

TRINITY COLLEGE
UNIVERSITY OF DUBLIN

A PERSON-CENTRED APPROACH TO CARE OF OLDER PEOPLE:
THE PERCEPTIONS OF OLDER PEOPLE IN THE
NORTH WEXFORD AREA

BY

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A DISSERTATION SUBMITTED TO THE FACULTY OF HEALTH SCIENCES
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE
AWARD OF THE DEGREE OF MASTER OF SCIENCE IN
HEALTH SERVICES MANAGEMENT

DUBLIN
SEPTEMBER 2004

**A Person-Centred Approach to Care of Older People:
The Perceptions of Older People in the North Wexford Area**
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ABSTRACT

The need for a more efficient co-ordination of care and service provision for older people is a constant theme in the reports and recommendations, both by government and voluntary agencies. This represents a crucial challenge to the development of appropriate health and social care planning for the growing numbers of older people, as a proportion of the population. Given the finite financial resources available, this population must be enabled to share in the responsibilities for priority setting of services and decision-making, leading to more efficient utilisation of resources.

The North Wexford Area was selected for this study, which includes the town of Gorey and its environs, as the number of individuals, aged 65 years or over, in this selected area increased by 18% between 1996 and 2002. This study explores the perceptions of people 70 years or over regarding their knowledge of and individual requirements of the service both now and in the future. It also sought to establish if the services provided by the health sector are people centred to meet the needs of older people. A qualitative research approach was adopted for this study, as it focuses on the individual's perspective of living the experience. It explores what people are doing and feeling, which could not be achieved through a quantitative research approach. A non-probability convenience sample was chosen comprised of 12 participants from the local retirement groups in the area. Data was obtained through semi-structured interviews.

The themes that emerged from the data analysis were then grouped into four significant categories, namely:

- Access to health and social services.
- Unmet needs of the services.
- The importance of being active and independent.
- Attitudes and how person centred the service is.

These are discussed under the following:

- Older peoples knowledge of what health and social services are available to them.
- Perceived service requirements with increasing age.
- Preferences of older people regarding care.

The findings of the study suggest that:

- The needs of older people, as articulated by the informants, are not specific to the health services alone, but incorporate social services and the environment in which they live.
- Older people are not generally aware of the services available to them.

- The participants in this study have varied lifestyles, which highlight the fact that it is important not to stereotype all older people.
- The needs identified by participants were not all adequately met.
- Older people are generally active and want to remain so, for as long as possible.
- Helping them to achieve this involves listening to their viewpoints about what affects their health, the social supports they require for physical and psychological well-being, and the creation of support structures as deemed appropriate.
- The active retirement groups are a source untapped by the Health Service for information dissemination and health promoting initiatives, to enhance active ageing.

There is a need for the SEHB to plan services to meet the needs of its ageing population in the area under study. This could be done by listening to their views and adequately assessing their needs, in order to maintain them in active retirement in their own homes, if they so desire.

DECLARATION

This thesis has been submitted in partial fulfillment of the M.Sc. in Health Services Management at Trinity College, University of Dublin. This piece of work has not been submitted as an exercise for a degree at this or any other University and is entirely the candidate's own work.

As a candidate, I agree that the University Library may lend or copy this thesis upon request.

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SUMMARY

The number of older people, as a proportion of the population, is growing and this represents a crucial challenge to the development of appropriate health and social care planning in this the 21st century. Demographic trends will impact on fiscal and healthcare policy formulation, given the finite financial resources available. Older people must be enabled to share in the responsibilities for priority setting of services and decision-making, leading to more efficient utilisation of resources.

The North Wexford Area was selected for the study, which includes the town of Gorey and its environs, as this area has had the largest percentage increase (34%) of people in Co. Wexford since the 1996 Census. The number of individuals aged 65 years or over in this selected area has increased by 18% between 1996 and 2002.

It was decided to carry out a study to establish if the services provided by the health service are person centered, to meet the needs of older people. This was achieved by exploring the perceptions of older people regarding their knowledge of and individual requirements of the services, both now and in the future.

A qualitative approach was adopted for the research study. The research was based in a specific area and as a result the findings are specific to a similar population. A non-probability convenience sample was chosen with participants from the local retirement groups in the town. All participants were aged 70 years or over, and all were residing in the community. Data was obtained through twelve semi-structured interviews, which were audio recorded. Content analysis was used to analyse the data. A full transcript of all interviews was prepared from which themes were extracted. The themes that emerged from the data at the analysis stage were then grouped into four significant categories namely: access to health and social services; unmet needs of the services; the importance of being active and independent; attitude - person centered. The themes are subsequently discussed under the following headings:

- Older peoples knowledge of what health and social services are available to them.
- Perceived service requirements with increasing age.
- Preferences of older people regarding care.

The findings of this study suggest, that while the health service endeavors through the health strategy “Quality and Fairness” to allow consumers to have their say, in reality this is not the case. The needs of older people, as articulated by the informants, are

not specific to the health services alone, but incorporate social services and the environment in which they live.

In conclusion, this qualitative study illustrates that older people are not aware of all the services that are available to them. The participants have varied lifestyles which highlights that it is important not to stereotype older people. Participants, who identified the need for services, found that their needs were not adequately met. Helping older people to stay healthy and increase their life expectancy, should involve listening to their viewpoints about what affects their health and what social supports they require for physical and psychological well-being, together with creating support structures as deemed appropriate. It emerged from the study, that older people are generally active and want to remain so, for as long as possible. The active retirement groups are an untapped source of information by the Health Service, for dissemination and health promoting initiatives, to enhance active ageing. The SEHB needs to plan services to meet the needs of its ageing population by listening to their views and adequately assessing their needs, in order to maintain them in active retirement in their own homes, if they so desire.

ACKNOWLEDGEMENTS

I would like to thank the South Eastern Health Board for funding me to undertake this course of study. I would also like to extend thanks to my supervisor, Sr. Marie de Montford Supple, for her time, support and guidance in preparing this thesis for submission and to the many people, known only to me, who in giving freely of their time, enabled and supported me in this undertaking. Lastly, I would like to thank my husband and family, without whose support and patience I would not have been able to complete the course.

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CHAPTER ONE

ORIGINS AND CONTEXT

1.1 Introduction

Since pre Christian times Irish civilization has a strong tradition of supportive care for older people, held in laws known as the Brehon Laws (Robins 1986). These laws fell into disuse with the colonization of Ireland by the Normans in the 12th century, and care of people was non-specific similar to that practiced in the rest of Europe. Little discrimination was apparent between the care of any group of people until the 19th century, when workhouses were built. These were the result of the great famine of the 1840s, and they later became the county homes. These houses later formed the basis for state funded institutionalised care of older people until the end of the 20th century.

Ireland is a relatively youthful country by European standards (Eurostat 1990). Of the population of Ireland, 11.13% are 65years or over (CSO 2002) compared to 15% in the rest of the European union. Fahey, (1995) predicts that this section of the Irish population will increase to 14% by 2011. Of the current population over 65 years nearly 22% are over 80 years and this is expected to increase to 25% by 2011. However life expectancy for Irish men and women is the lowest in the European Union (Prior to May 1st 2004). The 1999 census indicated that life expectancy for men over 65 years is a further 13.7 years and for women an additional 17.4 years (CSO 1999). This indicates that life expectancy for Irish men at age 65 has only improved by 1.8 years in the 40 years between 1952 and 1994 with Irish women

expecting to live an additional 4.1 years, in the same period. The increase of older people as a proportion of the population represents a crucial challenge for the development of health and social care for the future of this group in Ireland.

1.2 Scale of Demographics

Life expectancy in Ireland has increased consistently for both men and women since the first life table was completed in 1926 and this ageing of the population is a significant triumph of the 20th century. In 1926, males at birth had a life expectancy of 57.4 years while it was slightly higher for females at 57.9 years. The changes, which were a direct result of decreased mortality, particularly infant mortality, due to the improvements in economic and living conditions, with immunization and antibiotics adding to these improvements, occurred between 1946 and 1961. The gap in life expectancy between men and women has generally increased over the last 70 years, at all ages. Since 1926 life expectancy of male infants has increased by 16 years or 27% while for female infants the increase was 21 years or 36%. The increasing gap in life expectancy between the sexes is also true internationally. In 1960 the EU average gap between males and females was 5.5 years, while in 1996 it increased to 6.4 years, placing Ireland below the EU average (CSO 2001).

1.3 Demographics of the South Eastern Health Board (SEHB).

Looking specifically at the area under research, the SEHB population is currently the highest it has been in the past 100 years. (This upward population trend is present from Census 1961 onwards). This increased population size is illustrated in Figure 1.1 below.

Trend Graph of Population Change in the SEHB 1901-2002

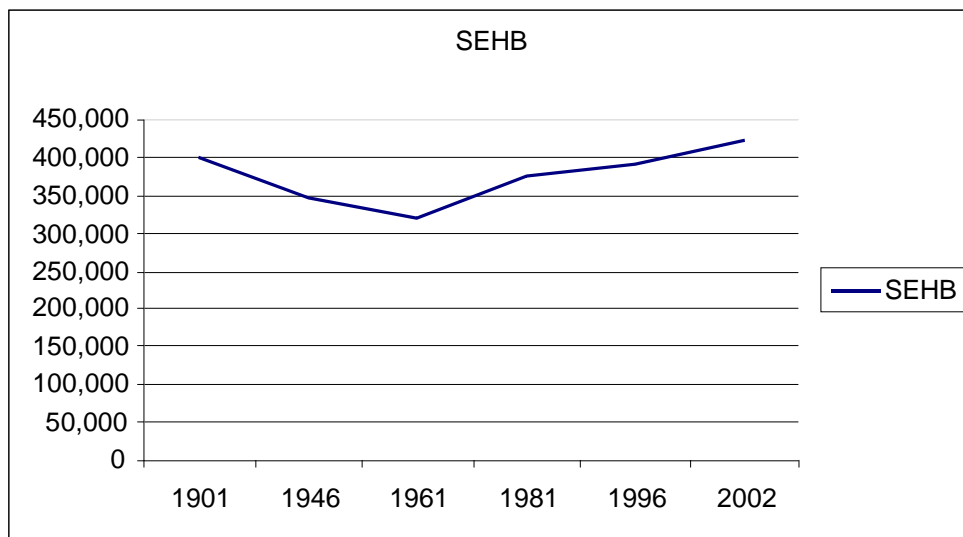


Figure 1.1. Population Change in the South Eastern Health Board 1901-2002

It is interesting to look at the trend in population change over the last 100 years. The SEHB population fell from 398,661 in 1901 to 319,883 in 1961. However, in the intervening years between 1961 and 1981 the population of the SEHB began to rise sharply and has continued to do so.

The overall population increase in this geographical area of 8% is the same as that of the National population increase (8%) since 1996. This is much larger than that projected by the CSO in 1996 of a 2.1% increase for 2003 (CSO 1996).

There have been two notable trends in the distribution of ages in the SEHB in the last twenty years (1981-2002):

- the number of individuals at the younger stage of life (0-7 years) has decreased (-4%),
- whilst those at the older stage of life (over 65) have increased (+12%) since the previous census (1996) (Public Health Department SEHB 2003).

More significantly, Co. Wexford has experienced the largest population increase in the SEHB with 12,225 more individuals in the Wexford community care area than in 1996 representing a 12.7% increase (CSO 2002). At present 11.7% of the population of Co. Wexford are aged over 65 years representing a 13% increase since 1996 with an increase of 22.3% in the over 70s population since 1981. The graph on the following page indicates the increase in the number of individuals aged 70 years and over.

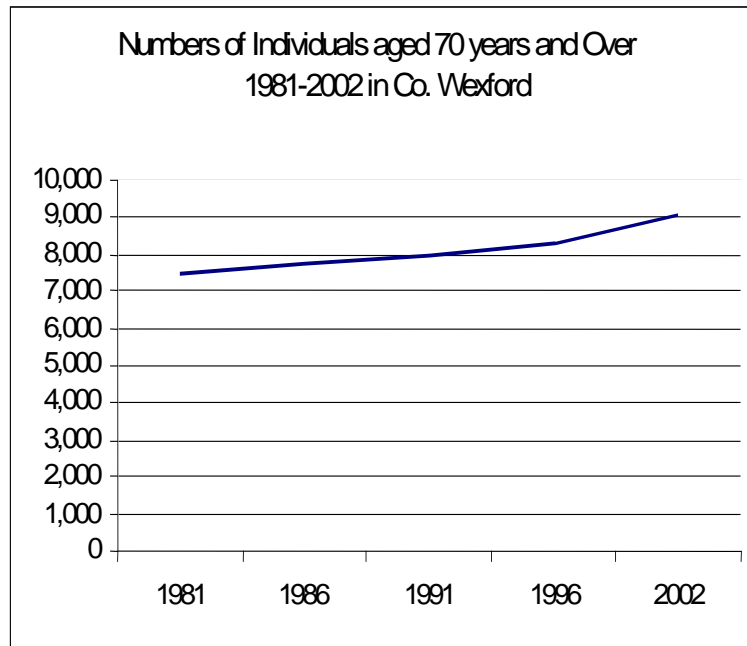
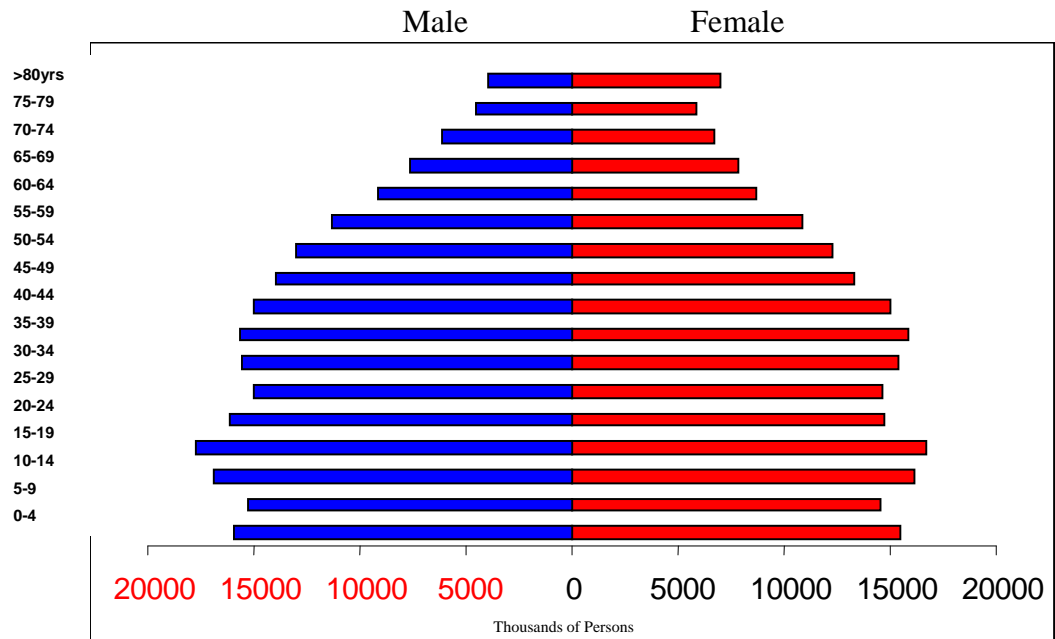


Figure 1.2 Graph Illustrating the Increase in Numbers of Individuals Aged 70 Years and Over in Co. Wexford, 1981-2002.

The area selected for research is the town of Gorey and its environs, Gorey town having the largest population increase (34%) in Co. Wexford since Census 1996. More significantly, the number of people aged 65 years or over increased by 18% between 1996 and 2002.

The ratio of males to females in the SEHB is almost 50:50. up to approximately age 65. Overall, males account for 49.77% of the population and females 50.23%. However, at age 70 years and over, females in the SEHB are living longer than males, similar to the national population.

The age and gender profile of the SEHB population as per April 2002 is illustrated in Figure 1.3



Source: CSO, 2002

Figure 1.3 Population Pyramid for South Eastern Health Board Region 2002

1.4 Population Change for Older Population (65+) in the SEHB 1981-2002

SEHB Services for the older population are aimed at those aged 65 years and over. The 2002 Census recorded 28,455 aged 65-74 and 21,320 individuals aged over 74 years. The figures for both older age groups have never been as high in the SEHB. In line with the national figures, both sections of the older population group in the SEHB have been increasing steadily over the past 21 years.

Table 1.4 Population Figures

South Eastern Health Board – Population Figures Over 65 years 1996/2002

Total Over 65 1996	Total Over 65 2002	Actual Change	% Change
46,590	49,775	3185	6.8

In the years 1981-2002 the numbers in the age group over 74 years have increased by 6,494. This represents a population increase of 44% in the SEHB for the age group over 74 years since 1981.

It is widely accepted that the population of Ireland and indeed of Europe is ageing. There is a greater proportion in the older age bracket and it is necessary to the future Health Service provision in the SEHB to take account of this fact. Therefore, it is important to have current and reliable population information when developing new services and policies. This has clear implications for both health and social care provisions given the finite resources and gross domestic product allocation, in respect of health care funding, demographic trends will impact on fiscal and health care policy formulation.

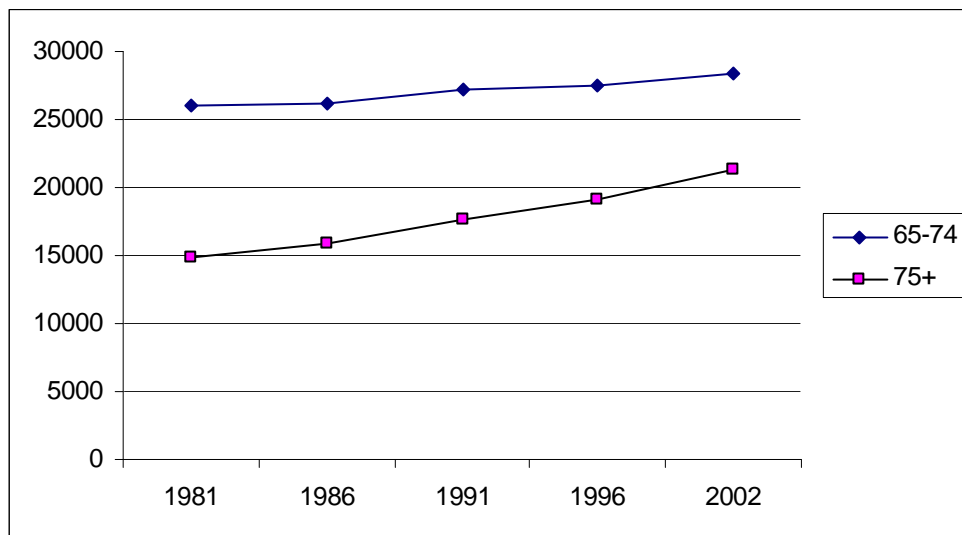


Figure 1.4 Trend Graph of Individuals Aged 65+ and 75+, 1981-2002

1.5 Significance of the Study

The term “older people” covers a vast range of individuals; each shaped by a unique life experience with needs and aspirations just like other members of society. The growing numbers of older people, as a proportion of the population, represents a crucial challenge to the development of appropriate health and social care planning in this new century. The projected population nationally of people over sixty-five years in 2031 is approximately 850,000 compared to 413,882 in 1996 (CSO 1999).

It is also expected that a high proportion of this increase will occur in pockets of the population nationally, which will result in high levels of need for health and social care, while the overall State population is expected to remain stable. These demographic trends will impact on fiscal and healthcare policy formulation given the finite financial resources available. This is compounded by the historically low level of funding, as found by Deloitte and Touche (DOHC 2001:256), that has characterised the provision of services to the elderly during the 1980s and 1990s. They state that the Department of Health is starting from a “relatively low investment base to ensure the adequate provision of services and the achievement of key policy aims”.

As people reach old age, they are entitled to expect the necessary support to live with dignity and independence. Older people must be enabled to participate to the greatest extent possible in decisions that affect them and in all facets of life that contribute to well being, as advocated by the organisation Age and Opportunity, whether they are living independently or in a care setting. The importance of finding the correct mix of

policy priorities is pertinent to the development of the 1999 U.N. theme, of a society for all ages. *Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990's* (DOH 1994), acknowledged the need to involve people in taking responsibility for their own health and securing the environmental support necessary to achieve health and social gain. However, evidence by Ruddle, O'Donoghue and Mulvihill (1997) suggested that achievements have fallen short of aspirations. While fundamental changes in the structures and processes of healthcare systems are occurring, a major effect of the change has been the paradigm shift from a provider to a consumer orientation.

In Britain the national service framework (NSF) for older people, on which care services will be based for the next 10years (DOH 2001), stresses a positive attitude towards older people. This policy was the result of extensive involvement with older people, however Bentley (2003) argues it is not clear how representation was achieved. While economic changes have empowered some older people in consumer society, Bentley (2003) highlights the groups of people over 65years who, 'through lack of knowledge about the process, perceptions of consumer status, or through incapacity or being house bound' may be excluded from such involvement. (Bentley 2003:37). The Irish health strategy, *Quality and Fairness - A Health System for You*, proposed the adoption of the principle, *people centredness*, which will result in: "a health system that will encourage you to have your say, listen to you, and ensures that your views are taken into account", (DOHC 2001: 80). A person-centred health system requires that consumers have access to high quality information on health and social services that will enable them to participate in decisions relating to their own health.

Therefore, the implications of an ageing population for both living and working conditions require consultation with the service users in the planning, monitoring and evaluation of services for the promotion of informed and realistic choices.

1.6 Healthcare for Older People in Ireland

In Ireland the vast majority, 91% of people 65 years and over live in the community in private households, while 5% of this population is resident in long term care institutions with the remaining 4% living in rented accommodation, (Layte, Fahey and Whelan 1999). According to Layte et al (1999) nearly 30% of people over 75 years live alone, therefore the implications for health and social care are quite profound.

Services for the elderly in Ireland are dominated by two major reports:

The Care of the Elderly report (1968)

The Years Ahead Report - A policy for the Elderly. (1988)

The Care of the Aged report (1968) was the first report to look specifically at services for the elderly. It was compiled by an interdepartmental committee, which considered that it was better to help elderly people live in the community, rather than in residential or hospital care, this was radical for its time. The official thinking, by policy makers, on elderly care up until 1968, was dominated by institutional solutions to the “problem” of dependent elderly people. *The Care of the Aged report* dominated Irish thinking regarding services for the elderly from 1968 onwards, with policy development being concerned with the implementations of its recommendations.

The Years Ahead - A policy for the Elderly (DOH 1988), provided a framework for the reorientation of resource allocation towards care in the community rather than care in long term institutions. The goal was to maintain older people at home with the optimal level of health and independence and, for those who could not live alone, to receive care and treatment as close to where they lived as possible. The report made extensive recommendations regarding health and social care needs of older people, including income, housing and comprehensive coordinated services for the elderly. However O'Shea (2002) found that the opposite happened, as a result of the Nursing Home Act (DOHC 1990), the nursing home sector grew and absorbed a major share of the increased funding. While some community initiatives were funded, the scale of funding could not deliver on the promises contained in the *Years Ahead*. This supports Ruddle, Donoghue and Mulvihill's (1997) review of the *Years Ahead*, they found that many recommendations were unfulfilled, with no extra funding directed to older people.

Shaping a Healthier future: A Strategy for Effective Healthcare in the 1990's (DOH 1994), prescribed significant reforms in health and social care in the community, and highlighted the importance of targeting services at those with the greatest need. They included the provision for the needs of carers and interprofessional collaboration and co-operation. As a result the Irish government stated, in its *Adding Years to Life and Life to Years* health promotion strategy that: '*The development and importance of services for the elderly is a Government priority*' (DOHC 1998: 28).

However, *Implementing Equity for Older People*, (2003:51) raises concerns that the Government's intended reforms of the operation of the Nursing Home Subvention

Scheme, and the Carers Allowance, will result in a “trade off” between funding for community care and residential care on a “win lose” basis, while acknowledging both are needed and both require funding.

Shaping a Healthier future: A Strategy for Effective Healthcare in the 1990's (DOH 1994), in its targets acknowledges the need to involve people in taking responsibility for their own health, and the environmental support necessary to achieve health and social gain. However evidence by Ruddle et al (1997) suggests achievements have fallen short of aspirations. The new strategy, *Quality and Fairness A Health System for You*, (DOHC 2001, Action 26: 70), has emphasized the need for the development of appropriate levels of services for the elderly, however the introduction of initiatives for the elderly are subject to the “prevailing budgetary situation”. In the opinion of O'Neill and O'Keeffe (2003), specific legislation is required in Ireland for the development of appropriate levels of services for older people, as was the case in the development of child care services after specific child care legislation was introduced in 1991. The importance of finding the correct mix of policy priorities is pertinent to the 1999 United Nations theme of a “society for all ages”.

