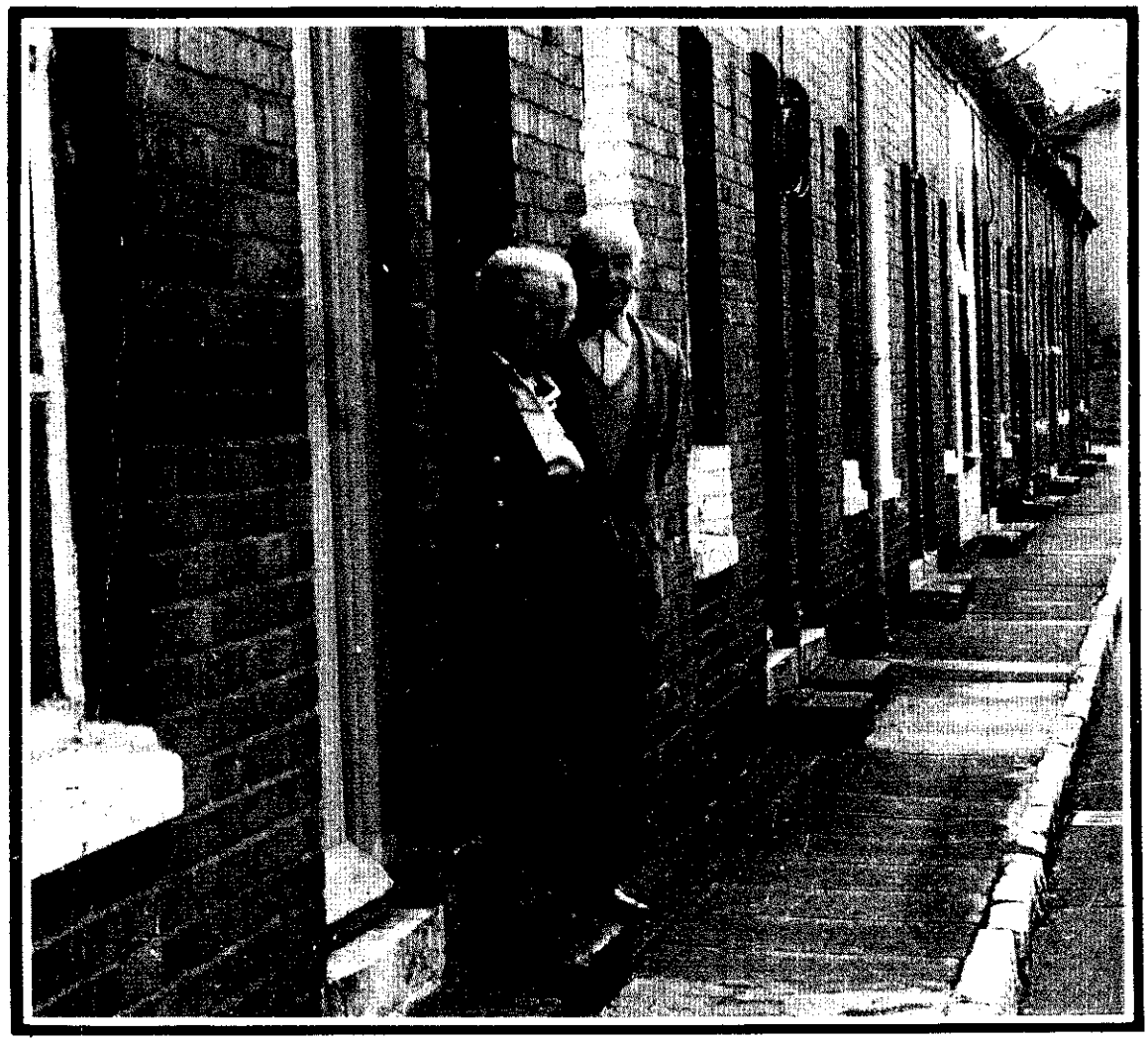
The years ahead...

A POLICY FOR THE ELDERLY



REPORT OF THE WORKING PARTY ON SERVICES FOR THE ELDERLY - OCTOBER 1988

The Years Ahead—
A Policy for the Elderly

Report of the Working Party on
Services for the Elderly

October 1988

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COVER PHOTO: Elderly residents in Roches Buildings, Cork—housing which has recently been renovated by Cork Corporation.

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Dr Rory O'Hanlon T.D.
Minister for Health

Dear Minister

In carrying out our terms of reference, the Working Party has been guided by certain basic considerations which we felt should influence our work. They arise from what we perceive as society's obligations towards its elderly citizens, tempered by the economic realities of the times in which we live. These considerations are;

- that old age demands our special respect:
- that improvements in life expectancy and the increasing number of elderly persons require a clear-cut public policy for the future in regard to the State's role towards the elderly:
- that the underlying aim of policy should be to help the elderly maintain their dignity and independence by protecting them from economic and social hardship:
- that the dignity and independence of the elderly can best be achieved by enabling them to continue to live at home with, if necessary, support services provided by the State:
- that when ill or disabled, the elderly are entitled to the same standard of treatment available to the rest of the population even if services have to be organised in ways that meet their particular needs:
- that when admission to long term care is unavoidable, such care should be of the highest standard and should respect the dignity and individuality of the elderly person.

We put forward our recommendations in the hope that they will be accepted and that they will be of benefit to the present and future generation of elderly citizens.

Yours sincerely

Joseph Robins

Chairman

22 June 1988.

Contents

Introduction

TERMS OF REFERENCE

1. We were appointed by the Minister for Health in September 1986 with the following terms of reference:

   "Accepting that the overall objectives of services for the elderly are:—

   (a) to enable the elderly person to live at home, where possible, at an optimum level of health and independence,

   (b) to enable those who cannot live at home to receive treatment, rehabilitation and care in accommodation and in an environment as near as possible to home,

   the Working Party is asked to review:

   (i) the role and function of existing health and welfare services in serving these objectives,

   (ii) the appropriateness of existing health and welfare services,

   (iii) the comparative effectiveness, efficiency and cost of alternative models and settings,

   (iv) the planning norms for services both residential and community".

MEMBERSHIP

2. The following were appointed members of the Working Party:

   Dr. Joseph Robins, Chairman
   Assistant Secretary, Department of Health.

   Mr. Alan Aylward
   Assistant Principal Officer, Department of Health.

   Dr. Jane Buttimer
   Medical Officer, Department of Health.

   Mr. John Carroll
   Principal Officer, Department of the Environment

Mr. Robert Carroll
Secretary, National Council for the Aged

Ms. Deirdre Fitzsimons
Nursing Adviser, Department of Health

Mr. Kieran Hickey
Acting Chief Executive Officer, Eastern Health Board

Dr. Michael Hyland
Consultant Physician in Geriatric Medicine, Southern Health Board

Ms. Ann Kelly
Superintendent Public Health Nurse, Donegal, North Western Health Board

Mr. Michael Kelly
Assistant Principal Officer, Department of Health

Mr. James Lillis
Principal Officer, Department of the Environment

Mr. Dermot McCarthy
Principal Officer, Department of Health

Mr. Vincent Millet
Programme Manager, Community Care, South Eastern Health Board

Mr. Matthew O'Connor
Assistant City Manager, Cork County Borough Council

Mr. Dermot Smyth
Principal Officer, Department of Health

Dr. Joseph Solan
Director of Community Care and Medical Officer of Health, Galway, Western Health Board.

Mr. Laurence Tuomey,
Chairman, National Council for the Aged.

Dr. James Walsh,
Deputy Chief Medical Officer, Department of Health.

Dr. Richard Whitty
Consultant Psychiatrist, St. Brendan's Hospital, Eastern Health Board.

Secretary
Dr. Ruth Barrington
Assistant Principal Officer, Department of Health.

Assistant to the Secretary
Mr. David Smith
Executive Officer, Department of Health.

Mr. Lillis was appointed in February, 1987 to replace Mr. John Carroll who left the group when he resigned from the Department of the Environment to take up another appointment. Mr. Smyth resigned in June, 1987 following his transfer to other duties within the Department of Health.

NUMBER OF MEETINGS

3. The Working Party met on nineteen occasions which included eight full-day meetings and one two-day meeting.

WORKING METHODS

4. In preparing our report, we relied to a great extent on existing research and reports which had been produced on the services for the elderly and on the experience of innovative projects carried out by health boards, local authorities and voluntary bodies. We initiated one research project on the comparative costs and efficiency of alternative models of care for the elderly. This study is being carried out by the Economic and Social Research Institute. Although the results of the research were not available before we completed our Report we consider the questions to be answered by the study are of vital importance to the future development of services for the elderly. We visited a wide range of facilities for the elderly—a list of which is contained in Appendix 3—and held discussions with the staff and voluntary groups involved in providing services. We invited and received submissions from many organisations involved with the elderly or whose activities affect the elderly. A list of groups and individuals who replied is in Appendix 4. In a number of cases we invited individuals and groups to elaborate on their submissions or their experience of an aspect of services for the elderly. We found the submissions, the visits and the discussions most useful in preparing our Report.

ACKNOWLEDGEMENTS

5. The quality of a report such as this depends to an important degree on the persons with responsibility for researching and drafting it. We have been singularly lucky in having Ruth Barrington as our Secretary and David Smith as her assistant.

Ruth Barrington brought to her work not only considerable research and literary skills but a knowledge and understanding of the needs of elderly people. We are indebted to her not only for her work in drafting the Report but for her valuable input into the ideas contained in it. David Smith did excellent work in his supporting role. His reliability, thoroughness and accuracy in collecting and drafting material and arranging our discussions and visits were of the highest standard.

Our work made a big demand on the word processing and duplicating resources of the Department of Health and we are particularly grateful for the assistance we received in that regard from Linda Roche, Eileen Byrne and Margaret Francois. We wish to thank Hugh Magee of the Department of Health and Owen Keegan of Davy, Kelleher, McCarthy, Ltd., who provided us with essential statistical information.

Finally, we would like to express our appreciation to those organisations who made submissions to the Working Party, to the staff of health boards, local authorities and voluntary organisations who took the time and trouble to show us facilities and discuss ideas with us and to the individuals and groups who made personal presentations. It was encouraging for us to see the extent of the goodwill towards the elderly and the concern to promote their welfare.

Summary of Main Recommendations

CHAPTER 3 A COMPREHENSIVE AND CO-ORDINATED SERVICE

Services for the elderly should be organised as far as possible in districts serving a population of 25-30,000 people. (3.12)

The function of co-ordinating services for the elderly in each district should be the responsibility of a district liaison nurse. (3.13)

District teams for the elderly should be formed to support the district liaison nurse in her co-ordinating role. The teams should be representative of those with direct responsibility for providing services to the elderly in the district. (3.14)

In each community care area, health boards should appoint a Co-ordinator of Services for the Elderly. (3.17)

In current circumstances, the task of Co-ordinator of Services for the Elderly should be assigned to a community physician. (3.20)

Health boards should appoint an Advisory Committee on the Elderly. (3.26)

The Departments of Health, the Environment and Social Welfare should agree administrative arrangements to ensure that there is a co-ordinated policy towards the elderly at national level and to monitor progress towards the implementation of the recommendations of this Report. (3.27)

We recommend that the National Council for the Aged's terms of reference be broadened to cover all aspects of the welfare of the elderly and that it be an advisory body to all Ministers with responsibility for the elderly. (3.28)

CHAPTER 4 MAINTAINING HEALTH

The promotion of health among the elderly should be a primary concern of the Cabinet sub-committee to co-ordinate policies affecting health, the Health Promotion Council, and the Health Promotion Unit of the Department of Health and this concern should be made explicit in a national plan to promote health. (4.8)

The Department of Health, in consultation with those organisations working with or on behalf of the elderly, should develop directly or indirectly, a health education policy for the elderly and their carers. It should be the responsibility of the Co-ordinator of Services for the Elderly in each area to ensure that an appropriate health education service for the elderly and their carers is available. (4.11, 4.13)

The teaching authorities of the professions concerned with the elderly should encourage more positive attitudes to caring for the elderly among students. (4.15)

Professorial chairs of geriatric medicine should be established in all medical schools. (4.15)

The proposed Authority for Occupational Safety and Health when established, should ensure that a comprehensive pre-retirement service is available to all employees and to self-employed people. (4.18)

The National Day on Ageing should become an annual event. (4.20)

The Department of Education should encourage schools to promote positive attitudes to ageing and the elderly within the school curriculum. (4.21)

CHAPTER 5 HOUSING

The Department of the Environment should carry out a national survey into the housing conditions of the elderly to establish more precisely the housing conditions of the elderly. (5.5)

The Minister for the Environment should monitor the implementation of the Housing Bill, 1988 and the position of the elderly requiring local authority accommodation to ensure that their needs are met comprehensively. (5.18)

The main emphasis in housing policy for the elderly should be to enable elderly people to choose between adapting their homes to the increasing disabilities of old age or to move to accommodation which is more suited to their needs. Priority should be given to improving the accommodation of the elderly lacking the basic amenities of an indoor toilet, hot and cold water and a bath or shower. (5.29)

Housing provision for the elderly should be based on the factual assessment of need carried out by housing authorities. (5.30)

Local authorities should give special attention to the elderly on low incomes in substandard, privately rented accommodation when planning and allocating accommodation for the elderly. (5.31)

Where it is not feasible to maintain elderly persons in their own house or in ordinary local authority housing, sheltered housing should be considered as the first choice. (5.32)

There should be close liaison with the health board in the planning of sheltered housing schemes. The board should provide domiciliary services for the elderly residents and, where appropriate, associated day care centres. (5.32)

Local authorities and health boards should co-operate to meet, in a flexible way, the accommodation needs of the small number of elderly who are homeless. (5.33)

Wherever possible, elderly people should be housed in their own area. Dependent elderly people in isolated rural areas should be encouraged to move to suitable accommodation in nearby villages and towns. (5.34)

The Department of the Environment should replace the existing ad hoc housing grant schemes with a comprehensive and flexible repairs and adaptations scheme for the elderly and disabled which local authorities could administer either by the provision of a grant or by organising the work on behalf of the elderly person. (5.36)

Pending the introduction of a comprehensive scheme to improve the accommodation of the elderly and disabled, increased resources should be allocated to the Task Force on Special Housing for the Elderly to allow more than minimal repairs to be carried out to the homes of vulnerable elderly people and to reduce the waiting list. Funding for the scheme of remedial works to older and substandard local authority houses should be expanded. (5.37)

In anticipation of the enactment of the Housing Bill, 1988, local authorities in consultation with health boards should carry out an immediate assessment of the need for housing repairs and adaptations among elderly households and, together with health boards, they should plan a programme of repairs to meet those needs using existing schemes. (5.38)

The Departments of Finance and the Environment should explore with the financial institutions ways in which elderly people can be encouraged to make greater use of the financial asset that is their home. (5.39)

The Department of the Environment should examine the possibility of introducing a scheme which would facilitate elderly people transferring their homes to a local authority in exchange for more suitable accommodation or for repairs and adaptations to their homes. (5.40)

The role of voluntary housing organisations in meeting the housing needs of the elderly should be expanded. All voluntary housing schemes for the elderly should be planned in consultation with the Co-ordinator of Services for the Elderly. The current Department of the Environment scheme to assist voluntary housing organisations should be amended to increase the capital loan facility to 95 per cent. The Department of the Environment should consider ways in which voluntary housing organisations could be assisted towards the cost of maintaining housing schemes. (5.42)

CHAPTER 6 CARE AT HOME

The district liaison nurse should maintain a register of elderly people at medical or social risk and be aware of elderly people receiving a significant amount of care from their families or neighbours. (6.4, 6.11)

Case finding among the elderly considered to be at risk should be developed as a normal part of general practitioner care of the elderly, and in particular as a normal part of the General Medical Service. (6.16)

Measures to enhance the capacity of general practitioners to care for patients without unnecessary referral to hospital should be implemented by the Department of Health and the health boards as a matter of urgency. (6.20, 6.21)

Additional public health nurses should be appointed as resources permit. (6.29)

Health boards should explore the possibility of employing care assistants who would work under the supervision of the public health nurse. (6.29)

A panel of general nurses willing to nurse elderly people at home on a part-time basis should be established in each district. The district liaison nurse should have discretion to call on the services of a nurse from the panel when an elderly person requires a more intensive level of care than can be provided by a public health nurse or in the evenings and at weekends. (6.30)

Public health nurses in their visits to the elderly should place a greater emphasis on anticipatory care of the elderly and the promotion of their health. (6.31)

In each community care area there should be at least one public health nurse with a special interest in the management of incontinence who would act as an advisor to other nurses. (6.32)

Health boards should develop a policy towards the supply and management of aids and appliances for the elderly as recommended in this Report. (6.34)

Occupational therapists should liaise with general practitioners and public health nurses to ensure that they are aware of the potential of adaptations and aids to improve the home conditions of the elderly. (6.35)

Physiotherapy, based in the community hospital or health centre, should be available to elderly people at home when justified by their medical condition. (6.37)

There is an urgent need for the Department of Health to review manpower requirements in physiotherapy to match the supply of graduates with the demand for physiotherapists. (6.37)

A domiciliary speech therapy service should be provided to meet the needs of elderly people with impaired speech being cared for at home. Health boards should support the Volunteer Strokes Scheme to train volunteers to assist those affected by strokes and their families. (6.38)

The flexibility and voluntary commitment, which form such an important part of the home help and meals service, should be safeguarded and built upon in future.(6.46)

Additional resources are necessary to expand the home help service. The immediate aim should be to develop the service to the extent of the whole time equivalent of 4.5 home helps per thousand elderly people. (6.46)

Health boards should be legally obliged to provide or make arrangements to provide services to maintain persons at home who would otherwise require care in another setting. (6.46)

The home help service should provide a more comprehensive level of care on the lines recommended in this Report. (6.46)

A domiciliary counselling service should be available to dependent elderly people and their families and community care social work departments should be gradually expanded for this purpose. (6.48)

A chiropody service should be available in all areas to treat disorders of the feet in elderly persons on referral from the nurse or the general practitioner. A domiciliary service should be provided for elderly patients who are immobile. (6.51)

A pilot scheme to assess the potential of radio and telephone based alarm systems to assist the elderly should be initiated in a rural area as soon as possible. The long term goal should be to provide a telephone or radio based alarm to elderly persons living alone and assessed by the district team for the elderly as being at medical or social risk. (6.54)

CHAPTER 7 CARE IN THE COMMUNITY

The Departments of Tourism and Transport and the Environment should examine ways in which transport in rural areas can be co-ordinated and how transport for the elderly can be improved. Pending such changes, the Co-ordinator of Services for the Elderly should review transport resources in the community and encourage the transport services of statutory agencies and the resources of voluntary bodies to provide more adequate transport for elderly people in remote rural areas. (7.6)

The Department of the Environment should encourage greater attention to the design of public transport vehicles to ensure easier entry and exit for elderly people, to providing sufficient grab rails in the right places and to improved seating design. (7.7)

Each health board should ensure that adequate transport arrangements exist to give dependent elderly people access to day care, day hospitals, and out-patient departments. (7.8)

Day care facilities for the elderly should be greatly expanded, on the lines recommended in this Report. (7.17)

In the interest of providing dentures to elderly people on low incomes, the Dental Council should introduce a scheme to permit dental technicians to fit dentures. (7.20)

Section 67 of the Health Act, 1970 should be amended to allow health boards make charges up to a half the cost of fitting and supplying dentures. (7.20)

All elderly people should be entitled to an annual dental check-up free of charge. Elderly people with medical cards should be offered treatment without charge for necessary dental care identified at the annual check-up. (7.21)

The National Rehabilitation Board should reduce the waiting period for hearing aid clinics so that no elderly person has to wait longer than three months for an appointment. The regulations governing the service should be changed to permit the National Rehabilitation Board to provide a service to those with Category II and Category III eligibility, at a charge. (7.22)

The ophthalmic service should be developed to meet the needs of the increasing population of elderly people. More information should be available locally to elderly people about coping with the disability of visual impairment through the use of better lighting, large print books and the lay out of facilities at home. (7.23)

Boarding out should be expanded as an option in caring for frail elderly people who can no longer live at home. (7.28) Health boards should have statutory authority to board out elderly persons under certain circumstances. (7.29)

CHAPTER 8 CARE IN GENERAL HOSPITALS

Every general hospital should develop a policy on the admission and discharge of elderly patients in consultation with the Co-ordinators of Services for the Elderly in the catchment area of the hospital. (8.10)

In city hospitals, a member of the staff of the hospital with sufficient authority should be responsible for liaising with departments of the hospital, general practitioners and district liaison nurses to arrange support for vulnerable elderly people on discharge. In hospitals outside the cities the ward sister responsible for the patient should notify the district liaison nurse in the elderly person's area to arrange for his or her discharge home or to the community hospital. (8.11)

In city hospitals, the hospital liaison officer should be responsible for informing general practitioners and district liaison nurses about elderly patients discharged from the accident and emergency department of the hospital. Elderly persons seen in accident and emergency departments in the night time should not be discharged at night unless they are accompanied by a relative or friend. (8.12)

Additional geriatric departments should be provided as a matter of urgency, priority being given to the establishment of departments in the three health boards which currently have no specialist geriatric departments - the Midland, the North Eastern and the South Eastern. In Dublin, geriatric departments are recommended at the Mater and in the hospitals which form the nucleus of the new Tallaght Hospital and an expanded department should be developed at Beaumont Hospital.

For planning purposes, a norm of 2.5 beds per 1,000 elderly in geriatric departments in general hosptials and a norm of 3.0 beds per 1,000 elderly for rehabilitation beds should be adopted. (8.29)

Beds and facilities in general hospitals should be re-allocated to the assessment and rehabilitation of the elderly in tandem with the appointment of additional physicians in geriatric medicine.

Every hospital with, or associated with, a specialist geriatric department should provide a day hospital to facilitate diagnosis, treatment and rehabilitation of elderly patients and transport to and from the day hospital should be available. (8.33)

Health boards should explore different ways of bringing the benefits of day hospitals to elderly patients remote from general hospitals. (8.34)

The Department of Health should undertake a review of the present organisation of elective orthopaedic surgery, and joint replacement surgery in particular, to ensure that elderly people have access to a service of high quality, that they receive the same priority as younger age groups, and that the service expands to cope with the increasing numbers of elderly people. (8.40)

The Department of Health should review present arrangements for cataract surgery in the elderly to ensure that those requiring treatment receive it in reasonable time and that the service is expanded to deal with increasing numbers of elderly people. (8.41)

CHAPTER 9 THE COMMUNITY HOSPITAL

Existing geriatric hospitals/homes, long-stay district hospitals and welfare homes should be developed,where appropriate, as community hospitals providing the following range of services for elderly persons and their carers in each district:

— assessment and rehabilitation of elderly patients

— convalescent care

— respite care to support caring relatives

— facilities for nursing highly dependent or terminally ill elderly patients who can no longer be cared for at home

— information, advice and support of those caring for elderly persons at home. (9.14)

Wherever possible, a physician in geriatric medicine should provide specialist advice to the assessment and rehabilitation unit of the community hospital. (9.20)

A tentative norm of 10 beds for extended care per 1,000 elderly is recommended, in the context of a norm of 2.5 beds per 1,000 elderly in the specialist department of geriatric medicine in the general hospital and 3 beds per 1,000 elderly for rehabilitation in general and community hospitals. (9.22)

Each district team for the elderly should have access to a community hospital providing a range of services for the elderly and with a maximum of 50-60 beds. (9.24)

Once an elderly patient has been accepted for extended, including respite, care in the community hospital, his or her own general practitioner should provide medical care while in hospital. (9.28)

Medical direction of the assessment and rehabilitation unit of the community hospital should be the responsibility of one general practitioner with an interest in the elderly who would be appointed as part-time medical officer to the hospital. (9.28)

A scheme of retraining for nursing staff in proposed community hospitals should be initiated, based in the specialist geriatric departments of general hospitals and in existing geriatric hospitals which have developed an active approach to the assessment and support of elderly people at home. (9.29)

The need for welfare accommodation for frail elderly persons should be met in a flexible way—in sheltered housing with support from day care and voluntary organisations, in boarding out arrangements, in accommodation associated with the community hospital and in hostels for the elderly mentally infirm. We recommend a norm of 20-25 places per 1,000 elderly for this kind of welfare accommodation. We recommend that those welfare homes which provide extended nursing care be developed as community hospitals providing a range of services for the elderly. (9.32)

The Health (Homes for Incapacitated Persons) Act 1964 should be amended to include nursing homes run by voluntary bodies and to provide for a licensing system for all nursing homes. (9.38)

Section 54 of the Health Act, 1970 should be amended to enable health boards to subvent the care of eligible elderly patients, after assessment, in nursing homes licenced by a board and to enable health boards to vary the level of subvention according to the patient's needs. (9.41)

The Co-ordinator of Services for the Elderly should establish liaison arrangements with the nusing homes operating in the community care area. (9.43)

It should be a condition of a nursing home licence that a nursing home makes available to prospective residents and their families a brochure detailing the services it provides, the charges, the qualifications of its staff and other information about the home. (9.44)

An independent inspectorate of extended care facilities for the elderly should be established within the Department of Health comprised of people with first hand experience of providing high standards of care for the elderly. (9.48)

The Department of Health in consultation with the health boards and the Irish Private Nursing Homes Association, should draw up and implement a code of good practice for extended care of the elderly suitable to this country's needs and a training programme for nursing home and community hospital staff. (9.48)

CHAPTER 10 THE CARE OF THE ELDERLY MENTALLY ILL AND INFIRM

General practitioners and public health nurses should be encouraged to screen elderly people at risk for early signs of dementia. (10.21)

A panel of people who are willing to care for elderly people with dementia should be available in each district under the supervision of the senior public health nurse to help the elderly person and his or her carers. (10.22)

Day care facilities for the elderly with dementia should be provided in each district and it should be the responsibility of the Co-ordinator of Services for the Elderly to develop such a service, directly through health boards or by agreement with voluntary bodies. (10.22)

Health boards should develop day hospitals for the elderly with dementia in the main urban centres, under the direction of psychiatrists with an interest in this field. A norm of 2 day hospital places for 1,000 elderly people for the confused elderly has been suggested in Great Britain and we recommend that it be used for planning purposes here. (10.23)

We recommend that sufficient welfare places be provided for the elderly with dementia who can no longer be supported at home. High support hostels should be provided for the elderly with the most severe form of dementia. A norm of 6 beds per 1,000 elderly for welfare accommodation and 3 beds per 1,000 elderly for high support hostels should be adopted for planning purposes to ensure sufficient accommodation for the elderly with dementia. (10.24)

In each community care area, a consultant psychiatrist with special responsibility for the elderly should assume responsibility for the smooth functioning of the high support hostel for the elderly with severe dementia and for ensuring that patients benefit from a multi-disciplinary approach to their care. (10.27)

Psychiatrists with responsibility for the elderly should be appointed as a matter of urgency in Dublin and Cork to provide a specialist service in their catchment areas, to develop a model service and to promote high standards in the care of the elderly mentally ill. (10.29)

One of the psychiatrists in the sectors which correspond to a community care area should have responsibility for the care of the elderly with severe dementia. (10.31)

CHAPTER 11 PARTNERSHIP BETWEEN CARERS, VOLUNTEERS AND STATUTORY AGENCIES

The recommendation of the Commission on Social Welfare, that carers be entitled to claim social assistance in their own right and that such entitlement should replace the Prescribed Relative Allowance, should be implemented. (11.5)

The Co-ordinator of Services for the Elderly should ensure that in each community care area, information and advice is available to carers on the ageing process, the medical aspects of caring, financial entitlements and services available locally. Health boards should encourage and assist financially where necessary, the formation of support groups for the carers of elderly people. (11.6)

Health boards and local authorities should encourage by all possible means the involvement of voluntary organisations in caring for the elderly. Each board and local authority should agree with the voluntary organisations working with the elderly in their functional area their respective responsibilities in the delivery of services. This agreement should be formalised as a contract between the voluntary organisation and the board or local authority for a period of 2 to 3 years. The district team for the elderly should be consulted in the preparation of a contract for services in its area. (11.17)

The Co-ordinator of Services for the Elderly should devleop a mechanism to co-ordinate voluntary activity in each community care area. Each health board should establish a fund for the development of voluntary organisations. (11.18)

The Government should undertake a formal review of the relationship of the statutory and voluntary sectors with a view to establishing national guidelines for the development of a more constructive relationship between the two sectors. (11.19)

CHAPTER 12 IMPLEMENTING THE REPORT

The Government should, in the light of the changing demographic trends, adopt a conscious long-term policy of redeploying resources to services for the elderly. (12.6)

In assessing housing needs, local authorities should assess the level of resources required for an effective repairs and adaptations scheme and to meet demand for public housing among the elderly. The Department of the Environment should ensure that as a matter of priority, adequate finance is allocated to operate the repairs and adaptations scheme and that sufficient dwellings are constructed for the elderly either directly by local authorities or through subsidies to voluntary housing agencies. (12.10)

A total of IR£.5m should be allocated by the Department of Health for the purpose of establishing day centres in each of the next five years. (12.11)

IR£.1m should be allocated each year over the next five years by the Department of Health to provide departments of geriatric medicine in general hospitals. (12.12)

IR£.5m should be allocated in each of the next five years from the Department of Health's capital programme to provide the required number of day hospital places. (12.13)

IR£2m should be made available each year over the next five years to adapt existing facilities as community hospitals and to provide purpose built buildings. (12.14)

IR£1.2m should be made available as a priority each year over the next 20 years to provide welfare and high support hostel accommodation for the elderly with dementia. (12.15)

IR£.2m should be made available in each of the next five years to provide central control units for home based alarm systems and for the installation of radio or telephone links in the homes of dependent elderly people. (12.16)

The Department of Health, in determining which posts in the health services should be filled, should bear in mind that the elderly will pose a continuing and increasing challenge to the health services which requires the immediate adoption of a policy to redeploy gradually staff resources towards services which meet their needs. (12.17)

Research should be carried out in two pilot community care areas to quantify the need for home nursing and for home care assistants. (12.18)

IR£2m should be made available immediately to provide a panel of nurses in every district to care for dependent elderly people at home and to employ home care assistants to help the elderly with dementia. (12.18)

An additional IR£6m should be made available to expand the home help service. (12.19)

Fifty physiotherapy assistants should be employed to expand physiotherapy services for the elderly at an approximate cost of IR£.5m annually. (12.20)

An additional IR£.25m per annum should be made available towards the cost of joint replacement and cataract surgery. (12.21)

IR£.5m should be allocated to provide and maintain a wider range of aids and appliances for use by the elderly. (12.23)

IR£.75m should be allocated to improve dental services, chiropody and speech therapy for the elderly. (12.24)

IR£.5m should be made available to encourage boarding out as a way of meeting the welfare needs of elderly people who can no longer live at home. (12.25)

The Departments of Health and the Environment should request the health boards and housing authorities to draw up a plan of action to implement the recommendations of this Report. (12.27)

The Departments of Health and the Environment should come to an arrangement whereby both can regularly discuss their respective plans for those services for the elderly for which they are responsible and progress towards implementing the recommendations of this Report. (12.28)

Two community care areas - one rural and one urban - should be developed as pilot areas in which the capacity of community services to support people at home can be evaluated. (12.30)

The Department of Health should make IR£.1m available each year over the next five years to fund research into the potential of community services to support people at home. (12.31)

We recommend the following legal framework for the development of services for the elderly:

— an obligation on health boards and local authorities to promote the well-being of the elderly in their areas of responsibility, espcially those on low incomes or vulnerable for medical and social reasons and to plan, in consultation with each other and voluntary bodies, to meet these needs;

— an obligation on health boards to provide services to support dependent elderly people and their carers in the home;

— an obligation on local authorities to provide for the repair and adaptation of the dwellings of elderly people, particularly those on low incomes;

— an obligation on health boards to appoint Co-ordinators of Services for the Elderly and Advisory Committees on the Elderly;

— that a distinction be made in law between an elderly person subvented in a nursing home by a health board and an elderly person placed by a health board with a private householder in a boarding out arrangement. Health boards should be empowered to make boarding out arrangements on behalf of elderly people, the details to be governed by regulations. (12.32)

Chapter 1

Services for the Elderly 1968-1988

1.1 The history of services for the elderly in the twenty years since 1968 is largely concerned with the implementation of the recommendations of the **Care of the Aged Report** of that year. The report was prepared by an interdepartmental committee, appointed by the Minister for Health in 1965. The Committee was asked to examine the general problem of the care of the aged and to recommend improvements in services. Its terms of reference included income maintenance, housing, health and welfare services for the elderly. The Report has dominated policy towards services for the elderly ever since.

1.2 The Care of the Aged Committee approached its task with what was at the time a radical belief—

> "that it is better, and probably much cheaper, to help the aged to live in the community than to provide for them in hospitals or other institutions".[1]

In the Committee's view, it was essential that

> "public and family care should be regarded as complimentary—not as alternatives—and that the public authority should endeavour to help the family, not take over from it".[2]

When the Committee began its work, official thinking on the care of the elderly was still dominated by institutional remedies rooted largely in the approach of the 19th Century Poor Law. A White Paper of 1951 had accepted that County Homes should be reserved for the aged and chronic sick and that the other groups which they accommodated—unmarried mothers, mentally handicapped persons, epileptics and homeless—should be accommodated elsewhere.[3] The White Paper envisaged the continuation of the large County Home, announcing that it was not the intention that there

should be a multiplicity of homes or hospitals for the aged and chronic sick in any area. Only in a few large counties would approval be given for the adaptation of a small number of subsidiary institutions where hardship would result from removing old people too great a distance from their friends. Following the White Paper, a programme of extension and reconstruction of county homes was initiated which by 1966 had resulted in 2,195 new or replacement beds at an estimated cost of £3.3m. The large number of institutional places contrasted with the absence of support for old people at home. Few local authorities had accepted a responsibility for meeting the special housing needs of the elderly. Home help, meals-on-wheels and day centres were services offered by a small number of pioneering voluntary organisations. The elderly who were poor and could no longer maintain themselves at home had no choice but to seek admission to the County Home. Admission to the County Home ensured that they were fed, kept warm and nursed where necessary but the routine of the homes undermined their independence and most remained there until they died.

1.3 The **Care of the Aged Report** put forward alternative objectives for services for the Elderly:

"(a) to enable the aged who can do so to continue to live in their own homes;

(b) to enable the aged who cannot live in their own homes to live in other similar accommodation;

(c) to provide substitutes for normal homes for those who cannot be dealt with as at (a) or (b);

(d) to provide hospital services for those who cannot be dealt with as at (a), (b) or (c)."[4]

To achieve these objectives, the Committee recommended that housing, financial assistance, health and welfare services be closely integrated to provide a comprehensive service for the elderly. The philosophy of the Report was widely accepted as the appropriate one in caring for the elderly and has influenced public policy over the last twenty years. It is reflected in the terms of reference of this Working Party.

1.4 The Report of the Committee recommended improvements in existing services, payments and the provision of new services and allowances where they identified a need. Many of these recommendations have been implemented and as a result, services for the elderly have been transformed. We examine the main developments under the headings of income maintenance, housing, health services, organisation and legislation.

INCOME MAINTENANCE

1.5 Perhaps the most significant improvement in income maintenance of the elderly has been the real increase in the value of old age pensions. The value of State pensions is critical to the incomes of the elderly as the majority rely on such pensions as their main or only source of income. Only 15 per cent of the elderly have pensions from previous employers. [5] Table 1.1 shows that social welfare pensions rose significantly in real terms between 1966 and 1985. The contributory pension for an eligible couple almost doubled in real terms during that period. The non-contributory pension increased by sixty percent. While it is difficult to judge the adequacy of social welfare payments, the Commission on Social Welfare found that recipients of old age pensions had personal rates of payment close to the upper range of the minimum income which the Commission estimated was necessary to maintain a single adult at a standard of living linked to standards in society generally.[6] Those aged 80 years and over in receipt of contributory old age pensions received a rate in excess of the Commission's estimates. State pensions have more than kept pace with inflation over the years and have kept pace with the rise in incomes of the gainfully employed.[7]

1.6 As well as real increases in the level of payments, there have been important extensions of benefit to the elderly. These include:

- the Prescribed Relative Allowance (1969) payable to old age pensioners in certain circumstances who are incapacitated and receiving full-time care from a prescribed relative;
- the Retirement Pension (1970) payable to insured persons aged 65 who retire and who fulfill the contribution conditions;
- the additional allowance for pensioners aged 80 years and over (1972);
- following entry to the European Economic Community in 1973, Irish people became entitled to receive the same treatment in social security matters as nationals of any EEC country in which they resided and EEC social insurance records could be combined to enable a claimant to qualify in this or another EEC country;
- between 1973 and 1977 the means test for the non-contributory pension was eased and the qualifying age for pensions was reduced from 70 to 66;
- the adult dependent allowance to cover the spouse of a pensioner not old enough to qualify for a pension in his or her own right (1974);
- the means tested Single Woman's Allowance for single women with no income between 58 and 68 years (1974);

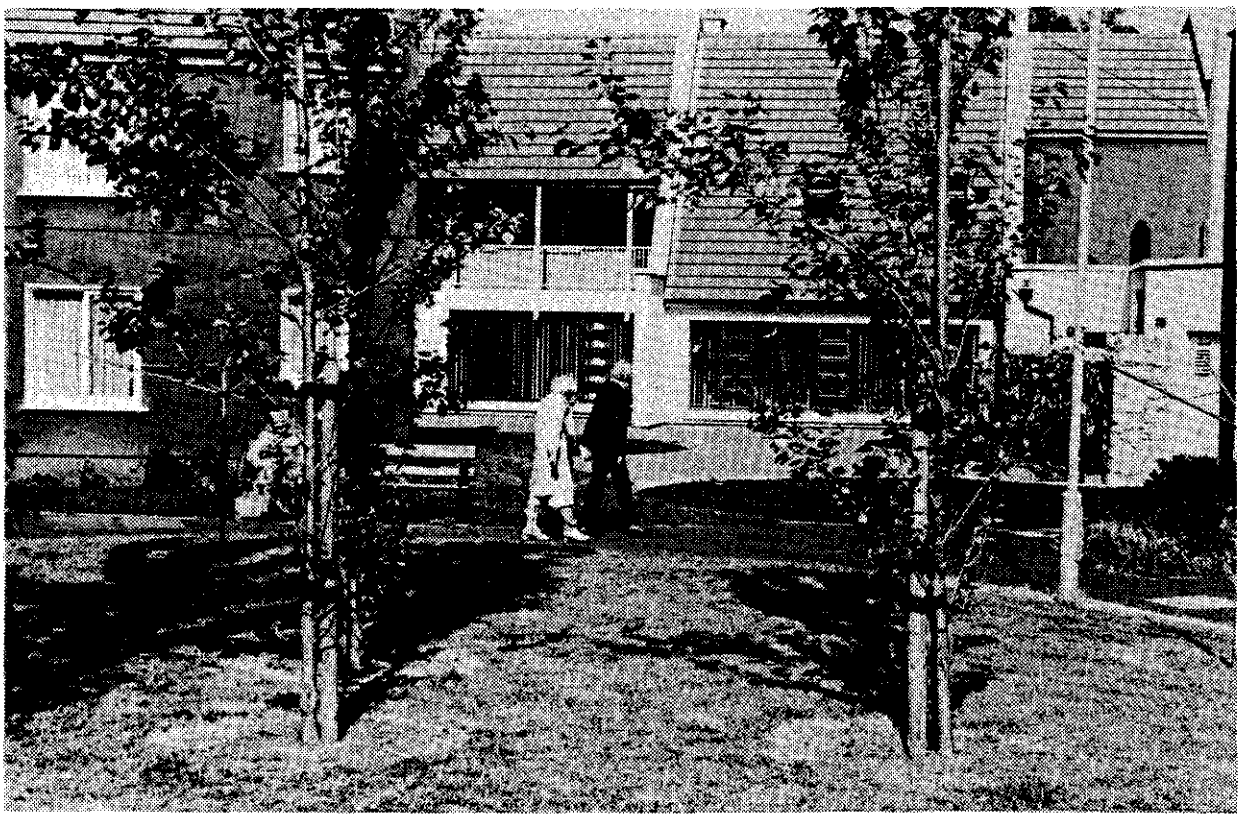
— the additional allowance for pensioners living alone (1977);

— the abolition in 1981 of the requirement that claimants for the non-contributory old age pension must have resided for a number of years in the state;

— a rent allowance for which certain old age pensioners are eligible (1982).

— the extension of PRSI to include the self-employed conferring contributory pension entitlements (1988).

1.7 In addition to these cash benefits, benefits in kind have also been improved. Among the most important improvements are the reduction in the eligibility for the free travel scheme from 70 to 66 years and the introduction of a free telephone rental scheme for which social welfare pensioners aged 66 years and over may qualify. A national fuel scheme and bottle gas allowance have also been introduced for which certain old age pensioners are eligible.



Beaufort Housing Scheme for the Elderly, Dun Laoghaire.

1.8 These improvements have helped reduce poverty among the elderly and increased their income relative to other groups. In a major survey, elderly persons expressed a high degree of satisfaction with the financial position

of their household. Their level of satisfaction was the highest of any group.[8] A small survey of elderly living in a rural area carried out by the National Council for the Aged found a similar level of satisfaction about income.[9] To what extent this satisfaction rating is due more to the lower material expectations of that generation rather than to objective factors is open to debate.

1.9 The general improvement in the income position of the elderly hides wide differences in income among the elderly themselves. The incomes of the elderly span a spectrum from the very wealthy to the very poor, with the mid-point somewhat below the level of younger age groups. Table 1.2 contains a comparative analysis of the incomes in 1980 of households with heads under 65 years, 65-79 years and 80 years and over using adult equivalance scales. It shows that net disposable income per head in households with an elderly head averaged 78 percent of that in households with a head aged under 65. The gap is narrowed somewhat if account is taken of the concessions in kind which are available to all or most elderly people - free public transport, medical cards, fuel allowances, free television licence and telephone rental.

1.10 The figures in Table 1.2 illustrate the weak financial position of elderly households relative to non-elderly households and highlight elderly single person households as a particularly disadvantaged group. The National Council for the Aged has estimated that in 1980, 30 percent of all elderly households had an income which brought them into the bottom 20 percent of all household incomes. More than half the elderly who are mainly dependent on social welfare pensions or who live alone fall into that group. Elderly women who live alone are heavily represented among the poorest households.[10] About 12 percent of elderly who depend mainly on income from social welfare pensions and 18 percent of the elderly living alone were defined by the Council as being in 'absolute' poverty.[11] These figures highlight the economic vulnerability of a minority of the elderly. The same minority of elderly tend to have the worst housing, to live in remote rural or deprived urban areas and to have fewer amenities such as telephones or cars.

1.11 Although income maintenance of the elderly is outside the terms of reference of this Working Party, it cannot be emphasised too much that an adequate income is a prerequisite for an independent, healthy and enjoyable old age. Particular attention needs to be given to increasing the income of those elderly in absolute poverty. In this Report, we address the housing, health and welfare problems which aggravate the problems of the elderly on low incomes

HOUSING

1.12 The elderly have benefited from the substantial and sustained improvement in housing which has taken place in this country in recent decades. Overcrowding has been reduced, the quality of housing improved and the range of home amenities increased. About the same proportion of the elderly as younger age groups—85 to 90 percent—express themselves 'fairly satisfied' with their dwellings.[12]

1.13 The recommendations of the **Care of the Aged Report** in regard to housing the elderly have been implemented to one degree or another. The most important developments in housing the elderly since 1968 have been

- the allocation by local authorities since the early 1970s of about 10 percent of local authority dwellings to the elderly and disabled. Table 5.3 gives a breakdown of the number and percentage of dwellings allocated to the elderly between 1973 and 1985;
- the provision by local authorities, health boards and voluntary organisations of sheltered and special housing schemes designed for the elderly;
- the introduction of special schemes to carry out repairs to the homes of elderly persons owning their own homes—the Scheme of Repairs for the Elderly and Disabled and the Special Task Force on Living Conditions of the Elderly;
- increased official support for voluntary housing bodies, especially since 1984;
- the introduction in 1982 of a scheme of tax relief on rent for elderly persons. The current age limit is 55 years and the maximum rent allowed is IR£750 for a single person and IR£1,500 for a married couple.
- the publication of the Housing Bill, 1988 which emphasises the role of local authorities in meeting the housing needs of the elderly and other groups.

1.14 A significant proportion of the elderly have benefited little from the general improvement in housing standards. The older elderly and those on low incomes tend to live in the oldest housing and to have fewer amenities. A survey carried out by the St Vincent de Paul Society found that 53 percent of the elderly living alone lived in housing built prior to 1919.[13] Table 1.3 highlights how many households headed by an elderly person still lack a bath or shower, an internal toilet and hot water and how few have a

telehone. Elderly households are only half as likely as other households to have central heating, despite the importance of warmth to older people.[14] The most severe housing deprivation among the elderly is in deprived urban and remote rural areas.

1.15 A distinguishing feature of housing among the elderly in this country is the high proportion of elderly owning their own homes. While home ownership has many advantages, it can have liabilities for the elderly. A house designed for a young married couple and family may cause problems for an elderly couple with increasing disability. They may lack the finance or organisation to adapt their home. The removal of rates on domestic property in 1977, while it reduced hardship on elderly rate payers, may have diminished the incentive for older people to move to accommodation more suited to their needs in later life. If elderly people are to be encouraged to remain in their homes or to move to more suitable homes, this objective needs to be given more concrete expression in housing policy.

1.16 The number of elderly people in private rented accommodation is small. Some of them tend to have problems with insecurity of tenure and rents and poor standards of accommodation. Those elderly persons in formerly rent controlled dwellings have been given a measure of security under new legislation. They have security of tenure, a procedure for determining rents through a rent tribunal, access to means-tested rent allowances, compensation in quitting a tenancy and standards for structural repair, basic amenities and common services. This protection is not available to private tenants whose tenancies were not affected by the removal of rent control and who continue to face problems of poor standards, and insecurity of tenure and rents.

HEALTH SERVICES

1.17 During the 1970s there was a rapid expansion in health services and improvement in the standards of care available to the population in general. Substantial progress was made towards implementing the recommendations of the **Care of the Aged Report** in regard to health services for the elderly. Among the most important developments in community health services have been

— the replacement in 1972 of the dispensary doctor service by the General Medical Service, giving eligible persons a choice of general practitioner and chemist, resulting in greater home visiting by doctors of the elderly;

— the expansion of the public health nursing service in the 1970s and the extension of domiciliary visiting by nurses to all parts of the country;

— the introduction in 1971 of the Refund of Drugs Scheme which entitled persons without medical cards to recoup from health boards the cost of drugs purchased for use in a calendar month above a certain amount;

— the introduction in 1984 of an age allowance for medical cards to ensure that elderly persons in receipt of a non-contributory old age pension qualified for a medical card;

— the introduction by public health nurses of local registers of elderly persons considered to be at risk;

— the development of home help, meals, laundry and day care services for elderly people by voluntary bodies and health boards;

— substantial increases in financial support by health boards to voluntary bodies providing services for the elderly.

Recommendations of the Report on which there has been less progress include the expansion of dental services, the provision of physiotherapy and chiropody, the development of a social work service for the elderly and the boarding out of elderly persons.

1.18 As far as hospital and institutional care of the elderly is concerned, the major developments have been

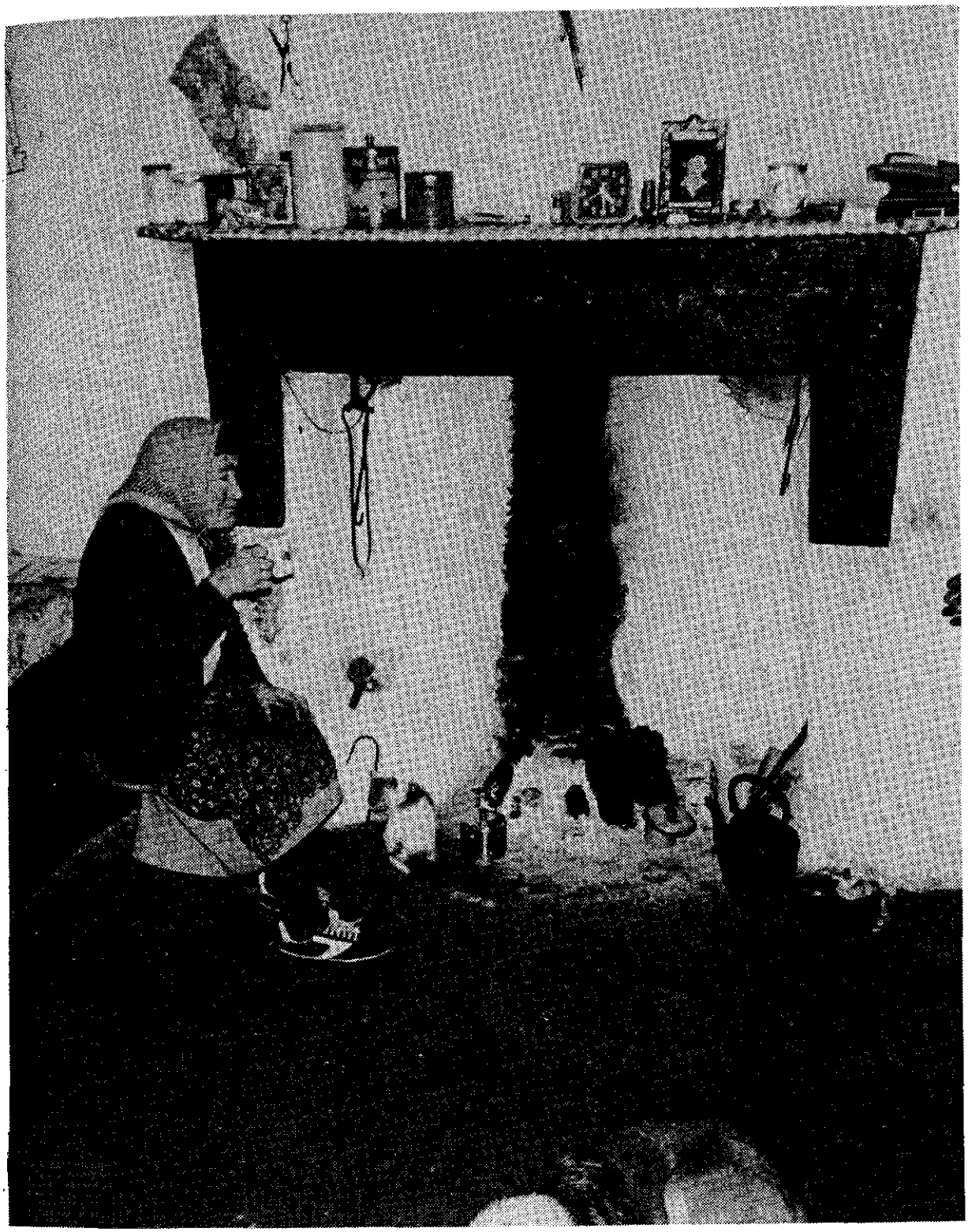
— the appointment of physicians in geriatric medicine to a number of general hospitals and the development of geriatric assessment and rehabilitation units;

— the gradual reduction in the number of elderly patients in former county homes, now known as geriatric hospitals, and the improvement of accommodation;

— the reduction in the number of elderly long-stay patients in psychiatric hospitals;

— the extension of eligibility for treatment in public hospitals to the entire population in 1979;

— the provision of approximately 30 welfare homes for elderly people who did not need care in a hospital but who could not manage at home;



Poor living conditions in the West of Ireland.

