

**Measures to Promote Health and  
Autonomy for Older People:  
A Position Paper**



**NATIONAL COUNCIL FOR THE ELDERLY**

## NATIONAL COUNCIL FOR THE ELDERLY

The National Council for the Elderly was established in January 1990 in succession to the National Council for the Aged which began in June, 1981. The terms of reference of the Council are:

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

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

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*"Old men ought to be explorers"*. T.S. Eliot.

# Measures to Promote Health and Autonomy for Older People: A Position Paper

By

Professor Cecily Kelleher,  
MD FRCPI MPH MFPHM MFPHMI



NATIONAL COUNCIL FOR THE ELDERLY  
PUBLICATION NO. 26

for

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# Foreword

The World Health Organisation, in its *Health for all in Europe by the year 2000* has identified four priority areas for action, as follows:

- to ensure equity in health,
- to add life to years,
- to add health to life, and
- to add years to life.

Referring to these priority areas, *The Years Ahead: A Policy for the Elderly* (1988) says

*A successful policy of health promotion would enable more people to reach old age, reduce the incidence of disease and handicap among the elderly and increase the number of elderly who are healthy and active. On each of these counts, the evidence suggests that there is much room for improvement.*

Accordingly, when the National Council for the Elderly was appointed in 1990 with revised terms of reference it was required to advise the Minister for Health on *Measures to Promote the Health of the Elderly*.

In addressing the task of identifying *Measures to Promote the Health and Autonomy of Older People in Ireland* the Council adopted a broad perspective and sought the advice of people with a wide range of experience and expertise. They now form a Consultative Committee and the Council is much indebted to them for their ongoing support and assistance.

The Consultative Committee advised undertaking the requisite research work on *Measures to Promote the Health and Autonomy of Older People* in stages. As a first step, the Special Projects Unit of the Eastern Health Board compiled a most useful compendium of data including a review of current literature, a commentary on the relevant data sources and identification of areas where further research is required. The Council is indebted to Dr. Mary Hynes, Eastern Health Board Specialist in

Public Health Medicine and her colleagues from the Special Projects Unit for providing this data to the Council and for assisting it to plan the succeeding stages of its programme.

At the Council's request, Professor Cecily Kelleher then took up the challenge of summarising the data and providing a practical focus on *Measures to Promote Health and Autonomy of Older People* in Ireland. In this paper she provides an overview of relevant socio-demographic factors, health service utilisation by the elderly, attitudes and behaviour in relation to ageing and health promotion strategies for the elderly. The paper then suggests options for the future, both in relation to research and to policy.

The Council is most grateful to Professor Kelleher for providing this paper. It will be helpful in focusing the discussion in the future, particularly at the forthcoming conference on *Measures to Promote the Health and Autonomy of Older People in Ireland* — and beyond, when recommendations to the Minister for Health are being formulated.

Michael White  
Chairman

## Author's Acknowledgements

While it should be stressed that this paper was written from my own perspective, I am very grateful for the views of my fellow Committee Members on the National Council for the Elderly Committee on Measures to Promote Health and Autonomy for Older People. I am particularly indebted to Mr. Joe Larragy, Research Officer with the National Council for the Elderly, for his assistance in providing relevant reference material. I would also like to acknowledge the work of Dr. Mary Hynes, Dr. Marie Laffoy and Dr. Anna Clarke of the EHB Special Projects Unit who produced an extensive resource document on this subject for the National Council for the Elderly during 1992 as a fore-runner to the present paper. I am also very grateful to my colleagues in the Centre for Health Promotion Studies in Galway, including Dr. Ricca Edmondson for her constructive contribution through drafts of this work. My thanks, too, to my secretaries, first Ms. Geraldine Byrne and then Ms. Aileen Glynn for their assistance in the typing of the work.

## CHAPTER 1

# Introduction: Health Promotion and Ageing

### Summary

**Health Promotion is a comprehensive term that includes personal development but also any form of environmental change that promotes personal health and wellbeing. It is a positive concept, implying more than the avoidance of illness, and is fundamentally related to the exercise of personal choice. In the case of older people, it can apply to several different aspects of daily life including preparation for ageing, health maintenance and lifestyle modification, personal skills development and social change to facilitate health. The principle of health promotion for the elderly is not neglected — it has been endorsed by national and international documents, including for example *The Years Ahead*, and by Eurolink Age, a Europe wide consortium of agencies. It has also been endorsed by a number of statutory and voluntary agencies within Ireland. Furthermore, policy documents of Government and of the Social Partners contain recommendations that are implicitly related to health and autonomy of older people, such as the *Programme for Economic and Social Progress* and the joint policy document, *Partnership for Government*. What is needed are coherent initiatives that can put these aspirations into practice.**

### Objectives

The main objective of this paper is to express what we know about the experience of ageing in modern Irish society, using the principles of health promotion. The gap between the reality and the aspiration is what policy makers must address and if necessary, redress. It is not intended to reiterate in detail all the data on which this might be founded, but rather to summarise initiatives to date in this field. This will include an examination of the impact of public policy at national, local and

individual level. It will incorporate reference to relevant research data and will lay particular emphasis on the perspectives of different disciplines and sectors concerned with the issues of ageing.

**Part One** will deal with the current situation in four broad areas: socio-demographic, health service utilisation, attitudes and behaviour of elderly people themselves and health promotion initiatives to date. Strengths and deficiencies of this information base will be outlined.

**Part Two** will suggest how a coherent health promotion policy might be shaped at central and local government level, at community level and at individual level. Intrinsic to this is the institution of an evaluation framework. How might cooperation between sectors be strengthened for instance? What are the obvious constraints to be overcome? A key contributory component is the kinds of research that, in the authors opinion, might be undertaken, both within Ireland, and in cooperation with other countries. This issue will be examined throughout the paper, with a general summary at the end. The types of research will range from description to intervention and field research and will be influenced by the information in Part One. It is understood that such research will serve as a tool for policy makers, whether directly or indirectly.

In an interesting anthology on the subject of ageing (Ricketts 1981), Lord Longford produces a characteristically refreshing essay. In its course, he reminds us of another venerable statesman's views. Cicero cites four reasons why old age might appear to be unhappy. These comprise the withdrawal from active pursuits, the weakness of the body, the relative deprivation of physical pleasures and the proximity of death. Cicero then, and Lord Longford now, deal with each of these in a positive manner.

### **General Perspectives**

A remarkable feature of the health promotion movement is its effort to draw together the perspectives of different disciplines and sectors to tackle issues such as ageing. Through this framework it is possible to challenge the prevailing paradigm in relation to health. Ageing is an inevitable feature of the human condition, but it is interpreted differently by different people. The health promotion movement attempts to synthesise and build on positive aspects of these perspectives.

To the health professional for instance the challenge is often perceived as a problem. This is a reflection of his or her experience, whether dealing with the sick, the infirm, or those concerned with health maintenance. Even in the field of primary care and preventive medicine

generally, the objective is to detect, to prevent, to contain, to palliate and even to cure, *specific problems*. The provision of a properly organised and funded health care service is a critical and legitimate activity within our society, but it has inherent handicaps that militate against it as the exclusive focus for health promotion. Throughout this paper, specific reference will be made to the importance of coordinated, proactive and largely community based health services. But the scope for health promotion does not stop, or even start, there.

What about the social scientists? To the economist, again, the issue is largely quantitative. What proportion of people in society are elderly? How do they, or did they, earn a living? What economic support do they now enjoy? What length of time will they remain functional? What can be done to maximise this period? What implications has this for the planning of social and health services? To the political scientist, the sociologist and the psychologist, the influences of society generally and the motivations of individuals in particular, are critical to the examination of the experience of ageing. In many ways therefore it is the social rather than the medical scientist who is producing the holistic individual-oriented perspective.

There are two key debates in modern health promotion. There is firstly the now well-known contrast of the biomedical versus the more holistic approach (illustrated above). Secondly, there is the distinction between quantitative and qualitative research. This latter might be summarised thus: I believe exercise is beneficial and wish to promote bicycling on this basis. I could estimate its benefit by examining the effect on physical fitness of such an activity. This can be measured objectively by effort in relation to oxygen uptake. I might also measure how many people take up cycling as a hobby. Perhaps however, I might want to measure what factors are likely to *incline* individuals to such an activity, particularly those who never have practised it in their lives. Though this may well be more difficult to demonstrate, without such information my policy is doomed to failure.

As a further example, consider why the Irish do not eat more fish. The fact that cultural or religious practice might contribute to this reluctance cannot be ignored just because it seems rational to accept the public health advice that fish oils are of benefit in preventing coronary heart disease. Or again, why do many journalists fall so gleefully on any apparent discrepancy in the dietary message about coronary heart disease? We see much in theory written about “healthism”, understood to be an over-zealous preoccupation with personal health. Perhaps the public response reflected in the media should be considered in part therefore as scepticism about the motivation behind health promotion.

The fact that it can be more difficult to find out or subsequently validate such attitudinal factors does not diminish their importance in determining participation in health promotion programmes.

Perhaps most interestingly of all, we should look to literature, both prose and poetry, to see the record of human experience about ageing (Coakley and Coakley 1985). As a trained quantitative scientist, I make no apology for this apparently whimsical deflection. While health promotion is an obvious and shared solution for many of those concerned with positive ageing, any initiative is destined to failure if it is cosmetic, insufficiently focused, or too superficial to properly respond to the experience of real people making health choices. Malcolm Johnson, Professor of Health and Social Studies at the Open University, made some apposite observations in this vein (1988). The vogue for community care, in his opinion, must not lose sight of the reality that a proportion of families are not particularly happy and, for this among other reasons, do not necessarily make an ideal focus for caring. A social policy that supports informal carers must therefore be flexible, sensitive and provide alternatives if it is to work. Equally, formal social services may sometimes be effective for reasons beside their main objective. His study of meals on wheels showed that a major benefit perceived by the clients was the simple gesture of human contact, albeit brief.

Old people are a diverse group, most of whom are fit and healthy. Old age is not in itself a satisfactory explanation for ill health. Health promotion in this age group should therefore concentrate not only on preventing disease and disability but on promoting good mental and social function. Of particular importance in promoting and protecting the health of the elderly are policies affecting housing, security, social cohesion, air quality, road safety, retirement and income. Without a solid foundation of these basic environmental necessities, the improvement of health by health education programmes is at best cosmetic and at worst damaging. The components of a comprehensive programme include accurate and usable information or knowledge about health factors, appropriate skills to promote health, supportive environments to enhance health, and opportunities for healthier choices.

The correlation between poor health and lower socio-economic status has been well documented (Black 1980, Marmot and Davey Smith 1991) and is particularly pertinent in the case of the elderly. Besides this, in recent years people have come to realise the influence that they, themselves, can have on their own health status. A successful health promotion policy would enable more people to reach old age, reduce the incidence of disease and handicap among the elderly and increase the number of elderly who are healthy and active. *The Years Ahead* our

national policy document produced in 1988, gave special attention to health promotion and identified strategies for improvement. The gaps identified then are still there now.

Health Promotion was defined in *Promoting Health through Public Policy* (Health Education Bureau 1987) as a process which aims at altering and developing fundamental features of society with a view to promoting good health and removing hazards and obstacles in the way of doing so. It seeks to mobilise resources for health and to pursue healthy public policy. The concept of health promotion is based on an understanding that health is more than the absence of disease. Health is a resource for everyday living and not the objective of living. It is a positive concept emphasising social and personal resources as well as physical capacities. Consequently, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being. Those who play a vital role in health promotion are health service managers, community organisers, planners, regulatory agencies, legislators and volunteers.

The Ottawa Charter, formulated at a multi-disciplinary conference in Canada in 1986, examines health promotion in its broadest sense, stating that it is a process of enabling people to increase control over and to improve their health. That charter stressed five key areas for action: *healthy public policy; supportive environments; personal skills development; community participation and the reorientation of health services*. Each aspect applies to the elderly, as will be shown in this paper. If anything, this is the instance where the spirit of the Charter is most integral. Health promotion policies aim to enable as many persons as possible to remain healthy and active throughout the years of their life: to add health to life by reducing the occurrence of illness and accidents and to add years to life by increasing the average life expectancy of the individual. (Targets for Health for All 1985).

