dressing on my leg needs changed every few days, but the Nurse only calls once a month so I have to get my daughter to come round and do it. (Female, 78)

Staff spoke of the pressures PHNs face, primarily attributed to lack of resources and/or community support.

We have no multi-disciplinary services in the community. The PHN is the community service in many areas with no support, so is it any wonder we have so many older people in hospital and nursing home beds. (Clinical Nurse Manager)

Most elderly care is left to PHNs – they do an assessment for other services and give older people false hope because services just aren't available. (Public Health Nurse)

In these particular instances, it is clear that resource deficits at community care level have a direct impact on the quality of life and independence of older people. Insufficient resourcing is a form of indirect discrimination as it reduces the possibility of older people remaining in their own homes, as is their stated preference (see Section 4.5.2.3).

4.5.2.2 'Social Admissions' to Acute Services

Inadequate community supports and services have a knock-on effect on other areas of the health service. There was much debate in the discussion groups with staff regarding the issue of 'social admissions' (i.e., where an older person is admitted to an acute hospital because s/he has been unable to access sufficient supports to remain at home and/or no long-stay places are available).

The wards are full of elderly. (Attendant)

When you see a social admission coming in, your heart sinks. You think when are they going to go home, because when they're well there's nowhere for them to go. (Registrar)

We have one patient who's been here for 163 days ... At the last count there were about 80 patients waiting for a long-term bed. (House Officer)

The emphasis is on not letting them in or getting them out quickly ... They get into a bed and have no medical requirements and can't see an OT for two or three weeks. (A&E Registrar)

Staff referred to a marked reluctance to discharge older people as promptly as younger patients. This was often attributed to a lack of home support infrastructure, which often results in a 'revolving door scenario' of failed discharges and re-admissions.

A lot of older people don't need to be in an acute hospital but they've no supports at home. (Staff Nurse, Acute Hospital)

Another explanation put forward regarding why there may be a reluctance to discharge older people from acute hospitals is that of organisational fear, closely related to the medical-legal culture.

A&E and GPs admit older people to acute beds because they won't take the chance of something going wrong. (Clinical Nurse Manager)

The labelling of an older person as a 'social admission' is a prejudicial value judgement. However it has become an almost acceptable phrase to apply to older patients with chronic health difficulties.

4.5.2.3 Independent Living and Accommodation Choices

Inadequate community supports were also identified as a problem for older people who wish to remain independent and/or in their own homes.

Community support is terrible. You need to be independent to survive at home. (Female, 87)

I am in a wheelchair and my house was never adapted for it. I didn't even have a ramp. My doctor told me I had no choice but to stay in hospital. I want to go home. (Female, 72)

There are no community services for older people. You just have to pray you can get a bed in a hospital somewhere. (Male, 68)

There's very poor services in the community once you get frail or ill and can't look after yourself. (Male, 78)

You end up in a nursing home when you want to be in your own home with a bit of help. (Female, 83)

There were no community services to let me go home from hospital so I ended up in a nursing home. (Male, 82)

There's a real passion from older people to stay at home ... The support and resourcing needed for community support is so minimal but would allow the old person to stay at home for much longer rather than be admitted to a long-term bed. (Social Worker)

There was a perception of a lack of choice in relation to accommodation preferences among the older people consulted. Some older people reported that they felt obliged to move in with family members due to disimproving health and/or decreasing mobility; some were already in long-term residential care because of the lack of availability of alternative options. Many felt that long-term care was the only option available to them.

There is nothing for older people who want to live at home. I am in residential care for ten years because there was no help in the community and I had no choice but to come into the hospital. (Male, 82)

Once you go into a nursing home you don't get out. It's very lonely. (Female, 78)

I worry if I get any worse I will end up in long-term care because there's nothing in the community. (Female, 72)

There's nothing for someone like me who needs a bit of help to live at home. I had to move in with my son and I'm very unhappy there. My daughter-in-law doesn't want me in the house and I spend most days in my bedroom with just my radio. The PHN or no-one calls, they don't want to know. (Female, 83)

I'm in a community hospital because I needed help to get up, washed, dressed and to the toilet. My husband has angina and couldn't do it. We have no home help and now I'm worrying about him. No-one calls with him. (Female, 78)

Community hospital beds are also believed to be scarce, with a number of older people who are still active and independent stating they had put their names on the waiting list so they would have accommodation when 'the time comes'. Nursing homes are the only perceived alternative to community hospitals for older people in need of full-time residential care. Staff in many health boards identified this as an issue that makes old people feel particularly vulnerable.

There is no choice but nursing homes for most of us. It is frightening and will we be able to afford it? (Male, 80)

Staff pointed out that adaptations to people's homes would make a significant contribution to maintaining their independence. There are several grant schemes in place to allow for such adaptations, but the application process can be quite cumbersome. Older people who had applied for grants for adaptations complained of the burden of paperwork – specifically the requirement to obtain three quotes from contractors (something they found quite difficult to get). Often they then had to wait for up to 18 months before any work commenced.

4.6 Summary

There is evidence of age discrimination with respect to older people's access to services. Many of the older people consulted felt 'fobbed off' because of their age and reported experiencing differential treatment on the part of health and social service providers.

Staff also highlighted the fact that they believed that some older people were not being referred to specialist services because of their age; this is a form of indirect discrimination. Individual service providers also appeared to be making negative value judgments about further treatment based on the age of their patients. There was also evidence of an organisational bias in favour of referrals for younger people rather than their older counterparts.

Evidence of discrimination in favour of treating acutely rather than chronically ill people was also provided, which disproportionately affects older people and is a further example of discrimination.

In addition, staff noted that eligibility criteria can act as barriers to access. They specifically highlighted age restrictions, geographic location, administrative complexities and possession of a medical card in this regard. Both staff and older people agreed that lack of transport, waiting lists and prolonged waiting times are significant barriers for older people attempting to access services. This implies both direct and indirect discrimination in operation, resulting in inequity in access to services throughout the country.

Service availability is also a problem for older people. Staff reported an acute shortage of staff and resources in the older care sector in general, and in the community support services sector in particular. Deficiencies in the community sector (particularly availability of Home Helps and PHNs) have knock-on effects in terms of putting pressure on the acute hospital and long-term care sectors.

Lack of community support services can also limit both the independence and the accommodation choices available to older people. As older people are the heaviest users of community support services, failure to resource these services adequately can be construed as ageist.



Chapter Five

Quality of Care for Older People

Chapter Five

Quality of Care for Older People

5.1 Introduction

The majority of older people who took part in this study reported few difficulties with the quality of care they received from staff within health and social services, with a significant number commending the staff in a variety of care settings.

What follows is an account of the difficulties and experiences of those older people who did have negative encounters with staff, juxtaposed with staff's perceptions in relation to quality of care issues for older people.

5.2 Assessment of Older People's Physical Needs

5.2.1 Acute Settings

Staff referred to poor assessment and identification of older people's needs in acute settings, particularly in relation to practical care delivery issues (mobility, nutrition, etc.).

The acute setting isn't geared towards mobilising patients, so mobility and continence are big issues. (Staff Nurse, Acute Hospital)

Many older people who need assistance with meals are not being helped – no-one checks. (Staff Nurse, Community Hospital)

[In relation to physiotherapy] *Older people have different needs ... they need more support and stimulating initially. Within three days the dynamic muscles in the legs lose strength ... [The system] geared towards mobilisation and independence in older people settings ... but not acute.* (Physiotherapist)

Staff felt that where patients were under the care of a geriatrician, assessment of their needs was much better with team meetings forming part of the care delivery mechanism.

5.2.2 Community Care Settings

Within the community care setting, lack of resources were attributed to assessments 'not being as good as they could be' with staff perceiving that there are few multi-disciplinary assessments and little measurement of activities of daily living (ADL).

Failure to identify the specific needs of an older individual in order to define the most appropriate programme of care can be implicitly ageist, particularly when it affects the basic elements of patient care: mobility, nutrition and hydration.

5.3 Assessment of Older People's Mental Health Needs

Mental health services for older people were cited in all health board areas as a field where appropriate assessment was vital, but not as developed or effective as it could be. There were a number of issues raised by staff here, as illustrated by the following comments.

There are poor psychiatric services ... older people with behavioural problems suffering dementia are being admitted to acute hospital beds or in community hospital beds. The only options are to transfer to EMI [Elderly Mentally Infirm] beds in Northern Ireland or use sedation. This is discrimination of the most vulnerable.

(Discharge Coordinator)

There are no acute services for older people with a mental health problem, so they end up in a general psychiatric ward where they could end up beside a 20-year-old patient with psychosis. There are no assessment beds or separate admission unit.

(Senior Staff Nurse)

Family pressures mean that GPs may hold on much longer than is good for the older person's mental health [before referring to specialist services].

(Psychiatric Registrar)

Security staff are usually called to deal with agitated patients but they're not equipped to deal with those who have actual medical difficulties. (A&E Registrar)

This suggests under-resourced specialised services looking after the mental health needs of the older population. The inadequacies of the service directly and indirectly discriminate against older people.