1.19 Important developments have also taken place which have supplemented those recommended by the Care of the Aged Committee. Advances in medicine have increased mobility and activity among the elderly, especially the replacement of arthritic joints and the insertion of cardiac pace makers. The appointment of 'access to services' or 'long-stay admissions' committees in some areas help to ensure that the elderly who come to the attention of the health board as in need of care are assessed and receive appropriate care at the right time. The development of an active approach to the management and rehabilitation of elderly people in some geriatric hospitals has proved successful in restoring elderly patients to independence and in preventing unnecessary admissions to long-stay beds. The community nursing units/homes developed originally in Donegal, have pioneered a new and more comprehensive approach to caring for elderly people, combining day care, welfare and respite facilities with extended nursing facilities. These innovations have confirmed the correctness of the Care of the Aged Committee's basic assumption that it is possible to maintain elderly people at home in dignity and independence. A smaller proportion of the elderly than even the Committee envisaged need to be cared for in an institution for an extended period.

1.20 Despite the undoubted improvements in the care of the elderly there are still considerable shortcomings in services. Although the "county homes" have become geriatric hospitals, too much of the atmosphere of the older institution survives in some centres. Furthermore, many elderly people still have little choice but to seek admission to institutional care because support is not available to allow them to manage at home. The appointment of physicians in geriatric medicine and the development of specialist assessment and rehabilitation units has been slow. In general, welfare homes have not worked out as planned. Throughout Europe it has been found that the kind of elderly person for whom the welfare home was designed - the frail but ambulant elderly person - no longer needs this form of care. Such elderly people now manage quite well at home with minimal support. The elderly who now require extended care tend to be much older and more disabled than those in the 1960s. Despite progress in developing domiciliary and community services insufficient support is available to thousands of relatives caring for elderly people at home, many of whom have severe disabilities. The expansion of private nursing homes catering mainly for the elderly in the higher socio-economic groups has raised the question of maintaining standards of care and of the relationship of the homes to the health boards. We return in more detail to these deficiencies later in the Report.

ORGANISATION

1.21 Changes in the structure of the health services in the 1970s have affected services to the elderly. The transfer of responsibility for health and welfare services from local authorities to health boards in 1970 meant that different authorities became responsible for housing the elderly and for meeting their health and welfare needs. The creation within health boards of community care teams, under the direction of the Director of Community Care and Medical Officer of Health, responsible for health and welfare services in areas corresponding in most cases with the counties, established a new framework for the development of health and welfare services for the elderly. The new health boards were given broader statutory powers and obligations to meet health and welfare needs than the local authorities had enjoyed. The removal of health charges from local taxation and the assumption by the Exchequer of the full cost of financing the health services stimulated the rapid expansion of services which took place in the 1970s.

1.22 Voluntary organisations serving the elderly grew vigorously during this period. Care of the Aged Committees and Social Service Councils were established in many parts of the country and proved invaluable in supporting and developing services for the elderly. Much of their funding has come from health boards in the form of grants paid under section 65 of the Health Act, 1953. As much as half of the home help service, almost all the meals-on-wheels and laundry service and a sizeable proportion of day care centres for the elderly are run by voluntary organisations. The establishment of the National Social Service Council (now Board) in 1973 provided an impetus to the expansion of voluntary bodies through its training and advisory programmes and the development of community information centres.

1.23 The appointment of a National Council for the Aged in 1981, as an advisory body to the Minister for Health, was a major step in highlighting the needs of the elderly in a comprehensive manner and in influencing policy at government level. The Council, which represents a broad spectrum of people involved with the elderly, has been responsible for instigating much useful research in this area. We have drawn heavily on work undertaken by the Council and have been influenced by its views in putting forward our own recommendations.

LEGISLATION

1.24 The Health Act, 1970 extended the powers of health boards to provide services for elderly people. Section 60 obliged health boards to provide a home nursing service without charge to persons with medical cards and to

other groups specified by the Minister for Health. Section 61 empowered, without obliging, health boards to provide a home help and other home support services with or without charge. Section 26 empowered health boards to make arrangements with bodies (including voluntary bodies), to provide services under the Health Act for eligible persons. The recommendation of the Committee that health boards be given legal authority to board out elderly persons was not, however, implemented. New regulations made in 1985 under the Health (Homes for Incapacitated Persons) Act, 1964 raised the minimum standards to be met by private nursing homes in caring for the elderly.

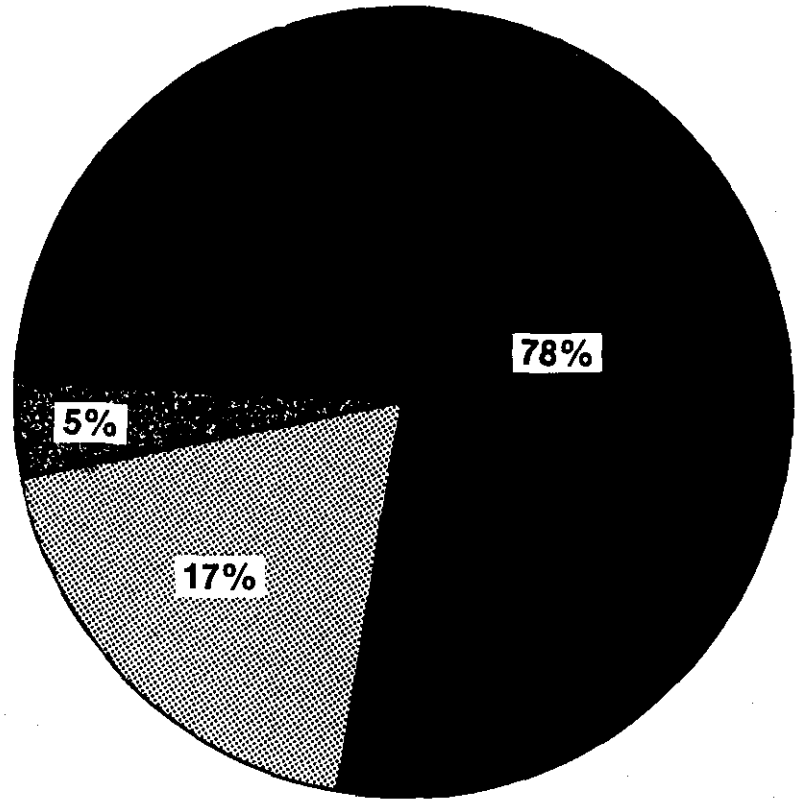
THE BALANCE SHEET

1.25 It is clear from the developments listed above that there have been substantial improvements in services for the elderly which have reinforced their independence and ability to live at home. The philosophy of the Care of the Aged Committee has been widely accepted and most of its recommendations have been implemented in part or in full. Their Report represented a major departure from the approach of the poor law which emphasised institutional care in dealing with problems of the elderly. In examining the issue of public services for the elderly nearly 20 years later, we are very conscious that we stand on the shoulders of the Care of the Aged Report. In approaching our task, we realise the many positive features about being elderly in Ireland today. While much remains to be done it cannot be said that as a nation we have failed our elderly citizens. The majority have an adequate income, own their own homes, are active and independent and express considerable satisfaction with their lives. While it is often claimed that families are no longer willing to care for their elderly relatives when they became dependent, the evidence before us does not support this claim. A recent survey of those caring for elderly relatives suggests that about 66,000 dependent elderly persons are being cared for by their families, compared with approximately 18,500 elderly persons in long-term care.[15] Figure 1.1 shows in a simplified way the proportion of the elderly at any one time leading independent lives, being cared for by their families and in long term care.

1.26 There are many strong points in the organisation of services for the elderly. Local authorities have a long and distinguished tradition of providing accommodation for them. The extensive network of general practitioners, available when required to visit elderly people at home and in most cases without charge to the patient, provides a very valuable medical service of which many other countries are envious. The public health nurse, the home

help, meals and laundry services and existing day care centres play a critical role in maintaining dependent elderly people at home. Most of the population lives in close proximity to a well staffed and equipped hospital, providing a high standard of acute medical and surgical care. Many voluntary bodies are active on behalf of the elderly, tapping the enormous good will that exists towards older members of the community. The National Council for the Aged and the National Social Service Board help to keep issues affecting the elderly before the public mind.

FIG 1 — THE INDEPENDENT AND DEPENDENT ELDERLY



78% = Independent Elderly

17% = Dependent Elderly at Home

5% = Elderly in long-term care

1.27 These positive points tend to highlight rather than obscure the negative aspects of being old in Ireland and the many gaps in service provision. Growing old for those living alone, in poor housing, on a low income and in poor health cannot be pleasant. Our task has been to identify the weaknesses in service provision and to recommend how they can be overcome. It is clear to us that housing, health and welfare services are not sufficiently targetted at assisting the most vulnerable elderly people. There is insufficient emphasis in public housing policy on improving the poor housing conditions of many of the elderly living alone and in enabling elderly people to live in their own homes for as long as possible. Existing domiciliary health and welfare services are inadequate in most parts of the country to maintain the elderly at home when ill or infirm. Persons caring for their elderly relatives at home receive insufficient support from statutory bodies. The shortcomings in domiciliary support services lead to a continuing bias towards long-term institutional care of the elderly. This is aggravated by the absence of adequate assessment and rehabilitation facilities. In our view one of the major deficiencies in services for the elderly is that too many elderly people are inappropriately cared for in geriatric hospitals, nursing homes and in psychiatric hospitals. Welfare homes as presently organised, make only a relatively limited contribution to the care of the elderly. There is a major gap in the provision of facilities for the demented elderly, a need to which little attention has been given up to now.

1.28 Where the administration of services is concerned, there is a lack of co-ordination in the delivery of housing, health and welfare services. The problem arises because different statutory bodies are involved and because the programme structure of health boards leads to the creation of independent elements within the health services and militates against co-ordinated delivery. The legal framework under which local authorities and health boards operate does not place sufficient emphasis on maintaining the elderly at home. Nor does it recognise the need to ensure co-ordination in the delivery of services.

1.29 Finally, the care of the elderly in the professional training courses of those who will work most closely with the elderly—doctors, nurses, physiotherapists, social workers, chiropodists—is accorded a low priority, although the elderly constitute a large and growing proportion of the clients of these professions.

1.30 In the subsequent chapters of the Report, we address these and other problems in providing services for the elderly. Our approach has been based on building on what is already there, emphasising the strong points in services for the elderly and overcoming the weak points. We are conscious of the

economic constraints on public expenditure, and for that reason we place particular emphasis on using what we have more efficiently. However, it will be necessary to expand key services for the elderly if the goal of maintaining the elderly in their own homes in dignity and independence is to be achieved. We put forward what we believe is a realistic framework for the development of services for the elderly in the years ahead.

NOTES TO CHAPTER 1—SERVICES FOR THE ELDERLY 1968—1988

1. *The Care of the Aged—Report of an Inter-Departmental Committee,* (1968), Stationery Office, Dublin, Prl 777 p.13
2. *Ibid.* p.45
3. *Reconstruction and Improvement of County Homes,* Stationery Office, (1951)
4. *The Care of the Aged op.cit* p.49
5. B J Whelan and R N Vaughan, *The Economic and Social Circumstances of the Elderly in Ireland* ESRI (1982) p.111
6. *Report of the Commission on Social Welfare,* (1986), Stationery Office, Pl 3851 p.191
7. B J Whelan and R N Vaughan. *op.cit* p.111
8. M Fogarty, L Ryan and J Lee. *Irish Values and Attitudes,* Dominican Press, Dublin (1984). p.25
9. National Council for the Aged. *The World of the Elderly. The Rural Experience,* (1984)
10. National Council for the Aged, *Incomes of the Elderly, (*1984) p.106.
11. *Ibid.* p.100
12. M Fogarty, L Ryan and J Lee *op. cit* p.25
13. St Vincent de Paul Society *Old and Alone in Ireland,* (1980) p.13
14. B J Whelan and R N Vaughan *op. cit* p.72
15. National Council for the Aged. *The Caring Process: A Study of Carers in the Home* (to be published).

Chapter 2

Demographic Change and the Elderly

LIFE EXPECTANCY

2.1. A feature of modern western society is that the great majority of people will live into old age, many into advanced old age. An Irish baby born in 1900 could expect to live to 50 years of age. A baby born now can expect to live until well into his or her seventies. This increased life expectancy is due to a combination of improved social and economic conditions, the control of major infections such as tuberculosis, and the increased capacity of medicine to control illness and disability. Current expectations of life at birth of 70.1 years for men and 75.6 years for women compare well with other developed countries. When life expectancy is analysed in more depth, however, it emerges that Irish life expectancy at age 65 compares less favourably with the experience of other EEC countries. (Table 2.1) Whereas a Frenchman can expect to live more than 14 years and a Frenchwoman 18 years at age 65, an Irishman is likely to live 12.5 years and an Irishwoman under 16 years. These figures are consistent with Ireland's relatively high incidence of cardiovascular disease and certain cancers as major causes of mortality from middle age onwards. The comparison with other EEC states suggests that life expectancy in this country could be increased among those over 65 if preventable deaths were reduced.

ELDERLY IN THE POPULATION

2.2. As a result of increased life expectancy and a fall in the birth rate, most western countries are experiencing a rapid ageing of their population. The number of elderly and the proportion of the elderly in the population are rising. In Denmark and the German Federal Republic, for example, the number of elderly has been increasing rapidly, to the extent that those over 65 number nearly 15 percent of the total population. (Table 2.2) In Ireland, the demographic position of the elderly is more complex. The number of

persons aged 65 and over in Ireland has increased from 323,000 in 1966 to 382,000 in 1986, representing a rise of 18 percent. But the elderly actually declined as a proportion of the population in recent decades, from 11.2 in 1966 to 10.8 in 1986. (Table 2.3) This decline is due largely to the effect of high emigration among that age cohort and a relatively high birth rate in recent decades. The age profile of the Irish population is overwhelmingly youthful with 38.2 percent of the population aged under 20 years and 53.4 under 30 years in 1986. If Irish fertility rates stabilise at the level projected for the 1990s, the proportion of the elderly during the first quarter of the next century will be considerably below those found today in countries such as Germany and the United Kingdom, and well below the levels projected for those countries at that time. (Table 2.4)

POPULATION PROJECTIONS

2.3. Projections of the size of the Irish population have proved unreliable in the past. Reasonable assumptions on migration and fertility trends have invariably been overtaken by events after a short space of time. Projections of the population in the older age groups have proved more accurate. It is easier to make predictions of the elderly population, at least up to the early years of the next century. The age group who will reach 65 at the turn of the century are now in their early fifties. They are the group of the population least likely to emigrate or even migrate within the country. We can be fairly confident in estimating the number of the elderly up to 2011. What is more difficult is to estimate the elderly as a proportion of the total population - an important issue in discussing the implications of funding services for the elderly.

2.4. There have been three recent attempts at projecting the population and estimating the elderly population within those projections. The first was carried out on behalf of the National Council for the Aged (NCA) in 1985.[1] The second was published in 1987 by Davy, Kelleher, McCarthy Ltd (DKM) economic consultants and the third was in 1988 by the Central Statistics Office (CSO).[2] Tables 2.5 and 2.6 compare the three sets of projections. The DKM study was based on the preliminary results of the 1986 Census of Population while the CSO projections were based on the final results of that census. Both the DKM and CSO projections take account of the resumption of significant emigration and the rapid decline in fertility between 1981 and 1986. The NCA projections are to 2006; the DKM to 2011 and the CSO to 2021.

2.5 The estimates differ on their overall projections for the total population in the early years of the next century. The NCA projects a continuous increase

in population while DKM and the CSO consider population growth to have ended in 1986 and to have begun a slow decline from then on. Differing assumptions about emigration and fertility account for most of the difference between the estimates.

2.6 As far as the elderly are concerned, their numbers are expected to increase by between 8,600 and 20,700, or by 2.3 to 5.7 percent between 1986 and 2006. DKM and the CSO project a substantial increase in the elderly population between 2006 and 2011, of 22,700 or 5.8 percent and 32,300 or 8 percent respectively. Estimates of the elderly as a proportion of the population in 2006 range from 10.4 to 11.7 percent. The DKM and CSO estimates agree that by 2011 the elderly will constitute about 12.5 percent of the population. The CSO projects an elderly population of 553,100 by 2021 or 16 percent of the total population. The differences between the projections are not large enough to affect the planning of services for the elderly.

DEPENDENCY AND OLD AGE SUPPORT RATIO

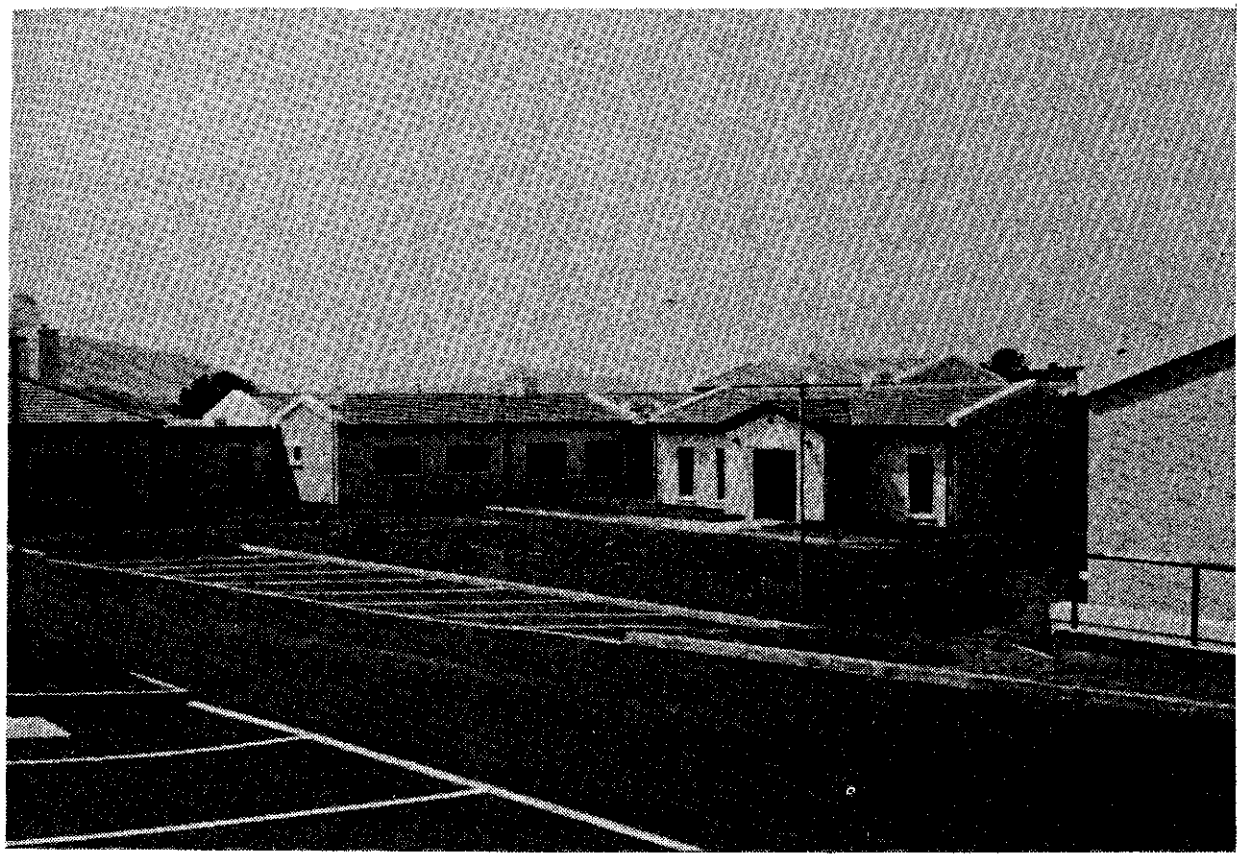
2.7 The high fertility of past decades means that for some considerable time the elderly in Ireland will have exceptionally large networks of adult descendents compared to the rest of Europe. Continuing high levels of emigration would offset this advantage to some extent. All three projections envisage an improvement in the ratio of dependent groups (children and the elderly) to those of working age. The CSO's projections for the dependency ratio are given in Table 2.7. The proportion of the population in the most dependent age groups will fall from 40.1 percent to 32.0 percent according to the DKM forecast. The increase of 8.3 percent in the elderly population in the DKM forecast will be more than offset by a projected decline of 37 percent in those aged under 15 years.

2.8 The projected decline in the number of children has important implications for social services, in particular reducing the demand for social welfare payments, health services and education. The growth of the proportion of the elderly in the population, according to the DKM projection, will increase their needs relative to children's. In our view **the decline in births presents an opportunity to redeploy the resources saved in social welfare, health and education to services for the elderly.**

2.9. The old age support ratio is the ratio of persons in the most active age groups to those aged 65 years and over. A favourable dependency ratio makes it easier to support services for the growing number of elderly persons. At

present, there are 5.6 persons aged 15-64 for every person aged 65 years and over. The CSO estimates that the ratio will improve to 5.7 to 1 by 2006 with a slight fall to 5.2 to 1 by 2011. (Table 2.7) What is important is that no significant worsening of the ratio is projected, unlike other OECD countries where the ratio is expected to fall steadily over the next decades. (Table 2.8) The 'caring ratio' may not be as favourable when account is taken of the relatively large number of dependent children in this country and the high level of unemployment among those in the most active age groups.

2.10 A recent survey of those caring for elderly persons found that female carers outnumber males by more than 5 to 1.[3] A female carer is most commonly looking after a parent, a spouse or a parent-in-law. The tendency of women to take on this role is influenced by the traditional caring role of women. It is also influenced by the low level of participation by married women in female employment. In the period 1971-1985 there was a dramatic increase in married women's participation rates in the labour force following



Community Nursing Unit for the Elderly, Buncrana, Co. Donegal

the removal of discriminatory employment practices, changes in social attitudes towards married women remaining in the labour force and increased employment in the services sector. The extent to which this trend continues

will affect married women's availability to care for dependent husbands and relatives. The estimates are that married women's participation rates in the labour force will increase from the current level of 20.4 percent to 42.2 percent in 1996. DKM, using more conservative assumptions, suggest that participation rates will be 34 percent in 2011.[4] While these increases are significant, the projected participation rates are still low by European standards and much of the work involved may be part-time. It does not appear that participation in the labour force by married women will have a major impact on the availability of women to care for dependent elderly people in the foreseeable future.

THE VERY ELDERLY

2.11 While the number of people reaching 65 years has been increasing rapidly, the rate of increase in those reaching 75 years has been slightly higher. This trend has significant implications for services because those aged 75 years and over are more likely to be living alone, are more dependent than the 'young' elderly and require much greater support. The rate of increase in the number of women reaching advanced old age is particularly marked. DKM forecast that the number of very old elderly, that is those aged 75 years and over, will increase by 8.5 percent between 1986 and 2011. The rate of increase will be much greater for very elderly women at 13.5 percent. (Table 2.9)

EFFECT ON SERVICES

2.12 Significant changes are expected in the marital status of the elderly. There will be a substantial drop in the number of elderly who never married, with a corresponding increase in the number married or widowed. (Table 2.10) This means that a higher proportion of the elderly in the future will have families to care for and support them. As far as the very old are concerned, a higher number of widows and widowers will reduce the benefit of increased marriage. Among the very old, the number widowed or single in 2011 will continue to outnumber those married. This aspect of the marital status of the elderly highlights the dependency of the very old on support from those other than spouses and immediate family.

2.13 The continuing increase in the number of elderly persons has important implications for demand for housing, social welfare pensions and health services. The number of elderly living alone or with a spouse doubled between 1961 and 1981. (Table 2.11) By contrast, the number living in multi-member households declined by 10 percent. These figures might indicate a decline in family responsibility for the elderly and increased mobility of younger

members of the family. However they are probably more a reflection of the growing independence and financial resources of the elderly, greater availability of special housing and in many cases, their wish to live alone or with their spouse. The NCA estimates that by the year 2006 the number of elderly persons living alone will have increased by 31 percent, with a much greater increase in the percentage of elderly women, particularly widows, living alone.

2.14 The demand for State pensions will be influenced by the numbers reaching pension age, by the expected increase in those reaching advanced old age and the number of elderly with private pension provisions. The increase in the elderly population and in those reaching advanced old age may be balanced by the growing number of people with occupational pensions. DKM have estimated the effect the ageing of the population will have on patterns of consumption of health services, based on 1979 patterns of consumption.[5] They estimate that the usage of acute hospital inpatient services will increase by 6.5 percent by 2011. They estimate a 3.5 percent increase in GMS consultations and a 7 percent increase in demand for geriatric services by 1996.

REGIONAL DISTRIBUTION

2.15 The increase in the elderly will be most uneven between one part of the country and another. (See Table 2.12). The NCA estimates that the Eastern Health Board region, consisting of Counties Dublin, Wicklow and Kildare, will experience an increase of the order of 31 percent in its elderly population while the North Western Health Board region, comprising counties Donegal, Leitrim and Sligo will experience a decrease of 12 percent in the number of elderly persons. The number of elderly in the Western Health Board region (counties Galway, Mayo and Roscommon) will decrease by almost 11 percent and in the Southern Health Board region (counties Cork and Kerry) by 1 percent. The remaining health board regions will experience increases ranging from 2 percent to 6.5 percent.

2.16 Counties Dublin, Carlow, Kildare, Louth, Meath, Wicklow and the cities of Limerick, Waterford and Cork are expected to have a rate of increase higher than the national average. In the case of Dublin county, the number of those aged 75 years and over is expected to more than double between 1981 and 2006. If in the past we have tended to associate an ageing population with the rural conditions of the west of Ireland, the concentration of the elderly in the future will be in the predominently urban counties of the Eastern seaboard. This trend is the result of the rapid expansion of population in recent

decades along the eastern seaboard. Because of the sheer scale of the increase in the elderly population in the greater Dublin area, it is likely that the demand on health and welfare services will be particularly acute in this region.

MORBIDITY

2.17 There is no comprehensive information on illness among the elderly in this country. Certain proxies can be used which give some idea of the extent and nature of serious illness among the elderly. A survey of the ten most common outcomes of general practitioner consultations with elderly people suggests that the most frequent treatable disorders are high blood pressure and heart failure, sleep disturbance, anxiety and depression, infections, arthritis, gastro-intestinal tract and respiratory disorders.[6] (Table 2.13) With the exception of infections, these disorders are largely degenerative and recurrent. The most common conditions among elderly people discharged from hospital are diseases of the respiratory and digestive system, ill-defined conditions, diseases of pulmonary circulation, ischaemic heart disease and fractures. (Table 2.14)

CAUSE OF DEATH

2.18 As might be expected, three quarters of all deaths are of persons aged 65 years and over. Elderly people die mainly from ischaemic and other forms of heart disease, malignant neoplasms, diseases of the respiratory system and cerebro-vascular disease as the statistics given in Table 2.15 indicate. The majority of deaths from these largely degenerative diseases and from hypertensive disease are to persons age 65 years and over.

SUMMARY

2.19 The demographic trends discussed in this chapter are mainly favourable to the elderly. Increasing numbers of people will live to old age. After the year 2006, the increase in the number of elderly will be particularly marked and the elderly will begin to grow slowly as a proportion of the population. The dependency ratio of the elderly to those aged 15-64 will stay much the same unlike other OECD countries where it will disimprove. Although married women will be increasingly employed outside the home, the increase is not expected to have a major impact on the care of dependent elderly relatives. Increasing numbers of elderly people, especially women, are reaching advanced old age and many more elderly people in future will live alone. The growth in the elderly population will increase demand for health services in particular and must be a major influence on the planning of these services

for the future. The growth in numbers of the elderly will be most uneven, with the Eastern Health Board region accounting for a disproportionate share of the increase. The North Western and Western Health Board regions will experience a significant decline in their numbers of elderly persons. The dramatic drop in projected births provides an opportunity to redeploy resources to meet increasing need among the elderly.

NOTES TO CHAPTER 2—DEMOGRAPHIC CHANGE AND THE ELDERLY

1. National Council for the Aged, *Housing of the Elderly in Ireland,* (1985)

2. Davy Kelleher McCarthy Ltd. *Ireland's Changing Population Structure,* (1987). Central Statistics Office, *Population and Labour Force Projections 1991-2021,* (1987)

3. National Council for the Aged. *The Caring Process: A Study of Carers in the Home,* (to be published)

4. Davy Kelleher McCarthy, *op. cit.* p.28

5. *Ibid.* p.38

6. J. Goggin, H. Jack, N. Golden and P. Lacey 'Prescribing Survey in Irish General Practice—1979' *Irish Medical Journal,* Supplement, January, 1986.

Chapter 3

A Comprehensive and Co-ordinated Service

3.1 Although there is universal acceptance of the principle that services for the elderly should enable them to live in their own homes as long as possible, the principle is not always evident in practice. From our examination of the situation it is clear that not only are the services required to support the elderly at home inadequate but their shortcomings are becoming more apparent as the need increases. The challenge is to make better use of the resources currently available for the elderly and to expand services to maintain greater numbers of elderly people in dignity and independence at home. This chapter is concerned with the appropriate framework for co-ordinating existing services and for developing more comprehensive health and welfare services for elderly people.

OBJECTIVES OF SERVICES FOR THE ELDERLY

3.2 In the light of our obligations towards our elderly citizens as they are perceived today, we consider that the following should be the objectives of public policy in regard to them:

- to maintain elderly people in dignity and independence in their own home;
- to restore those elderly people who become ill or dependent to independence at home;
- to encourage and support the care of the elderly in their own community by family, neighbours and voluntary bodies in every way possible;
- to provide a high quality of hospital and residential care for elderly people when they can no longer be maintained in dignity and independence at home.

In implementing these objectives, the primary concern of statutory services must be with the elderly who lack the economic means or the organisation to maintain their dignity and independence in old age.

PRINCIPLES UNDERLYING SERVICES

3.3 It follows from these objectives, that services for the elderly should be:

- comprehensive
- equitable
- accessible
- responsive
- flexible
- co-ordinated
- planned
- cost effective

3.4 A **comprehensive** service for the elderly would ensure whatever help an old person needed to live at, or return to, the community by way of suitable housing, medical or welfare services was provided. In many cases, it involves assisting relatives in their task of caring for the elderly person. Acute hospitals and long-term facilities should support and complement this objective. An **equitable** service would aim to provide the elderly who are disadvantaged by low income or disability with the services they need but cannot afford or avail of by their own efforts. As mobility, or the lack of it, is such an important factor in the lives of elderly people, services must be **accessible.** Some services must be brought to elderly people in their homes. Transport must be organised to bring elderly people to services which can only be provided in a community centre or in an acute hospital. Those providing services for the elderly must be able to **respond** quickly to emergencies in the home or to requests from other agencies. Services must be **flexible** enough to meet the individual requirements of an elderly person and caring relatives. There must be **co-ordination** between all those providing services to ensure that the needs of the elderly are met in a coherent way. The needs of the elderly in each area must be anticipated and services **planned** to meet them. Finally, services for the elderly must be provided in a **cost-effective** manner to ensure the best value for money spent. When judged against these principles, existing services for the elderly leave much to be desired.

CO-ORDINATION OF EXISTING RESOURCES

3.5 Considerable resources are already committed to caring for the elderly. For example, a substantial share of public expenditure on housing goes on substitute housing for the elderly or on repairs to the homes of elderly people.

More than two-thirds of the people on the visiting lists of public health nurses are aged over 65 years.[1] The elderly have one of the highest visiting rates of any age group for consultations in the General Medical Service and account for over 40 percent of bed days in acute general hospitals.[2] There are eleven consultant physicians in geriatric medicine and acute geriatric departments in nine general hospitals. Approximately 5.5 percent of the elderly are in long term care in public and private institutions.[3] Health boards and voluntary organisations provide extensive home help, meals, day-care, laundry, chiropody and other services for the elderly. The contribution of relatives and friends to the care of the elderly may be difficult to quantify but it is substantial in terms of time and opportunities foregone.

3.6 The problem, as we see it, is how to weld these resources into services that will support elderly people in their homes in dignity and independence. The present lack of co-ordination is evident in the tendency of each service and organisation to work independently of the other. Local authorities are responsible for housing elderly people living in inadequate accommodation, many of whom also have health problems, but no formal co-ordinating link exists between them and the health board services. General practitioners and public health nurses may visit the same patients but they have no formal reporting relationship to one another. The acute hospital may discharge an elderly person with a severe disability and in need of continuing attention without notifying those responsible for community care services or the general practitioner. People caring for elderly relatives at home receive little or no support from health board personnel.[4] The separation of responsibility for community care, acute hospital, psychiatric and long-term care into two or three administrative programmes of health boards contributes to the problems. Private nursing homes provide an increasing share of long-stay accommodation for the elderly but they operate with the minimum amount of co-ordination with health board services. Voluntary bodies working with the elderly have repeatedly pointed out the inadequacy of their working arrangements with health boards and the absence of a formal method whereby they can influence policy or the direction of services. All these factors point clearly to the need for a co-ordinated health and welfare service for the elderly.

3.7 The primary reason for co-ordinating health and welfare service for the elderly is to ensure that elderly people are supported in their homes with appropriate services whenever possible. This must be the objective not only of community services but also of acute hospital and extended care services. The resources of the acute hospital and the traditional long-stay geriatric hospital must support the efforts of the front-line community services. Health

and housing authorities must collaborate to the same end. The transfer of an elderly person from his or her home to extended residential care should only be considered when all options to support the elderly person at home have been tried and found inadequate to the person's needs.

3.8 We have been impressed by the improvements in services for the elderly which have resulted from co-ordination in different parts of the country. Co-operation between Cork Corporation, the voluntary organisation SHARE, and the Southern Health Board has greatly improved services for the elderly in Cork city. In the North Western Health Board, the co-ordination of community, acute hospital and long-term nursing care has resulted in much greater support for elderly people at home and care in relatively small and localised nursing homes when care at home is no longer viable. Co-operation between general practitioners, community care staff and the staff of the geriatric hospitals in Cashel, Athy and Baltinglass has led to much greater support for elderly people at home and dramatic reductions in the numbers of elderly people entering long-term institutional care. Other areas, too, have demonstrated the benefits of co-ordinated effort; but in many areas services for the elderly remain disjointed.

3.9 The National Council for the Aged, recognising the importance of administrative co-ordination to the planning and delivery of housing, health and welfare services to the elderly, has initiated a research project which will examine the difficulties and opportunities of co-ordination in practice. In South Tipperary and Dun Laoghaire the local authorities, the health boards and voluntary organisations have agreed to formalise their working relationships and to submit them to evaluation. The areas represent predominantly rural and urban populations respectively. We welcome this initiative in action research and **recommend that sufficient resources be provided to deepen understanding of the difficulties of ensuring co-ordination in the delivery of services to the elderly.** We hope that an evaluation of the projects will be undertaken and published.

3.10 The problem of co-ordination in the health services is a major issue discussed in **Health—The Wider Dimensions—A Consultative Statement on Health Policy** published by the Department of Health in 1986. It proposed a change in the unit of management of health boards from the present three care programmes to the administration of services by geographical area and the establishment of community health committees to provide a formal input by communities to decision making about health. It emphasised the need to adopt a planning system which would measure the health needs of the local population, identify health goals and choose the best options within available resources.

FIGURE 3.1: COMMUNITY CARE DISTRICTS

WESTERN HEALTH BOARD

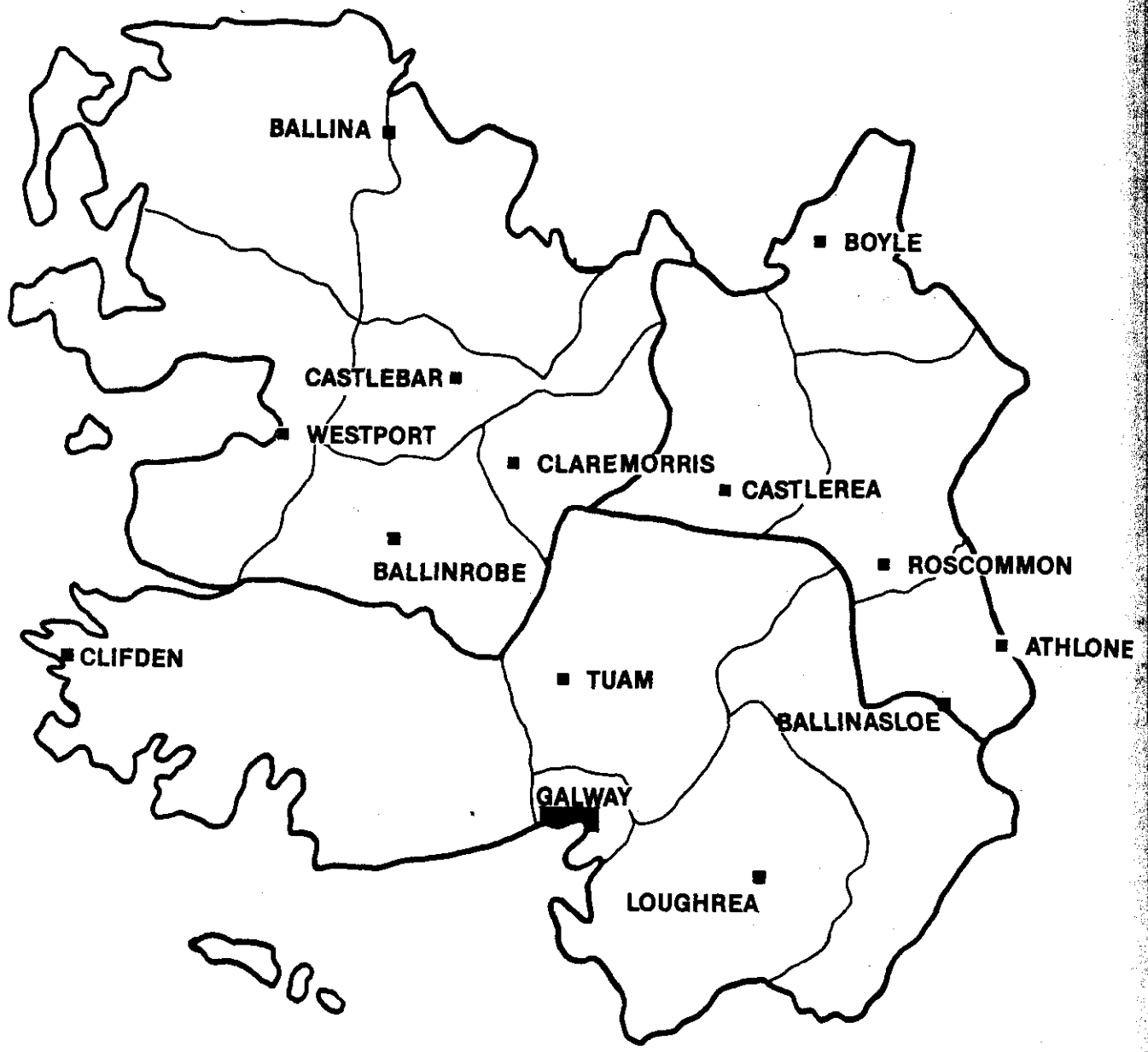
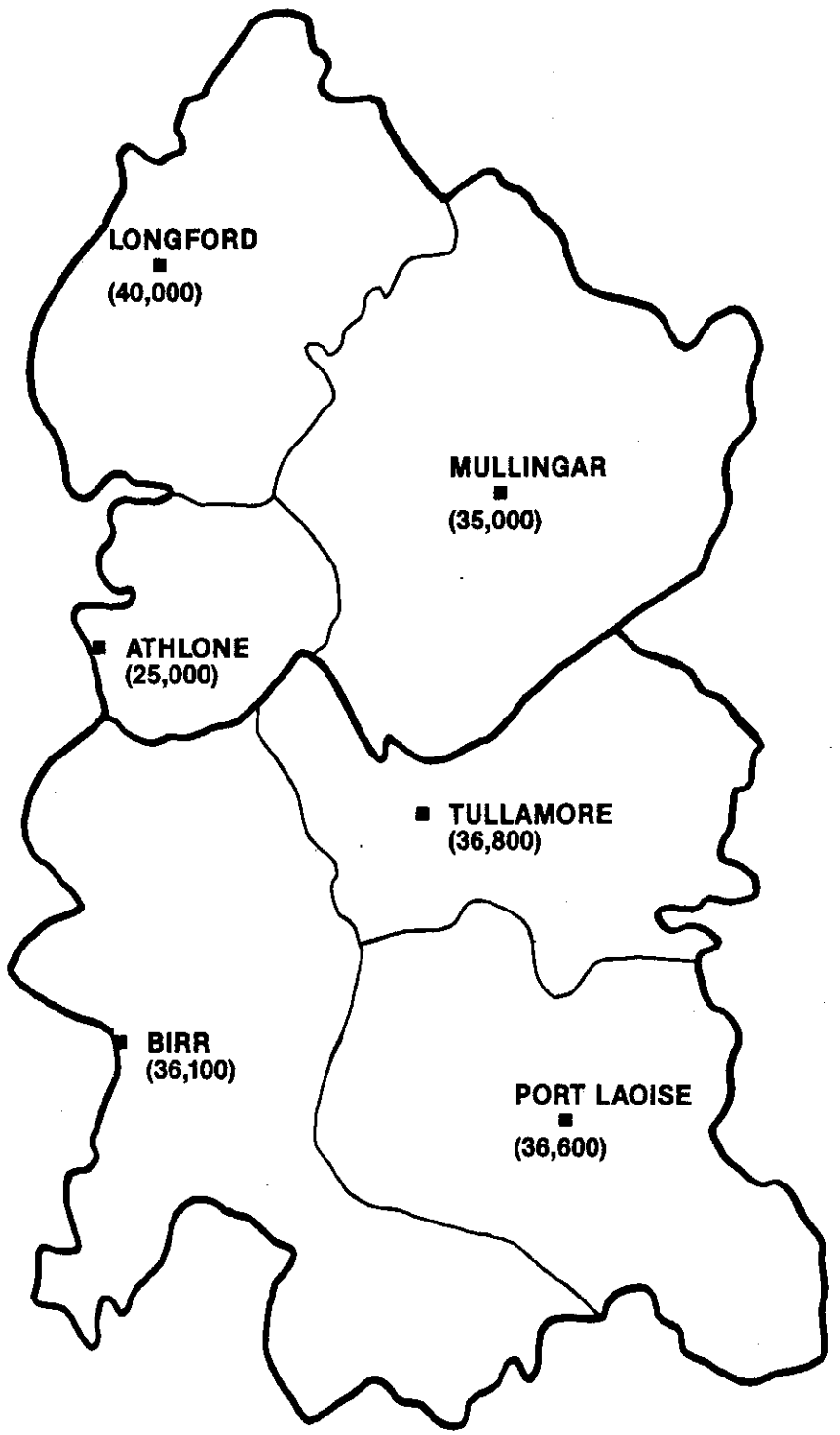


FIGURE 3.2: PSYCHIATRIC SECTORS AND COMMUNITY CARE DISTRICTS, WITH POPULATIONS—MIDLAND HEALTH BOARD



THE DISTRICT

3.11 We consider that the division of administrative responsibility between a number of programmes within health boards militates against the provision of a comprehensive and co-ordinated service for the elderly. We strongly endorse the proposal of the Consultative Statement that responsibility for the administration of health services be organised on a geographic or territorial basis. Careful thought needs to be given, however, to the organisation of administrative responsibility on a territorial basis if the shortcomings of the present system are not to be repeated. Administrative responsibility for the delivery of a service should, in general, be located as close as possible to the operational level. The operational level for most services for the elderly is very local—a doctor, a nurse, a voluntary worker making decisions about an individual, usually in the elderly person's home. The care of the elderly usually requires the skills and commitment of more than one professional. Administrative arrangements should reflect and strengthen the operational capacity of those providing the majority of services to the elderly person and their relatives.

3.12 Most health boards have recognised this operational level and have organised their community care personnel by district, a subdivision of the community care area. **Planning For The Future,** the report on the psychiatric services, recommended the re-organisation of the psychiatric services into 'sector' or district teams serving a population of 25—30,000 people, with larger populations in urban areas. Each health board is in the process of re-organising its psychiatric services on that basis. In some cases, the sectors follow the same boundaries as the districts used for the delivery of community care services. It appears that districts and sectors outside the main urban areas are centred around the main towns as Figs 3.1 and 3.2 illustrate. In the main urban areas, the density of the population justifies larger populations in each district. **We recommend that services for the elderly be organised as far as possible in districts serving a population of approximately 25—30,000 people.**

THE DISTRICT LIAISON NURSE AND TEAM FOR THE ELDERLY

3.13 There are certain tasks in relation to the well being of the elderly that are best carried out at district level. These include:

- ensuring that the elderly in need are identified;
- supporting caring relatives;
- mobilising home nursing, home help, day care and other services;

- arranging for repairs and adaptations to elderly persons' homes;
- developing a boarding out scheme as a form of welfare accommodation;
- recommending access to extended nursing or residential care;
- monitoring standards in private nursing homes;
- mobilising the resources of local voluntary bodies.

We recommend that the function of co-ordinating services for the elderly in each district should be the responsibility of a district liaison nurse. We have been impressed by the achievements of the liaison nurses who have been appointed in improving services to the elderly in different parts of the country. We envisage that the district liaison nurse for the elderly would normally be a senior public health nurse. It is essential that the person chosen should have a commitment to the elderly and should have the ability to work successfully with other professionals.

3.14 The district liaison nurse will rely to a great extent on the co-operation of other professionals to ensure that the elderly receive appropriate care at the right time. **We recommend the formation of district teams for the elderly, representative of those with direct responsibility for providing services to the elderly to support the district liaison nurse in her co-ordinating role.** The core members of the team would include the

- district liaison nurse for the elderly;
- area medical officer;
- matron of the community hospital;
- medical officer of the community hospital;
- representative of the general practitioners nominated by the local faculty of the Irish College of General Practitioners;
- housing official of the local authority;
- administrator, (who will also service the team);
- environmental health officer;
- representative of local voluntary organisations;
- community welfare officer.

3.15 Other professionals such as the sector psychiatrist, physiotherapist, occupational therapist, home help supervisors and social workers should be involved as the need arises. The chairmanship of the team would depend on local circumstances and personalities. We emphasise that the purpose of the district team is to co-ordinate services for the elderly; individual members will remain responsible for those services which they are obliged to provide. A well functioning team should not need to meet more frequently than once a month. **We recommend that the role of the district liaison nurse and the district team for the elderly be reviewed three years from the date arrangements are put in place for co-ordination at district level.**

3.16 The district teams for the elderly would serve a population of 25—30,000, with about 3—3,500 elderly people, over much of the country and larger populations in the main urban areas. As many community care and psychiatric services provided by health boards are already organised on a district basis and as the personnel are in post, the designation of district teams should cause little difficulty. In our view the team approach would have considerable advantages at operational level over the present programme structure. Apart from the elderly and the mentally ill, the district team approach would be valuable for the physically and mentally handicapped and children. It is essential that district and sector teams share a common boundary to ensure co-ordination in the delivery of services. Boundaries should follow those of district electoral divisions to ensure that information collected in the census can be used to give accurate information on the elderly population.

CO-ORDINATOR OF SERVICES FOR THE ELDERLY

3.17 We consider that there is also a need for co-ordination over a larger geographic area than the district. This is necessary to ensure that the services delivered by district teams develop coherently, that health services and the housing activities of local authorities work to the same end and that there is good liaison between the general hospital and the district teams and with voluntary bodies organised at the county level. We consider that the community care area, which follows the county boundaries in the majority of cases, is the appropriate unit for this co-ordination. Ideally, the community care area encompasses a population of 100,000 (or 3 to 4 districts) although in practice, the populations of the areas vary considerably above and below this number. **We recommend that in each community care area, health boards appoint a Co-ordinator of Services for the Elderly.**

3.18 The common boundary between many community care areas and counties should facilitate co-ordination with local authority housing programmes. In Cork and in Dublin in particular the organisation of the community care areas is more complex, and co-ordination with local authorities more difficult. If the proposed reorganisation of local Government in Dublin city and county by the creation of new counties comes into effect this will create the need to review the present alignment of community care areas so as to facilitate liaison and co-ordination with the housing departments of the new local authorities. Health Boards in defining catchment areas for acute hospitals and sectors for psychiatric services should ensure that the boundaries are coterminous with district and community care areas.

3.19 We have considered who should be responsible for co-ordinating services for the elderly in the community care area. Some would argue that this is a role for the consultant physician in geriatric medicine. However, in our view responsibility for co-ordinating services for the elderly could only be assumed at the expense of his or her clinical commitments. The shortage of physicians in geriatric medicine at the present time requires that their clinical commitment be maintained as a priority.

3.20 Because the programme structure of health boards is likely to be changed and the role of the Director of Community Care and Medical Officer for Health is under review, it is difficult for us, in the absence of certainty about future arrangements, to recommend precisely who should assume the role of co-ordinator. As some of the services which elderly people require to maintain their independence at home have no medical content, it could be argued that the co-ordinator should have a social work, environmental health or community welfare background. However, in the majority of cases, the intervention of the health board arises because of the illness or disability of an elderly person. Liaison with general practitioners, hospital consultants, sector psychiatrists and public health nurses is essential to successful co-ordination of services for the elderly. It would be an advantage if the person co-ordinating services for the elderly brought to the task expertise in social medicine, epidemiology and management. At present, the persons with such expertise are those who have acquired membership of the Faculty of Community Medicine of the Royal College of Physicians of Ireland. These doctors, known as community physicians, of whom there are about 30 at present, are increasingly employed in the post of Director of Community Care and as senior area medical officers. We recognise that other professionals, by virtue of their personal ability, may be suited to the co-ordinating role. **We recommend, however, that in current circumstances, the task of co-ordinating services for the elderly be assigned to a community physician.**

We envisage that the task of co-ordinator may initially be a full-time one but that once co-ordination is working smoothly, a part-time commitment will be sufficient. **We recommend that the appointment of community physicians as co-ordinators of services for the elderly be reviewed three years after arrangements have been established to co-ordinate services at district and community care level.**

3.21 We shall subsequently in this report refer to the person with responsibility for co-ordination as the Co-ordinator of Services for the Elderly (CSE). The responsibility of the CSE will be to

a) plan the development of services for the elderly in the community care area;

b) ensure that the district teams for the elderly achieve their objective of supporting elderly people with health or welfare needs at home for as long as possible;

c) encourage the provision of a range of support services for the elderly and their carers in each district, including day care facilities, boarding out, home nursing;

d) ensure co-operation between health board services, and the activities of housing authorities and voluntary housing bodies;

e) agree with the general hospital and the psychiatric service policies for the admission and discharge of elderly people to hospital.

f) liaise with voluntary organisations working with the elderly at a county level;

g) be the main source of information and advice to professionals, persons caring for elderly relatives and the public on services for the elderly in the community care area;

h) enforce the legal requirements governing the establishment and maintenance of private nursing homes;

i) service the Care of the Elderly Committee recommended below;

j) co-ordinate transport for the elderly to day care and hospital services.

CO-ORDINATION AT HEALTH BOARD LEVEL

3.22 There is a need to co-ordinate the planning and development of services for the elderly at the broader health board level. We recommend that such co-ordination be achieved through the introduction of a systematic approach to planning.