Existing European Union policy, *Towards a Europe of All Ages*, (EU 1999) is dedicated to maintaining social inclusion of older people. In order to fulfil the three themes emphasised in the policy; prevention, equity of access and an adequate supply of quality care for older people, O'Neill, Hastie and Williams (2003) state “access to a community of knowledge” is required. They contend that the opportunities and challenges of later life must be recognised, incorporating gerontological knowledge into a systematic approach, which recognises the complexities of disease presentation

and management. Therefore, the successful implementation of community care initiatives remains an integral objective, for health and social care agencies, as well as for policy makers.

1.7 Summary

In this chapter the demographic changes were considered and the need for designated services for people 65 years and over. Government policies have been explored which recognise the need to develop community services for older people to meet their needs.

In Chapter 2, 3, and 4 the literature will be reviewed in order to establish what is meant by person centred, ageism and concepts of health and illness. This review will endeavour to explore the current practices and trends in the area of services for older people, and how older people view themselves in relation to their health and the services they use or may require.

CHAPTER TWO

LITERATURE REVIEW: PERSON CENTRED

A systematic comprehensive review of relevant literature in the subject area, older people and people centred services, was derived from manual and electronic data bases as well as consultation with national and local experts in the field.

2.1 Introduction

The need for a more efficient co-ordination of care and service provision for older people, becomes a constant theme, in the reports and recommendations both of government and voluntary agencies. Just as the *Care of the Aged* dominated Irish thinking about services for the elderly from 1968 onward, *The Years Ahead* (1988) reviewed the role of health and welfare services and the degree to which they met service objectives in caring for the elderly. *The Health Strategy, Shaping a Healthier Future* (DOH 1994), placed the onus on health providers to monitor, evaluate and re-orientate if necessary, services for people to ensure that the optimum services are provided for those who might require them. However, two major interlinked factors, contributing to the increased realisation of the importance of evaluation, have been the growing voice of the consumer and the demand for quality community services.

In considering the situation of older people in Ireland today, it is necessary to question attitudes and perceptions of ageing and how social, economic and educational institutions shape them. It is necessary to develop an attitude in society where people are not seen as old first and people second but rather as people who happen to be old.

As Comfort (1977:13) suggests “No pill or regimen known or likely, could transform the later years of life as fully as could a change in our vision of age and the militancy in attaining that change”.

The meaning of old will now be explored and the question of what person centred means will now be examined.

2.2 Definition of Old

The term “older people” covers a vast range of individuals, each shaped by a unique life experience with needs and aspirations just like other members of society. The New Oxford Dictionary (1998: 32) defines age as a “naturally distinct period or stage of life: especially “old age”. Normal ageing is characterised “by progressive and irreversible changes in structure and function with time” Redfern and Ross (1999:4). These are visible, but as Miller (1991) found, societies define roles and expected behaviour for older people. He gives the example of age stratification, a social construct that determines retirement age and the classification of health statistics. The age of sixty-five has long been used to define the beginning of “old age” to the extent that the age of retirement or eligibility for pension entitlements reflects society’s view of the beginning of old age. Yet according to Hockey and James (1993) it is clear the definition is arbitrary, as is the distinction between ‘young old’ and ‘old old’ and with continuing reductions in morbidity and mortality rates, will become increasingly inappropriate as time passes.

Neugarten (1975:7) was the first to draw the distinction between the “young old” and the “old old” associating the former with ages 55-75 and the latter with ages 75 and over, although she emphasised that it was “lifestyles rather than chronological age that concerns us”.

Given the diversity of the population in relation to race, class and gender, biological ageing will vary between groups and the identical age will not have the same link with the biological processes for different types of people. Hence the ages used to define old age are rarely biologically or physiologically based, but one used as a social gatekeeper and regulator across the life course. It is evident that ageing is not fixed or a consequence of chronological age. It is a multifaceted experience resulting from the inter-relationship between biological and psychosocial variables. While acknowledging the diversity of human ageing, health care professionals and planners need to recognise the person who is old, in providing and developing services to meet their needs.

2.3 What is Person Centred?

Person centred approach to practice represents a stage in the development of healthcare services at which the needs of the individual are held central rather than the views of professionals or organisations, who meet these needs. Delivering appropriate care to people at their point of need is amongst the most complex of human endeavours and defeats the “rational – comprehensive” model of public policy. The strategy employed to deal with this situation, O’Ferrall (2001) contends, is that

the health service continues to try to “muddle through” taking very public “hits” along the way.

Person centred care has become a central concept in healthcare as a response to increasing attention to consumer needs, with health care costs rapidly increasing there is a shift in focus to the improvement of process and outcome of care, (Al Assaf 1993). Person centred care may be seen as relating to the reorganisation of health care delivery and recognising individual needs. Moreover, participation in healthcare is underpinned by participation in health. Fundamental changes are occurring in Ireland in the structure and process of healthcare systems. A major effect has been the paradigm shift from a “provider” to a “consumer” orientation. People centeredness emerged from the wide consultation process involved in drawing up the health strategy *Quality and Fairness* (DOHC 2001). It contains the basis of “thinking differently”, with its “whole system” approach and enshrines person centred care as a distinct objective approach in healthcare policy, planning and delivery. The Health Boards executive, in response to Action 52 of *Quality and Fairness*, published *Community Participation Guidelines* in 2002 to provide for community participation in decisions regarding the delivery of health and social services. In the same year The Office of Health Management (OHM) published *Public and Private Participation in Healthcare A Discussion Paper for the Irish Health Services* which focuses on shared decision making, community participation and participation in policy making. (OHM 2002).

2.4 Definition of Person

The word “person” aims to capture those attributes that represent the humanness of people and the factors regarded as most important and challenging in life. This can be achieved, Netwood and Breden (1992) suggest, if practitioners understand users/persons needs and engage in positive work with the person. The concept of freedom is an important aspect of personhood, which Frankfurt (1989), as cited in Ford and McCormack (2000:41), describes as being free to do something and to take responsibility for choices made. Central to all decisions and actions is the desire to maintain and improve well being.

A people centred approach to care, Winefield, Murrell, Clifford and Farmer (1996) regard as the optimum way of delivering health care, and is defined as valuing people as individuals. McCormack (2001) concurs with this view as the emphasis on person centred practices in services for older people has created a culture of practice that values the individuality of the older person and their biography. The importance of tailoring health and social care services to individual needs and preferences is becoming increasingly recognised (Lutz and Bowes 2000). However, in the organisation and delivery of services, the healthcare system and healthcare providers assume to understand patient/client needs. As a consequence, discussion centres on service organisation and outcome. This results in many health service managers relying on patient satisfaction surveys as the only means of evaluating delivery of service. This is limited, as Fitzpatrick and Hopkins (1993) found, as patients were reluctant to criticise their healthcare, as they did not want to appear ungrateful or unappreciative. More recently Bauld, Chesterman and Judge’s (2000) found that older

people are less critical of services and service providers, and have lower expectations of what services can provide. Haslett (2003) also found that older people tended not to give negative feedback. Therefore these types of patient satisfaction surveys acknowledge a person's view on the process and outcome of care but say little on their role in the decision-making and proactive involvement.

The National Council on Ageing and Older People (NCAOP 2002) believe that service objectives, developed in isolation from a user perspective, will not facilitate a person centred approach to care delivery. This could be achieved through Health Needs Assessment, which is a term used to describe the development and refinement of well-established approaches to understanding the needs of a local population. It is an objective and valued method of tailoring with evidence-based approach to commissioning and planning health services. The Health and Social Services for Older People (HeSSOP) study, (Garavan, Winder and McGee 2001) recommended a framework for the multidisciplinary assessment of older people to be developed nationally to ensure fair access to services based on clear and universal guidelines of eligibility. O'Shea (2002) contends that a broad-based assessment of the older persons needs, incorporating the range of social and economic factors that impact on his/her capacity to continue living in the community, is required. A distinction needs to be drawn between the dependency of an older person, and their situation of dependency, as a consequence of social and economic factors. The report, Care and Case Management (NCAOP 2001), highlights the unease among health and social care providers, both with the multiplicity of assessment tools for older people and the manner in which assessments are being carried out separately across disciplines.

2.5 Consumer Views

Efforts to improve health care will be wasted unless they reflect what consumers want from the service. Distinguishing between individual needs of the community in the planning and provision of local health services is important according to Wright, Williams and Wilkinson (1998). If these needs are ignored, then there is a danger of a top-down approach to providing health care services, which rely too heavily on what a few people perceive to be the needs of the population rather than what they actually are. Increased participation of patients and the public is desirable according to Wensing and Elwyn (2003). They found that by considering patients' views, processes and outcomes could be improved together with client satisfaction. Little, Everitt, Williamson, Warner, Moore, Gould, Ferrier and Payne's (2001) observational study of 865 patients, 18% of whom were over 65 years of age, attending general practitioner practices in the south of England, found that patient centeredness was a marker of the quality of care. They concluded that if doctors do not provide a positive centred approach, patients would be less satisfied, less enabled and may use more health service resources.

Corrig & Cook (1999) found that *person centred approach* to care has been adopted by many health care professionals. They see the omission of the client perspective as puzzling, as professional and client involvement in decision-making and client empowerment are thought to be fundamental elements of this approach to practice.

Beresford and Croft (1993) distinguished between consumer and democratic approaches to citizen involvement. They argue that the democratic approach is based

on empowerment, with citizens actively involved in the policy making process. This approach also raises people's social and political consciousness and incites them to collective action. This is also considered to be a feature of "good quality" health promotion which focuses on enabling and facilitating people to identify their own interests and needs, as well as choices and solutions (Ewles and Simnett 1999). In Ireland the results of the HeSSOP Survey, (Garavan, et al 2001: 273) found that, 'efforts at consulting with consumers in health and social systems have been limited and can be viewed as primarily consumerist in orientation'. Consumers have been encouraged to give their views but have no 'real' power to initiate change. The findings of this survey found that the method preferred in Ireland is the consumerist model. However arising from this, Garavan et al (2001) are of the opinion that the democratic model of consultation is the model Ireland needs to move towards, where consumers are directly involved in decision making and planning.

2.6 Consulting with Users of Health Services

Donovan and Coast, (1996) found that through consulting with users of health services, support for decisions, that would otherwise be unpopular could be obtained. This involvement of patients, according to Barnes (1999) has been viewed by many as a democratic and ethical requirement, because as patients pay for services through taxation (direct and indirect) they have a right to influence how they are managed. In Britain, since the government's white paper 'Local Voice', it has been official policy that the views of the public should play a greater role in setting healthcare priorities. Similarly in Ireland, the new principle of "people centeredness", included in the Health Strategy, Quality and Fairness (DOHC 2001), contains the basis of a new way

of thinking about health. However according to O’Ferrall (2003:266) “it has not engaged the public or the health system to any significant degree”.

Little et al’s, (2001) study, from a person centred approach to consultation, found that, the best way of measuring person centredness was from the assessment made by the person themselves, their reason for attending for care, their concerns and the need for information. However, Coyle’s (1999) qualitative research study, which explored problems experienced by people with their healthcare, found that patient identity was threatened by experiences perceived as dehumanising, objectifying, disempowering and devaluing: thus showing the extent to which people felt valued or not. Similarly, Coyle and William’s (2001) cross sectional survey in the United Kingdom (UK), with one third of participants over 65 years of age, found that while many patients were positive about their care, problems were highlighted around involvement in care and the approachability and availability of staff. They also found that women were more at risk to a “threat to identity” than were men in the healthcare settings. They recommended the need for improvement by health professionals in their understanding of the impact of illness on everyday life, also in their listening and enquiring skills to promote a service that truly values individuals.

Relationships between professionals and older people, Kivnick and Murray (1997) suggest, should be based on ‘interpersonal mutuality’. Similarly, Williams and Grant (1998) believe that person centred care requires knowledge of people as individuals in order to understand their ideas, beliefs and knowledge. Moreover, Carey (2000) maintains that empowerment has always been and should remain a tool for radical social change. On the same topic, Dolan, Cookson and Ferguson’s (1999) qualitative

study, in England, using focus group interviews, found that the public's views about priority setting in healthcare are systematically different when they are given an opportunity to discuss the issues. They contend that surveys that do not allow respondents time or opportunity for reflection may be of doubtful research value.

2.7 Summary

User involvement in health care is a priority with the Department of Health and Children, arising from the Health Strategy "Quality and Fairness" (DOHC 2001). While it is acknowledged that fundamental changes are occurring in healthcare systems, with the emergence of a people centred focus, it is still not evident how much the elderly are ready or willing to engage in health or policy formulation to any significant degree. Questioning people about their perceptions of need is intended to create an understanding of their experiences of health and illness that are surrounded by cultural values and expectations of health behaviour according to Ong (1991). Older people, for whom health care expenditure is highest, may be excluded from active participation through illness, being housebound or through lack of consumerist ethos. Health professionals who work with older people may not find time to explore the beliefs and practices of older people, which may result in decisions that do not embrace the older persons viewpoint.

CHAPTER THREE

LITERATURE REVIEW: AGEISM

3.1 Introduction

There is a profound transformation in the experience and meaning of old age by people as we enter the 21st century. Retirement is no longer the straightforward entry point to old age that it once was and therefore, it is increasingly anachronistic as a definition of older people.

Stereotyping or over generalisations about the elderly by society involves ‘lumping together’ this group as if they all possess the same characteristics. Aronson (1988) describes stereotyping as abusive, as it robs people of their right to be treated as individuals. While older people are more likely to experience illness and disability than younger people, the assumption that old age *per se* brings illness, and that all old people are ill and immobile, is what is damaging about the stereotyping process. The growth of a formal welfare and support system in recent decades has resulted in a loss of status for people in their later years.

Townsend (1981) argues that society establishes a framework of institutions and rules, which actually create dependency in old age. In America, Baltes and Carstensen (1996:400) have similar views, and they find it ironic, that by focusing on the problems of ageing – isolation, dependence, role loss and illness, ‘researchers have reinforced a negative portrayal of ageing’. They also find that the implementation of the Older American Act (OAC) and similar US policies to gain support for the infirm

elderly, has acted as a 'double edged sword' portraying the elderly as sick and needy. This has the effect of preventing older people from taking an active part in society, undermining their integrity and autonomy.

3.2 Definition of Ageism

It was Butler (1969) who coined the term ageism, which he described as

“the subjective experience implied in the popular notions of the generation gap ... a deep seated uneasiness on the part of the young and middle-ages – a personal revulsion to and distaste for growing old, disease, disability and fear of powerlessness, “uselessness” and death”.
(1969: 243).

Similarly, ageism can be defined as “any attitude, action or institutional structure, which subordinates a person or group because of age or any assignment of roles in society purely on the basis of age”. (Traxlet 1980:4). While Stones and Stones (1998) refer to ageism as a “quiet epidemic” that contributes to benign neglect or indifference towards older people as a social category rather than active antagonism.

Life at any time can be rewarding, yet most people resist the thought of growing older. Although ageing is not always pleasant, it is a natural process everyone will experience, the concept of which is well known to everyone but is hard to define. Gough and Darzine (1999) explore definitions of ageing in the “global” sense, “normal” ageing and “ideal” ageing. Ageing can be considered as equivalent to “development” embracing embryogenesis, maturation, and a period of adult vigour and senescence.

‘Ageing is a time of dependent process which is progressive, universal within a species, and intrinsic (i.e. not as a result of disease or environmental influences).’ Senescence is that part of the ageing process which is associated with an increasing probability of dying as a function of time, (Gough and Darzins 1999). Many fail to realise the fact, that illness in old age is mainly due to disease rather than being part of normal ageing.

The adverse effects of social policies on older people often result in the dominant values towards them remaining age discriminatory or ageist. The Carnegie Inquiry, conducted in Britain, identified this as a common theme (Carnegie Institute 1993). This undertone of ageism often condones the perception of older people as a homogeneous entity. The increase in numbers of older people is often seen as a *problem*, particularly in the case of welfare provision where older people are viewed as making excessive demands on the available resources. What is apparent from studies conducted during 1993 by the European Observatory on Ageing and Older People, is that older people should *not* be considered as a homogeneous group. Distinguishable differentiation exists among older people as a result of a combination of socio-economic factors, gender, financial situations and increasing age.

3.3 Society’s Attitude to Older People

There are many myths about ageing in Ireland, one of the most pervasive being that older people are a homogenous group ignoring the 1993 European study findings. Although the prevalence of disability increases with age, these increases are mostly confined to the less severe end of the disability spectrum. In Ireland, the majority of

older people are generally fit and healthy, dispelling the myth that old people are frail. Only 5% require long term institutional care, 87% are in care for less than one year and 77% less than three months. (Long stay care statistics DOH 1996). Fries (1990), finds that in Western societies, the reduction in infant mortality and the compression of morbidity allows the majority of people to live out their lives in relative good physical health. It is also evident from studies in Australia by Gough and Darzins (1999), that people are not only living longer, but have relatively good health, and enjoy considerable independence, especially until the eight and ninth decades of life.

The process of growing older has changed radically in Ireland in the last fifty years, according to Edmondson (1997). “Ageing is not a potentially pathological state which strikes at 65 but develops differently with different effects throughout the life course” (Cleary and Tracey 1997: 157). Therefore, growing old takes different forms, for individuals and social groups, according to the setting in which they find themselves. The nature of growing older is often influenced by the way in which societies, and subcultures within societies, regard ageing. This is highlighted every week in the newspapers with captions like “Ageism and Prejudice” driving the old off the roads (Irish Independent April 19th 2004). All drivers over 70 years of age must get a medical certificate to renew their licence, but O’Neill (2004) speaking at the Irish Medical Organisation Conference in Killarney, Co.Kerry, stated that “this is a misguided measure that feeds ageism and prejudice. Older people are the safest group of drivers on the road. They have the lowest per capita crash rates.” He urged doctors at the conference “to support scrapping the test”. He warned that, “by driving older people off the road they end up with more depression and more need.” He referred to an OECD report on ageing and transport, that said, “the type of mandatory

aged based testing, targeting older drivers, to be ineffective, and it would be better to zone in those older drivers who are considered at high risk. The report pointed to a wide set of measures that could be undertaken, including media campaigns to counter misconceptions that create a distorted image of old road users.”

The health service, through its strategy *Quality and Fairness*, endeavours like Age and Opportunity, (see section 1.5) to create a society where people are seen, not as old first, but as people first, who happen to be old. This presents a considerable challenge in a society that is still unaware of its own ageist attitude. “Ageism has been shown to begin as early as eight years of age, derived from attitudes of adults both within and outside the family” (National Council on Ageing and Older People 1998: 40).

Commonly held ideas “restrict the social role of older people, structure their expectations of themselves, prevent them achieving their potential and deny them equal opportunities”. (Scrutton 1990:13). Never has there been an era more conscious of chronological age than the present one, with people going to extraordinary lengths to maintain a youthful appearance. Therefore Bytheway (2001) suggests that the study of age is critical to the study of ageism. The use of chronological age is a modern development. Retirement is often seen as a withdrawal from usefulness and active participation in communities, according to Marshall (1990:41) and one of the fundamental ways of changing attitudes is through information. Often negative attitudes are based on misinformation. Baltes and Carstensen (1996) find that with the advent of industrial capitalism, human values were equated with productivity and retirement institutionalised as a symbol of non-productivity.

The prevailing attitudes to ageing and ageism are poorly documented in literature in Ireland. Studies conducted in America by Crockett and Press (1981) discovered that negative attitudes far exceeded positive attitudes towards older adults. Similarly Nuessel (1982) observed a negative perception or stereotype of ageing or aged in areas such as language, media and humour. Hummerts (1994), as cited in Nelson (2002), in research with undergraduate students asked his subjects to sort photographs of elderly adults based on their perceived age of the individual. The study revealed young adults associate facial cues with stereotypes of older people. Common phrases such as “old fuddy duddy” or “over the hill” denote old age as a period of impotency and incompetence. Indeed negative personality traits can be found in some people of all ages, at all stages of life. It is often used as an excuse for not providing a service or for giving preferential treatment to younger people.

A small quantitative study conducted in Ireland by Power (1987) supports the above view. The study assessed the attitudes of young people between the ages of 15 and 19 years to older people. It showed that negative images of older adults prevailed in over 50% of those studied. Young people’s reluctance to age is based partly on common myths, or falsehoods about what older people are like, which Power’s study concluded to be the lack of contact with older people and lack of awareness about older people’s issues.

Power found the terms ‘cranky’ (51%) and difficult to please (48%) often selected to describe the elderly. The study also revealed that the 28% of respondents believed that there was an age at which value in the community ceased, with 7% believing it to be at age 60. This is described by O’Shea (1993:45) in how the rapid modernisation,

since the early 1960's, has reduced the economic and moral influence of older people with labels being used negatively to confer stigma or deviant status. A noted researcher in this area was Goffman (1961) who showed how the behaviour of former mental patients was always under scrutiny once they had been labelled "mental patient".

A large Eurobarometer (1993) survey of 12,800 people of all ages, with an additional 5,000 over 60 years, examined peoples attitudes regarding caring for older people. The survey revealed 90% of E.U. citizens supported the concept of community rather than residential care for those requiring personal care. However, when asked in this survey who should decide on services for older people only 22% of the general public of Ireland said the elderly should decide for themselves. This is referred to by Midwinter (1990) as post adulthood.

These studies highlight the ambivalent public attitude towards older adults, showing an awareness of ageism, yet a belief that those older adults were not the best people to decide on their own future.

3.4 Professionals' Attitude to Ageing

Older people report a common problem with health service professionals, which is one of patronising treatment or condescension. "Ageism among health professionals is not unknown, and their negative attitudes are quickly recognised by older people with whom they are in contact"(DOHC1998: 40) Similarly the Eurobarometer (1993) survey as previously referred to, into age and attitudes towards older people, found

health professionals harbour patronising and disempowering attitudes towards older people. Palmore (1990) contends that they hold the same ageist stereotypes of older people as the rest of society. Ageist attitudes and beliefs often cause older people to receive different treatment or to be excluded from opportunities. Health care professionals make assumptions about older people based on age rather than on functional ability, which interferes with the care received by this group.

The demographic changes that are occurring are often referred to in negative terms by policy makers and the media e.g. of the *increasing dependency ratio*, not just here but in the rest of Europe. According to Wagnild (2003) poor health is not an inevitable consequence of ageing, and many interventions exist, that could reduce much of the premature death, disability and illness of older people. Similarly Fahey 's (1995:57) study, into the health care implications of population ageing in Ireland, found “a puzzling absence of a relationship between population ageing and health expenditure”. The study referred to the other factors that have a more significant effect on health expenditure like, gross domestic expenditure and government controls on health spending.

Meyer, Bridges and Spilsbury (1999) in Britain, generated unique exploratory data through action research, which suggests that older patients arrive at hospital with low expectations of care, and appear to understand many of the constraints under which staff are working. The findings indicate that the wider care needs of older people may be low on the list of priorities of care, not only by individual practitioners, but also of the wider organisation. A number of *gaps* were identified between needs and care delivered, which depended on the motivation and skills of staff performing the tasks.

The findings of this study were similar to those of Brehens (1998) and Pursey and Luker (1995) in other health care settings.

The first report of the Irish National Cancer Registry (NCR), (2002) revealed that older people were less likely to receive treatment for cancer than those diagnosed at a younger age. It indicated, many patients were not receiving specific treatment for their condition, and there were regional variations in cancer treatment services. It revealed that:

- Younger people were twice as likely to receive treatment for melanoma as older people
- Two- thirds of those over 80 years received no specific treatment for bowel cancer.
- 57% of older people with leukaemia were not offered chemotherapy.

However, it must be acknowledged that these statistics do not reflect the ethical and moral implications in the provision of cancer treatment for older people, that is, peoples right to refuse treatment, which they feel may impact on their quality of life for their remaining years.

During the consultation process, in the preparation of the National Strategy (DOHC 2001), it was revealed that the highest percentage of negative experiences were reported with Accident and Emergency (83%), followed by services for older people (76%). Therefore, this suggests that health and social services in Ireland are deficient, in the way older people are being ‘cared for’ in terms of adequate and appropriate

services, and ‘cared about’ as a person with equal rights and valued as a human being.

3.5 Successful Ageing

Population ageing is one of humanity’s greatest triumphs. It is also one of its greatest challenges. Global ageing will put increased social and economic demands on all countries. (WHO 2002). However, a resource that is often ignored is that older people make an important contribution to the fabric of society. ‘Successful ageing’ can be defined as the enjoyment of health and vigour of the mind, body and spirit into middle age and beyond. For many, it is the freedom from impairment and the ability to live independently (Wagnild 2003). O’Shea (2003:27) defined healthy ageing “as a positive concept relating to personal development and the exercise of personal choice, and including activities that influence social and environmental change, which promote health, well-being and which prevent illness”.