Stereotypes of old age frequently involve dependency. Yet the majority of elderly people are independent. Much loss of independence can be minimised or avoided through the application of health promotion principles in the areas of housing, environmental and social support. Whether curtailed independence involves an elderly person in a rural area without access to facilities or transport or a city-dweller afraid to venture out, the principle is the same. Appropriate and timely medical intervention and rehabilitation for the acutely ill elderly can be decisive in avoiding loss of personal autonomy. Our attitudes to old age as a society contribute to an insidious form of age discrimination. Preserving independence in the elderly is continuously being stressed as a goal of health promotion and autonomy.



Priorities for health promotion in the elderly, outlined in the United Kingdom by the Kings Fund Institute, include improvements in housing (especially insulation and heating) and nutrition, a decline in smoking and in excessive alcohol consumption, a reduction in poverty, more active participation in modest exercise, a reduction in the prevalence of iatrogenic disease by more careful and selective prescribing and monitoring of drugs and more effective procedures for case finding and early management of preventable disease. In a very real way however, health promotion is a philosophical position from which such specific measures flow. It moves away from the traditional biomedical approach towards a more comprehensive, holistic and contextual view of health-related decision (Kelleher 1992). Very importantly, there is a sense in which both individuals and society can only be healthy and self-confident when it is possible to look forward to the experience of ageing as a positive one.

Health promotion focuses on achieving equity in health, on reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. Reducing inequalities in health, increasing prevention and enhancing peoples capacity to cope with chronic illness and disability are three national health challenges identified in Canada for instance. To this end, the health promotion framework in Canada proposes three mechanisms: self-care, mutual aid, healthy environments; and three implementation strategies: fostering public participation, strengthening community health services and coordinating public policy. It is therefore clear that many different countries are starting to examine health promotion for the elderly as a policy issue. Where do we stand in Ireland and what should we be doing? It is hoped that this paper will contribute to the discussion.

**PART 1**

**The Current Position**

## CHAPTER 2

# Socio-Demographic Factors and their Effect on the Experience of Ageing

### Summary

This section reviews what we currently know about the social and demographic patterns in relation to ageing in Ireland. A major impetus behind the current interest in the older person has been the increase in the proportion of both aged and very aged people in communities worldwide, but particularly in the developed world. In Ireland, there are important demographic variations with practical policy implications. There are smaller absolute numbers of ageing people than other countries. There are also high rates of unmarried older people, particularly men in rural areas. We have continuing high levels of social support due to large families and low participation rates of women in the workforce. As elsewhere however, this is likely to decline in coming years. While poverty is inordinately related to ageing, the position of the older person has improved in relative and real terms in the last twenty years in Ireland. This does not mean that there is no scope for improvement for particular areas and sub-groups.

### *Life Expectancy*

The phenomenon of increasing life expectancy is most markedly one of the 20th century, particularly in developing countries. This is attributable of course primarily to increases from birth, which in turn largely reflect improved resistance to infectious disease (Figure 2.1). Factors such as housing and sanitation are classically considered and McKeown (1976) in particular has strongly advocated the case for improved nutrition as well. It is also possible to estimate life expectancy from middle age (Figure 2.2) and from retirement (Figure 2.3) and obviously different factors will play a part in the health gains seen here throughout the latter part of this century. Life expectancy at age 65 now averages over 16 years in Europeans. It is this key period, of considerable practical

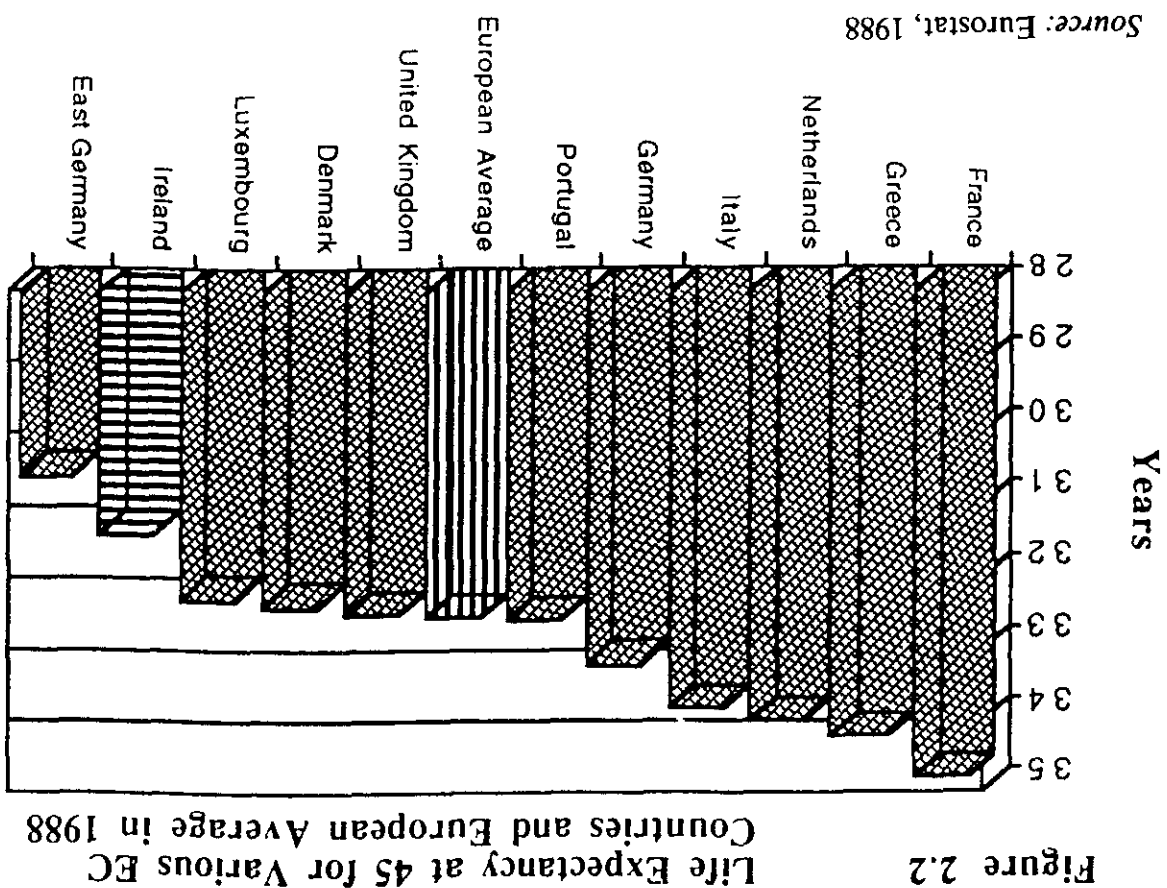
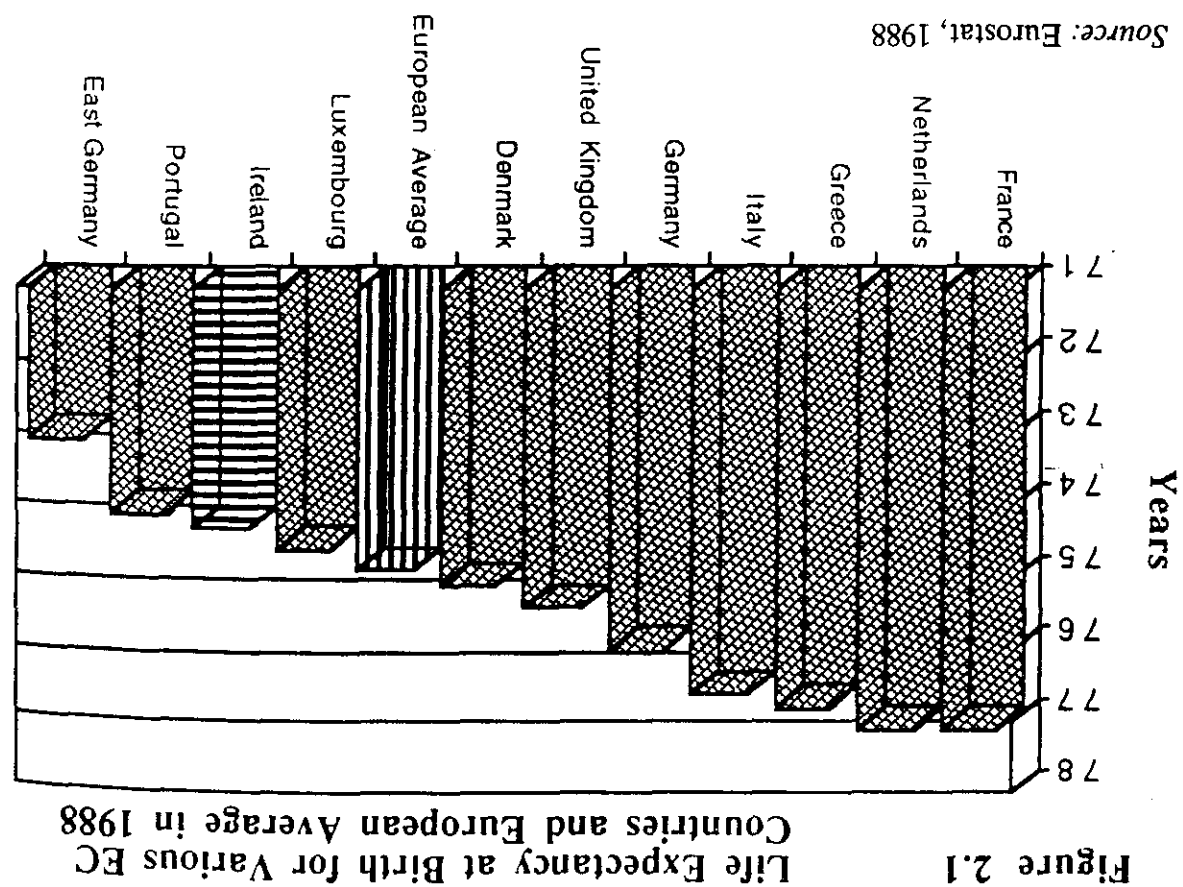
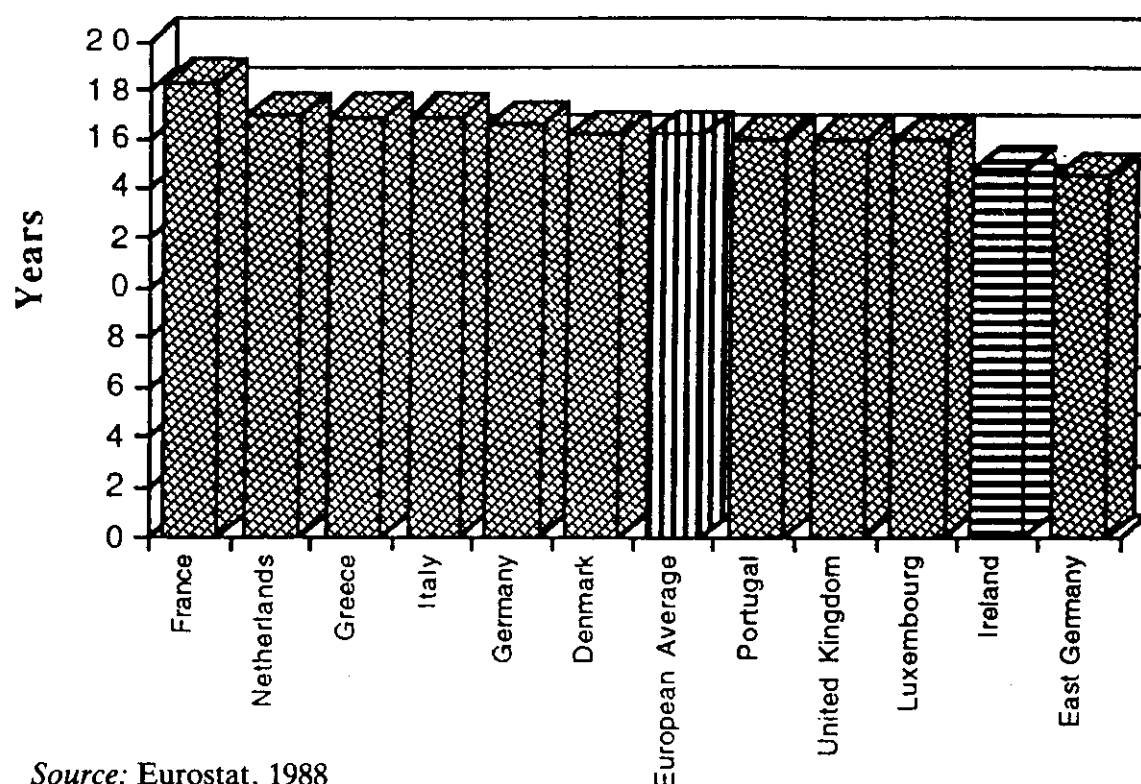