3.23 The consultative statement, **Health—The Wider Dimensions** outlined the following elements of a planning system which in our view is appropriate to planning services for the elderly:

— "measurement of health needs in the local population;

— identification of health goals, in terms of improved health in the population rather than improved health services;

— appraisal of options, combining a mix of health promotion and health services and selection of best options within available resource limits;

— a formal planning cycle incorporating annual programmes and four-year strategic plans at health board level and a long range (corporate) health plan at national level; and

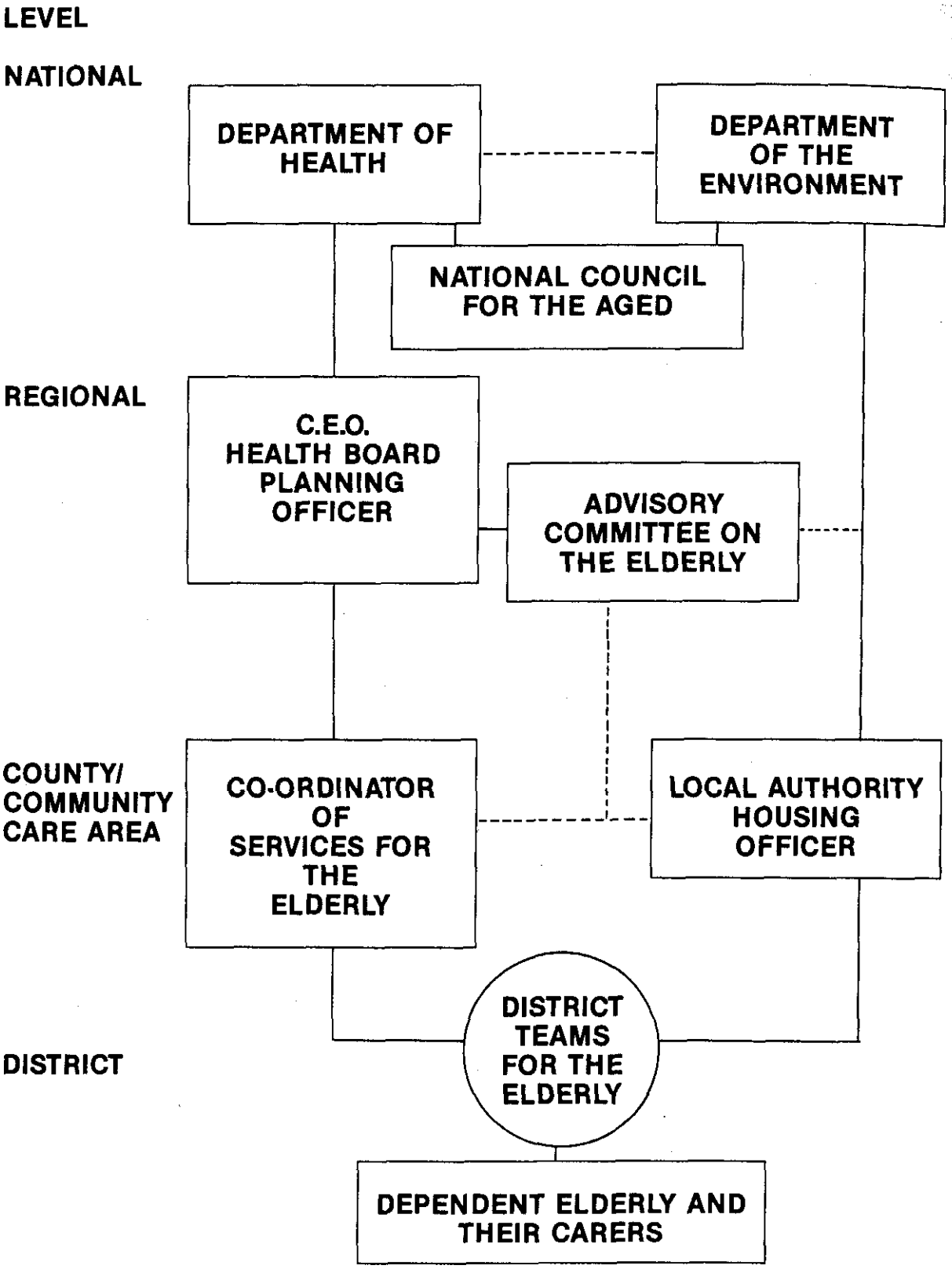
— a regular review of plans against previously identified indicators".[5]

3.24 **We recommend that the health and welfare needs of the elderly be considered as a distinct but integral part of a new planning system for the health services.** In the larger health boards, the planning and development of services for the elderly will require the full time attention of a designated person. The Eastern Health Board has already appointed a person to co-ordinate services for the elderly in Dublin city and county on a full-time basis. In the smaller boards, the task of planning services for the elderly might be combined with other planning functions. The person responsible for planning services for the elderly would work closely with the CSEs in the region to prepare a plan and in reviewing performance against the targets of the plan. Each CSE would be responsible for drafting a plan for the elderly in his or her area in consultation with the district teams for the elderly and within guidelines laid down by the Department of Health and the health board. These plans would be integrated at health board level and discussed with the Advisory Committee on the Elderly and incorporated in the health board's overall plan for the development of services in the region. We consider the requirements of plans for the development of services for the elderly in more detail in Chapter 12—Implementing the Recommendations.

ADVISORY COMMITTEE ON THE ELDERLY

3.25 We consider that there would be benefits from the introduction of committees to advise health boards on the development of health and welfare services for the elderly. We recommend the establishment in each health

FIG.3.3: RECOMMENDED ADMINISTRATIVE STRUCTURE FOR THE ORGANISATION OF HOUSING, HEALTH AND WELFARE SERVICES FOR THE ELDERLY



board of at least one Advisory Committee on the Elderly with the following functions:

- to advise on the health and welfare needs of the elderly and how they can be met;
- to represent the views of those working with or on behalf of the elderly;
- to recommend the planning and provision of services for the elderly—*and in particular to agree each year a plan for the development of services* for the elderly proposed by the designated planning officer of the health board;
- to encourage co-ordination between statutory and voluntary bodies in the delivery of services to the elderly.

3.26 The members of the Committee should include the CSEs, public representatives nominated by the health board and local authorities, a consultant physician in geriatric medicine (where such posts exist), the housing officers of the local authorities, general practitioners nominated by the relevant faculties of the Irish College of General Practitioners, public health nurses, and representatives of the voluntary organisations working on behalf of the elderly in the area. A proportion of the members should be elderly and the chairman should be elected by the Committee. Continuity would be ensured if one-third of the members changed every two years. The membership of the Committee should be kept small to increase its effectiveness. **We *recommend that health boards be obliged to appoint an Advisory* Committee on the Elderly with the functions and membership outlined above.**

CO-ORDINATION AT NATIONAL LEVEL

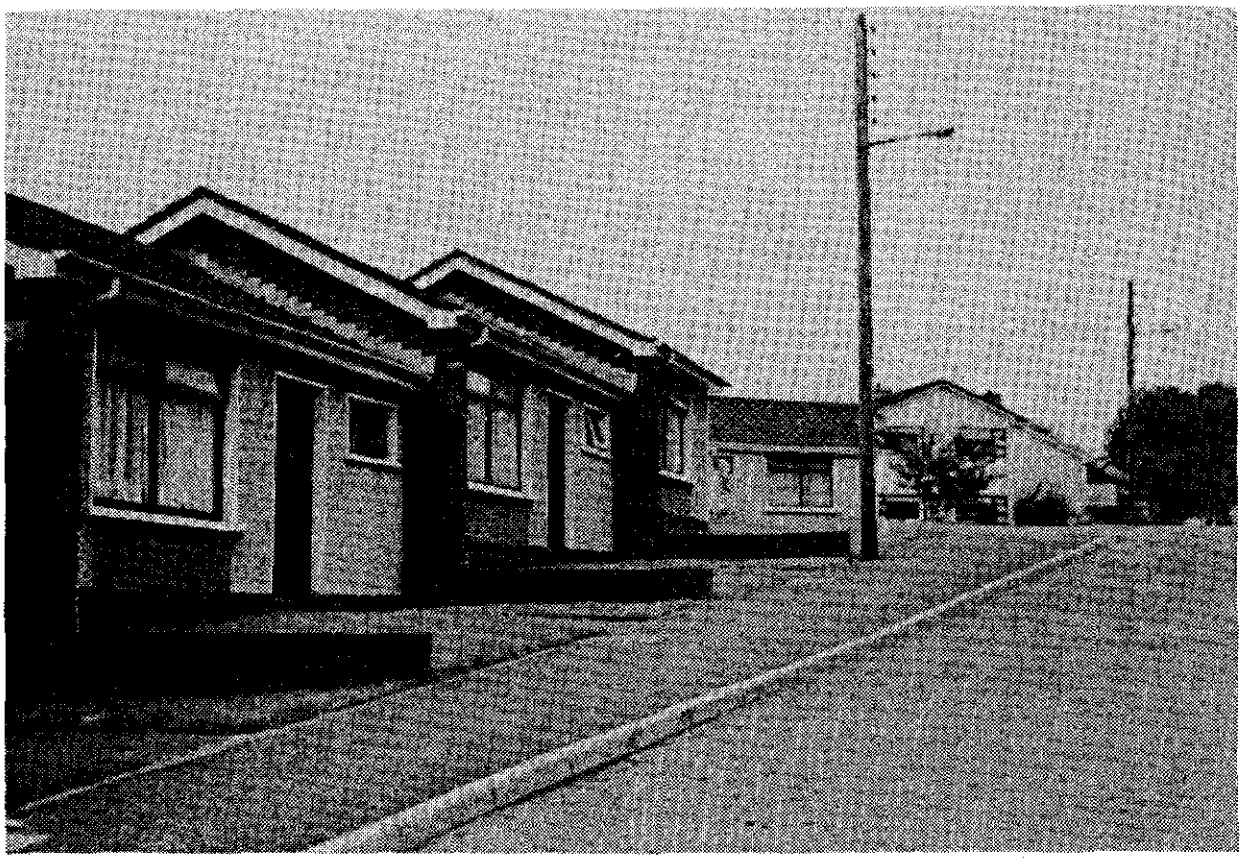
3.27 **We recommend that the Departments of Health, the Environment and Social Welfare agree administrative arrangements to ensure co-ordination of policy towards the elderly at national level and monitoring of progress towards the implementation of the recommendations of this Report.**

NATIONAL COUNCIL FOR THE AGED

3.28 The National Council for the Aged was established in 1981 to advise the Minister for Health on the development of services for the elderly. Its terms of reference were expanded in 1987 but its status remains as an advisory

body to the Minister for Health. The Council has made a major contribution to official thinking about the elderly and through its publications, has influenced a wider audience.

We consider that there will be a continuing need for an advisory body at national level with expertise on issues affecting the elderly. We recommend that the National Council for the Aged's terms of reference be broadened to cover all aspects of the welfare of the elderly and that it be an advisory body to all Ministers with responsibility for the elderly. The composition of its membership should reflect its new terms of reference. The necessary legislative and administrative provisions should be made to enable the Council to take on a wider role.



St. Vincent de Paul Housing Scheme for the Elderly, Ballinamore, Co. Leitrim

LEGISLATION

3.29 We consider that the function of co-ordinating and planning services for the elderly is so important that it should be given a firm foundation in legislation. **We recommend that health boards be obliged by law to co-ordinate and plan health and welfare services for the elderly, to appoint co-ordinators of services for the elderly and to establish advisory**

committees on the elderly. When the Housing Bill, 1988 becomes law, local authorities will be obliged to prepare plans to meet housing needs, including those of the elderly. In preparing these plans, they will have to consult with other statutory bodies and voluntary organisations. A similar obligation on health boards to plan health and welfare services for the elderly in consultation with local authorities and voluntary bodies would help ensure a co-ordinated response to the needs of the elderly and provide a firm legal basis for a comprehensive service.

NOTES TO CHAPTER 3—A COMPREHENSIVE AND CO-ORDINATED SERVICE

1. *Survey of Workload of Public Health Nurses,* 1975 p. 31
2. *Report of the Working Party on the General Medical Services* p.33 and *Hospital Inpatient Enquiry,* Department of Health
3. Long-stay Geriatric Statistics 1985, Planning Unit, Department of Health, Table B(1).
4. National Council for the Aged, *The Caring Process: A study of Carers in the Home,* (to be published)
5. *Health—The Wider Dimension, A Consultative Statement on Health Policy,* Department of Health, 1986, p. 35.

Chapter 4

Maintaining Health

4.1 Although ageing is irreversible, many of the problems of old age can be prevented or ameliorated. Most of the problems of older people are not caused by the ageing process but by disease, loss of fitness and the social changes that accompany ageing.[1] Staying healthy in old age is greatly influenced by environmental factors, by the lifestyle of the person, by the early diagnosis of disease, by adaptation to increasing disability and more intangibly, to a sense of usefulness and value. An active policy to promote health among the elderly does not aim to keep a person alive irrespective of the quality of that life. Its goal is to reduce morbidity among the elderly or in the words of one eminent physician, to enable people to 'die young as late as possible'.[2] There is some evidence that, as a result of medical, social and economic advances, people are, on average, staying fitter longer and having a shorter period of dependency at the end of their lives.[3]

4.2 The Vienna International Plan of Action on Ageing, to which this country is committed through its membership of the United Nations, advocates a broad approach to promoting the health of the elderly. The Plan recommends that the care of the elderly

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

HEALTH PROMOTION

4.3 The promotion of health amongst the elderly is closely linked to promoting the health of the population generally. The concept of health promotion in an Irish context has been explored in a recent report published

by the former Health Education Bureau, **Promoting Health Through Public Policy.** That report defines health promotion 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 mobilize resources for health and to pursue healthy public policy. The concept of health promotion is based on an understanding that health is more than an absence of disease".[4]

4.4 Health promotion policies aim to **add life to years** by enabling 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. 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. Fewer Irish people can expect to reach old age than in most other EEC countries.[5] A relatively high proportion of Irish people die at all ages from diseases which are to some extent preventable, such as ischaemic heart disease, hypertension and stroke, and certain forms of cancer, compared with other EEC countries.[6] Many of the conditions for which elderly patients are admitted to hospital are preventable. An unnecessarily high proportion of elderly persons are in long-stay institutions for social reasons. In 1984, more than a quarter of the 14,000 patients resident in geriatric units were there for social reasons.[7]

4.5 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. It has long been recognised that inadequate housing is a major impediment to older people leading an active life at home. While much has been done in recent years to improve the quality of accommodation for the elderly, the projected rise in the elderly population in the next decades will ensure that housing remains a central issue.

4.6 The quality of the environment is also important to the well-being of the elderly. The increase in crime in the last two decades has emphasised the vulnerability of elderly people in remote rural and in deprived urban areas. The fear of attack or robbery is a major cause of anxiety and ill-health in the elderly, especially in those elderly who live alone.[8] The insecurity of the elderly is aggravated by public policies which directly or indirectly have

undermined social cohesion. In many new housing estates in Dublin and Cork, there are no elderly people. Often it is difficult for families to maintain contact with their elderly relatives in the city centre or older suburbs. The quality of the air is particularly important to elderly people with respiratory and heart conditions. The impact of high concentrations of smoke and sulphur dioxide in certain parts of Dublin on elderly persons with respiratory disorders has already given cause for concern.[9] Elderly people are particularly vulnerable as pedestrians on the roads and policies to make roads safer will benefit them directly.

4.7 Policies which encourage greater flexibility in the age of retirement give older people more discretion in planning their lives and make the transition to retirement easier for many. On the other hand enforced early retirement may sometimes lead prematurely to a life of inactivity and to a sense of uselessness. Finally, the level of income at the disposal of the elderly is of vital importance to their well-being. If elderly people cannot afford to feed, house and warm themselves they will not be healthy and active.

4.8 Since the publication of **Promoting Health through Public Policy,** the Government has appointed a Cabinet Sub-committee to co-ordinate policies affecting health and a Health Promotion Council to identify priorities and advise on appropriate action as recommended in the Report. A Health Promotion Unit has been established within the Department of Health to ensure that health promotion becomes a major objective of the health services and informs the policies of other government departments and bodies. We welcome these developments and endorse the need for a statutory obligation on the Minister for Health to promote health and publish a plan to that effect. **We recommend that the promotion of health among the elderly be a primary concern of the Cabinet Sub-committee to co-ordinate policies affecting health, the Health Promotion Council, and the Health Promotion Unit of the Department of Health and that this concern be made explicit in a national plan to promote health.** As far as this report is concerned our recommendations have been influenced by a concern to promote an active, independent and healthy old age.

HEALTH EDUCATION

4.9 Health promotion is a broad concept aimed at facilitating citizens to achieve a healthier life through the co-ordination of public policy and health education directed at the individual. Health education emphasises the need for self-care, self-help and mutual aid. It makes relevant information about health and disease available to individuals and target groups and motivates

people to live healthier lives. The elderly have much to gain from a health education programme to encourage a healthy old age.

4.10 To prevent many of the diseases associated with disability in old age it is necessary to take action in childhood or early adult life. For this reason, most health education programmes concentrate on the young. But the onset of some diseases can be postponed and the disabilities associated with others reduced by action within the capacity of most elderly people. Such action includes stopping smoking, weight control, eating a balanced diet, limiting consumption of alcohol, stimulating mental activity, regular involvement with other people and keeping fit. The elderly no less than other age groups need the information and motivation to adopt healthy habits. Elderly people, because they had reached maturity before the relationship of certain habits to disease was demonstrated, may be the least affected of any age group by the health education campaigns of recent times. It is also more difficult to change the habits of a lifetime in advanced years.

Poor housing conditions for the elderly in County Galway

4.11 To date there has been only a limited effort to educate the elderly about staying healthy as other age groups were deemed to have a greater priority.

As the number of elderly people increases, the problems of ageing should receive greater attention in health education policies. The aim of a health education policy for the elderly should be to raise individual ability to understand and manage health problems and disease processes. It should alert elderly people to the benefits of early detection of treatable illness and disability. Health education for the elderly should provide information on issues directly affecting health such as nutrition and exercise, as well as useful advice on cooking, heating, insulation, accident prevention and security. There is also a need for information on particular problems associated with ageing such as coping with the disability of strokes and arthritis, and the management of incontinence. As far as possible, health education should be integrated with the social activities of elderly people in clubs, community and parish centres. It will require the involvement of professionals working with the elderly, in particular public health nurses, general practitioners, physicians in geriatric medicine and occupational therapists. **We recommend that the Health Promotion Unit of the Department of Health, in consultation with those organisations working with or on behalf of the elderly, develop directly or indirectly, a health education policy for the elderly. It should be the responsibility of the Co-ordinator of Services for the Elderly in each area to ensure that an appropriate health education service for the elderly is available.**

Health Education and Carers

4.12 About 85 per cent of all care provided for dependent elderly people is provided by non-professional 'carers'—relatives, neighbours and friends.[10] Despite their crucial role in caring for the elderly, the need of carers for information on the diseases and disabilities of elderly persons has not been formally recognised. Carers need information about coping with the problems of disability, chronic illness, foot care, incontinence, terminal care and death. There is a great need for information about mental illness in old age and its effects. The isolation of many carers and their lack of free time make it difficult for them to acquire information and skills in a formal way. The recent formation in Dublin of the Carers Association, a support group for those caring for dependent elderly people, is a major step towards highlighting the needs of carers and identifying ways in which they can be supported. More support groups involving carers and those concerned about their welfare are desirable to work closely with health professionals to provide information and assistance to carers.

4.13 **We recommend that the Department of Health should direct health boards to provide a health education service for carers of elderly people and provide guidelines on the content and operation of such a service. In**

each community care area, the Co-Ordinator of Services for the Elderly should ensure that support and advice are available to carers and that carers have sufficient information and advice to carry out their task.

PROFESSIONAL ATTITUDES

4.14 Those professionals working with the elderly have the greatest potential for educating the elderly and their carers about health, for preventing disease, for the early diagnosis of treatable diseases and the management of disability. The role of the medical practitioner, public health nurse, dentist, physiotherapist, occupational therapist and chiropodist is particularly important in this respect. The International Plan of Action on Ageing referred to above recommends that practitioners and students in the caring professions should be trained in principles and skills in the relevant areas of gerontology, geriatrics, psychogeriatrics and geriatric nursing. It further recommends that education and training be interdisciplinary and be available at all levels. However, many professionals in this country have not been trained to deal adequately with the problems of ageing or to be on the alert for the early signs of disease among the elderly. A study of elderly persons in Dublin city found a significant level of undetected but treatable illness among those examined.[11] Little attention has been paid in the past to the problems of ageing in most professional training courses at undergraduate level. The training for each profession tends to take place in isolation despite the fact that on qualification they will work with the same patients. Each profession may have a poor understanding of the contribution of another and may not appreciate the importance of a team approach to the care of the elderly. A much greater emphasis needs to be placed on anticipating care of the elderly and on rehabilitation in all professional training courses. Professional training courses should be more aware of the contribution of caring relatives and friends and of the strain that caring can place on families.

4.15 **To remedy these deficiencies, we recommend that the teaching authorities of the professions concerned encourage more positive attitudes to caring for the elderly among students and trainees and that more attention be given to ageing in professional training.** In particular, there should be a greater emphasis on caring for the elderly in the vocational training programmes for general practice and public health nursing and there should be much closer links between the training programmes of the two professions. We welcome the creation of the first chair of geriatric medicine at Trinity College, Dublin. ***We recommend that professiorial chairs of geriatric medicine be established in all medical schools.*** The potential of the departments of geriatric medicine in general hospitals to provide training in

the care of the elderly for a number of professions in a team environment should be developed and expanded. The department of geriatric medicine should also provide opportunities for established practitioners to keep abreast of the latest developments in the care of the elderly. The Co-ordinator of Services for the Elderly should ensure that professionals working with the elderly in the community care area have opportunities to improve their knowledge and skills in the care of the elderly.

RETIREMENT

4.16 Although retired employees represent only half of the population aged 65 and over, the health of those at retirement age is particularly vulnerable. Retired people often find it difficult to make the adjustment from a life in which work dominates their time to one in which they must organise their own activities. On retirement, a person may lose his or her sense of purpose and value as a contributing member of the community. In recent years a more flexible attitude to the age of retirement has given some elderly people a choice about when to retire. We welcome this trend and would like to see flexibility in the age of retirement become the norm.

4.17 Pre-retirement courses have great value in preparing those approaching retirement for another stage in life. They can emphasise the scope for new kinds of social participation by retired persons and the potential value of their skills to the community. The courses can transmit much information about maintaining health and independence and the services to which elderly people are entitled. Ideally pre-retirement education should be a continuation of life-long health education. It should commence at least five years prior to retirement and be delivered by experts. General guidance should relate to finance, housing, the use of time, social and voluntary work, continuing education together with fundamental aspects of health such as exercise, diet, care of feet, bowels, teeth, etc. The impact of retirement on the other members of the houshold should also be explored.

4.18 The Retirement Planning Council of Ireland has pioneered these courses around the country and through their publication **"What are you doing for the rest of your life—Retirement in Ireland"** has reached a wider audience. The Council emphasises the opportunities open to the elderly for self-development and for making a contribution to their communities. However, only about 3 percent of the 15,000 Irish people who retire every year receive any formal preparation for their new life. There is an obligation on employers and trade unions to ensure that their employees and members are well

prepared for retirement. **We recommend that the Federated Union of Employers and the Irish Congress of Trade Unions advise their members to give greater priority to the development of a comprehensive pre-retirement service. The proposed Authority for Occupational Safety and Health when established, should ensure that a comprehensive pre-retirement service is available to all employees and to self-employed people.**

INVOLVEMENT

4.19 The health and welfare of the elderly is greatly affected by whether or not they consider themselves to be valued members of the community. Many elderly people, particularly those over 75, feel depressed, lonely and remote.[12] To feel useless and a burden to one's family and neighbours may be a cause of illness and premature death. Because of the pace of change in recent decades and the mobility of modern families, the elderly may have less of a role and feel less highly valued today than in previous generations. The place of the elderly in society should receive more attention as the number of elderly rises.

4.20 The years after 65 can often afford the individual an ideal opportunity for increased personal fulfilment and time to enrich the community with the contribution of accumulated wisdom, life and practical skills. It is, therefore, important to make every effort to develop a social, cultural and economic milieu in which older people can participate and contribute effectively. This requires some attitudinal change on the part of older people and of society as a whole. The International Plan of Action on Ageing advocates 'a radical change of perspective in order to appreciate that the problem of ageing today is not just one of providing protection and care, but of the involvement and participation of the elderly and the ageing.' In this context, the National Council for the Aged, an advisory body to the Minister for Health on issues affecting the elderly, has proposed a National Day of Ageing to promote a more positive attitude to, and better understanding of, the process of ageing. The first National Day of Ageing will be on the 16 October, 1988, and the theme of the day will be 'Age is Opportunity'. **We recommend that the National Day on Ageing become an annual event.**

4.21 Studies carried out by the National Council for the Aged have highlighted the loneliness and sense of isolation which many elderly people feel, especially those living alone.[13] A survey of the attitudes of some school children carried out by the Council revealed predominantly negative images of elderly people among the young people interviewed.[14] The Council has

concluded that a programme should be introduced in schools which would have as its primary aim the improvement of the attitudes of young people towards the elderly and ageing. Such a programme would help strengthen social cohesion between the youngest and oldest generations by encouraging young people to engage in activities for and with the elderly. **We recommend that the Department of Education encourage schools to promote positive attitudes to ageing and the elderly within the school curriculum.**

NOTES TO CHAPTER 4—MAINTAINING HEALTH

1. J A Muir Gray, 'Practising Prevention in Old Age' *British Medical Journal,* Vol 285, (1982) pp 545-6
2. Sir Richard Doll, quoted in *Ibid.*
3. *Ibid.*
4. *Promoting Health through Public Policy,* Health Education Bureau, (1987) p.1
5. *Health Statistics, 1986,* Department of Health (1987). Table A7
6. *Promoting Health through Public Policy, op.cit.* pp.10-11
7. *Health Statistics 1986, op.cit.* Table G16
8. Department of Health, *Communication Networks and the Elderly,* 1986 pp.22-24
9. I. Kelly and L. Clancy "Mortality in a General Hospital and Urban Air Pollution", Irish Medical Journal, October, 1984 pp. 322-324
10. British Geriatric Society for the Health of the Aged—*Policy Statement—Health Education for the Elderly,* London, 1986.
11. B. Walsh 'Previously Unrecognised Treatable Illness in an Irish Elderly Population' *Journal of the Irish Medical Association,* (1980), 73, 2.
12. M. Fogarty, L. Ryan and J. Lee *Irish Values and Attitudes,* (1984). p.26
13. National Council for the Aged, *The World of the Elderly—The Rural Experience,* (1984), *This is Our World: Perspectives of some Elderly People on life in Suburban Dublin,* (1986)
14. National Council for the Aged, *Attitudes of Young People to Ageing and the Elderly,* (1987) pp. 20-22.

Chapter 5

Housing

5.1 It is fundamental to the welfare of the elderly that every elderly person has an opportunity to live in accommodation suited to his or her needs. The **Care of the Aged Report** of 1968 argued that the provision of suitable housing was one of the most important factors in enabling older people to continue to live in the community. Experience since the publication of the Report confirms the correctness of that contention. We fully endorse the proposition that proper housing is crucial to enable elderly people to live a dignified and reasonably independent life in the community for as long as possible. Housing policy should aim to ensure that elderly people have an opportunity to live in accommodation suited to their physical needs. Where there is a choice between moving to alternative accommodation or carrying out improvements to their existing accommodation, the elderly person's preferences on this as on other issues, should be respected.

HOUSING CONDITIONS OF THE ELDERLY

5.2 A distinguishing feature of housing among the elderly in this country is the high level of home ownership. Almost 80 percent or 206,800 elderly householders in 1981 were owner occupiers, compared with 77 percent of households generally. The proportion of the elderly owning their own homes is extremely high by international standards. Just over 20,000 elderly households (10 percent) occupy accommodation as tenants of local authorities and about 17,000 elderly households (8 percent) occupy private rented accommodation. (Table 5.1)

5.3 Although there is no recent, comprehensive survey of housing conditions among the elderly in Ireland, these conditions appear to vary as extensively as among the rest of the population. While the majority of elderly people are well housed, the poorer and more vulnerable elderly are more likely to live in older houses which have fewer basic amenities than the houses of the rest of the population. A survey of the housing conditions of the elderly carried out by the Economic and Social Research Institute (ESRI) in 1977 is somewhat dated but the situation today is still broadly similar to the survey's

findings. The ESRI found that in urban areas, 39 percent of the dwellings occupied by the elderly were built before 1919 compared to 23 percent of the population generally. The corresponding figures for rural areas were 53 percent and 46 percent.[1] The survey also showed that elderly people living alone tend to live in older dwellings than other types of households. A survey carried out by the Society of St Vincent de Paul in 1980 found that the elderly living alone tended to live in poor accommodation.[2] The 1981 census of population showed that of the 3,156 elderly people living in accommodation of a temporary nature, over half were living alone.

5.4 The ESRI survey also demonstrated that the elderly are much more likely to live in households without water and sanitation than the population as a whole. This tendency was more pronounced in those households occupied by those over eighty years of age. The National Council for the Aged estimated that in 1980, 31 percent of the elderly and 39 percent of those over 80 years did not have an internal toilet, and that 38 percent of the elderly, and almost 48 percent of those over 80, had no bath or shower. The figures are higher for those living on their own.[3] (Table 1.3) Because they live in older houses, the elderly were also more likely to experience problems with dampness and draughts. Local surveys indicate similar problems. A survey carried out in 1984 of 60 households occupied by elderly people in West Galway, found that nearly half the houses had no electricity or running water.[4] In another study in Galway, elderly people were asked to identify those aspects of their housing conditions which caused most problems in coping with daily living. They cited poor state of repair, problems with stairs, dampness, draughts, isolation and lack of amenities. Lack of amenities such as piped water, internal flush toilets, hot water and heating were particularly acute in rural areas. The study also indicated that those living alone lived in the least satisfactory conditions.[5] Information from the 1981 census shows that a high proportion of houses without basic amenities are in counties Sligo, Leitrim and Cavan.[6]

5.5 Some improvement in the housing conditions of the most vulnerable elderly has taken place in recent years as a result of the Task Force on Housing Conditions of the Elderly and the local authority building programme, which would not be reflected in the surveys referred to above. Some 10,000 elderly households have received assistance from the Task Force since its establishment in 1982. In the absence of a comprehensive survey of housing conditions among the elderly, it is difficult to assess precisely their current housing circumstances. **We recommend that the Department of the Environment carry out a comprehensive survey into the housing conditions of the elderly to establish more precisely the housing status of the elderly.**

5.6 Even where households occupied by the elderly have basic amenities, their accommodation may be unsuitable for other reasons. The absence of a downstairs toilet and badly designed banisters frequently cause problems for the elderly. Elderly people may lack the finance, knowledge and organisational ability to adapt their homes to the problems of increasing disability. Irish financial institutions have been slow to help elderly people unlock their main financial asset—their house—to generate income which could be used to adapt their homes. Existing local authority grant schemes for the adaptation of accommodation require a considerable amount of organisation on the part of the applicant.

5.7 In some cases there is a mismatch between the type of accommodation owned by the elderly and the type most appropriate to their needs. The ESRI study found that 23 percent of the elderly living alone considered that their accommodation was 'rather too big' but given the cost and other problems of transfer to more suitable accommodation, fewer than one in five of these and others who found their accommodation too big felt an actual incentive to move.[7] The direction of housing policy in the private sector has been to encourage first time house buyers to buy what are mainly standard family houses. Elderly people in general do not benefit from grants towards the cost of purchasing a new house. Elderly house owners are also deterred from moving house by legal costs and stamp duties.

5.8 Although elderly tenants in private rented accommodation represent a small and declining proportion of elderly households, they are a particularly vulnerable group of people. The Housing (Private Rented Dwellings) Acts 1982 and 1983 provide tenants in the previously controlled sector with a measure of security of tenure, a method of determining rents and other terms of tenancy by a Rent Tribunal, means-tested rent allowances, compensation for quitting a tenancy and standards for structural repair, amenities and common services. It is not clear how effective the repairs and amenities provisions are as many landlords are themselves elderly and do not have the resources for major capital expenditure. Elderly tenants in private rented accommodation not covered by the recent Rent Acts may face problems of poor standards and maintenance, and insecurity of tenure and of rents.

5.9 The number of homeless persons is difficult to estimate accurately. A figure of 3,000 has been suggested as the number of homeless people in Ireland, a substantial proportion of whom are elderly. [8]Although the number of homeless elderly is small, they present an intractable problem as their homelessness is often associated with psychiatric disorders and alcoholism. The homeless elderly have traditionally found shelter in the county homes

and in hostels run by voluntary groups such as the Legion of Mary and the Simon Community. In recent years, local authorities, in consultation with voluntary groups, have provided accommodation for some homeless persons, including the elderly.

PROJECTED INCREASE IN ELDERLY HOUSEHOLDS

5.10 Table 5.2 shows the projected number of elderly households for the years 1996 and 2011 based on information made available to the Working Party by Davy, Kelleher, McCarthy Ltd. On the basis of these figures, there will be a slight increase in the number of elderly households up to 1996, with a substantial increase by 2011. In 1986, there were an estimated 304,900 households headed by a person aged 60 years or more. In 2011, the number is projected to rise to 362,800. The largest increase will be in the age group 60—69, but the increase in those households with a head aged over 80 years and single will also grow significantly, increasing from 25,200 to 34,100 households, or by more than one third. On present trends, the bulk of the increase in elderly households will be in the owner occupied sector. This increase will focus attention to a greater extent than heretofore on maintaining and adapting existing housing to meet the needs of the elderly. Although the general position regarding demand for local authority housing is not clear, the growth in elderly households suggests that the proportion of elderly on local authority housing lists will increase.

HOUSING POLICY FOR THE ELDERLY

5.11 Present policy in relation to housing is 'to ensure that as far as the resources of the economy permit every household can obtain a home of good standard, located in an acceptable environment at a price they can afford'.[9] Most people prefer to purchase their homes and successive governments have encouraged owner occupation through tax relief, grants and special purchase arrangements for local authority tenants. Within this policy, governments have favoured first time house buyers and encouraged the provision of medium sized family houses. For those who cannot afford their own house and are not in a position to rent private accommodation, the state has undertaken to provide public housing at a low cost to the tenant. Public housing has been allocated mainly to families but the needs of groups such as the elderly and the disabled have been specifically recognised in local authority housing programmes. The State also contributes to the maintenance and improvement of the existing housing stock through tax relief on borrowings for house improvement and a number of grant schemes.

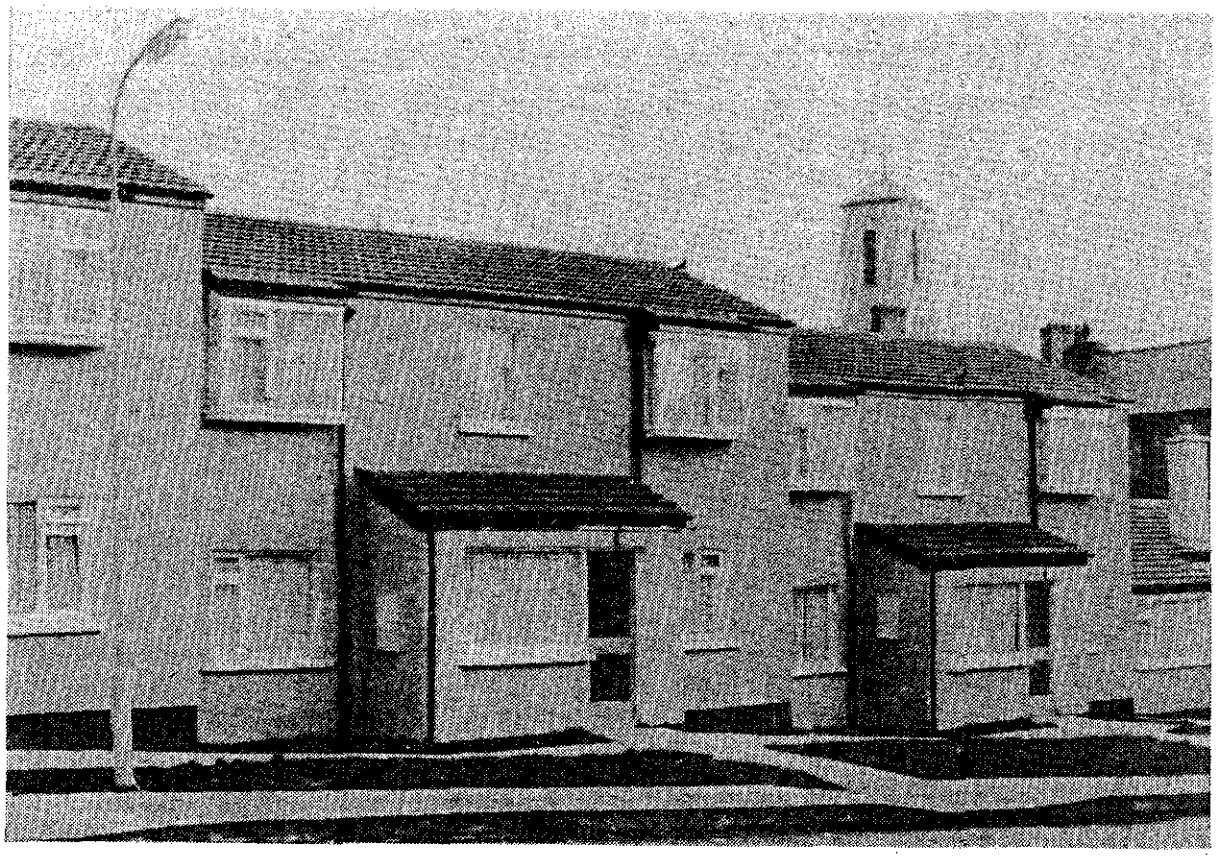
5.12 Publicly funded housing for the elderly is provided in a number of ways. Purpose built dwellings are provided for elderly people as part of the local authority housing programme. Voluntary bodies are encouraged to provide accommodation for the elderly through a scheme of financial assistance funded by the Department of the Environment. The current stock of local authority dwellings for the elderly is estimated to be over 12,000. An important aspect of housing policy is that these dwellings are specifically excluded from tenant purchase schemes. The dwellings remain part of the public housing stock and continue to be available to meet the needs of the elderly. Local authorities also provide demountable dwellings for elderly people in need of rehousing where there is unlikely to be a continuing need for the dwelling beyond the lifetime of the applicant. A number of grant schemes are also available to assist elderly and disabled people to improve their accommodation.

LOCAL AUTHORITY HOUSING PROGRAMME

5.13 The **Care of the Aged Report** of 1968 recommended that a minimum of ten percent of all new dwellings provided by local authorities should be reserved for the elderly.[10] Subsequently, the Department of the Environment requested local authorities to provide a reasonable proportion of new dwellings specially adapted to the needs of elderly persons. It also suggested that in larger towns, the elderly who lived in conventional local authority dwellings should be encouraged to move into sheltered housing where a range of support services could be conveniently delivered. Table 5.3 indicates that between 1972 and 1987, 12 percent of new dwellings provided by housing authorities were for the elderly and the disabled. This level of provision represents a major contribution to meeting the accommodation needs of the elderly with low incomes. However, the figures include a small number of demountable dwellings provided by local authorities. While demountable dwellings may be necessary in certain circumstances, we feel that generally they do not provide an adequate standard of accommodation for the elderly. Repairing the elderly person's house or offering the elderly person alternative accommodation in a nearby village are, in our view, better options than providing a demountable dwelling.

5.14 Since 1982, the number of approved applicants on waiting lists for local authority housing has fallen by 38 percent from just under 30,000 to 18,600. The number of applicants for elderly persons dwellings has fallen from 5,500 to just over 4,300 in the same period, a decrease of 22 percent. The number of local authority dwellings provided between 1982 and 1987 fell from 5,700 to 3,000, a drop of 47 percent. The number of houses to be completed in

1988 will be only half those built in 1987. It is clear from these figures that reserving a quota of about 10 percent of dwellings for the elderly will be insufficient to meet their needs so long as the number of local authority dwellings provided remains so low. Given the much reduced level of the local authority housing programme and the reduction in the number on the waiting list for housing, we feel that local authorities should pay greater attention to meeting the housing needs of the elderly within the housing programme.



Ardfert, Hutton's Alley, Cork—a SHARE/Cork Corporation housing scheme for the elderly

5.15 An elderly person may be allocated a house or a flat in a conventional local authority scheme, but some are allocated dwellings in a special or sheltered housing scheme. Special housing for the elderly is usually a small house or flat without support services such as a warden and an alarm system. A sheltered housing scheme normally consists of a number of flats within one building complex. There is usually a resident warden, or alarm system and some schemes are linked to a day care centre. A small number of sheltered complexes have been provided by local authorities, health boards and voluntary bodies. In some sparsely populated rural areas, elderly people have been encouraged to move to special or sheltered housing schemes in nearby villages or towns where they still live near their friends and neighbours and have easy access to the facilities of the village or town.

5.16 Members of the Working Party visited a sheltered housing scheme at Beaufort, Dun Laoghaire. Beaufort is an excellent example of co-operation between Dun Laoghaire Corporation, the Eastern Health Board and a voluntary organisation, in this instance, the Lions Club. The complex consists of flats for single persons and couples and accommodates sixty-three elderly people. Tenancies are allocated by Dun Laoghaire Corporation in consultation with Health Board community care personnel. Each flat is self-contained and has an alarm linked to a central control in the warden's flat. There is a day care centre in the complex which caters for dependent elderly persons living in the vicinity. A mid-day meal is provided for those attending the centre and for residents. The kitchen in the centre is also used by the local meals-on-wheels committee. The health board provides some para-medical services in the centre. Residents who temporarily leave flats for reasons such as admission to hospital, retain their tenancies. This arrangement often facilitates the early return home of residents because accommodation continues to be available. The medical and nursing needs of the residents are met largely by general practitioners and public health nurses. We were very impressed by the facilities and management of Beaufort and the obvious contentment of the residents.

5.17 Another example of a sheltered housing scheme which caters for frail elderly people is Marian Court in Clonmel. The complex was built by the South-Eastern Health Board on a site donated by a local charity. It is operated by a management committee made up of representatives of the Board and local voluntary bodies. Admissions are controlled by the Board. It caters for forty frail but ambulant elderly people, six of whom occupy individual bedrooms in the main block of the building. The remaining residents have flatlets with modern amenities and limited cooking facilities. Residents are encouraged to eat in the main dining room. Marian Court is another excellent example of co-operation between statutory and voluntary bodies and demonstrates how sheltered housing can be used to cater for very frail old people.

HOUSING BILL, 1988

5.18 Earlier this year the Minister for the Environment introduced the Housing Bill, 1988 to revise and up-date the statutory framework for local authority housing programmes with the particular objective of ensuring that specific categories of housing need, including the homeless, the elderly and the disabled are recognised and provided for at every stage of the planning, provision and allocation of local authority housing. The Bill places a twofold obligation on local authorities. Each local authority will be obliged to make

an estimate of its existing and prospective housing requirements and to carry out assessments of the housing needs of the categories of persons mentioned above. As part of such assessment, local authorities will have to consult other interested bodies, including health boards. These assessments must be submitted to the Minister for the Environment. The Bill also enables local authorities to establish an order of priority for letting local authority dwellings and they may designate particular dwellings for letting to specific categories including the elderly and the homeless. While the Bill provides an adequate framework for housing the elderly, we would be concerned that, at a time of diminishing resources for housing, the position of the elderly in need of accommodation may disimprove. **We recommend that the Minister monitor the implementation of the Housing Bill, 1988 and the position of the elderly requiring local authority accommodation to ensure that their needs are met comprehensively.**

REMEDIAL WORKS SCHEME

5.19 In 1985 the Department of Environment introduced a scheme which made subsidised loans available to housing authorities for remedical works to substandard local authority houses. In 1988, loans were replaced by a scheme of capital grants. The scheme enables local authorities to refurbish older local authority houses which lack basic amenities but which are, in size and location, suited to the needs of the elderly. In addition to improving standards in older, local authority housing currently occupied by elderly persons, the scheme also has the potential to increase significantly the capacity of housing authorities to provide accommodation of a high standard for elderly persons in settled communities by refurbishing older local authority rented stock. In 1988, £10m was allocated by the Department of the Environment for this scheme. The remedial works scheme has taken on a greater significance for housing the elderly as the number of new dwellings built by local authorities has declined.

VOLUNTARY HOUSING

5.20 The **Care of the Aged Report** drew attention to the potential of voluntary organisations in the provision of housing services for those elderly for whom ordinary private accommodation was no longer suitable or available and urged that this sector receive maximum encouragement. In recent years there has been a significant increase in the voluntary housing sector in Ireland. Despite this growth, the voluntary sector contributes less than in many other countries to housing the elderly. There are at present 144 voluntary groups approved by the Department of the Environment as eligible for grants from local authorities to provide rented accommodation for groups in need, including the elderly and the disabled.

5.21 A new scheme of financial assistance for voluntary groups providing housing for disadvantaged groups was introduced in 1984. Under this scheme, housing authorities may give fully subsidised loans to meet 80 percent of the cost of an eligible project, subject to a maximum of £20,000 per unit of accommodation. Accommodation receiving assistance under this scheme is not eligible for a grant of £2,000 for new houses from the Department of the Environment. However, the local authority is recouped in full by the Department provided the accommodation is used by certain categories of people. These include elderly persons eligible for local authority housing or institutional care at public expense. A voluntary body receiving assistance under this scheme is required to enter into a legal agreement with the local authority, obliging it to repay the loan if the accommodation ceases to be let to eligible persons or is disposed of while a balance remains outstanding on the debt.

5.22 Over 350 units of accommodation have been provided by voluntary housing organisations under the scheme. At the end of 1987, 234 units had been provided for the elderly, 80 were being built and a further 114 units were planned. In 1987 £2.5m was allocated for the scheme and provision for the scheme was increased to £4m in 1988, of which £1m is part of a special allocation of £3m over three years designed to encourage greater provision of accommodation for the homeless.

5.23 We visited housing schemes in Cork City where the voluntary housing association SHARE, in co-operation with Cork Corporation, has provided sheltered housing schemes for the elderly. Most of the accommodation is purpose built and carefully adapted to meet the needs of the elderly. Members of SHARE identify elderly people in need, raise money for houses, fit out the housing units before the tenant moves in, maintain contact on a regular basis and provide whatever support is necessary to enable SHARE tenants to lead comfortable lives. Cork Corporation builds the houses and maintains them. Many of the elderly people whom we met were in their eighties and had serious medical problems. It is clear that if sheltered accommodation had not been available, they would have required institutional care. Another good example of a voluntary housing scheme for the elderly is one developed by the St Vincent de Paul Society in Ballinamore, Co. Leitrim, catering for elderly people who formerly lived some distance from the village.

GRANTS FOR ADAPTATIONS AND REPAIRS

5.24 Local authorities operate an Essential Repairs Grants Scheme to improve substandard accommodation in rural areas. The scheme enables a local authority to carry out minimal repairs to the structure of a house to make

it habitable for the lifetime of the occupant, particularly where a continuing need for the dwelling is not envisaged beyond the lifetime of the occupant. The aim is to encourage householders, usually elderly people, to remain in their own homes instead of being accommodated elsewhere. The scheme was not applied to urban areas, where continued demand was envisaged for dwellings provided under the local authority housing programme. Under the Essential Repairs Scheme, a local authority may pay a grant of up to the full approved costs of the work considered necessary or carry out the work itself. The grant is usually confined to limited repairs to prolong the useful life of the dwelling to enable the elderly person to continue to live in the dwelling as his or her normal place of residence. A local authority may recoup half of the grant from the Department of the Environment, subject to a maximum of IR£600 in any one case. In 1987, local authorities recouped about IR£300,000 from the Department of the Environment under the scheme.

5.25 A more significant scheme which can be availed of by the elderly or by those looking after an elderly relative in their house is the House Improvement Grant for Disabled Persons. Under this scheme a local authority may pay a grant for an extra room or other structural change which is necessary for the accommodation of a disabled person, including elderly people who are immobile. The type of work that may be grant aided includes the construction of an extra room downstairs, the provision of a downstairs toilet and bathroom, ramps and the widening of doorways. The grant may meet the approved cost in the case of a local authority tenant or up to two thirds of the approved cost in any other case. The maximum amount payable to owner occupiers is IR£5,000. Expenditure on the scheme in 1987 was over IR£4.0m.

5.26 There is some evidence to suggest that those wishing to avail of grants under this scheme experience difficulties. A study carried out by the National Rehabilitation Board which looked at the the experience of relatively young disabled persons found that local authority tenants had many problems with the scheme. Many private home owners had difficulties organising the work where extensive construction had to be carried out.[11] In some cases the wrong kind of work was carried out because of poor advice or information. The study found that the method of payment and the fact that in the case of home owners a grant of only two-thirds of the cost was available, caused financial hardship in many cases. In general the grant is only paid on completion of the work whereas builders expect payments once work begins. This condition can force families to seek bridging finance, which is expensive and can lead to hardship.

5.27 The scheme that has probably made most impact on improving housing conditions for the elderly in their own homes is the Task Force on Special Housing Aid for the Elderly. The scheme was established in 1982 to carry out repairs to houses of elderly people in unfit and insanitary conditions. The scheme is operated by the health boards on behalf of the Department of the Environment. Health boards have established ad hoc committees to run the scheme, comprising representatives of the boards, the local authorities, voluntary bodies and FÁS, where they are involved in carrying out work under the scheme. The scheme is overseen at national level by a Task Force on which the Departments of the Environment and Health, the local authorities and voluntary bodies are represented. The objective of the Task Force is to implement an emergency programme to improve the housing conditions of elderly persons living in unfit or unsanitary accommodation. Typical work carried out under the scheme includes the provision of water and sanitary facilities and repairs to fire places, windows and doors. Where necessary, the Task Force may arrange alternative accommodation for an elderly person while work is being carried out to their dwelling. More extensive work has not been carried out in many cases due to lack of funds. Since it was established, expenditure on the scheme has been over IR£8m and 10,000 elderly households have been assisted under the scheme to carry out work. Despite limited resources, the Task Force has made an effective contribution to the welfare of many elderly persons. It is clear that a well organised repair scheme is a cost effective means of enabling elderly people to remain in their own homes. Expenditure on the scheme in 1987 was IR£1.5m. The main problem with the scheme is the length of the waiting list for repairs in many health board areas and the limited nature of the resources for the scheme.

5.28 In 1985, a comprehensive House Improvement Grants Scheme was introduced to subsidise the cost of repairs, improvements and extensions to houses. The generous provisions of the grant scheme stimulated a strong demand from householders. Under the scheme, grants of up to two thirds of the approved cost of the works were payable to applicants. The scheme was terminated in 1987. As far as the elderly are concerned, the scheme had similar drawbacks to those of the House Improvement Grant for Disabled persons discussed above in paragraph 5.26.

FUTURE PRIORITIES

5.29 It is clear from the discussion of the housing conditions of the elderly, the projected increase in elderly households and recent trends in the housing construction programme, that housing policy for the elderly needs to be reviewed. The objective of maintaining the elderly in dignity and

independence at home is as valid as ever but the strategy to achieve this goal needs to be adapted to changing circumstances. Given the extent of home ownership among the elderly now and in the future and the contraction of the local authority building programme, the priority in future must be to help the elderly adapt their accommodation to their needs as they grow older or to assist them to move to suitable accommodation. International experience suggests that repair and improvement schemes, subsidised by public funds, are effective in helping the elderly.[12] A United States Senate Committee argued that home repair services were justified as being not only cost effective but also compatible with the preference of many older home owners to age in peace in a familiar environment.[13] **We recommend that the main emphasis in housing policy for the elderly should be to enable elderly people to choose between adapting their homes to the increasing disabilities of old age or to move to accommodation which is more suited to their needs. Priority should be given to improving the accommodation of the elderly lacking the basic amenities of an indoor toilet, hot and cold water and a bath or shower. We recommend that, as part of the statutory assessment of housing needs, housing authorities should assess the need of elderly people for repairs and adaptations to their homes, where such work would enable them to remain in that accommodation.**

5.30 Although the demand for local authority housing may be falling, the projected increase in elderly households means that current demand by the elderly for public housing is unlikely to fall. The housing needs of the elderly can no longer be met by a target of 10 percent of new local authority accommodation. **We recommend that, in future, housing provision for the elderly be based on the factual assessment of need carried out by housing authorities.**

5.31 We have commented on the vulnerability of elderly tenants in private rented accommodation, particularly in accommodation outside the scope of the Rent Acts. **We recommend that local authorities give special attention to the elderly on low incomes in substandard private rented accommodation in planning and allocating accommodation for the elderly.**

5.32 **We recommend that where it is not feasible to maintain elderly persons in their own house or in ordinary local authority housing, sheltered housing should be considered as the first choice.** Health board and voluntary participation in these schemes is a vital element and is essential to ensure the continuing independence of the residents. **There should be close liaison with the health board in the planning of sheltered housing schemes. The board, for its part, should provide domiciliary services for the elderly residents and, where appropriate, associated day care centres.**

5.33 **We recommend that local authorities and health boards co-operate to meet, in a flexible way, the accommodation needs of the small number of elderly who are homeless.** The Housing Bill 1988, when implemented, will provide a legal framework for such co-operation.

