NATIONAL COUNCIL ON AGEING AND OLDER PEOPLE

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

The functions of the Council are as follows:

1. To advise the Minister for Health on all aspects of ageing and the welfare of older people, either at its own initiative or at the request of the Minister and in particular on:

   (a) measures to promote the health of older people;
   (b) measures to promote the social inclusion of older people;
   (c) the implementation of the recommendations contained in policy reports commissioned by the Minister for Health;
   (d) methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for older people;
   (e) methods of encouraging greater partnership between statutory and voluntary bodies in providing services for older people;
   (f) meeting the needs of the most vulnerable older people;
   (g) means of encouraging positive attitudes to life after 65 years and the process of ageing;
   (h) means of encouraging greater participation by older people;
   (i) whatever action, based on research, is required to plan and develop services for older people.

2. To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:

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

3. To promote the health, welfare and autonomy of older people.

4. To promote a better understanding of ageing and older people in Ireland.

5. To liaise with international bodies which have functions similar to the functions of the Council.

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

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CONFERENCE PROCEEDINGS

Review of the Implementation of the Recommendations of *The Years Ahead - A Policy for the Elderly* and Implications for Future Policy on Older People in Ireland
CONFERENCE PROCEEDINGS

Review of the Implementation of the Recommendations of *The Years Ahead - A Policy for the Elderly* and Implications for Future Policy on Older People in Ireland

Thursday 11th and Friday 12th September 1997

Jury’s Hotel, Ballsbridge, Dublin
The National Council on Ageing and Older People produces a wide range of publications on ageing and the welfare of older people in Ireland. Copies of the Council’s Publications Catalogue are available from the address above.
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Foreword

The National Council on Ageing and Older People is an advisory body to the Minister for Health on all aspects of ageing and the welfare of older people. In fulfilment of its terms of reference, the Council has recently published a Review of the implementation of the recommendations of the 1988 report The Years Ahead – A Policy for the Elderly.

The Review was a major undertaking and required contact with Government Departments, the eight health boards, a large sample of local authorities and many other organisations. All of the recommendations contained in The Years Ahead report were analysed, and a comprehensive picture of health and social services for older people was presented. The Council is indebted to the authors of the review, Dr Helen Ruddle, Dr Freda Donoghue and Mr Ray Mulvihill for their efforts in preparing such a comprehensive and high quality report.

The Review was launched by Dr Tom Moffatt, the Minister of State at the Department of Health with responsibility for Older People, at a conference held in Jury’s Hotel, Ballsbridge, Dublin, on September 11th-12th 1997. The conference generated a very high level of interest, attracting over 400 delegates on both days. Stimulating papers were presented on all aspects of the Review and are summarised in this Proceedings document.

I would like to express my thanks to the Minister for officially opening the conference, to the speakers for preparing such excellent papers and to all participants for their contributions to the event. I would also like to thank the Council’s Projects Officer, Ms Trish Whelan for
organising the conference and Mr Pádraig Ó’Moráin for his work in preparing this publication.

On reading both the Review and the Conference Proceedings it is clear that there is much concern about the manner in which *The Years Ahead* report was implemented. This is reflected in the Council’s recommendation (contained in the Review) that a new strategy on health and social care services for older people be developed, and that a legislative framework be created to govern the delivery of these services.

However, I would like to take this opportunity to stress the value of *The Years Ahead* report, and its great contribution to thinking on the delivery of services for older people. There were many welcome developments over the period 1988-1997, particularly in the field of geriatric medicine, which would not have occurred without the publication of the report. The original Working Party who produced *The Years Ahead* report deserve our thanks for prompting such developments.

*Michael White*

*Chairman*

*December 1997*
Thursday 11 September

FIRST SESSION: OPENING OF CONFERENCE

Introduction

Mr Michael White
Chairman, National Council on Ageing and Older People

The National Council on Ageing and Older People was set up as an independent statutory body in March 1997. It succeeded the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990). It is fitting therefore that this, the first conference in our new role, should be the examination of the most significant milestone to date in the relationship between the State and older members of the community.