Figure 2.3

## Life Expectancy at 65 for Various EC Countries and European Average in 1988



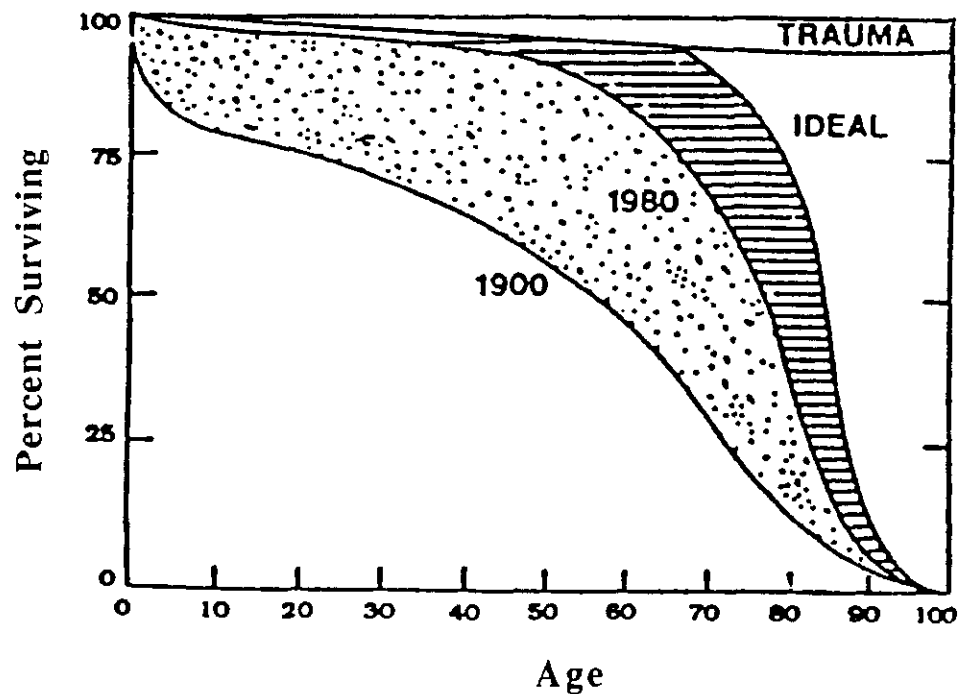
Source: Eurostat, 1988

relevance for health questions, that we are considering in this paper, endorsing the aim of adding both years to life, and life to years. From the outset, both quality and quantity of life are therefore of importance and must be examined from a variety of approaches.

### *The Theory of Natural Ageing*

What can we reasonably anticipate as man's natural span? This is of course the subject of controversy, with the most frequently discussed estimate being the so-called rectangular curve (Figure 2.4). This illustrates the percentage of a given cohort surviving at each age decile in 1900, in 1980 and in an ideal situation. There was a predictable loss due to infant mortality at the beginning of the century, which has now largely been combated. The rectangular concept implies that loss of life need in principle be negligible until the age of seventy, with a natural biological ceiling around the age of 100. This concept is based on a number of assumptions, not least our capacity to effectively challenge the incidence of the age-related diseases.

Figure 2.4 Ageing and the Rectangular Curve



Source: Johnson, 1988

#### *Trends in Specific Age-Related Conditions*

This need not necessarily be so improbable however. Cohort trends in the United States and Australia have indicated steady declines in coronary heart disease and stroke from mid century, achieving a 50% reduction in mortality from the latter in the US (Burke et al. 1989, Epstein 1989). These changes were not seen in the United Kingdom and Ireland until very recently, with the first signs occurring in this country only in the last two years. What *has* occurred is a widening in the socio-economic gap, so that the well established class gradient not only exists but is widening (Marmot and Davey-Smith 1991). This means that conditions such as heart disease and chronic bronchitis, which tend in any case to occur more frequently in lower income groups, are declining more rapidly in incidence among the better-off.

We are also learning that many of these long-term effects may be predicted during very early life, dating from patterns of foetal growth (Barker 1991). This correlation is not the complete explanation however. Nor is there any need to be fatalistic about the inevitability of one's own personal risk. At all life stages, changes in lifestyle pattern have been shown to be beneficial in altering risk factors (Burke et al. 1989). It must be clearly stressed that while chronic conditions like heart disease

increase in incidence in association with ageing, they are not due to the ageing process in itself. Indeed, in countries where these diseases are uncommon, contributory factors like blood pressure do not rise with age (Shaper 1989, Kelleher 1991).

### *The Demographic Pattern in Ireland*

In Ireland, there are just over 0.5 million people aged 60 years and over, representing approximately one in seven of the total population (O'Shea E. 1993). There are some remarkable differences between Ireland and other countries, particularly our European Community (EC) neighbours (Grundy and Harrop 1992). We have for instance the lowest population proportion of older people in the EC, at 11.3% over 65 and 4.5% over 75. In 1990, the proportion of very old people aged 85 and over was also lowest here. Again, increases in relative size of the percentage aged 75 and over in the last 40 years were smallest in Ireland. There are two explanations for this. In part, it is due to relatively high fertility rates. A second important factor is the ongoing influence of emigration, the peak occurring in the 1950's (O'Shea 1993). Life expectancy for women continues to be lowest in the EC (Grundy and Harrop 1992). Our rate of older people living alone is not however as high as in other countries. We are the only country in Europe with a fertility rate sufficient to reproduce our current population. We also have a relatively low rate of one parent families and of women in the conventional labour market, and a relatively high mean household size (3.7). Other remarkable features in Ireland include the high proportion of unmarried older people, particularly men (23.5%). Despite this, we are still facing significant demographic changes. By the year 2020, those aged 60 years and over will have increased a full 8%.

There are also important regional differences within Ireland itself which have policy implications. From 1981 to 2006 there is likely to be an absolute and relative decline in the numbers of older people on the Western seaboard, and a huge increase of 31% in the Eastern Health Board, explained by internal migration over the last half century (O'Shea 1993).

### *The Relationship Between Ageing and Poverty*

However, in Ireland older people may be relatively better off in economic terms than in other countries (Table 2.1; Eurolink Age 1992). An ESRI study also demonstrated that income is positively related to capacity, so that those on low incomes appeared to be further handicapped by poor functional capacity (Whelan & Vaughan 1982). The relationship between socio-economic status and ill-health is observed in virtually all studies

**TABLE 2.1: Ranked Percentage of Older People Living in Poverty in EC Countries in 1985**

Country	%
Portugal	45
Greece	28
Spain	24
United Kingdom	22
France	21
Denmark	20
Italy	20
Germany	14
<b>Ireland</b>	<b>14</b>
Belgium	11
Netherlands	5
Luxembourg	unavailable

Source: Eurolink Age 1992

that investigate the issue. Two other recent surveys imply that the situation in Ireland might be much as elsewhere. One, carried out in inner-city Dublin, found the same class gradient as that seen in the United Kingdom (Johnson & Lyons 1991). In a rural sample however, the relationship was not as clear-cut, though the authors concluded that the indicators of deprivation used might not have been appropriate to a rural community (Howell et al. 1993). It is also important to remember that it is not just *currently* elderly people experiencing deprivation whose health is poorer, but also that of today's children and young adults who, if they continue to experience deprivation and poverty, will face poor health as they age. Inadequate income is a major, if not the key, problem for large numbers of older people.

However, the situation may be improving in at least some EC countries. The 1989 ESRI study confirms that the relative position of the older person improved significantly between 1973 and 1987. In Ireland the proportion of people aged 65 and over living in poverty declined from 32% in 1980 to 19% in 1987. The real value of social welfare pensions has risen by 17% since 1980, and by 107% since 1973. This change is due in part to improvements in pensions, but related also to increasing poverty in other groups in the population; for instance average industrial earnings improved by only 88% in a similar time period; this is further exacerbated by the relatively more punitive taxation scale. Furthermore, retirees over this time period were increasingly likely to have had an adequate occupational pension. This is illustrated by Table 2.2 showing the risks of relative poverty in the three time periods, 1973, 1980 and 1987, and Table 2.3 showing the risk of poverty for a head of household



**TABLE 2.2: Risks of Relative Poverty for Households Headed by an Older Person 1973, 1980 and 1987**

Relative Poverty	1973 HBS	1980 HBS	1987 ESRI
40%	13.2	7.1	5.6
50%	33.8	24.4	9.7
60%	44.8	46.6	23.7

(HBS = Household Budget Survey)

Source: Callan et al. ESRI 1989: 99

**TABLE 2.3: Risk of Poverty by Labour Force Status of Head of Household, 1987**

Labour Force Status of HOH	Per cent of HH in Sample	40% Line Risk (%)	50% Line Risk (%)	60% Line Risk (%)
Retired	4.4	5.1	11.4	21.5
All Households	100.0	7.5	17.5	30.0

Source: Callan et al. ESRI 1989: 106

who is retired. The consequence of these developments is that while households headed by an older person constituted 23% of all households in the ESRI sample, they accounted for only 10-12% of those in poverty. Likewise, when examined by Labour Force Status, retired heads of household were relatively less likely to be in economic difficulties.

However, these relative gains must be weighted against the absolute disadvantages. It has been estimated that the coverage of occupational pension schemes is approximately 46% of the employed labour force. Thus, a large proportion of workers are not covered and face a substantial reduction in living standards on retirement. Even in the case of those who are covered, there are major differences in the adequacy of these schemes.

### *Living Conditions of the Elderly*

At present information on living conditions of older people, particularly in relation to housing, is collected by a variety of public sector and voluntary agencies. There is no evidence that this is centrally coordinated. *The Years Ahead* advocated a national survey on housing conditions. That has not yet taken place. While local authorities certainly maintain in part or in whole the basis for such a survey, it should be coordinated and standardised. O'Shea, in his recent position paper, also endorses the need for such a survey (1993).

We do know, however, a considerable amount about variable living conditions of older people in different areas of the country from various occasional surveys. The National Council for the Elderly for instance has frequently sponsored such research previously. O'Mahony in 1986 conducted a survey on the social circumstances of the rural elderly, highlighting the importance of adequate transport and access to facilities. It was also a key element identified in Connemara West (Byrne et al. 1990). A sample of medical card users revealed that 49% of that population were on unemployment assistance or old age pension and in every area, the ratio of car owners per household was less than one, a serious matter in a region with minimal provision of public transport.

The general picture which emerges from these surveys is of key sub groups of older people characterised by a lack of basic household amenities, a high level of dependency on State pensions and allowances, absence of a car or telephone, relatively high levels of illness and serious mobility problems, relatively long distances to travel to shops and other amenities and high costs incurred in gaining access to services by lifts, taxis or hackneys. Allied to this, and also mentioned by a number of authors, is the self evident need to elicit what older people *themselves* feel about their living arrangements. This kind of qualitative research has also been undertaken by the Council, for both urban (Horkan and Woods 1986) and rural people (Daly and O'Connor 1984). It may well be that older people are likely to balance the advantages of personal autonomy and land ownership against their anxiety in relation to living alone. A recent survey of public health nurses' "at risk" registers in the county of Galway, undertaken with the support of our own Department of Health Promotion, identified considerable heterogeneity in criteria for such a listing, but the main reason was that the client was living alone (O'Shea M. 1993). A key policy issue is the contribution of sheltered housing to longer term accommodation provision for older people. O'Connor, Ruddle and O'Gallagher (1989) rightly emphasised that such accommodation should not be institutionalised and should be adequate and broad ranging in its options. These are fundamental features of a health promoting housing policy.