5.34 **We recommend that the following factors, in addition to overcrowding and unfitness of dwellings, be taken into account by local authorities in relation to letting accommodation to the elderly:**

- **age, with special reference to those over 75 years;**
- **whether or not the elderly person is living alone or in isolation;**
- **the suitability for housing of those in long-stay institutions;**
- **homelessness;**
- **tenants in private rented accommodation unable to pay rent;**
- **the medical condition of the elderly person.**

Wherever possible, elderly people should be housed in their own area. Dependent elderly people in isolated rural areas should be encouraged to move to suitable accommodation in nearby villages and towns.

5.35 Some submissions to the Working Party have urged that older people should not be directed into what might become ghettos for the elderly. We recognise that there is a danger that sheltered or special housing could result in the elderly living apart from the rest of the community. This would be contrary to our belief that the elderly should be integrated with their communities and that they should have continuing contact with younger people. Well designed sheltered or special housing schemes can meet the special needs of the elderly and facilitate contact with younger households, shops, churches and community centres. **To avoid the problem of isolation, we recommend that the elderly be facilitated and encouraged to maintain their contacts in the community.** Voluntary groups have an important role in this regard. **We recommend that the size of sheltered or special housing schemes be kept in proportion to the size of the community in which they are built.**

5.36 The Essential Repairs Grants Scheme, the House Improvement Grant for Disabled Persons, and the Task Force on Special Housing for the Elderly are ad hoc responses to the needs of the elderly in poor accommodation. As a result they are often inadequate to meet the needs of the elderly and a

great deal of confusion arises as a result of the different bodies involved in their administration. We gave some thought to the question of which authority—the health board or the local authority—should be responsible for the administration of housing repair and adaptation schemes for the elderly. Health boards have a direct financial incentive to improve the homes of elderly people as the transfer of the elderly person to extended care will cost the boards more money. However, we believe that local authorities should have responsibility for repairs and adaptations as part of their wider housing functions provided the interest of the health board in improving the accommodation of the elderly is recognised. **We recommend that the Department of the Environment should replace the existing ad hoc grant schemes with a comprehensive and flexible repairs and adaptations scheme for the elderly and disabled which local authorities could administer either by the provision of a grant or by organising the work on behalf of the elderly person.**

5.37 We recognise, however, the difficulties such a recommendation could pose in the present financial circumstances. We recognise, too, that the Task Force on Special Housing for the Elderly is a flexible and cost effective means of carrying out improvements to sub-standard accommodation, although the level of resources available to carry out the work is far from adequate. **Pending the introduction of a comprehensive scheme to improve the accommodation of the elderly and disabled, we recommend that increased resources be allocated to the Task Force on Special Housing Aid for the Elderly to allow more than minimal repairs to be carried out to the homes of vulnerable elderly people and to reduce the waiting list. We recommend that funding for the scheme of remedial works to older and substandard local authority houses be expanded to ensure that it achieves its potential to improve the accommodation of elderly, local authority tenants. We also recommend in the short-term that the Department of the Environment examine ways in which the Essential Repairs Scheme and the House Improvement Grants for Disabled Persons could be better targeted to meet the needs of the more vulnerable elderly and disabled.**

5.38 As health boards have a major interest in maintaining the elderly at home, their role in assessing housing need among the elderly, in recommending repairs and adaptations and in assessing individual applications for grants towards repairs and adaptations should be developed. The Housing Bill, 1988, when passed, will oblige housing authorities to consult with health boards in assessing housing need among the elderly. The presence of a housing official on the district team for the elderly should encourage a quick response to a housing problem among the elderly. We envisage that problems

of co-ordination between health boards and local authorities can be resolved by the Co-ordinator of Services for the Elderly and the Housing Officer of the local authority. We have recommended that both be members of the health board advisory committee on the elderly. We note with approval that under the new Housing Bill, the local authority may have regard to a report from a medical officer of health in the letting of dwellings where medical grounds are involved. **We recommend that in anticipation of the enactment of the Housing Bill, 1988, local authorities in consultation with health boards carry out an immediate assessment of the need for housing repairs and adaptations among elderly households and that, together with health boards, they should plan a programme of repairs to meet those needs using existing schemes.**

HOME INCOME SCHEMES

5.39 The high level of home ownership among the elderly means that for many their house is their most valuable asset. Those on low incomes should be encouraged to realise their asset. Some financial institutions offer home income schemes whereby the owner can remortgage their house and use the money to buy an annuity. The interest on the mortgage is deducted from the annuity, and the elderly person has the remainder as income. Such an income can be used to improve and adapt the house. On the death of the elderly person, the house can be sold, the mortgage paid off, with the profit going to the person's heirs. **We recommend that the Departments of Finance and the Environment explore with the financial institutions ways in which elderly people can be encouraged to make greater use of the financial asset of their home.**

HOUSE TRANSFER AND SHARING

5.40 For some elderly people adaptations to their homes would be too costly and uneconomic where the person's life expectancy was likely to be short. Some local authorities provide more suitable accommodation for an elderly home owner in exchange for the transfer of the home to the local authority. **We recommend that the Department of the Environment examine the possibility of introducing a scheme which would facilitate elderly people transferring their homes to a local authority in exchange for more suitable accommodation or for repairs and adaptations to their homes. The Department of the Environment should also consider ways in which elderly people living in accommodation which is larger than their needs, might, with the help of voluntary housing organisations, be encouraged to share accommodation with other elderly persons.**

VOLUNTARY HOUSING

5.41 While the scheme to assist voluntary housing organisations is a valuable one, voluntary bodies still face problems financing projects. Many of them have difficulty in raising the remaining 20 percent of the cost of capital projects. The Housing Centre, a national body representing voluntary housing associations, has argued that because the loan of 80 percent of the cost is in the form of a first mortgage, it is difficult for organisations to borrow the remainder from private financial institutions on the security of the property as they insist on first mortgage conditions. The Centre has suggested that the legal status of the capital assistance should be changed to that of a non-repayable grant subject to certain supervisory controls. This would enable associations to raise loans to cover the deficit. Alternatively, the Centre suggests that the capital loan be increased to 95 percent of the cost of a project. The fully subsidised advance limit of 80 percent of the costs of the project could be retained, leaving the voluntary association to repay 15 percent of the capital borrowed over 30 years and to raise the 5 percent capital from its own resources.

5.42 **We recommend that the role of voluntary housing organisations be expanded to meet the housing needs of the elderly. All voluntary housing schemes for the elderly should be planned in consultation with the Co-ordinator of Services for the Elderly. We also recommend that the current Department of the Environment scheme to assist voluntary housing organisations be amended to increase the capital loan facility to 95 percent. The Department of the Environment should consider ways in which voluntary housing organisations could be assisted with the cost of maintaining housing schemes.**

NOTES TO CHAPTER 5—HOUSING

1. B.J. Whelan and R.N. Vaughan. *The Economic and Social Circumstances of the Elderly in Ireland,* ERSI (1982).

2. B Power, *Old and Alone in Ireland: A Report on a Survey of Old People Living Alone,* Society of St Vincent de Paul (1980).

3. National Council for the Aged, *Housing of the Elderly in Ireland,* (1985). p.28

4. *Ibid.* p.29

5. Anne O'Mahony, *The Elderly in the Community: Transport and Access to services in Rural Areas,* National Council for the Aged, (1986). p.21

6. A A Horner, J A Walsh, V P Harrington *Population in Ireland— A Census Atlas,* (1987)

7. B J Whelan and R M Vaughan, *op. cit* p.73

8. National Council for the Aged, *op. cit.* p.32

9. *Comprehensive Public Expenditure Programmes,* 1985 pl 3364.

10. *The Care of the Aged, Report of an Inter-Departmental Committee,* op. cit. p.55.

11. National Rehabilitation Board, *Housing Adaptations for the Disabled—A pilot scheme,* (1986).

12. A D Thomas *Housing and Urban Renewal—Residential Decay and Revitalisation in the Private Sector,* London, (1986) P.50

13. *Ibid.*

Chapter 6

Care at Home

6.1 As people become older or more frail, they experience increasing difficulty with the tasks of everyday living. Table 6.1 shows the proportion of the elderly in one survey who reported difficulty with everyday activities. Those activities which present the greatest difficulty are getting on and off a bus, climbing a flight of stairs, walking half a mile and bathing without help. Dependent elderly people being cared for at home experience greatest difficulty cooking a meal, cutting toe nails and washing and bathing. (Table 6.2) As well as suitable accommodation, elderly people with disabilities require help with the activities of daily living. The lack of mobility of the dependent elderly means that as far as possible services should be delivered to their homes.

6.2 The capacity of current health and welfare services to support dependent elderly people at home is limited. Until recent times health policy has tended to emphasise the central role of the hospital in the health services, with community health services playing a supporting part. By the standards of comparable countries this country has a high ratio of hospital beds to population and a very high level of hospital admissions.[1] The consultative statement on health policy published in 1986, **Health—The Wider Dimensions** signalled an important shift in official policy. A generous supply of long stay beds for the elderly over much of the country made it too easy to admit elderly people to institutions when they could no longer cope with daily activities at home. "For the future", the statement argues, "Primary Health Care will be regarded as the central component of the health care system supported by well organised and efficient secondary and continuing care sectors".[2] Primary care in future will "incorporate a comprehensive, integrated, multi-disiplinary provision of care for individuals, families and communities. It is not confined to medical care and curing but also encompasses prevention, health promotion, rehabilitation and a range of personal social services".[3] We endorse the proposals of the consultative statement on the need for a comprehensive system of primary care and in this and subsequent chapters spell out, as far as the elderly are concerned, what such care will involve.

ELDERLY AT RISK

6.3 We have already argued the need for a district liaison nurse, a district team for the elderly and a Co-ordinator of Services for the Elderly to ensure the integrated delivery of services to elderly people in each district and community care area. It is fundamental to the success of the liaison nurse and the team that they be able to identify the elderly in need of the services which they can mobilise. At present, public health nurses employed by health boards keep registers of elderly persons at social or medical risk. When a public health nurse is made aware of an elderly person in need, she carries out an assessment and where the circumstances warrant it, she places the name of the elderly person on a register. However, these registers tend to be compiled informally and their use confined to the public health nursing service.

6.4 There is a need to formalise the identification of the elderly at risk to form a basis for a co-ordinated programme of care for the individual in each district and to plan services for elderly persons at risk at the community care level. We considered whether a regular assessment should be made of all elderly people but rejected this option as unneccessary and impractical. Most elderly people are fit and well most of the time. Many might consider an unsolicited assessment by a public health nurse as an intrusion on their privacy. Furthermore, the resources of the public health nursing service are stretched under the present workload and a regular assessment of the 382,000 persons aged 65 and over would leave little time for their other responsibilities. We consider that a system of identification should be primarily concerned with those elderly people with a significant medical and/or social problem. **We recommend that the district liaison nurse maintain a register of elderly people at medical or social risk.**

6.5 There are a number of ways in which an 'early warning system' to identify the elderly at medical or social risk might be formalised. Informal co-operation between the staff of the Department of Social Welfare and the health boards in some areas has helped to bring elderly people in need to the attention of the relevant service. There is merit in formalising this co-operation through the routine notification of the district liaison nurse of elderly persons granted non-contributory and contributory old age pensions. Notification should be done in a way that respects the privacy of the individual elderly person and the information which they may have provided in claiming a non-contributory old age pension. The Departments of Health and Social Welfare should ensure that any arrangement for notifying the granting of pensions at local level does not impinge upon an elderly person's right to privacy or the confidential nature of any information supplied.

6.6 A second way in which the liaison nurse might anticipate need among the elderly in the district is through the medical card system. Some 69 percent of those aged 65 and over and 85 percent of those aged 80 and over have medical cards.[4] By definition, the elderly with medical cards are those with incomes inadequate to cover their medical expenses and correspond roughly to those elderly with the most significant medical and social problems. Medical cards are valued by the elderly and there appears to be little stigma attached to applying for a card. Medical cards are normally administered within the community care area and it should be relatively easy to notify a member of the district team for the elderly when a medical card holder or a dependent reaches 65 or when an elderly person is granted a medical card. The development of computer systems in community care should make the transmission of this information easier.

6.7 As the number of elderly people with medical cards is still too large for regular assessment, it will be necessary to use other criteria for including names on a register of those most at risk. It is well known that the elderly are most vulnerable and need most attention if they live on their own, are solely dependent on a social welfare pension, are suffering from an acute or chronic illness and following the death of a spouse or relative. Elderly people who fall into one or more of these categories, particularly if the person concerned is over 75 years, should receive priority for assessment. Whether an elderly person lives alone, is solely dependent on a social welfare pension, is suffering from an acute or chronic illness and is over 75 years should be established when applying for a medical card. It is essential that the medical card application process be seen not simply as a method of establishing the entitlement or otherwise of a claimant but also as a way of identifying the elderly at risk for medical or social reasons and as a way of mobilising support for them.

6.8 Once granted a medical card, elderly people tend to be exempted from the regular review of entitlement carried out by health boards on younger age groups. This means that the information provided when the elderly person applied for a medical card may become dated. The death of a spouse or a caring relative or the sudden onset of a disabling disease may reduce a formerly independent elderly person to dependence very quickly. Each liaison nurse for the elderly needs formal and informal ways of ensuring that the register of elderly persons at risk for medical or social reasons is kept up to date. The Co-ordinator of Services for the Elderly should ensure that the registers of the teams for the elderly are maintained for operational purposes in the district and are compatible with each other for planning and epidemiological purposes in each community care area.

6.9 While we envisage that information gathered on pension and medical card claimants will be the main source of information about vulnerable elderly persons, we would emphasise the importance of maintaining an informal means of identification. Some elderly persons requiring attention may not claim social welfare pensions or medical cards. All members of teams for the elderly, but particularly public health nurses, will have their own sources of information about vulnerable elderly persons which should be used to maintain an up to date register. General practitioners, voluntary bodies and concerned neighbours should all be encouraged to bring to notice those who appear to be at risk. It is in such a way that the community as a whole can be said to be a concerned community.

6.10 The compilation of registers of elderly persons at risk for medical or social reasons may be more complex in practice than we envisaged. **We recommend that the best method of identifying the elderly at medical or social risk be one of the priority issues to be examined in the two model community care areas recommended in the final chapter of the Report.** Based on the experience of these projects, the Department of Health should circulate guidelines to all health boards on the subject.

6.11 **We recommend that in addition to the elderly at medical or social risk, each district liaison nurse should also be aware of all elderly people receiving a significant amount of care from their families or neighbours.** Information on carers is essential if they are to be assisted in caring for dependent elderly people by the district team.

MEDICAL CARE

6.12 Referring to the medical care of the elderly, the **Care of the Aged Report** commented that family doctors were in a "key position" and that their "approach will determine, to a considerable degree, the extent to which domiciliary care of the aged will be feasible". Experience since the publication of that Report confirms the critical role of the general practitioner in caring for the elderly at home. The general practitioner is particularly well suited to provide medical care for the elderly. Older people tend to have more than one medical problem at the same time and to suffer from chronic diseases. One study found that six out of ten elderly people suffered from a long standing illness, compared with one in ten of those aged 18 to 29.[5] Nearly half of the "young elderly" and over two thirds of the over 80 year age group had seen a doctor or taken medication in the previous four weeks.[6] Table 6.3 shows that the physical disabilities of elderly people being cared for at home are due to disease of the joints, cardiovascular and renal disease, and

neurological disorders.[7] The general practitioner can provide an holistic approach to the different medical problems of an elderly person and continuity of care over a long period. There are about 2,300 general practitioners in practice, 1,400 of whom are registered with health boards to provide services to patients with medical cards. The number of general practitioners and their location throughout the country mean that a primary medical service is available to all elderly people. The general practitioner tends to be the first professional called by elderly persons when ill and his or her decisions are critical to the subsequent care of patients and the mobilisation of resources for their care.

6.13 The **Report of the Working Party on the General Medical Service** (GMS Working Party Report) has defined the characteristics of good general practice in the following manner:

"(a) direct access by patients to the general practitioner's services;

(b) a close, personal relationship between the general practitioner and an identifiable and reasonably constant group of patients and families;

(c) continuity of care of that population;

(d) an holistic approach to the care of patients, taking full account of the psychological, social and environmental factors influencing patients health status;

(e) concern with prevention and anticipatory care for that population, as well as effective response to illness;

(f) an ability to reach fully-rounded diagnoses, often under pressure, on the basis of special training for conditions met in general practice."[8]

6.14 Considerable improvements have occurred in the quality of general practitioner care available to the elderly during the last decade or so. Elderly persons who qualify for a medical card are entitled to free medical care from participating general practitioners and to free drugs and appliances for themselves and their dependants. With the replacement of the dispensary service by the General Medical Service in 1972, medical card patients were given a choice of medical practitioner among participating doctors in their locality. Until then, medical card patients were entitled only to the services of the dispensary doctor for the area. The introduction at the same time of a fee per item of service payment has resulted in much greater visiting of the elderly at home by participating doctors. Eligible patients were also given a choice of chemist for medications prescribed by their doctors. At present,

69 percent of those aged 65 and over and 85 percent of those aged 80 and over are covered by medical cards under the General Medical Service.[9] Elderly people with medical cards have an average of just over eight consultations with their doctor per year, the second highest consultation rate of any age group in the General Medical Service.

6.15 There are, however, shortcomings in Irish general practice and the General Medical Service which restrict the capacity of general practitioners to provide an optimum level of care. These shortcomings have been highlighted in the **GMS Working Party Report,** the Report of the Irish College of General Practitioners on the **Future Organisation of General Practice in Ireland** and in the consultative statement, **Health—The Wider Dimensions.** A major problem identified in these documents is that the care provided by general practitioners is not sufficiently oriented towards prevention and early detection of disease. Reference has already been made in this report to the scope for preventing disease among the elderly and for the early detection of treatable disease. The most easily preventable disorder in old age is probably iatrogenic illness induced by inappropriate medication.[10] The general practitioner can prevent such illness by careful prescribing and surveillance of people on long-term medication. The effects of many more diseases and conditions can be alleviated by early detection and treatment or referral by the general practitioner.

CASE-FINDING

6.16 The literature on medical screening suggests that there is little value in routine screening of all elderly people for early signs of disease but that "case finding" among elderly persons identified as at risk is worthwhile.[11] While the primary aim of screening is to prevent disease, case finding is concerned with the early detection of established disease and assessment of the physical, mental and social function of the patient to achieve earlier diagnosis and better prospects of cure, alleviation and rehabilitation. Case finding, also known as anticipatory care, is ideally suited to well organised general practice and is considered an extremely efficient use of resources.[12] In most cases it means taking advantage of a routine consultation to check blood pressure, vision, mobility, hearing, mental capacity and other functions which tend to deteriorate with age but which can be controlled. The elderly who are most in need of anticipatory care are those on the team for the elderly's at risk register. Case finding will therefore require close liaison between general practitioners and the district team for the elderly. **We recommend that case finding among the elderly population considered to be at risk be developed as a normal part of general practitioner care of the elderly, and in particular as a normal part of the General Medical Service.**

6.17 The fee structure for doctors participating in the General Medical Service should reflect the new emphasis on anticipatory care. The **GMS Working Party Report** recommended a restructuring of the method of payment to doctors providing care for medical card patients. It recommended that a modified fee payment be introduced which would be weighted to give a higher payment in the case of persons such as the elderly who give rise to particular demands on doctors. In addition to the basic payment per patient, fees would be paid for agreed services which it was desired to maintain or promote in general practice. However, the proposals of the **GMS Working Party Report** proved unacceptable to the Irish Medical Organisation. At the time of writing, negotiations are taking place between the Depatment of Health and the Irish Medical Organisation about the method of remuneration in the General Medical Service. **We recommend that any new system of remuneration in the General Medical Service should provide appropriate financial incentives to encourage anticipatory care of elderly patients deemed to be at risk.** We consider that, given the existing high level of consultation between doctors and elderly patients in the General Medical Service, a financial incentive to encourage case finding need not give rise to additional expenditure above the existing cost of the service to the elderly.

LIAISON WITH HEALTH BOARD SERVICES

6.18 A further factor inhibiting a co-ordinated primary care service for the elderly is the separation of general practitioners from colleagues and other professionals employed by the health board. The majority of Irish general practitioners work on their own, although the number of group practices is growing. The problem of liaison with health board services arises because of the different principles of organisation underlying general practice and health board services. General practitioners are independent contractors providing a service to patients who chose them as their doctor. Medical card patients are not limited by community care or the de facto district boundaries in their choice of doctor. Public health nursing, occupational therapy, home helps and other services of health boards are provided for defined populations within community care boundaries. Patients are not normally offered a choice of public health nurse, home help or occupational therapist. These administrative differences are compounded by the relative shortage of public health nurses compared with general practitioners. In general hospitals, the ratio of medical staff to nurses is 1 to 6. In the community, the situation is reversed with a ratio of .8 of a nurse to each general practitioner in the General Medical Service. Co-ordination of medical and nursing services is less of a problem in rural areas and in towns than in the cities where informal contact between doctors and public health nurses is less frequent.

6.19 The **GMS Working Party Report** made a number of recommendations to strengthen the links between community care personnel and general practitioners. In particular, it pointed to the urgency of promoting effective liaison between general practitioners and public health nurses, preferably through schemes of attachment of nurses to doctors' practices. There is widespread agreement that general practitioners and public health nurses must work more closely together but there is a reluctance to pursue the idea of attachment. As we consider a close working relationship between the district team for the elderly and general practitioners is essential to the success of a policy to support elderly people at home when ill or dependent, it is necessary to explore other means of co-ordination. We have already recommended that a representative of the general practitioners working in the district be a member of the team for the elderly. It would help if patients in urban areas, when choosing a general practitioner, were encouraged to choose a doctor from within the district. Greater encouragement towards group practice would also make co-ordination easier. Each public health nurse might assume responsibility for liaising with a number of general practitioners in a district. No decision should be taken on the care of an elderly person by the team for the elderly without a report from the general practitioner and the public health nurse. We have already recommended linkages in the vocational training programmes of public health nurses and general practitioners to strengthen the team approach to the care of the elderly. **We recommend that it be the responsibility of the CSE to ensure good working relationships between the teams for the elderly and the general practitioners working in the respective districts. We recommend that the Irish College of General Practitioners and the Institute of Community Nursing explore ways in which greater co-operation between general practitioners and public health nurses can be achieved in the interest of improved care of patients.**

6.20 The **GMS Working Party Report** and the Irish College of General Practitioners have both highlighted the extent of unnecessary referral of patients to general hospitals for outpatient and inpatient services. An increasing proportion of elderly patients are being seen in accident and emergency departments of general hospitals, particularly in urban areas. In many cases, they have not been seen by their general practitioner. Accident and emergency departments are by their very nature less than ideal places in which to assess the symptoms of a sick elderly person. The **GMS Working Party Report** and the Irish College of General Practitioners recommend that the capacity of general practitioners to care for their patients without unnecessary referral to hospital be enhanced by expanding general practitioner access to diagnostic and therapeutic facilities, better communication between hospital and family doctors on the management of patients, consultations

by specialists in patients' homes and in community settings and a reorientation of current incentives which encourage unnecessary admission to hospital. **We recommend that these measures be implemented as soon as possible. In addition, we recommend that the discharge of elderly people—which we considered in more detail in Chapter 8—be co-ordinated by the hospital, the general practitioner and district liaison nurse, that increasing use be made of day hospitals in assessing and rehabilitating elderly patients and that the expertise of general practitioners in the palliative care of the terminally ill be developed and expanded.** We consider the role of the general practitioner in the extended care of elderly outside the home in more detail in Chapter 9.

6.21 While much can be done to reduce unnecessary referrals to hospital, we are concerned at the possible effect on the elderly of current policies of reducing hospital beds and the pressure to bring down average patient stay in acute hospitals. Elderly people, when their medical condition justifies it, must be admitted to hospital on the same basis as all other age groups and they must not be discharged inappropriately. We accept the need for economies and welcome the move away from the present over-emphasis on institutionalisation. We would point out, however, that, without a corresponding increase in the capacity of the general practitioner and the district team for the elderly to care for sick people at home, elderly people will suffer from the impact of current policies. **We recommend, as a matter of urgency, that the Department of Health and the health boards implement the recommendations of the GMS Working Party Report to strengthen the capacity of general practitioners to diagnose and treat illness and the proposals of the consultative statement, Health—The Wider Dimensions to develop primary care services in general.**

NURSING SERVICE

6.22 A comprehensive nursing service is as vital to caring for elderly people at home as a good medical service. The nurse is also a key organisational figure in mobilising resources to assist elderly people at home. Much has been done since the late 1960s to provide a domiciliary nursing service throughout the country. Under section 60 of the Health Act 1970, health boards are obliged to provide a nursing service for persons covered by a medical card, and such other groups as the Minister may specify. The Act specifies that the service is "to give those persons advice and assistance on matters relating to their health and to assist them if they are sick." The service is provided by public health nurses who are also responsible for preventive health services for mothers and children. There are currently 1,154 public

health nurses employed by health boards giving a national ratio of nurses to population of 1:3,065. This ratio is considerably below the target of 1:2,616 recommended in 1975 by the **Report of the Working Party on the Workload of Public Health Nurses.** It compares unfavourably with the British ratio of district nurses and health visitors to population of 1:1722. The national ratio in Ireland hides significant differences in the ratio between health boards, as Table 6.4 illustrates.

6.23 In some parts of the country, a public health nurse has been designated as a liaison nurse to ensure a co-ordinated approach to the care of elderly patients by hospitals, general practitioners and community care staff. The remarkable success of these liaison nurses in carrying out their task is the basis for our recommendation in Chapter 4 that district liaison nurses for the elderly be appointed throughout the country.

6.24 The elderly account for by far the largest proportion of patients on the visiting lists of public health nurses. In 1975, 68 percent of all patients receiving home visits were aged 65 years and over.[13] About half of the patients aged 65 years and over were on the nurses' visiting lists for longer than 1 year. About 8 percent only of these patients were on visiting lists for one month or less. Nearly 40 percent of the time of public health nurses on district duties was taken up with the care of the elderly. More than 80 percent of the home visiting time of public health nurses was spent on strictly nursing duties. However, a significant part of the nurse's time with the elderly was taken up with social work and home help activities.

6.25 The present service makes a major contribution to the care of the elderly at home, mainly through the provision of nursing advice. The services of the public health nurse are highly valued by patients and other professionals. However, the evidence presented to the Working Party suggests that the service is unable to cope with the current need for nursing advice or nursing care at home and is certainly not in a position to cope with the demands of a rapidly ageing population. The main problems with the present service include:

— the low ratio of nurses to population means that public health nurses cannot provide a fully comprehensive nursing service to elderly people at home;

— the present service does not routinely provide cover outside the normal working day or at weekends;

— the absence of formal liaison with general practitioners;

— the insufficient attention paid to anticipatory care of the elderly among nursing staff;

— the shortage of public health nurses with expertise in the management of incontinence.

6.26 It is significant that the survey undertaken in 1975 found that 90 percent of the elderly on the list of public health nurses were visited no more frequently than once a week. Current restrictions on health expenditure have led to a reduction in the number of elderly persons visited by public health nurses in some areas. In Galway the number of visits by public health nurses to elderly people in October 1987 was over 5,000. In October 1988 the number of visits was just under 3,000.

Elderly residents outside the day centre, Beaufort, Dun Laoghaire.

6.27 Nursing at home, while it calls for similiar skills to nursing in hospital or in nursing homes, differs significantly from nursing in an institutional setting. The nurse in hospital is part of a team providing care for the patient around the clock. She does not have to worry about how the food is cooked, or who will dress the patient or wash the laundry. The nurse caring for an elderly person at home does not have the same level of support and must concern herself with all details of the patient's welfare. She must mobilise the resources of the primary health care team, the family and neighbours, advise and support those caring for the patient and help the patient and family when a crisis occurs. Public health nurses, as part of their training, are particularly well equipped to deal with these situations.

6.28 The nature of illness among the elderly means that they often require nursing care over a long period. This nursing care should be available to them in the familiar surroundings of their home whenever possible. If nursing care is not available at home, then elderly people will have to be admitted to hospital. Up to now, a generous provision of acute and long stay hospital beds over most of the country has helped to meet the need for nursing care for the elderly. As the number of acute and long stay beds contracts and the pressure for higher usage of existing beds increases, the elderly in need of nursing care will find it increasingly difficult to gain admission to hospital. The provision of an adequate home nursing service is a necessary part of the strategy to control hospital expenditure. We recommend that the home nursing service be expanded as a matter of urgency. Such a development can be justified in terms of the quality of care for the elderly and as the most efficient use of medical and nursing resources.

6.29 A comprehensive home nursing service for the elderly could be provided in a number of ways. Ideally, the number of public health nurses would be increased to meet the present and future demand for the service. Table 6.4 shows that an additional 243 nurses are required to bring the ratio of nurses to population up to that recommended in 1975. However, we accept that a large increase in the complement of public health nurses is ruled out by current constraints in public service expenditure. **We recommend however that additional public health nurses be appointed as resources permit.** Such a measure should not await the development of a situation where more resources become available for the health services in general. Health boards should immediately seek to re-allocate their existing nursing resources with the aim of improving the ratio of public health nurses to population in the more deficient districts. Health boards should also explore the possibility of employing care assistants who would work under the supervision of the public health nurse.

6.30 The **Report of the Working Party on General Nursing** recommended the introduction of general nurses to support the public health nursing service in providing nursing at home. The Midland Health Board introduced a pilot scheme in 1987 in which a panel of general nurses is available to provide additional nursing care to elderly patients at home following their discharge from hospital. The panel nurses work under the supervision of the superintendent public health nurse. **We recommend that a panel of general nurses willing to nurse elderly people at home on a part-time basis be established in each district. The district liaison nurse should have discretion to call on the services of a nurse from the panel when an elderly person requires a more intensive level of care than can be provided by a public health nurse or in the evenings and at weekends.** Such an arrangement would enable a nursing service to be provided quickly and flexibly for patients when they become ill at home or on discharge from hospital. Many nurses who are married and not working full-time would welcome the opportunity to work with the elderly on a part-time basis. In general we envisage that the nurses on the panel would live in or close to the district in which the elderly person was living. Nurses wishing to join the panel should be offered opportunities to acquaint themselves with recent developments in the care of the elderly and the demands of nursing in the home.

6.31 With the provision of a comprehensive home nursing service under the direction of the superintendent public health nurse, **we recommend that public health nurses in their visits to the elderly place a greater emphasis on anticipatory care of the elderly and the promotion of their health.** By checking the functional capacity of the elderly at risk on a routine basis the public health nurse may detect early signs of deterioration and encourage early referral for appropriate attention. **We recommend that greater attention be paid in the training of nurses generally and public health nurses in particular, to anticipatory care of the elderly.**

6.32 There is a particular need for more nurses trained in the management of incontinence. The Institute of Community Health Nursing has recently developed a course designed to increase the expertise of public health nurses in the management of incontinence. We welcome this initiative. **We recommend that in each community care area there should be at least one public health nurse with a special interest in the management of incontinence, who would act as an advisor to other nurses.**

MEDICAL APPLIANCES AND AIDS

6.33 For some dependent elderly people and their carers, the provision of a medical appliance or an aid can make all the difference to their ability to manage at home. The term 'medical appliance' refers to items which are necessary to maintain the health of the elderly person, such as walking frames, wheelchairs, commodes, bed rests and cradles, stoma equipment, special beds and incontinence pads. Aids for the elderly are usually smaller items which may not be medically necessary but which make the life of a dependent elderly person easier. They include bath rails, non-slip mats, specially designed cutlery, pick-up sticks and safety devices for cookers and fires. Under section 59 of the Health Act 1970 health boards are obliged to supply without charge medical appliances to persons with medical cards and to persons suffering from a prescribed disease or disability of a permanent or long term nature. They may supply aids with or without charge under section 61 of the same Act.

6.34 There are problems in current arrangements for the provision of medical appliances and aids. To rectify these problems we recommend that:

— **in each community care area, an occupational therapist or public health nurse should develop a special expertise concerning appliances and aids for the elderly;**

— **every elderly person requiring a medical appliance or aid be assessed by a public health nurse or occupational therapist with first hand knowledge of the individual circumstances;**

— **when an elderly person is being discharged from hospital, and requires a medical appliance, the hospital personnel should inform the public health nurse or occupational therapist in time for arrangements to be made for its supply prior to the patient's return home;**

— **within each community care area there should be a suitable premises with a person in charge of the purchase, storage, distribution, recovery, maintenance and cleansing of medical appliances and aids. An occupational therapist or public health nurse should advise on these aspects of the management of appliances and aids.**

— **health boards should not be precluded by legislation from charging a deposit on medical appliances which would encourage their return in good repair when no longer needed;**

- **health boards should consider charging for necessary aids, as they may do under section 61 of the Health Act 1970, rather than curtail the supply of aids completely;**
- **the allocation of appliances and aids should be reviewed each year to ensure that they are still required by the elderly person. Computerisation of information concerning appliances and aids on loan in the community would make this task easier;**
- **the National Rehabilitation Board should continue to advise health boards on the latest advances in medical appliances and aids for the elderly and advise on the 'best buy' available.**

OCCUPATIONAL THERAPY

6.35 The main contribution of the occupational therapist to the care of the elderly is to advise on adapting their homes to cope with increasing disability. The occupational therapist can advise on the value of a medical appliance or aid or on the need for an adaptation to accommodation. At present 127 occupational therapists are employed by health boards, a significant proportion of whom work in the community. In Chapter 5 we recommend that the health boards should have a greater role in recommending adaptations or repairs to the homes of dependent elderly people and in assessing individual applications for grant aid. An occupational therapist employed by a health board is usually the best equipped person to carry out this assessment. In addition, **we recommend that occupational therapists should liaise with general practitioners and public health nurses to ensure that they are aware of the potential of adaptations and aids to improve the home conditions of the elderly.**

PHYSIOTHERAPY

6.36 A domiciliary physiotherapy service has a number of advantages. The physiotherapists can help preserve the mobility and independence of elderly persons by advising patients and relatives on remedial measures. The physiotherapist can prevent hospitalisation by providing treatment for acute conditions such as respiratory infections. He or she can teach relatives and carers how to handle and lift an elderly patient and can educate them on the risks of inactivity. The physiotherapist can also advise and provide relevant supports and devices which improve the mobility of the elderly person. Domiciliary physiotherapy can facilitate earlier discharge from hospital. It avoids the necessity of transport to hospital or health centres, it can lead to greater involvement by relatives or carers in the handling of the patient and it encourages a more individual approach to the care of the patient. There is, however, virtually no physiotherapy available to elderly people at home.

6.37 We are convinced of the importance and cost effectiveness of domiciliary physiotherapy for the elderly. **We recommend that a physiotherapy service, based in the community hospital or health centre, should be available for elderly people at home where their medical condition justifies it.** Some of the difficulties which health boards have experienced in employing physiotherapists could be overcome by a more flexible approach to employment involving a mixture of full-time, part-time/sessional and private physiotherapists providing services under contract. **We recommend that the Department of Health review manpower requirements in physiotherapy as a matter of urgency in order to match the supply of graduates with the demand for physiotherapists.** Referrals from general practitioners for physiotherapy services should be channeled through the area medical officer on the district team for the elderly.

SPEECH THERAPY

6.38 Strokes are a major cause of dependency among the elderly. In many cases, the initial disability can be reversed and ameliorated. This is particularly true of speech impairment. **We recommend that a domiciliary speech therapy service be provided to meet the needs of elderly people with impaired speech being cared for at home. Health boards should support the Volunteer Strokes Scheme to train volunteers to assist those affected by strokes and their families.**

HELP AT HOME

6.39 Dependent elderly people need assistance with the tasks of everyday living if they are to remain in their homes. Since the **Care of the Aged Report,** great progress has been made by voluntary organisations and health boards in developing a home help, laundry and meals service, largely, but not exclusively, for elderly people.

6.40 Under section 61 of the Health Act 1970, health boards may make arrangements to assist in the maintenance at home of persons who, but for the provision of such a service would require to be maintained otherwise than at home. This section empowers, without obliging, health boards to provide or support services such as home help, laundry and meals. Unlike the nursing service, health boards are not limited in the categories of persons they can assist at home and may charge for the service. In practice, about half of the home helps and the vast majority of meals are provided by voluntary organisations with funding from health boards. The remaining home helps

are employed directly by health boards. The balance between voluntary and health board input to the home help service varies from health board to health board. Home helps are predominantly part-time, though a number of full time home helps and home help co-ordinators are employed by some boards. In 1987, there were over 11,000 beneficiaries, of whom 88 percent were aged 65 and over. (Table 6.5) Total expenditure on the service in 1987 was IR£7.65m.

6.41 The percentage of the elderly in receipt of home help services varies from health board to health board. Table 6.6 shows that 3.7 percent of the elderly in the Mid Western Health Board in 1987 were receiving a home help service, compared with 1.6 percent in the South Eastern Health Board. The national average of 2.6 percent of the elderly population benefiting from a home help is low. A study carried out by the St Vincent de Paul Society found that only 5 percent of the elderly living alone were in receipt of a home help service. [14] The proportion in Northern Ireland was 8 percent.

6.42 Because of the voluntary nature of much of the home help service, it is an extremely cost effective way of helping elderly people at home. Voluntary involvement also strengthens the sense of neighbourly obligation towards the elderly and encourages the self development of the home help. There are many advantages in the present arrangement whereby health boards fund voluntary organisations to provide a service, while retaining responsibility to provide a service directly where voluntary organisations do not exist or are unable to provide a comprehensive service.

6.43 The meals service is largely confined to urban areas where voluntary organisations are active. Traditionally the meal was prepared in a central kitchen and distributed to the old person's home by volunteers. Voluntary organisations usually charge a small fee for the meal. Increasingly, elderly people are being encouraged to share their meals in a community centre or club. Where a meal service is not provided, health boards sometimes provide meal vouchers to elderly people or pay a neighbour to provide a meal.

6.44 The home help and meal services are vulnerable at times of financial cutbacks because health boards are not legally obliged to provide them (unlike nursing and medical services) and because the voluntary organisations providing the services are largely dependent on funding from health boards. Real public expenditure on home helps and meals has declined significantly in recent years. Between 1980 and 1984, estimated expenditure on the home help service declined by 30 percent in real terms. Some of this shortfall in public funds may, however, have been met from increased charges to recipients.

6.45 We consider that the provision of help with the tasks of everyday living is of vital importance to the success of the strategy to support elderly people at home. The potential of the home help service to support relatives caring for disabled elderly people, as well as helping the elderly living alone, is great but unexplored. Every major report on community health services in recent years has emphasised the value of a good home help service and called for its expansion.[15] Expenditure on the home help service represents very good value for money in the health services. Despite its importance to maintaining the elderly at home in a cost effective way, the evidence suggests that the service is contracting.

6.46 It is clear that the home help and meals service are at a critical juncture in their development. **We recommend that the flexibility and voluntary commitment, which form such an important part of the home help and meals service, be safeguarded and built upon in future. We recommend that the following steps are necessary to develop the service:**

- **additional resources are necessary to expand the home help service. The immediate aim should be to develop the service to the extent of the whole time equivalent of 4.5 home helps per thousand elderly people;**

- **health boards should be legally obliged to provide or make arrangements to provide services to maintain persons at home who would otherwise require care in another setting;**

- **the home help service should be comprehensive enough to assist elderly people with all the tasks of daily living;**

- **the decision to provide a home help service to an elderly person should be taken locally at district team level;**

- **an emergency home help service should be available within a day of request. A service should also be available outside of normal working hours and at weekends;**

- **the home help service should be expanded in scope to provide an evening and weekend relief service for persons caring for elderly relatives at home;**

— **where neighbours are recruited by a health board to provide help or meals for an elderly person in need, they should be paid for this service;**

— **catering officers in health boards should review the nutritional content of meals prepared for the elderly by voluntary organisations and advise on the maintenance of high quality.**

A SOCIAL WORK SERVICE FOR THE ELDERLY

6.47 The dependency of elderly people can cause emotional and social problems for themselves and the relatives caring for them.[16] The death of close friends and contemporaries can make elderly people feel lonely and isolated. An elderly person may be unwilling to accept their dependency or to make allowances for the need of a caring relative for a life of his or her own. One member of the elderly person's family may be taking an unfair share of the work of caring for the elderly person but may not be in a position to involve other family members. Previous, unresolved family quarrels may prevent family members accepting their obligations towards the care of their parent or parents. In a small number of cases, intense strain on the carer can result in the physical or emotional abuse of elderly people. The need of dependent elderly people and their carers for a service to help with these problems has not been officially recognised up to now. A few voluntary organisations employ social workers who assist the elderly and their families and some members of religious orders are engaged in this work. Public health nurses, the social work departments of general hospitals and community care social workers deal with problems as best they can. Public health nurses are not primarily trained, however, to counsel people with inter- personal problems. The social work departments are only aware of cases that present difficulty in hospital. The community care social work service deals almost exclusively with the problems of vulnerable children and their families.

6.48 As the elderly population grows, and the number reaching the more dependent stage of advanced old age increases, greater attention will need to be given to resolving interpersonal problems which arise for families with a dependent elderly relative. The professionals best equipped to carry out this task are social workers and it would be logical if community based social workers provided this service as they do in Northern Ireland. The Working Party is aware that the community care social work service is overstretched at present in dealing with the needs of vulnerable children and their families. The rapid fall in the birth rate should in time permit some redeployment of

social work resources to the elderly. **We recommend that a domiciliary counselling service be available to dependent elderly people and their families and that the community care social work departments be gradually expanded for this purpose.**

CHIROPODY

6.49 Many problems of mobility in old age arise from foot conditions. A good chiropody service can help prevent deterioration of the feet and contribute significantly to maintaining the mobility of elderly people. The range of foot disorders necessitating chiropody can be divided into those which the chiropodist is competent to diagnose or treat, such as infective and inflammatory conditions, and structural and functional disturbances and more serious orthopaedic conditions which he or she treats in co-operation with a medical practitioner.

6.50 The current arrangements for the provision of chiropody are haphazard and inadequate. The existing services are provided in the main by part-time chiropodists employed by health boards on a sessional basis. In Dublin, 32 private practitioners provide a service under the General Medical Service. In Dublin city home visits are undertaken and chiropody is provided in many hospitals. The level of service in Cork city and county also appears adequate. In other areas the service is almost non-existent, with no domiciliary or community chiropody. As with the home help and meals service, there is a considerable voluntary input to the administration of chiropody services for the elderly. Voluntary bodies providing chiropody include local social service councils, care of the aged committees and the Irish Countrywomen's Association.

6.51 We consider that there is a need for a more comprehensive chiropody service to treat foot disorders in the elderly. The routine care of feet in the elderly should be part of the normal functions of the home nursing and home help service. **We recommend that a chiropody service should be available in all areas to treat disorders of the feet in elderly persons on referral from the nurse or the general practitioner.** Depending on circumstances, the service may need to be provided by full-time chiropodists, chiropodists employed under part-time or sessional basis and private chiropodists treating patients under contract. **We recommend that a domiciliary service should be provided for those elderly patients who are immobile.** Referrals for chiropody service from general practitioners should be made through the area medical officer on the district team for the elderly.

6.52 A review group has been established by the Minister for Health to recommend an appropriate mechanism to assess the competence of practising chiropodists to provide services for public patients. Pending agreement on such a mechanism, where voluntary organisations provide a chiropody service on behalf of a health board, it should be agreed in advance with the health board the nature of the service to be provided and the qualifications of the chiropodist to be employed.

ALARM SYSTEMS

6.53 Almost one fifth of the elderly live alone. Over 60 percent of those living alone report a long term illness.[17] A significant proportion of elderly people living alone, especially in rural areas, have no one to care for them in an emergency. The vulnerability of elderly people living alone has been highlighted in surveys carried out by the National Council for the Aged, the St Vincent de Paul and the Dublin South Inner City Development Association.[18] Many elderly people living alone tend to feel isolated, to be fearful of their security and apprehensive about their welfare in the event of a medical emergency. The low density of population over much of the country and the scarcity of telephones among the elderly compound the problem of isolation.

6.54 New developments in communications technology have considerable potential for assisting in the care of the elderly at home. The potential of the new technology to assist the elderly was explored in a study commissioned by the Department of Health and carried out by the Social Science Research Centre at the National Institute of Higher Education, Limerick.[19] This study concluded that an alarm system, based on new radio and telephone technology and supported by a network of relatives, neighbours and statutory bodies, would greatly increase the quality of life of many elderly people, particularly those living alone with significant medical problems. The new systems permit an elderly person to call for assistance or reassurance when in difficulty and can enable many elderly people to remain at home who would otherwise require continual surveillance. With such a system, the telephone or radio unit in the elderly person's home is linked to an answering centre which responds to distress calls 24 hours a day. The answering centre can alert a relative, the general practitioner, the public health nurse or the ambulance depending on the circumstances. To be fully effective, the system must be integrated with the emergency services of health boards. An alarm system is now a normal feature of local authority and voluntary sheltered housing schemes for the elderly. Extending the system to dispersed elderly households in rural and urban areas poses a greater problem. The Minister

for Health has made funds available for a pilot project in Dublin's inner city to test the new technology in practice. We welcome this initiative. **We recommend that a pilot scheme to assess the potential of radio and telephone based alarm systems to assist the elderly be initiated in a rural area as soon as possible. We recommend that the long term goal should be to provide a telephone or radio based alarm to elderly persons living alone and assessed by the district team for the elderly as being at medical or social risk.** It must be emphasised, however, that the success of such alarms depends on a local network of family and relatives who will respond immediately to the alarm and on the co-operation of the emergency services of health boards.

CONCLUSION

6.55 We have dealt in this chapter with those health and welfare services which must be available on a domiciliary basis to maintain elderly people at home through illness or disability. These include medical care, nursing, home help/meals, family counselling, occupational therapy, speech therapy, laundry, chiropody and physiotherapy services and appliances, aids and alarms. In some cases a re-orientation of the services is required, particularly medical services. In the case of nursing, home help, physiotherapy, speech therapy, family counselling and chiropody, a considerable expansion of existing services is required. The expansion of these services will cost money and we attempt to cost our proposals in the final chapter. However, we believe that the redeployment of resources towards developing domiciliary services makes sense both in terms of quality of care to the elderly and in reducing demand on expensive acute and long-stay hospital services. We would like to emphasise the need for flexibility in the delivery of services to elderly people in their homes. No two elderly persons will require the same level of support at home and the organisation of services in every area should be able to cope with individual need. It will be the task of the district team for the elderly and the Co-ordinator of Services for the Elderly to ensure that elderly people in need and their carers receive the right balance of support from statutory services to enable them to live in dignity at home.

NOTES TO CHAPTER 6—CARE AT HOME

1. National Economic and Social Council, *Health: The Implications of Demographic Change* (1985)

2. Department of Health, *Health the Wider Dimensions— Consultative Statement on Health Policy* (1986), p. 29.

3. *Ibid* p. 30.

4. *Report of the Working Party on the General Medical Service,* p.32

5. B.J. Whelan and R N Vaughan, *The Economic and Social Circumstances of the Elderly in Ireland,* ESRI, p.77

6. *Ibid,* p.78

7. National Council for the Aged. *The Caring Process: A Study of Carers in the Republic of Ireland* (to be published).

8. *Report of the Working Party on the General Medical Service op. cit* p.49

9. *Ibid.* p.32-33

10. J A Muir Gray 'Practising Prevention in Old Age' *British Medical Journal* Vol. 285, pp. 545-6.

11. E I Williams 'Anticipatory Care of the Elderly in General Practice' in *Recent Advances in Geriatric Medicine* ed. B. Isaacs, London, (1985)

12. *Ibid.*

13. *Report on the Workload of the Public Health Nursing Service,* 1975, p.31

14. Society of St Vincent de Paul *op. cit.* p.86

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Chapter 7

Care in the Community

7.1 Some services which assist the elderly and their carers can best be organised on a communal basis within districts or community care areas. Services which come within this category include transport, day care services, dental, aural and ophthalmic services and boarding-out.

TRANSPORT

7.2 The decline in mobility in later life increases the importance of efficient transport to the elderly in gaining access to essential services. The level of car ownership among elderly households is low so the elderly depend more than other age groups on public transport. All persons aged 66 years or over and their spouses are entitled to free travel on public transport. This concession to the elderly is the most generous in any EEC country and is of great benefit to active elderly people in areas with public transport. The annual Exchequer subvention of free travel for persons aged 66 or over amounted to over £22 million in 1987. Its value is limited by the absence of a regular public transport service over much of this country, the inaccessibility of buses to many elderly people and the need of dependent elderly for transport that fits in with their schedule.

7.3 The problems experienced by elderly persons gaining access to services, particularly in rural areas with little or no public transport, has received growing attention in recent years. A report published by the National Council for the Aged found that there is a significant problem of access to transport and services for elderly persons living in rural areas.[1] In some instances bus services in rural areas are infrequent and confined to a couple of days a week. The bus timetable may not correspond with the times of out-patient departments or day care services. The National Council for the Aged study found that 70 percent of the elderly in the survey had never used their free travel pass. The study highlighted the difficulties experienced by elderly people in the west of Ireland in attending out-patient departments or having prescriptions filled because of inadequate transport. A study of people attending out-patient clinics in Galway found that 45 percent of elderly attenders were spending IR£5 or more per trip.[2]

7.4 The situation could be improved. Better communication between hosptials and general practitioners could reduce the number of out-patient attendances at hospitals by elderly persons, particularly for follow-up visits. The possibility of holding outlying clinics by the hospital team should also be explored. There will, however, remain a need to provide a transport service for the elderly in rural areas. A Green Paper, **Transport Policy,** published in 1985 drew attention to 'the fundamental issue in the provision of the nation's transport services, particularly in rural areas, which is the minimum level of mobility which the State should provide for its citizens'.[3] It suggested that imaginative methods of providing public transport were needed to provide a service that was adequate, speedy, frequent and reliable. As the Council for the Aged study pointed out, different forms of transport funded by the public exist in even the most remote rural areas—the school transport network costing IR£23m in 1985, the postal bus, health board supply vans and a skeleton Bus Eireann service. We see no reason why, in the more sparsly populated areas, transport services should continue to be sectionalised by being exclusively related to a particular service. Given present economic circumstances it is an extravagence.

7.5 There is, however, nobody responsible for co-ordinating transport at regional or county level to ensure a cost effective service. In Britain, the county and borough councils are charged with this responsibility. A local body responsible for transport would permit a co-ordinated response to the problem of ensuring a minimum level of transport in rural areas and in particular, address the problem of mobility for elderly people. Some de-regulation of the inland transport market would encourage competitive tendering at local level for the subsidy towards the cost of free travel for the elderly which is paid automatically to CIE at present. Innovative measures such as a community bus scheme, run jointly by a voluntary and statutory body, and social car schemes in which volunteers make themselves available to drive elderly people to appointments could also be encouraged.

7.6 The Minister for Tourism and Transport has recently established an inter-departmental committee to review access by disabled persons to road and rail transport. The Committee has been asked to make recommendations for appropriate action, including new legislation, that may be necessary. **We recommend that the Departments of Tourism and Transport and the Environment examine ways in which transport in rural areas can be co-ordinated and how transport for the elderly can be improved. The law governing transport services and the use of subsidies should encourage greater flexibility in meeting the transport needs of the elderly in rural areas. Pending such changes, the Co-ordinator of Services for the Elderly should**

review transport resources in the community and encourage the transport services of statutory agencies and the resources of voluntary bodies to provide more adequate transport for elderly people in remote rural areas.