Therefore, population ageing raises fundamental questions for policy makers, in how to help people remain independent and active as they age, and at the same time measures to help older people achieve this are a necessity not a luxury. The world Health Organisation has adopted the term ‘active ageing’ to express the process for achieving ageing as a positive experience. According to WHO (2002)

‘Active ageing is the process of optimising opportunities for health participation and security in order to enhance quality of life as people age. It applies to both individuals and groups, to allow people to realise their potential for, physical, social and mental well being throughout the life course, to participate in society according to their needs, desires and capacities, while providing them with adequate protection and security and care when they require assistance,’ (WHO 2002:12).

Resilience, according to Wagnild (2003:42) is, “a positive personality characteristic enhancing individual adaptation” and has been associated with successful ageing. She examined whether resilience scores, and relationships between resilience and health related variables, would be similar, or different, among older adults reporting either high or low incomes. She found resilience was associated with indicators of successful ageing, regardless of income.

According to WHO (2002), non-communicable diseases (NCDs) become the leading cause of morbidity in all regions of the world as individuals age, which are essentially diseases of later life. Failure to prevent and manage the growth of NCDs will result in human and social costs. This is reiterated in O’Shea’s (2003) recent study *Healthy Ageing in Ireland: Policy Practice and Evaluation*. The findings of this study indicate that gender plays an important role in defining older people’s preferences in availing of opportunities for healthy ageing. Older Irish women have a lower life expectancy and greater incidence of ill health and disability compared to older women in other EU states. Consequently the study recommends that older women be prioritised in policy and strategic planning by statutory and voluntary agencies working on the agenda of women’s health. Consultation with older men is also required to understand their preferences in terms of group or individual approaches to healthy ageing.

3.6 Exercise and Health Promotion

The national health promotion strategy for 2000-2005 aims to increase the proportion of elderly who enjoy an active, independent and healthy old age with the promotion of

health as a stated outcome (SEHB 2002). The implementation of programmes like ‘Go for Life’ by Age and Opportunity and the SEHB “Being Well” are used to promote physical activity among elderly people in the community. Included in the targeted action to enhance health and well being in Adding Life to Years (DOHC 1998) is the promotion of participation in Active Retirement Associations and similar organisations.

Although loss of function and the existence of disease are characteristic of old age much of the decline may be due to reduced physical activity and according to Morris (1994) exercise is a ‘best buy’ for public health. Exercise is a determining factor in the healthy ageing process, which includes feelings of well-being, control of stress and improvement of mood. (Arent, Landers and Etnier 2000).

In Ireland significant numbers of older people have difficulty in performing basic activities, as found by Fahey and Murphy’s (1994) large-scale study, of self-reported health of older people. They also found that physical decline, leading to poor physical health, was a predictor of poor morale. Similarly, the SLAN survey (DOHC 1999) found that, 30% of older people (over 55) reported taking no exercise in a typical week. This was slightly higher in Britain as found by the British Allied Dunbar Fitness Survey, where 40% of the over 50’s of both sexes were found to be sedentary (Skelton1999).

‘Old age is no defence against t’ai chi’ according to Thompson reporting in The Irish Times Health Supplement (Feb17th 2004). She states that “while walking, golf, swimming and yoga are all activities pursued by older people in this country, T’ai chi

is gaining popularity in active retirement groups and day centres in Dublin and Wicklow areas”. “We realised that falls and breaks to the wrist and hips were a massive problem for older people, and studies in Britain and the US found t'ai chi was good for preventing falls by improving balance and flexibility so we decided to do a pilot study” says Gorman (2004) who, together with Dias, oversaw the project in the East Coast Area Health Board last year. The study, which was conducted in the Centre for Sports Science and Health at Dublin City University “also found that the incidence of falls in the t'ai chi group decreased by almost 50% following the classes”.

A major benefit for the promotion of physical activity in older people is the prevention of falls. 52% of deaths among older female are falls related (Australian Injury Bulletin, 1994). Steinweig (1997), in the US, supports this in finding, that the incidence of falls in the over 65 aged group is 30%, and account for the majority (40%) of trauma injuries in old age and are a major contributor to death. In Ireland the Office of Health Gain reports that 8000 people, over 85years of age, mostly females, are admitted to hospital each year with falls and only 50% of these are alive a year later. (Office of Health Gain, 1997).

It is evident from Munro, Brazier, Davey and Nicholl's study (1997) that physical activity programmes are cost effective according to an estimate based on 10,000 exercise participants. This is also substantiated by the report from the European Commission on the effectiveness of health promotion physical activity programmes on the health of older people. (European Commission 2000).

3.7 Summary

The search for successful outcomes in old age, whether longevity or life satisfaction, will ultimately hold limited benefits. This is due to the heterogeneity inherent in human ageing, as ideals of what old age and older people should be like have been debated and challenged over the years. It is apparent that health policy is ageist in its strong emphasis on the biological ageing process. This in turn leads to exclusive focus in health policy on illness, disability and service provision. The developments of community care as a priority, is a necessary first step to promote healthy ageing (O'Shea, 2003). If policy changes are not effective, older people who want to work or contribute their skills on a voluntary basis are not enabled to do so, they will become dependent on society rather than contributors or participants in society. Older people are not a homogenous group as previously stated. While they share common concerns, policy makers do not adequately address their needs. Young people will be old one day, therefore irrespective of age; all generations should have a shared interest in seeking to ensure greater quality of life for older people, and to have their participation and contributions taken into account.

CHAPTER FOUR

LITERATURE REVIEW:

CONCEPTS OF HEALTH AND ILLNESS

4.1 Introduction

Since the 1960s exploring people's knowledge and attitudes towards health has taken a more prominent position in academic research in Ireland. McFarlane (2000) found that the relevance of understanding the concept of health and illness, held by older people was important to inform health promotion work.

This point has also been highlighted by World Health Organisation (WHO 1989) with reference to the task of delaying the onset of age related problems as well as maintaining functional abilities to improve the quality of life experienced by older people. The dominance of the biomedical model of health has represented a reductionist approach to health, characterised by a focus on illness rather than on health, such that health is defined as an absence of disease. This according to Sidell (1995) is "bleak" for older people in terms of the likely increase in illness and disability during old age.

4.2 Health Beliefs

Age and gender are important determinants of the health of individuals. It is acknowledged that as people age they are more likely to suffer ill health, with men more likely to die prematurely than women. However, women while living longer

than men, suffer more illnesses, according to Bolanda and Wilde (2001). Old age in itself is not an adequate explanation for ill health, as stated by Peto and Doll (1997) as not all old people have chronic conditions. Those who do experience ill health provide positive ratings of their health as highlighted in Blaxter and Peterson's (1982) Scottish study. In this study, health was viewed positively despite the medical records reflecting the contrary. This indicates that self reported health and quality of life assessments by older people, are not bound by the biomedical model.

Similarly, a study of health beliefs in France by Pierette (1993) was conducted in urban and rural settings, and showed health was perceived as a form of wealth that made everything possible, especially work. The reference to work for older people was defined by Blaxter and Peterson (1982) as work in the home or garden, not paid work. This ability to engage in daily tasks, as found by Williams, was perceived to be an effective means of preventing illness and generating health. Sidell (1995) found similar beliefs in her case study analysis of states of health among older people in Britain.

The above is also reaffirmed in Ireland by McFarlane's (1998) study of health related concepts of people over 65 years. She revealed that three quarters of the 51 people studied, defined health as a functional concept (performance orientation). Over half described it as the absence of illness (symptom free orientation) with one-quarter defining health as feelings of well being (feeling state orientation). More recently, the Hessop study (Garvan et al, 2001) revealed that 75% of the elderly reported being self sufficient in their abilities to perform tasks of daily living, 60% had no functional disability and 80% rated their quality of life good or very good. Whelan and Vaughan

(1982) and Layte et al (1999) found similar positive ratings of health in earlier studies. However, McCluskey (1989) found that people's ideas of health are likely to incorporate a number of dimensions at once, showing that lay definitions of health have many dimensions.

4.3 Older Peoples Health in Ireland

The first comprehensive piece of Irish research to examine older peoples health was conducted by Whelan and Vaughan (1982), this involved interviews with 2000 people over 65 years. Over 60% of those interviewed reported some long-term illness or disability and this rose to 67% in those over 80 years, while O'Connor, Smyth and Whelan (1988) found 19% were partially dependent on help and required care. More recently, Fahey and Murray's (1994) study of 909 subjects agreed with Victor's research in Britain, that 'consistently, those from the professional and managerial classes experience better health than their contemporaries from the manual occupational groups' (Victor 1991: 33). The principal feature of Fahey and Murray's (1994) survey was the multidimensional concept of 'health' among the elderly. The two main illnesses for both men and women, were problems with the circulatory system (35% of first mentions) followed by diseases of muscular skeletal system. (27%), and respiratory system (10%). Together these main categories of disease accounted for second or third major illness mentioned by a respondent. Similar problems associated with older people are reported by O'Neill and O'Keeffe (2003). A comprehensive overview in the health promotion practices of older people are provided by O'Shea (2003), who concludes that not enough is being done to improve the health and well-being of the older population. The health status of older people

has deteriorated in the last decade and remains at the bottom of the table in Europe according to O'Neill (2003).

4.4 Care in the Community

The decline in the average family size in Ireland, increased labour force participation among married women and increased urbanisation and geographic mobility, may have an impact on the willingness and abilities of families (particularly women) to engage in care. Blackwell et al (1992) reaffirm the major role played by carers in keeping people at home. "Care in the community has increasingly come to mean care by the community" as stated by Nolan and Grant (1992: 44). Also the increase of those living alone may have implications for the demand for institutional care (O'Shea et al 1991). Any reduction or withdrawal of family care for people of high dependency, according to O'Shea (2000), would mean a demand for additional public and private residential care to a maximum of 13,000 places in nursing homes and long stay hospitals.

This, O'Shea (2000) contends, is a "doomsday scenario" for government and private insurers alike, given the additional costs associated with formal care. On the positive side, there is no evidence according to O'Shea and Hughes (1994) that family care giving is declining or that families are becoming more selfish. More recently Layet et al (1999) have found 44% of people received informal care on a regular basis. However the main problem is the fact that families are being asked to do too much without adequate support from the statutory sector. International and European research findings indicate that, inadequate attention has been paid to the inclusion of

older people and their carers in decision-making processes (Nolan and Grant 1989, Ruddle et al 1997, Kellett and Mannion (1999)

The enormous psychological stress on families is a constant finding in the literature, (O'Connor et al, 1988 Blackwell et al 1992, Fahey and Murphy 1994, Lane 2000), and particularly as O'Shea (2002) found, for carers of people with dementia. It is confirmed from research in the UK by Parker (1990) and Joshi (1995) that rising women's increased participation in employment has not led to a reduction in informal care. As previously mentioned, the main thrust in public policy for older people, over the last 25 years in Ireland, has been to try to extend their independence and keep them in the community for as long as possible. However, for this to be a reality, more resources are needed to maintain community support for older people. O'Shea (2002) in his review of the Nursing Home Subvention Scheme, found that expenditure towards community based initiatives increased by 8% in the period from 1993-1996, while the nursing home subvention scheme increased by 422% in the same period.

4.5 Developments of Services in Community Care

Most European countries have increased numbers of elderly people due to demographic changes, many of whom are living in the community to a much later age than has previously been experienced. This is partly due to the fact people are living longer, but also, as a reaction to institutionalized care.

The trends towards a reduction in state provided long stay beds, and shorter length of stay in acute hospitals, has led to elderly people in the community with greater levels

of dependency than previously experienced. The number of older people has increased in Ireland in the last century, which is indicated in the recent 2002 census with 11.13% over 65 as referred to earlier.

In the HeSSOP study (Garvan et al 2001), the role of health and social services for older people were found to be underdeveloped, limited and fragmented. O'Neill and O'Keeffe (2003) concur with this, and contend that the corner stone of these services is the public health nursing services, the family doctor and home help services. Ruddle et al (1997) identified that approximately 18% of all older people received some form of formal care at home. While, the HeSSOP study confirm Ruddle et al's conclusions they found that only 15%, of older people, had been visited by a public health nurse, and only 5% from other home based services. Similarly O'Neill and O'Keeffe (2003:5) found that only a small number of older Irish people avail of home help. They state that "in 1993 only 3.5% of the Irish older population used this service, compared with 14% in Northern Ireland and 19% in Sweden". In terms of adequacy and access home help services have various models of organisation, which leads to frustration among caregivers.

Brown (1996) compares the community care delivery of care for older people with reference to the organisation and structure in Ireland, with that in England and Wales. She found that while both had different organisational structures for the provision of care and different financing services, they share a common concern about the provision of services for elderly people. With the increasing proportion of people over 65 years, the continuing ability to finance care as part of a welfare package, poses a major challenge. The changes, in the provision and type of services in both

countries, are placing increasing pressure on the independent and formal sectors. Brown (1996) found that in the UK, citing Watson's (1995) study, that increasing numbers of services are being classed as social rather than health care and therefore no longer free, placing the burden of payment on individuals or families. She states that "one of the strengths of the Irish system, which to some extent awards the problems of altered boundaries and cost shifting, is that the health and social care divide does not exist as such. It seems therefore, that in Ireland there is a greater likelihood of a *seamless service*" (Brown 1996: 84). In theory this may be true, while home help services in practice, are within the health board's remit, the shifting of resources from one programme to another still poses a problem, despite the shift from primary to secondary care. In conclusion, Browne (1996) finds that despite the financial and organisational difficulties, the Irish community care system works well, mainly due to the commitment of the people providing the service.

4.6 Care Management

Older people have by and large expressed a preference for care at home rather than in institutions as indicated in Ireland in the HeSSOP (2001) and Haslett (2003) surveys. In the UK, care management is an accepted feature of health and welfare care of older people. There the designated care manager's (social worker or nurse) job, is to assess the need and develop a package of services from a variety of sources (informal, voluntary, statutory and private), to meet assessed care needs of the elderly. Similarly in Norway, community nurses, working for the municipality, which is responsible for health and social services including housing, manage the care of individual older people. In Ireland this is still in the early stages of development. (See Section 2.4).

However, there is growing evidence from the National Conference (NCAOP, 2002) for the need to establish a standardised multi-disciplinary approach to conducting health and social care assessments for older people.

4.7 Summary

Growing old takes different forms, for individuals and for social groups, according to the setting in which they find themselves. There are groups of people moving through life in separate social, political and economic circumstances.

Therefore, it is important to review the health and well being among older people in Ireland to establish those factors which contribute to their vulnerability and the implications for health promotion policy for them. A major goal of healthy ageing policy in the coming years, according to O'Shea (2003), should be the reduction in the gap in life expectancy at 65 years between Ireland and the rest of Europe.

CHAPTER FIVE

METHODOLOGY

5.1 Introduction

The purpose of this study is to explore how *person centered* the health services are from the perceptions of subjects, 70 years and over, who are users, or potential users, of the services.

With this in mind the aims of the study are:

- To determine if older people are aware of what health and social services are available to them in the community.
- To determine whether the existing services are what older people require.
- To gain information on what they consider they may require in the future.

5.2 The Setting for the Fieldwork

Part of the North Wexford community care area was selected for this study, as previously stated (see 1.3). This includes the town of Gorey and its environs. This area has the largest percentage increase (34%) of population in Co.Wexford since the 1996 census. The number of individuals aged 65 years or over in Gorey town and its environs increased by 18% between 1996 and 2002. In 2002 this equates to 1,699 males and 1,869 females, (Research Dept. SEHB, 2003).

5.3 Methodological Issues

The purpose of research in any profession is to find answers through empirical examination, and to institute the appropriate changes for a more effective service, (Kumar 1999:2). In order to select an appropriate design method to answer the research question, a review of the literature on research methods was conducted, specifically qualitative and quantitative research.

The quantitative approach is derived from the scientific methods used in the physical sciences (Cormack1991). It relies on information gathered and ordered in numeric terms, and understanding and meaning is obtained through the interpretation of statistics. This approach is aimed at describing and explaining natural and social phenomena. Cause and effect relationships are predicted through observation, quantification and verification. The advantage of this approach is that it allows for the accumulation and consolidation of data from a large number of people. Quantitative researchers carefully specify a research design, before collecting the data, and rarely depart from the design once the study has begun. (Mason 2002).

In qualitative research the belief is that the phenomena must be studied from the individual's perspective and in the context in which it happens. This method of research design, according to Lobiondo, Wood & Harber (1998) focuses on the whole human experience and the individual's perceptions of living the experience. It lends itself to "getting out in the field and finding out what people are doing and thinking" (Strauss & Corbin 1998:11). The study design in qualitative research evolves over the course of the study, and is referred to as an *emergent design*. The aims of qualitative

research, according to (Polit & Hungler1997) is to interpret, meaningful human actions and accounts which people offer about their lives, and to endeavor to record as accurately as possible those accounts. One of the crucial tasks in designing the research project is to decide on the number and characteristics of the respondents, who are invited to take part in the study. A limitation of a qualitative approach is the size of the sample, which raises questions as to the generality of the findings. The sample size in qualitative research tends to be small because of the large volume of verbal data for analysis, and the prolonged contact time with the participants.

Qualitative interviewing, Mason (2002) suggests, operates within the model that knowledge is constructed rather than excavated. Consequently the role of the interview is to ensure that the relevant contexts are brought into focus so that the situated knowledge can be produced. Interviews are one of the most commonly recognised forms of qualitative research methods and can be, face-to-face, telephone, or focus groups. The term ‘qualitative interviewing’ refers to in-depth, structured or loosely participant structured forms of interviewing, which are classified according to their degree of flexibility. The opportunity exists to go back to clarify or continue a previous conversation and validate people’s responses. However, in quantitative research once a structured interview has been conducted, the researcher cannot go back to the respondents to ask for clarification, or to verify whether what was said was correctly understood by the interviewer, (Parahoo 1997).

The focus group interview method can be described as an interaction between the researcher and more than one respondent, for the purpose of collecting research data. This is a popular method in market research, and it is also used in health research.

The purpose of focus group interviews differs from individual interviews when the researcher wants different perspectives on a phenomenon. Gathering people who can offer such insight in one or two sessions can achieve this. However, the reliance on volunteers may bias findings, (Parahoo 1997). The major advantage of focus group interviews is that valuable data can be collected quickly and cheaply. They provide participants the opportunity to react to, and reflect on, the opinions of others, which they might disagree with or be unaware of. However, dominant personalities can monopolise the discussion and express their views at the expense of others, (Parahoo 1997).

The essential difference between the qualitative and quantitative approach lies in their different philosophical assumptions, which in turn guide data collection and analysis. The quantitative approach utilises information that is numerical, to describe and understand, while the qualitative approach is more descriptive and relies more on the quality of its data than on the quantity.

5.3.1 Ethical Consideration

Research in the field of health involves studying and observing human subjects; therefore great care is taken to protect the rights of participants (Polit & Hungler 1997, Lo Biondo, Wood & Harber 1998). The ethical principles are respect for human dignity, justice and non-maleficence. These principles protect participants from physical or psychological harm, and exploitation. Respect for human dignity and the right to self-determination allow participants freedom to take part in the study, if they

so desire. Informed consent, which is signed, documents the participants' decision to join the study. (Polit & Hungler1997)

5.4 The Rigour in Qualitative Research

As there is a potential for subjectivity and therefore bias in qualitative research, the elements of reliability and validity need to be considered. Pope and Mays (2000) suggest the rigours in qualitative research can be achieved by creating an account of methods and data, which can stand independently, 'by producing a plausible and coherent explanation of the phenomena under scrutiny'. The data is collected by means of interviews. The reliability and validity of recorded interview data is tested by a content validation technique. These will need to be clear and demonstrable throughout the study. This means that a tape recorder is used; interviews are transcribed and presented to the respondents so that they can confirm that the data is correct. The procedure is repeated during the study until the end of data collection.

5.5 Research Design

A qualitative research approach was chosen as the most suitable design for this study, using semi structured interviews, in order to describe and explore the perceptions of older people, to gain an unbiased account of the services available to them. This approach allowed for the collection and analysis of descriptive data thereby producing findings that were not arrived at by means of quantification.

Qualitative interviews with subjects' 70 years and over were used to elicit information and explore the research aims as previously described in 5.1. The use of broad and open-ended questions uncovered the meaning people attached to their priorities in relation to the health and social services available to them, as they grow old.

This study allowed for a description of the social world of the participants, from the research perspective, within the social context. This approach lent itself to getting out into the field and finding out what people were doing and thinking. The strength of this research design allowed for flexibility and the attainment of a deeper, more valid understanding of the subject, than could be achieved through a quantitative study. This *emergent design* reflected what was learned about the questions posed. This provided insight into the realities and viewpoints of participants that were not known or understood at the start of the study.

5.6 Informed Consent

In order to protect the rights of the participants and to conform to ethical standards, the research proposal was presented to the ethics committee of the South Eastern Health Board, (see Appendix 1). All ethical and necessary documentation was completed prior to commencement of the study. Before data collection commenced, the writer's Hospital Manager, the Director of Public Health Nursing and Manager for Community Care were informed.

There was no obligation placed on anyone to participate in the study. Those who did participate did so willingly and voluntarily. The guarantee of confidentiality and

anonymity was assured, before each participant was offered the opportunity to sign a consent form. (See Appendices 2 and 3)

5.7 The Sample

A non-probability convenience sample, which consisted of the most readily accessible persons, was selected. The chairpersons of the two local retirement groups were contacted and the purpose of the study was explained. A list of names and telephone numbers of people from the two groups, who were willing to participate in the study, was supplied. For the purpose of this study the two groups were referred to as Group 1 and Group 2.

Group 1 is in existence for almost two years with a membership of 160, of which 80% are women and 20% are men, members are drawn from professional, skilled and unskilled backgrounds. Group 2 is in existence for over 40 years, with a membership of 70, of which 90% are women and 10% are men, members are drawn mainly from unskilled, laboring or farming backgrounds.

Group 1, furnished the researcher with 8 subjects, and Group 2 supplied 10 subjects who were willing to participate in the study. Thus the writer's influence on the sample selection was avoided. Each participant was contacted by telephone to establish if they met the criteria for the study.

5.8 Criteria for Inclusion and Exclusion

5.8.1 Inclusion Criteria

Subjects:

- Who are 70 years or over, of both sexes.
- Who reside in the North Wexford community area.
- Who are not dependent on care provided by the health board for activities of living.
- Who are living alone, or only with spouse /partner.

5.8.2 Exclusion

Subjects:

- Who are living with family /relatives other than spouse.
- Who are suffering from communication difficulties.

From the names of prospective participants, eighteen in total, one woman was excluded as she lived with her daughter. Another woman was excluded as she had had a stroke (cerebral vascular accident) and was unable to communicate coherently. One man, when contacted, was in hospital. Another man declined to participate, as he said he felt uncomfortable about answering questions. The remaining two people, who were women, were away on holidays for the duration the interviews were being conducted.

A sample of twelve participants was finally selected, six from Group 1, and six from Group 2, eight were female and four were male. A letter explaining the purpose of

the study was sent to each individual, along with a request for his or her written consent to become participants. Arrangements were then made to meet the writer, at a time and place suitable to the participant. The majority of participants agreed to meet in their own homes. One woman agreed to be interviewed at her local hotel. The writer met with each participant only once for the duration of between 35minutes to 1 hour and 10minutes, with a mean time of 45 minutes.

5.9 Characteristics of the Sample

The majority of participants, 11, are residing in the community in their own homes, with one in a rented local authority house. Of the female participants, only one woman is living with her husband, the remainder are widowed and living alone. Of the four male participants, three are living with their wives, one is widowed and living alone.

- Eight participants, live in urban settings, with four in rural settings
- The age profile ranges from 70 years to 84 years with a mean age of 77 years.
- The participants are from professional, skilled and unskilled classes, (see Table 5.1).

Table 5.1 Sampling Frame

**Group
1**

Code	Age	Sex	Occupation/ Retired From	Living Alone/ Spouse	Marital Status	Urban/ Rural	Home Own/Rent
A	73	F	Teacher	Alone	Widow	Rural	Own
B	84	F	School Cleaner	Alone	Widow	Urban	Own
C	76	F	Housewife	Alone	Widow	Urban	Own
D	79	F	Housekeeper	Alone	Widow	Rural	Own
E	83	F	Hospital Care Attendant (Night Duty)	Alone	Widow	Urban	Rented
F	83	M	Forestry Worker	Alone	Widower	Rural	Own

**Group
2**

Code	Age	Sex	Occupation/ Retired From	Living Alone/ Spouse	Marital Status	Urban/ Rural	Home Own/Rent
G	75	M	Shopkeeper	Spouse	Married	Urban	Own
H	74	M	Engineer	Spouse	Married	Urban	Own
I	76	F	Housewife (Civil Servant Prior)	Spouse	Married	Urban	Own
J	70	F	Homemaker	Alone	Widow	Urban	Own
K	82	F	Cook	Alone	Widow	Urban	Own
L	71	M	Machine Operator	Spouse	Married	Rural	Own

5.10 Pilot Study

A pilot study was conducted prior to the main study, with one female participant aged 74 years, seen in her own home. She was a member of the Active Retirement Group, but not part of the sample selected for interview. This interview tested the technique of using the tape recorder and identified flaws in the question guide. Following the pilot study, the open-ended questions were adapted and rephrased for greater clarity.