5.4 Inappropriate Referrals

Staff discussed the practice of 'over-referring' to mental health and A&E services, often for minor conditions, which creates 'unnecessary' waiting lists and waiting times for these services. It was suggested that lack of training in symptom recognition, confusion regarding the suitability of the services that are available and fear of litigation all contribute to this practice.

A major part of [the problem] is the lack of training of GPs in recognising signs of dementia, challenging behaviour [and] depression. (Clinical Psychologist)

[There is] confusion of GPs over services and differences between services, often leading to multiple referrals in the hopes that someone will pick them up. (Clinical Psychologist)

Fears of litigation mean that when a GP is in doubt, they refer automatically. There needs to be some kind of ranking system. (Management)

This suggests indirect discrimination of older people because of a lack of understanding of their needs and a lack of knowledge in relation to diagnosis and treatment of specific illnesses that may affect the older person.

5.5 Medication

There was a general perception among staff that there is a tendency towards poly-pharmacy, with older people being prescribed numerous medicines which increases the likelihood of adverse drug interactions. Some staff noted that the introduction of a Community Pharmacist into hospital wards made a substantial difference to older patients.

A number of the older people consulted were taking tablets but didn't know what they were or what they were for, while many reported being on multiple medications – some taking up to nineteen tablets a day.

This tendency towards unexplained poly-pharmacy could be construed as ageist, as older people are not informed or consulted.

5.6 Information and Consultation

Lack of information and consultation as a result of prejudicial value judgements was identified as the primary cause of discontent with older people who had experienced difficulties regarding quality of care. Older people felt that doctors were dismissive of them because of their age and that conditions/illnesses were not explained adequately, as illustrated by these comments.

Only for my daughter, who's a nurse, I wouldn't know what's wrong with me. She told me that I have high blood pressure – the doctors never bothered.

(Female, 79)

I think they must think I'm daft. They gave me anti-depressants in the hospital. I asked them why and they said 'you're not depressed but your body is'. What does that mean? Do you think they would treat a young person like that?

(Female, 78)

Hospitals don't care about you. They do tests but just say 'it's alright' and don't bother telling you what's wrong with you.

(Male, 82)

Staff don't explain things to you. They're always too busy.

(Female, 85)

I was told I had diabetes six months ago and was just given a sheet from the dietician. No-one's told me what I have to do.

(Female, 73)

They did all these tests and said it's probably something to do with my kidneys but they didn't tell me what.

(Male, 82)

Many staff attributed failed discharges to a lack of information provided to older people, as well as to a failure to ensure or confirm that information given to patients is fully understood. That said, many staff perceived that this was improving and that that newly qualified doctors are much better at communicating with patients. This perception was corroborated by a number of older people consulted.

5.7 Family Involvement in Patient Care

There was a perceived predisposition within the health service to speak with families of older people, as opposed to the older individuals themselves, regarding treatment and services.

[Staff] will usually talk to relatives on admission rather than patients.

(A&E Staff Nurse)

Whilst the practice of talking to the family rather than older people has transformed over last decade, it still exists.

(Management)

Telling people that they have Alzheimer's is a very delicate area ... [there's often] family pressure and it's not always correct to tell all.

(Management)

Families are becoming increasingly aggressive in terms of dealings with medical staff ... Frequently the family will become enraged because they don't want their older relative told about their condition.

(Senior House Officer)

Families tend to be appeased and kept on side.

(Staff Nurse, Acute Hospital)

While some older people did want a family member present when they were talking with medical staff, none expressed any desire or support for staff discussing their circumstances with their families in their absence. Where this had happened, the general sentiment expressed was that of disempowerment, particularly where decisions were taken in consultation with family members.

I needed help to stay at home – I had falls and was admitted to hospital. When I got discharged I thought I was going home. I asked my son why he was on this road and he said, 'I'm leaving you in a nursing home'. No one asked me or discussed with me if I wanted to go into a nursing home. The staff must have spoken to my family. My rights, my dignity were taken away from me. I had no choice. I am very unhappy but no-one cares.

(Female, 86)

I was treated like a non-person because I was old and frail. The staff organised everything with my family. Do you think they would do that to a younger person? No way!

(Female, 81)

5.8 Staff Attitudes and Conduct

Many of the older people consulted complimented the care and attention received from health and social services staff, particularly within day centres and other services for older people.

The staff here [in the day centre] are in a league of their own. (Male, 74)

*I've had nothing but help and kindness from the staff in the community hospital.
They do everything to encourage me to be independent.* (Female, 81)

However, some of the participants criticised the attitudes of staff and the quality of care received. There was a clear differentiation between older people's services (community hospitals, day centres and day hospitals) and acute services (general/regional hospitals and out-patient clinics), with acute services perceived as providing inferior care to older people. Older people recounted experiences which they felt reflected poor attitudes and conduct of staff towards them. Examples provided in this regard included lack of assistance for older people with mobility problems to get in or out of bed, inexperienced staff trying to 'walk' older people in a manner which aggravated their condition, and staff handling older people roughly and rushing them.

Many older people felt they were treated with disregard, ignored or not taken seriously.

They treat you like you are totally dependent and make you dependent. You have to fit into their system. (Male, 72)

They don't want to see you coming into the hospital. I heard staff talking about me being a 'bed-blocker'. (Female, 79)

The attitude of some nurses is that you're a nuisance – they don't want to be bothered with older people because we need more attention. (Female, 72)

The way they speak to you, you know they can't be bothered with you. They aren't as dismissive of younger people. (Male, 69)

We bore a lot of staff and we are a bit too slow and take a bit longer to do things. Staff like to get things done quickly, we're too much work. (Male, 78)

Because you're old, you're made to feel like your mind is gone. You become invisible. (Female, 76)

When hospital staff treat you like you are old and stupid, sometimes you lose heart, but I am determined that they will not put me down. I'm not mentally retarded just because I'm 78. (Male, 78)

The difference between treatment of older people in community and acute hospitals can possibly be attributed to what was aptly described by one member of staff as the 'frenetic environment' in acute hospitals, which can have a more rushed atmosphere and less focus on individual patients.

At one end you could be trying to stop a young person overdosing, a drunk falling over a banister and so on, then at the other you could be sitting with an older person and giving them a sip of water from a beaker. (Staff Nurse, Acute Hospital)

Resources were again raised as an issue in relation to quality of care, with many specifying a lack of staff complement to deal with the additional care requirements of older people, as well as increased demands on existing staff affecting the time that staff can afford to spend with individual patients.

Trained staff are not at the bedside enough. This affects the overall quality of care. (Clinical Nurse Manager)

Staff are constantly being taken away from the bedside by more and more paperwork. This affects older people who probably rely on more assistance. (Management)

While lack of individual attention was felt by staff in the acute sector to be applicable to all age groups, with a basic rule of thumb being 'attention goes to those who shout loudest, regardless of age', it is the older population that is disproportionately affected as older people are the acute sector's largest client group.

5.9 Stereotyping Older People

Though staff in many health board areas talked of significant improvements in the approach to the care of older people, it was still felt that there is a degree of stereotyping when it comes to older patients.

There's a generic assumption that 'older people are not as capable of looking after themselves'; then they're labelled 'bed-blockers'. (Public Health Nurse)

Some staff can be very patronising to older people. There can be a lot of stereotyping. (Care Attendant)

Such stereotyping demeans older people, diminishes their individuality and, potentially, reduces the quality of the care that they receive.

5.10 Summary

Staff highlighted the fact that assessments of both physical and mental health needs of older people are not 'as good as they could be', mainly due to resource difficulties. Inadequate assessments lead to less-than-effective treatments and can have a detrimental effect on the health and well-being of older people.

Inappropriate referrals are also problematic, as they add unnecessarily to waiting lists and waiting times for treatment. It was argued that over-referring occurs because of a lack of training, a lack of understanding of available services and a fear of litigation on the part of service providers.

The tendency to practice poly-pharmacy is an issue that exercises both staff and older people themselves. It is an issue that must be addressed because it has major resource implications as well as detrimental effects on the health of individual older people.

According to staff, poor communication and information provision can lead to failed discharges. Conditions and illnesses must be explained better if treatment is to be successful. The older people consulted also highlighted problems with communication. They particularly resented the practice of staff consulting with family members about their condition while not consulting with them. Staff acknowledged that this does occur, but not to the same extent as in the past.

Many of the older people in the study reported negative experiences with staff in the acute sector. They felt that they were often ignored or not taken seriously. Some staff agreed that the quality of care in acute hospitals can be less than optimal, and cited lack of resources and limited staff complement as possible reasons for this.

Stereotyping of older people does exist in the health and social services, according to staff. The tendency to make generic assumptions about older people – that they are all frail, incapable of looking after themselves, are 'bed-blockers', etc. – has decreased in recent years, but has not been eradicated.