7.7 Greater attention needs to be given to improving the design of buses to make them more accessible to elderly people. High entry and exit steps are a particular problem. **We recommend that the Department of the Environment encourage greater attention to the design of public transport vehicles to ensure easier entry and exit for elderly people, to providing sufficient grab rails in the right places and to improved seating design.**

7.8 Even if access to transport by the elderly is improved through better co-ordination, more flexible use of public subsidies and innovative schemes, a specialised transport service may still be necessary to ensure that disabled elderly people are able to attend day care centres, day hospitals and out-patient appointments. The curtailment of health board transport services in recent years has jeopardised the development of day care and threatened the existence of some day centres. Families and volunteers can transport a large proportion of patients to day care but few domestic cars are suitable to carry severely disabled patients. We believe that the curtailment of health board transport services which facilitate access by elderly people to day centres and day hospitals is false economy. The cost savings of preventing unnecessary admissions to acute and long stay hospital beds alone justifies the provision of an adequate transport service. **We recommend that each health board ensure that adequate transport arrangements exist to give dependent elderly people access to day care, day hospitals, and out-patient departments.**

DAY CENTRES AND CLUBS

7.9 Day centres serve four main purposes:

— they provide a service such as a mid-day meal, a bath, physiotherapy, occupational therapy, chiropody, laundry and hair dressing;

— they promote social contact among the elderly and prevent loneliness;

— they relieve caring relatives, particularly those who have to go to work, of the responsibility of caring for elderly persons during the day;

— they provide social stimulation in a safe environment for elderly people with mild forms of dementia.

Day centres do not as a rule provide medical investigation or treatment. People attending a day centre are generally active but many require assistance in some activity of daily living, such as preparing food, bathing or washing clothes. Day centres are most easily organised where the density of population is greatest. The wider the catchment area of the day centre, the greater the importance of transport becomes to the success of the centre.

7.10 The development of day care centres in this country is relatively recent. They were recommended by the **Care of the Aged Report** and many were provided in the early 1970s. The term 'day care' covers a range of services. There is no legal obligation on health boards to provide day care services. Health boards may do so, directly or indirectly. The majority of day centres are operated by voluntary bodies with grants from health boards. There are no national figures for the numbers of elderly people attending day centres. The average number of persons attending a day care centre varies, but many appear to cater for approximately 25 clients a day.[4] Some centres charge small fees to cover some of their costs. A new feature is the opening of private day care facilities run on a commercial basis.

7.11 Day centres must meet certain criteria if they are to function effectively. They must open for an adequate number of hours on five days a week. The range of services provided at the centres should be available on a continuous basis. Day centres should be located in areas which have a high concentration of elderly people, and transport must be available.

7.12 A recent study of twenty eight day care centres in the Eastern Health Board came to the following conclusions about this form of care as currently organised:

— that day centre services have not achieved anything near their potential in assisting the elderly up to now;

— that day centre services remain at a minimum level, coverage is uneven and inequities exist in access to services, the services available and fees charged for attendance;

— that the absence of national guidelines on the operation of day care centres has adversly affected their operation;

— that many elderly people who would benefit from day care are unable to do so because they have no means of transport to the centre;

— that arrangements between health boards and voluntary bodies operating day centres have been ad-hoc, uncertain and unsatisfactory.

— that more development is needed of staff running day centres.[5]

We consider that, in addition to the above shortcomings, the absence of a statutory obligation on health boards to provide day services has inhibited the development of this form of care and made existing day centres vulnerable in times of financial constraints.

7.13 We consider that day centres provide an important service in the continuum of services necessary to support the elderly at home, to assist those caring for elderly relatives and to reduce unnecessary admission to institutional care. At a fraction of the cost of residential care, they offer a life line to many old people who live alone and are unable to look after themselves. They support relatives by sharing the task of caring for the elderly person for at least one day a week. Attendance at a day centre may make the difference between a family continuing to care for an elderly relative and seeking institutional care because the strain of caring is too great. The more comprehensive the service provided by a day centre, the less need there is for institutional care. The provision of day care facilities, in association with sheltered housing schemes, as provided in Beaufort, Dun Laoghaire and Marian Court, Clonmel is a particularly attractive option in maintaining the independence of elderly residents.

Day Care Centre, Clara, Co. Wicklow.

7.14 The cost of day centres varies but detailed information from one Dublin centre gives an idea of the expenses involved.[6] In 1984, the expenses of the centre amounted to £17,700 or less than the cost of the salaries of two full-time nurses. Half of the finances of the centre was raised through fund raising and the other half by way of a grant from the Eastern Health Board. The centre assisted 22 clients, few of whom could be considered agile or active. The average weekly cost per client was approximately IR£15, only half of which came from public funds. This figure compares extremely favourably with the much higher cost of long stay care, detailed in Appendix 2. It is significant that even in an urban area, over 46 percent of the centre's expenses arose from transport.

7.15 The purpose of clubs for the elderly is to provide a meeting place for elderly people, especially the isolated and lonely, where they can socialise with contemporaries. Meals or other services are not normally provided but tea may be served. Opening times can be flexible to suit the members. Most clubs are run by voluntary and especially by parish groups.

7.16 Day centres and clubs, by their nature, tend to be small and intimate serving a population within a narrow radius. In 1982, the Eastern Health Board estimated that it needed one day centre for every three parishes and one club for every parish.[7] The average population of a parish is 6,000 and assuming that 10 percent are over 65 years, the Eastern Health Board ratio would mean one day centre per 1,800 elderly persons and one club per 600 elderly. In 1982 the Eastern Health Board had 17 day centres and 34 clubs. By its own reckoning, about 25 additional day centres and 121 clubs are required in Dublin, Wicklow and Kildare. The North-Western and Midland Health Boards, which serve less densely populated areas, aim to provide day care centres in the main towns each serving a catchment area of 15 miles. In this way, most elderly in need of day care are covered and transport is more manageable.

7.17 We recommend that the following steps be taken to develop day care services:

— **that each Co-ordinator of Services for the Elderly estimate the number of day care places needed for the elderly to be incorporated in the plan for the development of services for the elderly in that area;**

— **that the Department of Health prepare guidelines for the operation and management of day centres;**

— **that a model contract be drawn up by the Department of Health for use by health boards and voluntary bodies where voluntary organisations provide a day service on behalf of a health board;**

— **that health boards be obliged by law to provide or support day care centres for the elderly, including transport to and from such centres;**

— **that day centres be provided as a normal part of sheltered housing complexes;**

— **that where charges are made for services, they should not be so high as to discourage elderly people on low incomes from attending the centre;**

— **that health boards provide opportunities for staff working for voluntary organisations providing day care services to develop their expertise.**

DENTAL HEALTH

7.18 There is no comprehensive information about the dental health of the elderly in Ireland. The information that is available suggests that the degree of edentulousness—teeth loss—among elderly people in Ireland is similar to that in other countries. About 72 percent of the elderly have no natural teeth.[8] Where we differ from other countries is in the proportion of edentulous elderly people without dentures. Surveys of elderly people in institutions in this country found that a much lower proportion of edentulous patients had dentures than comparable populations in other countries.[9] A study of nutrition among isolated elderly people in West Galway found that 40 percent had no teeth or dentures.[10] The absence of teeth is a contributory factor to malnutrition in the elderly and can cause considerable discomfort.

7.19 Elderly persons with medical cards are entitled to dental treatment, including the supply of dentures, without charge under section 67 of the Health Act, 1970. Despite this statutory entitlement, a dental service for the elderly in the community is not available at present because of shortage of funds. The public dental service of health boards is almost totally concerned with the dental care of children. While the dental health of children is understandably the priority at a time of financial scarcity, it is a matter of great concern that no service exists for the elderly despite their statutory entitlement. We welcome the recent establishment by the Minister for Health of a working group to report on ways in which the dental service should be improved.

7.20 The main issue in dental care for the present generation of elderly is the provision of dentures. The cost of fitting a set of dentures privately is high, about IR£500. This figure is beyond what elderly people dependent on state pensions can afford. Dentures could be supplied by dental technicians at a cost of IR£140 a set. Under the Dentists Act, 1985 the Dental Council is empowered to make schemes for establising classes of auxiliary dental workers, including dental technicians, who would fit and supply dentures. To date it has not done so. **We recommend that, in the interest of providing dentures to elderly people on low incomes, the Dental Council introduce a scheme to permit dental technicians to fit dentures.** Elderly people may be willing to pay a contribution towards the cost of dentures but health boards are precluded by section 67 of the Health act, 1970 from making any charges. ***We recommend that in the interest of providing elderly people with dentures, section 67 of the Act be amended to allow health boards make charges up to half the cost of fitting and supplying dentures.***

7.21 The dental profile of those reaching old age in the coming decades will change dramatically. Most elderly people in future will have their own teeth. The maintenance of healthy teeth and gums will be the main challenge. If a dental service is not available to elderly people who cannot afford to pay privately, many elderly people will suffer unnecessary pain and hardship. The emphasis in a service for the elderly should be on preventing dental decay and gum disease. **We recommend that all elderly people be entitled to an annual dental check-up free of charge. Elderly people with medical cards should be offered treatment without charge for necessary dental care identified at the annual check-up. Health boards should also be able to contribute towards the cost of treatment. We also recommend that comprehensive information be collected on the dental health of the elderly and middle-aged as a basis on which to plan and cost services in the future.**

AURAL AND OPHTHALMIC SERVICES

7.22 The impairment of hearing can be a major handicap associated with ageing. A small number of elderly people have treatable causes of deafness and a larger number can benefit from a hearing aid. Under section 67 of the Health Act, 1970, health boards are obliged to make aural treatment and appliances available without charge to medical card holders and their dependents and to persons with Category II eligibility at a charge. An elderly person with hearing loss would normally be referred by their general practitioner to an ear, nose and throat specialist to exclude treatable causes of deafness and to assess their suitability for a hearing aid. The fitting of hearing aids in persons with medical cards is carried out on behalf of the health boards

by the National Rehabilitation Board which holds clinics throughout the country. The majority of referrals to the clinics are elderly persons. The main problem with the present service is the length of time people may have to wait for an appointment at a clinic. Waiting times can be as long as a year in some parts of the country. A further problem is the exclusion of those with Category II and Category III eligibility from the National Rehabilitation Board fitting service. **We recommend that the National Rehabilitation Board should reduce the waiting period for hearing aid clinics so that no elderly person has to wait longer than three months for an appointment. We recommend that the regulations governing the service be changed to permit the National Rehabilitation Board to provide a service to those with Category II and Category III eligibility at a charge.**

7.23 Failing eyesight is one of the most common causes of disability in the elderly. Visual impairment due to cataracts can be reversed through surgery and we consider how the present service can be improved in Chapter 8—Acute Hospital Care. Many other elderly people with deteriorating eyesight can be helped by spectacles. Health boards are obliged to provide ophthalmic treatment and appliances in the same way as aural treatment and appliances. Health boards provide sight testing services in two ways. First, through county ophthalmologists who work on a sessional basis and who provide sight testing services for children and the elderly. Second, through the sight testing scheme, first introduced in 1979, which permits eligible adults to attend an optician of their choice from a panel of opticians who have entered into a contract with the health board. In recent times, the sight testing scheme has been curtailed or suspended in a number of health boards. Where this has happened, priority has been given to the elderly by the county ophthalmologists. Spectacles are dispensed for persons found to need them by opticians in private practice who have entered into a contract with the board. The present service appears to be reasonably satisfactory but we would be concerned that the present economic constraints would adversely affect this essential service for the elderly. **We recommend that the present ophthalmic service be developed to meet the needs of the increasing population of elderly people. More information should be available locally to elderly people about coping with the disability of visual impairment through the use of better lighting, large print books and the lay-out of facilities at home.**

BOARDING-OUT

7.24 The placment of elderly people with persons willing to care for them when the elderly person can no longer live at home provides an attractive alternative to long-term care in an institution. Such placement or "boarding-out" of

elderly people has been adopted by a few health boards as an option in caring for the elderly. It is particularly suited to elderly people who can no longer live on their own but who do not need nursing care. Boarding-out is a form of welfare accommodation for the elderly which appears to work very well in some areas.

7.25 A survey carried out for the National Council for the Aged in 1984 found that 122 elderly persons were boarded out in eight schemes.[11] Although the details of each scheme vary, a common feature is that the health board makes arrangements with a private householder to care for one or more elderly people who can no longer manage at home but who do not require extended nursing care. Between 60 and 70 elderly people are boarded-out at any time in Mayo, representing a significant proportion of the elderly being cared for by the health board. All the current schemes are in rural areas or small towns. The schemes offer elderly persons an opportunity to remain in their locality with people they know and trust. Placement provides companionship as well as shelter, food and warmth. While boarding-out would normally be long-term, it can also be short-term where, for instance, the elderly person requires temporary supervision following discharge from hospital or as a respite arrangement for his or her family. Experience from existing schemes suggests that quite dependent elderly people can be boarded-out successfully.

7.26 In the Mayo scheme, the elderly person and the household are thoroughly assessed prior to placement. Householders must comply with guidelines laid down by the Western Health Board. The health board fire officer must be satisfied with the safety of the home. The householder must provide adequate food and accommodation for the elderly residents. He or she cannot enter into any private arrangements to board elderly people and there must be a responsible person in the house at all times. Each home is inspected every six months by a public health nurse. Householders are given a guarantee that if the placement breaks down or a crisis occurs, the health board will assume direct responsibility for the elderly person and transfer him or her to suitable accommodation. The health board pays IR£20 a week towards the cost of the placement and the elderly person pays a similar amount from his or her pension. A survey of fifteen elderly persons in boarding-out placements and of the same number in a welfare home, with similar levels of disability, found that the cost of maintaining an elderly person in a welfare home was nearly three times the cost of a boarding-out placement.[12]

7.27 The NCA report on boarding-out referred to above, argues that the potential of boarding-out to assist the elderly has not been fully explored. Existing schemes are the result of local initiatives rather than that of national

policy. The absence of a statutory authority for the boarding out of elderly people has inhibited the development of this form of caring. This has also given rise to problems of distinguishing, in legal terms, between a person prepared to care for an elderly person under a boarding-out arrangement and a person running a nursing home. In some cases health boards or local authorities insist that householders accepting elderly persons under boarding-out arrangements seek planning permission and comply with the stringent safety requirements for nursing homes. By contrast, families caring for elderly relatives at home and persons offering bed and breakfast accommodation in their homes, do not have to seek planning permission or comply with strict safety requirements. Giving health boards legal power to make boarding-out arrangements following assessment of the elderly person and the household, together with continuing supervision, would overcome this problem.

7.28 **We recommend much greater use of boarding-out in the care of frail elderly people who can no longer live at home.** Health boards have a distinguished record in placing children in foster care and the boarding-out of elderly people presents a challenge no different in kind. The rapid expansion of bed and breakfast accommodation throughout the country suggests that many householders are prepared to offer accommodation in their homes for reward. It might be possible to take advantage of this development by boarding-out elderly people during the winter and returning them to their homes during the summer.

7.29 **We recommend that:**

— **health boards be given statutory authority to board-out elderly persons under certain circumstances;**

— **the Department of Health prepare guidelines on boarding-out based on the experience of successful schemes to date;**

— **the Co-ordinator of Services for the Elderly in each area be responsible for developing boarding-out arrangements.**

NOTES TO CHAPTER 7—CARE IN THE COMMUNITY

1. National Council for the Aged, *Transport and Access to Services in Rural Areas,* (1986)

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3. Department of Tourism and Transport, *Transport Policy—A Green Paper* (1985).

4. National Council for the Aged, *Day Care Centres in the Eastern Health Board* (1987) p.39.

5. *Ibid.* pp, 105-8

6. *Ibid.* pp, 57-8

7. Eastern Health Board, *Geriatric Services in South Dublin, Kildare and Wicklow* (1982) p.106

8. Clarkson J and O'Mullane D. 'Edentulousness in the United Kingdom and Ireland'. *Community Dental and Oral Epidemiological Journal* (1983) 11. 317-320

9. J.P. Corridan 'The Dental State of the Elderly in County Homes and Cottage Hospitals in Cork'. *Journal of the Irish Dental Association* 1965, 11, 132-6 and J. Lemasney and E Murphy 'Survey of the dental health and denture status of institutionalised elderly patients in Ireland'. *Community Dental and Oral Epidemiological Journal* 1984 12, 39-42.

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11. National Council for the Aged, *Home from Home? Boarding Out of Elderly Persons in Ireland* (1985)

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Chapter 8

Care in General Hospitals

8.1 This chapter deals with the services needed by elderly people with acute illness who require admission to hospital. Even if the medical and nursing services available to elderly people in their homes are expanded and greater use is made of out-patient and day hospital attendance, the elderly will still require to be admitted to hospital more frequently than other age groups. The higher incidence of disease in the elderly and their slower recuperative powers account for their greater demands on hospital facilities. In this Chapter we look at the admission of elderly patients to general hospitals, and the role of departments of geriatric medicine in general hospitals.

THE ELDERLY AND GENERAL HOSPITALS

8.2 The elderly account for over 25 percent of admissions and over 40 percent of bed days in acute hospitals, although their number constitutes only 11 percent of the population.[1] (Fig. 8.1) Table 2.14 lists the most common conditions for which elderly people are admitted to acute hospitals. Diseases of the respiratory and digestive system are by far the most common conditions among the elderly treated in general hospitals, amounting to almost one quarter of all admissions of elderly people to hospital in 1985. The average duration of stay in acute hospitals rises with age (Fig. 8.2). For those aged 65 to 74 it is 13.4 days; for those aged 75 years and over, 17.6 days.[2] By comparison, the average stay for those aged 25 to 44 years is 5.6 days. The average duration of stay of all patients in acute hospitals has been falling as Fig. 8.3 illustrates. The average duration of stay of the elderly has fallen faster than that of younger age groups (Fig. 8.4). Hospitals with a department of geriatric medicine tend to have a shorter duration of stay for the elderly than other acute hospitals. The average duration of stay of elderly people under the care of the department of geriatric medicine in Cork Regional Hospital is only slightly longer than the average stay of patients of all ages in the other medical wards.

8.3 Elderly patients often experience difficulties in gaining admission to hospital when their medical condition justifies it. Despite the extensive

improvements in hospital services and the large increase in admissions to general hospitals in the past twenty years, elderly patients may not be given the same priority as younger age groups by those deciding who should be admitted to a hospital bed. Acute hospitals are geared to diagnose and treat short episodes of acute illness in patients who are otherwise healthy. They may be reluctant to admit elderly patients who tend to suffer from more than one disease, whose conditions are frequently chronic and whose recovery is slow. Elderly patients are frequently accused of "blocking" beds by acute hospital staff. Their reluctance to admit elderly patients may be rooted in previous experience of relatives refusing to accept the discharge of an elderly patient or of delayed discharge because of inadequate community care services. Only a minority of hospitals have a department of geriatric medicine whose purpose it is to ensure that the elderly receive high class medical care and rehabilitation.

8.4 The recent closure of many acute beds and growing pressure on existing beds has increased concern about the admission of elderly people to hospital. Admissions to general hospitals can be arbitrarily divided into "planned" admissions and "unplanned" admissions. The "planned" admissions are patients with non-acute conditions requiring investigation and treatment. "Unplanned" are emergency admissions and the elderly account for a high proportion of these patients. General hospitals are under pressure to admit the same numbers of "planned" admissions as before the reduction in the number of acute hospital beds which leaves less beds for acute emergency admissions, many of whom are elderly. There are often no beds in general hospitals for elderly patients requiring emergency admission. An acutely ill elderly patient may be redirected to district and geriatric hospitals and nursing homes which are not staffed or equipped to treat acute medical conditions.

8.5 In some cases, elderly patients may be inappropriately admitted to hospital. We have outlined in Chapter 6 some of the problems which arise because of unnecessary referrals to general hospital for in-patient and out-patient services and recommended ways of enhancing the capacity of general practitioners to care for patients.

8.6 There is insufficient liaison between the general hospital, general practitioners and community care personnel on the discharge of elderly patients from general hospitals. An elderly person may attend at the casualty department of a general hospital and be discharged home without his or her general practitioner or public health nurse being informed. An elderly person may be sent home unaccompanied without any attempt being made to establish whether the person can manage alone. The problem is more

common in urban areas where the casualty departments of hospitals traditionally have been used by local people as a substitute for general practitioner care.

8.7 Certain economic incentives may also be encouraging medical practitioners and hospitals to use different standards in deciding whether or not to admit elderly persons to hospital. Because of their financial situation, public hospitals have an incentive to increase their income from patients covered by the Voluntary Health Insurance Board. Similarly, consultants have a financial incentive to admit to hospital patients covered by the VHI. Among VHI members, those aged 65 years and over number only 82,300, or 6.8 percent of the total, a significantly smaller proportion than the elderly as a proportion of the total population. It would be disturbing if the effect of financial incentives for hospitals and doctors were different criteria of admission for public and VHI patients.

PROJECTED NEED

8.8 The expected increase in the elderly population will have significant implications for demand for acute hospital services. Based on patterns of usage in 1979, the National Economic and Social Council (NESC) has estimated that the number of acute hospital in-patient days accounted for by the elderly in 1991 will increase by 11.5 percent.[3] The increase in bed usage by those over 75 years is estimated to be of the order of 20.6 percent. In reaching these estimates, the NESC assumed that 1979 patterns of bed usage would continue. We consider that much of the current and expected need for acute hospital services could be met more appropriately by out-patient and day care and by more intensive home nursing. Whether as in- or out-patients, the elderly will continue to count for a substantial and growing share of the workload of general hospitals.

8.9 Attention must be given to how greater need among the elderly for acute hospital services can be met from scarce resources. The most successful approach to managing illness in the elderly is that of immediate intervention. With prompt diagnosis, treatment and rehabilitation, elderly patients can be discharged home relatively quickly. Where there is delay in admission, the complications which develop may be more serious than the original problem. The modern approach to illness in the elderly, however, demands close liaison between the general hospital and home-based services and the continuing support of the elderly person after discharge. It is increasingly clear that general hospitals and community services for the elderly must co-ordinate their services if the best interests of the elderly and the tax payer are to be served.

8.10 We consider that no elderly person should be denied admission to a general hospital solely on account of their age. Elderly patients requiring admission must be admitted promptly and treated appropriately with the aim of restoring them to independence as soon as possible. **We recommend that every general hospital develop a policy on the admission and discharge of elderly patients in consultation with the co-ordinators of services for the elderly in the catchment area of the hospital.** In particular, the policy should cover procedures for the admission and discharge of elderly persons on the "at risk" register of the district liaison nurse for the elderly. It should provide for the notification of the general practitioner and the district liaison nurse of the discharge of an elderly person 24 hours in advance. On discharge, the hospital, the general practitioner and the district liaison nurse should have agreed on the necessary follow-up procedures.

8.11 In recommending how communication can be improved regarding the admission and discharge of elderly people, we distinguish between city and other general hospitals. **We recommend that in city hospitals, a member of the staff of the hospital with sufficient authority be responsible for liaising with departments of the hospital, general practitioners and district liaison nurses to arrange support for vulnerable elderly people on discharge. Where there is a department of geriatric medicine in the hospital, the hospital liaison officer should be a member of that department.** In hospitals outside the cities, **we recommend that the ward sister responsible for the patient notify the district liaison nurse in the elderly person's area to arrange for his or her discharge home or to the community hospital. The district liaison nurse would be responsible for mobilising the support of the members of the district team for the elderly to ensure that the elderly person is appropriately cared for on discharge.**

8.12 **To deal with the specific problems of elderly people in accident and emergency departments in city hospitals, we recommend that the hospital liaison officer be responsible for informing general practitioner and district liaison nurses about elderly patients discharged from the accident and emergency department of the hospital. Elderly persons seen in accident and emergency departments in the night-time should not be discharged at night unless they are accompanied by a relative or friend.** Preferably, such patients should remain in an overnight or observation ward. Before discharging an elderly patient who lives alone, the medical staff of an accident and emergency department should have satisfied themselves that the person can walk and perform safely tasks vital for daily living. If the elderly person cannot perform such tasks but his or her medical condition does not justify

admission to the hospital, the hospital liaison officer should inform the district liaison nurse so that support can be provided in the elderly person's home. The staff of the accident and emergency department should ensure that the elderly person has an acceptable form of transport home. In hospitals outside the cities, an arrangement similar to that recommended for co-ordinating discharges generally should ensure that there is adequate support for elderly patients discharged from the accident and emergency department.

Poor living conditions in the West of Ireland

8.13 Diagnostic and therapeutic advances in medicine are making it possible to treat an increasing proportion of people on a day basis. The day hospital (discussed below) is becoming a more common feature of departments of geriatric medicine. The day hospital for the elderly makes it possible to diagnose and treat more surgical and medical conditions in the elderly without overnight admission to hospital. Treatment on a day basis is of particular value to the elderly as it minimises the disruption to their home lives. At

present many hospitals are restricted in their capacity to expand their day care facilities because of lack of space or inadequate facilities. A shortage of capital funds is a major limiting factor in achieving what may be one of the most cost effective developments in hospital medicine in many decades. **We recommend that capital funds be made available to hospitals to expand their day care facilities to be off-set, if necessary, by subsequent savings on in-patient care.** As with discharges from an overnight bed or the accident and emergency department, the hospital liaison officer in city hospitals and the ward sister in other hospitals should be responsible for ensuring that the general practitioner and the district liaison nurse are alerted to the discharge of vulnerable elderly patients following day treatment.

8.14 As well as day care, hospitals are making greater use of 'five day' wards. A five day ward is open from Monday to Friday evening and closes for the weekend. Its success rests on the assumption that all patients will be discharged by Friday evening. While the treatment of some conditions in the elderly can be dealt with within the constraints of a five day ward, in many cases it is not possible to be certain that elderly patients will be fit for discharge by the fifth day of their stay in hospital. For this reason we do not consider the five day ward to have as much value to the treatment of the elderly as to younger age groups.

DEPARTMENTS OF GERIATRIC MEDICINE

8.15 The facility which we see as of most value to the care of the elderly in general hospitals is the department of geriatric medicine. The development of specialist geriatric departments in general hospitals has been one of the most significant advances in the care of the elderly in recent decades. The geriatric department ensures prompt admission of elderly patients to hospital, specialist diagnosis and treatment, skilled nursing and rehabilitation and, in many cases, continuing support in a day hospital on discharge. Geriatric departments tend to encourage close liaison between domiciliary, community and extended care facilities in the interest of a comprehensive response to the problems of vulnerable elderly people.

8.16 The operation of the department of geriatric medicine at St James's Hospital, Dublin illustrates the role of such departments in the care of the elderly.[4] The department serves a catchment area which is geographically compact and densely populated. A high proportion of the elderly population in the catchment area are on low incomes and live in poor housing. When a general practitioner refers a patient for assessment by the specialist team, he or she contacts the department's visiting nurse who immediately goes

to see the patient. Depending on the circumstances, the nurse arranges for early admission or attendance at the out-patient clinic. All patients scheduled for out-patient attendance are seen by the consultant within seven days of referral. During her visit, the visiting nurse takes blood samples from the patient so that the consultant will have the results before seeing the patient at the out-patient clinic.

8.17 If admitted to the department, the elderly patient's medical condition will be assessed by the physician in geriatric medicine and a treatment programme involving the close co-operation of nursing, physiotherapy, occupational therapy, speech therapy and medical social work staff will be initiated. Of the 1,994 patients discharged from the department in 1985, 80 percent were discharged home. Only 4 percent of patients discharged home in 1984 were readmitted within one month of discharge. Discharges are co-ordinated by a nurse liaison sister who is a public health nurse attached to a community care team. The department is very dependent on the home help and public health nursing services to support elderly patients at home after discharge. The day hospital attached to the department provides continuing support for patients after discharge and enables patients to be discharged home earlier. In 1985 there were 5,272 attendances at the day hospital.

8.18 The effect of timely and appropriate intervention by the acute geriatric department has been a much higher patient throughput and a dramatic reduction in the need for long stay beds. Despite a reduction in long-stay beds at St James's from 530 to 345 between 1979 and 1985, the department increased its annual admissions from less than 600 to nearly 2,000 in the same period. Bed numbers were reduced to provide space for more efficient treatment and rehabilitation facilities.

8.19 Before the establishment of the department of geriatric medicine, elderly patients were admitted to long stay beds at St James's according to their position on a waiting list or by decision of a committee. Many were admitted inappropriately and others suffered great hardship at home while waiting. The reduction in the need for long-stay beds was achieved by prompt admission of those in need of acute care or rehabilitation and by tight control over long-stay facilities so that only those severely incapacitated were admitted.

8.20 The department of geriatric medicine at Cork Regional Hospital operates in a slightly different way. The hospital serves a catchment area which is 50 or 60 miles wide and includes the elderly living in Cork city and in

sparsely populated rural areas. Because of the size of the catchment area, a liaison nurse visits only a small proportion of patients. Most of the admissions to the department of geriatric medicine are direct from home, following discussion between the general practitioner and the consultant. The department of geriatric medicine in Cork has also had the effect of reducing dramatically the need for long-stay beds.

8.21 The geriatric departments in Cork Regional Hospital and in St James's Hospital treat a proportion of elderly patients only, typically those with a number of medical problems. Elderly patients with more straightforward medical or surgical problems are referred by their general practitioners to other specialists in the hospital. A significant proportion of the work of the physicians in geriatric medicine is to advise other specialists on the care of elderly patients throughout the hospital. Figure 8.5 illustrates the difference in the management of an elderly patient in the general medical department of the hospital compared with the management in the geriatric department.

8.22 Comhairle na nOspideal has identified the characteristics of patients properly occupying geriatric beds which, in general, distinguishes them from elderly patients in other beds in the general hospitals. These characteristics include:

(a) medical problems are usually multiple,

(b) physiological ageing is a complicating factor,

(c) residual disabilities are common,

(d) social and environmental factors are usually relevant,

(e) patients have serious emotional and psychological problems in relation to their role and status in the future,

(f) falling, incontinence and confusion are common presenting features.[5]

The Comhairle clearly envisages that in hospitals with geriatric departments, elderly patients with more straight forward problems will continue to be admitted to the care of other specialists.

8.23 Initial problems with the role and staffing of acute geriatric departments have gradually been resolved. The **Care of the Aged Committee** was not sure whether geriatric units should be under the direction of a general physician with an interest in the elderly or of a physician in geriatric medicine. In 1975 Comhairle na nOspideal recommended that responsibility for geriatric departments should be given to physicians in geriatric medicine on the grounds that the geriatric service required the full-time commitment of a whole-time specialist.

8.24 At the time of writing, there are ten general hospitals with acute geriatric departments under the direction of twelve physicians in geriatric medicine. Geriatric departments have been developed in hospitals in five of the eight health boards—the Eastern (3 departments, 6 physicians), the Mid-Western (1 department, 1 physician), the Southern (1 department, 2 physicians), the Western (2 departments, 2 physicians) and the North Western (1 department, 1 physician). In the South Eastern Health Board, a physician in geriatric medicine is employed in a part-time capacity as an area medical officer to co-ordinate specialist and extended care of the elderly in Waterford. This arrangement appears to work well but arose out of circumstances particular to that county. Comhairle na nOspideal has approved a further three posts which have not been filled because the posts as advertised have been inadequately structured and because of a lack of funding. It is significant that Northern Ireland, with a population of less than one third of the Republic's, has a complement of 18 physicians in geriatric medicine.

8.25 Comhairle na nOspideal has recommended that the minimum viable catchment population justifying the appointment of a physician in geriatric medicine should be 80,000.[6] Based on that population norm, a viable geriatric department can be justified in only half of the 23 general hospitals outside Dublin, Cork and Galway. As Sligo and Castlebar General and Limerick Regional Hospitals already have geriatric departments, a case can be made for 9 additional geriatric departments in general hospitals. In addition, it can be argued that an additional two departments are needed in the Dublin area—at the Mater and in the hospitals which will form the nucleus of the new Tallaght Hospital—to cope with the dramatic rise in the number of the elderly in the next two decades. An expanded department should also be developed at Beaumont Hospital.

8.26 We consider that there is a need for a further 11 specialist geriatric departments and for the expansion of some existing departments in general hospitals. The facilities for these departments need not be additional to those existing in general hospitals. The patients treated by physicians in geriatric medicine are not 'new' patients to the health services. They are a group of patients who were previously treated by general physicians. We consider that there are sound medical and economic reasons for the redeployment of resources for specialist geriatric departments in acute hospitals in recognition of the medical needs of an increasingly elderly population. The facilities required by a physician in geriatric medicine are relatively inexpensive—a small number of acute beds, a small team of junior doctors, nurses and therapeutic staff, facilities for out-patients and a day hospital and access to rehabilitation and extended care beds. The experience of the existing

specialist geriatric departments shows that they restore the overwhelming majority of patients to independent living quickly, reduce admissions to long stay beds and reduce pressure on other acute hospital beds. For these reasons, the geriatric department is cost effective by ensuring the most efficient use of scarce resources. **We recommend that additional geriatric departments be provided as a matter of urgency, priority being given to the establishment of departments in the three health boards which currently have no specialist geriatric departments—the Midland, the North Eastern and the South Eastern. In Dublin, geriatric departments are recommended at the Mater and in the hospitals which form the nucleus of the new Tallaght Hospital and an expanded department should be developed at Beaumont Hospital. We recommend that the units be called "specialist geriatric departments" to distinguish them from the assessment unit in the community hospitals which we propose later.**

BED NUMBERS

8.27 The physician in geriatric medicine requires beds to assess and rehabilitate elderly patients. The precise number of assessment and rehabilitation beds required to serve a particular population has been estimated differently by different bodies. The Care of the Aged Committee recommended a ratio of 4.5 beds per 1,000 population aged 65 years or over for assessment and rehabilitation, giving a total of 1,720 beds on 1986 population figures.[7] The Committee recommended that 20 to 25 percent of the total should be reserved for assessment in general hospitals. The ratios used by the Department of Health in the 1970s were 0.1 to 0.15 beds per 1,000 population for assessment in general hospitals and 0.4 per 1,000 population, for rehabilitation, giving a figure of 1,700 to 1,950 beds. The ratio recommended by the Irish Society of Geriatric Physicians is somewhat higher than the other two at 2.5 beds per 1,000 persons aged 65 or over for assessment in general hospitals and 3 beds per 1,000 elderly persons for rehabilitation.[8] This would give a total of 950 beds for assessment and 1,150 for rehabilitation, a total of 2,100 beds. While the Society's ratios are higher than those used by the Department, the ratio they recommend for extended care beds, at 10 per 1,000 elderly, is only half that used by the Department up to now.

8.28 We consider the need for extended care beds in Chapter 9 in more detail. We would emphasise at this point, however, that norms for assessment, rehabilitation and extended care cannot be looked at in isolation from each other or from the resources available to care for the elderly at home. A deficiency in one of these services will cause problems for the other services.

In the care of the elderly, community, acute hospital and extended care services are interdependent and bed or other norms for service development reflect this interdependency.

8.29 Because the norms for assessment and rehabilitation proposed by the Society of Geriatric Physicians are based on the experience of well functioning geriatric departments in this country and show what can be achieved through good co-ordination of services for the elderly, we accept the norms for assessment and rehabilitation they propose. **We recommend that, a norm of 2.5 beds per 1,000 elderly persons in geriatric departments in general hospitals and a norm of 3.0 beds per 1,000 elderly persons for rehabilitation beds be adopted for planning purposes.** These norms should be seen in the context of the other norms we recommend for services for the elderly as set out in Appendix 5.

8.30 The actual number of acute assessment and rehabilitation beds under the direction of consultants in geriatric medicine, at about 500, falls well below even the lowest bed ratio referred to above.[9] Even when the 165 day hospital places are included, the number of available beds or places falls well below recommended standards. The allocation of beds for geriatric assessment and rehabilitation is clearly linked to the appointment of sufficient physicians in geriatric medicine. Comhairle na nOspideal has estimated that a minimum of twenty beds is necessary for a viable geriatric department.[10] The adequate provision of hospital beds nationally should allow beds to be re-allocated to the assessment and rehabilitation of the elderly without increasing the overall number of beds. The experience of those hospitals with geriatric departments is that they make a major contribution to the increased efficiency of the hospitals by ensuring that elderly patients are admitted promptly and discharged appropriately. **We recommend the re-allocation of beds and facilities in general hospitals for assessment and rehabilitation of the elderly in tandem with the appointment of additional physicians in geriatric medicine.**

8.31 Ideally, all assessment and rehabilitation beds would be on the campus of the general hospital for the convenience of patients and staff. However, this is seldom possible and most rehabilitation beds are in separate institutions, usually long-stay geriatric hospitals. The Comhairle has pointed to the difficulty which may arise as a result of the separation of acute assessment and rehabilitation facilities. It has recommended the closest possible contact between the two facilities, including the rotation of junior medical, nursing and supporting staff between the two locations and regular visits by other consultants from the general hospital to advise on particular patients. **We endorse these recommendations of Comhairle na nOspideal for greater integration of general hospital and rehabilitation facilities for the elderly.**

DAY HOSPITALS

8.32 A day hospital is a way of providing for the investigation, treatment and rehabilitation of elderly patients without an overnight stay in hospital. The day hospital may be attached to the geriatric department of the general hospital where the full range of general hospital services are provided, or it may be attached to a long-stay hospital with more limited facilities. In particular, day hospitals are of value for the assessment and rehabilitation of patients who are being considered for various forms of residential care and for the continuity of care of patients at risk. The staff of day hospitals in a general hospital are able to contribute to the rehabilitation of the hospital in-patients. Good transport arrangements are essential to the success of a day hospital.

8.33 The development of day hospitals in this country has been slow. In early 1988, there were 6 day hospitals associated with geriatric departments—at St James's, Sligo General, James Connolly Memorial, St Finbarr's, St Mary's Hospital, Phoenix Park and the Royal Hospital, Donnybrook. The Irish Society of Physicians in Geriatric Medicine has recommended a norm of two day hospital places per 1,000 population aged 65 years and over, a figure endorsed by a report on geriatric services in the Eastern Health Board in 1982.[11]. The application of this ratio would give a national figure of 740 places, compared with approximately 200 at present. **We recommend that every hospital with or associated with a specialist geriatric department provide a day hospital to facilitate diagnosis, treatment and rehabilitation of elderly patients and that transport to and from the day hospital be provided.**

8.34 Where a day hospital serves a large area, the establishment of satellite day hospitals avoids the problem of long journeys by bus or ambulance for elderly patients. A novel approach to bringing the benefits of a day hospital to the elderly in areas distant from a general hospital is being tried in the Eastern Health Board. The Board has introduced a mobile day hospital to serve the elderly in North County Dublin and parts of County Kildare. A large touring coach has been converted as a day hospital providing accommodation for elderly patients and medical, nursing and paramedical staff. The coach visits a number of health centres, liaising closely with general practitioners and public health nurses. The day hospital team is led by a registrar in geriatric medicine. Consultant physicians in geriatric medicine from St James's and St Laurence's hospital travel in the mobile day hospital once a month to assess new referrals and review certain patients. The project will be evaluated to assess its impact and suitability for other areas. We welcome this initiative and hope it will provide a useful model for the development of a similar

service in other areas. **We recommend that health boards explore different ways of bringing the benefits of day hospitals to elderly patients remote from general hospitals.**

8.35 The success of day hospitals relies heavily on the efficient transport of elderly patients. We have referred to the need to improve transport for the elderly in Chapter 7. We must emphasise again that without transport, many services for the elderly will be of little value. **We recommend that the health board plans for the development of services for the elderly pay close attention to ways in which a more efficient transport service for the elderly can be encouraged.**

SPECIAL HOSPITAL NEEDS OF THE ELDERLY

Joint Replacement

8.36 Developments in orthopaedic surgery have revolutionised the care of elderly people with damaged hip and knee joints in the past twenty five years. The replacement of damaged joints with sophisticated prostheses has greatly increased the quality of life of many elderly people. Before these operations became available, elderly people with hip and knee joints damaged by arthritis were often immobile and in constant pain. They needed help with many of the activities of daily living. Their enforced immobility undermined their mental health. The replacement of a damaged joint restores the mobility and activity of such elderly people and permits them to live independently of caring relatives or nursing staff. Looked at from the point of view of its impact on the lives of elderly people, joint replacement surgery is one of the most effective medical interventions available today.

8.37 Orthopaedic surgeons argue that no patient is too old to be denied the relief of pain and improvement in mobility that may be expected to follow joint replacement surgery.[12] It is important that once an elderly person can no longer manage a normal life with the damaged joint he or she be operated on as soon as possible. Otherwise, the elderly person may develop pressure sores and find rehabilitation to normal living increasingly difficult.

8.38 The replacement of damaged joints is usually known as 'elective' surgery. In other words, the patient's life is seldom put in danger by the scheduling of the operation for some date in the future, although the patient may be in considerable discomfort. The operation usually takes place in specialised hospitals, not in general hospitals. The elective nature of the

operation and the fact that it usually takes place in specialist hospitals, have made joint replacements susceptible to cut-backs in the current effort to control spending on health services. The number of joint replacement operations which took place in 1987 was considerably lower than in 1986. The number of joint replacement operations at Cappagh Hospital, the largest elective orthopaedic hospital in the country, fell from 623 in 1986 to 432 in 1987. In the Southern Health Board, no joint replacement operations were carried out between September and January 1988 on public patients because the supply of prostheses had been exhausted. Waiting lists have lengthened and the discomfort and dependency of elderly people waiting for operations have greatly increased. We would be concerned that in a situation where decisions must be taken on priorities for joint replacement, the elderly might be seen as in lesser need than younger age groups. The elderly who are most vulnerable are those on low incomes as the operation is available privately for those who can pay or who have VHI cover.

8.39 We consider that the reduction in the number of joint replacement operations is short sighted and a most inefficient use of resources in the health services. The cost of the prostheses and fittings for a hip replacement operation is IR£500. An elderly person who is immobilised by an arthritic hip and who is unable to have an operation will quickly consume the same amount of money at home in drug prescriptions and may become institutionalised prematurely. A large investment has been made in orthopaedic facilities and in medical and nursing staff but that investment is not being used to its optimum capacity. There are significant variations from health board to health board in the number of joint replacement operations per 1,000 elderly population and in waiting times.

8.40 **We recommend that the Department of Health undertake a review of the present organisation of elective orthopaedic surgery and joint replacement surgery in particular, to ensure that elderly people have access to a service of high quality,that they receive the same priority as younger age groups, and that the service expands to cope with the increasing numbers of elderly people.**

Cataract Removal

8.41 Similar advances in ophthalmic surgery have transformed the treatment of certain eye conditions in the elderly. The impairment of eyesight in old age, is a major cause of immobility and dependency. The removal of cataracts by micro-surgery is one of the most effective ways of improving the sight of elderly people. The number of cataract operations on the elderly had

been increasing in recent years but the effect of the recent cut-backs has been to reduce the service offered. For the same reasons as joint replacement, we consider cataract operations to be cost effective and a service which should be expanded. **We recommend that the Department of Health review present arrangements for cataract surgery in the elderly to ensure that those requiring treatment receive it in reasonable time and that the service is expanded to deal with increasing numbers of elderly people.**

NOTES TO CHAPTER 8—CARE IN GENERAL HOSPITALS

1. Hospital In-patient Inquiry, Department of Health.
2. *Ibid.*
3. National Economic and Social Council *Health—The Implications of Demographic Change,* (1983)
4. Dr J Bernard Walsh, 'Coping with a rapidly, increasing elderly population—St James's Experience, Dublin (1986)
5. Comhairle na nOspideal, *Long-term Institutional Care— The Medical Aspects—A Discussion Document* (1985) p. 12
6. *Ibid.* p.13
7. *The Care of the Aged op. cit.* p.88
8. Irish Society of Physicians in Geriatric Medicine, *Hospital and Residential Care of the Elderly,* (1987).
9. National Council for the Aged—*Institutional Care of the Elderly in Ireland* (1985) pp. 36-7
10. Dr. M. Hyland, 'Future of Health Services for the Elderly', paper read at a Conference 'Health—The Wider Dimensions', Beaumont Hospital, October 1987.
11. Eastern Health Board *op. cit.* p.35
12. R.E. Irvine 'A Geriatric Orthopaedic Unit' in Davis Coakley, ed. *Establishing A Geriatric Service,* London (1982), p.168.

Chapter 9

The Community Hospital

9.1 In this Chapter we are concerned with the needs of elderly people who have become so dependent that they require a level of care which domiciliary and day services cannot provide. In this context we consider how to make the best use of the facilities currently providing extended care for the elderly.

EXTENDED CARE FACILITIES

9.2 The admission of elderly persons to institutional care at the first sign of dependency continues to be a common occurrence. A number of factors has contributed to this trend. A legacy of buildings from the days of the poor law, a scattered rural population and heavy migration of those in the most active age groups have encouraged reliance on institutions as the first option in caring for dependent elderly people. In recent times, elderly people and their relatives with financial means have increasingly chosen to use private nursing homes when dependency arises.

9.3 Extended care of the elderly is provided in a variety of settings—in health board geriatric hospitals and homes, district hospitals and welfare homes, voluntary hospitals, and in nursing homes run by voluntary bodies or privately as business concerns. These institutions provided 16,500 beds approximately in 1984, all but a small proportion of which were occupied by elderly persons. Table 9.1 gives a breakdown of the number of beds and the category of institution and compares the figures for 1980 with those for 1985. The comparison between 1980 and 1985 shows a decrease in the number of beds in health board hospitals and homes, an increase in beds in welfare homes and a dramatic rise in the number of voluntary and private nursing home beds. In 1980, for every 2.2 beds in a health board institution, there was one bed in a voluntary or private nursing home. By 1985, the ratio had fallen to 1.6 health board beds to one voluntary or private bed.

9.4 The main reason for the admission of elderly people to extended care (excluding psychiatric hospitals) is chronic illness. (Table 9.2) Two-thirds of patients in health board geriatric hospitals and homes and over one-third of

those in private nursing homes were so described in 1985. A significantly high proportion of elderly patients in health board long-stay beds (18 percent) and private nursing homes (36 percent) were there for social reasons. In a study of one geriatric hospital it was found that 37 percent of patients were fully capable of managing their own self care needs and that 35 percent of the study population were living alone prior to admission.[1]

9.5 Interesting gender differences emerge between the patients resident in health board and private institutions. (Table 9.3) There is a much higher proportion of males and a smaller proportion of females in health board institutions than in private homes. The age profile of the elderly in health board institutions is younger than that in private homes. (Table 9.4) The residents of all long-stay hospitals and homes are ageing. Sixty percent of patients in health board institutions and 76 percent of those in private nursing homes are aged 75 years or over. Admissions to health board institutions originate almost equally between the community and the acute hospital. (Table 9.5) Admissions to nursing homes however are more likely to come from the community than from acute hospitals. A significant proportion of patients in health board geriatric hospitals and private homes are discharged home. Almost as many elderly people return home as die in long-stay care. (Table 9.6) Discharges to the community increased from 29 percent in 1980 to 37.8 percent in 1985. More than half the patients in health board geriatric hospitals and homes and in private nursing homes were discharged less than 6 months after admission. Sixteen percent of patients in health board institutions were there longer than 2 years. (Table 9.7)

9.6 The profile of elderly patients in long-stay care which emerges from the information available is a mixed one. The majority are chronically ill but a significant proportion are in care for social reasons. Living alone appears to be an important factor in decisions to admit elderly people to long-term care. The proportion of elderly patients discharged home is growing, reflecting both increased pressure for places and greater activity in some geriatric hospitals. A majority will be discharged or die within six months of admission. A significant proportion remain in care for more than two years.

9.7 Although there has been a significant reduction in the size of many health board geriatric hospitals since 1980, many remain very large, as Table 9.8 shows. The largest hospital has 457 beds, with the majority in the range from 100 to 299 beds. By contrast, 25 of the 32 long-stay district hospitals have no more than 45 beds for the elderly. Many of the health board geriatric hospitals date back to the 1830s and 1840s, although some of the largest were built in the 1950s and 1960s. The size of the hospitals reflects the policy

in the early years of the State to concentrate the old and destitute into single "county homes", a policy which continued until the late 1960s. Although much has been done in recent years to improve the accommodation in the hospitals, they are far from ideal places in which to care for the elderly for extended periods. The accommodation in district hospitals is better because they are smaller and more recently built. The majority of nursing homes have less than 100 beds but few are in purpose built accommodation.[2]

9.8 There is great variation in the number of long-stay geriatric beds per 1,000 elderly from one health board to another. The number of beds, excluding psychiatric beds, providing extended care for the elderly ranges from 34.2 beds per 1,000 elderly people in the Western Health Board to 62.1 beds in the Mid-Western Health Board. The planning norm for rehabilitation, long-stay and welfare beds used by the Department of Health in the 1970s estimated that 33.5 beds per thousand elderly population would be adequate to meet this need. As this figure is considerably below the actual national provision of 44.9 beds per thousand population, it would appear that there is considerable overprovision of extended care beds. The impression of overprovision is confirmed by the fact that those health boards with lower bed ratios appear to be coping as well, if not better, than those boards with higher ratios.[3] Waiting lists for admission to extended care places are, for example, less common in those areas with lower bed ratios than in those areas with high ratios.

9.9 The association of waiting lists with large numbers of extended care beds suggests that the critical point is not the number of beds for the extended care of the elderly but the use made of the beds. One crude measure of the use of beds is to examine the number of discharges per bed per year. A high throughput suggests more active use of the beds than a lower throughput. Table 9.9 reveals significant differences between health boards in the number of persons discharged from long-stay beds in 1985. The figures range from .63 patients in the Eastern Health Board to 1.6 patients per bed in the South Eastern Health Board. Boards with the highest ratio of beds to population have among the lowest number of discharges per bed per year. The low figure for the Eastern Health Board may reflect the preponderance of private nursing homes in the region which, by and large, do not see their function as rehabilitating elderly people to return home as soon as possible. A further complicating factor is that while a health board may have a high ratio of beds to population, the beds may not be located where the need is greatest, making it difficult to return elderly people to independent living.

9.10 A comparison between existing beds and projected figures for the elderly population in each health board highlights the boards which will experience increasing pressure on beds in the years ahead. Table 9.10 shows that the greatest pressure will be felt on beds in the Eastern Health Board area. It cannot be assumed, however, that the provision of additional beds will, in itself, meet the needs of heavily dependent elderly persons.

9.11 The financing and staffing of extended care beds at present constitutes the largest share of resources spent on the care of the elderly. Estimated expenditure on services in health board long-stay geriatric hospitals and homes in 1986 was IR£59.287m. Expenditure on district hospitals, over half of which cater almost exclusively for the elderly, was IR£25.406m. In the same year, health boards contributed IR£14.5m towards the cost of the care of elderly patients in private and voluntary nursing homes.

ROLE OF EXTENDED CARE

9.12 The elderly may require rehabilitation, convalescent or terminal care following discharge from the general hospital. They may be admitted to such care direct from home when suffering from an illness that does not require admission to a general hospital. Extended care facilities can in addition play a vital role in supporting relatives caring for dependent elderly people at home by providing respite care while the family is on holidays, crisis admission due to a death or other event in the family and the regular admission of a dependent relative for a short period of time to a bed which is retained for this purpose. We use the term 'respite care' to cover a number of arrangements including planned admission of an elderly relative.

9.13 It is critical to the success of extended care facilities that before admission every elderly patient has been assessed as in need of these facilities by professional staff. In those parts of the country where assessment prior to admission to long-term care is routine and where emphasis is placed on rehabilitation, much more effective use is being made of the long-stay beds than in those areas where admission is still from waiting lists. Ideally, every elderly person requiring extended care should be assessed by the consultant in geriatric medicine and the members of his or her department. With the appointment of consultant geriatricians in the larger hospitals as we recommend, this ideal may be realised.