### *Source of Income*

Older people's households are more dependent on the state as a source of income than other households. In 1987, for elderly households without spouse or children, state transfers constituted 57% of gross income; for elderly households with wife and/or children state transfers amounted to 53% of gross income. The corresponding figure for all households in the economy was 18%. Private pensions accounted for 20% of gross

incomes for single elderly households and 26% for older people's households with wife or children. Income from investments, property, wages and salaries constituted only a small percentage of older people's gross income. This information must be interpreted with caution given the reluctance of individuals to reveal details of personal income to interviewers.

While the basic economic situation of older people in the country may be relatively improved, this is not a cause for complacency. Finally, if one accepts the health impact of long term unemployment and its implications for old age, the long-term investment in ill-health is likely to be considerable in a country with such high rates as Ireland. We know for instance that mental health is affected by such circumstances, and that major illnesses like heart disease and its predictive risk factors may be affected.

## CHAPTER 3

# Health Service Utilisation by the Elderly

### Summary

**Health service utilisation and its likely economic implications are important components of a health promotion strategy. Health costs worldwide are escalating. The importance of dependency and disability is a key factor. Allied to this is the role of social care. The economic gradient associated with ill-health also applies to the elderly. For instance, depression and other evidence of psychiatric illness are strongly means-related in older people. The health promotion approach must therefore focus both on skills development at all ages in preparation for ageing and on a concerted socio-economic perspective to reduce inequality. The gain in economic terms should be quantified but will need to be broad-based and inter-sectoral in its considerations. Where the older person comes in contact with the health service, it should be both philosophically and organisationally client oriented. The contextual approach to health promotion recognises the importance of supportive environments at all stages of the caring process, but most particularly of course in primary care. Concepts such as the Patient's Charter and quality assurance in care can all be directed to a more caring approach.**

Although it is repeatedly stressed that only a minority of older people are dependent, health service utilisation remains a critical factor in long-term social provision. More than anything else, it is the economic implications of increased health service utilisation by an ageing population that have concentrated attention on the scope for prevention of specific illness and health maintenance generally (Schneider & Guralnik 1990). Expenditure on health care is expanding everywhere, most developed countries spending an appreciable proportion of their Gross National Product (GNP) on this annually. In Ireland, this figure is around 6%, having contracted relatively in the last decade. In the United States, the rise in expenditure on health care has been exponential since the Second World War. In addition, the social change in the status of the elderly, discussed earlier, has greatly increased collective political lobbying power, particularly in the United States.

## **The Economics of Health Promotion**

In economic terms, the issues in relation to older people are complex. Firstly, improved survival time clearly means an increased volume of clients who must ultimately require some kind of health services. We do intend, at the least, to attenuate the effects of the age related chronic diseases by health promotion strategies, and in some cases, to eliminate them altogether. However, there are certainly resource and manpower implications of increased preventive medicine and personal health education programmes needed to achieve this. The objective is that this should be offset by health gains later on. Many of the organisational changes required in social and health services will require negotiation and short-term upheaval, but this does not necessarily imply increased overall monetary costs. Although it has been stated earlier that community care is not a simple, *cheaper* prescription, it is likely to be a cost beneficial one if adequately applied. The real need in economic terms is for indicators that will measure gain so that these can be relatively evaluated.

### *Measures of Health Gain*

We have only recently started to formulate such measures. As Maynard points out (1992), health economics in treatment services grew up in a haphazard, relatively poorly evaluated way. Despite criticism to the contrary, we are in fact being more fastidious in measuring outcome related to health promotion. The QALY method is one which at least allows for a more realistic costing of competing therapies (Godfrey et al. 1989). It is possible for instance to compare the relative cost of coronary artery by-pass surgery with general practitioner advice to stop smoking, by making certain logically linked assumptions, including estimates of outcome. By definition, such methodology requires a wide-ranging database to inform it accurately. I do not believe that the costs of investment in developing databases of this kind will outweigh the gains and I would like to see the kind of health services research to prove it. This is however in the earliest stages as yet in this country.

In expressing health gain, we now discuss life expectancy in terms of active or dependent expectancy. This at least focuses our thinking on quality as well as quantity. It can be demonstrated for instance that while women live longer, their functional independence is less than surviving men of an equivalent age (Katz et al. 1983)

### **Disability and Dependency**

A key difference in preventive medicine strategies for older people and that of other groups is the goal of preventing chronic disability and

alleviating the dependency imposed by disability. Disability is defined as a loss of resources which interferes with an individual's ability to independently engage in activities needed to maintain his or her quality of life. Dependency consequently is the need to rely on other people to perform tasks important to an individual's quality of life. This is clearly relative, in that hearing may be more important to a music lover or perfect visual acuity to a craftsman. Discovering the extent to which these real disadvantages infringe on quality of life is a legitimate component of health promotion.

Dependency is an age-related phenomenon. Population based figures are hard to find. Whelan and Vaughan (1982) assessed the functional capacity of older people by a number of measures related to everyday tasks. This confirmed the differences between men and women and the

**TABLE 3.1: Functional Capacity of Older People at Differing Age Ranges:**

Activity	Level of Difficulty	65 — 69		70 — 79		>80	
		M	F	M	F	M	F
Getting on or off a bus	None (%)	63	60	58	39	33	18
	Impossible (%)	10	12	10	18	24	43
To climb a flight of stairs	None (%)	72	70	64	52	36	24
	Impossible	4	5	5	8	14	31
To walk half a mile	None (%)	77	74	74	55	40	26
	Impossible (%)	5	7	5	10	23	38
To take a bath without help	None (%)	80	83	75	62	45	28
	Impossible	4	5	5	9	15	37
To dress without help	None (%)	92	92	88	82	73	60
	Impossible (%)	0.6	1	1	2	5	11
To hear easily	None	86	90	81	83	58	62
	Impossible (%)	1	0.3	0.5	2	2	6
To see, read a newspaper	None (%)	87	87	84	78	64	56
	Impossible (%)	2	2	2	4	6	11

Source: Whelan and Vaughan, ESRI 1982

age gradient (Table 3.1). Ten to twelve per cent of men and women aged over 65 found it impossible to board a bus, for instance. By the age of 80, those numbers had risen to 24% of men and 43% of women. When looked at in a different way, according to the days per year when unable to carry out normal activities, a trend over time could be seen for both sexes, with a particularly steep increase, four-fold in women between the ages of 55 and 80. There is also a shift in the distribution, so that the ratio of dependency is much greater in middle age in men (Table 3.2).

**TABLE 3.2: Average Number of Days per Year When Unable to Carry out Normal Activities**

Age in Years	18-29	<39	<54	<64	<69	<79	≥80
MEN	0.38	0.41	0.81	2.38	2.05	1.53	2.86
WOMEN	0.66	0.46	0.46	1.02	1.05	1.77	4.16
RATIO	0.6	0.9	1.8	2.3	1.95	0.86	0.69

Note that there is a trend for both sexes, with a particularly steep increase, four fold in women, between the ages of 65 and 80. There is also a shift in the distribution, so that the male:female ratio of dependency is much greater in middle age and early old age in men.

Source: Whelan & Vaughan, ESRI 1982

The health sector provides us with a different kind of data in that the rates are likely to be skewed toward more serious disability. The proportion of older people on the Public Health Nurse (PHN) register who are physically dependent varies arbitrarily, but is less than 33% in a representative sample of people over 75 in the West of Ireland (O'Shea, M. 1993). This contrasts sharply with the proportion deemed socially dependent in the same study, living alone being the most commonly cited reason for inclusion (55%).

There are therefore two areas to be focused on in discussing dependency, and hence the scope for health promotion strategies. Firstly, there is a review of the support that individual people have, which can vary from their personal resources and skills to family and wider social support. Secondly there is the question of the degree of preventable medical conditions from which they suffer.

### *Cognitive and Psycho-Social Dependency*

One of the prevailing myths in contemporary society is that ageing in itself is a disease. While it is true that there is a progressive decline in function and capacity over time, specific conditions are the predominant cause of debility and dependency at any age.

Deterioration of mental function is particularly critical. Epidemiological data do not support the contention that loss of cognitive function is specifically due to ageing (Breteler et al. 1992). Only about 10% of the population over 65 have significant mental impairment. When present it is most commonly due to atherosclerotic conditions including stroke, Alzheimer's disease, Parkinson's disease and other degenerative neurological conditions. There is a wide time range between onset and deterioration from Alzheimer's disease, which is of unknown aetiology. Overall estimates in Europe, based on a recent analysis of such surveys,

suggest a prevalence of 0.4%-11.2% for women from 60 to 80 years and 0.3%-10% for men at the same ages. It is not currently either preventable or treatable. However, early intervention, home care and residential support can all be focused on this condition. Because of its prevalence and its devastating impact for all concerned, it does merit scrupulous attention to divine its aetiology.

### *Psycho-Social Dependency*

Health promotion is a positive concept but it does not seek to deny the reality of the human condition. Increasingly, as one ages, bereavement is a part of life. The loss of a spouse or close companion is a highly stressful development. Epidemiological evidence supports the fact that individuals have higher rates of symptoms, illness and death in such circumstances (Kaprio et al. 1987). On the other hand, the ritual of mourning and subsequent family support is an ancient part of human civilisation. Care for the terminally ill can also be approached in a positive, holistic and supportive way. The hospice movement and its role in palliative care in terminal illness is relatively well developed in Ireland. A review of this, comparing institutional and home care in the management of final illness would be research of considerable importance.

Another area to be considered in this context is the fear of personal violence, which occurs for different reasons in both urban and country dwellers and can be a serious limitation in the lives of older people, whether in fearing to live alone, or in being limited in their social activities.

### *Social Care*

A key determinant of service utilisation is the contribution of informal care. A recent report has identified that, in the case of dependent older people at least, there is a largely un-costed and substantial contribution (Blackwell et al. 1992). In the majority of cases the carer is a woman, being either a child of the older person (29%) or a child-in-law (29%). There was evidence also of relative under-utilisation of available services and lack of knowledge about both professional and voluntary services among carers (Tables 3.3 and 3.4). There was a huge commitment in time terms by carers to their dependent relatives, and a significant trend towards lower socio-economic status among carers. Their requirements included some financial recompense for their work, improved training and information in relation to caring, and the provision of adequate respite services. The authors conclude that community care may not necessarily be the cheaper option, but if considerations such as quality



**TABLE 3.3: Average Number of Visits per Week Made to Older People by Professional and Voluntary Agencies, by Category of Dependency**

Dependency Category	Number of Visits Per Week						
	GP	PHN	Chiropodist	Social Worker	Home Help	Meals-on-Wheels	Priest
A	0.12	0.10	0.002	0.00	0.00	0.00	0.10
B	0.23	0.04	0.002	0.00	0.14	0.17	0.15
C	0.24	0.11	0.013	0.01	0.53	0.00	0.22
D	0.28	0.27	0.002	0.00	0.00	0.00	0.38
E	0.23	0.76	0.000	0.00	0.64	0.42	0.59
Non-scale	0.13	0.50	0.000	0.00	0.49	0.00	0.24
All	0.17	0.17	0.003	0.00	0.16	0.05	0.19

Source: Blackwell et al. 1992

**TABLE 3.4: Average Number of Visits per Week Made by the Elderly Person to Statutory and Voluntary Services by Category of Dependency**

Dependency Category	Number of Visits Per Week				
	GP	Chiropodist	Pharmacist	Out-patient Clinics	Hospital Day Care Centre
A	0.11	0.04	0.06	0.03	0.01
B	0.11	0.02	0.05	0.01	0.00
C	0.11	0.02	0.02	0.05	0.00
D	0.03	0.01	0.00	0.05	0.00
E	0.00	0.00	0.00	0.00	0.08
Non-scale	0.01	0.01	0.02	0.00	0.13
All	0.09	0.03	0.04	0.03	0.02

Source: Blackwell et al. 1992

of life are taken into account, then this continues to be a cost beneficial option in health promotion terms.

However, there are surprising gaps in what we can infer about carers. For instance we do not appreciate that many such carers are older people themselves and that older people often prefer to work with people their own age. A considerable burden of caring falls on informal carers at home. Their needs constitute a significant focus for health promotion efforts in this country.