The pilot interview lasted one hour and ten minutes. This was perhaps the longest length of time a single interview should take, given the age profiles of the respondents. However, it proved useful in testing and modifying the research instrument.

5.11 The Interview

The semi structured interview approach was selected for this study, as it was considered to be the most appropriate form of data collection to answer the research question. Careful planning was required, to obtain valid and reliable information. This involved face- to- face ‘conversation with a purpose’ rather than a formal ‘question and answer’ format. The content of the interview inquired into older people’s health and social care needs. The over-arching topic was the perspectives of older people on how person centered the health services were for them, the users, or potential users.

5.11.1 The Interview Process

A focused set of questions and a topic guide, (see appendix 4) were used as a starting point for discussion, with general questions about the participants age and background and their membership of the retirement group. This fluid and flexible approach using open-ended questions allowed the participants to talk freely in their own words and enabled the writer to focus specifically on issues that required clarification and further probing. It also allowed the writer and participants to develop unexpected themes. A tape recorder was used to record the interviews, so that an accurate record of the

answers was available for later scrutiny and transcription. As the tape recorder could inhibit respondent's answers, they were assured that it could be stopped whenever they wished. The interview process varied between thirty minutes and one hour and ten minutes. At the end of each interview, each participant was thanked and offered an opportunity to read the transcript of the interview when available. An alphabetical code was allocated to each participant and the same coded letter to his or her respective tape-recorded interview. The recorded tapes were then transcribed for analysis, (see Appendix 6). The results obtained from the present study are described in Chapter 6.

CHAPTER SIX

RESULTS

6.1 Introduction

The data for this study was collected as described in chapter 5. This chapter sets out the results from the twelve qualitative, semi-structured interviews, that were described in 5.8.1. From the analysis of the data, the themes that emerged from the results will be explored. When informants' own words are used they are set in italics. The research questions addressed and answered by this study were:

- Are older people aware of what health and social services are available to them in the community.
- Are the existing services what older people perceive they require.
- Are there services that older people consider they may require in the future.

6.2 Data Analysis

In order to make sense of the findings and give meaning and significance to the research, content analysis was used to analyse the data. A full transcript of all interviews was prepared. Each transcript was then examined and any dross removed. The text of each transcript was then examined for themes. The transcripts were read line by line in search of significant incidences or phenomena. Each individual transcript was divided into "meaning units". Following this the "meaning units" were grouped into distinct descriptive categories. These categories afforded a great deal of

insight into the respondents' knowledge and perspective of the issues that were discussed.

6.3 Emerging Themes

Several themes emerged from the data at the analysis stage, which were then grouped into four significant categories.

- Access to health and social services.
 - Home help service.
 - Meals-on-wheels service.
 - Chiropody service.
 - General Practitioner service.
 - Public Health nursing service.
- The importance of being active and independent.
 - The retirement groups.
 - Travel insurance.
- Unmet needs of the services.
 - Occupational and Physiotherapy.
 - Transport.
 - Finance.
 - Security.
- Attitude - Person centered

The needs of older people, as articulated by the informants, are not specific to the health services alone, but incorporate social services and the environment in which they live. How society views older people was articulated by many as a negative aspect of ageing, and perceived by many as a hindrance to “*getting involved and not*

wanting to be a bother to anyone". This is discussed under the theme of identity. Suggestions regarding ways of involving older people in remaining active and independent are incorporated under that theme. While each section adopts a unique focus the emerging issues and insights reflect the interrelatedness of the themes. Reliance on family emerged throughout the data and is incorporated in the themes; it is not discussed under a separate heading.

6.4 Access to Health and Social Services

Respondents were asked directly if they knew what services were available to them, and how to access a particular service if they required it. Those who required a particular service were asked if it met their needs and if the service was sufficient.

It emerged from the data that respondents were aware of some of the health and social services that were available to them. Two people obtained their knowledge through their involvement in the local social service organisation, while three mentioned the media or local information centre as their source of information, seven were not aware of everything that was available. One respondent's view was that "*there were probably enough services but you don't know how to access them*". One married man's response was that, "*a man living on his own ...used to having his wife doing the household chores and other things ...obviously at a certain age he needs assistance of some sort, caring of some kind. I don't know how much of that is available and to what extent it is available .I just don't know that*". However, generally respondents did not see a need to find out what was available, unless a crisis occurred or something happened, which prompted them to enquire. It emerged that all

respondents were aware that services like home help, meals-on-wheels, chiropody, and public health nursing existed.

Table 6.1 Knowledge of How to Access the Health and Social Services

Local involvement with social service council	Through media or information center	Unaware of how to access the service
2 (17 %)	3 (25%)	7 (58 %)

6.4.1 Home Help Service

While all respondents had heard of the home help service, five did not know how to access the service, two of whom expressed a need for it. Four relied on their family to do their shopping and heavy housework. One of the respondents, not in receipt of home help, replied they had no need for home help as *“my grand children do my housework for me”*. Another relied on neighbours *“to bring me shopping as I am not able to drive since I got a little stroke”*. This respondent did not like asking the neighbours all the time and she paid for a taxi to take her into town. While another said *“the shop down the road Mrs. ...brought me up my groceries when I broke my ankle last year”*.

Only three of the respondents had the actual experience of using the home help service. One respondent had occasion to use the service for two months, when his wife had a knee operation, *“I found out about the service from pamphlets I got in the information centre”*. Another availed of the service on the public health nurse’s suggestion, two months ago, when her husband was ill, *“I don’t like using something that I am able to pay for. The nurse gave me a name of a woman who did home help*

privately. However, she only came for three days and we never saw her again. I just told the nurse we were managing, I don't like to make a fuss."

Another respondent in his 80's said, *"I don't know if I would get a home help, would I? ... Sure I manage O.K. The Mrs. was in bad health for years ... I had to do all".*

When this respondent was asked had he looked for a home help, he answered *"no"*.

Another respondent's view of home help was *"It's fine for someone who has no family to call on, my daughter does anything I want"*.

The lack of availability of the home help service was evident by the response of one woman living alone in a rural setting, with no family living near her *"I can't get a home help, the public health nurse said there was worse than me. I pay a lady to come in once a fortnight. She does the hoovering and changes my bed and things I find difficult to do. I take a shower when she's here, as I feel safe when there is someone in the house. I can call for help if I need it. I pay her 40 euros which is a lot out of my pension but I feel I am not a burden on anyone when I can pay my way"*.

One respondent gave a thought provoking response when asked if she would use the home help service, *"Yes, I would, although I might not need the physical help but the company would be nice"*. With regard to accessing the service in the future, it was the stated opinion of all the respondents that they would avail of the service if they had no one *"I prefer that, than have to go away somewhere"*

Table 6.2 Preferences for the Home Help Service

Availed of service	Preferred help by relatives/family	Unaware of how to access the service
3 (25 %)	4 (33 %)	5 (42 %)

6.4.2 Meals-on-Wheels Service

Respondents had different views as to accessing the meals-on-wheels service. *“I think it’s great for anyone living alone who doesn’t want to cook for themselves”...especially men on their own.* Two respondents were not aware the service existed in the area. Half felt *“that there was not enough of that service, because there is a lot of old people now, and some are like my age and can’t walk or get about”.* Four respondents would not use the service for various reasons; *“I wouldn’t have the neighbours see me getting charity”.* This included one person who was happy to avail of the home help service if offered, but preferred to *“do my own cooking”.* The remaining two disliked availing of the service. *“The meals on wheels I’d disagree with that, you don’t know what you’re getting half the time.... You have your own tastes and your own dislikes... I wonder do they eat it ... people would have thought you were getting a meal and you’re not eating anything”.*

An interesting response was that made by a female respondent in her 70’s, who lived alone but did not like the idea of the meals-on-wheels service, *“I meet with my friends from the group once a week for lunch. It’s a way of socialising and you’re not eating on your own. It’s an excuse to dress up and go out. The restaurants do half portions and that’s enough for me.... My appetite isn’t what it used to be”.* The majority of respondents perceived that, should they require some help with meals, their family was their first choice. Those with no family would consider the service if it were offered, should they require it in the future.

Table 6.3 Meals on Wheels Service

Insufficient services	Declined to use	Unaware that the service existed
6 (50 %)	4 (33%)	2 (17%)

6.4.3 Chiropody Services

As people age, foot care is important, particularly for those who have trouble with bending, with their sight or have diabetes, therefore there is an increased need for a chiropody service. When asked as to the availability of chiropody services, there was no consistency as to its availability or cost. Half of the respondents, four women and two men never used a chiropodist. The responses to the uptake or need for the service were varied. *“I’ve only been to a chiropodist twice so far ‘twas nails hanging off you know. I suppose I could need it more often...don’t feel I need it just at the moment but I’ve good toes and feet anyway”* was the response of a male respondent. One of respondents paid 20 euro every six weeks *“I have trouble with my feet and also have diabetes, I go without having my hair done so that I can go to the chiropodist. I don’t get it free because I go to ... and she only works from her home”*.

Complaints about the waiting time for chiropody were also highlighted. *“I had to wait for three months for an appointment and I could hardly walk”*. There is no designated health board chiropody service in this area and all chiropodists are self-employed. The day center provides a limited service, which is subsidized by the Health Board. One of the respondents availed of this service *“I used to go to... but now they do them in the Centre”*. When asked if there was a charge the response was *“not a lot, about three or four euro”*. When the respondents were asked why they do

not avail of the chiropody at a reduced rate in the Day Centre, four were not aware that such a service existed. However of the half who attended the chiropodist five preferred to pay in order to stay with the person they attended. Further probing revealed that they all attended the same chiropodist and when asked why, the response of one woman articulated the responses of the others “*when she finishes with my toes she bathes my feet in lavender water and then gives them a massage*”. It emerged from these responses that people were prepared to wait and pay for a quality service they consider to be person centered.

Table 6.4 Knowledge and Preferences for Chiropody Services

Did not use service	Availed of fee paying service	Day care service for chiropody
6 (50 %)	5 (42 %)	1 (8 %)

6.4.4 General Practitioner Service

Respondents were asked regarding their contact and experience of the general practitioners (GPs). All respondents identified having their *own* GP, including four respondents who had moved to the area in the last five years, the other eight had a long association with their GP. It emerged from the data that while all respondents are aware of the GP service, nine respondents do not attend their GP on a regular basis. “*I’m not a doctor person and keep away from them as much as possible*”. However, what was a cause for concern was the reply of another woman who took a tablet each night to relax her, “*I call to the surgery and get my prescription renewed, the last time I saw the doctor was a couple of years ago. I’ve no need to see him and waste his time*”. Three respondents attend their GP regularly and have a good

relationship with them. *“My Dr is ... he’s very thorough and spends the time with me”*.

Although all respondents were happy with their GP, dissatisfaction was expressed by the fact that house calls were less frequent. *“Years ago the Dr. would call and stay for a chat, now he won’t come out ...I had to go in... I had an awful flu. I have no car and have to hire a taxi to bring me to the Dr.”*. This respondent lived five miles from his GP, and it cost him 12 euro for a taxi when he needed to visit him.

A major benefit that was mentioned by all was the introduction of the medical card to the over 70s, *“particularly for those on a lot of medicine and the cost of the doctor’s visits”*. Another was delighted to be able to get her hearing aid free *“but I had to wait six months for it”*. However, the view of more than half of the respondents was, *“that some charge should be made, even let it be a fiver, just something that you would feel you control it, just not getting it for nothing”*. Four felt that visiting the doctor could be abused *“I mean there is nothing stopping people... I think I’ll go to the doctor this morning, I’ve nothing else to do ...you can just wander in, go in every week ...and that isn’t a good thing”*. While the view of wasting the doctor’s time was mentioned on several occasions, *“there is nothing wrong with me”* was the view even if a screening program or vaccination program was suggested.

The uptake on the flu vaccination was also poor, only half availed of this, despite widespread media coverage and letters sent from their GPs to avail of the service. *“He sent me a letter early in the year to go for the flu injection but I turned a deaf ear to it”*. Nine of the respondents perceived their GPs as always busy. Overall

respondents were reluctant to complain about services as *“they think you’re ungrateful after getting the medical card”*. However one respondent felt that, *“It is not good enough to wait until something happens to you to go to the Doctor, he should call you once a year to have a good check over and not wait until you’re sick”*.

Other services like the Dentist and Optician were mentioned. All respondents required glasses and they all attended their optician on a regular basis. Of the twelve respondents eight attended their dentist yearly, the remaining four had dentures and did not see *“a need to worry about the dentist”*, despite knowing the service was free. While reference was made to taking vitamins and eating what was thought of as a good diet only one of respondents made reference to the dietician, who gave advice regarding diet following heart surgery, the remaining respondents had no opinion regarding this service.

6.4.5 Public Health Nursing Service

Respondents were asked if they knew about the public health nursing service, or if the public health nurse called. The response of eight was that they did not see *“the public health nurse”*. This included one who remarked that *“I have never seen a nurse but then I go to the Day Centre once a month and I see the nurse there”*. Three respondents had a visit from the Public health nurse, *“ She asked me a few questions... ..was I managing all right... she told me to contact the clinic if I needed her to call... I’m out most days so she’d not find me in”*. One was disappointed with the service *“I only saw the nurse once when I came out of hospital after breaking my leg and she said I was coping fine ”*. The fact that there are not enough public health nurses was

acknowledged, *“but it would be nice if someone from the clinic called you. It doesn’t have to be the nurse and asked were you all right today ... did you need to go to the doctor or need any shopping rather than be a burden on your neighbours”*. The general view of respondents was that if they needed a nurse to call their GP would organise it. Interestingly, two of those respondents who did not see the public health nurse, said they would *“contact ...[the caretaker in the health center] and he’ll sort out what I need or he’d know where to send me”*.

Table 6.5 Public Health Nursing Service

Disappointed with service	Did not see a public health nurse	Visited by Public Health Nurse
1 (8 %)	8 (67 %)	3 (25 %)

6.5 Being Active and Independent

It emerged from the data that respondents were generally very active for their age, irrespective of their social backgrounds, and in the words of one respondent, *“plan to be around for a long time”*. The meaning of good health involved leading *“a normal life”*. This included having the ability to keep busy, carry out daily and recreational activities and be free of mental stress. *“Old age is a state of mind and in my mind I’m only seventeen”*. It emerged that there was no difference between the males and females in how they rated their health, which was rated as good, despite having medical problems e.g.; diabetes, high blood pressure, arthritis, and one respondent had had a hip replacement. *“I’m able to get up and go to Mass every day and thank God for being so well”*. *“I go for a walk every day, even in the rain”*. In response to how do you get into town; one respondent in her 80’s answer was *“I get up on my bike*

and cycle the three miles". It's important to stay going, a woman down the road, she is dead now, she wouldn't get out and about or do anything... they get crippled up and are not able to stir". Respondents generally wanted to remain as independent as possible "and not a burden on anyone".

Preventative measures were taken to lessen the risk of being ill. These included self-protection and not taking unnecessary risks, *"I don't get up on ladders any more I know my limits"*, and slowing down, but getting sufficient exercise and eating a healthy diet. Taking supplements was seen as an additional way of keeping healthy. *"I take cod liver oil and vitamins and I am never sick"*.

The general opinion regarding retirement was *"a person should be allowed to work if they were able and wanted to do so"*. The idea also emerged that people should be allowed to retire from their regular employment *"and take up something less stressful or demanding... When I retired from engineering, I gave talks to sixth forms in our local comprehensive school to portray a positive attitude to older people. I was invited back to help with students who were behind with their work in engineering and metal work... with the individual attention they caught up... I got a great thrill out of helping those boys, which was in England before we moved over to here. I'd like to do something like that here in the local secondary school. Older people should not be written off ...they have a lot to contribute especially with younger people "*. Two respondents were still doing paid housework. Another one had only retired from business in the last year at age seventy-two. *"I am enjoying my retirement, I didn't realise the stress I was under until I finished, but I wasn't ready to go before then"*.

6.5.1 The Retirement Groups

All respondents were of the opinion that it was very important to remain in contact with people and being a member of the retirement group was a “*great social outlet, great company*”. It also emerged that the retirement groups were a source of information. Group One had talks from people on home alarm systems, and from community watch and about heating and cooking for one. People could avail of activities if they wished in the respective clubs. “*I love the club*”. “*I look forward to Wednesday nights we have dancing, but some only want to sit and talk ...you might not be out or talk to people since you were there last*”, were the responses from members of Group 1. Group 2 organised holidays and day trips and other activities, “*You can be as active as you like. Walks are organised every Wednesday and you go at your own pace, there are also art classes. My wife [wife’s name] has taken up painting with other members of the group and they have organised art lessons. Older people are not very political but through our group hopefully that will change*”.

6.5.2 Travel Insurance

The issue of travel insurance emerged as an area in which the respondents felt discriminated, as older people who had time to travel felt they were targeted because of their age. Responses included “*I am organising a trip to Canada, there are eight going and the insurance varies with our age*”, or “*We were going to Malta and we shopped around for insurance. We were nearly canceling the trip because the insurance was so dear. You feel you should not want to fly because of your age... are you supposed just to wait around to die*”... “*In Germany, where my daughter lives, people over 65years are not singled out for high insurance to travel...Our*

chairperson is taking the matter up with the senior citizens parliament and the federation of retirement groups". Respondents felt that more should be done to rectify this situation.

6.6 Unmet Needs of the Service

Respondents were asked questions about what they considered was needed to make life easier as they aged. The initial response from many was they hadn't thought about it, further probing revealed a number of needs that were not specifically under the health service. It emerged from the data that respondents were worried, if and when they could no longer manage alone what would happen. Three of the respondents, who were married, were worried if anything happened to them how would their spouse cope. A sense of no longer being in control was also articulated, as was, being a burden on their family. Four of the female respondents were confident their daughters would care for them while one was happy to "*go to the home, the County home*". There was also concern expressed regarding the level of services provided if they were required. The home help service was already referred to in 6.4.1. It emerged that while some respondents were not in favour of having a home help, "*I would like to have my laundry collected... the heavy things...my sister lives in ...and they have that service there*". The chiropody service was also referred to in 6.4.3. However the view was articulated that the services should be free to everyone, irrespective of your choice of chiropodist. While respondents were aware of the existence of a day centre in the town, they were unsure of its location. One respondent attended the day centre once a month, "*I would like to go more often. I don't meet many people now. Years ago, people had time to visit you, nowadays,*

everyone is out working. In the day center you can get a nice meal and have a chat".

The lack of neighbourliness and community spirit emerged in various forms from the data. *"There is no one to call on if you need them". "When I moved here 46 years ago there was only one house down the road and I had more company than I have now, and there are nine houses...and it was nice to have a neighbour you could call on if anything happened to you". "There's not a community like it used to be".*

6.6.1 Occupational and Physiotherapy Therapy

Respondents were disappointed with the lack of service provided from the Occupational Therapist (OT). *"They came out and measured the door step for a rail. I waited for six months for that, and in the end I went off and I paid for job to be done myself".* One respondent had a chair lift installed for his wife who suffered with arthritis *"I got a grant towards the cost, we could afford to pay the rest. If we didn't I don't know how long it would have taken".* It emerged from responses that aids were available quickly, *"I got the toilet seat after I had my hip operation".* Respondents were of the opinion that if you needed home modification the OT service was very slow and it could hinder someone from remaining at home.

The physiotherapy service was perceived as not meeting the needs of those who required it. *"The Physio has left and no one has replaced her. I need physio for my arthritis but there is a waiting list. I pay to go to a reflexologist to help with my symptoms".* Another respondent's husband needed physio, *"we attended a physio privately in A...which is 12 miles away. For someone who could not afford to go privately I don't know how they would manage".*

6.6.2 Transport

Transport was mentioned as an area that needed change, especially for those living in rural areas. Difficulties with transport poses problems with a variety of aspects of community life, like shopping, religious services and social events. This has the potential both directly and indirectly of affecting a person's health and well being. While five of the respondents, were still driving their car, the remainder had to rely on public transport, neighbours or family. For those living in rural areas, difficulties were reported, *"It's no good having a bus pass, you can't use it to get to town, the bus does not take this route any more. I don't get to town as often now because I have to get a taxi or a lift to the town. We used to get a bus for two euros into the club on a Wednesday night the health board subsidised it, but that's stopped, now I have to pay ten euros to go, but I'd hate to miss the club"*. Another view expressed was that people were isolated when they no longer were able to drive or had no car. *"I'm ok I can drive but I often give my neighbour a lift into town, he can't drive now, he's in his eighties and his sight is poor. There should be a bus service to collect people and bring them to town or a taxi service to meet the bus, that is subsidised for those with the bus pass"*

6.6.3 Finance

Fuel allowance was also mentioned as an issue for change. *“The fuel allowance stops for the summer months but I still light a fire in the evening, it can be cold, ...its company as well”*. The rising cost of fuel was also a concern. Four had no central heating and the fire was their main source of heating their homes.

People were asked directly, if the old age pension was enough to live on. There were mixed responses; one did not know the amount of the old age pension. Two were happy with the amount they received; the remainder felt it was not in line with inflation. *“I manage but you wouldn’t go mad”*. *“When you have to pay for insurance for the house or a big bill you need to put a bit by”*. *“I don’t smoke or drink, but someone who does would find it hard to manage on the pension”*. *“We were told that the pension was to go up to 200 Euros but that has not happened”*. *“It’s harder for someone on their own to manage, they would still have the same bills coming in, the ESB and insurance”*. Only two received the non-contributory old age pension the remaining ten had contributory old age pensions and work pensions.

6.6.4 Security

The changing values in society were articulated as areas that had changed community life. *“If they have no respect for God they’ve no respect for the elderly”*. Vandalism was a worry for respondents living alone, *“there were a number of break-ins around here recently, and you don’t feel safe anymore”*. Seven of the respondents had the pendant alarm, the remaining five had not heard about it or no one had asked them if they needed one. The need for security lighting was also mentioned. *“There should*

be a grant for old people towards house security. I got phone watch last year, it was expensive but I feel safer with it”.

6.7 Attitude - Person Centered

Respondents were asked if services were person centered towards older people. Some respondents were of the opinion that some services were the same for everyone but that some Doctors were better with older people than others. Generally respondents didn't want to be perceived as complainers. Appointment times were highlighted as an area where older people were not considered, with long waiting time in outpatient departments and everyone having the same appointment time. Respondents were then asked if their opinion was asked for regarding services. *“I think Wexford people are very easy going they don't complain”.* *“The politicians don't call and ask old people what we think ”... “Our opinion is not wanted once you retire you are forgotten about”.*

Respondents' perceptions on how young people view older people were varied. One is actively involved in the drama group *“On stage peoples age is not significant...we're all one family”.* *“Young peoples attitude varies to older people ... some young people are very tolerant to old people, ...not all old people are nice”.* Working with young people can be rewarding.

Attitudes in general were *“...a bit off putting, a thing I'm not happy with. A lot of people have a habit of shouting at you ...Talk to you as if you're mentally retarded”.* *Young people are not as mannerly as they were years ago but you can't paint them all the same”.*

The views of respondents, on what they wanted to be referred to as, were mixed and indifferent, however senior citizen was the most preferred title. *“I don’t care what I’m called, I’m still me inside... “I think senior citizen is more respectful”*. A very positive attitude to ageing was expressed as, *“Old people are just young people getting old. In your mind you’re not old”*. Respondents found professionals’ attitudes to older people, *similar to any walk of life*. Those who had occasion to go to hospital found *“some staff are better with older people than others”*, however generally respondents were reluctant to complain.

6.8 Summary

The perceptions of the participants have been presented within the themes listed in 6.3. While every effort was made to obtain the information in an unbiased manner, it became obvious that some of the participants considered the researcher as capable of rectifying any deficiencies in the service. As the researcher was known to be from the local area this could have inhibited the information process.

The next chapter will discuss the findings in relation to the literature reviewed.

CHAPTER SEVEN

DISCUSSION

7.1 Introduction

This study represents the first attempt to explore the perceptions of active older people in the North Wexford area of the South Eastern Health Board, with regard to their knowledge of what health and social services are available to them. It also attempts to identify what services they perceive they will require with increasing age and if requirements for care are being met.