THE COMMUNITY HOSPITAL

9.14 At present geriatric hospitals and homes, most district hospitals and many welfare homes are providing extended care for the elderly. The National Council for the Aged has described these institutions as an 'under exploited

resource within the community'.[4] The Council has recommended that these institutions play a more effective role in the provision of services for the elderly by operating as 'community hospitals'. The community hospital would fulfill three roles towards the elderly. It would offer facilities to restore independence to elderly persons to allow them live independently at home. It would support caring relatives by providing respite care for dependent elderly people and it would provide sensitive and sympathetic continuing nursing and terminal care. Comhairle na nOspideal has also endorsed the idea of the community hospital providing a range of services for the elderly.[5] We agree with the recommendations of the National Council for the Aged and Comhairle na nOspideal. **We recommend that existing geriatric hospitals/homes, long-stay district hospitals and welfare homes, be developed as community hospitals, where appropriate, providing the following range of services for elderly persons and their carers in each district:**

- **assessment and rehabilitation of elderly patients,**
- **convalescent care,**
- **day hospital and/or day care services,**
- **respite care to support caring relatives,**
- **facilities for nursing highly dependent or terminally ill elderly patients who can no longer be cared for at home,**
- **information, advice and support for those caring for elderly persons at home.**

In larger urban areas, particularly in Dublin, the community hospitals may have to be purpose built.

Assessment and Rehabilitation

9.15 The assessment and rehabilitation of elderly patients takes place at different levels. We have already advocated more attention to prevention and case finding among the elderly by public health nurses and general practitioners. Specialist geriatric departments in general hospitals, even if provided in many more general hospitals, will treat a relatively small number of elderly patients, generally those with severe multiple pathology. There is a case for some form of intermediate assessment and rehabilitation between that which a doctor or nurse can do at home or in the surgery and that carried out with the sophisticated facilities of a general hospital. Comhairle na

nOspideal has commented that "in the ideal situation, there should be screening and assessment of patients in all institutions catering for the elderly—general hospitals, district hospitals, geriatric hospitals and psychiatric hospitals."[6] In those areas where specialist geriatric departments provide assessment in general hospitals, community hospitals may not need assessment units, or the consultant geriatrician could provide specialist cover for the assessment unit. They will, however, have to provide for the rehabilitation of elderly patients. We emphasise that assessment in community hospitals is not a substitute for assessment in a specialist geriatric department of a general hospital. It should not be used as a means of providing a lower level of medical care for the elderly simply because they are old.

9.16 **We were impressed by the assessment and rehabilitation being carried out in a number of geriatric hospitals and extended care units.** St Patrick's Hospital, Cashel, a geriatric hospital, was one of the first hospitals to develop an active approach to the care of the elderly. The assessment and rehabilitation unit was opened in 1979 following recommendations of a committee of the South Eastern Health Board to improve services for elderly people at home and to provide assessment of elderly people seeking long-term care. The unit at St Patrick's offers assessment, treatment and rehabilitation of patients referred by general practitioners or on discharge from general hospitals. The problems of the elderly are dealt with in a comprehensive way by a geriatric team. The team includes the medical officer of the hospital, an area medical officer, a public health nurse, the nursing and ancillary staff of the unit and a physiotherapist. No elderly patient is admitted to long-stay accommodation in the hospital without every effort being made by community care and hospital staff to discharge and maintain the elderly patient at home. The assessment and rehabilitation unit has 21 beds and provides day care facilities on two days a week. In 1986, 208 patients were admitted to the unit, more than half of them from home. On discharge, 63 percent returned home and 25 percent were admitted to long-stay beds at the hospital. Admissions to the acute unit have increased by 30 percent since it opened, with the proportion of patients discharged home increasing by 13 percent. The number of long-stay patients in St Patrick's Hospital has fallen from 307 in 1976 to 191 in 1986, largely as a result of the success of the acute unit. The unit is clearly playing an important role in restoring elderly people to independence and preventing long-term dependency.

9.17 A similar picture emerges from the assessment and rehabilitation units which have developed at St Vincent's Hospital, Athy and Baltinglass District Hospital, in close association with community care personnel and Naas County Hospital. In both cases, more than 50 percent of patients admitted

were discharged home in 1986. In Athy, it has been possible to reduce the number of long-stay beds from 310 to 254 and to convert others to provide respite and terminal care. There is no longer a waiting list for admission to long-stay beds at St Vincent's and the problem of "blocked" beds at Naas General Hospital has been resolved. The combination of the assessment unit and a comprehensive day centre at Baltinglass District Hospital has done away with the need for a waiting list for admission to long-stay beds in the hospital.

9.18 The unit at St Patrick's Hospital, Cashel operates without any formal specialist medical advice as there is no physician in geriatric medicine appointed in the area. The general hospital situation in South Tipperary is complicated by the location of the surgical hospital in Cashel and the medical hospital in Clonmel. When necessary, patients are referred from St Patrick's to either hospital for attention. In the case of Athy and Baltinglass, a physician who was a specialist in geriatric medicine attached to the County Hospital in Naas had an input to the operation of the units. The physician visited the units on a regular basis and ensured immediate admission of patients from the units to Naas County Hospital when necessary. It is clearly desirable that assessment units in settings other than general hospitals should have access to specialist advice, preferably that of a physician in geriatric medicine.

9.19 Comhairle na nOspideal has examined the role of the physician in geriatric medicine in relation to assessment units in hospitals outside the general hospital.[7] The Comhairle recommended that an overall assessment policy should be developed in each area with the guidance of the physicians in geriatric medicine. The Comhairle envisaged that, ideally the physicians in geriatric medicine should co-ordinate all assessment services, including the admission policy to apply in each institution. The physicians would accept patients on referral from the assessment unit or assess patients in the unit in consultation with the medical officer or general practitioner. We agree with the Comhairle on the role of physicians in geriatric medicine in relation to assessment units outside the general hospital. However, with so few physicians appointed, the question is largely an academic one at present. It would be a pity to delay the development of assessment units in long-stay hospitals while waiting for more physicians to be appointed. The experience of the units in Cashel, Athy and Baltinglass suggests that they can function effectively with the support of the physicians in the nearest hospital. The Irish Society of Physicians in Geriatric Medicine indicated to us their willingness as a body to advise on the establishment of assessment and rehabilitation units in community hospitals, and on the guidelines for the successful operation of such units.

9.20 **We recommend that health boards ensure that each community hospital provides assessment and rehabilitation facilities for the elderly in its district.** We do not see such units as substitutes for specialist geriatric departments in general hospitals, but as complementary to them. The units should be a major resource for the district liaison nurse and team for the elderly and should operate in close association with the specialist services of the nearest general hospital. The aim of the units should be to restore elderly people to independence as soon as possible. No elderly person should be admitted to a long-stay bed without an assessment by the specialist or district geriatric team. **We recommend that where possible, a physician in geriatric medicine should provide specialist advice to the assessment and rehabilitation unit of the community hospital by means of regular visits, seeing patients on referral from the unit to the general hospital, and by providing training opportunities for staff from the unit in the specialist geriatric department. In those areas where physicians in geriatric medicine have not been appointed, we recommend that the Society of Physicians in Geriatric Medicine be involved in an advisory capacity in the establishment of the unit and that the unit staff develop an arrangement with the physician attached to the main hospital in the area to provide specialist medical advice.**

9.21 We believe that an active approach to the assessment and rehabilitation of elderly people is a key to the success of the community hospital. Such an approach links the hospital closely with the domiciliary and community services for the elderly. Hospital and community staff share a common goal of returning the elderly person home wherever possible. It takes the pressure off the extended care beds and frees resources to provide respite and intermittent care for relatives caring for dependent elderly relatives. Elderly people who really need extended nursing care have no difficulty in gaining admission. Because of the emphasis on rehabilitation, staff find their work more rewarding and are more willing to consider new ways of helping the elderly. An active day hospital or day centre enables the hospital to reach a much greater number of elderly people and families.

Number of Beds

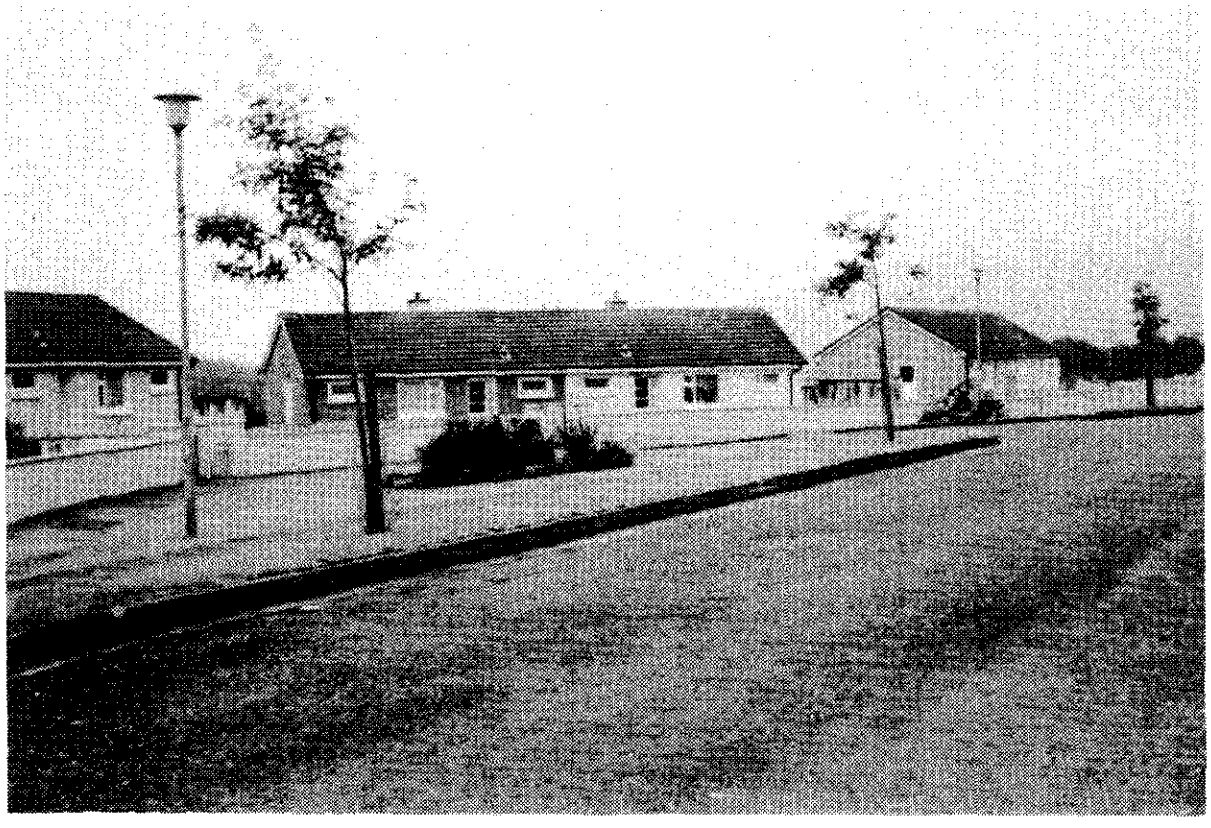
9.22 During the 1970s, the Department of Health used a planning norm of 20 beds for extended care and 3.5 for rehabilitation per 1,000 population aged 65 years or over. On that basis, about 7,650 beds are required for the extended care of the elderly and 1,350 for rehabilitation. More recent norms proposed by the Irish Society of Physicians in Geriatric Medicine suggest that a norm of 10 beds for extended care and 3 beds for rehabilitation per 1,000 elderly would be adequate, on the assumption of increased resources

for specialist geriatric departments in general hospitals.[8] The Society's norms suggest a need for 3,800 extended care beds and 1,150 beds for rehabilitation. These norms are based on what can be achieved in extended care facilities closely associated with a specialist geriatric department. The norm for rehabilitation includes beds in general and in community hospitals. We are inclined to accept the Society's norm for extended care beds, provided that it is applied in the context of their norm for specialist geriatric beds in general hospitals. (Appendix 5) We believe that assessment and respite care beds in the community hospital should be covered by the norm of 10 beds per thousand elderly as these beds are ways of dealing with demand for extended nursing care. **We recommend a tentative norm of 10 beds for extended care per 1,000 elderly, in the context of a norm of 2.5 beds per 1,000 elderly in the specialist department of geriatric medicine in the general hospital and 3 beds per 1,000 elderly for rehabilitation in general and community hospitals. We recommend that these norms be reviewed by the Department of Health to ensure their adequacy. Beds for assessment and respite care in community hospitals should be met from the norm of 10 beds per 1,000 elderly for extended care.**

9.23 Comhairle na nOspideal has described the large geriatric hospital as "inappropriate to the needs of the elderly (apart from patients who come from the immediate vicinity of the institution) and such institutions should, as soon as is possible, be replaced by smaller-scale, long-term accommodation related to the local community in which they are located".[9] We consider that the location and size of the future community hospitals will have an important influence on their success in achieving their objectives. The challenge is to strike a balance between efficient size and close identity with the elderly and their carers in a particular community.

9.24 The Comhairle has recommended that community hospitals should have no more than 50-60 beds and we consider that number to be more than adequate to provide each district team for the elderly with sufficient assessment, extended nursing, longer term rehabilitation, respite and intermittent care beds. An active day hospital could increase the catchment population to be served or reduce the number of beds required. We see no objection to the use of the community hospital to meet the needs of the heavily dependent and terminally ill younger patients provided the facilities they require are seen as additional to those required by the elderly in the district. **We recommend that each district team for the elderly have access to a community hospital providing a range of services for the elderly and with a maximum of 50-60 beds.**

9.25 Ideally, the community hospital/home would be purpose built to provide a higher standard of accommodation for the elderly. However, we cannot ignore the legacy of the large geriatric hospitals with extensive, if outdated, accommodation. It is unrealistic to recommend the immediate replacement of unsuitable hospitals with purpose-built community hospitals or homes. **We recommend, that those geriatric hospitals which become community hospitals should develop a range of support services for the elderly and their families in the districts they serve. This will involve the expansion of assessment, rehabilitation, day hospital/centre and respite facilities and the reduction of beds to a maximum of 50 to 60. Many long-stay district hospitals and welfare homes can be adapted relatively easily to the new role of community hospitals. In those areas where new accommodation for the elderly is required, such as in Dublin, it should be provided in purpose-built community hospitals for the elderly.**



Housing for the Elderly, Sneem, Co. Kerry

Administration of Community Hospitals

9.26 Our recommendations for the expansion of home and community based facilities for the elderly imply the blurring of the traditional distinction between "community" and "institutional" services for the elderly. The primary aim of all services for the elderly in a district will be the maintenance

of the elderly in dignity and independence at home. The extended care beds of the community hospital will be reserved for those elderly persons who have become so dependent that they can no longer be cared for at home. The success of the geriatric service in each district will depend on the common purpose of those providing services for the elderly and the smooth interaction of services provided in the home and community setting. The current arrangement whereby domiciliary and community services for the elderly are administered by one programme of health boards and institutional services by another make such integration difficult. Our recommendation for the appointment of a district liaison nurse with direct access to the community hospital, supported by a district team for the elderly and the Co-ordinator of Services for the Elderly where necessary, should overcome some of the existing management problems.

Staffing and Equipment

9.27 If community hospitals are to provide a comprehensive service for the elderly, they must be equipped or have access to X-ray, laboratory and rehabilitation facilities. In some cases, access to the X-ray and laboratory facilities of a nearby general hospital is all that is required. They will also need access on a regular basis to the expertise of physiotherapists, chiropodists, dentists and occupational therapists. **We recommend that community hospitals have access to necessary support facilities and professional expertise.**

9.28 Medical cover in geriatric hospitals has traditionally been provided by a medical officer who is usually a general practitioner in the area with a part-time commitment to the hospital. Comhairle na nOspideal recommends that all general practitioners practising in an area should be able to treat their patients in the community hospital. **We recommend that once an elderly patient has been accepted for extended, including respite, care in the community hospital, his or her own general practitioner should provide medical care while in hospital.** General practitioner access to patients admitted for assessment or rehabilitation is more problematical. **We recommend that medical direction of the assessment and rehabilitation unit of the community hospital should be the responsibility of one general practitioner with an interest in the elderly who would be appointed as part-time medical officer to the hospital. The medical officer of the community hospital would also be responsible for the implementation of the medical policy of the hospital generally. We recommend that appointment as medical officer to a community hospital should be for a period of five years and the post should be filled by open competition. We recommend that the consultant physician in geriatric medicine, where appointed, would**

provide specialist medical advice to the staff of the community hospital and assist in the monitoring of the agreed policies of a hospital in relation to admissions, discharges and standards of care.

9.29 A high quality of nursing care is of critical importance to the success of the community hospital in meeting the needs of the elderly. It may be difficult for some nursing staff used to a custodial approach to the care of the dependent elderly to adapt to a service in which the main aim is to support the elderly person at home. Nurses may need training in the latest rehabilitation techniques and in communication skills. **We recommend that a scheme of retraining for nursing staff be initiated in the proposed community hospitals, based in the specialist geriatric departments of general hospitals and in existing geriatric hospitals which have developed an active approach to the assessment and support of elderly people at home.**

WELFARE ACCOMMODATION

9.30 Even with improved home and community support, and an active rehabilitation programme, some elderly people will require a level of support which cannot be provided at home but are not in need of extended nursing care. The term 'welfare accommodation' is used to describe the kind of accommodation these elderly people need. The Care of the Aged Committee recommended that welfare homes be provided mainly to meet the needs of dependent elderly people "where relatives or other suitable persons are not available to provide them with the help they need in their own home".[10] The Welfare Home was intended to provide an alternative to admission to the county home. The Committee envisaged the welfare home as a major step away from the poor law mentality of an earlier generation.

9.31 Experience with welfare homes in this and other European countries has, however, raised doubts about their effectiveness in meeting the accommodation needs of the elderly.[11] This is partly because, in some cases, the residents became increasingly dependent with age and residents were reluctant to move to a more intensive setting. More fundamentally, the nature of the problem which the welfare homes were designed to meet has changed. In the 1960s, many frail elderly people in their sixties and seventies required substitute accommodation. Better health and increased mobility among the elderly, combined with the movement against institutionalising the elderly, has meant that the accommodation needs of these people has been met in other ways. Many welfare homes, particularly in the west, now provide extended nursing care for elderly patients. Some welfare homes have already been adapted to cater for heavily dependent patients and no further welfare homes on the traditional model are planned.

9.32 We consider that while there is continuing need for welfare accommodation, the need that the welfare home was designed to meet can be better met in other ways. Sheltered housing has proved particularly successful in supporting frail elderly people while protecting their independence. The provision of day care facilities in association with sheltered housing and the involvement of voluntary organisations is, in our view, one of the best ways of supporting elderly people with a limited to moderate degree of dependency. Boarding-out elderly people in households under the supervision of the health board provides a further option in providing welfare accommodation for the elderly. The provision of welfare accommodation in the multi-purpose homes for the elderly in Donegal is another way of meeting this need. There is scope for providing welfare accommodation in association with the community hospital we recommend. We recommend in Chapter 10 the provision of hostel accommodation for the elderly with dementia who can no longer live at home. **We recommend that the need for welfare accommodation for frail elderly persons be met in a flexible way in sheltered housing with support from day care and voluntary organisations, in boarding-out arrangements, in accommodation associated with the community hospital and in hostels for the elderly mentally infirm. We recommend a norm of 20-25 places per 1,000 elderly for this kind of welfare accommodation. We recommend that those welfare homes which provide extended nursing care be developed as community hospitals providing a range of services for the elderly.**

PRIVATE AND VOLUNTARY NURSING HOMES

9.33 The private and voluntary nursing home, offering extended care of dependent elderly persons, has a long tradition. To judge from the rapid increase in the number of private homes in recent years, there is a growing demand for the kind of care they provide. As the elderly population increases, demand seems certain to rise, even allowing for better community support for elderly people at home. We see no reason why this trend should be discouraged since those elderly persons wishing to provide privately for their latter years are entitled to do so.

9.34 Although not part of the State's provision for the elderly, private and voluntary nursing homes cannot be considered in isolation from publicly organised services. The State has a statutory responsibility to ensure a minimum standard of care in private nursing homes under the Health (Homes for Incapacitated Persons) Act, 1964 and subsequent regulations. Private and voluntary nursing homes are also in receipt of a considerable amount of public funds. Patients who are eligible for health board services may choose to avail

of the services of a home approved by the Minister and are entitled to a grant towards the cost of their care under Section 54 of the Health Act, 1970. Under section 26 of the Health Act, 1970 health boards may use beds in nursing homes as an alternative to providing accommodation themselves. In 1986, the amount of the subsidy paid by health boards to nursing homes was IR£15 million. We must also have regard to the nursing home sector as the extent to which people make private arrangements for their care in old age directly affects demand for publicly funded or subsidised care. It is on the basis of these considerations that we have looked at policy in regard to private and voluntary nursing homes. In doing so, we have not concerned ourselves with private retirement homes, as the service they provide is closer to that of a hotel than a nursing home.

9.35 Table 9.11 indicates that there are over 200 private nursing homes in the country with by far the greatest concentration in the Eastern Health Board region. Although 27.5 percent of elderly people live in the Eastern Health Board region, nursing homes in Dublin, Kildare and Wicklow account for nearly half of all patients in private nursing homes. The concentration of beds in the region reflects its higher per capita income relative to other regions and the relative under provision of health board beds for the elderly. Most of the homes are concentrated in South East Dublin and North Wicklow and many are in buildings which were former hotels or guest houses.

LEGAL CONTROLS

9.36 Under the Health (Homes for Incapacitated Persons) Act 1964, the Minister for Health may make regulations to govern the operation of nursing homes managed for profit. Nursing homes managed by voluntary bodies do not come within the scope of the legislation. The Act obliges any person who is setting up a nursing home for profit to notify the health board, in writing, at least one month before commencing operation.

9.37 The first set of regulations made under the Act were introduced in April, 1966. Dissatisfaction with the regulations led to the introduction of new regulations in 1985. In addition to laying down minimum standards for accommodation, food and care in the home, the new regulations have introduced stricter standards in relation to patient records, staff qualifications, fire safety and equipment. Health boards have the power to inspect the homes regularly. When the regulations were published, the Department of Health issued guidelines as an aid to health board staff who have responsibility for inspecting the homes. These guidelines recommend that in addition to medical and nursing care, patients have access to dental and ophthalmic care and

to chiropody and physiotherapy. They also recommend the minimum area per resident in bedrooms, day and dining areas and minimum requirements for sanitary facilities.

9.38 In enforcing the regulations, the policy of health boards has been to allow homes a period of time in which to raise the standards to that required by law. We are aware that considerable improvements in the standards of nursing homes have taken place as a result of the introduction of the new regulations. However, the legislation governing private nursing homes remains defective in a number of respects. At present, homes run for philanthropic purposes are excluded from the scope of nursing home legislation. **We recommend that the Health (Homes for Incapacitated Persons) Act 1964 be amended to include the operation of nursing homes run by voluntary bodies.** The requirement that homes notify the health board one month in advance of opening should be replaced by an obligation on homes to hold a licence from the health board as a precondition for accepting patients. Licences should be renewed each year, at a fee related to the number of beds in the home. Health boards should be able to revoke a licence where they are dissatisfied with the standards of the home. Revenue from licence fees should help to pay the cost of monitoring standards in the homes. A nursing home should have the right to appeal to the Minister for Health against a health board decision to refuse a licence if it considers that the Board acted unreasonably. A home should not have the right to appeal to the Minister against a prosecution by a health board for breaking the law as regards standards in the home. **We recommend that the Health (Homes for Incapacitated Persons) Act 1964 be amended to include an annual licensing system for nursing homes.**

Subsidies

9.39 As mentioned above, health boards are obliged by Section 54 of the Health Act, 1970 to subsidise the care of eligible elderly persons who choose care in approved nursing homes. Some 85 out of a total of approximately 260 nursing homes are approved for services under the Act. The fact that a particular nursing home has not been approved by the Minister for Health for the purpose of subsidies does not necessarily mean that the service provided is below an acceptable standard. For financial reasons, the Minister has not approved any additional nursing homes since 1980. The difficulty for health boards under Section 54 of the Health Act, 1970 is that they cannot by law refuse to subsidise the care of an eligible person who chooses to be cared for in an approved nursing home. But the cost of subsidising all elderly persons who choose nursing home care would be excessive. Expenditure under the Section can be controlled only by reducing the level of payment

or limiting the number of approved homes. The number of approved homes was limited by the Minister's decision in 1980 and the amount which health boards may pay towards the cost of elderly patients in nursing homes is laid down by ministerial regulation. The current amount is IR£6 a day. Health boards may, under Section 26 of the Health Act, 1970, make an arrangement with voluntary or private nursing homes to provide a service for eligible persons. A small number of health boards make use of this section.

9.40 The present relationship of health boards to nursing homes is unsatisfactory for a number of reasons. The open ended nature of Section 54 subsidies gives health boards no control in law over admissions to nursing homes of eligible patients, even though they may not need the kind of care a home offers. Since the extension of eligibility for public hospital treatment to the entire population in 1979, all persons are entitled to a subsidy under Section 54, regardless of income. On the other hand the refusal of the Minister to approve any new homes is unfair to elderly persons who require a subsidy but who are unable to find a place in an approved home. There are, for example, no approved private nursing homes in the North Eastern Health Board. Present arrangements discriminate against homes which have opened since 1980 and which provide an excellent service but because they have never been approved by the Minister for Health under Section 54 of the Health Act, 1970, cannot attract patients with a health board subsidy. The prescribed rates of subsidy, laid down by the Minister by regulation and unchanged for a number of years, give health boards little discretion in catering for the differing needs of frail but ambulant elderly and highly dependent elderly patients. Section 26 of the Health Act, 1970 gives health boards the kind of flexibility they need to match the needs of dependent elderly people with the services provided by nursing homes but only a small number of boards use this option.

9.41 We consider that there are many advantages in having a mix of public, private and voluntary beds for the care of the dependent elderly. Section 54 of the Health Act, 1970 offers elderly persons eligible for health services a choice which should not be done away with lightly. The use of subsidies to voluntary and private homes also reduces the amount of money which must be found from public sources to provide and staff extended care beds for the elderly. However, a person who seeks a subvention from a health board towards care in a private or voluntary nursing home should be assessed as thoroughly as a candidate for long-term care in a health board community hospital. Only when admission to extended care is recommended by the physician in geriatric medicine or the district team for the elderly, should an elderly person receive a subvention towards his or her care in a nursing

home. A health board should be able to subsidise care in any home licenced by the board. They should also have discretion to vary the level of payment depending on the needs of the individual elderly person concerned. The number of beds in nursing homes subvented by the health board should be taken into account in planning bed numbers for the extended care of the dependent elderly. **We recommend that Section 54 of the Health Act, 1970 be amended to enable health boards to subvent the care of eligible elderly patients, after assessment, in nursing homes licensed by the board and to enable health boards to vary the level of subvention according to the patient's needs.**

9.42 Elderly persons receiving a subsidy towards their care in nursing homes should receive services similar to those provided in a community hospital. Health boards have a responsibility to ensure that they receive adequate medical, nursing and dental care and a physiotherapy and chiropody service when the need arises. **We recommend that private and voluntary nursing homes arrange to provide these services directly, or on a contract basis with the health board.**

9.43 There is scope for better liaison between health boards and private nursing homes. The Eastern Health Board holds bi-monthly meetings with the Private Hospitals and Nursing Homes Associated to iron out difficulties which may arise in the Board's relationship with the homes. The Board has recently offered the staff of private nursing homes the opportunity to undertake training courses in St Mary's Hospital, a large geriatric hospital. These are important steps towards establishing a better relationship between the Board and the homes, steps which we would like to see repeated in other parts of the country. **We recommend that the Co-ordinator of Services for the Elderly establish liaison arrangements with the nursing homes operating in the community care area.**

9.44 The National Council for the Aged has recommended that all applicants to private nursing homes should be thoroughly assessed before admission.[12] Such assessment would ensure that no elderly person was placed unnecessarily in a nursing home. However, it could be argued that individuals who wish to pay the full cost of nursing home care are entitled to do so and that they should not be obliged to avail of assessment or other services. We consider that the independence of individuals and their families must be respected. There is a need, however, for more information to be available to elderly persons and their relatives when choosing a nursing home. **We recommend that it should be a condition of a nursing home licence that a nursing home makes available to prospective residents and their families a brochure detailing the services it provides, the charges, the qualifications of its staff and other information about the home.**

MAINTAINING STANDARDS

9.45 The elderly who are unable to maintain an independent life in the community, even where comprehensive support services are available, are a particularly vulnerable sector of the population. The quality of their lives is dependent upon the nature and quality of the care provided by those who work in the institutions catering for the elderly. This is particularly the case having regard to the susceptibility of the elderly to institutionalisation in a care setting. The vulnerability of the elderly in these settings is comparable to that of children and mentally ill patients cared for in residential settings.

9.46 It is desirable that effective mechanisms exist to protect the interests and well-being of patients in all such settings. Evidence from abroad suggests that in some circumstances, management responsibility for the provision of sufficient places may serve to weaken concern with the quality of life of the individual. Our recommendation of a licensing system for nursing homes will serve to strenghen the safeguards for patients cared for in these settings. Such safeguards are of particular importance in the light of the projected increase in the number of elderly patients and the trend towards growing numbers of places in private nursing homes.

9.47 It is imperative that the licensing system be supported by an adequate system of inspection. However, such support to the development of good practice is also relevant to patients cared for in the community hospitals we recommend. It is clearly an important function of the Co-ordinator of Services for the Elderly to ensure that standards are maintained in homes, both public and private, in his or her area. It is also desirable that some independent view be available in cases of complaint or difficulty, particularly where these arise from complaints by patients or their relatives, whether in respect of public or private settings. Furthermore, if there is to be an appeal to the Minister against decisions to refuse to grant a licence to operators of nursing homes or to revoke a licence, appropriate independent advice will be required by the Minister.

9.48 Accordingly, **we recommend that an independent inspectorate of extended care facilities for the elderly be established within the Department of Health comprised of people with first hand experience of providing high standards of care for the elderly.** A licence fee of IR£10 per place per annum for nursing homes would generate a significant sum to fund a multi-disciplinary group within the Department. In addition to their inspectorial role, the group would be a valuable source of expertise and support to the CSEs and those providing services in both public and private settings. The members of the group would facilitate the development of codes of good practice and the

training of staff, while helping to promote uniformly high standards of care throughout the country. **We recommend that the Department of Health, through the inspectorate of extended care facilities, in consultation with the health boards and the Private Hospitals and Nursing Homes Association, draw up and implement a code of good practice suitable to this country's needs and a training programme for nursing home and community hospital staff.**

NOTES TO CHAPTER 9—THE COMMUNITY HOSPITAL

1. F. Powell and F. Powell 'Too fit for Hospital' *Community Care* 10 October, 1980 pp 19-21
2. National Council for the Aged, *Nursing Homes in the Republic of Ireland. A Study of the Private and Voluntary Nursing Homes* (1986) p.35
3. Department of Health, *Long Stay Accommodation Requirements for the Elderly and the Young Chronic Sick,* (unpublished) (1983)
4. National Council for the Aged, *Institutional Care of the Elderly in Ireland,* (1985) p.46
5. Comhairle na nOspideal, (1985) *op. cit.* p.18
6. *Ibid.* p. 14
7. *Ibid.* pp. 16-17
8. Irish Society of Physicians in Geriatric Medicine, *Hospital and Residential Care of the Elderly, op. cit.*
9. Comhairle na nOspideal, (1985) *op. cit.* p.17
10. Care of the Aged Committee, *op. cit.* p.82
11. M.R.P. Hall 'Assessing the needs of an Area' in *Establishing a Geriatric Service,* Davis Coakley ed. op. cit. p.27
12. National Council for the Aged, *Nursing Homes in the Republic of Ireland, op. cit.* p.11

Chapter 10

The Care of the Elderly Mentally Ill and Infirm

10.1 The elderly are at greater risk of psychiatric illness than younger people. Between 20 and 25 percent of the population aged over 65 years suffers from an identifiable psychiatric disability, compared with an estimated prevalence of 10 percent in the population aged 18 to 64.[1] The incidence of depressive disorders tends to increase with age and dementia is more common in the elderly than in younger age groups. The majority of the elderly with mental illness suffer from functional disorders such as depression and neuroses. These conditions can be treated as successfully in elderly people as in younger age groups. However, the symptoms of functional mental illness in the elderly are often attributed to the ageing process and the underlying condition may not be diagnosed. Walsh's study of 105 elderly persons living at home in north Dublin city found that twenty five had mental disorders, seven of them severe. Only three of the twenty five patients had been diagnosed by their family doctors as in need of psychiatric care.[2]

10.2 Despite the higher prevalence of mental illness in the elderly, this excess is not reflected in their use of psychiatric facilities. In 1981, 4,627 admissions to psychiatric hospitals and units were over 65 years, representing 16 percent of admissions—a much lower level of demand than made by the elderly on general hospitals. The number of elderly patients in psychiatric hospitals has been declining, reflecting the greater emphasis on discharge in recent years and the number of long-stay elderly residents who have died. Table 10.1 gives information on elderly residents in psychiatric hospitals and units at the end of 1984. It shows that for every one elderly patient with organic psychosis, nearly five suffered from functional mental illness.

FUNCTIONAL MENTAL ILLNESS

10.3 There is general agreement that functional mental illness in the elderly should be managed in the same way as in younger people. The majority should be treated by their general practitioners at home or in the surgery,

with referral to the specialist psychiatric team when necessary. The psychiatric service is being reorganised on the model outlined in **Planning for the Future.** That Report recommended that specialist psychiatric care be delivered by a specialist team serving a 'sector' or district with a population of 25—30,000 under the direction of a consultant psychiatrist. The aim of the team is to provide a comprehensive range of psychiatric care to people while they continue to live at home. Most progress has been made in establishing specialist teams serving defined sectors and in expanding the range of psychiatric care available to people in community settings. We welcome these developments and see them as complementary to the organisation of services for the elderly which we propose. We have already recommended that the sector psychiatrist should be a member of the district team for the elderly and that the boundary for the psychiatric sectors should correspond with the districts for the delivery of services to the elderly.

10.4 A small number of elderly people with functional illness, mainly schizophrenia, will require residential care for an extended period. The report, **Planning for the Future,** recommended that residential care for 'new' long-stay patients be provided in high support hostels in the community. The Report suggested a tentative norm of 1.7 places per thousand population aged 65 years or over with functional mental illness.[3] Applied to a population of 25—30,000 (the figure recommended for psychiatric sectors and which we recommend as the catchment population for the district team for the elderly) of whom about 11 percent would be elderly, this norm would suggest a hostel with five or six places. **Planning for the Future** recommended that high support hostels should accommodate a minimum of 15 residents and that the same hostel should serve all age groups. We endorse this approach to caring for elderly persons with functional mental illness who need a high level of continuing support. **We recommend that in the interests of the elderly, high support hostels should be kept near to the minimum size recommended in Planning for the Future.**

DEMENTIA

10.5 The care of elderly persons with dementia poses a more difficult problem for the delivery of care. Dementia is a condition which damages the brain leading to a slow, progressive impairment of memory, personality and intellect which limits the individual's ability to cope with the needs of everyday life. The World Health Organisation includes within the term 'dementia', dementias due to Alzheimer's disease, cerebral infarction, those dementias secondary to known physical disease and those of unknown origin.[4] The onset of some types of dementia is associated with a shortened

life expectancy. The average expectancy of an elderly person who is diagnosed as suffering from dementia is about two and a half years. Most estimates for the severer degrees of dementia among persons aged over 65 years lie between five and eight percent. The lifetime cumulative risk of becoming severly demented by the age of 80 years has been computed to lie between 15 and 20 percent.[5]

10.6 The management of dementia has received increasing attention in recent years because the condition has become more common as more people have reached advanced old age and because of the absence of services to cope adequately with severe forms of the condition. As yet there is no effective pharmacological or surgical treatment for the disorder. The elderly who suffer from dementia depend mainly on the care of their relatives. It has been estimated that for every one elderly person with dementia in an institution, five are cared for at home.[6]

10.7 The strain on the family of an elderly person with dementia is great. The problems which families find most burdensome and difficult to accept in the behaviour of a relative with dementia include sleep disturbance, nocturnal wandering, shouting and faecal incontinence.[7] The physical strain of lifting the patient is also a major problem. A study carried out by the National Council for the Aged on carers looking after elderly relatives found that about one quarter of elderly persons being cared for at home suffered from a significant degree of mental confusion. Of those confused elderly, about one fifth had a high or very high level of psychological dependency on their carers.

10.8 Those caring for elderly relatives with dementia at home often receive little or no support from the statutory services. In the experience of the staff of one psychiatric hospital we visited, families often continue to care for elderly relatives with severe dementia with little outside help until a crisis occurs and they seek institutional care as a last resort. Families are justifiably reluctant to resume care once the crisis that precipitated admission to hospital is passed. They would find the burden of caring less troublesome if they could be assured of assistance at home from the health services, of respite care and admission to institutional care during a crisis or when the affected person becomes unmanageable at home. The problems of caring relatives are compounded by lack of agreement as to who should be responsible for the long term care of the elderly with dementia. What is required is a continuum of care that will provide such elderly people and their carers with appropriate help at the appropriate time. The absence of such a continuum of care is, in our view, one of the major gaps in services for the elderly at present and one that requires urgent attention.

10.9 Although much attention has been given in recent years to the "rising tide" of dementia among the elderly, closer analysis of the figures does not suggest that the problem will be unmanageable.[9] Applying the prevalence rate to the projected elderly population suggests that in the year 2001, about 20,000 elderly people will be suffering from a significant form of dementia, the majority of whom will be over 80 years of age. Only a small proportion of these will develop a severe form of the condition. A general practitioner with 1,500 patients, of whom about 10 percent are elderly, could expect to have 15 elderly people with some degree of dementia, mostly of a mild form. Only two or three patients would have behavioural problems which would cause difficulties.[10] These patients should be manageable for most of the time in a community setting with support from statutory and voluntary services. They may need referral to a psychiatrist for specialist advice and institutional care during crises or in the final stages of the condition. Provided a continuum of care exists which aims to support the elderly person with dementia at home for as long as possible, institutional requirements for those with this condition can be kept reasonably small.

CATEGORIES OF DEMENTIA

10.10 It has proved useful, for the purpose of planning services, to categorise elderly persons suffering from dementia as follows:

(i) those with mild dementia but not suffering from a significant physical disability or illness;

(ii) those with severe dementia but not suffering from a significant physical disability or illness;

(iii) those with dementia, whether mild or severe and also suffering from a significant physical disability or illness.[11]

Mildly demented—no physical disease

10.11 The elderly which come under the category (i) above (those with mild dementia but with no significant physical disease or illness) are likely to be treated by their general practitioner, with minimal involvement by the specialist geriatric or psychiatric services. The early identification of dementia is important to the management of the disorder. The recommendation which we have made earlier in this Report for routine case finding among the elderly by general practitioners and public health nurses is of great relevance to the early detection of dementia. For the most part, elderly persons with mild dementia may be dealt with effectively at home, provided that their families

receive support. Carers often need help in the home and relief from the constant supervision of the confused elderly person. Attendance by the elderly person at a day centre a couple of days a week may be the most valuable support of all to carers. The focus of the day centre should be social stimulation rather than medical or nursing care. The elderly person with dementia living alone also needs the kind of support a day centre can offer.

Severely demented—no physical disease

10.12 Elderly people suffering from severe dementia but without a significant physical disease or illness require more comprehensive care. They usually have serious behavioural disorders which place great strain upon caring relatives. If they have no families, they require care in a residential setting designed to meet their needs. They may be agitated, restless and occasionally violent. A request for professional assistance often comes unexpectedly. It may follow a crisis involving the person's family or neighbours. The report, **Planning for the Future** recommends that assessment should always be carried out, in the first instance, by the general practitioner and the community care team. They may request specialist psychiatric advice when necessary. The same report recommends that when an elderly person has difficulty attending an out-patient clinic, a visit to the patients's home by the psychiatrist, the psychiatric nurse or social worker should be part of the service. The organisation of psychiatric services serving the same population as the district team for the elderly we propose, should facilitate liaison between general practitioners, the psychiatric team and staff working primarily with elderly.

10.13 Following assessment, elderly people with severe dementia and their relatives will require continuing support. At present little or no support is available for people with severe dementia at home or in the community. Families may have no alternative but to seek institutional care in nursing homes and psychiatric and geriatric hospitals. In many cases, such care is not suited to the needs of the patient with dementia. The physical accommodation may not allow patients enough space to wander in safety. Patients with dementia may be sharing accommodation with elderly people whose problems are largely physical. If elderly people with dementia are in unsuitable accommodation, it is difficult to avoid restraining them unnecessarily by physical or chemical means. We consider that the absence of accommodation specifically designed for the elderly with severe dementia is the major gap in services for the elderly in this country at present.

Demented and physically ill

10.14 Elderly people with dementia and who also have a significant physical disease or illness require assessment and treatment of their physical problem on the same basis as any other person with acute illness. Ideally, they should be treated in a shared psychiatric and geriatric assessment unit.

SOUTH BELFAST MODEL

10.15 During the course of our work, members of the Working Party visited facilities for the elderly mentally infirm in the South Belfast district of the Eastern Health and Social Services Board. We were impressed by the service for the population of 14,262 elderly persons representing 18 percent of the population of the district. The service provides a continuum of care to meet the needs of elderly people with different degrees of dementia. The services depend on close working relationships between general practitioners, the social services department and the geriatric and psychiatric services. When a general practitioner diagnoses dementia in an elderly person, the social services department may be asked to assist. The social services department can help by providing a social work assistant who will assist with caring in the home or the elderly person may be offered a place in a day centre. The centres provide social stimulation, supervision and relief for caring relatives.

10.16 If the dementia is severe, the general practitioner may seek the advice of the psychiatrist with special responsibility for the elderly. He and a social worker will visit the patient at home to assess the medical and social conditions of the elderly person. Where necessary, the patient will be offered a place in the day hospital in the Department of Psychiatry at Belfast City Hospital. The day hospital has 15 places, catering for 22 elderly people and there is no waiting list. Some elderly patients attend 5 days a week and others for 2 days. Transport is provided for those day patients whose families cannot drive them to the hospital. At the day hospital, patients receive physical care—feeding, bathing, dressing and toiletting—and therapy which helps them regain intellectual and social functions. Few of the patients are sedated—only three out of the 22 patients were on medication for disturbed behaviour at the time of our visit. The day hospital is staffed by three nurses, one occupational therapist and part-time catering staff. Because of the degree of confusion amongst the patients, continuity of staff is very important.

10.17 When an elderly person needs more support than their relatives and the day hospital can provide, they will be referred to the district's home for the mentally infirm following joint assessment by the psychiatric and social

services departments. The home, with 30 places, is managed by the social services department. It provides the kind of care a family or good neighbour would provide and is not a nursing home in the traditional sense. Some 25 care staff are employed on a full and part-time basis. Staff work as a team, with each member individually responsible for one or more residents. The home is cleverly designed with long corridors around a central garden to allow the elderly residents space to wander in safety. The entrance door is locked to prevent residents wandering onto the public road. Residents are treated by their own general practitioner and cared for in the home for as long as possible. Special attention is given to the management of incontinence among the residents. If their physical condition deteriorates to such an extent that the staff can no longer provide a satisfactory level of care, the elderly person will be referred to the specialist geriatric service. The most difficult problem for the staff to handle is aggressive behaviour on the part of the residents. When the staff can no longer manage an aggressive resident, he or she may be transferred to a special long-stay unit with 36 beds at Purdysburn mental hospital.

10.18 The Purdysburn unit is operated on a more conventional medical and nursing model. Only those elderly people with dementia who can no longer be cared for in less intensive settings are admitted to the unit. Although sited within a mental hospital, the unit could have been sited independently, ideally in a community setting.

10.19 In South Belfast, an elderly person who is demented and who is also suffering from a significant physical illness, is normally assessed in the first instance by the geriatric service. Once their physical problems have been dealt with, psychiatric assessment and rehabilitation can begin. Only if the dementia is so severe that it inhibits appropriate medical care, will the psychiatrist first deal with the dementia.

A SERVICE FOR THE ELDERLY WITH DEMENTIA

10.20 We consider that the organisation of services for the mentally infirm developed in South Belfast provides a model for the development of services in this part of the country. The model provides a continuum of services, with increasing support as the dependency of the elderly person grows. Its success relies to a great extent on interdisciplinary co-operation, the range of facilities provided and on agreed procedures for the admission and discharge of elderly people to different facilities. The organisation of health services for the elderly in Northern Ireland has some advantages over ours in dealing with the challenge of dementia. General practitioners tend to work more closely with

other professionals in the primary care team than their counterparts in this part of the country. Social service departments have a much wider responsibility for the delivery of welfare services to the elderly than our social work service. The specialist geriatric service is more highly developed and psychiatrists with special responsibility for the elderly have been appointed. Health and welfare services are managed on a geographic basis rather than through different care programmes, allowing for greater interdisciplinary co-operation. Conscious of these differences, we have given some thought to how the South Belfast model can be replicated in our circumstances.

10.21 It is clear that a service for the confused elderly should be built from the bottom up. Elderly people with dementia should receive the level of care they require at a particular moment rather than a level of care which it is anticipated they will need some time in the future. On the basis of the experience of other countries, one would expect that in a district with a population of 25—30,000, about 11 percent of the population over 65 years, up to 260 elderly people, would be severly demented of whom about 5 percent, or 10 to 15 persons, would require a great deal of support. Early identification is critical to meeting the needs of elderly people with dementia and their carers in a planned way. General practitioners and public health nurses are the professionals who are most likely to be the first to diagnose dementia. **We recommend that as part of the anticipatory care of the elderly which we recommend in chapter 6, general practitioners and public health nurses should be encouraged to screen elderly people at risk for early signs of dementia.**

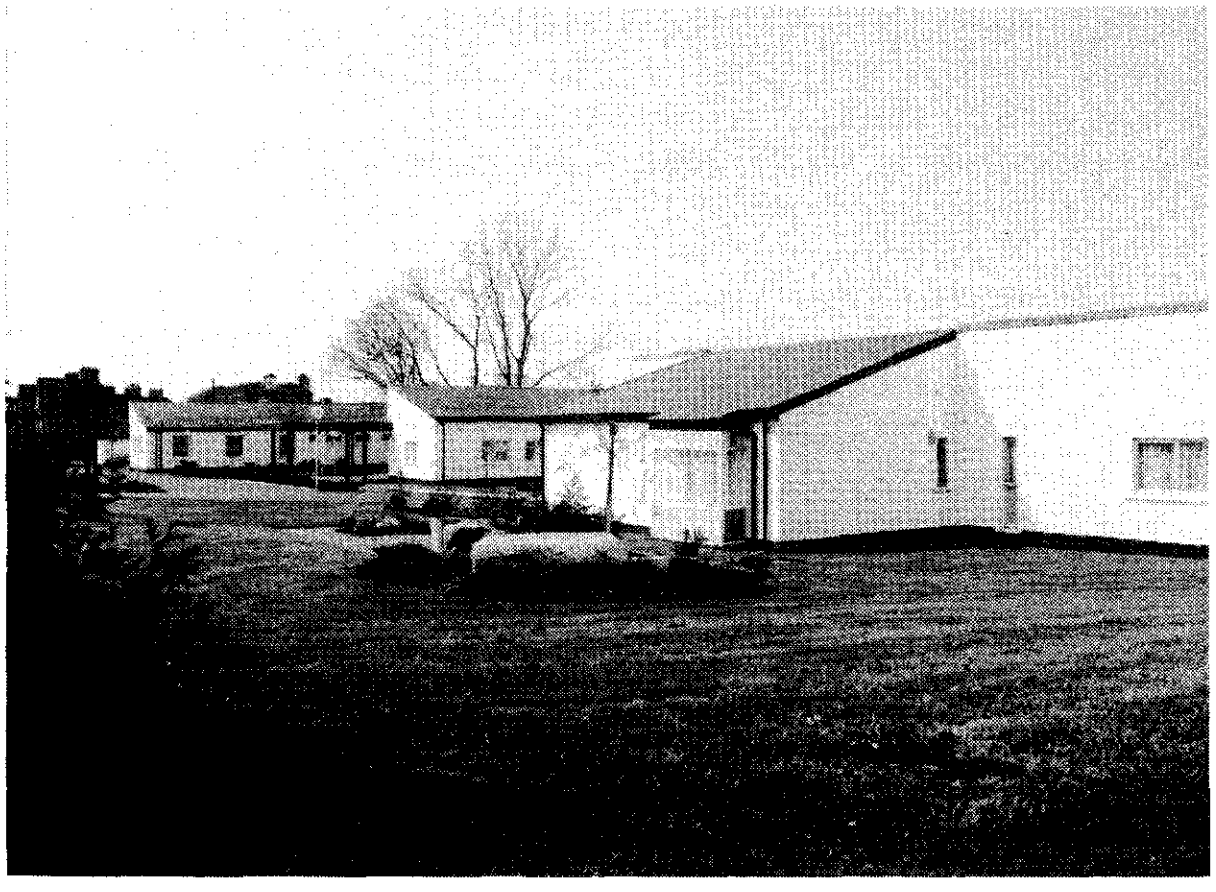
10.22 When dementia is diagnosed, and the elderly person and his or her family need assistance, **we recommend that a panel of people who are willing and available to care for elderly people with dementia be available in each district under the supervision of the senior public health nurse to help the elderly person and his or her carers.** Assistance could be by way of help in the home with the physical care of the person with dementia or by night sitting or weekend relief to allow caring relatives some time of their own. Those providing assistance for elderly people suffering from dementia may need some special training and appreciation of the problems of the condition. Voluntary support groups such as the Alzheimer Society have an important role to play. Additional support will be necessary in day care centres. A population of 25—30,000 would require about 30 day care places, ideally in two or three locations. Day care for the elderly with dementia could be provided separately or as part of normal day care provisions for the elderly by using normal day care facilities at different hours or on different days. Transport must be available to and from the day centre for those who cannot

make arrangements for themselves. The objective of day care for those with dementia is to provide intellectual and social situmulation and to offer support to caring relatives. We welcome the recent opening of a day care centre for confused elderly people run by The Alzheimer Society in Blackrock, Co Dublin. It should provide a valuable model for the development of day care facilities for the elderly with this condition in other areas. **We recommend that day care facilities for the elderly with dementia be provided in each district and that it should be the responsibility of the Co-ordinator of Services for the Elderly to develop such a service, directly by health boards or by agreement with voluntary bodies.**

10.23 A day hospital can make a major contribution to the management of severe dementia. It is difficult to estimate the number of places needed in each district. The experience of South Belfast suggests that 15 places are adequate for a population of just over 14,000 elderly. It would be difficult to justify a day hospital with fewer than 15 places. This suggests that one day hospital may serve a number of districts. A day hospital for the elderly with dementia could be in a geriatric or psychiatric setting. Either way, the commitment of a psychiatrist with responsibility for the elderly (discussed below) is essential to its success. A day hospital in a psychiatric setting should have close links with the geriatric department of the general hospital. Day hospitals for the confused elderly are most suited to urban areas where the population is concentrated and where there is a psychiatrist with an interest in the elderly and a specialist geriatric department. It is important that the staff in the day hospital be suited to and trained for the job of caring for elderly patients with dementia. **We recommend that health boards develop day hospitals for the elderly with dementia in the main urban centres, under the direction of psychiatrists with an interest in this field. A norm of 2 day hospital places per 1,000 elderly people for the confused elderly has been suggested in Great Britain and we recommend that it be used for planning purposes here.**

10.24 Residential accommodation is required for those elderly with dementia who can no longer be cared for by a combination of caring relatives, home-help, attendance at a day centre or at a day hospital. The current ratio referred to in paragraph 10.6 above of one elderly person with dementia in institutional care to every five cared for at home and a prevalence of dementia of 5 per cent per thousand elderly suggest that about 4,000 institutional places will be necessary for the severely demented by the year 2,000. **Planning for the Future** recommended a tentative norm of .8 residential places for the elderly with the most severe form of dementia per 1,000 population aged 65 years or over. It did not suggest norms for accommodation for those with less

severe forms of the condition as it recommended that the care of such patients should be part of an expanded geriatric service. The Irish Society of Physicians in Geriatric Medicine have suggested a norm of 6 beds per 1,000 elderly for elderly people with dementia requiring low support hostel or welfare accommodation.[12] These beds would be part of the norm of 20-25 places recommended for welfare accommodation for the elderly generally. The Society suggests a norm of 3 beds per 1,000 elderly requiring the type of care provided in a high support hostel or hospital. Of these beds, one would be reserved for assessment in a general, psychiatric or geriatric hospital. Applied to the projected population in the year 2000, this norm indicates the need for about 3,600 hospital and hostel beds. **We recommend that sufficient welfare places be provided for the elderly with dementia who can no longer be supported at home. High support hostels should be provided for the elderly with the most severe forms of dementia. We recommend a norm of 6 beds per 1,000 elderly for welfare accommodation and 3 beds per 1,000 elderly for high support hostels for planning purposes to ensure sufficient accommodation for the elderly with dementia.** These norms should be seen in the context of the norms we recommend for services for the elderly generally, as set out in Appendix 5.