We know less about the specific educational needs of carers and about what the most appropriate courses might be. Much of these needs are being catered for by various voluntary and adult education groups. There are likely for instance to be different demands by formal and informal

carers. Our recent survey in Galway confirms this (Counihan et al. 1993). Both groups would like to develop their knowledge and coping skills, but those in employment would also like to see some benefit to their career prospects.

The many issues related to caring have been relatively well researched in Ireland in recent years, (O'Connor J. et al. 1988a and 1988b) both in quantitative and qualitative terms. The picture we have presented so far is of ageing as a process in which more and less serious problems are to be anticipated, even if they are not actually present in many cases.

While it is often thought that isolation and loneliness are common problems in old age, this may be largely untrue for the majority of old people. In any case, isolation cannot be automatically equated with loneliness. Older people may have a wide variety of social supports. Johnson points out that the prevailing belief that the nuclear family has been destructive in its effects on the elderly may not necessarily be true (1988). It is likely that modern families are at least as supportive as in the past, but the sheer volume of the ageing population due to population expansion has occurred in a climate of contracting social services and has resulted in a mismatch of provision.

Voluntary groups in Ireland provide a wide range of community services for the elderly. While substantial heterogeneity is evident in the elderly population, those who live alone do seem to be significantly more deprived than others. Effective policies to alleviate the problems of this group would make a substantial contribution to the overall well being of the elderly population.

Older dependent persons being cared for at home are likely to be women over eighty and have many health problems. Many have high levels of dependency. Carers may themselves have some health problem. The caring role can be stressful, often involving a restriction in employment, added expenses and a poor social life. Personal relationships may also suffer. The opportunity cost of becoming a carer is therefore high.

### **Health Service Utilisation**

A general examination of health service utilisation confirms the age gradient one might expect (Table 3.5). Only infants under one year rival those over 75 years in frequency of hospital stay (Nolan 1991). Again, out-patient visits increase in frequency with age as do visits to the general practitioner. However, while physical illness is strongly related to age this is not necessarily so in the case of mental distress, as measured by

**TABLE 3.5: Out-patient Visits by Age Group**

Age	% Having had a Visit	Average Number of Visits for These
Under 5	9.9	3.7
5-24	6.9	3.9
25-64	11.2	4.4
65 and over	12.9	4.5
All	9.7	4.2

Source: Nolan, ESRI 1991

**TABLE 3.6 : General Health Questionnaire (GHQ) Scores According to General Medical Services Entitlement Category**

Entitlement Category	Percentage of Respondents in Category with Score above Threshold	Percentage of all Those with Scores Above Threshold in that Category
Category I	25.3	53.0
Category II	13.5	41.3
Category III	8.3	5.7
All	17.1	100.0

Source: Nolan, ESRI 1991

the General Health Questionnaire (Table 3.6). This is shown in Nolan's Study to be much more likely to relate to social class *per se*.

### *Quality Assurance in Service Provision*

What, in health promotion terms, constitutes an appropriate service? It involves a re-orientation, not simply in organisation, but, more subtly, in philosophy. The objective is that it should be client directed, user friendly and geared to the needs of people on the ground; the paramount aim should be to help make old age a positive experience. This is necessarily difficult to achieve.

### *The Client-Provider Relationship*

There is a potential dilemma on the part of the health professional, precisely because he or she is the product of a lengthy training process which involves the accumulation of knowledge, skills and experience directed towards dealing with problems rather than the support of healthy living and the exercise of more choice on the part of the patient. Indeed, it is often on the basis of having a problem that, by definition, advice is being sought by the client. In addition, the relationship between client and provider can, to some degree, have an underlying adversarial element, fuelled in recent years by factors such as the threat of litigation

in relation to malpractice. Finally, professionals within the health services find themselves harassed by increasing workloads, and the impact of cuts in health service expenditure. Health workers who are themselves under stress are unlikely to function well as health promoters for their clients. The aspirational aspects of the relationship are therefore strained by very real concerns on the part of the providers.

However, for the older person too, the experience of soliciting assistance or care can be difficult. Older people, by definition, are more experienced in life than the health professional in whose charge they find themselves. Here, changing social customs may be relevant. Issues as basic as how one is addressed can be difficult. Should one be addressed by one's Christian name (friendly) or by one's surname (respectful)? Research presents arguments for either side (Mc Kinstry 1990). The Patients' Charter, issued by the Department of Health in 1992, took up the promise made earlier by the PESP (Programme for Economic and Social Progress, 1991) in regard to the issue of patient rights. As it stands, it is a limited and over-general document, but the basic principle is in line with similar developments in the United Kingdom with a message of quality assurance in service provision generally. These principles are also part of the explicit General Mission Statements of many of the health boards in this country. To date the provisions of the Charter have been confined to the hospital sector. Indeed, the WHO concept of Supportive Environments recognises the principle of the Health Promoting Hospital. This means active consideration of how conducive a place it is for all concerned, including the patient.

### *Provision of Services*

An important issue arises in relation to the conventional organisation of the health sector by programme. We know that there has been considerable upheaval in the hospital sector because of acute cost constraints, and of the special hospital services due to a more community led policy. In the community care area too, there are signs of change. The re-organisation of public health medicine has been advocated by a report entitled *Community Medicine and Public Health: The Future* under examination by the Department of Health (1990). A key feature of all proactive health services is that they should be need based and budgeted on such a basis. This calls for two things, improved community surveillance that takes account of socio-demographic health status and health requirements, and an organisational structure that can ensure effective service delivery. At the moment this is lacking in all our service sectors. It is small wonder then that impediments arise at all levels to the implementation of necessarily complex and sensitive client led

programmes. Crucially, no service can be truly client led unless it contains a systematic and significant input on the part of older people themselves.

Better communication between sectors would be highly beneficial. In the last number of years the overlap with community psychiatric services has not been clear. In practice the community care programme in Ireland has a much wider remit than that in other countries, including functions that overlap with social welfare, environment, and transport. The United Kingdom solution to this diversity was the introduction of a service purchase mechanism that moves with the client.

Rationalisation of out-patient services could include more local satellite clinics for specialist services and closer cooperation between general practitioners and consultants in management of chronic problems. This ties in closely with genuine logistical constraints such as geographical distance. The population density in the Western Health Board is one-tenth that of the Eastern for instance, while the geographical area is much greater, meaning that the provision of a cost effective service by definition requires different management strategies in both areas.

### *Consumer Satisfaction*

There is evidence that by and large consumers are satisfied with those providing health services, though, as will be discussed elsewhere, this may to some extent be a function of the techniques used in eliciting the information. Those in Connemara West were for instance very appreciative of public health nurses and general practitioners (Byrne et al. 1990) though they were particularly concerned with problems of access and distance from acute hospital services. There is also considerable concern at a political level in this country about the availability of adequate hospital services. This so-called medicalised view of health can coexist with trends towards personal empowerment. The same Galway area for instance has been the focus of active community participation, particularly by women, in the last decade (McNamara 1991).

A key figure in the liaison between community services has been the public health nurse. Nurses themselves, health service managers and the general public all recognise their potential role in promoting health. In effect however, a high proportion of their time is engaged in clinical services. Maura O'Shea's recent survey (1993) of the At Risk Registration process for the elderly revealed considerable flexibility between nurses in criteria for inclusion. Rationalisation of liaison between health professionals within the formal health sector would be a considerable gain to the elderly. The notion that the client knows best is a basic tenet

of economics. It is also a first principle of marketing. We therefore find a concept developed independently in several social science disciplines being applied in health promotion, though it should be said that more research is certainly needed on what clients' views really are. The Geriatric Medicine service does recognise the social context in which individuals cope with specific problems, the possibility of multi factorial and multiple problems and the need for a seamless multidisciplinary service. This is also the principle on which the coordinator of services for the older person must function in the community; correspondingly flexible information retrieval systems are required.

### *Client-Oriented Services*

It is probably necessary to point out that two very different impressions are produced when we look at the large-scale patterns of provision for older people in Ireland from the planner's perspective and conversely the experiences which individuals themselves are likely to have when they face, or attempt to respond to, predicaments associated with ageing. Even though the majority of older people may be in good physical health by accepted medical standards, the same individuals' actual experience of their own bodily conditions may be frightening, depressing or humiliating. This was particularly well expressed by Simone de Beauvoir (1970). How do people assess whether or when to attend the doctor's surgery, for instance, and whether to ask the doctor to visit at home? How do they interpret their symptoms — perhaps as precursors of a state of dependency and social exclusion? Other stages of maturing — parenthood, for example — are more widely discussed than ageing, both in everyday social life and the media, so that individuals have more opportunity to discover what the general norms of behaviour are and to decide whether or not to orient their conduct towards them. Significant individual predicaments may be masked by a quantitative overview that does not take these factors into account.

Applying such consumerist principles to housing, for example, we might ask what situation an older individual is likely to enter when reaching a stage of heightened dependence. Can this person easily acquire information about the options available? Can carers or other concerned people acquire the same information? Is there a wide range of choices on offer, so that the individual can take an informed decision on, say, whether to make physical alterations in his or her own home or whether to enter a residential home? Are there personnel available to make a socio-medical assessment of the older person's abilities and requirements? Is there a wide range of residential accommodation, suited to different needs and lifestyles, and is there ample information to guide

individuals. In most parts of Ireland the answers to these questions will be largely negative, not alone because such services are not always available, but also because they are poorly accessible. Listening to the expressed needs of individuals themselves may be more effective in the long run, as was found in an initiative undertaken in Clonmel in the late 70s (Dr. Patrick Joseph Solan, personal communication).

If we continue to consider characteristic predicaments of older people from the point of view of responsible individuals, in charge of their own fates, residential care provision for them can be seen to be starkly wanting. Maura O'Shea (1993) has shown that although a majority of residents in care have owned their homes before entry, in private establishments in County Galway only 20% of them have their own furniture — and in public long-stay care only 5%. In view of the practical and symbolic value of one's own property, representing the experience and the attitudes built up during a whole lifetime, this figure represents a tragic overall situation, and one which contributes to the image of ageing as passive and empty.

It is urgent that a survey of possible residential choices be drawn up and pursued; options include adaptation of the individual's original dwelling, age-mixed and age-unmixed sheltered housing, and care which allows control of their own lives to residents. In establishing such a survey it should be recalled that we do not yet know all the preferences which older people have for the conduct of their lives, and it has now become crucial to institute research on this topic.

## CHAPTER 4

# Societal Attitudes and Behaviour in Relation to Ageing

### Summary

Perhaps the most critical determinant of future policy in relation to ageing is our view, as a society, of what is appropriate health behaviour in the “third age”. This includes our understanding of ageing generally, the expectations of the young and middle-aged and the views of those already old. Health promotion is about perceived control and so personal outlook is the starting point for this process. Research to date indicates that many attitudes are highly variable across cultures. New research is being undertaken to establish an agenda of need on the part of the older people, with important practical policy implications. Paradoxically however, many of the methodologies are simplistic and under-developed and the application of more sophisticated techniques is likely to be time-consuming. More research is needed into this. The influences on attitude formation are various and stretch from early childhood. Agencies such as Age and Opportunity, established to promote attitude change where needed, are extremely important.

### *Ageism*

Before proceeding to discuss what we know generally about societal attitudes and behaviour in relation to ageing, it is worth examining how arbitrary our definitions of ageing and retirement are in the first place. One remarkable aspect for instance is the way in which 65 years became virtually ubiquitously accepted as the normal age for retirement. This has never been satisfactorily explained. There are no economic, social, gerontological or other reasons for the selection of this particular age. Ageism, the widespread stereotyping of people because they are old, leads to attitudes with generally negative features which show prejudice against older people. It is likely that some of the attitudes based on the age of a person are also based on personal experiences with older people, including relatives. One’s attitude towards ageing is also relative to one’s own age and ageist attitudes have been shown to begin as early as eight



years of age (National Council for the Elderly 1987). Ageism leads to people thinking of, and behaving towards, older people as though all older people were the same and not individuals in their own right. This is an area that has been targeted by agencies in Ireland such as the National Council for the Elderly and Age and Opportunity. In addition, it is an important focus for media campaigns during this European Year for Older People. In 1993 for instance, the National Council for the Elderly is launching two publications for use in the classroom with primary and secondary level pupils. Age Concern in the United Kingdom has already begun a poster campaign to combat these apparently highly prevalent attitudes (Bedell 1993). The report on attitudes to ageing produced on behalf of Age Concern in 1991 highlighted a number of these factors. Midwinter (1991) identifies the polar concept of age as opposed to youth as a contributory factor. For this reason the emphasis is now placed on progression as a natural lifetime process and an attempt to promote empathy by asking individuals to see this in their own life situation. Ageism, since it denies a process inevitable in oneself, is destructive to the individuals and groups manifesting it as well as to older people themselves. It also has a 'freezing' effect on both parties in such a relationship, reducing the opportunities for choice on both sides. In this sense it is the antithesis of health promotion.