Chapter Six

Policies and Practices in the Irish Health Service

Chapter Six

Policies and Practices in the Irish Health Service

6.1 Introduction

This chapter illustrates and explores the perceptions and experiences of staff working in the health and social services. It also provides an insight into how the organisation and delivery of these services can discriminate indirectly against older people.

6.2 Service Planning and Implementation

6.2.1 Strategic Planning

During the discussion groups, staff highlighted the lack of implementation of national and regional strategies.

The Years Ahead and Golden Years ... bibles ... beautiful and a great fanfare but no follow-up or money put in. (Clinical Nurse Manager)

Theory is great, reality disheartening. (Staff Nurse, Community Hospital)

No planning or cognisance for implementation. (Management)

Different generations of older people – young old, old old, healthy old, non-healthy old – based on education, money and health. Planning needs to take into account the differences in the older population. (Management)

Plans are made but not implemented. (Physiotherapist)

6.2.2 Fragmentation of Services

In addition to patchy implementation of national and regional strategies, staff identified a level of fragmentation within current health service structures that makes interaction and communication between disciplines difficult. The 'organisation of people into boxes' was an analogy used by some staff consulted to describe the impact of fragmentation of services. For example, it was noted that:

- services, such as the Personal Assistant, available through the disability service are not offered to people aged 65 and over, despite large numbers of older people experiencing mobility and sensory problems
- those with age-related mental health difficulties who have had previous psychiatric problems are not entitled to access psychiatry for later life services.

The health service is geared towards organisation of people into boxes.

(Management)

Poor communication and linkages were reported across the country between disciplines including community and acute services, community and mental health services, GPs, PHNs, Physiotherapists and Occupational Therapists. This results in staff inadvertently duplicating the work of other disciplines.

There's a lovely philosophy of seamless services [but] the reality is very different.

(Clinical Nurse Manager)

Garrison or insular attitude within the health service, with everyone minding their own patch.

(Physiotherapist)

General managers are too far removed ... don't know what's going on.

(Staff Nurse, Community Hospital)

In the health board areas where the care and case management approach had been piloted with integrated team-working employed across disciplines to address the complex needs of older patients, it was viewed very positively by those staff involved.

6.3 Resource Allocation

6.3.1 Community Supports

The general perception among most staff consulted was one of a health service where 'money goes into crisis management'. The majority of staff referred to a considerable shortage of adequate resources in the community, both in terms of staffing and physical supports, which indirectly discriminated against older people.

Community services, on which older people are hugely reliant, are often seen as the 'poor cousin' of acute services. There needs to be more resources here.

(Management)

Skeletal community services – no profile or knowledge and no resources. This is contributing to discharge plans not being implemented. The budget's just not big enough and PHNs are having to wash, dress and change older people because there's no-one in the community to do it.

(Public Health Nurse)

Funding always goes towards acute care rather than community services.

(Physiotherapist)

There are inadequate budgets for home help services, and what resources are available for a year are gone within months.

(Management)

The way the whole health service is structured ... primary care is not developed to the extent it should be.

(Management)

In this regard, staff felt that the introduction of Primary Care Teams and the adoption of the care management system (which is currently being piloted in a number of health board areas) would result in more effective and efficient resource allocation.

6.3.2 Independent Living and Accommodation Choices

Staff highlighted the fact that there is little in terms of resources invested in assisting older people to live independently at home. There was also a fear expressed that there is a 'creation of dependency on nursing homes' with subvention schemes, and concerns about the financial viability of these schemes over the longer term.

While it was stated that there should be a greater element of choice for older people in terms of where and how they live, many staff felt that accommodation choices are currently very limited. It was reported that some older people were living in poor conditions due to a lack of resources to alleviate them.

[Some older people are afforded] no dignity ... using commodes rather than getting a downstairs toilet. (Public Health Nurse)

[Some] old people in rural areas are living in appalling conditions – no heating, water, [poor] doors and windows ... (Social Worker)

There is a huge need for housing aid – some old people are living in horrific conditions but can't get help. There is a ... charge just to apply for assistance and this is a huge deterrent for old people managing on a pension. (Public Health Nurse)

Need ... to create independence rather than allow development into institutionalisation and dependency – a change of approach is needed. (Management)

Other staff highlighted a scarcity of long-stay beds in community hospitals, creating limited choices even in accessing residential care. Supported accommodation was generally perceived as the way forward to assist older people in remaining independent.

There's no choice given to older people in terms of accommodation. (Clinical Psychologist)

Nursing homes are too expensive and those with possessions feel more of a target. (Care Attendant)

[There is a] lack of sheltered housing. (Radiographer)

The increase in voluntary sheltered housing helps the community hospital situation. (Management)

Psychiatric and mental health institutions were removed, but no hostels or alternatives were put in place to provide accommodation options for older clients. (Social Worker)

Additional suggestions made by staff regarding assisting older people to remain at home on the basis of personal experiences included implementing care and case management programmes, and implementing intermediate care scheme and subsidised good neighbour scheme initiatives.

Care and case management is the way it should be for all old people – detection and prioritisation at an early stage then measures in place to enable independence at home for as long as is reasonably possible.

(Occupational Therapist)

6.3.3 Admission and Discharge from Acute Services

The area of 'social admissions' of older people to acute hospitals has been raised in previous chapters. There was a clear perception among staff that the lack of an appropriately resourced community support infrastructure, as well as a lack of integration of community and acute services results in 'social admissions'. This leads to the stereotyping of older people as frail and unable to care for themselves, thus demeaning the older individual.

[There are a lot of] admissions to acute beds, especially in winter, due to no community services.

(Staff Nurse, Acute Hospital)

[There are] no community services at all, so hospitals get clogged up.

(Staff Nurse, Community Hospital)

Need social worker or discharge worker attached to wards to relieve social admissions.

(Clinical Nurse Manager)

The introduction of a medical day unit by GPs at [name of hospital] significantly decreased A&E admissions.

(A&E Registrar)

A&E departments are often at the frontline in terms of 'social admissions' – they are regarded as the interface between GPs and acute services in the absence of community supports.

GPs always go to A&E with home treatable illnesses, however they seem to think, 'if I leave this person in the community who will look after them?' This seems to be the guiding force that directs GPs.

(Management)

A&E and GPs admit older people to acute beds because they won't take the chance of something going wrong. (Respiratory Nurse Specialist)

Hospitals 'throw a fit' when they see an older person coming. They automatically associate this with losing a bed space which could be subsequently tied up for days or weeks, and there is a tendency to discharge home before actual treatment. (Radiographer)

Discharging older people from acute hospitals into the community is a hugely contentious issue. Staff repeatedly discussed failed discharges due to inadequate convalescent and/or rehabilitation facilities for older people, coupled with the lack of community supports required for recuperation from illness.

There are big differences in services we are giving them [in hospitals] and what they are going home to. (Registrar)

... not enough resources for move on/step down from acute services. (Public Health Nurse)

There is a lack of community specialists, so once older people leave the acute setting there's no support or access ... there's nothing either to cross the divide between acute and community. (Social Worker)

[There is] pressure on acute and surgical settings for high turnover. (House Officer)

With older people it is a revolving door scenario. (Physiotherapist)

Whilst discharge policies exist they are not being implemented simply because there are no choices and options available in the community if their case is complex. (Discharge Coordinator)

Have major problems with hospitals discharging older people just to free up a bed ... a pilot programme has been set up looking at failed discharges and this is making a big difference. (Management)

6.3.4 Eligibility Criteria

Staff felt that there was a lack of clear standards and information regarding eligibility criteria, which indirectly discriminates against older people in accessing services.

Community services are virtually impossible to access – there are so many different levels to go through and no clarity or information available. Then there’s so much red tape and bureaucracy before finding out if the older person’s eligible. (Public Health Nurse)

Means-testing system for care allowances makes it very difficult to access. (Care Attendant)

They also highlighted differences in eligibility criteria for certain resources and services, which penalise and discriminate against older people.

[In relation to means-testing] *Older people that have any money get nothing.* (Clinical Psychologist)

If you can afford it it’s available. (Management)

[There is] no screening if in a residential institution but elsewhere it’s available under the medical card scheme. (Community Registered General Nurse)

Once older people go into a private nursing home, they become disqualified for additional services like physio and chiropody. (Physiotherapist)

6.4 Recruitment, Retention and Training of Staff

6.4.1 Recruitment and Retention of Staff

Staffing is perceived as a major issue in relation to caring for older people. On numerous occasions, staff raised the issue of older people with increasing health and social care needs being admitted to hospitals, where the ratio of staff to patients prevented their needs from being adequately addressed.

It was also perceived that there has been some improvement in attracting new staff to older people's services, but that recruitment remains problematic for a number of reasons.

... not attractive to staff ... a wake-up call. (Physiotherapist)

... not the 'sexy number' – most [staff] want to see progress rather than maintenance. (Occupational Therapist)

... seen as back-breaking, no buzz or great return ... unsociable hours and patients only going one way. (Staff Nurse, Community Hospital)

... physically harder therefore not as attractive. (Sister)

... not seen as first choice of many. (Management)

It's like you've written yourself off if you work in older people's services. (Care Attendant)

Home Helps and Care Assistants were identified by many staff as being particularly difficult to recruit due to comparatively low wages and the perception of there being little opportunity for career development.