As the sample was drawn from a limited geographical area, the results may be compared only to a similar population. This study nevertheless presents information on health and social services that can be compared to similar studies nationally, for example the large scale HeSSOP study by Garvan et al, (2001) (see 2.4). Through the present study's qualitative approach, an in-depth understanding of the needs and perceptions of older people have been uncovered which could not be achieved by a quantitative method of data collection.

The themes, which emerged following an analysis of the data obtained through interview, were:

- Access to health and social services.
- Unmet needs of the services.
- The importance of being active and independent.
- Attitudes -Person centred service.
- Reliance on family.

These themes are interrelated as one theme has impact on the outcome of another. While respondents initially had to consider what services they might need as they aged, they appreciated being asked their opinion and having it valued.

The themes will now be discussed under the following headings:

- Older peoples knowledge of what health and social services are available to them.
- Perceived service requirements with increasing age.
- Preferences of older people regarding care.

7.2 Older Peoples' Knowledge of What Health and Social Services are Available to Them

The findings of this present study revealed that participants were aware of some but not all of the health and social services available to them. This result is similar to the HeSSOP study by Garvan et al (2001) (see 4.5), who found that people generally are not aware of what health and social services are available to them until a crisis occurs. Few of the participants in the present study had availed of the home help service, but approximately half preferred to rely on their family for informal care, and did not see the need to find out if they would be entitled to a home help. This compares with the low percentages found in the studies by Ruddle et al (1997) and O'Neill and O'Keefe (2003). Layet et al (1999) found 44% of older people received informal care, (see 4.4). It also emerged from the data that some respondents were aware that the service existed, but they did not want to ask for a service for which they could afford to pay and deprive others of the service, who may not have had the financial means to pay privately.

The environment in which people and their families live should all be taken into account in the planning and delivery of care. Without family support the community care system for older people would have collapsed a long time ago, a fact that was also found by Nolan and Grant in their study, (1992:44), (see 4.4). Families provide extremely high levels of care, even for those who have low dependency levels. In general, family commitment to caring is still strong in this geographical area.

7.3 Perceived Service Requirements with Increasing Age

It emerged from the present study that respondents had concerns relating to the possibility of becoming a burden on their families. They were of the opinion that, it was necessary to remain active for as long as possible and identified the importance of their retirement groups in achieving this. Wagnild (2003) refers to this as resilience, (see 3.5). Morris (1994) and Arent, et al (2000) also support the importance of exercise and health promotion in the elderly in remaining active and healthy (see 3.6).

The contribution made by the community care system, to keeping older people active and independent at home is inadequate primarily because of current resources. O'Shea (2002), highlights this fact in his review of the nursing home subvention scheme which indicated, that in the three years from 1993 to 1996 expenditure towards community care initiatives increased by only 8% while in the same period the nursing home subvention scheme grew by 422% (see 4.6).

A key element of public policy initiatives, designed to keep older people living at home, is the development of a good community care system. This was described in

the 119 recommendations of *The Years Ahead Report – a policy for the Elderly* (1988), the optimal model of best practice for dependent elderly in terms of a continuum of services. However, it is apparent that the nursing home subvention scheme, through the Health (Nursing Home) Act 1990, absorbed the bulk of resources available for dependent elderly people, drawing on resources that could have been used to improve the community care system. This has resulted in the *crowding out* of much needed community based facilities, as more and more subventions are being sought.

What is evident from this study, and also referred to earlier by Garvan et al (2001), is that services are fragmented, (see 4.5). This study revealed that services were not available to people living in rural areas as readily as for those in urban areas e.g. home help services, meals-on-wheels and transport. The fragmentation of services was not only confined to the local area. Laundry services were reported by one respondent, to be available to older people in other areas of the Board (SEHB), but were not available at all in the Gorey area. It also emerged from the data that services like chiropody were not available to all participants if they required them, and were only available at a reduced rate to those who attended the local Day Centre. Garvan et al (2001:51) recommended that chiropody services be expanded significantly on a community and domiciliary basis, however there are issues surrounding the payment structure which act as a deterrent to chiropodists working in the health service according to Haslett (2003), (see 4.6).

7.4 Preferences of Older People Regarding Care

The findings of this study would indicate, that the majority (10) of respondents declared that they were completely self-sufficient and had not used any community-based service. This was a higher percentage, when compared to 57% found in Garvan et al's (2001) study, (see 4.5). However, while most of the participants in this present study were self-sufficient in daily tasks, two participants had some level of reduced abilities and were not in receipt of any health or social services. Garvan et al (2001) study involved a cross section of older people, they also found that 12% of respondents had some level of reduced ability and 10% of those not receiving any health or social services complained of an illness that caused extreme disruption in their lives.

Because older people do not generally come in contact with the health and social services until a crisis occurs, this leads to late intervention with poor outcome and may lead to institutional care. The results of this study would indicate the existence of a system geared at providing residential care for dependent older people, rather than providing anticipatory and ongoing care in partnership with clients and family carers. Therefore, the current trend for care in the community veers towards institutional care, as it is easier to avail of nursing home subvention than to have care in the community.

It became obvious during the course of the interviews that it is vital that adequate assessment and complimentary domiciliary care is provided to all older people living in the community when they require it. If home help, social work services, allied

health services and nursing care are not provided at home when older people require them, it is inevitable that they, as they become dependent will be institutionalised prematurely. Regular evaluation of the services at all levels is essential if services are to become more efficient and appropriate to the needs of older people. The evaluation process was, and still is, regarded by service planners and providers as a burden that involves proving the success or failure of a programme. This approach, as Mc Namara (1999) describes, resulted in the careful selection of conclusions, reiterating the obvious, with generalisation and recommendations avoided. Evaluation should not be confused with related activities like assessment, monitoring or quality assurance. While these activities are linked to the evaluation process, by examining aspects of a service, they are not substitutes for evaluation per se.

The Eurobarometer survey conducted in 1992; of attitudes in twelve EU states asked how people over 60 should be described. 41.9% of Irish people chose “senior citizen” as the most popular, next was “retired”. In the EU in general “senior citizen” was the most popular term (30.9%), older people was also popular, (27.4%), (see 3.3). Twelve years later this study found that the term “senior citizen” is still deemed to be the most respectful. What is also evident from the study is that older people do not mind what they are referred to as long as they are not spoken to, or shouted at as if they were all deaf and deranged. Whatever older people are referred to is not strictly a health issue, yet it may impact on how older people perceive themselves and how they are valued by society. It has been referred to on several occasions during the course of the interviews that participants felt undermined even by children. This is supported by Power’s (1987) study where half of those studied had negative attitudes towards older adults, (see 3.3). A survey in Dingle, Co. Kerry (Comhar Dhuibhne, Dochas, Nexus,

2003) substantiates this view and found severe isolation, feelings of despair, depression and thoughts of suicide as among the problems resulting from social isolation. It should be borne in mind that other age groups may also express similar sentiments.

A constant theme that emerged from the data was the lack of community spirit. The too rapid development of rural areas has sadly brought about the demise of the rural community spirit. This was more apparent from those participants who lived in the area all their lives, with references such as “not knowing your neighbour, and no one to call on”. This fact was also highlighted in Britain by Bently (2003).

Older people report a common problem with health service professionals, which is one of patronising treatment or condescension. “ Ageism among health professionals is not unknown, and their negative attitudes are quickly recognised by older people with whom they are in contact” (DOHC1998: 40), (see 3.4). While respondents did not state factually that they found negative attitudes towards them, through the course of the interviews it emerged that these attitudes existed. Participants were told, by health care staff that they were “great for their age”, or that they didn’t need services like the day centre or home help, even if they themselves perceived they did. Participants were reluctant to complain and *made do* with their current situation. This also has implications for service provision as found in Bauld, Chesterman and Judge’s (2000) study, where older people are less critical of services and service providers, and have lower expectations of what services can provide. Haslett (2003) also found that older people tend not to give negative feedback (See 2.4). The vulnerability of the older person may also contribute to acceptance of what is offered.

The recent health strategy, *Quality and Fairness A Health System for You*, (DOHC 2001: 80) envisaged, as previously stated (see 1.4), “a health system that will encourage you to have your say, listen to you, and ensures that your views are taken into account”. However, the results of this study would indicate this is still not a reality. The respondents in this study are willing to be involved in prioritising their own health care, but may be excluded through lack of a “consumer ethos”.

7.5 Summary

In conclusion this qualitative study illustrates that older people are not aware of all the services that are available to them. The participants have varied lifestyles which highlights that it is important not to stereotype older people. For those participants that identified the need for services, their needs were not adequately met. Those who live independent and active lives do so by availing of the social networks in their community. Helping older people to stay healthy and increase their life expectancy should involve listening to their viewpoints about what affects their health and what social supports they require for physical and psychological well-being, and creating support structures as deemed appropriate. How they define health within their own culture must also be taken into consideration when providing the current services and in future planning.

The importance of local community cannot be emphasised enough, since it is here that the older person’s human needs can be expressed to the maximum. There is a quality chasm in relation to provision of health care at present, and the optimum service required by the individual. This gap is attributed to the fact that too often people;

consumers and patients, must adapt to the customs and practices of health care organisations and professionals, rather than receiving services designed to focus on individual needs and preferences.

CHAPTER 8

CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

The previous chapter discussed the findings of the present study in relation to the perceptions of older people, who live in the North Wexford area of the South Eastern Health Board, with regard to their knowledge of what health and social services are available to them. It highlighted the perceived requirements of older people to receive care and support in the community. This final chapter outlines the conclusions and recommendations from the results of the study.

8.2 Conclusions

This qualitative research study confirms the findings reported in the literature review that older people are a diverse population group, living in different circumstances, with different life experiences, which influence their perceptions and aspirations.

- There was a lack of awareness among older people as to what health and social services are available to them. The existing services are fragmented, ad hoc and arbitrary, which is compounded by inadequate resources for the community care system. This hinders the development of proactive, preventative and innovative approaches to care for older people in the community.
- There was a considerable amount of agreement expressed by respondents regarding their desire to remain as active as possible, for as long as possible and to

- The promotion of active ageing reflects the desires and abilities of many older people to remain in socially productive lives. The stereotyping of older people as unproductive and dependent is unfair and detrimental to society and the dignity of the individual.
- Despite the fact that the General Practitioners are the *corner stone* of care for older people in the community, there is no evidence from this study to suggest that healthy ageing initiatives were promoted in the general practice setting.
- Involving older people in their health care and encouraging them to act as consumers presents a major challenge: older people have tended to be disempowered and disinterested with low expectations of what the health and social services have to offer. The views of individual citizens and of health service staff need to be at the centre of participation and partnership. Partnership, according to Winkler (1987) requires the medical profession to relinquish some of its independence and users some of their dependence. Consultation with older people at all stages of the planning process is essential in planning services for older people, and their opinion should be sought regarding improvements which could be made to the service they receive.
- In order for society to have a more positive vision of the ageing process, improvement and change are required, so that older people are viewed as people who happen to be old. Gender plays an important part in defining older peoples preferences in availing of opportunities for healthy ageing. There is a need to prioritise older women's health in policy and strategic planning as Irish women compare less favorably than their European counterparts, (pre May 1st 2004)

8.3 Limitations

The writer is aware of bias with a convenience sample. She acknowledges the fact that those selected were from active retirement groups, while those living in the community aged 70 years and over, who are not members of these groups, are not included.

- The origins of the group would dictate that these subjects are motivated and active and this may not be the case for all older people. This could pose a problem to the representativeness of the findings for this group in general.
- This is a small study, and a focus group would have allowed for a broad ranging exploration of the key issues, however due to the time and resource constraints of the study, that was not possible.
- The writer was aware that participants knew the position she held in the local hospital, this may have inhibited their openness.

8.4 Recommendations

As this was a small convenience study, it is not possible to make definitive recommendations for the general population. However, several factors that arose from this study would merit further investigation such as, the putting in place of procedures regarding the renewal of prescriptions and the uptake of chiropody visits by older people living with diabetes. Peoples trust in the service also needs to be re-ignited.

1. Consumers need to be informed about what they can expect of individual health agencies and the health care system. Active retirement groups/associations represent a powerful means for health and social care information dissemination and healthy ageing initiatives, which have hitherto been untapped.
2. The Department of Health and Children and the Department of Social Community and Family Affairs are committed advocates of older people and therefore hold a responsibility to monitor services and identify service gaps and deficiencies. As a result, reliable information bases are required both nationally and locally to plan a needs orientated service.
3. Health service policies should promote active ageing, including the fostering of socially important activities such as volunteering and support for social care organisations. The valued contribution made by older people to society must be recognised and they should not be portrayed only in terms of the financial burden they are perceived to represent to younger generations.

4. Barriers to older people remaining independent need to be removed. There is a need for interdepartmental collaboration between the Department of Health and Children and the Department of Transport, to address the inadequacy of the public transport system and remove what are considered obstacles for older people to living independent lives, e.g. bus stops too far from people's homes.
5. Training programmes for all health professionals should incorporate the care and needs of older people.
6. Information and advice needs to be person centered and consumer focused. The dissemination of information in a user-friendly, readable form is required, with the provision of resource centers like a *one-stop-shop* in all local areas.

8.5 Further Research

Further research is required using focus group interviews with people in the age group under study, who are not members of a retirement group. A comparative study in another area of the health board, or an adjacent health board, where the researcher is not known, would be useful to dismiss the writers concern regarding the openness of respondents.

A large-scale study using a quantitative approach could build on the findings of this study and develop the research question further.

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Appendix 1



Address: Waterford Regional Hospital,
Dunmore Road,
Waterford,
Ireland.

Telephone: 051 848000
Fax: 051 848572
Web: www.sehb.ie

SOUTH EASTERN HEALTH BOARD REGIONAL RESEARCH ETHICS COMMITTEE

STUDY TITLE Person centred approach to the care of older people. The perceptions of older people in the North Wexford area.

PROTOCOL NUMBER:

AMENDMENT

NAME AND ADDRESS OF SPONSOR

NAME AND ADDRESS OF PRINCIPAL INVESTIGATOR Ann Coakley, Director of Nursing,
District Hospital, Gorey

The committee has reviewed the above study

- | | |
|--|---|
| 1. <input checked="" type="checkbox"/> Protocol | 7. <input type="checkbox"/> (na/) Investigator brochure |
| 2. <input type="checkbox"/> (n/a) Amendment | 8. <input checked="" type="checkbox"/> Investigator's CV |
| 3. <input checked="" type="checkbox"/> Patient Information Leaflet | 9. <input type="checkbox"/> (n/a) Investigators MDU/Insurance |
| 4. <input checked="" type="checkbox"/> Patient Consent Form | 10. <input type="checkbox"/> (n/a) Sponsor insurance |
| 5. <input checked="" type="checkbox"/> Recruitment Literature | 11. <input type="checkbox"/> (n/a) Funding for the study |
| 6. <input type="checkbox"/> (n/a) Indemnity letter | 12. <input type="checkbox"/> () Other (to specify) _ |

This study has now been.....

- Approved:
- Conditionally approved pending :
- Approval denied

Comments

Date of review

19/04/04

Signed

B. Wakeford.

Pp: Chairperson/Co Chair Dr Foley-Nolan / Dr Calvert
South Eastern Health Board Regional Research Ethics Committee

Appendix 2

CONSENT FORM

The purpose of this interview has been explained to me and

I, the undersigned, (please print name)

agree to be interviewed.

I understand the information obtained will remain confidential
and all reference to persons and details will remain anonymous.

This research is in part fulfilment of the requirement for MSc. in
Health Services Management for Trinity College, Dublin.

Signature: _____ Date: _____

Appendix 3

LETTER OF INTRODUCTION

Muskerry House,
Creagh,
Gorey,
Co. Wexford.

19th January, 2004.

Dear Sir/Madam,

My name is Ann Coakley, I am the Director of Nursing in the District Hospital, Gorey, Co. Wexford. At present, I am studying for my Masters in Health Services Management and as part of the requirements for this; I intend to conduct a study of older people's views of the services needed and available to them in the North Wexford Area.

I would like to invite you to take part in this study. All information given will be treated in the strictest confidence and names will be omitted to maintain confidentiality. The information given by you will be available at any time, for your inspection.

Yours sincerely,

Ann Coakley,
Director of Nursing,
District Hospital, Gorey.

Appendix 4

QUESTIONNAIRE

1. Do you know about what health and social services are available to you?
2. Where did you hear about these services?
3. Do you think there are adequate services available for people, as they grow older?
4. Do you receive any services at present – e.g., chiropody, home help, G.P?
5. Do you think that you would avail of, or have you been offered, a home help service.
6. What do you think of the meals on wheels service?
7. What type of transportation have you used in the last six months.
8. What changes could be made or provided to make life easier.
9. How would you describe your health?
10. How do you keep healthy?
11. At present what do you think you would need to remain in your present state of health and mobility?
12. What could be done to make this area a healthier place to live?
13. Do you need help with one or more tasks of daily living – shopping, housework, preparing a meal, taking a bath, shampooing hair, foot care, etc.
14. Where do you think you would prefer to live, as you get older?
15. What would you prefer to be referred to or called – older person, senior citizen, elderly.
16. Do you think older people should be allowed to work?
17. What rights do you think you have as an older patient – as an older citizen?
18. How do you decide if you need to attend a doctor for a complaint?
19. Can you tell me about the last time you called to see your doctor.
20. Who made that decision?
21. What were the circumstances (time of day, weather, distance)?

Appendix 5

INTERVIEW A

I: Interviewer

R: Respondent

I: What age did you retire at?

R: I retired at sixty, actually I retired when I came to Ireland, 5th April 1989. But until I was sixty I was on disability because my diabetes was out of control at the time when I came to Ireland. I didn't realise it until I had to go to Enniscorthy. That time you went there for a check-up if you were on disability and came from England. When they were checking my diabetes the doctor said to me "do you know what else is wrong with you?" and I said "no I don't know" and he said, "you're a severe asthmatic". I didn't know that until then, I didn't know that I had bronchitis till then.

I: Since your retirement, have you any trouble filling your time?

R: Oh my God! I haven't got enough time. I really don't have enough time to do the things I need to do!

I: Do you know what health and social services available to you?

R: I know that anytime that I have ever looked for anything I can get nothing, and I mean that very sincerely. When was very bad and I was out in, [previous house] fair enough we were fairly comfortably off, but you see when he died his money went with him. Pensions and life assurance died with him, and it was a good one. When he was ill I took him to Wexford. I never knew you could get carer's allowance.

I: Did you get the carer's allowance.

R: No, because it was means tested and I was over the limit. I have never been able to get anything. When I fell and broke my hip my sister came to stay with me for two weeks. I asked if there was any help I could get. Nurseorganised the toilet seat for me and she got bars but they weren't good enough. I contacted... the O.T. and she came and measured the doorstep for the rail. I waited for six months for that and in the end I went off and paid for the job to be done myself.

I: How do you get to town and out and about?

R: I'm not able to drive at the moment and only that I have very good neighbours and they bring me shopping I would have to hire a taxi. I had a little mini

stroke in January and since then I am afraid to drive. I still have the car insured and my license is up to date so I'm hoping in the summer I'll feel well enough to be back in the road. You see I don't like asking people to do things for me. I would like to see a service that if you were not able to get out, someone from the health centre would phone. They don't have to be a nurse. They could check if you are all right, or if you need anything like maybe to organise a taxi to bring you to the Dr. or have someone call to do your shopping. It would make you feel less dependent on your neighbours. I am always afraid...or [neighbours] will get fed up of helping me.

I: What do you think of home help services?

R: Well as I said, I don't seem to be able to get anything. When I had a mini stroke in Jan. I looked for home help but I was told I wasn't entitled. I have a woman who comes to me once a fortnight. She does the heavy things like the Hoovering and she changes my bed. I usually take my shower when she's here because I feel safe when someone is in the house while I'm in the shower. I have someone to call on if I felt weak or anything like that. I pay her €40 a time. It's worth it to me, and it keeps me feeling independent.

I: Do you find it hard to manage?

R: Yes, at times I find it is hard to manage, especially when insurance is due, or an unexpected job that has to be done in the house. No one makes allowances for you living on their own. It still costs the same to maintain a house the way you want it to be when you are alone. I got rid of a lot of ornaments and bits of furniture to my sons. It is easier to move around, less clutter and less dusting to be done.

I: Would you know how to find out why you are not getting home help?

R: I asked up in the health centre but it was unsatisfactory. I think it is because I live a bit from the town and there are not many home helps in this area that have cars. I think I'll need a home help in a year or so.

I: Do your family live near you.

R: No, I have one son who is married and lives in England. He visits when he can but he has his own problems, his wife is in a wheelchair..... My other son lives in Carlow and he comes over every month. They have their own lives to lead I don't want to be bothering them if I can sort things out myself.

I: Do you know if there is a chiropody service?

R: Oh yes, we had so many free visits for the chiropodist then the service stopped. For a while Gorey Local Social Service subsidised it to €5 for each visit, up to three visits. I go to G.... and pay her myself. I would rather do that than go and have my hair done as often. I need to have my feet done regularly because of the diabetes you see. I think you can have it done in the Day Centre

but you have to be going there. I go for Reflexology as well. I have the arthritis and to keep me right I used to go to the Physiotherapist in the Hospital. But as you know she has left and there is no one yet to replace her, I can't afford the Physiotherapist privately so I go to the Reflexologist and it helps. There definitely should be a full time Physiotherapist especially for people who have chronic conditions and need that therapy to keep going.

I: Have you been asked to attend the Day Centre?

R: No I haven't. But I think you have to be very old or frail to go there. I know from the women in the club that there are limited places and I wouldn't like to take a place on someone who needed it worse than me. Also, the Nurse never mentioned it to me and I did not like to ask.

I: Do you think older people are politically minded?

R: Well I am a member of the Senior Citizens Parliament and I notice people are becoming more aware of their rights. We have a long way to go to make the politicians sit up and listen to us.

I: I know you mentioned the idea of a service where the Day Centre phones you to see if you were in need of anything, but are there any other services you think you may need as you get older?

R: I think there should be a service like my sister gets in T.... There the laundry is collected and brought back to you. I think that would be a great help because it can be heavy trying to hang clothes on the line especially the sheets and then you are dependent on the weather, and not everyone can afford a tumble dryer. I think that it would be a little more dignified to have someone call for your washing than expect someone coming in to sort your dirty clothes.

I: That sounds a good service and is it not available here in Gorey.

R: No, but maybe that's something we could look into in the club.

I: Moving on now ...What about the meals-on-wheels, do you know much about that service.

R: I have never had need to use it, but for anyone that is, I think it is a good service. You know if you can't cook for yourself and have no one to cook for you, it's great to know you will get a dinner. I don't know how much of the service is out there. I knew people who delivered the dinners. They said that the people were delighted with their meal but they often wondered was it the meal or the call every week. I wouldn't mind having a meal delivered to me if I needed it. But some restaurants deliver if you make arrangements with them. They have a special rate if you are a regular. I know one man who has his dinner delivered from ...everyday if he can't get out, or he has his main meal there when he is out and about. I think that keeps you independent.

- I: What do you like to be referred to now that you are getting older?
- R: I don't like being referred to as the elderly. You feel that you are all the same because you are a certain age. I suppose senior citizen is preferable.
- I: How do you rate your health
- R: As I have said I have a lot wrong with me but I would still say I am in good health. I'm still getting around and going to the club on Wednesday evenings. I go to the house of stories out in on Tuesday nights. There you have young and old together, and we sing some old songs.
- I: Where would you like to live, as you get older.
- R: I would love to live out my days here in my comfortable home if I were able. I would hate to be a bother to people especially my sons.
- I: Do you worry about security.
- R: Well, I do but I have the phone watch in and I have my pendant alarm and I feel much safer with that.
- I: Thank you for allowing me the opportunity to interview you this afternoon.

INTERVIEW B

I: Interviewer

R: Respondent

I: So, I'm just going to use this tape and I hope you'll forget about it while I have it in me hand. I want to find out what you feel you need, as you get older from the Health Service and what you know about what health and social services are available to you.

R: Do I have to talk on pensions or anything like that?

I: No, No, I know you have a pension, but do you know about home help and things like that.

R: I don't need a home help, cause I'm capable of looking after myself, so far anyway. And I have a good daughter living here in Gorey, and she's very good to me,... and she's the chef in And I have another daughter living in Dublin. Well she doesn't come every week, she comes once every 3 weeks or once every month. As regards that I'm very lucky

I: Right, and if you wanted services, would you know where to go.

R: Yes I have the phone, I have the emergency phone for Bunclody and I have to wear this thing around my neck.