In 1986, the then Minister for Health, Dr Rory O’Hanlon brought together a Working Party broadly representing all providers of State services to older people at that time. The terms of reference of the Working Party were as follows:

“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.”


*The Years Ahead* report had more than 120 main recommendations relating to health and social care services for elderly people at home, in the community, in hospitals and in long-term care. It was adopted as official policy by the Department of Health and, according to the 1994 Health Strategy document *Shaping a Healthier Future,* remains the guiding influence on the development of services for older people.

As part of its terms of reference the National Council for the Elderly was asked to advise the Minister for Health on the implementation of the recommendations contained in *The Years Ahead* report. This conference will enable you to hear the results of that review and to discuss its findings in greater detail.

There are, however, a few general points that I would like to make as a background to the review.

*The Years Ahead* report has been a progressive force in developing services for older people since 1988 and even where specific recommendations were not implemented it acted as a yardstick and as a stimulus to subsequent developments. It has become apparent, however, that in spite of its unquestionable value, a new blueprint is now required. This new blueprint
should build on the achievements resulting from the implementation of some of the recommendations of *The Years Ahead* report and take into consideration subsequent policy initiatives and developments. The Council endorses the target set in the Department of Health Strategy for Effective Healthcare - *Shaping a Healthier Future* - of 90 per cent of people over 75 years residing in their own homes in the community. This will mean an extra 60,000 by the year 2011. The Department of Health target is useless, however, unless we have a plan for ensuring that it is met.

The Council believes a legislative framework governing the provision of essential services to older people is necessary. These care services should particularly include the home help service. It is noteworthy that the only significant legislation on services for older people since 1988 (the 1990 Health Act) has led to a growth in institutional rather than community-based care.

Since 1988 there has been a growing appreciation of the contribution of voluntary groups and family carers in the provision of care and health services. A new strategy should include a commitment to meaningful partnership between statutory and voluntary agencies and to adequate support for family carers who are the backbone of community care for dependent older people in Ireland. The strategy should be ‘consumer orientated’, meaning that the particular needs of older people should be taken into account in the planning and delivery of services to them. It should also support initiatives which promote healthy ageing and positive attitudes towards older people in society at large and among health service providers in particular.

The Council is concerned at the ongoing growth in the private home sector and the rising costs to the State associated with this increase. While private nursing homes undoubtedly meet an existing need, home and community care must be the cornerstone of any health and social care strategy for older people.

Our Review of *The Years Ahead* report is not an isolated study and should be read in parallel with a number of other reports produced by the Council in recent years. It is clear now that
the Irish health care system, in its present guise, has great difficulty in redeploying resources from one sector to another. Although there has been a large expansion in spending on child care following the 1991 Child Care Act, there is little to indicate a corresponding growth in services for older people, despite the demographic shift. Even within services for older people there seems to have been little change in the proportion of resources devoted to community versus institutional care, in spite of an emphatic commitment to the former in many official policy documents. There is little evidence to date that population ageing in Ireland will lead to an increase in resources directed towards older people.

There is, however, a mood for change throughout our health care system and most of the health boards are currently reviewing their own effectiveness. The Offices for Health Gain and for Health Management have been created. In addition, we are told that we now live in the land of the Celtic Tiger and I am quite confident that not a single taxpayer would object to some of our new found affluence going towards frail elderly in the community.

Most importantly, in my view, we have for the first time a Minister of State at the Department of Health with responsibility for Older People. This is an appointment by our new Government that I greatly welcome and the Council looks forward to supporting the Minister in his new role. Dr Tom Moffatt brings to his Cabinet post all the experience of his former work as a General Practitioner in the West of Ireland and is now ideally placed to co-ordinate the activities of relevant Departments in creating and implementing the necessary strategies.
Opening Address

Dr Tom Moffatt T.D.
Minister of State at the Department of Health with Responsibility for Older People

The Years Ahead report, for close on ten years now, has formed the basis for policy decisions on services for the elderly. Ten years is quite a long period and it is entirely appropriate that we should now take stock on what has happened over the past decade and take a long hard look at what needs to be done in the coming years.