The specialisation of older people's services as a division within health and social care was viewed as positive in terms of recruiting medical staff and health and social care professionals. However, it was still generally felt by staff that there are inherent difficulties in recruiting staff to work with older people, and that staff shortages must be addressed. As mentioned in previous chapters, difficulties were reported in recruiting for community-based posts including Chiropractors, Social Workers, Physiotherapists, Occupational Therapists, Psychologists and Speech Therapists.

6.4.2 Training

Training was seen by many staff to be academically focused, particularly with regard to nursing care, with insufficient emphasis placed on experience and practical service delivery. It was also felt by many nursing staff that there is a need for practical support for newly-trained nursing staff. This is currently impossible due to other demands on experienced nurses' time and inadequate staffing levels generally.

It was considered by some staff that a proper training and accreditation programme for Care Assistants and Home Helps would both improve quality of care, and assist in attracting more people to these positions.

Many staff working in the field of care delivery for older people felt that there is a need to clarify the health and social care needs of this client group within traditional training, particularly in relation to areas including nutrition, dehydration, mental health, ageing and physiological differences of older people in relation to rehabilitation and mobility.

While it was felt that communication skills training for medical staff had improved, there was still a perception among staff that communication with patients in general is an area that needs further development.

6.4.3 Standards in Quality of Care Delivery

It was felt by many staff that there is a need to emphasise personal interaction with patients, particularly in the acute setting. It was proposed that this should be adopted as a productivity focus or Quality Customer Service (QCS) measure. While person-centred care has seen much improvement, it was generally perceived that the quality of personal interaction has not been a focus in health and social services delivery.

It was also felt that standardisation of duties and responsibilities is required in relation to service providers such as Home Helps, Personal Assistants and Care Assistants. Considerable disparity was noted within and across health boards in relation to the duty of care and responsibilities of these disciplines.

6.5 Health Promotion and Active Ageing

6.5.1 Health Promotion

A distinct lack of provision for older people was reported in terms of health promotion and preventative treatment.

The whole area of health promotion is not targeting older people – it is a crisis intervention service. (Management)

Health promotion [is] neglected to some extent for older people ... need to teach [them] about taking responsibility for their own health and care.

(Clinical Psychologist)

There's no preventative or proactive campaigns for older people.

(Health Promotion Officer)

[There is a] major gap in prevention services ... little health promotion ... and a system geared towards reaction, not prevention.

(Registrar)

There is a perception that investment in health promotion in old people isn't as important as with the younger generation.

(Dentist)

Staff noted an *ad hoc* approach to health promotion for older people. While some board areas had a Health Promotion Officer for Older People, others did not. In particular, staff referred to the need for a standardised approach to falls prevention and retirement planning.

6.5.2 Retirement Planning

Staff in general felt that, with people living longer and in comparatively better health than previous generations, there is a need to promote planning for old age, and it was suggested by some staff that GPs could assist in this area.

A number of staff expressed the opinion that as age and dependency increase, expectations of health boards can often be unrealistic and it is becoming increasingly difficult to satisfy patients. It was felt by these staff that there is a need for the public sector in general to help people 'plan for old age', and evaluate housing needs, impact of decreased mobility, etc. at an early stage.

Everyone looks to the health board for help and support, but there's a responsibility on the person too to plan for their old age. This is something that the Government and Department of Health need to start promoting. It shouldn't all be the responsibility of the health board.

(Staff Nurse, Acute Hospital)

6.6 Elder Abuse, Do Not Resuscitate Orders and Living Wills

6.6.1 Elder Abuse

Elder abuse was an issue that arose in many discussion groups with staff, some of whom felt a sense of frustration and powerlessness in relation to protecting older people from abuse by family members, usually in relation to protection of the older person's home and assets. Others felt that there was an unrealistic expectation of health and social services staff to intervene in such situations.

The policy on elder abuse is very vague. (Management)

There is much more protection for children. Older vulnerable people are neglected by the law. (Community Welfare Officer)

Older people are more likely to have their rights taken away than protected. (Staff Nurse, Acute Hospital)

Older people who were consulted as part of this study felt that the health service should be more proactive in protecting them, as the health service is usually the first port of call when an older person becomes vulnerable.

Three of us have had our families rip us off and we have been left without a penny. There's no law to protect us and no one wants to know. Staff tell us there is nothing they can do ... It's a poor state that doesn't protect their old folk. (Female, 79)

6.6.2 Do Not Resuscitate Orders and Living Wills

Do Not Resuscitate (DNR) orders were described as a 'grey area' by staff who reported no clear knowledge of a defined policy in this regard.¹³ Living Wills were a similar grey area.¹⁴ The quotes that follow show the complex difficulties facing staff in the absence of guidelines.

13. A DNR order generally means that, should a patient suffer cardiopulmonary failure, cardiopulmonary resuscitation (CPR) should not be attempted. It does not relate to the withholding of any other type of treatment.

14. A Living Will is a document in which a person states his or her intention to refuse medical treatment and release health care providers from liability if the person becomes terminally ill and is unable to state his or her refusal.

No one takes responsibility ... clear policy and guidelines are needed.

(Staff Nurse, Community Hospital)

Living Wills are a big problem for doctors trying to decide between patient wishes and families.

(Registrar)

There are no guidelines, often staff are forced to go along with the decision [to resuscitate] even though they know the outcome.

(Clinical Nurse Manager)

It's not an age issue, it's quality of life ... older people are more likely to have quality of life issues.

(Senior House Officer)

The ethical issue regarding sustaining of life with no quality needs to be addressed.

(Cardiac Rehabilitation Coordinator)

6.7 Political Considerations

The issue of politics was frequently raised during staff discussion groups, in relation to legislation, the influence of politics in health board decisions, as well as on health board priorities and service provision.

Legislation guides policy ... huge emphasis on child health at the minute.

(Social Worker)

Quality of service [and service provision] is often proportionate to what is in the 'national interest' ... the focus on childcare indicators at the moment distracts professionals from ensuring consistent quality of care across all patient groups.

(Management)

Politicians can put pressure on to get certain people admitted to community hospital beds when they do not need to be there and are not a priority. There needs to be more accountability regarding admission policies.

(Staff Nurse, Community Hospital)

Some of the older people interviewed echoed these sentiments.

Old people have no political clout – that’s what gets things done here. I served my time as a soldier and served my country, now I’m being treated like a second class citizen. (Male, 87)

Getting older is having to fight more to be heard but nothing changes. It’s the political system that shapes the health service here. (Male, 75)

6.8 Summary

If ageism is pervasive at national and societal levels, it tends to filter down through institutional policies and practices. It would appear from the discussions with staff that a level of discrimination is evident in some of the policies and practices of the Irish health and social services sector.

Due to a perception of a lack of national direction in policy, the majority of staff consulted believed that ‘money goes into crisis management’, without proper planning with service providers and recipients. Resourcing older people’s services in a planned and permanent manner was viewed as more appropriate than ‘short-term measures for long-term problems’.

Staff also identified a lack of national guidelines in a number of service areas. In the absence of such guidelines, there is an *ad hoc* approach to service delivery at local level. Where policies have been devised at local level, e.g. discharge policies, staff reported that there are insufficient community resources to implement the discharge plan, which often results in a failed discharge and re-admission of the patient to acute services.

Fragmentation of service delivery was another area that raised major concern. Staff emphasised a need for national standards in relation to resource allocation, care delivery and quality standards. In particular, they highlighted primary care initiatives, care and case management programmes, discharge planning and quality of care.

There was also a general conviction that there is a need to provide more choice to older people in relation to independent living, which should be in the nature of home support and supported accommodation. The care and case management model, and intermediate care scheme and subsidised good neighbour scheme initiatives were identified in this regard.

Health promotion and preventative care were viewed as significant issues, with varying approaches reported throughout the country and a clearly identified need to promote planning for old age. This is particularly relevant to future generations of older people and their health status, in terms of dealing with negative attitudes towards ageing and promoting both physical and mental health and well-being.

Staff recruitment, retention and training was deemed to be an area that needed to be addressed at national level. Particular difficulty in recruiting for community-based posts including Chiropodists, Home Helps and Occupational Therapists was noted. Training was seen by many staff in the nursing profession as being too academically based with insufficient emphasis placed on experience and practical services delivery. It was also felt that there was a need for national standards on accredited training for Care Assistants and Home Helps.



Chapter Seven

Conclusions

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Conclusions

7.1 Evidence of Ageism within Health and Social Services

Robert Butler (1969) identified three distinguishable, yet interconnecting components to ageism:

- prejudicial attitudes towards older people, old age and the ageing process, which includes attitudes held by older people themselves
- discriminatory practices towards older people
- institutional practices and policies that fuel the stereotypes about older people, reduce their opportunity for life satisfaction and undermine their personal dignity.