### *Eurobarometer*

For over 18 years, the Commission of the European Community, through DG X, the Directorate-General for Information, Communication and Culture, has organised a twice-yearly survey covering each of the Member States. In 1992, a special survey of the European population aged 60 and over was also undertaken. There were a number of interesting findings, both in relation to Ireland in particular and in comparison to other countries.

Firstly, the term previously most commonly applied to this age group by policy makers, "the elderly", was overwhelmingly rejected. Just 6.6% of Europeans generally favoured it. In Ireland the percentage was 12.3%. We here favoured the term "senior citizens", as, interestingly, did our closest neighbours (both physically and lingually), the United Kingdom.

Despite the prevailing adverse publicity given to alleged antipathy by the young towards older people, 44% of Irish people felt that they were treated with greater respect as they aged. The most frequently cited ageist institutions were those with responsibility for social security (18%) and local authorities generally (19%), contrasted with one's own family (8%).

Those viewing old age positively as giving a new lease of life constituted almost half the sample (44.8%), Ireland scoring fairly typically (43.9%). Most interestingly, a third of older Europeans (33.9%) felt themselves to be very busy. Half of all Irish people surveyed had daily contact with family, and only between 10% and 14% stated that they were often lonely. There was also a high level of interaction between young and old people, 36.4% in Europe generally, with Ireland highest in Europe at 46.4%.

However, issue-specific politicisation was relatively low. There was evidence of active interest in current affairs, in that three-quarters of older Europeans read a newspaper or magazine regularly. In Ireland, that proportion reaches 9 out of 10. However, only 17% of Irish people would support an issue based party. This might be taken to mean equally that they felt well represented by the structure as it stands, or the converse.

The proportion of people receiving regular household help again varied by country, Ireland ranking sixth at 32%. Overall, the rate of reported functional incapacity was 38% of the population over 60, but this varied considerably between countries, suggesting some subjectivity in interpretation. It also displayed an age gradient.

A classical issue that is much discussed in both professional and more general circles is that families are no longer as caring as they once were. Just over a third of the total sample agreed strongly with this, a further third agreeing slightly. This was less marked in Ireland, being about a quarter in each of these categories.

The survey of the general population also yielded some interesting findings. There was strong support for legislative measures to limit age discrimination. Nearly 79% believed that such discrimination currently existed. There was some variability in the proportion who supported flexible retirement. This was lowest in Greece at 20% and highest in the Netherlands at approximately 66%. In Ireland the figure was almost 40%.

The survey also found that financial security in old age may have some connection with the degree of optimism with which those of a working age view the future.

Data of this kind are highly useful at several levels. Firstly, they provide a basis to persuade policy makers of the need for change by measuring the degree of manifest support. Secondly, they establish a cross-cultural comparison. However tantalising, a quantitative survey of this nature

cannot adequately probe the underlying reasons for these attitudes or successfully predict changes.

### *Violence Against Elderly People*

The adverse side of ageism has also been to some extent expressed in the growth of a phenomenon defined as elder abuse. Again, there is some danger in categorising abuse in relation to age and hence creating a form of pejorative terminology. However, for practical purposes what is meant is some form of physical, emotional or psychological abuse of an older person by someone in a position of trust, possibly a formal or informal carer. A key factor is the powerlessness of the victimised older individual. This has been increasingly studied in recent years. The reported incidence varies, but could be in the region of 30-40 per thousand (McCreadie 1991).

This issue is a legitimate concern for any health promotion policy, since its causes lie in the social circumstances of both the older person and his or her carer. It is the subject of a report produced by the Council of Europe in 1992. Measures to intervene include due recognition and support of the carer role, which has been mentioned elsewhere, and adequate wider social support. However, the complex interaction between individuals as we age merits further study and is certainly inter-linked with our general attitudes as a society to the process of ageing.

### *Research Methodology for Elderly People*

While the importance of understanding individual and collective motivation in relation to health behaviour is undoubted, it is surprising how little the methodology for such research has advanced, not only in Ireland, but also worldwide.

Work carried out elsewhere on the requirements of elderly people itself leaves a good deal to be desired. Research on needs and attitudes of older people tends to be too generalised (suggesting across-the-board solutions for elderly people despite their wide variety of different situations), rather inflexible, and lacking sufficient input by elderly people themselves. This is partly related to insufficiently self-reflective methodologies and to inadequate conceptualisations of the central questions involved. Although policy formation urgently requires information about the attitudes of elderly people towards themselves, and about what people expect from ageing and the elderly, conventional methods of asking the relevant questions are to date not adequate.

Policy formation is also handicapped by the fact that sociological and health-related work on elderly people has failed as yet to establish a

range of profiles of perceived needs and abilities for the vast majority of older people who enjoy good health. This is a significant failure if old age is to be perceived and experienced in a positive manner as a period in which the individual exercises choice about his or her activities and circumstances.

Social gerontology, understandably enough, has no definitive theoretical framework. This is because it is fundamentally an applied multi-disciplinary area of study. However, there have been distinct trends in this field of research that both reflect the wider theoretical debates of the period in the social sciences generally and also reflect the prevailing paradigms current in the management of ageing. Victor, in her review, *Old Age in Modern Society*, summarises these (1987). She confirms the thrust of the present paper, that old age is frequently framed as a problem, automatically reinforcing the usage of measures of ill-health as yard-sticks for the management of ageing. Cumming and Henry's disengagement theory, formulated in 1961, implies that natural ageing involves a gradual withdrawal from one's social commitments, the ultimate expression of this process being death. This theory fits within the more general functionalist tradition of sociology. Indeed, health definitions are problematic generally. McCluskey's recent Irish survey (1989) found that almost 49% of the study population defined health as being illness-free and 33.5% used a performance orientation, as in retaining the capacity to work.

The antithesis of disengagement on the face of it, is the activity theory. This prescription for successful ageing seeks to deny decrepitude by preserving the attitudes and characteristics of middle-age. Both theories however seem to me to make the assumption that there is a qualitative distinction between old age and other life stages, and to a lesser extent that there are inevitable characteristics associated with that process. The last thirty years have seen the application of a wide variety of theories to the issue of ageing. A more developmental approach is now employed, focusing on biographical approaches. An important feature of these new approaches is their attempt to more fully elucidate the cumulative and diverse influences on longer human lives. What I would like to stress here is that we have not sufficiently explored the possibility that the paradigm employed by the investigators may be dictating in itself the outcome of attitudinal research to some extent. This is particularly true when we try to transfer inferences from one culture to another. Victor also cautions her readers on this, citing the fact that much of the existing database is North American in origin.

### *Media Influence on Attitude Formation*

One powerful influence on social attitudes is likely to be that of the media. However, the role of the media in health promotion has undergone considerable reassessment in recent years. Though initially felt to be a very strong force in forming social attitudes, it is now recognised that mass media, at least, function primarily by raising awareness and providing an external cue to action (Winett, King and Altman, 1989). In other words, an inclination on the part of the viewer may be reinforced by what he or she sees. There are also different effects on the parts of the print and visual media so that more focused and detailed messages can be transmitted by means of print, whereas the visual rather than the verbal content is more important in television and film.

The maturing of health education strategies in this respect also refers to the type and content of material. Most of the community intervention programmes to date have either used local media or relied on solicited material by journalists. However, there is still a tendency to produce health education material that is earnest in content or overly negative. It is true that the budget for health promotion marketing is minuscule compared with the commercial sector. However, in general, it is also not very appealing. In particular the use of humour is both a highly skilled and under-used approach.

Meanwhile, the media themselves are responding to consumer demand by a change in strategy. The achievement of a Hollywood Oscar by an octogenarian is arguably a signal of change, the merits of Jessica Tandy's performance in "Driving Miss Daisy" aside. In addition, the success of situation comedies like 'The Golden Girls' (which is concerned with the lifestyle of four ageing women friends) may well be indicative of change. The recently published policy document of the British Broadcasting Corporation (1992) is specifically concerned with the influence of ageing on their target audience.

Age Concern in the United Kingdom has offered advice to programme makers on technical aspects of the content. This is to be strongly welcomed.

### *The Influence of Socio-Economic Circumstances*

Attitudes to health maintenance among older people themselves are influenced by disposable income, social class and education. In turn, empowerment of older people is likely to be highly influenced by their expanding numbers, giving them particular power as a lobby group. The Grey Panther movement in North America for instance has been strongly associated with issues related to health maintenance and health care

generally. Their particular case is for a properly funded National Health Service (Robbins 1987).

### *The Relationship Between Lifestyle Behaviour and Underlying Attitudes*

Health promotion initiatives among older people have, as discussed earlier, tended to focus upon the epidemiology of the health problems of older people, with priority attention paid to smoking, alcohol use, nutrition, stress, safety and accident prevention. To a lesser degree, conditions of mental health such as depression and dementia have been considered principal areas for health promotion. While this focus is undoubtedly important, it sheds little light on motivation and outcomes of intervention strategies cannot necessarily be inferred from one elderly community to another.

### *Attitudes to Differing Causes of Ill-health*

From the outset, both quality and quantity of life are of importance and must be examined from a variety of approaches. As a provider of health care, I might want to maintain a healthy independent population as long as possible; as an ageing person myself, I might be interested in quality of life. Repeated attitudinal surveys in an Irish population (McCluskey 1989, Kilkenny Health Project 1986) show people fear cancer for instance more than heart disease. In a review of the efficacy of a strategy to reduce total population cholesterol compared with one to stop smoking, Rose and Shipley (1990) make essentially the same point. Many would prefer the swift heart attack to the lingering cancer. These very real sensibilities are an indication of common-sense motivation of ordinary people in relation to their health and they must be accounted for in any concerted strategy.

Health promotion for older people has to be based on the recognition that overall, despite a relatively high incidence of chronic ill-health, most older people are healthy. What therefore should they be looking forward to positively in old age? A sizable proportion of older people consider themselves to be of 'good or very good' health for their advanced age. Whelan and Vaughan (1989) show for instance that 59 % of men over 65 felt their health to be good or very good. The comparable figure for women was 56%. Likewise, it has been shown that the health and preventive practices of older citizens are generally equal to or better than those of younger people (National Council for the Elderly 1987). Fit elderly people are known to be capable of acting upon health promotion advice about factors such as diet, exercise and smoking. This is despite the fact that their habits earlier in life may not have been particularly 'healthy'. Hence, there is potential and scope for carrying

out health promotion activities among the elderly, and here a comprehensive, community-based approach is probably most productive.

What still needs to be discovered is what measures are appropriate enough in attitudinal terms to be effective in this area. In addition, these issues need to be examined in sub-groups of the elderly, such as by geographical area and by social class. As indicated earlier, mental well-being was correlated with socio-economic status and dependency is likewise a predictor of well-being. Ethnographic techniques have the value of minimising observer intrusion but are difficult to implement and evaluate.

Social participation and active leisure pursuits can make an important contribution to the well-being of older people. Negative attitudes to older people are common among the general public, health professionals and older people themselves. Such attitudes are one barrier to older people participating in leisure, educational and other activities and realising their full potential. There is for instance a marked regional difference in the exercise profiles of older people in Europe, so that many mainland northern Europeans continue quite vigorous leisure pursuits into old age. There has been a growth in the concept of the "third age" in Europe and North America. This has been much less marked in Ireland.