Riada House (Welfare Home) Tullamore

10.25 Residential facilities for the elderly should, as recommended by **Planning for the Future,** be provided in a community setting, not in the grounds of a psychiatric, geriatric or general hospital. As in Belfast, a distinction should be made between elderly people with dementia who need welfare accommodation and those who require nursing and medical care in a high support hostel. As many elderly people with dementia as possible should be cared for in welfare type accommodation. Admissions to the high support hostel should only occur when welfare accommodation can no longer meet the elderly person's needs. Close attention should be paid to the design of the residential facilities, to ensure that residents have space to wander in safety and, as far as possible, have rooms of their own. The special units for the elderly with dementia at Vergemount, Clonskeagh, Dublin are an excellent example of the kind of accommodation that is required. Whether the management of these units should be the responsibility of the sector psychiatric team or a member of the district team for the elderly should be determined according to local circumstances. It is vitally important however that operational policies be agreed between the two services for the operation of the units and that there is co-operation between those working with the elderly, the psychiatric team and the geriatric department of the general hospital. **We recommend that health boards provide residential accommodation adapted to the needs of the elderly with dementia as a matter of urgency.**

10.26 A small minority of the elderly with dementia are so disturbed that they require constant nursing supervision. They do not need the diagnostic and treatment facilities of a hospital. **Planning for the Future** recommended that disturbed and demented elderly people should be cared for in small nursing units which would be separate from the accommodation used for less severly demented persons and that both kinds of accommodation should be located close together in a geriatric setting. In approaching the question of which service should have responsibility for the elderly with severe dementia, we were aware that difficulties have arisen in the past between the geriatric and psychiatric services on this issue. These difficulties have to a large extent arisen because of the absence of appropriate facilities for this category of patient. We are convinced that the provision of sufficient and appropriately designed residential facilities for the elderly with dementia, including severe forms of the disorder, will largely overcome such problems and will lead to much closer co-operation between the geriatric and psychiatric services. The experience of the Belfast service supports this view.

10.27 We agree with **Planning for the Future** on the need for separate small units for the disturbed elderly with dementia. We emphasise the need for a

multidisciplinary approach to the treatment and care of the elderly with severe dementia. The psychiatric team, the district team for the elderly, the specialist geriatric department of the general hospital and the staff of the home must agree procedures to ensure that the hostel caters for those elderly and disturbed patients who require that level of care. It should be most unusual, for example, for an elderly patient to be admitted to the high support hostel who has not been cared for at an earlier stage in a less intensive way. **We recommend that in each community care area a consultant psychiatrist with special responsibility for the elderly should assume responsibility for the smooth functioning of the high support hostel for the elderly with severe dementia and for ensuring that patients benefit from a multidisciplinary approach to their care.**

CONSULTANT STAFFING

10.28 It is clear from the South Belfast model that inter-disciplinary co-operation and agreed procedures about the use of different facilities are vital to the success of services for elderly people with dementia. The under-developed state of specialist geriatric and psychiatric services makes it difficult at present to allocate responsibilities and define roles. Comhairle na nOspideal considers that there is an urgent need to initiate an organised service for elderly people with dementia and to appoint trained consultants. It has recommended that initially, a limited number of properly trained consultants should be appointed to organise a psychogeriatric service in liaison with well established psychiatric and geriatric teams. The consultants would be part of the psychiatric team, headed by a clinical director or chief psychiatrist, serving the local catchment area in which he or she is based. The new consultant would not assume responsibility for treating mental illness in all those aged 65 years or over. Each psychiatrist would continue to treat a proportion of the elderly with functional mental illness. The consultant would, however, take a special interest in those elderly with severe forms of dementia. He or she would provide specialist advice to general practitioners, ideally in the surgery or patient's home, assessment and rehabilitation at an acute unit in a general hospital, and arrange for continuing care where necessary.

10.29 The Comhairle recommended in 1985 that three consultant psychiatrists with responsibility for in the elderly be appointed[13] . It envisaged that two posts would be created in Dublin at St. James's and James Connolly Memorial Hospitals and one at the Regional Hospital, Cork. The consultants appointed would have a full-time commitment to the elderly. The Eastern Health Board has since proposed the creation of three posts in Dublin. Despite some progress towards creating the posts, no appointments have yet been

made. **We recommend, as a matter of urgency, that psychiatrists with responsibility for the elderly be appointed in Dublin and Cork to provide a specialist service in their catchment areas, to develop a model service and to promote high standards in the care of the elderly mentally ill.**

10.30 The provision of a service for elderly people with dementia who do not have access to a psychiatrist with a full time responsibility for the elderly must also be considered. If, as we recommend, a small number of psychiatrists with responsibility for the elderly are appointed in the near future, their immediate impact will be confined to their catchment areas. Over much of the country, the appointment of psychiatrists with full time responsibility for the elderly can never be justified on the basis of population.

10.31 The aim should be to ensure that in each community care area, there is either a full-time psychiatrist for the elderly, with acute facilities in a general hospital, or a sector psychiatrist with a part-time commitment to the elderly. In each case, general practitioners would have specialist advice readily available in dealing with severe dementia in elderly people and there would be a framework for managing day hospital services and nursing units for the elderly with the most severe forms of dementia. The psychiatrist with responsibility for the elderly, in consultation with the CSE would be responsible for initiating and managing day hospital and residential services for the elderly with severe dementia. **We recommend that one of the psychiatrists in the sectors which correspond to a community care area should have responsibility for the care of the elderly with severe dementia. Special training arrangements may be necessary to encourage psychiatrists to develop an interest in this field.**

NOTES TO CHAPTER 10—THE CARE OF THE ELDERLY MENTALLY ILL AND INFIRM

1. Department of Health *Planning for the Future* 1984 pp.80-153 and Dr Colin Godbar, 'Organisation of Comprehensive Community based Health Services for the Elderly with Mental Disabilities', WHO (Regional Office for Europe) 1983

2. Dr J.B. Walsh, 'Previously unrecognised treatable illness in an Irish elderly population'. *Journal of the Irish Medical Association,* 1980, 73.2.

3. *Planning for the Future, op cit* p.88

4. World Health Organisation *Dementia in Later Life—Research and Action,* Report of a WHO Scientific Group, WHO, Geneva, 1986. p.10

5. *Ibid.* p.13 p.80

6. Office of Health Ecomomics, *Dementia in Old Age,* London, (1979) p.18

7. World Health Organisation *op cit.* p.18

8. National Council for the Aged, *The Caring Process: A Study of Carers in the Home* (to be published)

9. National Health Service—Health Advisory Service, *The Rising Tide—Developing Services for Mental Illness in Old Age,* London, (1982)

10. Dr M Hyland 'Future of Health Services for the Elderly' Paper read at the conference 'Health—The Wider Dimesnions' Beaumont Hospital, October 1987.

11. Office of Health Economics, *op cit.*

12. The Society of Physicians in Geriatric Medicine, *op. cit.*

13. Comhairle na nOspideal *Long term Institutional Care—The Medical Aspects,* March 1985, p.37

Chapter 11

Partnership between Carers, Volunteers and Statutory Agencies

11.1 There are three major partners in the care of dependent elderly people—their families, members of voluntary organisations and professionals working for statutory agencies. In terms of the numbers of elderly receiving care, families make by far the largest contribution. Yet family carers receive little formal recognition and insufficient support from statutory agencies. Voluntary organisations make an enormous contribution to the welfare of the elderly, particularly, to those living alone, but their relationship with health boards and local authorities is an uneasy one. Health boards and local authorities have a statutory obligation to provide services for vulnerable elderly people but their contribution is inevitably limited by the availability of resources and the competing priority of other groups. A comprehensive service for the elderly depends on each partner playing its part and complementing the work of the others. In this chapter we examine the contribution of family carers and voluntary organisations to the care of the elderly and the nature of the partnership which is required with statutory bodies.

FAMILY CARERS

11.2 A recent study provides information for the first time on family members caring for elderly relatives.[1] An estimated 66,000 elderly people are receiving a significant amount of care at home from a relative. Most carers are women caring for parents or spouses on a full-time basis. The majority of carers are aged between 40 and 60 but a substantial number are over 65. A significant proportion have given up work to take on the caring role. One third of carer households are totally dependent on State benefits and allowances. Caring for an elderly relative can be a demanding task. A quarter of the elderly being cared for cannot manage four of the following activities of daily living—

washing, dressing, going to the toilet, feeding themselves, getting out of bed and walking unaided. The vast majority have a significant physical disability and nearly 40 percent are incontinent. Almost one quarter exhibit four or six symptoms of dementia.

11.3 Half of the carers surveyed devote between four and seven hours each day to caring, with more than one third giving more time. The most common tasks performed for the elderly person are preparing food, washing and bathing, dressing, toiletting, laundering soiled clothes and bed linen, and assisting with mobility. Carers report considerable informal support from other family members, friends and neighbours, but practical help from statutory or voluntary services by way of home help or meals is virtually non-existent.

11.4 Although the majority of carers get on well with the elderly relative, about a quarter feel there is a strain in the relationship. The strain arises because of restrictions in personal time, social life, lack of privacy and the deterioration in the carer's health. Others find the elderly person overly manipulative or demanding and many find it difficult to combine the caring role with their other roles. The carers in the study reported a high degree of ill-health. One quarter rated their health as fair, poor or very poor and somewhat more felt that their health had suffered because of caring. Many make considerable financial sacrifices to care for their elderly relatives.

11.5 The profile of carers in this study suggests the need for much greater recognition of the role of the family carer in policy and services for the elderly. The recent formation of the Carers Association has already helped highlight the problems of caring for elderly relatives at home. The evidence suggests that many families care for their elderly members, even when they become highly dependent. Many more would do so if their was greater help available to them in the home. Many of the recommendations made earlier in this report, if implemented, would assist family carers in looking after elderly relatives. The maintenance of registers of dependent elderly people receiving care at home by district teams for the elderly should encourage a greater awareness by professionals of their problems. A comprehensive scheme to adapt the accommodation of elderly people to cope with their disabilities would make caring easier for many families. The use of 'panel' nurses to supplement the public health nursing services, advice on the management of incontinence and the expansion of the home help service to provide night sitting, weekend relief and home care for the elderly with dementia would provide a level of support to carers not currently available. More day care places and the provision of respite and intermittent care beds for the elderly in community hospitals would be of great benefit to many carers. The expansion of geriatric assessment units in general hospitals would provide

easier access to specialist assessment and rehabilitation for dependent elderly people. In addition, **we recommend the implementation of the recommendation of the Commission on Social Welfare that carers be entitled to claim social assistance in their own right and that such entitlement should replace the Prescribed Relatives Allowance.**

11.6 In addition to these measures, **we recommend that the Co-Ordinator of Services for the Elderly should ensure that in each community care area, information and advice is available to carers on the ageing process, the medical aspects of caring, financial entitlements and services available locally. Health boards should encourage and assist financially where necessary, the formation of support groups for the carers of elderly people.**

VOLUNTARY ORGANISATIONS

11.7 Much of the care of the elderly is voluntary, in the sense that it is given gratuitously by family members, neighbours and friends. Voluntary organisations tap the innate concern and altruism of people and translate them into caring networks in the community. A large proportion of voluntary activity is organised on behalf of the elderly. The services provided for the elderly by voluntary organisations are extensive. They include:

- extended care in voluntary nursing homes;
- residential care as provided by, for example, Kilkenny Social Services Council;
- special and sheltered housing as provided by SHARE in Cork;
- repair and maintenance of homes—ALONE, St Vincent de Paul Society and Care of the Aged Committees;
- shelter for homeless elderly people—the Simon Community;
- material aid—St Vincent de Paul;
- day care services;
- transport to and from services;
- home help, meals and laundry services;
- support groups—Alzheimer Society, the Carers Association;
- information and advice—Social Service Councils, Community Councils, Information Centres;
- surveillance—Community Alert and Neighbourhood Watch Schemes;
- visitation—Friends of the Elderly, St Vincent de Paul;
- social contact—clubs and church groups.

Growth of Voluntary Activity

11.8 Much of the current voluntary activity on behalf of the elderly developed in the 1970s stimulated by the recommendations of the **Care of the Aged Report.** Many social services councils were established, loosely co-ordinated by a national federation. The expansion of voluntary organisations was facilitated by the establishment of the regional health boards in 1972 and the creation of community care teams within the health board structure. The expansion of voluntary activity was supported financially by health boards by increased use of grants paid under Section 65 of the Health Act, 1953. That section empowers health boards to support organisations providing a service "similar or ancillary" to a health board service. In 1988, Section 65 grants to voluntary organisations will amount to IR£33m, a significant proportion of which will go to voluntary organisations working with the elderly. In 1971, the National Social Service Council (now Board) was established to encourage the growth of voluntary organisations. The first National Council for the Aged was appointed in 1981. The Council provides a forum in which voluntary personnel working with the elderly and those responsible for statutory services can reach a consensus on policy towards the elderly and advise the Minister for Health accordingly.

11.9 In 1978, the National Social Service Council listed nearly three hundred organisations providing voluntary services, a large proportion of which provided services for the elderly. It has been estimated that upwards of 200,000 persons are actively involved in voluntary work with religious bodies and charities concerned with welfare.[2] A large proportion of these volunteers work with the elderly. Voluntary activity tends to be stronger in urban than in rural areas.

Organisation

11.10 The organisation of the voluntary sector is complex, reflecting diverse philosophies, purposes and priorities, different organisational structures and different modes of liaison and co-operation with statutory bodies. Voluntary organisations involved in providing health and welfare services for the elderly are as multi-faceted as the sector as a whole. They include religious organisations, lay bodies and individuals giving some of their time to serving the needs of old people. Some voluntary agencies include the elderly in those they serve; others are dedicated to providing health and/or welfare services for the elderly only. Many elderly people are themselves active in these voluntary organisations.

11.11 Most voluntary activity on behalf of the elderly takes place at a very local level. In County Roscommon, for example, there are eight social services

councils and three care of the aged committees, each associated with a town or small district of the county. It is part of the success of bodies such as these that their members can respond to the needs of their own parish or neighbourhood. Support from statutory bodies must respect the close identity of the councils and committees with the people they serve.

Gougane Barra, Abbey Street, Cork consists of 15 chalets and community room

11.12 At county or community care level, voluntary activity on behalf of the elderly is largely concerned with co-ordinating the activities of local groups, representing the volunteer sector vis-a-vis health boards and local authorities and sometimes providing services on a small scale. County based social service councils illustrate this level of voluntary activity. At national level, organisations such as the St Vincent de Paul Society and Muintir na Tire have a policy making role and represent the interests of the elderly to government and interest groups.

Advantages of Voluntary Organisations

11.13 Traditionally, a number of reasons have been put forward in support of voluntary involvement in the provision of social services. These include:

(i) voluntary services provide welcome diversity and, in some cases, an element of choice for recipients;

(ii) some services are more appropriately provided by volunteers than by statutory personnel, for example "social contact" services which can be provided more personally and flexibly by volunteers;

(iii) voluntary organisations are sometimes innovative in a way which one cannot normally expect statutory bodies to be;

(iv) most voluntary bodies are free from the legalistic procedures and strict accountability which sometimes characterise statutory bodies. They can often, therefore, provide services inappropriate to a statutory agency.

(v) involvement in voluntary services does much to promote social cohesion and community integration and development. In this way, voluntary service has a significance far beyond the level of helping the elderly or other client groups;

(vi) the opportunity to concentrate more single-mindedly on particular issues or needs places the voluntary organisation in a strong position to be a watchdog in the field in which it specialises;

(vii) voluntary services are cost effective because they are voluntary. Kilkenny Social Services Council has estimated that its volunteers contributed 2,075 hours work per week in 1978/79, the equivalent work load of 51 full-time staff.[3] Similarly impressive statistics might be compiled by large national voluntary organisations such as the Society of St Vincent de Paul with its membership of approximately 10,000 in the 32 counties.

11.14 For these and other reasons, voluntary involvement with the elderly should receive encouragement from health boards and local authorities. Not every voluntary activity corresponds to the ideal of the innovative, flexible and cost effective service described above. But where there is a good working relationship between statutory agencies and voluntary organisations, with each respecting each other's role and capabilities, remarkable things can be achieved. The partnership between the voluntary housing association SHARE—consisting largely of school children, their teachers and parents—and Cork Corporation has greatly improved housing and welfare services for elderly people in Cork City. Similarly, co-operation between the Care of the Aged Committees in Donegal and the North Western Health Board has been the foundation of much improved services for the elderly in that county. We believe it is possible to learn from those areas where statutory and voluntary bodies work well together and apply similar principles to develop true partnership in the care of the elderly throughout the country.

PROBLEMS WITH VOLUNTARY/STATUTORY PARTNERSHIP

11.15 The National Council for the Aged, in a submission to the Working Party, identified shortcomings in the relationship of voluntary and statutory organisations, with which we agree in general. These shortcomings are:

(i) the contribution of the voluntary sector has been largely taken for granted and has not been sufficiently recognised or supported by statutory authorities. Health boards do not always give sufficient support to voluntary organisations providing high-quality services. Some voluntary groups providing services receive no health board aid, although such aid might enable them to make a more effective contribution;

(ii) there is inadequate co-ordination of services at the point of delivery and a lack of integration of the voluntary sector;

(iii) in some instances volunteers are being asked to take on too much responsibility without adequate direction, funding or support from health boards and the rationale may not be apparent;

(iv) the development of voluntary activity around the country is uneven both geographically and in terms of function and structure. In some areas there is a serious dearth of volunteers;

(v) many voluntary organisations spend much of their time and energy raising funds and, as a result, lose their enthusiasm and momentum;

(vi) voluntary organisations in recent years may have tended to concentrate on services which are more likely to attract statutory funding than on those considered by the organisation to be of most value to the community;

(vii) There appears to be a great variation in practice from one area to another, even within health boards, as to the kinds of activity that are grant-aided and the level of grants paid. Branches of the same organisation may receive different levels of support depending on the health board region in which they are located;

(viii) in dealing with statutory bodies, the voluntary sector lacks influence relative to other interest groups such as unionised workers;

(ix) some groups (the Alzheimer Society of Ireland) experience great difficulty in getting health board support for setting up innovative services (such as day centres);

(x) some voluntary organisations experience difficulty in liaising with health boards in respect of the home help service;

(xi) provision of housing for the elderly by voluntary groups is greatly hindered by problems in fund-raising in respect of the balance of capital expenditure not met by existing government subsidy schemes and funds required to meet ongoing maintenance and service provision costs;

(xii) voluntary organisations have little opportunity to influence health board or local authorities in their plans for services. Voluntary organisations do not have access to information or to discussions on the allocation of resources. They are kept at arm's length from the decision making process. Few health boards invest time, resources, staff or energy in consultation with voluntary bodies.

(xiii) Some voluntary bodies experience difficulty in getting and/or paying for insurance in respect of their activities.

11.16 Some of these problems will be ameliorated by the recommendations we have made earlier in the Report. The contribution of the voluntary sector would be formally recognised by the involvement of a voluntary representative on the district team for the elderly, the obligation on the CSE to liaise with voluntary organisations at community care level and the involvement of voluntary representatives on the health board's advisory committee on the

elderly. At national level, voluntary organisations would be represented on the National Council for the Aged. Our recommendations on the home help service, day care and on voluntary housing schemes for the elderly would expand the role of the voluntary sector in providing services for the elderly. The Housing Bill, 1988, when passed, will place a statutory obligation on local authorities to consult voluntary organisations when assessing housing needs. Our recommendation for a similar obligation on health boards to assess health and welfare needs among the elderly in consultation with voluntary organisations would ensure a voice for voluntary bodies in planning services.

RECOMMENDATIONS

11.17 In addition **we recommend that health boards and local authorities should encourage by all possible means the involvement of voluntary organisations in caring for the elderly. Each board and local authority should agree with the voluntary organisations working with the elderly in their functional area their respective responsibilities in the delivery of services. We recommend that this agreement be formalised as a contract between the voluntary organisation and the board or local authority for a period of 2 or 3 years. The district team for the elderly should be consulted in the preparation of a contract for services in its area.** The contracts should set out the services to be provided by the voluntary organisation, the financial and other resources to be made available to the voluntary organisation, and the method of accountability which will be used. Care should be taken that the introduction of contracts for services does not undermine the flexibility and discretion of voluntary organisations in dealing with issues to which they attach importance.

11.18 **We recommend that the co-ordinator of services for the elderly develop a mechanism to co-ordinate voluntary activity in each community care area. We recommend that each health board establish a fund for the development of voluntary organisations.** Allocations from the fund would be made following consultation with the CSEs and the district teams for the elderly.

11.19 Many of the wider issues affecting the relationship of statutory and voluntary bodies are outside the terms of reference of our Working Party. However, the 'policy vacuum' which appears to exist about the role of volunary organisations vis-a-vis the administrative system impinges on services for the elderly.[3] **We recommend that the Government undertake a formal review of the relationship of the statutory and voluntary sectors with a view to establishing national guidelines for the development of a more constructive relationship between the two sectors.**

NOTES TO CHAPTER 11—PARTNERSHIP BETWEEN CARERS, VOLUNTEERS AND STATUTORY AGENCIES

1. National Council for the Aged, *The Caring Process—A Study of Carers in the Home* (to be published).

2. National Social Services Board, *The Development of Voluntary Social Services in Ireland,* 1982.

3. National Council for the Aged, *Community Services for the Elderly,* 1982.

Chapter 12

Implementing the Report

REDEPLOYING RESOURCES TO THE ELDERLY

12.1 As has already been indicated in Chapter 2 of the Report, the elderly population is increasing, and will grow rapidly after 2006. The increase in those reaching advanced old age is particularly significant. The implications of this growth for services must be faced. A growing elderly population will increase demand on health and welfare services and create new challenges for housing policy. On the assumption that society wishes to do the best it can for its elderly citizens, resources will have to be diverted to support the elderly. In considering where the resources can be found to fund services for the elderly, we distinguish between the short and the longer-term.

12.2 In the short term, we are conscious of the current difficulties facing the Government in relation to public finances. We are aware that the reduction of the national debt is a priority of Government policy. In the absence of substantial economic growth, achieving this objective means reducing the level of public expenditure. This strategy will contain or reduce expenditure on public services such as housing, health and other services on which the elderly depend unless the Government decides to protect them from the consequences of its economic measures. There can be no doubt that the very old elderly and the elderly on low incomes are among the most disadvantaged groups in our society.

12.3 In considering the financial implications of implementing our Report, we were concious that the Government has established a Commission on Health Funding to examine the financing of the health services. The Commission has also been asked to make recommendations on the extent and sources of the future funding required to provide an equitable, comprehensive and cost effective public health service and on any changes in administration which might seem desirable for that purpose. We therefore decided not to make detailed proposals about methods of financing the recommendations of our report as this might pre-empt the findings of the

Commission. **However, we wish to emphasise the dependence of the elderly on the State for their chief or only means of income and their relatively high level of dependency on services, particularly in their later years.** This suggests that general taxation is likely to remain the chief source of funding for services for the elderly, with insurance playing a minor role. We do not see any objection to reasonable charges for certain services, provided that charges do not discourage elderly people in need from receiving a service. Nor do we see any reason why elderly persons with means should not contribute towards the cost of extended nursing care provided by health boards.

12.4 We believe that the improvement of services for the elderly which we have outlined in this Report can be funded in a number of ways. There is considerable scope in the health services for the redeployment of resources towards services for the elderly. As the population ages, resources should be redeployed within the health services towards the care of the elderly. We outlined in Chapter 8 how acute medical services for the elderly can be improved by the redesignation of medical and nursing staff and facilities for the elderly. Not only will such a step improve the medical care of the elderly, but we believe that it is also the most cost effective way of providing the service. Similarly, we recommend the transformation of long stay institutions for the elderly into more active facilities which will support those caring for elderly people at home. In some cases, this change can be achieved with a minimal outlay of finance. In recommending an inspectorate of extended care facilities in the Department of Health, we suggest that the cost be met in part by the licence fee paid to health boards by nursing homes.

12.5 We distinguish in this chapter between recommendations which have capital implications and those which have revenue implications. As far as capital expenditure on health facilities is concerned, we recommend an allocation of IR£4.5m in each of the next five years to carry out what we consider to be essential improvements to facilities for the elderly. This figure represents .3 percent of the public capital programme in 1988 and should be easily found by redeployment within the capital programme. We estimate that over the next five years, additional revenue expenditure of IR£11.00m needs to be provided to expand health and welfare services for the elderly and to carry out research into the most effective way of delivering these services. This figure represents about .8 percent of current expenditure on the health services. If the overall level of expenditure on the health services remains the same over the next five years, it would be reasonable to oblige health boards and health agencies to make savings of .2 percent of their allocation each year to fund an extension of services for the elderly. If,

however, the real level of the Exchequer allocation to the health services falls, it would be unreasonable to expect health boards and agencies to find savings of this order and a separate allocation should be made from the Exchequer to fund the improvements to services which we recommend as necessary. Apart from homes for the elderly with dementia, we do not make any recommendations for expenditure beyond the next five years. The Departments of Health and the Environment should at that stage review the extent to which additional expenditure is required in the light of health board and local authority plans concerning the elderly.

12.6 In the longer term, as we enter the 21st century and the projected rapid increase in the elderly population occurs, economic growth may generate increased wealth to fund the development of services for the elderly. If economic growth is insufficient for the purpose, it will be necessary to consider the question of redeployment in a broader way. The projected decline in the birth rate into the next century presents an opportunity to redeploy resources from the care and education of children to the care of the elderly. Sweden has adopted this approach and built redeployment towards services for the elderly into its annual budgetary procedures. **We recommend that the Government should, in the light of the changing demographic trends, adopt a conscious long-term policy of redeploying resources to services for the elderly.**

FINANCIAL IMPLICATIONS OF RECOMMENDATIONS

12.7 In the following paragraphs we consider those of our recommendations which have significant capital and revenue financial implications. Many of our most important recommendations—the appointment of district liaison nurses, the formation of district teams for the elderly, the appointment of coordinators of services for the elderly, greater emphasis on the care of the elderly in professional training—will have little or no financial implications and are not referred to here as for the most part it will be existing personnel who will assume these roles.

CAPITAL IMPLICATIONS

Housing

12.8 The main thrust of our recommendations is to ensure that as far as possible the elderly in need are given sufficient support to remain in their own community, preferably in their own home. The vast majority of elderly people own their own homes. We recommend in Chapter 5 that extra resources should be allocated to the Task Force on Special Housing Aid for

the Elderly and that the Department of the Environment examine ways of improving existing schemes which facilitate repairs and adaptations with a view to introducing a comprehensive repairs and adaptations scheme. Aid should be concentrated on those elderly who cannot afford, or who cannot organise, the repairs and adaptations themselves. Priority should be given to bringing those houses lacking basic amenities up to a modern standard.

12.9 For several reasons, there is unlikely to be any fall in the numbers of elderly people requiring public housing, although the proportion of elderly who are local authority tenants may fall. The local authorities have allocated an average of ten percent of new public housing to the elderly and disabled. In 1987, a total of 577 special units were built for them. However, in the last two years there has been a considerable reduction in the construction of new local authority housing (Table 5.3). We feel therefore, that the practice of allocating a percentage of new dwellings to the elderly will not be sufficient to meet their needs.

12.10 Under the Housing Bill, 1988 local authorities will be obliged to assess the housing needs of the elderly, for whom they may provide accommodation. They will also be obliged to consult certain other housing authorities, health boards and other groups which provide accommodation, shelter or welfare services for the elderly, which the authority thinks should be consulted. **We recommend that in assessing housing needs, local authorities also assess the level of resources required for an effective repairs and adaptations scheme and to meet demand for public housing among the elderly. We further recommend that the Department of the Environment ensure that as a matter of priority, adequate finance is allocated to operate the repairs and adaptations scheme and that sufficient dwellings are constructed for the elderly either directly by local authorities or through subsidies to voluntary housing agencies.**

Day Care Facilities

12.11 As we have already said in Chapter 7, we regard day care facilities as being a very cost-effective and necessary means of helping the elderly in the community. There are at present 114 day care centres in the country, many run by voluntary bodies with assistance from health boards. Based on the norm we recommend of one centre per 1,800 persons aged sixty five or over there will be a need for a further 100 centres by 1991. While a purpose built centre may cost as much as IR£100,000, most could be sited within existing buildings and would require little extra capital expenditure to make them suitable for use as day care centres. **We recommend that in each of the next five years, a total of IR£.5m be allocated by the Department of Health for the purpose of establishing day centres.**

Departments of Geriatric Medicine

12.12 We have recommended that departments of geriatric medicine with acute assessment and rehabilitation facilities be provided in hospitals serving a catchment population of 80,000 or more and in certain Dublin hospitals. As we have pointed out, these departments can be developed by re-deploying existing staff and resources from general medical and other departments to serve the elderly. However, we appreciate that it will be necessary to provide some capital money to make the necessary adaptations. **We recommend that IR £.1m be allocated each year over the next five years by the Department of Health to provide departments of geriatric medicine.**

Day Hospitals

12.13 The growth in the number of elderly and the increasing cost of in-patient care in hospitals emphasise the role day hospitals can play in the acute medical assessment and rehabilitation of elderly patients. We have strongly recommended that day hospital facilities be developed and have indicated that an extra 540 places are needed. The accommodation for a day hospital should come from within the existing hospital complex but some capital funding may be required to carry out repairs and alterations. **We recommend that IR£.5m annually be allocated over the next five years from the Department of Health's capital programme to provide the required number of day hospital places.**

Community Hospitals

12.14 Generally speaking we feel that there is sufficient long-stay accommodation for the elderly which could be adapted for use as community hospitals. However, the increase in the elderly population will affect mainly the urban areas in the Eastern half of the country. In Dublin which, for demographic reasons, is relatively underprovided with health board accommodation for the elderly, there is already an acute problem in placing elderly people in need of extended nursing care. The Eastern Health Board relies heavily on accommodation provided by private nursing homes. Planning is at an advanced stage for purpose built, extended care facilities providing the range of facilities we recommend for the community hospital. In other health boards, existing accommodation for the elderly needs to be improved if the concept of the community hospital is to work. **We recommend that IR£2m be made available each year over the next five years for adapting existing facilities as community hospitals and for purpose built buildings.**

Facilities for the Elderly Mentally Infirm

12.15 We recognise that meeting the needs of the elderly mentally infirm and their carers will pose one of the greatest challenges to the psychiatric and geriatric services in the years to come. Our Report recommends the development of a continuum of facilities from day care to heavy nursing care to provide for patients with dementia. It may be possible to make the most of day care facilities for the physically dependent elderly by using them at different times for the elderly with dementia. However, some specialised day centres for the elderly with dementia may be required. The psychiatric day hospitals which are being planned should also cater for the elderly with dementia. We are particularly concerned that elderly patients with severe forms of dementia should be catered for in specially designed units in a community setting and not in the wards or on the grounds of psychiatric hospitals. It will be necessary to provide accommodation similar to that built at Vergemount, Clonskeagh in Dublin, where justified by the number of elderly. Based on the norms recommended in Chapter 10, we estimate that another 900 beds will be required at a capital cost of IR£1.2m each year over the next 20 years. **We strongly recommend that as a priority IR£1.2m be made available each year over the next 20 years to provide welfare and high support hostel accommodation for the elderly with dementia.**

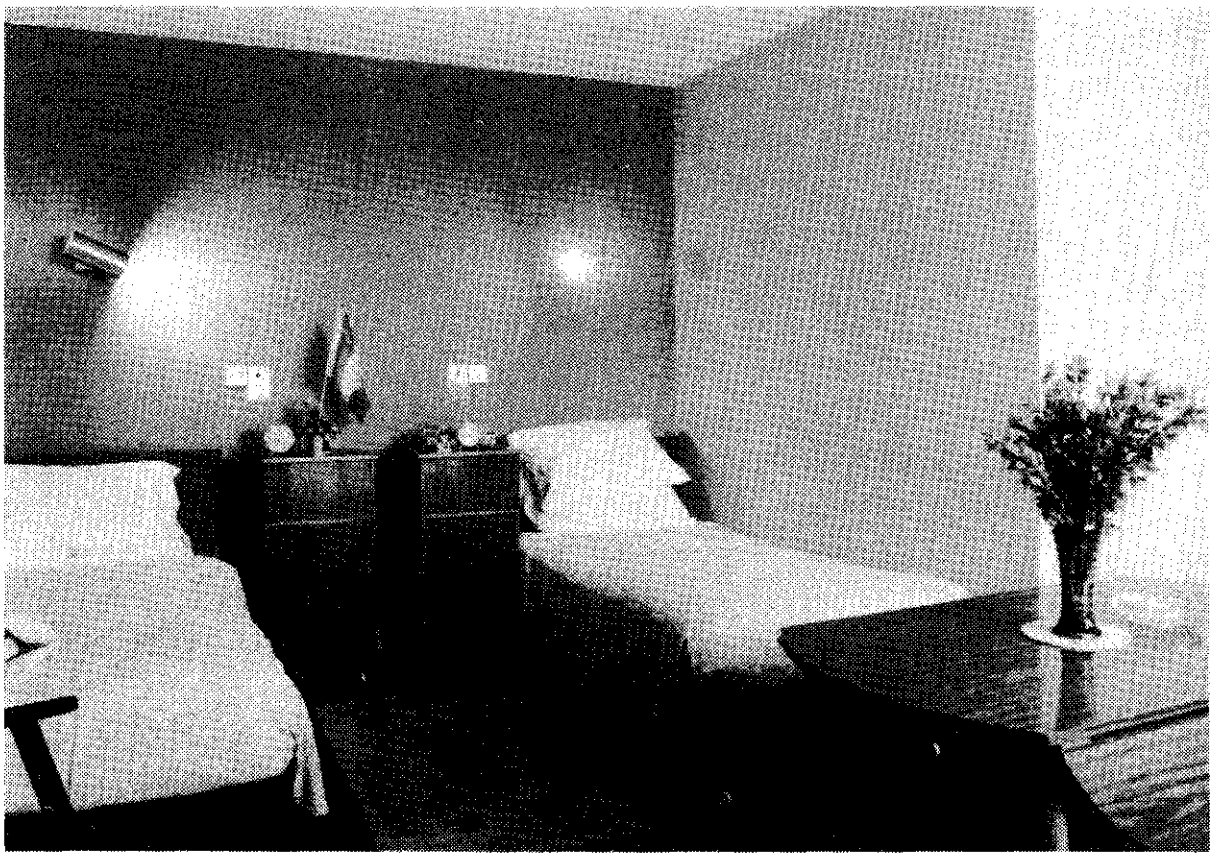
Alarm Systems

12.16 The installation of an alarm in an elderly person's home linked to a 24 hour answering service is one of the most effective ways of maintaining an elderly person at home while ensuring their well-being. **We recommend that IR£.2m be made available in each of the next five years to provide central control units for home based alarm systems and for the installation of radio or telephone links in the homes of dependent elderly people.**

REVENUE IMPLICATIONS

12.17 The dependent elderly make considerable demands on a wide range of medical, para-medical and personal social services. We conclude that in many instances these services are under severe strain because of the shortage of personnel and finance. We identified a number of critical services that require extra resources. They are domiciliary nursing, home help, home care assistants for the elderly with dementia, day care, physiotherapy, joint replacement and cataract surgery. There are other services which we regard as seriously deficient. They include the provision of medical appliances and aids, chiropody, speech therapy, dental care, family counselling and boarding out. Most of the deficiencies to which we refer require the appointment of additional personnel if they are to be remedied. We are mindful of the fact

that it is Government policy to restrict employment in the public sector and that in the health services, a relatively small number of posts are being filled. Nevertheless, **we recommend that the Department of Health, in determining which posts in the health services are to be filled, bear in mind that the elderly will pose a continuing and increasing challenge to the health services which requires the immediate adoption of a policy to redeploy gradually staff resources towards services which meet their needs.**



Riada House (Welfare Home) Tullamore—Double Self-Catering Flatlet

12.18 We have recommended that panels of general nurses be established to provide nursing care for elderly persons at home under the supervision of a senior public health nurse. These nurses would be employed on a temporary part-time basis and paid an hourly rate plus a travel allowance. The absence of information on the extent of the need for home nursing makes it difficult to estimate the cost of this proposal. The same difficulty arises in estimating the number of home care assistants required to assist the elderly with dementia and their families. **We recommend that research be carried out in the two pilot community care areas recommended below to quantify the need for home nursing and for home care assistants.** The absence of norms should not prevent the introduction of an expanded home nursing

service or the employment of home care assistants for the elderly with dementia. On this basis, **we recommend that a sum of IR£2m be made available immediately to provide a panel of general nurses in every district to nurse dependent elderly people at home and to employ home care assistants to help the elderly with dementia.**

12.19 We have recommended that the immediate goal of health boards and voluntary organisations should be to expand the home help service to a norm of 4.5 whole time equivalent home helps per 1,000 elderly population, giving a total of 1,700 whole time equivalent home helps. Existing public expenditure on the home help services is IR £7.65m. **We recommend that an additional IR£6m be made available to expand the home help service.**

12.20 Easier access to physiotherapy would greatly improve the quality of life of many elderly people. We recognise that there are serious shortages in the number of physiotherapists and that they are costly to train and employ. We have recommended that physiotherapy assistants, working under the supervision of a qualified therapist, be appointed to augment this service. **We recommend that 50 physiotherapy assistants be employed to expand physiotherapy services for the elderly at an approximate cost of IR £.5m annually.**

12.21 We have argued in Chapter 8 there is a need to reduce the waiting lists for joint replacement and cataract surgery. **We recommend, tentatively, that an additional IR£.25m per annum be made available towards the cost of joint replacement and cataract surgery.**

12.22 We have made a number of proposals which will involve the allocation of extra staff and resources to assessment and rehabilitation services, day hospitals and psycho-geriatric services. In relation to assessment and rehabilitation, we have pointed out that the elderly are not 'new' consumers of medical services. They are in many cases being treated in general medical departments in hospitals. We feel that it would be more appropriate to reallocate some of the staff and resources from these departments to departments specialising in the care of the elderly. We consider that the revenue costs of day hospitals can be met by redeployment of existing medical, nursing and para-medical personnel within the hospitals. The necessary posts and financial resources required to operate homes and hostels for the elderly mentally infirm could, we believe, be obtained by redeployment within the psychiatric service.

Medical Aids and Appliances

12.23 **We recommend that IR£.5m be allocated to provide and maintain a wider range of aids and appliances for use by the elderly.**

Dental Care, Chiropody, Speech Therapy and Family Counselling

12.24 **We recommend that IR£.75m be allocated to improve dental services, chiropody and speech therapy for the elderly.**

Boarding Out

12.25 **We recommend that IR£.5m be made available initially to encourage boarding out as a way of meeting the welfare needs of elderly people who can no longer live at home.**

Real Level of Resources

12.26 We wish to emphasise that all the financial figures quoted in this chapter are at 1988 prices and that in future years they would have to be adjusted to take account of any rise in costs for public services.

ORGANISATION

12.27 In Chapter 3 we indicated the structures which we consider should be established at district and community care level, to deliver services to the elderly. The structure we propose will increase the effectiveness of services for the elderly throughout the country. **We recommend that the Departments of Health and the Environment request the health boards and housing authorities to draw up a plan of action to implement the recommendations of this Report. Each health board plan of action should:**

- **show the districts to be used for the delivery of domiciliary and community services to dependent elderly people and their carers;**
- **assign responsibility for co-ordinating services in each district to a district liaison nurse;**
- **identify the members of the district teams for the elderly in each district;**
- **assign the functions of the co-ordinator of services for the elderly;**
- **set out the terms of reference and membership of the Advisory Committee on the Elderly;**
- **quantify the number of dependent elderly people in each district at present and in the light of demographic trends;**

- **set out the arrangements for the identification of elderly people at risk in each district;**
- **describe the resources, including those of voluntary organisations, available to the elderly and their carers in each district and community care area;**
- **indicate the level of service development required in each district and area;**
- **indicate which existing institutions will function as community hospitals and the range of services they will provide;**
- **specify arrangements to ensure that elderly people are not admitted unnecessarily to extended nursing care;**
- **identify how resources will be redeployed to develop specialist geriatric departments in general hospitals;**
- **include proposals for staff training in the care of the elderly;**
- **include proposals for the expansion of facilities for the elderly with dementia.**

The Department of Health should approve these plans and monitor their implementation. Similar plans of action should be drawn up by housing authorities to assess and meet the accommodation needs of the elderly and be approved by the Department of the Environment.

12.28 In a number of chapters, we emphasised the need for co-operation between health boards and local authorities to provide a comprehensive response to the needs of the dependent elderly. We also feel that there is a need for co-ordination of policy towards the elderly at a national level. **We recommend that the Departments of Health and the Environment come to an arrangement whereby both can regularly discuss their respective plans for those services for the elderly for which they are responsible and progress towards implementing the recommendations of this Report.**

RESEARCH ON SERVICES FOR THE ELDERLY

12.29 Shortly after beginning our work, we became aware that a fundamental question about services for the elderly could not be answered on the basis of the information available. The question is: when is it more cost effective to care for an elderly person at home and when is it more

cost effective to care for an elderly person in a long stay hospital or nursing home. With the assistance of the Department of Health, we initiated research on this issue, which is being carried out by the Economic and Social Research Institute and funded by the National Council for the Aged, the Health Research Board and the Voluntary Health Insurance Board. The results of the research were not available before we completed this report but the answer to this question should fill an important gap in current information and have significant implications for health policy towards the elderly.

12.30 We were impressed by the results of practical measures to co-ordinate services for the elderly in different parts of the country. These initiatives have shown what well organised services can do to support elderly people at home and have strongly influenced our recommendations. However, many questions about the potential of community services to support people at home when ill remain unanswered and a more systematic effort is needed to try to answer them. Where services are provided in an institutional setting, it is relatively easy to establish ratios for the number of medical, nursing and para-medical staff to patients and the relative amount of professional expertise for different case-loads. Because services delivered to people's homes or in relatively small community based units are spread over a wide area, it is much more difficult to know how much professional support an elderly person needs when ill or what difference a caring relative or neighbour may make to the level of statutory support. This kind of information is important if services for the elderly are to be planned in a coherent way. **To overcome this problem, we recommend that two community care areas—one rural and one urban—be developed as pilot areas in which the capacity of community services to support people at home can be evaluated.**

12.31 In the two areas chosen, the CSE and the district geriatric teams would have discretion to mobilise whatever resources were necessary to support elderly people at home and to prevent unnecessary admission to acute or long stay hospitals or nursing homes. With experience, it would be possible to prepare profiles of the service inputs necessary to maintain elderly people with different degrees of dependency at home, to establish the balance between the amount of medical, nursing, home help and other supports required and to make comparisons of costs and benefits. The lessons learned in these two areas should form the basis for guidelines for the development of services nationally. Some extra resources will be necessary to support initiatives in the pilot areas but we consider that such a development is essential if official commitment to primary care and to maintaining the elderly at home is to be given substance. **We recommend that the Department of Health make IR£.1m available each year over the next five years to fund research into the potential of community services to support people at home.**

LEGAL IMPLICATIONS

12.32 Throughout the Report, we have referred to the absence of an adequate legislative framework to underpin the maintenance of dependent elderly people at home. While in some cases there is no legal barrier to health boards or local authorities carrying out what we recommend, the absence of a legal obligation is a weakness. In other cases, new legislation is required if health boards and local authorities are to implement our recommendations.

We recommend the following legal framework for the development of services for the elderly:

- **an obligation on health boards and local authorities to promote the wellbeing of the elderly in their areas of responsibility, especially those on low incomes or vulnerable for medical and social reasons and to plan, in consultation with each other and voluntary bodies, to meet these needs;**

- **an obligation on health boards to provide services to support dependent elderly people and their carers in the home;**

- **an obligation on local authorities to provide for the repair and adaptation of the dwellings of elderly people, particularly those on low incomes;**

- **an obligation on health boards to appoint Co-ordinators of Services for the Elderly and Advisory Committees on the Elderly;**

- **a requirement that all private or voluntary nursing homes have a licence from the health board before opening; that the licence be renewable on a regular basis and that licence fees be payable. Health boards should have the power to revoke a licence if certain standards are not met and to contract and pay for services provided by private and voluntary homes having regard to the medical condition and income of an elderly person;**

- **that a distinction be made in law between an elderly person subvented in a nursing home by a health board and an elderly person placed by a health board with a private householder in a boarding out arrangement. Health boards should be empowered to make boarding out arrangements on behalf of elderly people, the details to be governed by regulations.**

CONCLUSION

12.33 A central theme of our Report is the need for co-ordination in providing services for the elderly, within health boards and between health boards and local authorities. We attach equal importance to the strengthening of certain services to support elderly people at home and to ensuring that the elderly receive first class care. We believe that in the long run it will be more cost-effective to strengthen and promote services which support elderly people at home than to rely, as we have in the past, on institutional care. We are concious of the need to control strictly the level of public expenditure. On the other hand, we must point out the implications for our society of the increasing number of elderly people. We believe the needs of our elderly population can be met in a planned way and at reasonable cost. There is immense goodwill in our society towards the elderly and a consensus that the elderly should be supported in the years ahead as we would wish to be supported in old age.

SIGNED

Joseph Robins, Chairman

Alan Aylward

Jane Buttimer

Bob Carroll

Deirdre Fitzsimons

K.J. Hickey

Michael Hyland

Ann Kelly

Michael Kelly

James Lillis

Dermot McCarthy

Vincent Millet

Matt O'Connor

Joe Solan

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James H. Walsh

Richard Whitty

Ruth Barrington, Secretary

Appendix 1

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TABLE 1.1 INDEX OF THE REAL VALUE OF SELECTED WELFARE PAYMENTS, CERTAIN YEARS (C.P.I. 1966 = 100)

Payments	1966	1976	1985	Average Annual % Change 1966/ 1976	Average Annual % Change 1976/ 1985
Social Insurance					
Old age pension (couple aged 70/80)	100	130	192	2.7	4.4
Unemployment benefit (single man)	100	114	145	1.3	2.7
Unemployment benefit (couple)	100	133	162	2.9	1.8
Widow's pension (four children)	100	161	218	4.9	3.4
Disability benefit (couple & four children)	100	133	164	2.9	2.3
Social Assistance					
Old age pension (couple)	100	141	160	3.5	1.3
Unemployment Assistance (single man)	100	149	205	4.1	3.3
Unemployment Assistance (couple & four children)	100	160	210	4.8	3.1
Widow's pension (four children)	100	193	258	6.8	3.3

Note: Payments and prices at May each year.

Source: *Report of the Commission on Social Welfare,* Table 7.1 p.130

TABLE 1.2 INCOME OF ELDERLY HOUSEHOLDS COMPARED WITH NON-ELDERLY HOUSEHOLDS, 1980

	All households by age of Head		Single person households by age		House-holds with non-elderly heads
	65 and over	80 and over	65 and over	80 and over	
	£ per week				
Average size of household	2.2	2.0	1.0	1.0	4.2
Direct Income	46.3	33.9	15.4	13.0	130.2
of which, earned income of employees	21.5	13.8	1.3	0	100.7
of which, retirement pensions	8.7	6.8	5.9	4.9	1.1
of which, investment income	2.8	2.3	2.1	1.3	1.5
Social welfare old age and retirement pensions	19.4	21.0	13.7	16.4	1.1
Total State transfers	24.6	26.8	17.5	19.4	11.2
Gross Income	70.9	60.8	32.9	32.3	141.4
Direct taxation	6.5	4.4	1.3	0.9	22.6
Disposable income	64.4	56.3	31.5	31.4	118.8

Source: National Council for the Aged, *Incomes of the Elderly in Ireland,* 1984 Appendix 2 Table 12

TABLE 1.3 HOUSING AMENITIES OF ELDERLY HOUSEHOLDS (%)

Amenities	Head 65 or over		Head 80 or over	
	All	Living Alone	All	Living Alone
SANITARY FACILITIES				
Bath or Shower	62	53	52	47
Internal Toilet	69	63	61	57
Piped Water—hot	64	55	56	46
—cold	85	79	86	84
TELEPHONE	24	23	22	26
CONSUMER DURABLES:				
T.V.—coloured	29	17	21	21
—monochrome	55	54	58	45
Washing Machine	35	13	22	12
Refrigerator	73	57	60	47

Source: NCA *Incomes of the Elderly in Ireland* 1984 Appendix 2, Table 15.

TABLE 2.1: LIFE EXPECTANCY AT SELECTED AGES FOR EEC COUNTRIES

Country	Period	Sex	Life expectancy in years of age				Excess of female life expectancy over male at age 0
			0	1	40	65	
Belgium	1979-82	M	70.04	69.99	32.98	12.95	6.75
		F	76.79	76.61	38.82	16.90	
Denmark	1982-83	M	71.5	71.2	33.9	13.9	6.0
		F	77.5	77.1	39.1	17.8	
France	1982	M	70.7	70.5	33.7	14.3	8.1
		F	78.8	78.5	40.7	18.5	
Germany (FR)	1980-82	M	70.18	70.11	33.07	13.09	6.67
		F	76.85	76.66	38.78	16.77	
Greece	1980	M	72.15	72.82	35.58	14.59	4.20
		F	76.35	76.78	38.95	16.69	
Ireland*	1980-82	M	70.14	69.94	32.63	12.57	5.48
		F	75.62	75.35	37.26	15.73	
Italy	1977-79	M	70.61	70.93	33.58	13.64	6.58
		F	77.19	77.32	39.25	17.04	
Luxembourg	1980-82	M	70.0	68.9	32.4	12.8	6.7
		F	76.7	76.6	38.4	16.7	
Netherlands	1982	M	72.7	72.4	34.8	14.0	6.7
		F	79.4	79.0	40.9	18.5	
United Kingdom	1978-80	M	70.2	70.2	32.7	12.6	6.0
		F	76.2	76.1	38.1	16.6	

Source: Demographic Statistics, Eurostat 1985.

*Source: Central Statistics Office.