The findings and conclusions of this study are discussed using these components of ageism as a backdrop.

7.1.1 Prejudicial Attitudes and Stereotyping

7.1.1.1 Sustaining the Stereotype

This study echoed the findings of the King's Fund (2001), that older people tend to be stereotyped by some service providers as a homogenous group characterised by passivity, failing physical and mental health, and dependency.

The reported practice of speaking to families of older patients regarding their conditions and treatment without consulting the older person, as well as the failure to inform older people about the reasons for medical tests, indicate adherence to the stereotype that older people have limited understanding and are unable to make decisions regarding their own care.

The tendency towards characterisation of older patients in acute settings as 'bed-blockers' is a further manifestation of prejudice towards older people. Staff interviewed referred frequently to 'social admissions', and some admitted to their 'hearts sinking' when they saw an older person coming into an A&E department. Such stereotyping demeans older people and may, ultimately, reduce the quality of care they receive.

Discussions with staff pointed to a tendency to discharge older patients before treatment is received, or recovery complete, to prevent occupancy of a hospital bed on the basis that, because the patient is of advancing years, their stay will be prolonged. This is, perhaps, an example of this prejudice at its most extreme, as is the tendency to postpone discharge unnecessarily (despite an older person's expressed desire to return home). Such practices can be attributed to the stereotyping of older people as being frail and unable to look after themselves.

7.1.1.2 A 'Natural' Consequence of Ageing

In a qualitative sense, discrimination based on prejudicial attitudes is suggested in the finding that older people are not referred to specialist services because of their age. The older people consulted cited numerous examples of having health complaints dismissed as part of the 'ageing process' – some experiencing considerable pain and suffering, others enduring negative limitations on their quality of life. This is consistent with the international research in this area (Green *et al.*, 1996). Certainly, the older people consulted in the course of this study referred to being dismissed or felt their doctors were not taking their health needs and concerns seriously.

7.1.2 Discriminatory Practices

Discrimination in the health and social services sector was evidenced in a lack of understanding of older people's needs, as well as by an element of fatalism and low expectations about what services and interventions can achieve for older people. Examples of this in the study included:

- a reluctance to refer older people to specialist services
- under-resourced community supports to facilitate older people to live independently
- under-resourced mental health service provision
- limited screening, health promotion and preventative care for older people

- a general absence of a multi-disciplinary approach to care of older people with complex needs.

7.1.3 Institutional Practices and Policies

Walker *et al.* (1996) argued that ageist stereotypes underlie many of the services designed for older people, with the focus centred mostly on care and less on the supports necessary to allow an older person to achieve his/her full potential. This certainly reflects the views of staff consulted as part of this study, who perceived that resources are allocated to 'crisis management' and to funding acute and long-stay beds rather than community services. Such a pattern of resource allocation prevents older people from ageing independently and creates bottlenecks in the delivery of care.

In addition, there was a general perception that, while the motivation and will exists to recognise the changing needs of an ageing population, there is a lack of implementation in terms of the necessary structures, systems and resources. A perceived absence of integration of services under the current health system was also felt to be discriminatory to those older people who would benefit from a multi-disciplinary approach to care delivery.

A level of bureaucracy and lack of information was also identified by both staff and older people (many of whom have limited formal education) as a form of institutional ageism in the creation of complex structures that many older people are simply unable to access.

Furthermore, the findings from the consultations with staff and older people corroborated the findings of the Alliance for Aging Research (2003) regarding shortcomings in medical training, prevention screening and treatment patterns that disadvantage older patients:

- health care professionals receive insufficient training in the care of older people in order to care properly and holistically for many older patients
- older people are less likely than younger people to receive preventative care
- work with older people is considered occupationally unattractive
- doctors and other health care professionals may feel uncomfortable with conditions they cannot cure, and may focus on acute rather than chronic conditions.

Finally, in relation to institutional practices and policies that may discriminate against older people, the observation made by the Working Group on Elder Abuse (WGEA) in relation to elder abuse can equally be applied to the construct of ageism. Ageism is 'something that happens culturally and corporately as well as on an individual basis ... and a lot of the [ageism] that goes on is purely unintentional ageism that is institutionalised'.

7.2 Rooting Out Ageism in the Health and Social Services Sector

There are four key areas in which measures are required in order to address direct and indirect ageist discrimination in the health and social services sector. They are:

- policies and practices
- systems and structures
- resources and staffing
- health promotion and age awareness.

7.2.1 Policies and Practices

7.2.1.1 Strategic Planning and Leadership

The majority of staff believed that, due to inadequacies in the national implementation of policy for older people, 'money goes into crisis management' without proper planning. Resourcing older people's services in a planned and permanent manner was viewed by those consulted as much more appropriate than 'short-term measures for long-term problems'.

The broad aim of health and social service provision for older people in Ireland is to maintain older people in dignity and independence in their own homes for as long as is possible or practicable (DoH, 1988). In order to maintain older people in their own homes in comfort, security and independence, a continuum of care is needed. This should involve appropriate services, which are easily accessible and timely. However, as these findings have shown, access to services can be uneven and barriers have been identified which have a significant impact on the quality of life of older people.

7.2.1.2 Equitable Access

This study has identified issues relating to policies and practices within health board areas and the institutions of the health service as a whole. A possible lack of strategic direction at national level is perceived as resulting in *ad hoc* approaches to policy development at local level, with many different approaches identified throughout the country.

This particularly relates to eligibility criteria for services and service availability. Staff in various health board areas outlined different unwritten policies and practices for referral and eligibility to services and cut-off ages for certain services. This results in confusion for both staff and older people, and creates inequity in access to services and service provision.

Where policies have been devised at local level, e.g. discharge plans, staff reported that there are often insufficient community resources, systems and structures to implement these policies.

7.2.1.3 Independent Living

Staff highlighted the fact that only limited resources are invested in assisting older people to live independently at home. The fear was also expressed that we are creating 'dependency on nursing homes' through the provision of subventions; concerns were also expressed about the financial viability of these schemes over the longer term. While many of those consulted were of the opinion that there should be a greater element of choice for older people in terms of where and how they live, many older people and staff felt that accommodation choices are limited. Suggested options included increased home support and supported living accommodation.

Transport was also identified as a major problem, as many of the older people consulted reported missing out-patient appointments because of lack of transport. Other issues highlighted included the withdrawal of ambulance services to out-patient clinics, the unsuitability and unavailability of public transport, and the prohibitive cost of taxi fares.

7.2.1.4 Protection of Vulnerable Adults

Elder abuse was identified as an area that requires legislation, with examples of unchallenged psychological and financial abuse of vulnerable older people being provided by the staff interviewed. While the WGEA and the NCAOP have made recommendations designed to provide a basis for an effective response to elder abuse,

there was no evidence from this study that these recommendations have been incorporated into board policies.¹⁵

7.2.3 Systems and Structures

7.2.3.1 Fragmentation of Services

Concern was expressed about the fragmentation of service delivery and its adverse effect on the delivery of services to older people, whose needs often cross many specialties. Systems and structures are required to ensure that older people receive service equity, access and quality irrespective of where they live.

7.2.3.2 Accessibility

Confusion surrounding eligibility criteria, means-testing and assessment creates barriers and inequities for older people attempting to access services. Systems and structures should be designed in such a way that they are easily understood and facilitate access to services.

7.2.4 Resources and Staffing

7.2.4.1 Resource Allocation

A major theme highlighted in the study is the lack of resources allocated to implementing *The Years Ahead: A Policy for the Elderly* (DoH, 1988). The majority of staff consulted believed that 'money goes into crisis management', rather than resourcing the implementation of the strategy.

Staff consulted felt that if older people are to be maintained in the community, there is a need for multi-disciplinary teams that are adequately resourced together with community supports, in order to reduce hospital admissions, effect shorter stays in hospital, ensure effective discharge planning and reduce dependency on institutional care. The shortage of key professionals such as Occupational Therapists, Speech and Language Therapists, Chiropodists and Physiotherapists, as well as Home Helps and Care Assistants, was also highlighted.

15. In its report, the WGEA made a range of recommendations under several headings: policy; staff structure; legislation; carers; awareness; education and training; financial abuse; advocacy; implementation; research; and education and reporting. The report recommended that elder abuse be placed in the wider context of health and social care services for older people through the implementation of a framework for service provision for older people. It further recommended that a clear policy on elder abuse be formulated and implemented at all levels of governance within the health, social and protection services in Ireland.

In addition, a lack of sufficiently resourced mental health services for older people was of concern to those consulted throughout the country. Staff reported that older people with mental health problems or experiencing confusion are being inadequately assessed in the acute setting. Some also complained that it is difficult to get mental health assessments for older people and it would appear that there is a perception that there are few psychological services available to older people.

7.2.4.2 Staffing

Staff recruitment and retention was perceived to be an area that required action at national level. Particular difficulties were reported in recruiting for community-based posts such as Chiropractors, Social Workers, Physiotherapists, Occupational Therapists, Psychologists and Speech Therapists. Home Helps, who many regarded as the main support workers in care in the community, are also proving to be extremely difficult to recruit.