At present, then, there is a gap in both popular and academic literature with regard to what life in old age could offer positively, and we should aim to contribute to filling this gap. Here it would be important to avoid failings shown in some other work. Studies of older people frequently suffer from two related errors: an imprecise conception and methodological application of concepts such as 'attitude', 'value' or 'need'; and a tendency to reproduce taken-for-granted expectations of the elderly, whether these originate in society at large or within the academic world. One telling recurrent fault is an uncritical use of conventional social terminology, so that investigations fail to develop methods of tapping attitudes not easily be expressed in words, but which may have great potential for influencing action.

A case illustrating this difficulty is the question of choice. Many elderly individuals, for instance, may be unaccustomed at present to the idea that public services should enhance their capacity for taking control over their own circumstances. Thus, relatively standard questioning about their satisfaction with present services may elicit positive answers. As the same people become acquainted with modes of appraisal in whose terms situational choice is important, they may come to see that their own levels of contentment with what is available are not as high as they

had conveyed. This implies that positive comments on services may be highly misleading, and that we need methods of enquiry which yield greater depth and detail of response. Such problems show that original and appropriate conceptualisations and methodology need to be developed for use in areas such as this.



## CHAPTER 5

# Existing Strategies for Intervention

### Summary

**Health promotion strategies differ in various countries. Some, especially earlier initiatives, are primarily based around personal education and skills development for individuals. Others focus primarily on environmental change. Some have a specific health objective. Others have primarily social objectives that could result also in health gain. Community projects of different types have been instituted worldwide. The second generation of these are likely to focus more specifically on groups within society who have special requirements. Older people constitute one such group.**

Health promotion and service or care provision for older people must be addressed in parallel in order to fulfil health goals. A basic principle underlying such development, however, is that elderly people should be encouraged to take an active part in interpersonal and community life. In order to prolong the period of healthy ageing, healthy lifestyles and supportive environments are needed.

Health maintenance programmes in the United States which emphasise knowledge about service entitlement and facility for utilisation are very successful and might also be so here. In general, the programmes are based around self help in relation to medical matters. Anderson and Huntington (1987) cite a variety of health promotion programmes for older people which illustrate differing approaches in North America. These are predominantly education-based and are dependent on participation by aged people themselves. The *Wisdom Project* for instance is aimed at low income people of different racial origin with hypertension and involves a series of training programmes which focus on early recognition of disease and entitlement to services. Another, called *People Care for People*, is concerned with coping and caring strategies for life events generally, including with sexual matters.

### *Community Intervention Programmes*

An alternate strategy is more service based and places greater stress on environmental factors such as access, housing and transport. In Ireland

for instance, the *Forum Connemara West Project*, a poverty programme, is based around improved services, liaison with general practice and personal skills development in a social setting.

The hallmark of community intervention projects has been to facilitate social and community change that make health choices easier for individuals. On this basis it is recognised that they need personal skills to make such choices, but also conducive circumstances. Projects such as that in *Kilkenny Health Project* (1993) involve the traditional health and educational sector, voluntary and social organisations, local industry and commerce and the media to bring this about. This project will show its value as formative rather than outcome research and its principles could be utilised in a focused intervention for older people. This particular project was concerned with structures in a community and had a clinical focus as well.

As summarised in *Heartbeat Wales* (1985), there are three areas for approach: The need to teach (communication-behaviour change) the need to reach (social marketing skills) and the need to sustain (organisational framework). In all such projects, feasibility and process have been at least as important as outcome. Thus, formative as well as summative evaluation is relevant.

It is clear that awareness can be raised locally by such initiatives, but it is difficult to ascribe health gains specifically to the project itself, often precisely because of the ambitious broad-ranging nature of the initiative. The second stage of such projects worldwide may entail more specific intervention, as in the case of those on lower incomes or older people. This might serve as a useful framework for pilot projects of different kinds in health promotion for older people. The scope for community intervention programmes which incorporate intersectoral schemes such as transport schedules should also be encouraged.

It has been mentioned in several places in this document, and indeed by every relevant agency and committee in the last number of years, that community projects to facilitate multi-disciplinary and inter-sectoral cooperation are integral to the health needs of older people. In this respect, the National Council for the Elderly's recently published outcome of the Dun Laoghaire/Tipperary pilot projects on coordinating services for older people at local level, *Swimming against the Tide* (Browne 1992), is worthy of some examination. These projects were based in Dun Laoghaire Borough, a predominantly urban area in South County Dublin and South Tipperary, predominantly rural area. In both cases, the objective was to establish formal arrangements for the exchange of expertise, joint action and planning at community care area

level in order to improve the delivery of services at local level to elderly persons. Interestingly, despite the different socio-demographic and geographical locations, the frustrations and successes seemed similar. There was a sense of much effort for small reward. However, it might also be said that the barriers are truly formidable and that the commitment to change in itself was an achievement. There was also a sense of the goals being beyond the scope of the available resources. More worryingly, the membership of committees was less than representative. The voluntary sector, the general practitioner service, the private nursing home sector and carers were not adequately involved. Above all, older people themselves were not involved. The policy recommendations from this experience are similar indeed to what I am advocating. It is to tackle these problems that an urgent policy reform is required by Government. This is due to separate functional responsibilities by Government Departments, centralised administration, conventional status differences between professions, agency traditions at odds with the needs for co-operation and the absence of an articulated policy for partnership.

### *Adult Education Strategies*

The development of adult education programmes for older people in Ireland is relatively less developed than in other countries. This may have been a question of priority, given the fact that our relatively large young population and high rates of unemployment have created the focus so markedly in the area of young people. However, the growth in interest in adult education has been enormous. Most of the health boards have been prominent in health education initiatives (Madden 1992). An example of which I have personal experience is the Western Health Board which has sponsored health education courses in conjunction with local voluntary groups for a decade (McNamara 1991). These include the fostering of specific skills and improved knowledge in the area of nutrition, but also assertiveness courses are extremely popular. There are a number of practical home maintenance programmes that could be developed, as part of adult education programmes. Home maintenance includes self-help, catering and domestic skills. Another context is through the workplace with preparation for retirement programmes. A key feature of the North American health promotion movement, as indicated earlier, has been education programmes, both in the workplace and for ageing groups. This is one particular area which must be seen as an investment of ageing, since the person who is 55 now, will be a pensioner at the end of any strategic 10 year health promotion plan. However, we need to evaluate whether these programmes transfer from one culture to another.

## *Preventive Medicine*

A recent report of the Royal College of Physicians in the United Kingdom largely endorsed the findings of many similar groups worldwide in terms of appropriate preventive care for older people (1991). It recognised the benefits of giving up smoking at any age. It also stressed what should have been self evident, that the paucity of information on the effectiveness of intervention in older people derives from the fact that it has never been tried, rather than that it has been shown to be ineffective. (Most major intervention trials for instance have a recruitment age ceiling which precludes older participants (Medical Research Council 1985)). The report therefore endorsed a prudent lifestyle advice programme. In particular, it urged caution in terms of annual assessments for older people over 75 until more thorough comparative evaluation had been undertaken. Screening of older people in the United Kingdom has become a routine requirement of the General Practice contract. However, our General Medical Service is available free to only about one-third of the population and we have a choice of doctor scheme. The resulting flexible total patient registration and two-tiered entitlement service makes the administration of wide-scale opportunistic or recall health checks much less practical in an Irish context. Given our differential entitlement system to primary care, this issue might well merit a proper randomised study.

General screening programmes for elderly people have tended to have disappointing results but this may be a function of inadequate trials (RCP London 1992). In contrast, however, anticipatory care has been shown to be worthwhile. As over 90% of elderly people are estimated to see their G.P. each year, case-finding (anticipatory care) could readily be conducted in the G.P.'s surgery. It is considered to be an efficient use of resources. In most cases it means taking advantage of a routine consultation to check blood pressure, vision, hearing, mobility and mental capacity. To enable maximum independence and autonomy of elderly patients, careful assessment of their needs is important. Good rehabilitative facilities are recognised as being of prime importance in the care of older people. A pilot initiative on these lines is now underway through the Irish College of General Practitioners (ICGP) and is to be welcomed.

The importance of cohort changes in the major chronic diseases, mentioned in Chapter 2, must not be under-estimated in planning for future programmes. Consider for instance the relative declines in stroke, coronary heart disease and conditions such as stomach cancer. Also, changing lifestyle behaviour may reduce the rate of osteoporosis and hence hip fracture in the future. In the same way, successful health promotion

strategies for the young and middle aged are therefore an investment for healthy ageing.

A number of common health problems apply particularly to older people. Under-nutrition may be more of a problem than over-nutrition. Diet plays a role in the management of many health problems affecting old people (Mc Laughlin 1991). Elderly people require nutrient-dense foods. Many take dietary supplements. It has been shown that current supplementation practices are unlikely to alleviate the most common dietary inadequacies of old age. Hearing and vision deteriorate with increasing age (Whelan & Vaughan 1982). Impaired hearing can lead to social isolation. Wax is a common yet easily treatable cause of hearing loss. Audiometric screening of all elderly people can only be an option when available for all who need it. Elderly people are at greater risk than other adults of sustaining injuries. Elderly pedestrians are at higher risk of being killed or injured. Falls are the most frequent and serious home accidents involving this age group. Even minor injuries can pose major problems for old people in terms of lost confidence and fear of accidents. Falls should not be regarded as intrinsic parts of the ageing process. Many can be prevented by the implementation of simple measures. Any accident prevention programme must be multidisciplinary.

Osteoporosis is a common source of morbidity in older people leading to increased skeletal fragility and fracturing. Oestrogen therapy can delay the onset of rapid phase bone loss. Exercise is of benefit in maintaining muscle strength and joint flexibility and may retard the onset of osteoporosis. Important allied trends that may have a long-term impact include more widespread prescription of hormone replacement therapy for women, some studies showing a 30% reduction in the incidence of coronary heart disease in cohorts of women on unopposed, or oestrogen therapy. If these figures were reproduced on a wide scale there would be a major health gain for older women in two common causes of morbidity. However, the evidence at present is from self selected cohorts of Northern American women and applies to older formulations of hormone replacement therapy that contained oestrogen only preparations. Therefore, large scale intervention trials are urgently needed. A pilot scheme for these is under way in the United Kingdom and will commence in Ireland in 1994 with the support of the E.C. Biomedical Research programme.

Three-quarters of the population over 75 years of age are on some form of medication. Elderly people are the largest drug consumer group. Adverse drug reactions are not uncommon in this age group. Physicians need to be aware of the problems of older people in taking medication. Elderly people require to be informed about precise details of their

medication. Controversy about the benefit of anti-hypertensive medication has however been resolved to a large extent in recent years, the benefit for stroke reduction and congestive cardiac failure being appreciable.

## **PART 2**

# **The Future**

## CHAPTER 6

# Options for Future Research: General Considerations

### Introduction

This paper concerned itself with what we already know about the health status of elderly people in Ireland today. We must now examine how we can evolve an appropriate social environment to support ageing as a positive and even welcome phenomenon. It may be seen by now that the scope for health promotion is very wide-ranging. It can involve in principle any activity within the control of individuals, groups or societies that makes an impact on their health status. The following might be said to summarise the current situation: ageing is a gradual process. Worldwide and in developing countries particularly, life expectancy continues to increase. This means that for the first time in human history many people can expect to live a very long life, well past the currently accepted active stage of existence. A key issue is whether the chronic debilitating conditions that mar the later years can be curtailed. Is it inevitable that cardiovascular diseases, cancers, osteoporosis and dementias, to name the most common and troubling, must accompany ageing? Furthermore, are there cohort differences that may have important predictions for future resource allocation? Finally, having answered these basic questions, how do we put appropriate supportive strategies in place?

### Types of Study Design

Possible categories for further examination in relation to areas for future research include:

- (a) surveillance in relation to the social and physical environment of older people.
- (b) their attitudes to their own health.
- (c) ongoing epidemiological surveys of key age-related conditions.
- (d) basic methodological research into the causes of these specific conditions.



- (e) considerably improved, coordinated health and social services research.
- (f) intervention studies, clinical and field, of strategies for health promotion that build on the existing data base. This includes formative and summative intervention research.
- (g) evaluation of the teaching of personal skills and health education techniques generally.

The object of this paper is not to summarise each and every research initiative to date, rather to endorse effort where it is being made, whether by statutory, academic or voluntary agencies.