I: The pendent.

R: But I don't wear it all the time, I've never put it on me. If I wanted any, if I took suddenly ill or anything and my contact is my next-door neighbour..... and my daughter.

I: But where did you hear about services.

R: Well I was on the Social Services Committee for years, and then I opted out to let younger people come on. And I know what they can do for the people, if you need any help or any advice. You can always approach them. But I never had to do that, but at Christmas time Social Services was good to me. They would leave me my box of groceries for over the Christmas. I don't ask for them. But my name is on the list for so long, they have always come to me

I: Right, Do you think that there is adequate services for people as they get older, now I know you are independent but do you think, say if you weren't independent.

- R: I don't think so. There could be a little bit more. You know we are the people, who have made this circle. I was just listening to Mary Harney this morning on the news and we are the people that should be looked after, the elderly. I'm 84 years of age now in May
- I: I would of put you in your 70's
- R: I have a son 62 in England. He's over there for nearly 40 years
- I: But what services do you feel there should be more of, have you even thought about that
- R: No.
- I: On the line of home help or meals on wheels.
- R: The meals on wheels I'd disagree with that, you don't know what your getting half the time. Meals on wheels are great, I'm not running them down or anything, but then there's people that don't like this nor don't like that, you know yourself. Everyone has his or her own taste. I don't like a stew now, my next door neighbour would love one, I always ask myself that, I wonder do they eat it.
- I: Do you receive any services present, chiropody, do you go for chiropody.
- R: No, I don't go for anything like that at all. I have my eyes tested once, maybe every 2 years with
- I: And do you go to the G.P, your G.P often.
- R: Well I'm with Dr., I was with the old man. is my doctor now. I'm only on one tablet a night, they're a relax tablet, that's the only medicine I'm not on anything else. I take these my self, these are my own suggestion.
- I: Right, that's Cod Liver Oil. And do you take the flu vaccine, do you go for the flu vaccine.
- R: No, I'm afraid of needles.
- I: Right.
- R: Thank God I've never had a cold the whole winter
- I: I know you live in the town, is there transport available to you, if say, you have to go for an appointment to the hospital, do you find the transport good for older people
- R: Well there's only one objection I'd have, lets say I had to go to Wexford Hospital or Waterford. It's a bit early. I'd have to walk from

..... to the hospital to get me transport, which is a bit lengthy, cause it's all up hill, I think it (transport) should call right to their door That's my opinion anyway. Sometimes, if it's an early start if you have an appointment for Wexford or Waterford for 9.30, you have to be leaving at half 6 or 7 o'clock. It's an early rise for an elderly person. Thank God I never had to go.

I: But you do know others that have.

R: Oh I do. As a matter of fact she lives across the road from me

I: What changes then could be made to make life easier for people.

R: Well I think there should be more facilities for the elderly.

I: Like what.

R: Like getting to different places. People who have no transport they have to hire a mini bus and its costing money, if there's no C.I.E bus at the waiting point, if none of the family have transport or if the family is away or working all day. They won't be home till late in the evenings. Because most times, old people don't want to pull in on their family, they want to remain independent. They want to stay as independent.

I: How do you keep healthy

R: I walk, every day, never miss, I'm never here in the afternoon. Well I have a routine, in the morning now when I get up I get me breakfast, make my bed, light the fire in the morning now round 10 o'clock I go to mass some mornings not every morning, but I go to the grave yard in the morning, My husband is 18 years dead now in June and I come back then and I prepare, (grandson) lunch He gets his lunch here with me every day causeis out every day. And then I go to her house, I do the ironing and tidy up, do the back.

I: So you're working for your daughter, really

R: No I don't work for her, but I help her, I don't except money from her. She is very good to me. They brought me out last Sunday to the house; I had my dinner and tea. But I'm active, I don't walk to the club every Wednesday night I'll you the story about that, I don't want it on that. I get a lift every Wednesday night with the mini bus. But there's a bit of a problem now at the moment with the mini bus

I: Do you want me to record this, I know that transport is important for people

R: Very important. It's the only night of the week, the best part of them get out.

I: I know, so it's a social night out.

- R: The cup of tea the bit of crack and a bit of dancing and the music. So really there are not enough services for the elderly
- I: Right and what, where would you prefer to live if you get older, I know your 84
- R: You know, I've started, I gathered my crumbs here and I'll stay here now, unless that I, which I never been, if I have to go to hospital.
- I: You would prefer to stay your home
- R: Oh yes.
- I: And then could you imagine somebody coming in to do a bit of home help or...
- R: No, my daughter would come to me.
- I: Your daughter right and what about day centres.
- R: I've never been, I've never been to the day centre, I've never got an invitation to go to the day centre. I'm too well so(the nurse in the day centre) says anyway. Well I'm 29 years in the club and 12 years secretary.
- I: That's fantastic. Now you know as people, as you get older, what would you like to be called: older person or senior citizen or what?
- R: Senior Citizen sounds very good. A lot of people say oh she's old, no it's not the same Senior Citizen is better
- I: You prefer that, you don't like being referred to as old.
- R: No, not at all. Neither would you. When you come on into 60 or 70 well that old thing.
- I: Do you think older people should be allowed to work, you know beyond 65 years.
- R: Well, yes, I think, if people, if they're mobile and they have it up here. (pointing to her head.) I think they should be allowed to 65 at least not at the latest
- I: But after 65.
- R: Well it's time to retire then.
- I: What rights do you think you have as an older person or senior citizen?
- R: Well I think older people should be now, held up and well respected. You know looked up to and looked after properly. That's if they need looking after,

but they're anyway comfortable. I'm all right now, I'm comfortable enough and I have a good family. I'm not in want, and I'm independent and I can go out when I like and come in when I like etc. You know I'm not relying on anyone to help me any way but I've a very good family.

I: What way do you see society looks at older people.

R: Well she is getting older and she'd be no good to anybody you know what I mean, she is finished you know what I mean. They are sort of in the way in other words. As you know yourself when you get old, you know how many people are gone to nursing homes and all their families are married and they're out working, which is a very good idea, they are well maintained in these nursing homes. I think in some, with some they are an encumbrance.

I: Is it the way they are made feel.

R: I know, unwanted.

I: What about young people's attitude towards older people?

R: Well I don't think the young people at the present day have much thought. I'm not putting them all down as wrong, but there is a lot of them have no respect for the elderly, none what so ever.

I: Have you encountered anything?

R: Yes.

I: Can you describe it?

R: Well when a young lad will turn around and tell you, you're an old one, you have no sense, an eight year old.

I: What did you do?

R: I just passed along. It's sad though I'd say they here it from home.

I: How would you decide if you wanted to attend the doctor for a complaint.

R: I make an appointment.

I: And when was the last time you went to the doctor.

R: To the doctor, don't ask me, I get my prescriptions, which is for three months. I will give him a tingle, ...or one of the receptionist answer the phone and they will know me. I will do it in the morning and drop in, in the afternoon and collect it I don't think I have seen a doctor in six or seven year.

I: And how come you are on tablets does the doctor not review your tablets?

R: Reviews them no

I: He doesn't review them; he doesn't see you and see if you need them at all.

R: Not at all.

I: You haven't seen the doctor in six years.

R: You see I explain to him now, when I come in here on Wednesday night out of the club. You are coming in to an empty house. Well as you know at the moment the times that are in it. You understand me I know, I get a cup of tea and a fag.

I: The smoking ban won't bother you then

R: No it doesn't bother me cause I don't smoke that much. It's for company and I take one tablet; maybe half a one and I know that I am settled for the night the tension goes.

I: You take them every night.

R: Not every night. But the tension gradually flows away. No he (The GP.) never asks to see me, but he sent me a letter there early in the year for me to go for a flu injection I turned a deaf ear to it.

I: Do you think that may be you should be seen more often.

R: No, because there is nothing wrong with me. Why should I waste South Eastern Health Board money for to go, to have a chat with him.

I: How long are you a widow now.

R: Eighteen years in this June the 10th.

I: And how old was your husband when he died.

R: He was, wait now for a minute, I'm eighty-four and if he was a live to day he would be eighty-nine, this coming September.

I: He was five years older than you. When you were working what did you do, were you ever in paid working or did you give it up at 65.

R: Well I am on retirement pension. I was nineteen year a bank cleaner and caretaker of the old Bank of Ireland where ...is now and then I moved down to the middle (Bank). I was insured there. I was twenty-one years in primary schools and secondary school. I am still working but don't tell anybody.

I: Where are you working.

R: I am three hours a week with.....I am thirty-eight year with her.

- I: And you're saying that people should give up at 65 and yet you are still working. Well you don't obviously have trouble filling in your time.
- R: No, if I had nothing to do, I'd get up and find something to do. I never get lonely, I never get depressed or anything like that. I keep going, in the evening now that the extra hour is gone on, I'm down the road with me dog.
- I: Do you think that there actually are enough services for older people?
- R: There are a lot, a good lot of services. I mean to say they have, the hospitals here in Gorey. It is a beautiful place. I don't know much about St John's, if there is enough room, if you get a bed in St John's, that's if they have to go into long term. But while they're in their own home, sure the doctor's there at hand and everyone has a phone now. They have nothing to do now but to ring their family or the doctor. I think services are very good for the elderly. The only thing about elderly people they are not getting enough pensions. You know the pension it is only pittance money. When you think the tribunals are costing what a daily what a pensioner gets a year. I'm ok now I'm all right, I've no complaints, and I have a hundred and seventy seven sixty a week. But after the end of this April we are cut back € on our fuel. We got €10 of a rise in December and our bins are almost €300, which they should be given free to pensioners.
- I: The fuel allowance it is cut now, do you think that it should be kept on?
- R: It should be kept on the whole year round; because there is a lot of people relying on electric cooker, I have a gas cooker, and they may want to switch the electric fire on in the afternoons as you know it gets chilly enough summer evenings. I think it should be left with them, but €; it cost me €50 a fortnight for fuel now..... We are not getting enough, they could bring it up to the two hundred, which they hope to do, but there will be many an elderly person won't live to get to two hundred euros.
- I: Do you ever think about dying?
- R: I have that by long go, I have all me arrangements made long go. I often pictures myself above in a coffin in...s funeral home. You might as well have a laugh as not, I do. My mother was ninety-nine when she died, you weren't up in the hospital at the time Sister ...was up there, nine days my mother was in it. She was piping a hundred when she died she was ten years dead this August and she would have a hundred the following June. She was nine days only nine days in it. Father was seventy-eight but he died in Dublin. But she had her senses, she died of kidney failure etc.... its complicated, but she had her senses up till the time she died.

- I: Would you like to do that?
- R: I wouldn't mind if well, if I can get the shoes on me and get out, I wouldn't mind staying there. But there's no point in talking about that now, when the Lord is ready to call you he will.
- I: That it.
- R: You have to be ready to go. And when you think of it, all the people that are fighting to live, and more are going out and getting rid of themselves, it's a sad world.
- I: Do you think that older people are lonely?
- R: I know a lot of people now that would complain about being lonely. and a lot of them elderly they never complain, she's a wonderful woman, she's always out.
- I: What's your views on say security in the home for older people what do you think about that, you just say when you coming in the evening after being out, your kind of a little bit anxious.
- R: More so in the wintertime, but not too much in the summer time.
- I: Is there anything in your view that you think might.
- R: Well I think the government should supply free alarms to the elderly. You know get the alarm in to the really elderly people. There are alarms on private houses, but old people are they're breaking into them.
- I: That's right
- R: But I think there should be more facilities by all means, definitely the transport, the people from the country where there's no proper transport. If it can be made available of course. And you know yourself the hired mini bus just from... to the Hospital and was telling me €6, that's a bit sticky, she was getting her husband up to the hospital for a rest, in that line there's not enough facilities.
- I: I think I've exhausted you enough.
- R: No you haven't I could talk all day to you.
- I: What do you think of younger people in general.
- R: Well some are o.k. I can't be blacking them all. There are some very good students and very respectable students, I know a few of the girls and boys that pass up through the street and if I were at the door, they'd always give me a wave. But I worked for 21 years in that Secondary school. All them boys

that's gone now. They had the greatest of respect in the, of course I was quite younger then I'm 22 years out of it.

I: You still would have been in your 60's.

R: They always had great respect for me and it was Mrs ...and as for the Brothers that I worked with they were top. They are in contact with me every Christmas. Its lovely to get a card from somebody that you haven't seen in a while. Brother ...always contacts me at Christmas. It is lovely to be remembered. As for the boys that were in it, now some of them are doctors, lawyers and everything else, to this day if they meet me they always have a Hello for me.

I: Do you think the same would apply now?

R: I would say it wouldn't be as good now as it had been then but then when your working among people its different. But no, there's not the same atmosphere among the youth of today at all. You know they're different, different generation altogether

I: You were in the Senior Citizens Group, what do you think of day services?

R: Well the day centre down here if you are refereeing to the centre down in... Well I think they are doing very well down there and they're looking after the elderly both from the town and the country. They're brought in there and they get a lovely meal and they have a bit of fun down there and I think they've been looked after very well, and wouldn't they be lost without it especially the people that living in the town, its just like the week of the elderly. We go to the week of the elderly, every year in May that starts around the 16th of May. There are people there that have come in from the country and they haven't been in, and they haven't seen you since last year.

I: Do you think there should be more done for those people?

R: Oh definitely, But there's nowhere to bring them, only to the centre. There's no other facilities for them, but if they wanted a little bit of respite in Gorey Hospital, lets say I was minding somebody and I wanted a week away

I: So you know about Respite

R: Oh I know about that. You know its grand and its lovely to be so welcome up there, and it's a beautiful hospital, every comfort. They have everything they want, good staff. Very kind people in it I think their facilities are very good.

I: Thank you for allowing me the opportunity to talk with you today.

INTERVIEW C

I: Interviewer

R: Respondent

I: How old are you.

R: I was born on 13th April, 1928.

I: That makes you 76 this April.

R: 75 years at the moment.

I: Do you live alone.

R: I live alone.

I: Were you married.

R: I was married for 35 years and he died 20th January 1981.

I: How old was he when he died.

R: 57.

I: Did you work outside the home.

R: I went to England for a while. I did auxiliary nursing in England in South Western Hospital, in Cambelwell. I came back to Ireland in 1959; I came home to have Paddy here.

I: So you didn't work after that and you never worked outside the home again.

R: No.

I: Do you find that you have trouble filling your time.

R: No, not really. I enjoy going up to the Old Folks and doing a bit of sweeping and tidying out the ould cupboards. I'm after being up there this morning and sorting out the delph and things like that, you know.

I: What do you know about the Health and Social Services that are available to you.

- R: I don't know much about them because I have never really asked them for anything. I know I was a long time waiting for the hearing aid, all right, but that is a different crack, you know. They have knocked us down now with the transport for the Old Folks on a Wednesday night. You probably know all about that.
- I: I'm more concerned about do you know what services are available to you if you weren't able to do your own housework, what would you think of home help and things like that.
- R: I can't say much about them, I never had them.
- I: Would you consider using Home Help if you couldn't sweep the floor say, or you needed to light your fire.
- R: I suppose so, if you are not able, I would.
- I: Do you know much about other services, like the Public Health Nurse.
- R: I wouldn't say I do.
- I: Do you go to the Chiropodist.
- R: I don't, no.
- I: Do you go to the G.P.
- R: Once in a blue moon. He gives me ventolin.
- I: How do you rate your health, are you healthy.
- R: Yes, so far so good. I eat very well.
- I: Have you any arthritis.
- R: No, so far.
- I: And you are able to dance away.
- R: I'm dancing away. I'm dancing tonight up in the Old Folks. I look forward to going there. I must be going over there for thirty years or more.
- I: What do you think of Meals on Wheels.
- R: I have heard mention of it, but I have never heard tell of people getting the meals.
- I: What would you think of it, if you needed it.

R: I suppose anyone who needs them it's a good idea. Anybody not able to cook they are sure of their dinner anyway. Your breakfast and your dinner are the two most important things. It keeps you going.

I: And would you have a good breakfast.

R: I would.

I: What would you have.

R: I have two weetabix, a banana and a yogurt. Then a pot of tea, maybe a slice of toast and maybe not, and then my few cigarettes.

I: Would you ever consider giving up cigarettes.

R: Oh no, they are not doing me any harm.

I: Do you walk everywhere, do you drive.

R: I walk everywhere.

I: If you need to go somewhere, how do you get there.

R: The bus, free travel.

I: And do you use it much.

R: I do, I go to Arklow and to Wexford.

I: And you don't need to go to hospital, or anything.

R: No, so far so good.

I: What changes do you think could be made to make life easier for people as they get older.

R: Keep the vandalism away from people anyway.

I: But to make it easier for you as you get older, what do you think you might need or what needs to be put in place.

R: What would you need – when you get older and you are not able to walk you go into a home somewhere, isn't that right.

I: Have you got a pendant alarm

R: Oh yes, I got it there not so long ago.

I: Do you any other types of security are a good idea, what about lights around houses.

R: Oh that is a good idea, more lights on it, yes.

I: How do you keep healthy.

R: It's just the way you feel, I suppose.

I: Do you walk much.

R: Yes, I'm out every day.

I: And the dancing then, with the Old Folks.

R: Yes and any parade down Ballygarrett or wherever we go.

I: Do you need help with any tasks of living, like shopping, housework or anything.

R: No, not so far.

I: But if you couldn't go out shopping, who would do it for you.

R: I'd have to ask one of my own, wouldn't I?

I: You have family around.

R: Yes.

I: For housework, you wouldn't mind a home help going in.

R: I wouldn't, no.

I: Do you ever go to the Day Centre.

R: I did go. Nurse told me I was too frisky for down here

I: What do you want to be called – older person, senior citizen, over 65.

R: Old people, senior citizen is only after coming in the last so many years.

I: And what do you yourself prefer to be called.

R: I don't care what they call me, that's the truth.

I: But if you had a choice, if you were to be referred to Mrs.

R: Mrs., she's an old woman, and that's it.

I: As an old person, do you think older people have enough say in what goes on.

R: I don't know really, to be honest with you, I wouldn't pinpoint it. Because when are old people asked for their opinion, really. No one has ever come to me and said, I want your opinion ..., you know.

I: And do you think they should be.

R: Well maybe they should be, with all the vandalism now and all the people that have come into the town, it's not Gorey at all now.

I: Roadways, paths or transport, do you think their views should be asked before these things go in. For example, Meals on Wheels, some people wouldn't mind them but others wouldn't ask.

R: No, I suppose they would be too proud, but I wouldn't be. If it had come to the case, I'd say thank you very much.

I: If you decide to go to the doctor, do you make an appointment.

R: I just walk up to him and if I can't get in then that's it, I go another day.

I: Do you think that the doctor on a regular basis should contact you

R: The doctors do be busy they are heavy worked.

I: Do you think that you should have a check-up.

R: From what I hear about this so call "Doc" or whatever you call him, "Caredoc", one woman had to go to Enniscorthy at two o'clock in the morning to get her son to drive her in her nightdress. There was another young woman down in the Garden City and she rang him around the three o'clock and they said they would be four hours, could she come to the Gorey Clinic. As her husband said, "if she was able to get up out of the bed, I wouldn't ring you". Sure what use is the "Caredoc" then?

I: Has the Public Health Nurse ever called to see you.

R: No, sure there is no need for her so far.

I: Do you think that once a year you should be sent for just to have your blood pressure checked or do you think there is a need for that.

R: Ah! Well the doctor often does that when I would go in to see the man.

I: And you are happy enough with that.

R: Oh yes, I'm happy enough now the way the doctor treats me.

I: But if you needed something, would you know where to go.

R: What like.

- I: Say for example, you needed a raised toilet seat or a grab bar on the side of your house. Would you know where to go.
- R: No, unless up to(the caretaker) here in the Clinic.
- I: There is nowhere that lets you know about different aids or things like that. You wouldn't know what to do or how to access the Public Health Nurse.
- R: No, I wouldn't know one of the Public Health Nurses. But as I say, so far so good. I don't need them.
- I: Where would you prefer to live, as you get older.
- R: Where I am, but my name is down in the County Home.
- I: Do you think the fuel allowance should be kept on during the summer.
- R: I suppose they could like, but I'm happy with what I'm getting.
- I: Do you think the pension is enough.
- R: Well I get one eighty something.
- I: Do you think that older people should get out more, go for lunch maybe.
- R: Yes.
- I: Thank you for your time and the opportunity to interview you.

INTERVIEW D

I: Interviewer

R: Respondent

I: Do you have trouble filling your time during the day.

R: No I don't because I go out and I mow the grass and cut the hedges and I do everything outside as well.

I: So your days are busy and you are involved in the social club for senior citizens.

R: Yes, I love that club it's great.

I: And would you think of joining the new club, the active retirement group.

R: No, I'd prefer to stay in my own club

I: How would you describe your health?

R: Well I know I have diabetes and I have thyroid and blood pressure but I'm on tablets for all of those and it keeps it right.

I: How would you rate your health?

R: I'd say it is good.

I: Do you keep an eye on your diabetes.

R: Oh I do.

I: Do you know what social services are available to you now that you're getting on.

R: Don't really. No.

I: If you needed anything, where would you go? Would you know where to go to look?

R: I wouldn't. The only thing if I got sick I have my phone here. I press that and my daughter will be contacted. So she'd get me whatever I wanted then.

I: If you needed to go to the doctor, how you would go about it.

- R: Well if I needed to go to the doctor I'd just get up on my bike and go into him.
- I: Would you know anything about the Health Centre.
- R: No I was only there once when I had to go up to get my eyes tested. I didn't get them tested there but I had to go up with the form there. That's about all I know about that. I used to go up to it for Mrs
- I: And would you know anything about the public health nurse or what she does.
- R: Well one public health nurse came. She's gone now and she said to me 'do you want a nurse calling' and she asked me what I was doing 'Oh she said you don't want any nurse she said I won't be calling to you.
- I: Do you think they should make contact with you even though you are well so that you have a face to a name.
- R: Of course, yes it would be nice all right.
- I: Do you think there's enough services for older people.
- R: I don't think so; I wouldn't think there are enough services. And one thing I think has gone wrong since I came over here, which is 46 years ago, when I came over here there was only one house down the road, and.... off down the Avenue. I had more company than I have now and there are nine houses around now. I never see anyone.
- I: Everybody's busy working.
- R: Yes, everybody's busy, they never call to see you or anything, you know. I think that's gone. And it was nice to have a neighbour; you could call on if anything did happen to you.
- I: I suppose really, the need for Health Services and such are needed because there's not a community.
- R: There's not a community like it used to be. It used to be years ago, every ones neighbour was running into every ones house.
- I: What services do you think are good for older people; that you know of, for example chiropody, or anything like that?
- R: No, I haven't, I never had the need to use it. But, I would use it if I thought I needed to use it.
- I: And you know you're entitled to chiropody.
- R: Yes. I know as a diabetic about looking after your feet. I know that, because my sister had it, and she let her feet go and she died aged 66 because she didn't look after her feet.

I: You've never gone? And are you able to cut your own toenails.

R: Oh, yes.

I: Do you think that as you get older, you'd avail of home help.

R: No, I wouldn't.

I: And, why.

R: I prefer to do my own work.

I: But say, you just couldn't get the hoover out someday or the brush and shovel. Would you then consider it?

R: No. I'd make me daughter come and do it for me.

I: So, your daughter would be willing to do it for you.

R: Oh, she would, yes.

I: And what if your diabetes went a little out of control. Would you get worried then that you'd have to go in anywhere?

R: No, it wouldn't worry me, No, it wouldn't worry me at all.

I: Where would you prefer to be as you get older?

R: I wouldn't mind if I had to go to Wexford, but I wouldn't want to go a nursing home.

I: So you don't think even to keep yourself at home, you bother using Home Help Services.

R: I wouldn't.

I: You wouldn't like somebody coming in.

R: I'd prefer not to have them coming in.

I: What's your view on the meals on wheels service.

R: I suppose that's great for anyone who is not able to make his or her own meals. I think it's great for them.

I: Do you think there's enough of that service?

R: No I don't think there's enough. Because there are a lot of old people now. And some like my age, they are not able to walk or anything you know. And it would be handy.