It was also felt by many nursing staff that there is a need for mentorship and practical support for newly-trained nursing staff. This is currently impossible due to other demands on experienced nurses' time and inadequate staffing levels generally. Many staff working in the field of care delivery for older people also felt that there is a need to clarify the health and social care needs of this client group within traditional training.

In addition, many staff thought that there is a need to emphasise personal interaction with patients, particularly in the acute setting. It was proposed that this should be adopted as a productivity focus or Quality Customer Service (QCS) measure.

7.2.5 Health Promotion and Age Awareness

7.2.5.1 Health Promotion

Lack of preventative work with older people was highlighted as a deficit in current care provision. It was reported that health and lifestyle advice is not always offered to older people, although many older people are unaware that their lifestyles are unhealthy. There appears to be an *ad hoc* approach to health promotion throughout the country, with some health board areas having a Health Promotion Officer for Older People and others not.

The need to promote retirement planning was identified by many participants in the study. This is particularly relevant to the impact of ageing on the next generation of older people and their health status in terms of dealing with negative attitudes towards ageing and promoting both physical and mental health and well-being.

7.2.5.2 Age Awareness

Some of the older people interviewed firmly believed that it was best just to accept what happens and get on with things. Although they may encounter and recognise stereotyping of older people and witness or experience instances of discrimination, it appeared that they accept these with resignation and a sense of powerlessness to act or to prevent such situations from occurring.

This research also noted that older people are reluctant to complain even when they feel that the care they receive is of poor quality. This would appear to be in response to a perception held by many older people that they are dependent and rely on staff to take care of them, and thus will not complain.

7.3 Initiatives and Models of Best Practice

7.3.1 Policy and Practice

7.3.1.1 Policies and Standards

There is a wealth of information available in relation to good practice in the development of policies and standards that address age discrimination within health and social services, including recommendations developed by the Equality Authority (2002), the UK NSF, Help Age International and the Council of Europe. Areas of commonality in good practice include:

- consultation with older people in policy development
- recognition of the diversity of older people and their range of needs when allocating resources
- 'age proofing' existing policies to root out discrimination on the basis of age
- establishment of standards and regulatory mechanisms.

7.3.1.2 Independent Living

To challenge ageist stereotypes and respond to older people's preferences to remain in their own homes, ways in which older people can be supported to remain in their homes and communities must be identified and implemented. Examples of best practice in this regard include:

- care and case management – a method of providing health and social care services through collaborative assessment of the needs of the older person and their family, when appropriate, and the arrangement, coordination, monitoring and review of a package of multi-disciplinary services to meet complex needs. It targets older people who are at high risk of hospital or residential care admission or who are already making heavy use of services, to enable them to remain at home
- intermediate care scheme – an initiative which supports older patients on discharge from hospital through intensive rehabilitation input after illnesses such as stroke, chest infections or orthopaedic surgery. It stands mid-way between full in-patient hospital care and care in the patient's own home
- subsidised good neighbour scheme – an initiative aimed at reducing social isolation and loneliness experienced by older people. The role of the 'good neighbour' can be varied. It could involve escorting a housebound person to out-patient appointments or social functions, or providing some support in activities of daily living
- homeshare – an English initiative which links the housing needs of young key workers for affordable accommodation with the needs of older people for companionship and support, e.g. through the provision of financial support for older owner occupiers to divide their houses into flats
- liveable communities – a multi-agency approach in which health and social care needs are addressed with other issues such as accommodation adaptations, transport, security, and recreational, cultural and leisure facilities. The underlying principle of a 'liveable community' is that if a community is developed to meet the needs of older people, it will benefit the community as a whole.

7.3.2 Systems and Structures

7.3.2.1 Fragmentation of Services

On the basis of discussion with service providers, it is concluded that a care and case management approach, as outlined in Section 7.3.1.2, which includes multi-disciplinary teams, is the best model to prevent fragmentation of service delivery.

7.3.2.2 Accessibility

The disability model of best practice for accessing services could be used as a model for older people's services. This model is based on the principles of readily available, clear and concise information that is easily accessible for a variety of audiences (www.nda.ie).

7.3.3 Resources and Staffing

7.3.3.1 Resourcing Older People's Mental Health Needs

In Ireland, the Mental Health Commission, established under the Mental Health Act 2001 is charged with promoting and fostering high standards of care and best practice in the delivery of mental health services. It is also responsible for the development of guidelines, protocols and standard documentation in relation to treatment, patient information, etc., and codes of practice for those working in the mental health services.

The UK Department of Health has identified a number of models of best practice in delivery of mental health services for older people. These include:

- the South Manchester Memory Clinic – provides a comprehensive assessment service, which includes an initial visit at home by a member of nursing staff, a detailed neuropsychological assessment, a diagnostic interview with the patient and their family, and a follow-up review
- Age Concern Oxfordshire Flexible Carers Service – a service in which trained care staff provide home-based, individual support to older people with significant mental health needs and assist in rehabilitation to improve levels of functioning, prevent further deterioration, enhance quality of life and enable the individual to remain in his/her own home.

7.3.3.2 Staffing

In order to compete with other areas of employment both within and external to the health service, the following areas have been identified in the literature:

- developing accredited training for unqualified staff linked to pay scale and career development¹⁶
- making hourly rates of pay equivalent to similar areas of work
- attracting professional staff that have left employment to return
- developing professional return to employment courses
- developing of career pathways, i.e. recognised promotion for staff to remain at the bedside.

7.3.4 Health Promotion and Age Awareness

7.3.4.1 Promoting Healthy and Positive Ageing

Arguments for promoting healthy and positive ageing are widely accepted, however to date the implementation of *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998) has been *ad hoc*. There is a need for health promotion agencies, service providers and voluntary organisations to identify and build on initiatives that promote the health, well-being and independence of older people in a variety of circumstances and settings.

Many initiatives exist in Ireland that could be expanded and developed in any strategic approach to combat ageism including:

- Bealtaine – a month-long festival organised by Age and Opportunity, which celebrates creativity in older age
- Forum 55+ – a new initiative by Age and Opportunity that seeks to inform, stimulate and empower older people by bringing people together in an information exchange
- Go for Life – a campaign organised by the Irish Sports Council and Age and Opportunity, which aims to encourage older people to be more active and challenges the stereotype that physical activity is only of benefit to younger people.

16. The researchers were made aware of such initiatives in the NWHB and NEHB areas.

Other programmes identified through the research include:

- Rotherham Active in Later Life project – which provides health promotion activities for older people in local leisure centres at six locations. It is managed by Age Concern and includes keep-fit sessions and line dancing, and health promotion presentations
- Moving More Often – a national UK training programme established by the British Heart Foundation in 2003 for health and care workers and volunteers who work with frail older people. The programme develops appropriate resources and opportunities for use with older people in a range of settings such as day centres, sheltered and other supported living accommodation and residential and nursing settings.

7.4 Conclusion

Through its consultative process with older people and service providers, this exploratory study has found evidence of ageism in health and social services in Ireland. Age discrimination erodes the values we espouse for our society, as well as for our health and social services. It devalues and excludes people; it refuses to see people as individuals; it rejects difference and diversity; it fails to treat people with dignity and respect; it denies people choices; and it strips people of the power to be independent, active participants in life.



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Appendices

Appendix 1: Staff Invitation to Discussion Group

187 Killyclogher Rd
Omagh
Co Tyrone BT79 7PN
Tel: (028) 8077 1212
Fax: (028) 8077 1692
Email: info@qe5.co.uk

[Date]
[Name]
[Position]
[Workplace Address]

Dear [Name],

QE5 Ltd has been commissioned by the National Council on Ageing and Older People to undertake a national study on Perceptions of Ageing in the Health and Social Services Sector. We have already been in contact with all health board CEOs across the country, who have sanctioned this research to be undertaken in their respective areas. The purpose of the study is to examine perceptions and thoughts in relation to ageing and older people throughout Ireland, and we plan to enhance this part of the Study with focus group discussions in each Board area in the coming months.

You have been selected at random from a list of professional staff forwarded to us from your Board's personnel records. Please be assured that, in the interests of protecting confidentiality, we do not hold any information other than your name, place of work, and position.

We are holding an open discussion in the [Venue], on [Date] from [Start/End Times] and would be very grateful if you could come along. Tea and coffee will be there as you arrive.

Can you please contact me by calling 048 8224 6224, or e-mail qe5@qe5.co.uk as soon as possible to let me know if you will be able to come along, or if you have any questions.

Yours sincerely,

Eileen McGlone
Managing Director
QE5 Ltd

Appendix 2: Older People Letter of Explanation and Questionnaire

187 Killyclogher Rd, Omagh
Co Tyrone
BT79 7PN
Tel: (048) 80771212
Fax: (048) 80771692

[Date]

Dear Client,

QE5 Consultancy has been commissioned by the National Council on Ageing and Older People to undertake a National Research Study on Perceptions of Ageing and Older People and Experiences of Ageism in the Health and Social Services Sector. The process will involve postal questionnaires and round-table discussions with professional staff, and discussion groups and face-to-face interviews with older people, in each board area.