The Review on the implementation of the report provides us with a comprehensive evaluation of the extent to which the recommendations of The Years Ahead have been implemented and points to areas where a reorientation of policy may be required. As such, I regard it as a very valuable document and one which will help me in shaping policy on services for older people into the new millennium.

Changes in demography have implications for health service planning for older people. The increase in life expectancy, especially in the number of people reaching advanced old age, has implications for the manner in which services for older people are planned. Most older people are healthy and take an active part in the social and economic life of their communities. Nevertheless, as episodes of illness increase with age, it is important that service planning is carried out in good time to ensure that the necessary facilities and support structures are in place to meet the needs of older people.

The Council's predecessor, the National Council for the Elderly, has been to the forefront in highlighting the needs of older people arising from such demographic changes. The many research projects undertaken by the Council have added greatly to our understanding of the needs of older people. The work undertaken by the current and previous Councils is highly regarded by my Department and is seen as an important contribution to health service planning. I look forward, therefore, to having a good working relationship with the National
Council on Ageing and Older People and hope to be meeting with Council representatives shortly.

The commission of this major study by the National Council is to be commended, as is the painstaking work of the Policy Research Centre at the National College of Industrial Relations in producing this most comprehensive report. I do not intend to comment on individual findings as the Department's response will be given later during the conference. However, it is quite obvious to me that there are clear messages coming from the report to which Minister Cowen and I will have to give very serious consideration.

We need to get away from the dependency culture which exists at present and engage in a vision on ageing which encompasses a broader view of the needs of older people. There needs to be better co-ordination between the various Government Departments who have the responsibility of providing services for older people and I will endeavour, during my term of office, to bring this about.

The report has identified gaps in the services for older people and I will be doing all in my power to eliminate these deficiencies. I am referring especially to the community-based services such as Day-Care, Home Help and Nursing/Paramedical Care in the home. I would like to see older people themselves being consulted about their needs and thus be involved, in a practical way, in the future planning of the services. I will be particularly interested in hearing practical suggestions for improving feedback from older people when I meet with the various interest groups over the coming weeks and months.

In an ideal world, I would of course like to be able to tackle all of the issues raised in the Review over a short time frame. However, successive Governments have been faced with the difficulty of finding the necessary resources to meet the many pressing demands in the health and personal social services. Notwithstanding such difficulties, it is my aim to ensure that services for older people get an equitable share of developmental funding. Within that funding it is my intention to implement a programme of initiatives based on priorities which I hope to establish following consultation with the National Council and other groups involved
in promoting the interests of older people. The National Council has identified a number of areas in need of improvement in the short-term arising from the findings of this Review which will be of particular relevance in this process.

While the Review highlights a number of shortcomings in services for older people, it would be unfortunate if we failed to recognise that significant developments have taken place in the period since The Years Ahead was published.

One of the most important advances in the care of older people has been the establishment of specialist departments of medicine for older people in most of our general hospitals. Arrangements are in train to appoint consultant geriatricians to the remaining hospitals. These specialist departments ensure prompt admission of older persons, specialist assessment and treatment, rehabilitation and, in many cases, continuing support in a day hospital on discharge.

We are also implementing a capital programme of providing small- to medium-sized community nursing units, either in new locations or to replace old unsatisfactory accommodation. Respite care and day care facilities have been improved to provide some support for carers. Additional nurses, paramedical staff and Home Helps have been employed and additional equipment purchased to support older people particularly in their own homes.

A major development has been the implementation, with effect from the 1st September 1993, of the Health (Nursing Homes) Act 1990. This Act has as its objective, the provision of high standards of care and financial assistance to those dependent elderly in need of care in private nursing homes.