- I: What you think about other services, do you think anything else could be used in the community to keep people at home, like doing washing and things like that.
- R: Yes, that's true.
- I: What do you think about those sorts of things?
- R: Yes that would be great if there was something like that for people that are not able to do it, particularly the sheets and blankets.
- I: What do you think you need to keep yourself in your present state of health, have you thought about that.
- R: I think I'm going to go on for ever, I think, no I haven't thought about that.
- I: What do you think could be done in this area to keep people healthier, for it to be a healthier place to live in?
- R: Well I think what happens a lot of people, I know of a women down the road, when they wont get up and out or do anything, they get crippled up and they are not able to stir, that's an awful way to get. I have a cousin now in Gorey and she's not as old as I am. She was telling me the other day she could not walk to the post office. But I was talking to her daughter and she said she just doesn't want to do it, you know.
- I: She might be a bit fed up maybe; she might be depressed.
- R: Maybe that's it, some people get very lonely, which I never do thank God.
- I: Do you think that many people in the club are lonely or do you think they're all happy.
- R: No I think they're o.k., most of the people that come to the club are all very happy.
- I: Do you think that most people are not lonely either.
- R: Yes, that's true.
- I: Do you need any help with shopping or housework.
- R: No.
- I: Bathing or anything like that.
- R: No, I don't.
- I: What would you like to be called now that you're getting on in years, would you prefer the term older person or senior citizen.

R: It wouldn't matter but I think senior citizen now is nice. Even though up in the club they don't like to be called that.

I: Thank you for affording me the opportunity for interviewing you today.

INTERVIEW E

I: Interviewer

R: Respondent

I: Do you know about what health and social services are available to you.

R: I would know about some, but I don't think I know about all of them.

I: Where did you hear about these services.

R: From my friends in the club and the doctor.

I: Do you think there are adequate services available for people, as they get older.

R: Yes, I think the services are very good and hopefully they will improve every year.

I: Do you receive any services at present.

R: Yes, I use the chiropody service regularly. The Public Health Nurse called after I came out of hospital after my bad chest infection. She was very nice. I told her my daughter would help me. She said to phone the clinic if I wanted her – I haven't yet and that was nearly a year ago.

I: Do you pay for it or do you get it as a free service.

R: No, I have to pay for it myself, but I'd rather do that and have my feet right than get my hair done.

I: What do you know about the Home Help service.

R: Not a lot, my neighbour got it recently and she finds it very good, but she only gets it for one hour a week.

I: Do you think that you would avail of it yourself.

R: No – my daughter comes every day to see me and she does the heavy work for me. My son is in the process of putting in a new wooden floor. They're very good to me.

I: What do you think of the meals on wheels service.

R: I think it is a very good service, it guarantees hot meals at least one day a week for people who without it, might not get a proper meal at all.

- I: What type of transportation have you used in the last six months.
- R: Well, I have my bus pass, so whenever I need to go anywhere I know I don't have to pay, but I rarely use it. I would only have used it twice this year.
- I: How would you describe your health.
- R: I keep in very good health overall, I get the usual colds and flu in the winter time and would have the odd ache or pain but Thank God, other than that I am very well.
- I: How do you keep healthy.
- R: Well, I don't drink or smoke, so that's a good start. I try to eat well and keep myself fit by walking as much as I can, when I am able. I take my vitamins every day and drink plenty of water. I go to the club every Wednesday night. We used to have a free bus, I'm sure you have heard about that.....
Now my daughter brings me down and one of my friends from the club brings me home. I love the chat and company of my old pals.
- I: Do you need help with one or more tasks, shopping, housework, etc.
- R: My daughter comes up in the car to bring me shopping. I would be all right going down if I did walk, but I'd have trouble with the hill coming back.
- I: Where would you prefer to live, as you get older.
- R: I like it here. I got one of these council flats. I'm near to everything and I would hopefully end my days here, but if I couldn't, if I got bad, my daughter would take me.
- I: What would you prefer to be referred to or called – older person, senior citizen, or elderly.
- R: Elderly, I suppose. Senior citizen is very impersonal, don't you think. I don't mind really, but I don't think I would like to be called a pensioner.
- I: Do you think older people should be allowed to work.
- R: Yes I do, I feel it's very unfair to put the older people out to pasture just because they have reached a certain age, it's not like their brain stops functioning when they reach the age of 65 or 70, does it. To be able to continue working, even part time, gives a sense of worth and dignity to a person who has worked all their lives and because they have reached retirement age, have to pack up and go home to do nothing. I had to retire early; I was a night attendant up in the hospital that was before your time. I got dermatitis and it became very severe I couldn't hold a thing when it was first bad. I missed the patients when I had to stop. I get a pension from the health board as well as my old age pension.

- I: How do you decide if you need to attend a doctor for a complaint.
- R: I try to take care of myself as best I can, for minor complaints I would take something I can buy in the chemist, like paracetamol for pains and aches and such things, but if I had a flu or chest infection I would go to the doctor straight away to have it seen to. Any he keeps a check on my dermatitis.
- I: Can you tell me about the last time you called to see your doctor.
- R: Well, it was some time ago now, but I got a bad chest infection last winter. It started off with a bit of cough but it got worse and worse until I could hardly catch my breath. I had to go then and get an antibiotic, that's the time I ended up in hospital.
- I: Who made that decision.
- R: Oh I knew myself I had to go to the doctor, I felt myself getting worse and getting all caught up on the chest.
- I: Did the doctor give you the flu vaccine.
- R: Yes, I got that in September, that year.
- I: Would you have any complaints about your G.P. or the G.P. Service.
- R: There would be a few things, but I wouldn't like to complain, they would think you were ungrateful, after getting the Medical Card.
- I: Do you feel safe in your own home.
- R: Yes, I do but a few new late night discos have opened up in the town recently, which don't close until very late at night, or should I say, very early in the morning and the young people are very noisy coming home from them. I have never had any trouble, Thank God, but if you were any way nervous the noise they make going home would frighten you. I have the pendant alarm, but sometimes I leave it here (sitting room) and it should be by my bed if I needed it. I think everyone should have one.
- I: Are you happy with your Pension.
- R: I manage but you wouldn't go mad. As I said I don't smoke or drink, but any one who does would find it hard to manage on the pension. I think we get very good money in comparison to what they get in other countries, like England for instance. I have a friend over there that doesn't get as much as I do. And as well as my pension, I get the fuel allowance for the winter, so I am quite happy. I suppose they could keep the fuel allowance on for the summer.
- I: Thank you for your time and the opportunity to interview you today.

INTERVIEW F

I: Interviewer

R: Respondent

I: You live on your own?

R: Yes, I do.

I: Do you feel lonely?

R: Sometimes I do, the winter is to worst though, the long nights with no one to talk to. It's not like old times either, you have no one to talk to now, it used to be you could go to a house to visit, or someone would drop in or something like that. Television finished that.

I: Have you a television?

R: I have yes, but I'm not over fond of it. I love music, all right.

I: Do you go out at night yourself, do you go down to the pub or anything.

R: I don't, no, the only place I do go is on Wednesday nights to the club.

I: Do you get a lift in or do they have a minibus.

R: They have a minibus.

I: Do you drink?

R: Well, I used to drink all right, but I don't drink much now because I'm on a good few tablets now for the arthritis. The drink and the tablets don't agree. You do suffer after it. I used to love a couple of pints all right, but then you are the worst of them the next day.

I: What do you know about the Health and Social Services that are available.

R: I don't know a lot about them, no.

I: Do you know anything about Home Help?

R: I do yes, I don't know if I'd get a home help or not – would I?

I: Have you asked for it?

R: I haven't, no.

- I: Do you see the Public Health Nurse much?
- R: I never see her at all, to tell you the truth and I'll tell you the reason I don't see her. I go to the day centre in Gorey, Nurse ... would be there over us. I mentioned that to her one day, we were talking, it's about two or three years ago. I said that the District nurse does not come near me. She said there is no need, I'm here.
- I: That's right, she would sort any problems for you.
- R: She said I needn't worry about that at all.
- I: Can you manage in the house yourself?
- R: Yes, I manage the best I can.
- I: Do you find it hard doing the housework?
- R: No, I was used to it, the Mrs. was in bad health for years. There was three years she was able to do nothing. I had to do it all.
- I: Do you think that if you needed it, you would get a home help.
- R: I don't know about that now.
- I: Do you know of any other home services, Meals on Wheels, or anything like that. Can you cook for yourself?
- R: I do my own cooking.
- I: Do you go to the Chiropodist for your feet – are your toes all right.
- R: I haven't got them done this good bit; most times I get them done in the Centre. I used to go to Gladys Ridley but now they do them in the Centre.
- I: Do they charge you in the Centre to do them?
- R: Not a lot, about three or four euro.
- I: Do you go to the Doctor much.
- R: I do, I do a good bit to the Doctor, I get a bit of trouble with the stomach after the operation.
- I: Who do you go to?
- R: M..... my Doctor.
- I: Do you find him good?

R: I do yes, he is a nice man.

I: Would they have time for you, do you ever feel that you are rushed out?

R: No, he wouldn't rush you at all. I find he is good.

I: What kind of transport have you used.

R: I have no transport at all, sometimes I get a lift and sometimes I get Mrs. C..... I have a pass, but it is no good to me cause there is no bus out this way. What happened about a year ago, this Community thing with the Inch crowd. They put on a bus here to bring people into Gorey on a Friday. The money to go into Gorey was three euros to go in and to bring you home. I went for four weeks but they couldn't keep it going, there were three from Kilanerin and two from Coolgreaney, about five every week. For the like of me, if I had no shopping to do, it would be a bit of a drive to go into Gorey and meet with someone. It was cheap, even if I did not want any shopping, itself.

I: You definitely think a bus is a good idea, to keep you mixing.

R: Oh yes.

I: How do you keep healthy?

R: I suppose doing my few turns, exercising.

I: Do you cycle or did you?

R: I did cycle for year, but I don't do it now, it's too dangerous on the roads.

I: Do you do dancing on a Wednesday night.

R: We do a bit, yes.

I: Do you get up.

R: I do yes, I get up the odd time. I get up for the old time waltzes and that.

I: You have no trouble at the moment, with tasks like shopping, housework.

R: No, the shop is near me, it's only a few yards up the road.

I: And if you were stuck, they would send it down to you.

R: Yes, they are very good that way. About three years ago, I got up into the ceiling here one night after mice, at half ten at night, I fell down the ladder and broke my ankle and I was on crutches for twelve weeks. They used to bring me down the stuff. I used to write it down and give it to Mrs. M....., she

would go around collecting whatever I wanted and then she would bring it down to me.

I: Have you ever had the opportunity to get Meals on Wheels or anything like that?

R: No.

I: Would you think that would be a good thing if you couldn't cook.

R: I suppose it would be.

I: And you get your dinner in the Day Centre, when you go in.

R: Yes, I get a very good dinner, but then I only go in there about twice a month.

I: Would you think you need to go more to that.

R: I suppose it wouldn't be any harm, all right. They do it different day, in different areas.

I: Would you like to go more often or are you happy just with the twice a month?

R: Well I suppose the twice a month would be all right like, but if it was convenient, I could go another day.

I: You retired early, but do you think older people should be allowed to work over 65?

R: Well, if they were in good health, I think they should be.

I: Until they want to give up.

R: Yes.

I: Now you are on your own, where would you like to live, would you like to see your days out here.

R: I suppose I would. Where would I go at my age now? The town is very handy all right; the trouble is getting a house in the town.

I: And have you ever considered that?

R: Sometimes, I would think of it you know.

I: You are a long time here now.

R: A long time here, yes.

I: Do the neighbours call into you or anything?

R: Ah, very seldom, I hardly ever see anyone.

I: What do you think of sheltered housing and thing like that, they are building sheltered housing in Gorey now, would you apply for one of them.

R: Would they be what you call old folks houses. Yes, but sure I wouldn't have a chance of getting one, when you have a house, that's the trouble.

I: Are you sure now.

R: I don't know.

I: What do you like to be referred to – old person, over 65, senior citizen – what do you like to be called?

R: Well I suppose senior citizen.

I: It's more dignified?

R: It would be, yes.

I: What would you regard your health? Would you say you have good health? I know you said that you had an operation.

R: I did yes, I had a big operation, I was on the table for four hours. I was very low going for it, well under seven stone. Course I wasn't eating or anything. It took me a good bit to pull back all right.

I: How would you rate your health?

R: Fairly good now, when I eat, I wouldn't be too bad.

I: You can get up in the morning and get out.

R: Yes, only the arthritis, I have that now, in my shoulders and in my hands too.

I: How do you feel about the pension, do you think it is enough.

R: I think it is fairly good, I have a bit of a pension from the Council, and I worked on the Council for seventeen year. I'd be happy enough with it anyhow.

I: What about the Fuel or Living Alone allowance?

R: I get the Living Alone all right but I don't get the Fuel. I applied for that but they wouldn't give it to me.

I: And why wouldn't they give it to you.

R: I don't know they turned me down anyway.

I: And how long ago did you apply.

R: I don't know it could be a year ago anyway.

I: Would you not apply again?

R: Not much point in applying now, it's over for this year now anyway.

I: But next year, you will be eighty-three. Do you find it hard to live on a Pension?

R: That's if I'm here, of course.

I: Of course you'll be here, you look sprightly enough to me. Do you think the Pension is enough to live on?

R: Yes, I think the Pension is fairly reasonable now.

I: What do you think about younger people, towards older people.

R: Do you mean helpful or like that?

I: Respectful?

R: Well they wouldn't have as much respect as they used to years ago anyhow. You would meet a lot of young people now and they wouldn't even look at you or speak to you, you know.

I: What do you think of young people?

R: There's a big change in people, they are not the same as they used to be years ago.

I: Have you any children.

R: No, I've no family.

I: Any nieces or nephews with children?

R: I have a sister that lived in England, she died a couple of years ago. She had three sons and a daughter.

I: If you wanted to access some service, would you know how to go about it.

R: What do you mean, service.

I: Say you wanted the Public Health Nurse to call or to get a home help, would you now what to do?

R: Yes I can contact her in the Health Centre in Gorey.

I: What made you go to the Doctor, the last time you went.

R: The last time I went was about the arthritis, I'm on tablets for that.

I: How did you get there.

R: The last few times I got a neighbour to bring me in but sometimes I get Mrs. ... to bring me in.

I: Do you go in to see the Doctor regularly.

R: Well no, I don't go in regularly, it's just when ever I'd want to go.

I: Do you think there should be some sort of a service, now that you are getting over the young stage, if you wanted to go to the Doctor, that the Health Board should provide a taxi. Do you think that kind of a service should be there?

R: Yes, I do.

I: Have you a phone.

R: I have, yes.

I: Do you think that someone should check on you on a regular basis, phone up and say how are you P.....

R: Yes, it would be a help too, someone to talk to.

I: To see do you need shopping and things like that, rather than relying on neighbours, staying independent.

R: Yes, I have the security alarm as well.

I: Do you find that good.

R: Yes I do, I told you about the night that I fell. When I fell down there and broke my ankle, I was lying on the floor for a while. The security alarm was there behind me and believe it or believe it not, with the fright I got, I never thought of it.

I: Are you afraid on your own.

R: Well, sometimes there are cars knocking around there at night and you would be nervous. If there were any cars out there at night, I'd get up out of the bed and I'd look out. There should be better lighting provided for people around their house, like lights that come on if someone came to the door.

I: Did you ever think of what you might need as you get older.

R: I don't know, except for help or something like that.

I: What would you think of Laundry Services or something like that.

R: Definitely, yes.

I: Someone coming in, if you needed them.

R: Yes.

I: You wouldn't be afraid of someone coming into your house, would you, to do a bit of housework.

R: No, as long as you'd know them. I am wary of strangers, all right.

I: Is there anything else you want to tell me.

R: I don't know.

I: Do you think there should be more activities, more outings, etc., for old people.

R: Yes.

I: But generally, you don't think you are doing too badly.

R: No, not too badly, no.

I: Do you do your own gardening.

R: No, I don't do any gardening now.

I: Do you find it good in the Day Centre.

R: Yes they are very good in there, good company.

I: Can you get a bath in the Day Centre or do you have a bath at home.

R: Yes, you can get a bath, I haven't a bath at home.

I: And would you use it?

R: Yes, an odd time I would. They are very good that way.

I: Thank youfor you time and permitting me to interview you.

INTERVIEW G

I: Interviewer

R: Respondent

I: How old are you.

R: I'm 75 years.

I: I know you had the shop in town, what age did you retire at?

R: That's right, I retired only two years ago. Well three in June.

I: What do you think if people have to retire at 65?

R: Oh, I think that it should be an optional situation, depending on the person's own ability and health and attitude of life. It definitely should be optional. Some people think that they'll never get out of work, its how fond of the work they are, even at that stage they might even do a change you know. High-pressure jobs, or something with less pressure within the same company you know. Like in England, out of hours in supermarkets and things like that as well, and what with the health service now with the way it's changing.

I: What do you know about health and social services that are available to you?

R: Well the medical card's available and that in its self is a great thing, and GP treatment. Also, all the pharmacy bills, that's the main thing, especially anybody who's on multiple tablets, medicine and the like. That can rake in a lot of money. The only thing I would say, with the medical card for the over seventy's - I still think there should have been some kind of a means test or even if we were asked to pay a small sum even let it be a fiver, just something that you would feel that you control it.

I: Like you're not getting it for nothing.

R: Just not getting it for nothing, I mean there nothing stopping people saying ah I'll think I'll go to the doctors this morning, I've nothing else to do like, I've read the papers I might as well go up there and spend some time, you can just wander in, go in every week, and that isn't a good thing. Ok, I mean there's always been those who just can't afford it, that's ok, but that's the some for anything.

I: That's right.

R: But the average person is going to pay a little bit, I think I would have, that's fair.

- I: That's a good idea ..., because your generation would not have grown up with taking handouts.
- R: Yes, that's right, and it gives people a sense of control back.
- I: Where did you hear about services? Do you know anything else that's available for older people?
- R: The only way is through the media, you might have to pick up things that way. I can't say that things came flying in the door at me to tell me where to go, or what's what. Now I know that there's an information services available, but we're not inclined to make use of those. We're not inclined to use those unless you're really up against something specific. You just don't wander in, saying what's going. I reckon it's like going into the booking office. Is there any chance of getting a win today?
- I: Do you think that services are adequate for people, as they get older.
- R: Well I suppose adequate yes, are they complete as well though..... Adequate.... well I don't know because, I haven't been up against it, reached a wall yet, you know as regards my needs. But obviously if you think of somebody living on their own, a man living on his own who's used to his wife doing the household chores and other things. Obviously at a certain age, he needs assistance of some sort, caring of some kind. I don't know how much of that is available and what extent it is available, I just don't know that.
- I: That's what I'm actually finding ... from most people I've interviewed, do you know about or have you used any services like chiropody or do you know if there is a chiropody service.
- R: No, I don't know that.
- I: Do you go to a chiropodist?
- R: I've only been twice to a chiropodist so far; it was for nails hanging off.
- I: And do you think you'll need to use that service more often in the future.
- R: I suppose I could need it more often. I don't feel I need it just at the moment but I have good toes and feet anyway so.
- I: Good, you're all right. I suppose it's more for bending and posture. People find that they can't see to cut their own nails.
- R: Yes I could see that coming, I could see that could happen, definitely...possibly sometime in the future. I could see that some people could have that problem. And then again, now, I'm asking you a question now. Is there any chiropody service free?
- I: No. Not in this area.

- R: Everything has to be paid for so.
- I: Well, there was some chiropody free, three times a year in this area. From what I can gather now, social services used to fund some of it but I'm not too sure if that service is still in place. There was some change over the registration of chiropodists because the Health Board can only accept the English qualification you know. Do you know anything or have you heard anything about home help service. Do you know anything about that?
- R: Well to give you an honest answer, I don't. No.
- I: If, say your wife wasn't able to do the housework would you mind a home help coming in or would you look for a home help to come in.
- R: Oh, I would yes, I wouldn't mind.
- I: You wouldn't mind
- R: No, I prefer that, than have to go away somewhere. I think it would be a great anchor for a person living on their own who feels that sources are available.
- I: What about the meals on wheels service, have you heard anything about that.
- R: I think it's great for anyone living alone who doesn't want to cook for themselves, especially men on their own. I'm O.K. because does everything for me, but if anything happened to her, I'd be lost and I wouldn't refuse a hot meal if it were handed to me.
- I: Is your wife over seventy as well?
- R: She is, yes
- I: But the two of you are very active, I know you've had some operations... but how would you rate your health generally.
- R: I'd rate it good.
- I: And you're very active in the drama.
- R: Yes, I haven't got [] phone number out.(the local undertaker)
- I: No and please God not for a long time.
- R: But, oh yes I feel, I feel very active. Well, living life is good since we retired. Ah, we've had it very good, you know.
- I: And what would you put that down to, is it how you feel about life?
- R: Yes, I suppose you could put it down to that. When your working it's so tough that the release of the whole thing, certainly in my case, you don't realise the

pressure your under in business until you don't have it there. When you wake up in the morning, such a person to see and all the new stuff after coming in, having to have it marked, not meaning to order this, customers, staff, this person and that, whether its working or not working very well, are they trustworthy and all these things. So instead of all that you know, your thinking of, God there's a play on in W... tonight, God I might go to that tonight, I might go to that, I might not go, you don't get to plan.

I: Yes I know.

R: Then there's Saturdays off, going on Holidays or breaks should I say.

I: That's right.

R: Well that's my opinion, other people might be different, I 'd say a person in a very routine job, clocking in at the same time every day and the same time every night, they might find it more difficult to retire, they would be so used to the routine. When me and were together in the shop, when we came home, we'd have lunch, we wouldn't be getting in each others way all of a sudden.

I: And looking towards the future, how do you see yourself, do you see yourself as old or do you see yourself as just another year.

R: I suppose another year and old. I get concern about the reality of the mobility thing. I get a bit concerned about that. I'm just going to have to relax, try a bit harder, mentally and physically. That would be the only thing, I think. I don't see death around the corner or anything. We're going on holidays now in June, over to Germany. You start thinking life is for living and onwards.

I: Yes, that's right.

R: I suppose when you have a family, and things work out fairly well, when you go to bed at night, mostly what you'd pray for is to thank God for the things that happen, not looking for something very much. Small things maybe. The small things are important. All those things could have gone pear shaped and terrible problems with you and with your children.

I: Yes indeed.

R: Whatever, I know money isn't everything. I mean there is peace, happiness and contentment in everything, getting along with your fellow man does help.

I: Just speaking of that Would you think the old age pension is sufficient?

R: Again we're back to a means test situation. There's no hope for anyone who genuinely hasn't got any other source of income.

I: Some people would say it's all right.

- R: Now I know that you could come up with the argument that some people had a good source of income, the resources they have used in their life time instead of sort of saving a bit of that along the way, if they knew there was €300 a week that's when they come to a certain age, sure why should we bother, it'll be all there for you. Just like the Voluntary Health Insurance, there are people making sacrifices, to stay in the V.H.I. There's no point in those who keep criticising them for having that service.
- I: That's right, its choice.
- R: Instead of going down to have three pints every night, if you put one of them pints into the V.H.I everyday, you would have it.
- I: That's right.
- R: Now it's a matter of choice what you do with your money, some people depended on our public service to do everything. That's not on either, so you have got to have a balance, but ok having said that, there are people genuinely, for what ever reason, need it. Maybe a woman widowed, the husband didn't have a very good job or sometimes in bad health or financial difficulties all along, genuine financial difficulties, all their lifetime you know, they certainly should, specially an old age pensioner.
- I: What do you think about transport? Are you're still driving first of all. Do you think it's fair that older people should be picked on about the driving licence once they get to a certain age.
- R: Oh, I think statistics have proved that the older driver is safer, I don't have a problem, and I'm probably a more careful driver now than I was 40 years ago.
- I: Do you think it's fair that at 80 some are put off the road?
- R: No, No I don't think that's fair. We all know people that are 80, 90 that are still very sharp.
- I: What about transport though, everybody has the bus pass, do you think that's good or do you think that it's a piece of paper that half the people can't use.
- R: Oh no, I think its good. We use it ourselves from time to time. Sometimes you get that fear, that it is going to be taken back, with everything that being going on with the EU. It's not a standard size thing, its not available in every country, in other words, that maybe there's a possibility of an attempt to draw that back. Which would be very bad, I know politically it would be very bad for it, as its very popular. But it could happen with the medical card. The telephone and television licence have been paid for them. Now there's a small charge on that. Its only a small its only like 50c or something, it could be the thin edge of the wedge with regards claw backs. These things have to be monitored. Social welfare people, it's very easy to pull back on them.
- I: And they're on the thin edge as well.