In order to meet with older people who have been in contact with the health service in the past six months, we have asked the health boards to supply the name and contact details of approximately 200 older people in each Board who would voluntarily consent to partake in the study. We will then randomly select 50 people in each board (25 in each locality), to attend a half-day focus group. We will also randomly select 25 people (12/13 in each locality) for face-to-face interviews with our staff, which will last approximately 30 minutes.

If you are agreeable to be included in the study then will you kindly sign the consent form for your name and contact details to be forwarded to us. If your name is one of those that is picked out in the random selection, we will then contact you directly to invite you to either attend the focus group in your area or to arrange for us to meet with you for interview.

Your assistance and co-operation is much appreciated and we look forward to meeting older people and to hear of their own personal experiences when in receipt of care/treatment from health and social services personnel.

Thank you.

Yours faithfully,
Eileen Mc Glone
Managing Director
QE5 Ltd

Ref	
HB Area	

D1. Gender	
1 Male	
2 Female	

D2. Marital status	
1 Single	
2 Married/Living with Partner	
3 Separated/Divorced	
4 Widowed	

D3. Age			
1 Under 50		6 71 to 75	
2 51 to 55		7 76 to 80	
3 56 to 60		8 81 to 85	
4 61 to 65		9 86 to 90	
5 66 to 70		10 91 and over	

D4. Do you live...	
1 Alone	
2 With Spouse	
3 With Children	
4 With Siblings	
5 In Residential Care	
6 In Sheltered Accommodation	
Other (please tell us about this)	

D5. What education have you?	
1 Primary	
2 Secondary	
3 Trade	
4 University	
Other (please tell us about this)	

H1. General health	
1 Very Good	
2 Good	
3 Fair	
4 Poor	
5 Very Poor	

H2. Which of these have you attended in the last year?	
1 A&E	
2 Community Hospital	
3 Day Centre	
4 Day Hospital	
5 General Hospital	
6 GP Surgery	
7 Nursing Home	
8 Out-patients	
9 Psychiatric Hospital	

H3. Which of the following apply to you?	I suffer with	I'm being treated for
1 Arthritis		
2 Asthma/Breathlessness		
3 Blood Pressure		
4 Confusion/Memory Problems		
5 Continence (Waterworks!)		
6 Depression		
7 Heart Attack/Angina		
8 Kidney Problems		
9 Liver Problems		
10 Mobility Problems		
11 Poor Vision		
12 Stroke		
13 Ulcers		
14 Other (please tell us about this)		

H4. Which of the following do you receive at home?	
Chiropody	
Community Psychiatry	
GP visits	
Hairdressing/Barbering	
Home Help	
Occupational Therapy	
Physiotherapy	
Public Health Nurse visits	
Social Worker visits	
Other (please tell us about this)	

Q1. Have you had any difficulties in accessing services from the Health Board?

Q2. Have you had any difficulties with the quality of care received?

Q3. Do you find as a result of getting older you are treated differently? How?

Appendix 3: Older People Consent Form

187 Killyclogher Rd,
Omagh
Co Tyrone
BT79 7PN
Tel: (048) 80771212
Fax: (048) 80771692

Consent Form:

National Research Study on Perceptions of Ageing and Older People and Experiences of Ageism in the Health and Social Services Sector

I have today received the letter explaining what the above study entails and what is required of me from my participation in the study. I fully understand that my name and contact details will be passed to the researches at QE5 Consultancy who may contact me to attend a focus group or to be interviewed in person by the researchers.

I fully consent to attend the *Focus group/Interviews* (Delete as appropriate) and I am happy for my details to be given to QE5 Consultancy.

Signed:

Date:

Health and Social Services Staff

A total of 150 professional staff employed within the health and social services in Ireland participated in discussion groups across the country.

There was a general lack of medical staff involvement at individual health board level (i.e. consultant and registrar grades) due to unavailability of invited personnel or clinical obligations.

For this reason, discussions groups originally planned for the ERHA area were foregone in favour of holding a bespoke workshop with medical students, house officers and registrars in Beaumont Hospital in Dublin.

Professional Discipline

Staff involved represented all fields and disciplines of health service delivery to older people. The nursing category represented the highest number of participants, with two in five in this field. However, participants were from a wide range of grades and expertise, including Staff Nurses, Nursing Sisters, Diabetic and Respiratory Nurse Specialists, Stroke Liaison Nurses, Clinical Nurse Managers and Directors.

Table A1: Distribution of staff by professional discipline

Profession/Grade	Number	Percentage	2002 DoHC Personnel Census
General support services	4	2.7%	14.3%
Health and social care professionals	24	16.0%	13.1%
Management/admin	19	12.7%	16.4%
Medical/dental	18	12.0%	7.1%
Nursing	61	40.7%	34.9%
Other patient services	24	16.0%	14.2%
	150	100%	100%

Age, Gender and Marital Status

The majority of those participating in the discussion groups were female, with just under half employed in the nursing category (46 per cent of all females). Over half of the men who participated were employed in the medical/dental category (32 per cent of all males), and the health and social care professionals category (23 per cent).

A broad range of ages was represented, as detailed in Table A2. There was a high representation of staff aged 21-25 years and 51-55 years, with a comparatively low representation at the youngest and oldest ends of the age spectrum (under 20 years and over 61 years).¹⁷

Table A2: Distribution of staff by age group

	Number	Percentage
Under 20 years	5	3.3%
21-25 years	26	17.3%
26-30 years	16	10.7%
31-35 years	18	12.0%
36-40 years	16	10.7%
41-45 years	12	8.0%
46-50 years	15	10.0%
51-55 years	25	16.7%
56-60 years	14	9.3%
61+ years	3	2.0%
	150	100.0%

Over three quarters of staff participating are married or living with a partner (77 per cent) with a further one in six single (17 per cent). The proportion of single male participants was much higher than single females (36 per cent of men; 14 per cent of women). Five of those staff participating are widowed, all of whom are aged in their fifties.

17. Mean 34.7; Std Dev 10.27

Professional Environment and Background

Over two thirds of staff participating in the discussion groups are based in urban surroundings, with a further one in six (16 per cent) working across both urban and rural areas. Over two thirds of those participating are based in a hospital or residential setting (including community hospital, acute hospital), with approximately one in eight (12 per cent) based in a centre (including health centres, day centres and community outreach facilities).

Only two of those staff participating worked across the community and acute settings (Table A3).

Table A3: Distribution of staff

Locality	Number	Percentage	Location	Number	Percentage
Urban	104	69.3%	Centre	18	12.0%
Rural	19	12.7%	Hospital/residential	101	67.3%
Both	24	16.0%	Community outreach	25	16.7%
	147	98.0%	Hospital and community	2	1.3%
Missing responses: 3 (2.0%)				146	97.3%
			Missing responses: 4 (2.7%)		

67 per cent of the staff consulted spend more than half their average week working with people over 65 years, with 41 per cent reporting that over three quarters of their time is spent with older people.

Given the high proportion of staff consulted working within hospital and residential settings, this suggests a high uptake of in-patient services among older people. Those spending the highest level of time working with older people were aged less than 40 years; 75 per cent of this age group spent half or more of their working week with older people. Those aged 61 years and over spent the least amount of time working with older people (33 per cent of staff in this category spending half or more of their working week with older people).

Those who spend the greatest amount of time working with older people were found to be those employed in the other patient care (including Care Attendants, Home Helps, Community Welfare Officers), nursing and medical/dental categories. Fewer than two in three of those employed in the health and social care professionals category (63 per cent) spend more than half their working week with older people.

Almost half of those participating (46 per cent) have been working in their chosen profession for more than 20 years, with only 16.7 per cent having less than five years' experience.

Table A4: Distribution of staff by years in profession

	Number	Percentage
Less than 5 years	25	16.7%
6-10 years	17	11.3%
11-15 years	19	12.7%
16-20 years	19	12.7%
21-25 years	24	16.0%
26-30 years	16	10.7%
31-35 years	16	10.7%
36+ years	13	8.7%
	149	99.3%
*Missing responses: 1 (0.7%)		

Those in the nursing category had the most significant level of experience in relation to longevity, with 60 per cent having more than 20 years' experience.

Older People

A total of 456 older people were consulted across the ten health board areas, with 69 per cent (313) of these through one-to-one interviews and 31 per cent (143) through discussion groups. All of the older people participating in the study were asked to provide demographic information around their age, gender, marital and accommodation status, health status and uptake/receipt of health and social services (Appendix Two).

Age, Gender and Marital Status

The majority of the older people consulted were female, with 284 women (62 per cent) and 172 men (38 per cent).

Census 2002 notes a gender ratio for those aged 65 years and over of 57 per cent females to 43 per cent males. Whilst the number of older people consulted broadly reflects this, it is nonetheless inclined towards a higher level of older female participation. This is most likely attributable to the majority of interviews taking place in a day care setting.