But I, as the very first Minister with specific responsibility for the well-being of older people, must look to the future. My main responsibility is obviously in the provision of health services, although I will be seeking to achieve better co-ordination in the manner in which all State services are organised and delivered to older people.
I accept that we still have much work to do to achieve a comprehensive support service to enable older people to continue to live in their local communities. In this regard, I intend to listen to the views of older people themselves and the various interest groups involved in their welfare. I look forward to working with the National Council whose expert advice will be of great benefit to me.
SECOND SESSION: THE REVIEW FINDINGS

The Years Ahead - A Policy for the Elderly: Review of the Implementation of Recommendations and Implications for Future Policy

Dr Helen Ruddle
Policy Research Centre, National College of Industrial Relations and Co-Author of Report

Introduction

The aims of this paper are:

• to draw together the main findings of the Review on implementation of the recommendations of The Years Ahead;

• to examine the obstacles to implementation of the recommendations which have emerged in the Review;

• to consider the appropriateness of The Years Ahead as a continuing blueprint for the care of older people and to present a possible framework for the development of future strategy.

Objectives of the Review and research procedures

Since its publication in 1988, The Years Ahead has formed the basis for official policy on the care of older people in this country. Now, almost 10 years on, it is timely to review the current situation and to consider the way forward for an appropriate and effective care system for older people as we face the 21st century.

In commissioning this Review, the specific objectives set out by the National Council for the Elderly - now the National Council on Ageing and Older People - were to elicit:

• factual information on the recommendations that have been implemented;
• factual information on the recommendations that are in the process of being implemented;
• factual information on the recommendations that have not been implemented;
• perceptions of the effects of recommendations implemented;
• reasons for the non-implementation of recommendations.

Implementation of the recommendations required action from different agencies and from people at different levels within those agencies. Accordingly, in the Review information and feedback was sought -:

At the level of policy-making from -

At the level of management from -
   CEOs of the health boards, Programme Managers in the health boards, City and County Managers from a sample of local authorities.

At the level of public service provision from -
   Directors of Community Care, Co-ordinators of Services for the Elderly, District Liaison Nurses, Superintendent and Senior Public Health Nurses, GPs, Chief Nursing Officers (Psychiatry), Environmental Health Officers, Social Workers, Superintendent Community Welfare Officers, Home Help Organisers, Hospital Liaison Officers, Geriatricians, Consultants in Psychiatry of Old Age, Paramedical Services (Physiotherapists, Occupational Therapists, Chiropodists, Speech Therapists, Dieticians) Consultant Orthopaedic Surgeons and Ophthalmologists.

At the level of voluntary and private provision from -
   Voluntary housing organisations, Voluntary bodies representing different interests of older people, Voluntary organisations providing certain core services to older people, Carers organisations, Nursing homes organisations.
A number of data collection procedures were employed, including documents analysis, individual and group interviews, written questionnaires and written submissions. It should be noted that the data was collected over the first half of 1996 and changes in services and further efforts at implementation of recommendations may have occurred between then and now.

Focus and objectives of recommendations in The Years Ahead

The major focus of the Working Party was to enable older people to remain in their own homes for as long as possible and, where this was no longer possible, to provide appropriate residential options. In order to achieve this aim the Working Party made something in the region of 200 recommendations in relation to types and levels of services, organisation and delivery of services and the funding of services.

In order to address the first aim of this paper, which is to draw together the findings on the extent of implementation of the many recommendations, the organising framework adopted is the objectives for service provision set out by the Working Party. These were that services should be:

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

Since the bulk of the recommendations were concerned with the objective of comprehensiveness, this paper focuses mainly on the question: What do the findings tell us about how comprehensive the current care system is? The paper will also address two further questions: What do the findings tell us about how equitable the current system is? What do
the findings tell us about how co-ordinated the current system is?

Is the care provided comprehensive?

Comprehensiveness of care: Continuum of care options
A comprehensive care system implies the provision of a range of care options along a continuum which has preventive care as one of its end-points and long-stay care at the other end:

| Preventive Care | Anticipatory Care | Care at Home | Care through Housing | Care in the Community | Acute Hospital Care | Long Stay Care |

The findings reveal that while improvements in services have been made and new initiatives have been instigated, there are still significant gaps in the care options available to older people. Gaps at different points on the continuum of care mean that there is no real choice about the care option that should be selected when a care need arises, and implementation of the most appropriate care is seriously hampered. The gaps can also mean that older people find themselves either remaining at a stage too low down on the continuum and receiving an insufficient level of care or being moved to a care option too far up the continuum and being prematurely moved to institutional care. The comprehensiveness of each of these care options will now be discussed.