TABLE 2.2 TOTAL POPULATION AND PERCENTAGE DISTRIBUTION BY AGE FOR EEC COUNTRIES, 1983

Country	Total Population '000	Percentage Aged			
		0—14 years	15—44 years	46—64 years	65 years and over
Belgium	9,858.0	19.4	45.9	23.4	13.3
Denmark (a)	5,112.1	19.0	44.9	21.3	14.8
France	54,832.0	21.6	43.6	21.9	12.9
Germany (FR) (a)	61,306.7	15.9	45.0	24.5	14.6
Greece (a)	9,892.1	21.5	41.0	24.2	13.3
Ireland	3,502.3	30.1	42.4	16.9	10.6
Italy (b)	57,250.7	21.1	42.5	22.8	13.6
Luxembourg	365.5	18.0	45.3	23.3	13.4
Netherlands (a)	14,394.6	20.4	47.6	20.2	11.8
United Kingdom	56,384.4	20.0	42.8	22.2	15.0

(a) 1984 (b) 1982; Source: Demographic Statistics, Eurostat 1985.

TABLE 2.3 POPULATION AGED 65 YEARS AND OVER BY AGE GROUP AND AS A PROPORTION OF TOTAL POPULATION

Age	1966	% of total population	1981	% of total population	1986	% of total population
65 +	323,007	11.2	368,954	10.7	384,400	10.9
75 +	118,682	4.1	131,897	3.8	143,900	4.1
80 +	55,881	1.9	63,446	1.8	68,400	1.9

Source: Central Statistics Office, *Census of Population, 1981 and Population and Labour Force Projections, 1991-2021,* (1988)

TABLE 2.4 PERCENTAGE OF POPULATION AGED 65 AND OVER 1950-2025

Country	1950	1980	2000	2025
Canada	7.7	8.9	10.4	17.3
France	11.4	13.7	14.6	18.6
Germany	9.4	15.0	15.4	20.0
Italy	8.3	13.5	16.9	20.7
Japan	4.9	8.9	14.5	19.5
United Kingdom	10.7	14.9	15.3	18.6
United States	8.1	10.7	11.3	15.8
Average of above countries (a)	8.6	12.2	14.1	18.6
Australia	8.1	9.3	10.9	15.7
Austria	10.4	15.5	15.0	19.3
Belgium	11.1	14.3	15.8	19.4
Denmark	9.1	14.3	14.7	19.6
Finland	6.7	11.8	13.7	21.1
Greece	6.8	13.3	16.2	17.0
Iceland	7.7	9.5	11.2	17.3
Ireland	10.7	11.1	9.4	11.0
Luxembourg	9.8	13.9	16.9	22.5
Netherlands	7.7	11.5	13.5	20.0
New Zealand	9.0	9.2	9.9	14.7
Norway	9.7	14.6	14.6	18.6
Portugal	7.0	10.4	12.3	15.8
Spain	7.3	10.9	14.3	16.0
Sweden	10.3	16.2	16.7	20.9
Switzerland	9.6	13.5	15.9	22.0
Turkey	3.3	4.6	5.5	8.6
OECD average (a)	8.5	12.1	13.5	17.9

(a) Unweighted average

Source: *Demographic Indicators of Countries: Estimates and Projections as Assessed in 1980,* United Nations, New York, 1982. OECD MAS/WP1(84)1.

TABLE 2.5 PROJECTED POPULATION 1986—2021
NCA, DKM and CSO (000s)

Age/Year	1986	1996			2006			2011		2021
		NCA	DKM	CSO	NCA	DKM	CSO	DKM	CSO	CSO
0—14	1024.8	891.5	873.4	861.3	821.3	701.2	753.8	641.9	734.9	690.9
15—29	875.9	898.8	779.1	812.5	844.7	755.4	737.1	665.3	688.6	643.9
30—44	664.2	819.2	751.1	744.0	852.2	674.1	712.1	671.9	701.6	680.9
45—64	591.4	699.7	695.2	691.0	890.2	867.2	848.0	910.3	903.2	894.8
65 +	384.4	387.0	394.7	394.7	396.4	389.9	405.1	413.7	437.4	553.1
TOTAL	3540.7	3696.4	3493.8	3503.5	3804.9	3387.8	3456.1	3310.3	3456.7	3463.6

Sources: *Housing of the Elderly in Ireland, National Council for the Aged,* 1985
Ireland's Changing Population Structure, Davy Kelleher McCarthy Ltd, 1987 (Medium emigration projections).
Population and Labour Force Projections 1991-2021, Central Statistics Office, 1988 (Medium Emigration projections, Fertility assumption 1)

TABLE 2.6 POPULATION PROJECTIONS—PERCENTAGE DISTRIBUTION BY AGE 1986—2011
(NCA and DKM '000s)

Age/Year	1986	1996			2006			2011		2021
		NCA	DKM	CSO	NCA	DKM	CSO	DKM	CSO	CSO
0—14	28.9	24.1	25.0	24.6	21.6	20.7	21.8	19.6	21.2	19.9
15—29	24.7	24.3	22.3	23.2	22.2	22.3	21.3	20.1	19.9	18.6
30—44	18.8	22.2	21.5	21.2	22.4	19.9	20.6	20.3	20.2	19.7
45—64	16.7	18.9	19.9	19.7	23.4	25.6	24.5	27.5	26.1	25.8
65 +	10.9	10.5	11.3	11.3	10.4	11.5	11.7	12.5	12.6	16.0
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.0	100.0	100.0

Source: As Table 2.5

TABLE 2.7 DEPENDENCY AND OLD AGE SUPPORT RATIO

	1986	2006	2011	2021
Young (0-14)	0.481	0.328	0.320	0.311
Old (65+)	0.180	0.176	0.119	0.249
Total	0.661	0.504	0.511	0.560
Old Age Support Ratio	5.55	5.67	5.24	4.01

Source: Central Statistics Office, Population and Labour Force Projections 1991-2021 (1988)

TABLE 2.8 OLD AGE SUPPORT RATIO (A)—INTERNATIONAL COMPARISONS

Country	1980	Projected	
		2000	2025
Canada	7.61	6.61	3.66
France	4.66	4.55	3.40
Germany	4.41	4.39	3.13
Italy	4.79	3.89	3.04
Japan	7.63	4.60	3.19
United Kingdom	4.33	4.34	3.43
United States	5.15	5.91	4.00
Average of above countries (b)	5.65	4.90	3.41
Australia	7.03	6.17	4.09
Austria	4.15	4.48	3.30
Belgium	4.59	4.21	3.20
Denmark	4.54	4.57	3.20
Finland	5.78	5.03	2.93
Greece	4.81	3.84	3.70
Iceland	6.64	5.94	3.75
Ireland	5.22	6.82	6.22
Luxembourg	4.86	4.00	2.73
Netherlands	5.78	5.04	3.11
New Zealand	6.91	6.74	4.36
Norway	4.32	4.53	3.40
Portugal	6.09	5.32	4.13
Spain	5.82	4.47	4.01
Sweden	3.97	4.01	2.97
Switzerland	4.94	4.26	2.79
Turkey	12.44	11.02	7.64
OECD average (b)	5.73	5.20	3.72

(a) Ratio of working population (15-64) to elderly (65+)
(b) Unweighted Average.
Source: As Table 2.4.

TABLE 2.9 THE VERY OLD ELDERLY—PROJECTED INCREASE 1986—2011 (000s)

Age	1986		1996		2011		% Change 1986-2011		% Change 1986-2011
	M	F	M	F	M	F	M	F	M & F
75-79	32.5	43.0	32.2	46.1	30.7	43.5	— 5.0	— 1.0	— 1.7
80 +	24.0	43.2	28.0	52.4	26.7	54.3	+ 11.2	+ 25.7	+ 20.5
Total	56.5	86.2	60.2	98.5	57.4	97.8	+ 1.6	+ 13.5	+ 8.5

Source: *Ireland's Changing Population Structure,* Davy Kelleher McCarthy Ltd, 1987 (Medium emigration projections)

TABLE 2.10 MARITAL STATUS OF THE ELDERLY 1986-2011 (000s)

	1986						2011					
	Single		Married		Widowed		Single		Married		Widowed	
	M	F	M	F	M	F	M	F	M	F	M	F
65-74	29.6	25.6	65.9	46.7	16.0	55.9	18.2	12.3	75.8	67.8	26.1	58.3
75-79	8.5	10.0	16.2	6.5	7.8	26.3	6.4	5.3	12.8	9.2	11.4	28.9
80 +	6.1	10.7	8.3	3.1	9.7	29.4	6.7	9.1	7.5	2.8	12.4	42.4

Source: *Ireland's Changing Population Structure,* Davy Kelleher McCarthy Ltd., 1987 (Medium emigration projections)

TABLE 2.11. ELDERLY PERSONS CLASSIFIED BY TYPE OF HOUSEHOLD

Type of Household	1966		1971		1979		1981		% increase 1966-1981
	Number	%	Number	%	Number	%	Number	%	
One Person	35,024	10.8	43,378	13.1	61,327	17.0	68,034	18.4	94.2
Man and Wife	35,977	11.1	44,754	13.6	62,685	17.3	67,364	18.3	87.2
Multi-Member Total	225,640	69.9	214,820	65.1	208,425	57.7	202,961	55.0	10.0

Source: Census of Population, 1961-81, Central Statistics Office, Dublin.

TABLE 2.12 ACTUAL AND PROJECTED NUMBERS OF ELDERLY PERSONS BY HEALTH BOARD 1981—2011 (000s)

Health Board	Actual		Projected						% change 1981-2006
	1981		1991		2001		2006		
	Nos.	% of population	Nos.	% of population	Nos.	% of population	Nos.	% of population	
EHB	101.6	8.5	113.4	8.6	124.2	9.0	133.0	9.2	30.9
MHB	21.9	9.5	23.4	11.1	22.8	11.0	22.6	10.7	3.2
MWHB	34.3	11.1	35.4	11.0	34.3	10.7	34.9	10.8	1.9
NEHB	30.1	10.4	32.4	10.3	31.5	9.7	32.1	9.6	6.5
NWHB	30.2	14.5	29.5	13.6	26.6	12.3	26.5	12.1	—12.1
SEHB	40.8	10.9	42.2	10.8	41.7	10.7	42.3	10.7	3.7
SHB	61.7	11.7	63.2	11.6	60.6	11.3	61.1	11.3	— 1.0
WHB	48.3	14.2	47.7	13.8	43.6	13.0	43.1	12.8	—10.8
Total	369.0	10.7	387.2	10.6	385.8	10.4	396.4	10.4	+ 7.4

Source: Census of Population 1981 and 1986 and John Blackwell *Housing of the Eldery in Ireland,* National Council for the Aged 1985.

TABLE 2.13 TEN MOST COMMON OUTCOMES OF GENERAL PRACTITIONER CONSULTATIONS WITH PATIENTS OVER 65

Outcome/Prescription	% of all outcomes of consultations (No. 4314)
Cardiovascular drugs	15.6
Diuretic drugs	12.5
Psychotropic drugs	12.4
Antibiotics	8.3
Advice only	8.0
Analgesics (peripheral)	7.6
Gastro Intestinal Tract preparations	5.1
Synpathomimetics	3.2
Vitamins	2.3
Referrals	2.3

Source: J. Goggin, H.Jack, N. Golden and P. Lacey 'Prescribing survey in Irish General Practice'—1979 *Irish Medical Journal,* supplement, Jan. 1986

TABLE 2.14 MOST COMMON ACUTE IN-PATIENT DIAGNOSES FROM AGES 65 AND OVER, 1985

Principal Disease Category	Number of Admissions	Average *Length* of Stay	Number of Bed Days
Diseases of the Respiratory System	11541	20.5	236207
Diseases of the Digestive System	10275	10.6	108500
Systems, Signs, Ill-Defined Conditions	7833	9.3	72541
Diseases of Pulmonary Circulation	5930	17.9	106320
Ischaemic Heart Disease	5537	14.4	79928
Fractures	5393	18.1	97383
Observation, Prosthetic Fitting, Screening (etc)	4410	12.3	54101
Cerebrovascular Disease	3924	24.4	95931
Disorders of Eye & Adnexa	3660	7.7	28196
Other Diseases of Circulatory System	3595	17.8	64045
Diseases of Musculoskeletal System	3424	15.3	52247
Diseases of Urinary System	2970	11.1	32913
Endocrine & Metabolic Diseases	2645	14.8	39060
Diseases of Male Genital Organs	2318	11.9	27689
Neoplasms of Digestive Organs	2288	22.6	51650
Neoplasms of Bone, Skin and Breast	2081	12.5	25970
Neoplasms of Genito-Urinary Organs	2076	15.1	31405
Skin & Subcutaneous Tissue Diseases	1765	17.3	30545
Diseases of Nervous System	1705	22.8	38833
Neoplasms of Respiratory Organs	1569	18.0	28242
Blood & Blood-Forming Organ Diseases	1445	13.7	19786
Mental Disorders	1404	23.3	32678
Intracranial & Internal Injuries	1025	7.5	7710
Diseases of Female Genital Organs	973	8.9	8672
Lymphatic, Haemopoietic Neoplasms	878	16.4	14369
TOTAL	90664	15.3	1384921

TABLE 2.15 CAUSES OF DEATH IN PERSONS AGED 65 YEARS AND OVER—1983

		65—74	75 years and over	Total M + F		As a % of all deaths from each cause
Tuberculosis	M	24	22		M	61.3
	F	9	15	70	F	70.5
Other Infective & Parasitic Diseases	M	12	28		M	51.2
	F	6	22	68	F	48.2
Malignant Neoplasms	M	1267	1086		M	66.8
	F	862	1029	4244	F	64.0
Ischaemic and other forms of Heart Disease	M	2177	2789		M	74.0
	F	1151	3106	9223	F	88.7
Hypertensive Disease	M	42	53		M	79.1
	F	32	94	221	F	93.7
Cerebrovascular Disease	M	504	895		M	91.0
	F	447	1431	3277	F	90.3
Other Diseases of Circulatory System	M	163	301		M	87.0
	F	90	400	955	F	91.9
Diseases of Respiratory system	M	708	1358		M	84.0
	F	389	1402	3857	F	89.5
Senility	M	1	9		M	100.0
	F	—	29	39	F	100.0
Other Diseases	M	415	660		M	58.8
	F	344	861	2280	F	61.7
Injury & Poisoning	M	110	105		M	20.3
	F	64	187	466	F	47.7
All Causes	M	5423	7307		M	70.6
	F	3394	8576	24700	F	79.3
Total M & F		8817	15883	24600		74.5

Source: Table 24 Report on Vital Statistics 1983, Department of Health, compiled by the Central Statistics Office.

TABLE 5.1 HOUSING TENURE OF ELDERLY PERSON HOUSEHOLDS BY AGE OF HEAD,1980 (%)

	Age of Head		Single Person Households by Age of Head	
	65 and over	80 and over	65 and over	80 and over
Owned				
—Outright	67.0	64.7	62.2	55.0
—Tenant purchase	8.2	3.6	5.7	4.4
—With mortgage	4.3	1.2	2.1	2.0
Rented local authority	10.3	13.1	14.0	16.0
Rented, private				
Furnished	1.9	3.8	4.0	6.0
Unfurnished	5.9	9.6	8.1	13.3
Rent free	2.3	3.9	3.8	3.4
All tenures	100.0	100.0	100.0	100.0

Source: National Council for the Aged, *Incomes of the Elderly in Ireland* 1984, Appendix 2 Table 15

TABLE 5.2 PROJECTED HOUSEHOLD FORMATION AMONG THE ELDERLY (000s)

Age Group	1986			1996			2011			% increase 1986—2011
	Single/ Widowed	Married	Total	Single/ Widowed	Married	Total	Single/ Widowed	Married	Total	
60—64	36.5	44.3	80.0	33.8	43.0	76.8	42.1	69.4	111.5	38.0
65—69	42.0	37.0	79.0	43.0	36.5	79.5	42.8	52.3	95.0	20.2
70—74	40.7	28.2	68.9	43.6	26.2	69.7	39.6	30.8	70.4	2.2
75—79	30.4	13.8	44.2	35.1	12.0	47.1	32.3	13.4	45.7	3.4
80 +	25.2	6.7	32.0	32.0	7.2	39.2	34.1	6.1	40.2	25.6
TOTAL	174.8	130.0	304.9	187.5	124.9	312.3	190.9	172.0	362.8	

Source: Davy, Kelleher, McCarthy Ltd 1987. The Working Party is grateful to DKM for making this information available.

TABLE 5.3 NEW DWELLING COMPLETIONS, INCLUDING LOCAL AUTHORITY DWELLINGS FOR ELDERLY AND DISABLED 1972-88

Year	Total No. of new private dwellings completed	Total No. of new housing units provided by local authorities	No. of Special units provided for the elderly and disabled	%
1972	15,670	5,902	590	10.0
1973	18,588	6,072	600	9.9
1974	19,510	6,746	670	9.9
1975	18,098	8,794	875	9.9
1976	16,737	7,263	763	10.5
1977	18,215	6,333	893	14.1
1978	19,317	6,073	925	15.2
1979	20,330	6,214	681	11.0
1980	21,801	5,984	625	10.4
1981	23,236	5,681	631 (120)*	11.1
1982	21,112	5,686	550 (121)*	9.7
1983	19,948	6,190	609 (79)*	9.8
1984	17,942	7,002	1,013 (71)*	14.5
1985	17,425	6,523	944 (85)*	14.5
1986	17,164	5,516	830 (35)*	15.0
1987	15,000	3,074	577 (38)*	18.8
1988		1,600(e)		

Source: Department of the Environment, 1988.

*Number of demountables in brackets—most though not necessarily all would have been provided for elderly persons.

(e) Estimated.

TABLE 6.1 DIFFICULTY IN CARRYING OUT DAY TO DAY ACTIVITIES (%)

Activity with which elderly people experience difficulty	Men Aged			Women Aged		
	65—69	70—79	80 +	65—69	70—79	80 +
Getting on or off a bus	37	41	67	40	61	82
Climbing a flight of stairs	28	36	64	30	48	76
Walking half a mile	23	26	60	26	45	74
Taking a bath without help	20	25	55	17	39	72
Dressing without help	8	12	27	8	18	40
Hearing easily	8	19	42	10	17	38
Seeing to read a newspaper	13	16	36	13	22	44

Source: B J Whelan and R N Vaughan *The Economic and Social Circumstances of the Elderly in Ireland,* 1982 Table 8.5 p.83

TABLE 6.2 PERCENTAGE OF DEPENDENT ELDERLY AT HOME EXPERIENCING DIFFICULTY WITH DAILY ACTIVITIES

Activity	% with difficulty
Cooking meals	94.3
Cutting toe nails	93.0
Washing and bathing	78.0
Walking	58.0
Dressing (apart from shoes, stockings, buttons & zips)	49.0
Using toilet	40.4
Feeding	21.0

Source: National Council for the Aged *The Caring Process: A Study of Carers in the Home* (to be published)

TABLE 6.3 TYPE OF PHYSICAL DISABILITY OF ELDERLY PERSON BEING CARED FOR AT HOME (NO. 200)

Type of Disability	%
Joints	30.5
Cardiovascular/Renal	16.0
Neurological	12.0
Vision/Hearing	9.5
Respiratory	7.5
Gastro-intestinal	4.5
Malignancy	1.5
Skin	1.5
Endocrine	1.5
No physical disability	15.5

Source: As Table 6.2

TABLE 6.4 PUBLIC HEALTH NURSING POSTS BY HEALTH BOARD AND COMMUNITY CARE AREA AT 31 DECEMBER 1987

HB/CCA		No. of PHN Posts assigned to community care	District Health *Nurse/Pop. Ratio* 1 : (1986 Census)	No. of Extra Posts *required to meet* target of 1 : 2616
EASTERN				
Dun Laoghaire	1	33	3730	14
Dublin S.E.	2	33	3797	15
Dublin S.W.	3	29	2615	—
Crumlin/Tallaght	4	38	3915	19
Dublin W	5	33	3129	6
Dublin NW	6	42	3241	10
Dublin NC	7	42	2886	4
Dublin N	8	53	3544	19
Kildare	9	35	3321	9
Wicklow	10	27	3501	9
TOTAL		365*	3375	105
MIDLAND				
Offaly/Laois		41	2758	2
Longford/Westmeath		37	2562	—
TOTAL		78	2665	2
MID-WESTERN				
Limerick		38	4321	25
Tipperary N.R.		35	1697	—
Clare		30	3044	5
TOTAL		103	3058	30
NORTH EASTERN				
Meath		39	2660	—
Louth		36	2547	1
Cavan/Monaghan		30	3540	11
TOTAL		105	2873	12
NORTH WESTERN				
Donegal		58	2232	—
Sligo/Leitrim		39	2128	—
TOTAL		97	2190	—
SOUTH EASTERN				
Kilkenny/Carlow		35	3259	9
Tipperary S.R.		29	2657	—
Waterford		33	2761	2
Wexford		33	3104	6
TOTAL		130	2959	17
SOUTHERN				
Cork (Nr. Lee)	1	28	5056	26
Cork (Sth. Lee)	2	26	5617	30
Cork (North)	3	19	4150	11
Cork (West)	4	19	2546	—
Kerry		37	3349	10
TOTAL		129§	4176	77
WESTERN				
Mayo		49	2347	—
Galway		73	2441	—
Roscommon		25	2182	—
TOTAL		147	2365	—
TOTAL (ALL BOARDS)		1154	3065	243

Source: Department of Health.

*Excludes 8 posts assigned to central duties.

§Figure excludes 6 posts assigned to special duties.

TABLE 6.5 HOME HELP SERVICE 1987

Health Board	No. of Home Help Organisers	No. of Home Helps* employed full-time	No. of Home Helps* employed part-time	No. of Beneficiaries	No. of Beneficiaries who are elderly	Expenditure IR£
Eastern	77[1]	—	2,965	4,389	3,081	2,837,000
Midland	2	13	323	463	306	416,228
Mid-Western	6[2]	—	784	1,176	1,845	754,798
North Eastern	—	5	684	838	725	470,084
North Western	7[3]	32	330	979	839	969,837
South Eastern	2	7	630	766	672	424,628
Southern	4	—	1,450	1,681	1,512	913,255
Western	3	55	738	1,729	1,535	867,242
TOTAL	101	112	7,904	12,021	9,515	7,653,072

*Includes those employed directly by the health board and those employed by voluntary agencies which receive grants from health boards to provide a home help service
[1]Includes 37 part-time organisers
[2]Includes 2 part-time organisers
[3]Includes 1 part-time organiser
Source: Department of Health

TABLE 6.6 PERCENTAGE OF POPULATION AGED 65 AND OVER IN RECEIPT OF HOME HELP SERVICES—1987

Health Board	Percentage of population aged 65 and over receiving Home Help Service
Eastern	2.8
Midland	1.3
Mid-Western	3.1
North-Eastern	2.3
North-Western	2.8
South-Eastern	1.6
Southern	2.6
Western	3.1
TOTAL	2.6

Source: Department of Health

TABLE 9.1 EXTENDED CARE BEDS, 1980—1985

No. of Beds	Health Board Geriatric Hospitals/ Homes	Health Board Welfare Homes	District Hospitals (long-stay)	Voluntary Nursing Homes	Private Nursing Homes	Total
1980	7,541	1,185	1,417	4,700	—	14,843
1985	7,275	1,506	1,497	3,197	3,091	16,566

Sources: Department of Health, *Long-Stay Geriatric Statistics,* 1985; *Health Statistics* 1982 and 1986.

TABLE 9.2 MEDICAL/SOCIAL STATUS OF PATIENTS RESIDENT IN LONG-STAY GERIATRIC UNITS ON 31/12/85

Category of Unit / Patients	Health Board Geriatric Hospitals/ Homes %	Health Board Welfare Homes %	Voluntary Approved Nursing Homes %	Other Private Nursing Homes %	Total %
Social	17.7	64.0	32.1	51.4	32.3
Acute Illness	4.1	0.2	5.6	2.9	3.8
Chronic Sick	60.0	22.3	36.2	31.2	45.3
Terminal	4.3	0.9	1.8	3.3	3.2
Mental Handicap	3.2	1.7	0.8	1.7	2.2
Chronic Psychiatric	6.2	9.7	6.7	3.9	6.2
Other	4.5	1.0	4.3	2.8	3.8
Not Stated	—	0.2	12.5	2.8	3.2
Total—Per Cent	100.0	100.0	100.0	100.0	100.0
—Number	6,900	1,437	2,992	2,881	14,210

Source: Department of Health, *Long-Stay Geriatric Statistics, 1985* Table B (2)

TABLE 9.3 SEX OF PATIENTS RESIDENT IN LONG-STAY GERIATRIC UNITS ON 31/12/85

Category of Unit / Sex	Health Board Geriatric Hospitals/ Homes %	Health Board Welfare Homes %	Voluntary Approved Nursing Homes %	Other Private Nursing Homes %	Total %
Male	42.4	40.2	25.8	23.4	34.8
Female	57.5	59.8	74.2	76.6	65.2
Not Stated	—	—	—	—	—
Total—Per Cent	100.0	100.0	100.0	100.0	100.0
—Number	6,900	1,437	2,992	2,881	14,210

Source: Department of Health, *Long-Stay Geriatric Statistics, 1985* Table B(3)

TABLE 9.4 AGE DISTRIBUTION OF PATIENTS IN LONG-STAY GERIATRIC UNITS ON 31/12/85

Category of Unit / Age	Health Board Geriatric Hospitals/ Homes %	Health Board Welfare Homes %	Voluntary Approved Nursing Homes %	Other Private Nursing Homes %	Total %
Under 40 years	0.7	0.1	0.7	0.3	0.5
40-65 years	8.4	6.9	4.3	2.3	6.2
65-74 years	24.2	22.6	15.2	15.8	20.5
75 years and over	66.7	70.4	69.8	81.6	70.7
Not Stated	—	—	10.1	—	2.1
Total—Per Cent	100.0	100.0	100.1	100.0	100.0
Number	6,900	1,437	2,992	2,881	14,210

Source: Department of Health *Long-Stay Geriatric Statistics 1985* Table B (4).

TABLE 9.5 SOURCE OF ADMISSION TO LONG-STAY GERIATRIC UNITS IN 1985

Category of Unit / Source of Admission	Health Board Geriatric Hospitals/ Homes %	Health Board Welfare Homes %	Voluntary Approved Nursing Homes %	Other Private Nursing Homes %	Total %
Community	45.8	52.4	70.5	43.1	51.1
Acute Hospital	41.4	20.2	25.2	36.2	36.1
Long-Stay Hospital/Home	7.5	25.8	3.5	6.3	7.3
Other	5.2	1.5	0.8	1.0	3.4
Not Stated	—	—	—	—	—
Total—Per Cent	99.9	99.9	100.0	99.9	100.0
—Number	6,910	534	2,605	1,905	11,954

Source: Department of Health *Long Stay Geriatric Statistics in 1985* Table B (5)

TABLE 9.6 DESTINATION OF DISCHARGES FROM LONG-STAY GERIATRIC UNITS IN 1985

Category of Unit / Sex	Health Board Geriatric Hospitals/ Homes %	Health Board Welfare Homes %	Voluntary Approved Nursing Homes %	Other Private Nursing Homes %	Total %
Community	35.6	25.6	61.3	26.6	39.8
Acute Hospital	9.7	11.7	5.4	6.1	8.3
Long Stay Hospital/Home	7.3	29.3	3.5	6.5	7.2
Death	43.5	32.4	28.9	50.0	40.6
Other	3.8	1.0	0.3	1.8	2.6
Not Stated	0.1	—	0.5	9.0	1.5
Total—Per Cent	100.0	100.0	99.9	100.0	100.0
—Number	6,904	519	2,795	1,783	12,001

Source: Department of Health *Long-Stay Geriatric Statistics, 1985* Table B(6).

TABLE 9.7 LENGTH OF STAY OF PATIENTS DISCHARGED FROM LONG-STAY GERIATRIC UNITS IN 1985

Category of Unit / Length of Stay	Health Board Geriatric Hospitals/ Homes %	Health Board Welfare Homes %	Voluntary Approved Nursing Homes %	Other Private Nursing Homes %	Total %
Less than 6 months	56.6	38.7	52.4	58.1	55.1
6 months to 1 year	14.7	13.3	7.4	6.7	11.8
1 to 2 years	11.0	11.4	5.3	4.7	8.7
2 to 4 years	6.9	17.5	8.0	10.7	8.2
4 to 6 years	3.7	9.8	3.4	5.4	4.2
6 to 10 years	4.1	7.3	2.0	5.1	3.9
More than 10 years	3.1	1.9	1.4	3.3	2.7
Not Stated	—	—	20.0	6.1	5.6
Total—Per Cent	100.1	99.9	99.9	100.1	100.2
—Number	6,904	519	2,795	1,783	12,001

Source: Department of *Health Long-Stay Geriatric Statistics 1985* Table B(7).

TABLE 9.8 SIZE OF GERIATRIC HOSPITALS AND HOMES AND DISTRICT HOSPITALS 1985

Bed Size	Geriatric Hospitals/ Homes	District Hospitals
	Number	Number
0— 45	5	22
50— 99	8	6
100—149	7	1
150—199	10	—
200—249	7	—
250—299	3	—
300—349	3	1
350—399	1	—
400—449	—	—
450—499	1	—
Total	45	30

TABLE 9.9 GERIATRIC BEDS AND POPULATION AGED 65 YEARS AND OVER AND DISCHARGES PER BED BY HEALTH BOARD 1985

	Eastern	Midland	Mid-West	North-East	North-West	South-East	Southern	Western	Total
No of Beds	4,784	1,188	2,104	1,366	1,281	1,946	2,297	1,606	16,572
No of Beds per 1000 pop. age 65 years and over	44.1	51.6	60.6	42.9	42.3	46.2	36.3	32.6	43.3
No of Discharges	2,924	1,592	2,165	770	2,184	2,849	3,476	1,527	
Discharges per bed	.61	1.3	1.0	.6	1.7	1.5	1.5	1.0	

NOTE Bed numbers include long-stay district hospital beds but exclude psychiatric beds.

Sources: *Long-stay Geriatric Statistics* 1985, Planning Unit, Department of Health *Health Statistics* 1986, ibid.

TABLE 9.10 COMPARISON BETWEEN CURRENT AND PROJECTED RATIO OF ELDERLY POPULATION AND LONG-STAY BEDS

Health Board	Current ratio of beds per 1,000 aged 65+	Ratio of current beds to projected pop. 2001
Eastern	44.1	38.5
Midland	51.6	52.1
Mid-Western	60.6	61.3
North Eastern	42.9	43.4
North Western	42.3	48.1
South Eastern	46.2	46.7
Southern	36.3	37.9
Western	32.6	36.8
Average	43.3	43.0

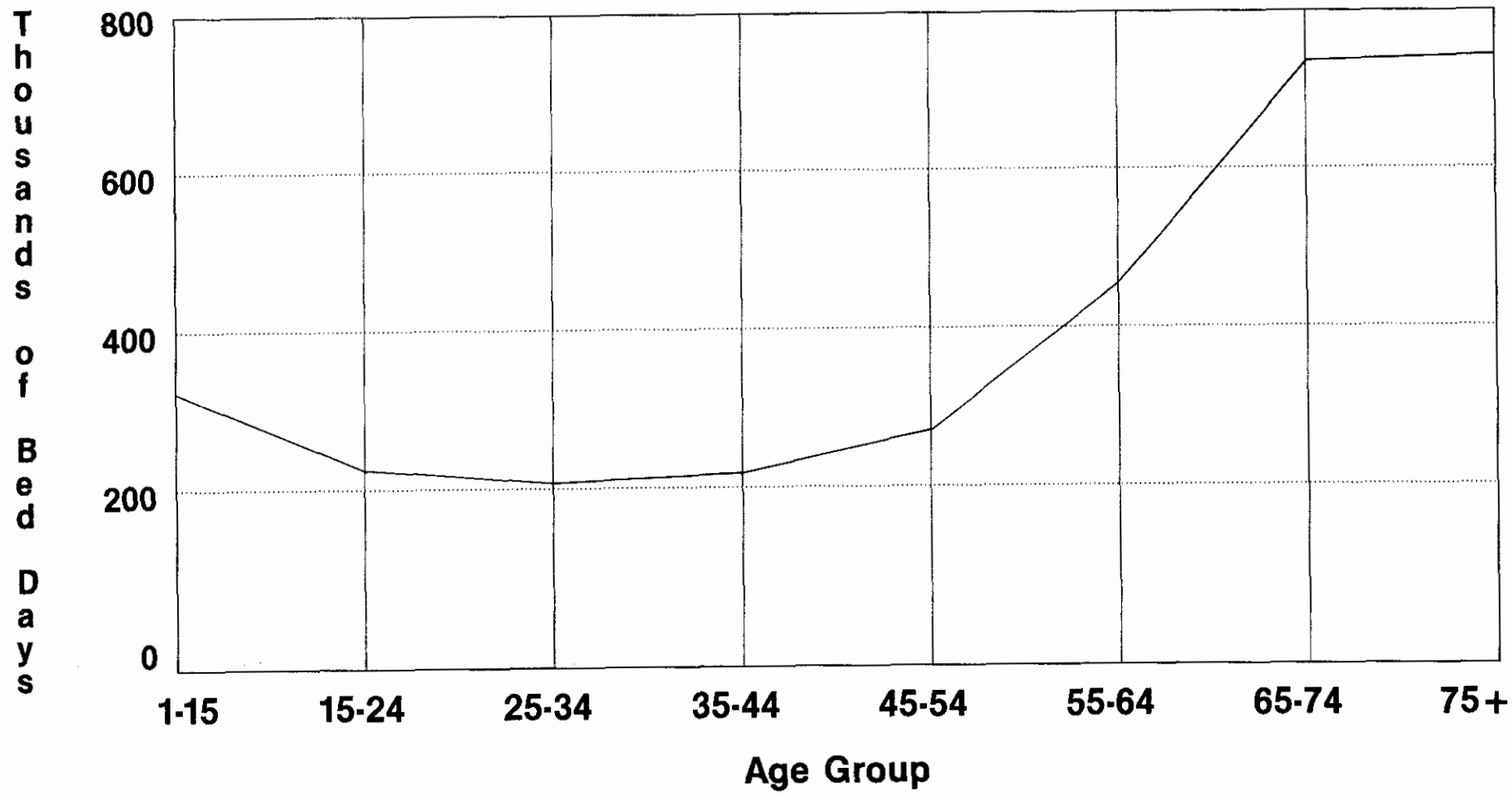
Source: Department of Health.

TABLE 9.11 PRIVATE NURSING HOMES

	No. of Nursing Homes in Health Board Area	Total No. of Beds in Nursing Homes in Health Board Area	No. of Homes Approved under Section 54 of the Health Act 1970 for subvention purposes	No. of Beds subvented in approved homes	No. of Patients resident in nursing homes in Health Board Area on 31/12/87	No of beds subvented under Section 26 of the Health Act 1970
Eastern	95	1,921	27	N.A.	N.A.	1,340
Midland	15	332	7	192	205	24
Mid-Western	22	771	16	599	667	—
North-Eastern	15	198	—	—	177	—
North-Western	5	96	1	18	83	—
South-Eastern	25	649	17	314	586	80
Southern	30	613	3	110	N.A.	—
Western	29	527	7	167	N.A.	—
Total	236	5,107	78	—	—	1,444

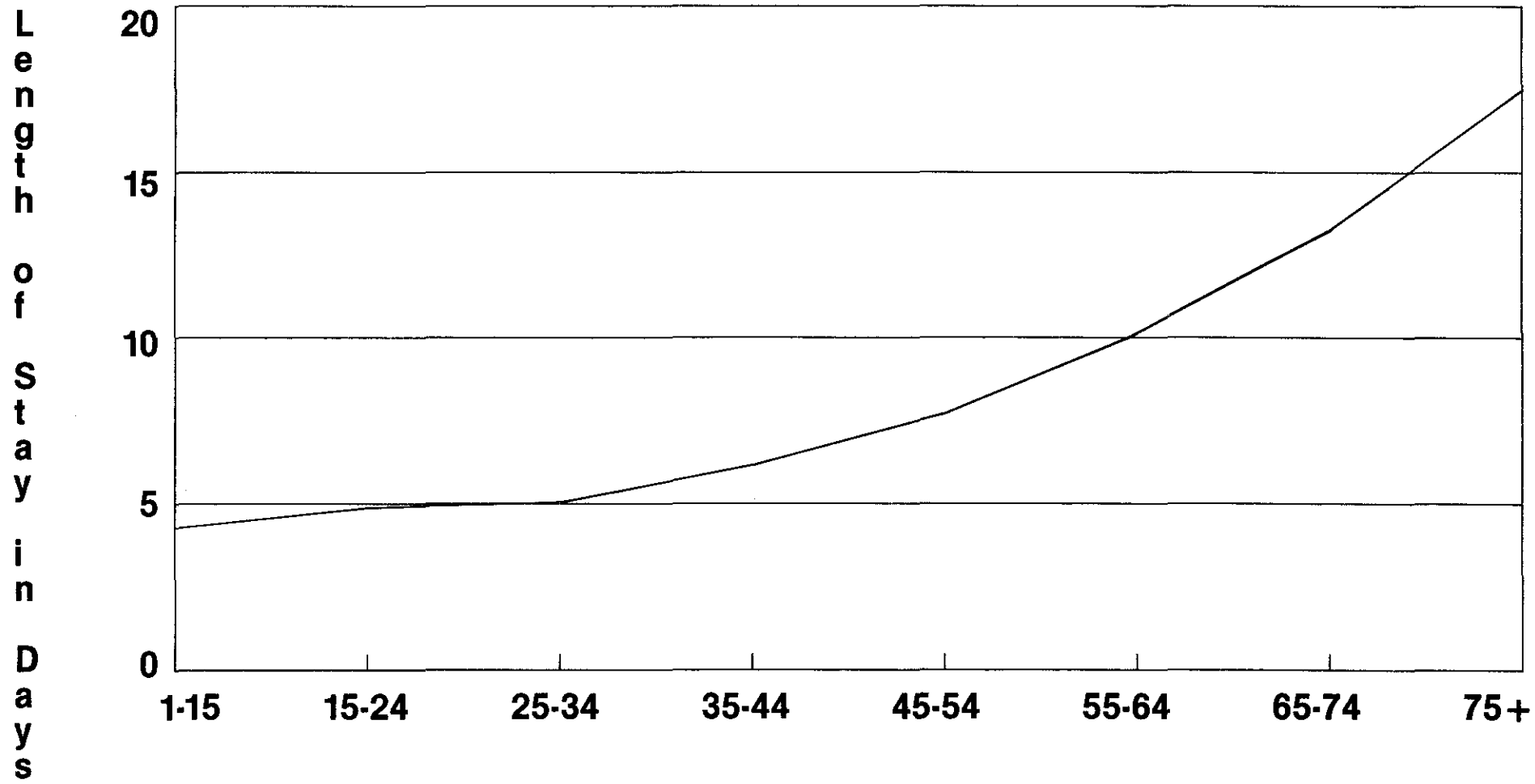
N.A.— Not Available

FIGURE 8.1 NUMBER OF BED DAYS BY AGE 1985



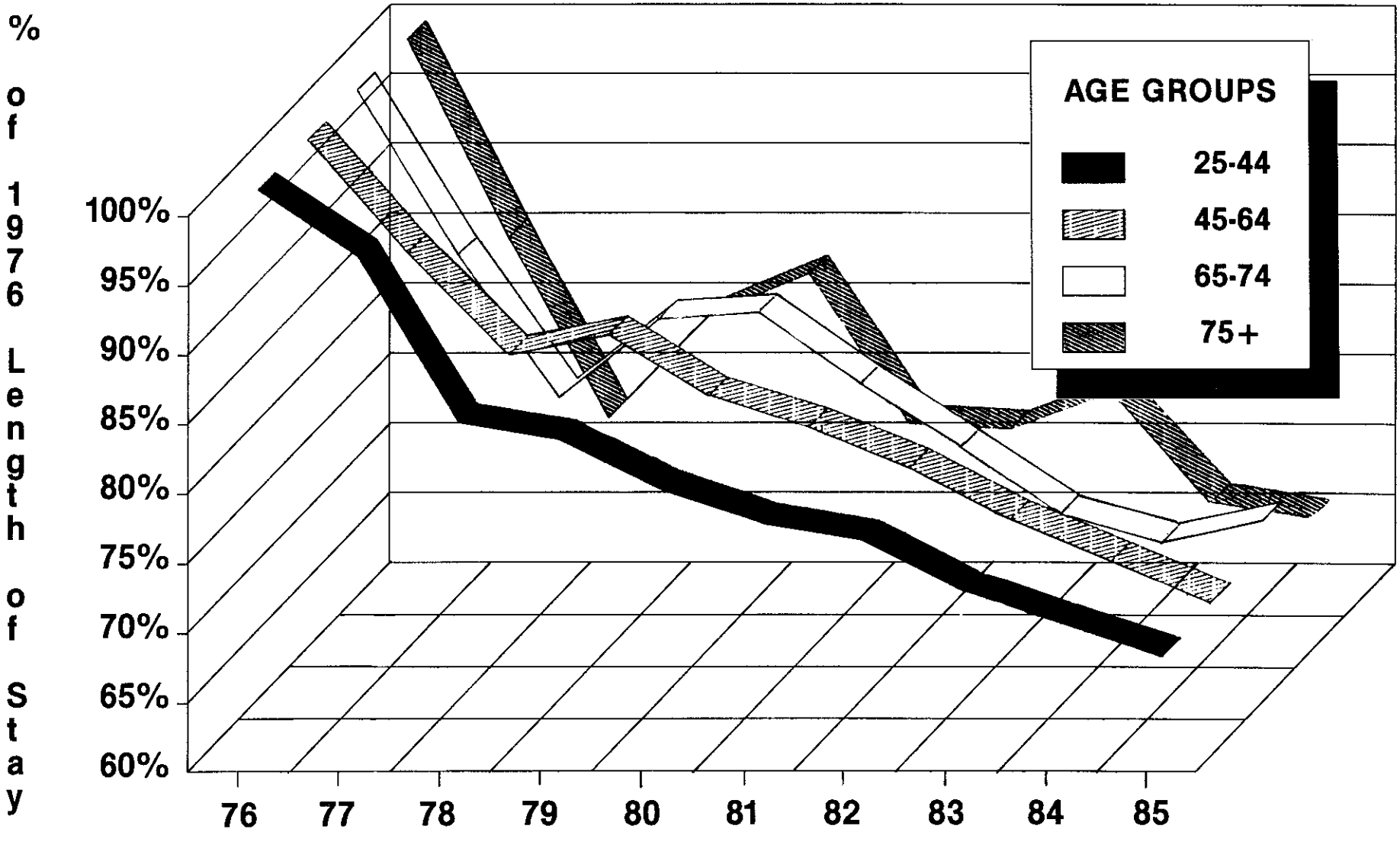
Source: Hospital In-Patient Enquiry, 1985

FIGURE 8.2 AVERAGE LENGTH OF STAY IN DAYS BY AGE 1985



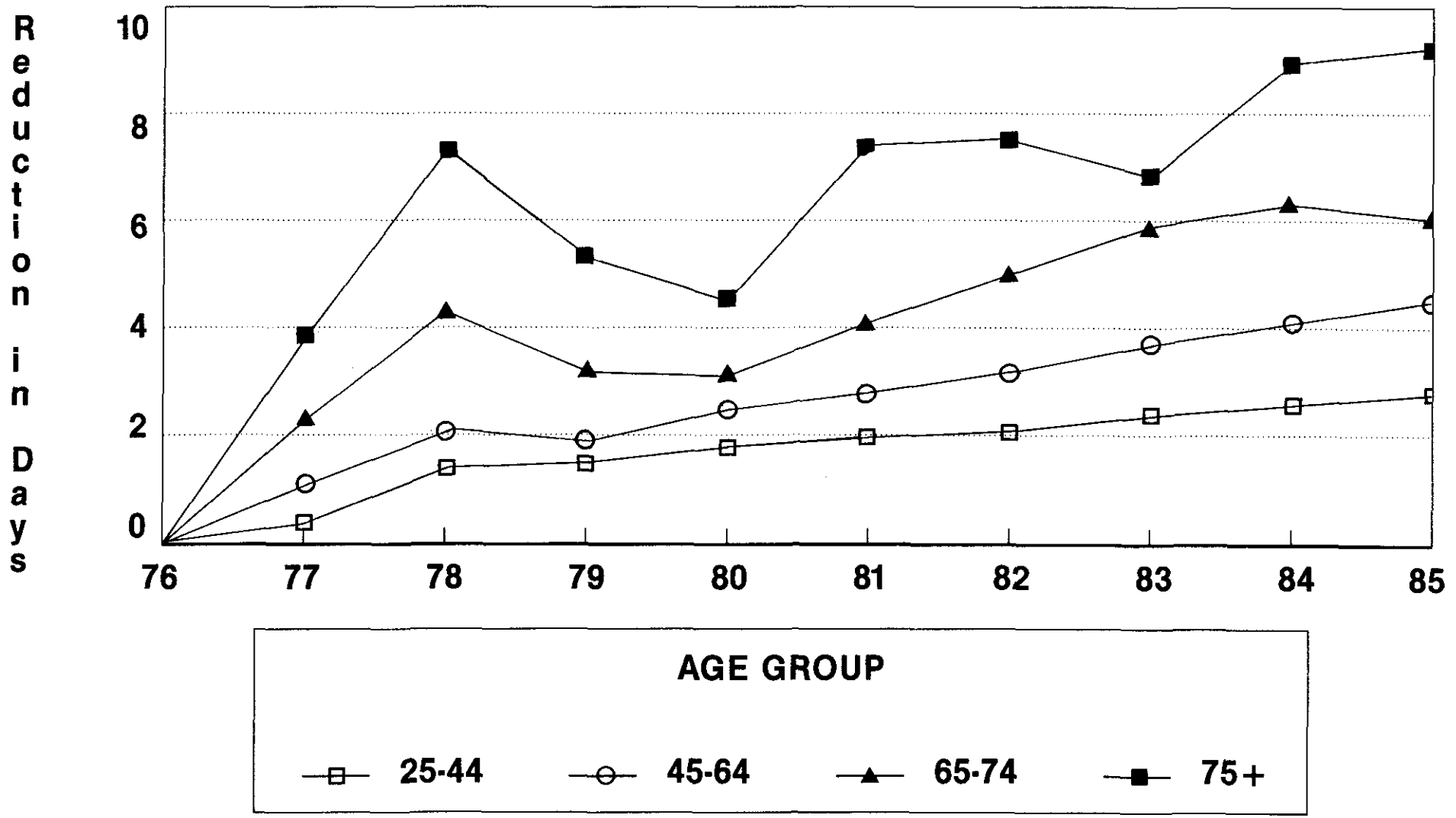
Source: Hospital In-Patient Enquiry, 1985

FIGURE 8.3 PERCENTAGE OF 1976 LENGTH OF STAY BY AGE 1976-1985



Source: Hospital In-Patient Enquiry, 1976-1985

FIGURE 8.4 ABSOLUTE REDUCTION IN MEAN STAY FROM 1976 to 1985 BY AGE GROUP



Source: Hospital In-Patient Enquiry, 1976-1985

Appendix 2

Average Weekly Costs to Health Boards of Selected Forms of Long-Stay Geriatric Care: November 1984

(i)	District (Long-Stay) Hospitals (estimated average)[1]	£267.67
(ii)	Health Board Long-Stay Geriatric (estimated average)[1]	£159.00
(iii)	Health Board Welfare Homes (estimated average)[1]	£ 85.90
(iv)	Private Nursing Homes and Centres (maximum at 1.7.84)	£ 40.25
(v)	Boarding Out (range of payments)[2]	£6.00—£30.00

Source: [1]Dail Debates Vol 353 No 9 Columns 1761 2, 13th November 1984

[2]*Home from Home? Report on Boarding Out Schemes for Older People in Ireland,* National Council for the Aged, 1985, Table 3.3 p. 23

Appendix 3

Facilities for the Elderly which were visited by members of the Working Party

1. Day hospital, assessment and rehabilitation facilities and long-stay accommodation at St James's Hospital, Dublin.

2. Housing accommodation for the elderly in Cork City, including voluntary housing provided by SHARE.

3. St Joseph's Geriatric Assessment/Rehabilitation Unit, St Vincent's Hospital, Athy.

4. Baltinglass District Hospital.

5. Sheltered housing and day care centre at Beaufort, Glasthule, Dun Laoghaire.

6. St Patrick's Geriatric Hospital, Cashel, Co. Tipperary.

7. Community Nursing Unit, Buncrana, Co. Donegal.

8. Facilities for the Confused Elderly, South Belfast.

9. Facilities for the Confused Elderly, St Brendan's Hospital, Dublin.

10. Welfare Home and Day Care Centre, Tullamore, Co. Offaly

11. Welfare Homes in Boyle and Castlerea, Co. Roscommon

12. One member of the Working Party accompanied a public health nurse on visits for one day.

Appendix 4

Organisations and Individuals who made written submissions

1. Association of Occupational Therapists of Ireland
2. County and City Managers' Association
3. Department of Social Science, University College, Dublin
4. Department of Social Studies, Trinity College, Dublin
5. Faculty of Health Sciences, Trinity College, Dublin
6. Faculty of Medicine, University College, Dublin
7. Home Help Organisers' Association
8. Ms Mary Horkan, Department of Social Science, University College, Dublin.
9. Irish Association of Social Workers
10. Irish Congress of Trade Unions
11. Irish Private Hospitals' and Nursing Homes' Association
12. Irish Society of Physicians in Geriatric Medicine
13. Irish Society of Medical Officers of Health
14. Medical Officers of Hospitals in the South East
15. Muinter Na Tire
16. Dr. J. Murphy, Consultant Physician in Geriatric Medicine, Castlebar General Hospital
17. National Council for the Aged
18. National Social Service Board
19. Ms. Anne O'Loughlin, Social Worker, Department of Geriatric Medicine, St Laurence's Hospital.

20. Royal College of Physicians in Ireland
21. Royal College of Psychiatrists—Irish Division
22. Senior Citizens' Committee, Irish Red Cross Society
23. SHARE
24. Society of Chiropodists of Ireland
25. South Inner City Community Development Association
26. The Alzheimer Society of Ireland
27. The Housing Centre
28. The Institute of Community Health Nursing
29. The Irish Association of Chartered Physiotherapists
30. The Irish College of General Practitioners
31. Mr Gerry Whyte, Lecturer in Law, Trinity College, Dublin

Organisations and Individuals who made oral submissions

1. Mr. D. Doherty, Chief Executive Officer, Mr D. O'Dwyer and Mr. P. J. Fitzpatrick, Programme Managers, Midland Health Board.
2. Geriatric Assessment Team, Co. Mayo
3. Dr. J. Gibbons, South-Eastern Health Board
4. Irish Society of Physicians in Geriatric Medicine
5. The Institute of Community Health Nursing
6. The Irish College of General Practitioners

Appendix 5

Norms for Service

1. Community Services

(a)	*Public Health Nurses to General Population*	1 : 2,616
(b)	Home helps to elderly population	4.5 (whole-time equivalent) : 1,000
(c)	*Day centres to elderly population*	1 : 1,800

2. General Hospital Services and Extended Care

(a)	Department/Consultant Physician, geriatric medicine, to general population	1 : 80,000
(b)	Assessment beds in general hospital to elderly population	2.5 : 1,000
(c)	Rehabilitation beds to elderly population	3 : 1,000
(d)	Day hospital places to elderly population	2 : 1,000
(e)	Extended nursing care beds to elderly population	10 : 1,000
(f)	Welfare home beds to elderly population	25 : 1,000

3. Psychiatric services

(a)	Acute assessment beds to elderly population	1.5 : 1,000
(b)	Beds for elderly severely mentally infirm to elderly population	3 : 1,000
(c)	Hostel/welfare beds for elderly mentally infirm to elderly population	6 : 1,000 (included in norm at (f) above)
(d)	*Day hospital places to elderly population*	2 : 1,000