Whilst the researchers worked within the criteria for admittance to services for older persons within health boards (65 years and over) ten of the older people consulted (2 per cent) were below this age. Their views were included in the study as they are currently accessing services for older people in their respective health board areas.

Half of all older people consulted were aged 76-85 years (229), with 32 per cent (144) aged 75 years and under.

Table A5: Distribution of older people by age group

	Number	Percentage
56-60 years	4	0.9%
61-65 years	6	1.3%
66-70 years	68	14.9%
71-75 years	66	14.5%
76-80 years	118	25.9%
81-85 years	111	24.3%
86- 90 years	57	12.5%
90+ years	26	5.7%
	456	100.0%

Over half of all the older people consulted are widowed (53 per cent). Based on those people consulted, women were more than two and a half times more likely to be widowed than men (70 per cent of all women; 27 per cent of men), with a much higher ratio of single males to females (39 per cent of single men against 14 per cent of single women).

There were comparatively almost twice as many married men as women (27 per cent of men; 14 per cent of women). The majority of those separated or divorced were aged under 70 years of age (59 per cent), with 93 per cent of those who were widowed aged over 70 years.

Residential Status

49 per cent of the older people consulted live alone (Table A6), while 24 per cent live with their child/children (24 per cent) and 4 per cent live with another family relative. The proportion of older people consulted living in supported accommodation was very low (1 per cent).

Table A6: Living arrangements

	Number	Percentage
Living alone	223	48.9%
Living with children	104	22.8%
Living with spouse	65	14.3%
Living in residential care	34	7.5%
Living with siblings	15	3.3%
Living with spouse and children	6	1.3%
Living in supported accommodation	5	1.1%
Living with other relatives	3	0.7%
	455	99.8%
Missing responses: 1 (0.2%)		

Of those married older people who were consulted, 17 per cent are not living with their spouse due to their husband/wife being in long-term residential care. A slightly higher ratio of women consulted live alone in comparison to men (52 per cent of women; 44 per cent of men), however more than twice the level of men were in residential care compared to women (11 per cent of men; 5 per cent of women). Women consulted were also three times more likely to live with their child/children proportionate to men (48 per cent to 16 per cent).

There was no noticeable differential regarding residential status in relation to age, however one in five people (20 per cent) consulted who were single lived in residential care, and over one in three widowed (36 per cent) live with their child/children.

Educational Status

The level of educational attainment of the older people interviewed is representative of the older population as a whole.

Table A7: Educational status

	Number	Percentage
Primary school	266	58.3%
Post-primary school	84	18.4%
University	23	5.0%
Trade/vocation	17	3.7%
	390	85.5%
Missing responses: 66 (14.5%)		

Only one in twenty overall (5 per cent) progressed to college or university, with older men consulted almost four times more likely to study at college or university than women (11 per cent of men; 3 per cent of women).

A significant number of older people (13 per cent) consulted made known that they were not able to read or write, and found this a great source of embarrassment and difficulty.

Health Status

Many of the older people consulted felt their health to be relatively good: less than one in five (19 per cent) felt that their health was poor or very poor.

There was no difference in perception of health status between older men and women interviewed, however those aged 66-75 years generally reported a much poorer standard of health overall.

Those living with children reported their health as relatively good, while the few living in supported accommodation felt their health to be poor.

All of the older people interviewed suffer with and/or are being treated for a health problem. Arthritis, blood pressure and mobility problems were the most frequently noted conditions affecting older people (Table A8).

Table A8: Health problems and conditions

	Number	Percentage
Arthritis	258	56.6%
Blood pressure	224	49.1%
Mobility problems	172	37.7%
Heart attack/angina	116	25.4%
Poor vision	85	18.6%
Asthma/breathlessness	68	14.9%
Depression	61	13.4%
Stroke	61	13.4%
Continence problems	46	10.1%
Diabetes	44	9.6%
Ulcers	41	9.0%
Hip/knee problems	36	7.9%
Kidney problems	35	7.7%
Hearing problems	29	6.4%
Confusion/memory problems	22	4.8%

Of concern is the fact that over one in ten (11 per cent) stated they were on tablets, but had no idea or knowledge as to what these tablets were, or the specific condition for which they were prescribed. A considerable number of older people talked of taking in excess of five different tablets on a daily basis (some as many as nineteen), often taking tablets to negate side effects from other tablets.

More than one in three older people who reported suffering from depression are not receiving any treatment or support for this (34 per cent), while a quarter of the older people interviewed reported suffering untreated arthritis and mobility problems.

Older people consulted suffered with anything from 1 to 13 different health problems or conditions, with an overall average of 3.5 conditions.¹⁸

There is a relationship between age and total number of health problems/conditions amongst those older people consulted, with increasing numbers of conditions occurring with increasing age. 34 per cent of older people aged 70 and under had four or more health problems, as opposed to 46 per cent of those aged 71-80 years and 51 per cent of those aged 81 years and over.

Health and Social Services Usage

The GP is the most common source of health assistance for older people, with over three quarters (78 per cent) visiting their GP in the preceding year. A high number of older people attend day centres, however this is more a reflection of the methodology employed in the study than an accurate reflection of the older population as a whole.

Four in five of the older people consulted had stayed in either a hospital or nursing home during the preceding year (81 per cent), with over half being admitted to a general hospital. Just under a quarter had visited an A&E department (23 per cent) (Table A9).

18. Mean 3.5; Std Dev 1.6

Table A9: Services accessed in preceding year

	Number	Percentage
GP surgery	356	78%
Day centre	323	71%
General hospital	247	54%
Out-patient clinic	159	35%
A&E department	105	23%
Community hospital	67	15%
Day hospital	64	14%
Nursing home	36	8%
Psychiatric hospital	21	5%

Over three quarters of older people living alone (78 per cent) were admitted to a hospital or nursing home during the preceding year, with 75 per cent of people who live alone attending day centres.

The average number of services accessed was three, with almost one in three (31 per cent) older people accessing four and more providers.¹⁹

Only two in three of the older people consulted receive any health and/or social services from their health boards at home (67 per cent), with PHNs and Home Helps being the most commonly noted (although both were evidenced in only one third of cases). A further 9 per cent of older people interviewed stated they received 'occasional' visits from their PHN. More than one in five stated their GP came to their home to visit them (22 per cent) (Table A10).

19. Mean 2.96; Std Dev 1.40

Table A10: Home visits/services received

	Frequency	Percentage
PHN	148	32%
Home Help	145	32%
GP	99	22%
Chiropody	35	8%
Physiotherapy	22	5%
Occupational therapy	17	4%
Community psychiatry	10	2%
Social worker	9	2%



Terms of Reference

Terms of Reference

The National Council on Ageing and Older People was established on 19th March 1997 in succession to the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990).

The functions of the Council are as follows:

1. To advise the Minister for Health on all aspects of ageing and the welfare of older people, either at its own initiative or at the request of the Minister and in particular on:
 - a) measures to promote the health of older people;
 - b) measures to promote the social inclusion of older people;
 - c) the implementation of the recommendations contained in policy reports commissioned by the Minister for Health;
 - d) methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for older people;
 - e) methods of encouraging greater partnership between statutory and voluntary bodies in providing services for older people;
 - f) meeting the needs of the most vulnerable older people;
 - g) means of encouraging positive attitudes to life after 65 years and the process of ageing;
 - h) means of encouraging greater participation by older people;
 - i) whatever action, based on research, is required to plan and develop services for older people.
2. To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:

- a) undertaking research on the lifestyle and the needs of older people in Ireland;
 - b) identifying and promoting models of good practice in the care of older people and service delivery to them;
 - c) providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health, well-being and autonomy of older people;
 - d) liaising with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for older people.
3. To promote the health, welfare and autonomy of older people.
 4. To promote a better understanding of ageing and older people in Ireland.
 5. To liaise with international bodies which have functions similar to the functions of the Council.

The Council may also advise other Ministers, at their request, on aspects of ageing and the welfare of older people which are within the functions of the Council.

Membership

Chairperson: Cllr Éibhlin Byrne

Mr Bernard Thompson	Ms Mary O'Neill
Mr Eddie Wade	Cllr Jim Cousins
Mr Michael Dineen	Dr Ciaran Donegan
Fr Peter Finnerty	Mr James Flanagan
Mr Eamon Kane	Dr Michael Loftus
Mr Michael Murphy	Ms Mary Nally
Mr Pat O'Toole	Ms Rosemary Smith
Ms Pauline Clancy-Seymour	Mr John Brady
Mr Noel Byrne	Ms Kit Carolan
Dr Davida de la Harpe	Mr John Grant
Dr Ruth Loane	Ms Sylvia Meehan
Mr Paddy O'Brien	Ms Martina Queally
Ms Bernard Thompson	Mr Oliver R Cleary
Ms Annette Kelly	Ms Eileen O'Dolan
Mr Paul O'Donoghue	Ms Elaine Saffe

Director: Bob Carroll