Scope for research has become recently very constrained in this country by the reduction in funding. National agencies such as the National Council for the Elderly itself, professional and voluntary organisations and industry do all substantially apply resources. A coordinated register of these would be a good start and could be undertaken by an appropriate body. The limited amount of available funding for research in this country is regrettable for many reasons, not least because it means that capable researchers in the medical and social science fields leave the country at a critical point in their career path and are less likely to return.

### **Surveillance**

Nevertheless, some new developments have taken place that assist in setting up research projects by providing a fundamental database. These should be welcomed and improved. The Government has recently established a *National Tumour Registry*, by building on the existing Southern Tumour Registry in Cork. This gives us, at last, the opportunity to monitor trends in cancer morbidity. To plan long term preventive strategies is impossible without such data.

The Department of Health also reestablished a *National Nutrition Surveillance Centre* at the Department of Health Promotion in University College Galway. This will utilise existing data from public agencies and research bodies to predict trends in relation to food consumption. Two recent national surveys of dietary practice had been undertaken through the Irish Nutrition and Dietetic Institute for instance, one for the general population and one on the habits of school-children. There is indeed a need to conduct similar periodic surveys on older people and also across socio-economic groups.

Within the health sector generally, data on morbidity and on needs assessment is minimal. This has been referred to previously as part of

the section on health service utilisation. Many of the health boards have been examining the coordination of databases. This is a discrete cost that should be budgeted for separately as an incentive to health boards and those contracted to them.

### **Attitudinal Research**

Throughout this paper I have been advocating change at two levels in order to seriously, coherently promote health for older people; Firstly, in the way we think about the issues involved, as individuals at all ages and collectively, as a society. To that end, I am suggesting a fundamental attitudinal review and if necessary further research to inform this process. The climate in which elderly people live at present is one in which their age in itself is regarded as a reason for stripping them of their identity, if necessary by the loss of factors which express that identity. We all live in fear of this fate and collude in it. This fear of ageing is expressed in the pessimism found in surveys in the young and is a way of coping with that reality. The alternative to this is to re-think our attitudes, and is probably just as feasible. The National Council for the Elderly has sponsored a further stage of attitudinal research by commissioning the Economic and Social Research Institute to conduct a population survey into a wide range of issues affecting older people in this country, together with their own responses. This is a very welcome development. In turn the Centre for Health Promotion Studies in UCG (with the grant-support of the Health Research Board) will be undertaking a more basic research project into appropriate interview methodologies for older people, using people who are themselves older.

### **Health Services Research**

The second area of change, which logically follows from the first, is of structural and organisational change to bring that about. This has involved building on the various but similarly motivated initiatives to inform policy and the putting in place of adequate surveillance mechanisms to direct client oriented services. Examples of the issues arising from this and possible scope for research have been discussed in Chapters 3 and 5. In earlier sections of this paper, I have advocated appropriate research into basic epidemiology, into health service provision, into community intervention and health education projects.

Epidemiological and basic scientific research into the aetiology of major chronic diseases may well be on a scale which is outside the scope of a country this size. However, considerable valuable research has been conducted in this country across all the areas of expertise mentioned above.

Research should be seen as integral to cost effective policy rather than an erudite or expendable extra in times of budgetary constraint. Recognition of economic constraint does however point to the usefulness of collaborative research both within the country and abroad.

### **International Collaboration**

There is of course every reason why Ireland should participate in collaborative European research projects. Public health will be recognised as a legitimate category under the terms of the Maastricht treaty, if ratified. We already have a number of schemes in place with Irish centres involved. This is especially important in areas such as cancer and cardiovascular diseases, (where international patterns are heterogeneous), for two reasons. Firstly, the cohort effect is likely to confound comparisons between generations. Secondly, we are critically concerned in health promotion with motivation. This is certainly culturally determined, to some degree. The importance of accurate comparisons in this respect are therefore critical.

The problem at present is that many of the programmes either require matched funds or are concerted actions which do not fund the internal national research. The Government should specifically support the national funds related to international projects that are suitably peer reviewed. This could be administered in a number of ways as necessary. The Health Research Board already channels resources and advice in this field. In the case of health services research for instance there is scope for more earmarked funding of active research and development and such schemes might be facilitated by individual boards, in cooperation with inter-sectoral partners as necessary.

## CHAPTER 7

# Directions for Future Policy

### Introduction: Strategic Perspectives

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

- (a) **Short term strategy** is based around the immediate needs of an already elderly population. Examples might include initiatives such as a review of housing and living conditions generally (*Chapter 2*), of existing health (*Chapter 3*) and educational services (*Chapter 5*) and how they might be improved. Where quality of life is concerned, the social needs that promote autonomy could be addressed (*Chapters 2 and 4*).
- (b) **Intermediate approaches** include the preparation for old age of those now in early to late middle age (*Chapter 5*). This is where planning and education for retirement as part of health promotion at work can be envisaged and examples here will include attitudinal surveys in relation to beliefs about health and people's own perceived capacity to change (*Chapter 4*). Within the health sector, screening programmes for the prevention of CHD and cancers could be considered (*Chapter 5*).
- (c) **Longer term strategies** are our investment for ageing into the next century. This means a review of socio-demographic factors such as emigration, unemployment, the shift from the Western seaboard (*Chapter 2*). Innovation into living conditions such as housing will also be necessary. Here too allied issues such as pensions and retirement schemes for significant and sizable communities like farmers may have a bearing on health. Government policy initiatives will be taken for motives other than health policy of course, but it will form a part. It also includes education of the young (*Chapters 4 and 5*) with consideration of ageing and attitude shift of upcoming school-children.

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

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

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

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

### **Build Healthy Public Policy**

Public policy for older people must, of necessity, be intersectoral. The existing Cabinet Subcommittee on Health Promotion, chaired by the Minister for Health, is underutilised and should be re-emphasised by the present administration. *The Years Ahead* made specific reference to such an inter-departmental Cabinet sub-committee, chaired by the Minister for Health, established as part of a revised national structure for health promotion in 1987. This component of the revision was highly

innovative, in line with the aspiration of the health promotion movement worldwide. It is to be hoped that it will be exploited more fully as a mechanism for addressing complex situations, where there is no real option but to involve all sectors and interests at policy level.

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

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

A recent International Conference under the auspices of Eurolink Age was held to discuss how European member states proposed to mark 1993 as Year of Older People. The general provisions of *The Years Ahead* were endorsed by the Irish group at that meeting and issues raised included the exploitation of this cabinet subcommittee as a policy forum.

The Health Promotion Unit in the Department of Health was established with the intention of influencing health policy generally, as well as the educational function previously undertaken by the Health Education Bureau. It also has the benefit, with the Minister, of advice from a National Advisory Council for Health Promotion. In this context, the Minister also has the advice of the National Council for the Elderly, whose terms of reference include advice on promoting the health of older people and action, based on research, to plan and develop services. Recent initiatives to network agencies providing services for older people and organisations of older people could also contribute a representative voice.

The Health Promotion Unit is relatively under-funded, both in relation to comparable agencies in other countries and as a proportion of our total national expenditure on the health sector. A number of important national policy documents are in preparation by the Health Promotion Unit at present, including ones on alcohol, nutrition and a more general one on a ten year strategic plan for health promotion. This latter policy document, like that in the United Kingdom, should specifically address how the World Health Organisation's 32 *Targets for Health for All* of the European region are being addressed. These concern a number of aspects that have a bearing on the health of older people. Ultimately, many of the Health Promotion Unit's operational health education

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

### Encourage Community Participation

Environmental planning in housing, roads, shopping services and urban planning must be seen as a priority for health promotion. Unless these fundamental structural issues are reviewed, the rest is cosmetic. This also includes the development of wide range of living options for older people. The range of long-stay homes available to old people at present does not allow for personal development in old age. The fact that a residential home is an institution does not mean that it has to be institutionalised. The same point has also been made in relation to sheltered housing. The need for a housing survey was mentioned earlier. The implementation of the Nursing Homes Act is also very important. That legislation should be understood in the spirit of its intention. Many of the more serious threats to home autonomy for older people include threats to their personal safety. This is part of wider social changes in the fabric of Irish life generally. To the extent that ageist attitudes contribute to this, education may make some long-term impact. Meanwhile, *Community Watch* schemes and other forms of support could also serve to improve socialisation of elderly people.

### Create Supportive Environments

functions could be devolved regionally to a much larger extent. This in turn depends on having properly trained professionals in place. It is in recognition of this need that my department has established a diploma/MA programme in health promotion to commence in Autumn, 1993. We are also preparing a register of training programmes in health education available at all levels.

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

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

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

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



The advocacy of community participation and collaboration with voluntary agencies is precisely to avoid the situation for elderly people whereby state aid is paramount in social as well as financial terms. This is stated in recognition of the difficulties mentioned earlier with such models and is not intended to undermine the statutory duties of government.

Given that many people in Europe do not apparently welcome compulsory retirement, voluntary bodies might be encouraged to research into and channel the capacities for continued activity which elderly people have. Here, as elsewhere, it is important to ensure that the activities of voluntary organisations are adequately inter-connected, in both practical and informational terms, with state systems.

### **Develop Personal Skills**

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

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

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

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

If education both to promote health maintenance and to combat ageism among the young is to be taken seriously, then it will require a comprehensive review of teaching methods and materials. How are older people to be represented in such materials? The scope for health education in schools has been addressed by the recent Government Green Paper, which supports the health promoting school curriculum. This concept involves the integration of health education in all aspects of school life, including the physical structure of the building. It has traditionally been difficult for young people to empathise with their own health predicaments long-term, let alone of their parents and grandparents. In an integrated curriculum a spiral approach is used, so that one returns to concepts in increasing depth and complexity and in different contexts. Why not use this to reinforce our message? Consider for instance the poetry of Yeats "That is no country for old men ..." or Kavanagh "Every old man I see reminds me of my Father" or Maurice O'Sullivan's "Fiche bhliain ag fás". A programme for schools which focuses on two different age groups is being launched in 1993 by the National Council for the Elderly and is a welcome development.

In medical education negative attitudes to ageing are also pervasive. The policy document, *The Years Ahead*, has informed much of the discussion on future policy directions for older people in recent years. It advocated better training of health professionals, particularly of doctors, and more attention through the school education system to our attitudes to older people. More specific educational programmes for health professionals would improve their management of older people, particularly in taking a more holistic and less defeatist approach to their problems. This is particularly applicable to those destined for a career in primary care. The further development of geriatric medicine is similarly to be endorsed.

### **Re-Orientation of Health Services: Preventive Medicine**

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

What problems ought to be more closely targeted for rehabilitation? Although the emphasis of this paper is on wellness and positive approaches to health, it remains true that the prevention of dementia, osteoporosis, coronary heart disease and cancer would have major long term public health benefits. Established areas of success in previously studied cohorts include improved and sustained levels of exercise, an emphasis on a high fibre, nutritionally balanced diet, smoking cessation and early detection and management of hypertension. Cohort trials

imply considerable differences in the incidence of these chronic diseases and cross-cultural studies imply that the changes are not necessarily inevitably associated with ageing. Basic epidemiological research to clarify these issues continues to be necessary and will be crucial to long-term planning. It is recognised that research on this scale cannot be confined to national cohorts, but it provides an ideal instance of collaborative work that might be undertaken.

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

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

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

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

psychiatric services. The development of appropriate needs assessment models are a basic public health function.

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

## Conclusion

What then can we say generally about health promotion in older people? The objective is to build constructively on what we have already. To recognise that there is no weakness in those trained in individual disciplines also calling on their experience as human beings to carry out their jobs. To remember, finally, that we all want to be lucky enough to get old. Former United States President, Richard Nixon apparently said recently that he used to hate the idea of being eighty, until he thought of the alternative. While the objective is not to be irreligious, we would like to retain our sense of humour, amongst other things, and our *joie de vivre*. Health promotion is, after all, a positive concept.

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24. *The Impact of Social and Economic Policies on Older People in Ireland*, January 1993.
25. *Voluntary-Statutory Partnership in Community Care of the Elderly*, January 1993.

## **NATIONAL COUNCIL FOR THE ELDERLY FACT SHEETS:**

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