Comprehensiveness of preventive care: health promotion
As a result of *The Years Ahead*, when the National Council for the Aged was reconstituted as the National Council for the Elderly in 1990, one of its new Terms of Reference was to advise the Minister for Health on measures to promote the health of the elderly. Since *The Years Ahead* the publication of *Shaping a Healthier Future* in 1994 brought a new emphasis on general health promotion, followed in 1995 by the national Health Promotion Strategy.

In the specific case of older people, one of the most significant steps in health promotion at
national level is the present Healthy Ageing Programme of the National Council on Ageing and Older People; one strand of which is the development of a healthy ageing strategy. The strategy will enable the health concerns specific to older life to be properly addressed and it will enable identification of the most appropriate channels and means of access for health promotion among older people.

While progress is evident at national level, at local level much remains to be done. In accordance with the Working Party's recommendation, the health boards do provide some health education for older people and for carers but the services are patchy, unstructured, uncoordinated and ad hoc. Health boards need to develop specific structures for provision of a comprehensive, coherent health education service dedicated to the needs of older people. The development of the national healthy ageing strategy will be very important in guiding and informing the programmes provided at local level.

**Comprehensiveness of anticipatory care**

The GP and the PHN are the central players in anticipatory care of older people. The findings show, however, that in both cases there are problems preventing them from playing their full role.

The PHN is frequently distracted from anticipatory care because of managerial and supervisory duties and the demands on her for curative nursing care. If the PHN is to fulfil her proper role, there must be an increase in the numbers dedicated to anticipatory care and an increase in back up services such as RGN panels, care assistants and Home Helps. With regard to the role of the GP in anticipatory care, it emerges from the findings that, at present, case finding by GPs is opportunistic rather than proactive. Contrary to the recommendation of the Working Party, there is little incentive in the current General Medical Service system to encourage anticipatory care and the infrastructure to support it is lacking. There are still major questions about the best ways of implementing and supporting anticipatory care, especially when dealing with vulnerable older people who do not wish to be treated.

Contrary to the recommendation of the Working Party, a continuing issue in anticipatory care
is the failure to modernise and standardise the procedure for identifying older people 'at risk'. The Review shows widespread concern among PHNs about this issue with definitions and criteria for 'risk' varying between, and even within, health boards. National guidelines must be developed for a formal, structured and standardised 'at risk' register which allows the most appropriate use of, and ready access to, the information compiled.

**Comprehensiveness of home and community-based care**

The major home-based services considered by the Working Party were the PHN service, the home help service, paramedical services (physiotherapy, speech therapy, chiropody) and counselling services. The main community-based service considered was day care centres. Many improvements have been made in home and community-based services since 1988. However, in 1994 *Shaping a Healthier Future* acknowledged that community-based services are not, as yet, developed to the extent that they can appropriately complement and substitute for institutional care or provide adequately for those in the community dependent on support. Based on 1996 data, this Review again notes continuing deficits.

**Home care: PHN service**

The findings show that the current PHN service faces three major problems: inadequacy of the numbers employed and, as already mentioned, distraction from proper role and inadequacy of back-up services. Figures from the Department of Health for 1995 reveal that all but two of the health boards have reached the 1975 recommended ratio of 1:2616; the overall ratio being 1:2567. However, when those performing a managerial role (Superintendent and Senior PHNs) are excluded from the figures, it emerges that the number of PHNs on district duties is below the recommended level in four of the eight health boards. The figures also include RGNs who are not qualified to undertake the full range of PHN duties. The Review shows that the RGN panels recommended by the Working Party have been established in all boards and are highly regarded and seen to play a crucial role in home-based curative nursing. There are problems, however, with high turnover in panel participation and with the inadequate numbers employed. The service is under-funded and must be given a much greater level of resources if it is to fulfil its potential value.
**Home care: Home help service**

It is widely recognised that home help is a key service in home care for older people. Despite the recommendation of the Working Party that there should be a legal obligation for its provision and calls from the National Council on Ageing and Older People to designate it as a core service, the service is still discretionary. This contributes to variations in levels of provision, eligibility for the service and the nature of the tasks carried out. While all the health boards have attained the norms for provision recommended in *The Years Ahead*, the level of the service still falls short of what is required.