- R: I don't know what they are getting, it's still small cheese comprising to what some people are earning.
- I: And the economy we're living in.
- R: I wouldn't even use the word earning.
- I: Do you think older people are vocal enough in this country.
- R: No, not at all they wouldn't have a hope. Elderly people, in particular are very gracious, living quietly and simple, they are glad of anything. You know I saw there in the shop, too, the difference, the different attitudes people had.
- I: Do you think that older peoples views are listened to. Has anybody ever gone to you, like politicians, do they actually ask older people for their views.
- R: No, I don't think so anyway, I would imagine, that society would say, Ah, ya, the poor unfortunates, they need to be looked after. But at the end of the day, they're really not that important. You know, at the end of the day the younger crowd are coming up, the whole thing is geared for the 20 to 35 age group there. The big A class spenders. They are being targeted. They are being surveyed, monitored and everything geared towards them.
- I: And that's not right.
- R: No, No.
- I: It will be good to be involved. Our newsletter for the Active Retirement Group, is asking us to question politicians concerning the rights of senior citizens when they come canvassing to the door. Where they stand, for example, state pensions and services, which used to be free and are now incurring a small charge i.e. telephone lines. In particular, asking them their policy of free travel. But even with housing and that.
- I: What do you think of sheltered housing.
- R: Yes, it's good, I have an experience with that, my brother who lives inhe's an engineer there for County Council. They had the house; they built a house out in They lived there, his wife didn't drive, and he reached a stage that he wouldn't be able to, so they, lucky got a sheltered house in it was in the convent grounds. A nice little house. The nuns administered these, and they had a communal area. They provided lunch for them every day and they also did their laundry and they had panic buttons that they could use if in trouble.
- I: And how old was he when he moved into that.
- R: 74, he's 84 now, 10 years ago.
- I: Oh, really so he was quiet young moving in.

- R: He had a daughter living in K....., which is quiet close; she would do other things for him.
- I: You just mentioned their panic buttons, do you think people over 70 should automatically get those, or do you think it should be only when you start to worry that if you were on your own and that you fell.
- R: The day you're presented with a panic button means that you're at risk. It's highlighting that fact. I don't know that they should be given automatically.
- I: What do you think.
- R: Wait till they are older, maybe the availability should be there. I don't know what that situation is here. Maybe the information mightn't be known.
- I: The Social Services would let you know about that or the public health nurse. Would you have had the public health nurse call to you?
- R: I only think, once after my operation she called.
- I: You've had heart surgery ...
- R: I had the by pass, 8 years ago.
- I: How have you been ever since?
- R: I had a couple of little scares, but generally I'm fine, I watch the diet, and try to walk a bit more.
- I: Do you think, as you get older that there is this fear of being broken into, or is it just a fact of life with everybody.
- R: Well it does probably worry me now, it would worry more than it does me. If they have no respect for God they've no respect for the elderly. There were a number of break-ins around here recently and you don't feel safe anymore, so we got in phone watch.
- I: Does that make you feel safe?
- R: Yes, and that's peace of mind.
- I: Do you think that there should be grants towards getting in a security alarm?
- R: Yes I do, something to help with the cost.
- I: I think we have covered a lot of topicsThank you for your time and the opportunity to interview you.

INTERVIEW H

I: Interviewer

R: Respondent

I: What age did you retire at.

R: About 60.

I: 60 for England was normal, was it.

R: Yes, it was normal. I could have perhaps stayed on another year or two, but they offered me good terms

I: Did you say you went back to work after that.

R: Yes I did, I did a post retirement job working in the school. It was really working as a school technician and I felt that I was giving something back in the sense that a lot of my know how, mechanical electrical side, I was helping 6th Form students and they got good results.

I: And how did they react to you.

R: Well, generally speaking when they found that you were talking sense, they would listen and co-operate and after a while, became like friends. I really enjoyed it. I enjoyed that part better than my other career, in the sense that it was youngsters, there is nothing like working, even as an older person, with younger people. You do obviously; get wiser as you get older. You get more knowledge at least you have that to give to younger people. The tutor himself of course, was the boss and he said well you know, you have contributed a lot. A lot of the grades they attained is thanks to you. It was very satisfying.

I: Do you think older people, who retire, say the Community School, do you think they could be involved.

R: I think they could. I think its an awful waste, in some ways. You work all your life, you retire, with the knowledge you have, you want to share. You don't suddenly become old. Can I tell you a little story – when I was working in Chester I saw these people going to the Post Office to collect their pensions and I hear the Post Mistress shouting out “Now have your pension books ready!” as loud as that and everybody in the shop was looking round at you. She was thinking because they were old, they were deaf!. A lot of society's attitude to older people is the feeling that they are finished, on the scrap heap and they're not. They have a contribution to make. In our day you didn't have computers, you had to write things down, calculate, you had to use logs and maths and all these type of things. Now they use calculators, but at the same time, I don't envy them one bit. I learned what I had to learn, that way

my time. When you finish your job, it's a serious business working, you are responsible for people's lives, and I was in my job. So when you retire, the tension is released, you can relax.

I: Do you know what health and social services are available here.

R: Yes I do, even though I haven't been sick myself, only for the odd cold,.. has had trouble with her knees. I have got a medical card. It could be better, it's good until you need it, but then you find out the shortcomings, concern over there being no proper hospital.

I: So you think that there isn't an adequate hospital.

R: If it was serious, yes. We lived in, it had a fantastic hospital. One time I thought I had something wrong with my eye, and a specialist saw us, within a few hours. Well you couldn't have that here, it just doesn't exist. I think the choice would be to go to Waterford or Loughlinstown. Kilkenny is too far. The Health Centre has been extremely helpful. Because of condition we had to get a lift, but we paid a contribution.

I: So you have a home help.

R: Oh yes and we are very, very grateful for that.

I: And was it the Public Health Nurse came to see you.

R:was very bad, she could hardly get round.

I: How many days a week do you have the home help.

R: She comes twice for one and a half hours at a time, that is adequate.

I: Would you think you need more.

R: We don't have any relatives really, so we could do with somebody to help us with lifting things. I have got to stay fit.

I: How would you rate your health.

R: A1, I have been very concerned about what I should and should not do. None of us are going to live forever, I don't expect that, but while we are here, we have all got a duty of responsibility to keep ourselves as fit as we can, while we are here. While I am here I want to be as healthy as possible and also I don't want to be a burden on others, I don't think we should. We have a duty to do that, I think.

I: Do you know that there are pendant alarms for the elderly.

R: No, I didn't know this.

- I: Do you think that physiotherapy should be more available.
- R: There is no physio at present. We have actually been in contact with a lady as far away as Dublin. It's too far away. The doctors all say needs physiotherapy, that it is important.
- I: What do you think about the G.P. Service.
- R: Well, I wouldn't like to complain about it, but I think it's not good enough to wait until something happens to you, to go to the doctor, he should call you once a year to have a good check over and not wait until you're sick.
- I: Do you avail of any other service, like chiropody.
- R: Yes, I have paid to have it.
- I: Do you think that the Pension is adequate.
- R: It could be better. I have got an Occupational Pension from my work and a U.K. state retirement Pension. gets a pension from the U.K. We don't get anything from Ireland.
- I: Do you think older people are political enough.
- R: No, they are not. I made a speech a week ago today at the active retirement. I was sitting with the chairman and a few others, facing about 600 people and I told them all about this. A lot of them feel, the over 70s especially, that the most important thing is your health and independence, they feel there is a stigma in Ireland that any payment of social security, whether it's fuel allowance, travel allowance or free doctors, a lot of the younger ones the daughters and sons, they don't like to think their mother is on the social. I said "don't worry about that" there are places there to help us all, this money has been voted in by the Government and if it is not used, it can be taken away, it is not a charity.
- I: Do you think it is good to be in that type of group.
- R: It's essential, I think. It's great, you are inter-acting with people, you are mixing with your own age group. Before that, you are totally dependent on your family and they have their own lives.
- I: Do you think that sheltered housing should be in the community or should they not.
- R: I think we are part of the community, we are not outcasts, we have got to be integrated and I like to think of people of different ages all around. There is nothing as aging as to see other people, like in a ghetto. It is not good for the morale, unless you are really old.
- I: Do you think that as people get older security should be an issue.

- R: Yes, I worry about this. As of now it's not too bad, but there is always a case and unfortunately the history here in Ireland is not good for that. We have con men and there are worse than that. If you have a lot of elderly people living in a batch, they can be targeted.
- I: What do you think older people should be referred to, or do you think they should be referred to as anything, some call them senior citizens, others call them elderly.
- R: It's Americanism, in a sense. I don't mind being called the elderly, because this is the truth, you know. Being old stretches over a period of thirty to forty years. If I were 66 and lived to be 96, which is thirty years, and I could still be called old.

Interview continued but Respondent requested that it not be recorded. Interview concluded with Interviewer thanking the Respondent for participating in this Survey.

INTERVIEW I

I: Interviewer

R: Respondent

I: What do you know about the Health and Social Services that are available, if you needed services, would you know where to go.

R: I came up to the physiotherapist when I had a bit of shoulder trouble, but I don't really know much about them.

I: What about the Public Health Nurse.

R: The Public Health Nurse contacted me when my husband came out of hospital. She contacted me, I didn't initiate it She was marvellous actually; it was she who told me about getting this home help.

I: And that was the first time you heard that you could avail of home help.

R: Oh yes.

I: Were you under the impression that would be free of charge.

R: Yes I was, I'm always afraid of using something that we can afford to pay for. If anything happens to me would be better off because he would still have his pension and he would have his widowers pension. But if anything happens to him I'd only get half of his half of his pension. It was a private arrangement we had with the home help, but it didn't work out.....

I: Have you heard of the Meals on Wheels service.

R: Yes, I know quite a bit about it as I was involved in doing the Meals on Wheels. I think it is a great service and I feel it is contact for people who cannot get out and about.

I: Do you use public transport.

R: Oh yes I do, we use the bus and the dart. I don't like driving in Dublin any more because of the traffic.

I: Do you still drive locally.

R: Oh I do.

I: Do you think it is right that older people loose their licence or have to do a test again at a certain age, do you agree with that.

- R: I hadn't thought seriously about it, I'm not very politically minded. I find it a little bit tough going now and also you have to get a passport every three years, in other words, they don't know if you'll see through the three years.
- I: Do you think that is discriminating against older people.
- R: Well it is if they are fit, if they pass a medical fitness, otherwise they could be a menace on the road. But if your eyes are good and that sort of thing, you know.
- I: What do you think could be done to make this area a healthier place to live for older people, more conducive to older people as they grow older, to make life easier for older people.
- R: Well the shops are pretty helpful now, they will deliver. I suppose when people get confidence in a particular shop they know that they won't just sell them any old thing. If you write down Lyons Tea they will sell them Lyons Tea.
- I: How would you regard your own health.
- R: I have a bit of arthritis and my feet give me trouble at times. I had corrective surgery on one of my feet but it wasn't a success, but I regard myself in good health.
- I: Do you do your own housework.
- R: Yes, I like working at home and in the garden, I like the challenge. We have just bought one of the new apartments in town and are in the process of moving in, so I'm busy with that at present.
- I: Will you miss being in this house.
- R: It's getting too big for me to manage. My son will still be in this house, so we'll come and go and I'll still be able to help with the garden. I think we'll have the best of both worlds.
- I: Do you think the Old Age Pension is sufficient to maintain somebody.
- R: I don't even know what it is.....
- I: Do you have need to go to the chiropodist.
- R: Oh yes, I do.
- I: Is there any free chiropody for you.
- R: Well I don't know of anybody who does it.has good feet compared to mine but he wants something done and the last time it was for

both of us and it was €40 or €45. I wouldn't feel inclined to be running up every fortnight.

I: Do you feel that it should be subsidised.

R: Well I did ask her, and she said that that's the way she operates and I made another appointment with her. It means an awful lot to me to have comfortable feet.

I: What would you prefer to be called or referred to, senior citizen or elderly or older person.

R: My stupid mind tells me that I'm just not old. Sometimes I find myself scooting along like an idiot along the street for no reason. I have to say to myself, why am I tearing along like this, why. And I'd be limping maybe doing it, but I still like movement. But I am an old person.

I: So in your mindset you are active and young.

R: Yes, fairly.

I: Do you think society values people less when they retire.

R: Well I felt for a while that I was certainly valued an awful lot less in that I had no identity.

I: Do you think older people are respected and valued.

R: Well I always hope they are.

I: Do you think people should be allowed to work longer if they wish.

R: Oh if they wish, sure. couldn't go on for that extra year the Department offered him because when the training college closed, they offered him to relocate.....

I: Do you think older people in Ireland are getting political.

R: Oh yes, they carry a lot of clout. I am a great reader and I read a fair bit of the political stuff but I was never in the political arena. I did think that it would be a shame if older people stopped having their voice heard, and also too, we must have picked views along the way about how things work.

I: Do you think they are consulted enough.

R: Well, I suppose anybody who is in organisations, that's the only way they can be heard. I really admire the way some people phone in to contribute; they are so well spoken and vocal about their views.

I: Thank you very much for affording me the opportunity to interview you today.

INTERVIEW J

I: Interviewer

R: Respondent

I: I would like to ask you some questions about the health service, but first tell me a little about yourself, is that O.K.

R: Yes, I'll do my best to answer any questions, if they will help.

I: Have you lived here long.

R: We moved here eight years ago from Dublin. We used to come down a lot on holidays and always loved it here. died four years ago.

I: Oh I'm sorry to hear that, was it sudden.

R: Yes, he had a heart condition, but it was sudden in the end.

I: Do you feel lonely now.

R: No. Of course I miss but I'm not that kind of person who feels lonely.

I: Do you know what health or social services are available to you.

R: I didn't know what we were entitled to until we moved to this area. Our G.P. is very good and he told us where to go for some things, like a grab rail beside the toilet. Wexford Hospital was very good at explaining things about condition.

I: How would you rate your own health.

R: I had a mastectomy in 1979 but I haven't looked back. I would say I'm in good health. I don't allow my health to prevent me doing something.

I: What do you do to stay healthy.

R: I walk a lot, nearly every day, even on rainy days. If I feel a bit lonely I get out and walk and that does me good. I also take vitamins and cod liver oil.

I: Have you ever used any of the services.

R: Well, I go to the Doctor and used the chiropody service. He had to wait for two months on one occasion to get an appointment. We learned to make the appointments when went for the next visit.

- I: Did you have to pay for the service or was it free.
- R: We had to pay but we didn't mind. always felt great after having his feet done.
- I: What do you think would make the area healthier for yourself.
- R: Well, for one thing, the bus pass is no good for people living in rural areas like I am because there's no bus service. I'm fine because I drive, but my neighbours up the road have problems at times getting to town. He's 80 but can't drive anymore because of his sight. I give himself and his wife lifts to town when I'm going. I know some people end up depressed because they are not in contact with others. The fact that they can't get out and are cut off from their families. I think taxis should be available to connect with the main public transport bus stops. I don't think people should get it for nothing, I think they should pay something so it's not abused, but not too much.
- I: If you needed help who would you contact.
- R: My daughter, she's in Dublin but she'd come down.
- I: Would you use the home help service if offered it.
- R: I don't need it now, but later while I might not need the physical help, the company would be nice.
- I: What are your views on the meals on wheels service.
- R: I think it is great for men, especially living on their own, but I think a dinner club would be better. I meet with a few people once a week for lunch. This gives you an excuse to dress up and get out and about.
- I: What name would you think best suits older people – older person, senior citizen or what.
- R: I don't like any. You can't put a label on yourself. I'm me, but I don't mind what I'm called as long as it's not insulting. You hear young people in shops calling older people "that old biddy" or "that ould fella" and not in a nice way.
- I: Have you a problem living out here on your own.
- R: I'd be more afraid living on my own in Dublin than here.
- I: Do you have the pendant alarm.
- R: No, I don't have one yet but I think it's a good thing. However, it depends on the person, you don't want to mention too many things or you'll take their independence away.
- I: Do you think older people are vocal enough.

- R: No, older people are not that vocal and I think coming from Dublin that Wexford people are too gentle and laid back. Especially the fact that we've no T.D. in the North Wexford area. Another thing I feel we are discriminated against as regards travel insurance. I am organising a trip for six of us from our retirement group to Canada and the insurance goes from the normal price at 70 years of age to double from 70-74 and it trebles over 74 years of age, if you can get it all. If people want to travel they should not be penalised because of their age, especially when they are healthy.
- I: Do you think older people should be allowed work beyond 65.
- R: Yes, I do especially if they are able. My father is 89 and he worked well into his 70s he was quite capable of working longer, but he enjoys his retirement now.
- I: Do you think the Pension is enough to live on.
- R: No I don't. I'm O.K. because I have a pension from my husband's work along with the Widows Pension but for anyone living on their own, with only the Old Age Pension, I don't think that is enough because you have still the same heating and insurance bills as you would have if there were two of you.
- I: Where do you see yourself living out the rest of your days.
- R: I want to live out my days in my own home.
- I: Thank you for allowing me the opportunity to interview you this morning.

INTERVIEW K

I: Interviewer

R: Respondent

I: You live on your own?

R: Yes, I do.

I: Would you ever feel lonely?

R: Sometimes, yes. I try to keep myself busy, I read a lot and I follow Coronation Street and Fair City.

I: So you enjoy watching television.

R: Yes I do. I love music as well and I get a great kick out of the grandchildren watching the television with me.

I: Do you go out at night yourself, do you go down to the pub or anything.

R: I joined the Retirement Group when it started and I really enjoy it. We have loads of activities. We can go walking in the woods, I don't do much of that, but some of us go down for a swim in the pool and I have been away on outings. I've just come back from a week in Galway with the group.

I: Do you get a lift in or do they have a minibus.

R: My daughter, who moved down here as well, brings me down and comes to collect me and brings me home.

I: Do you drink?

R: Oh, no, no I don't. I have my pledge since my confirmation and that's not today or yesterday.

I: What do you know about the Health and Social Services that are available.

R: Well I know that there's the G.P. He's a very nice man, very attentive. Nicer than the doctor I had in Dublin. He's only a young fellow, but he listens to you, he makes time for you when you go in. I saw the nurse all right, she came to see me when I moved in, but I only saw her the once, I'm out most days anyway, she won't catch me in. She told me I was great for my age, sure why wouldn't I be.

I: Do you know anything about Home Help?

- R: Well I've heard about it but I don't want it. I have my grandchildren to do any thing I want here in the house. I give them a few bob pocket money.
- I: Can you manage in the house yourself?
- R: Yes, I can. This is only a new house and everything is on the level. Everything is new so I have no maintenance to do.
- I: Do you find it hard doing the housework?
- R: No, I'm still able to cook my own dinner every day. Some days I meet some of the ladies from the group downtown for lunch.
- I: Do you know of any other home services, Meals on Wheels, or anything like that.
- R: Like I said, I do my own cooking but for anyone who can't it's a good thing. But I don't think I'd like anyone calling to my door with a dinner on a plate.
- I: Do you go to the Chiropodist for your feet – are your toes all right.
- R: No, my feet are fine at the moment. I soak them every so often and I get my daughter to cut my toenails for me. I don't know where I would go for a chiropodist, but I suppose the health centre would tell me.
- I: Do you go to the Doctor much.
- R: No I don't, I'm not a doctor person. I stay away from them as much as possible.
- I: How do you keep healthy?
- R: Well I'm always on the go I walk all the time. You'd never find me in.
- I: Yes, I could agree with that, it took me quite a few phone calls to catch you in. What do you think of the younger people now?
- R: I find them a little bit off putting; their attitude with older people is a thing I'm not happy with. Old people are just young people getting old. In your mind you are not old. A lot of people have a habit of shouting at you; they talk to you as if you are mentally retarded. Young people are not as helpful as they used to be years ago and I am trying to teach my grandchildren to be kind and helpful to older people, treat them with a little bit of respect.
- I: Do you mind what people call older people.
- R: No it doesn't really matter what they call me – it doesn't bother me. What would bother me would be if I hadn't got enough money.
- I: Do you think the old age pension is adequate.

- R: Well, I have a pension from my husband he worked in the brewery. But still you'd be struggling if you had any major repairs. I even now, put money aside for the house insurance that would be my major big bill every year. But people on the old age pension, I'm sure that they must find it hard to make ends meet.
- I: Do you think it is right that some people have to give up working in some jobs at age 65.
- R: No, I don't. I think older people should be allow to work as long as they are able, if they want to.
- I: Have you a phone.
- R: I have, yes. It keeps me in contact with everyone. I use it a fair bit to keep in touch with all my friends in Dublin as well.
- I: Are you afraid on your own.
- R: No, I feel safer here in this new house than I did when I lived in Dublin. We have great lighting and everything around the estate and my daughter only lives up a couple of doors away form me.
- I: Did you ever think of what you might need as you get older.
- R: I don't know, I suppose I think I am going to go on forever. I know I'll need some more help but my daughter is there and my other family members come down on a regular basis. I hadn't really thought about it.
- I: What would you think of Laundry Services or something like that.
- R: Definitely, yes. That's a good idea because while you mightn't like someone in your house, it would be lovely to have your laundry done and brought back to you and it would save my daughter doing it.
- I: Do you think older people are politically minded.
- R: Up to now, I think we don't speak out enough but I think with being in the retirement group, I'm beginning to hear people voice their concerns and the chairman is very good. He is bringing our issues to the Senior Citizens Parliament, but I think more need to be done there.
- I: Well thank you very much for affording me the opportunity of interviewing you this evening.

INTERVIEW L

I: Interviewer

R: Respondent

I: How long have you lived here.

R: We moved down in 1996 permanently. We came to this area for years on holidays, like a lot of Dubliners.

I: Do you know what health and social services are available to you.

R: I know about some things because my wife has Parkinson's and we had to find out. At the moment, we are managing grand.

I: Have you needed to use a home help.

R: We don't receive home help from the health board, but my sister in law comes in three times a week. My wife did not want a stranger coming into the house. But if I had to use a home help, I would.

I: Does the Public Health Nurse call.

R: No, she doesn't call; we've never seen her.

I: What about the meals-on wheels service.

R: I think it is great for anyone who needs it. It's hard for someone especially out here to get a hot meal. In the town there are restaurants but out here there is nothing for someone who couldn't cook for themselves.

I: How do you rate your own health.

R: Well, I have had a mini stroke and a heart attack a few years ago, in 2001 but I put that to the back of my mind. The more I can do for myself, the better I feel.

I: How do you feel about getting older.

R: If I was to tell you how I feel – I feel 18. I feel I can go on forever. We joined the retirement groups when it started and we feel we would be lost without it. We are very active in it. We play bowls on Tuesdays and Thursdays. We choose what we want to do and we've just come back from a holiday in the West with the group. We go off on day trips as well.

- I: How do you think younger people and indeed society treat older people.
- R: I think older people are forgotten. To younger people I think we are invisible, but I think its up to us to change that a bit.
- I: In what way.
- R: Working with young people and maybe inviting them to one of our meetings.
- I: How do you find younger people.
- R: Well I find them mostly very good. I'm a sort of suspicious person by nature and if I saw a young fellow up the road with a skinhead haircut I wonder what he is up to. I have to know the young person and indeed any person, there are too many things happening nowadays and it makes you suspicious. I use to give hitchhikers a lift but I don't do that any more.
- I: What would you like to be called or referred to.
- R: It doesn't matter what they call me. It doesn't bother me.
- I: What does worry you.
- R: I suppose having enough money and peace of mind.
- I: What about security.
- R: One of the reasons we bought here was that we have security on the gate. That's why I had to meet you at the gate to key you in. We don't have it on the house, but I'm not saying I wouldn't need it but its too expensive and we can't afford it.
- I: Do you think that there should be a grant towards house security for older people?
- R: I do but I'm not one for looking for grants. Years ago when my wife had the big bills the Doctor and the Chemist use to say to me that to fill out the form and I would only have to pay the £10 or whatever it was then. I didn't and in the end the Chemist handed me the form and told me to go to the Doctor and get him to sign it, I wouldn't have done it myself. I don't like looking for things, maybe I'm shy or backward or too proud. I'll give you an instance as well. I went to the optician lately and when they looked up my chart I had not had my eyes tested since before my heart attack. I have a habit of putting things on the long finger if I don't have to do something.
- I: Do you drive.
- R: Oh, yes. If I didn't have the car we'd have to walk. We have the bus pass, but that's no good out here. No bus passes this way.

- I: How do you keep healthy.
- R: I don't get up on a ladder anymore, I know my limits, but I keep active, I like swimming and walking. There are plenty of outings and we love getting out and about. I go for blood checks twice a year. I was with him recently and he is contacting the Heart crowd and they are going to contact me about exercises. I think the G.P. could do more like a well man/woman clinic. For my wife, breast check should be available more. I think you would relax more.
- I: How do you find the Doctor.
- R: He's very friendly and helpful.
- I: Do you think men are good for going to the Doctor.
- R: Probably not. I think it might be the macho thing, they think that they have nothing wrong with them.
- I: Have you any family living near?
- R: I have 5 sons and 4 daughters and the nearest is living in Dublin. The others are all over Ireland, and I have one son in America and a daughter in Australia.
- I: Where do you think you will live as you get on in years?
- R: I love it here but if anything happened me... would have to go back to Dublin.
- I: Thank you for your time and the opportunity to interview you.