The scope of the service is also limited and it fulfils only to a limited extent the kind of out-of-hours and respite functions envisaged by the Working Party. Not only did *The Years Ahead* underestimate the level of provision required but it also underestimated the funding needed and despite increases, the service is still under-funded.

A further issue to be addressed is the relationship between the Home Help and care attendant services. The specific role, functions and focus of the home help service need to be clearly delineated so that decisions about the most appropriate care can be made more easily. (It should be noted that the Policy Research Centre is currently carrying out a review of the Home Help Service on behalf of the Department of Health).

**Home care: Paramedical services**

The Working Party had envisaged that a range of paramedical services would be available in the home. One of the most evident deficits emerging from the findings is the inadequate level of provision of paramedical services. Not only is domiciliary delivery of services extremely limited, but there is wide concern about the level and nature of community-based provision. Physiotherapists, for example, are concerned about the gap between hospital care and care in the community and the inadequacy of rehabilitation facilities. Speech therapy services are perceived as being overstretched from the huge demands of children. The major issue in the chiropody service is its uneven distribution across different parts of the country. As well as financial constraints there seems to be an ambivalence among health board managers about the necessity and feasibility of a domiciliary service. There is a suggestion from frontline
service providers that the value of such services, particularly in the prevention of health problems among older people, is not properly acknowledged.

**Community-based care: social work services**

The Working Party identified social workers as being best equipped to address the interpersonal problems that can arise in the caring relationship between an older person and a family member. A major gap in services for older people identified in this Review is the lack of a community social work service, with only one health board currently providing such a service. The major problem is that community social work services are focused almost totally on families and children and are greatly overstretched in attempting to meet the demands of this group. There also appears to be an attitudinal problem whereby the full potential of a community social work service for older people is not recognised.

The narrow view of the social work service must be countered and, as in most other European countries, social workers must be recognised as having a unique contribution to make in areas such as case management, resolution of family problems, assessment of needs and advocacy. The growing awareness of abuse of older people further underlines the need to provide a community social work service for older people. Development of a social work service for older people has been given little attention since *The Years Ahead* and requires much greater exploration and research to allow the development of appropriate working models.

**Community-based care: day care centres**

An integral element in community care for older people and their carers is the day care centre. Because of their importance, the Working Party recommended that health boards should be obliged by law to provide them. The National Council for the Elderly also recommended that day care facilities should be considered a 'core service' that is underpinned by legislation and appropriate statutory funding. This recommendation has not been implemented and the provision of day care facilities is still at the discretion of the health boards. The findings highlight the inadequacy of current levels of provision and the unevenness in provision across different areas with some areas having no day care at all. Legislation must be enacted to ensure that such an essential service is provided to a certain standard throughout the country.
and is available to any older person who requires such care.

Further issues arise around the major role of voluntary organisations in day care provision. The Working party recommended that the Department of Health should draw up a model contract for use where voluntary organisations provide day care on behalf of a health board. Failure to implement this recommendation makes it very difficult to ensure standards of provision and quality of service. Contracts of service should be drawn up which set out the obligations of both the health board and the voluntary organisation providing the service, and funding procedures should be formalised and standardised across the country. The recommendation that health boards provide training for voluntary staff in day care centres has not been implemented to any great extent. A further source of concern is the lack of transport which makes the day care centre inaccessible for older people in some areas.

There is a widespread perception among managers and service providers that day care facilities are one of the most valuable services for older people. Research is needed, however, to systematically evaluate the activities of day care centres, to assess their benefits from the point of view of the users and to determine principles of good practice.

**Comprehensiveness of housing options**

The Working Party recommended that the role of voluntary organisations in meeting the housing needs of elderly people should be expanded. This has happened; over the period 1988-1996 voluntary housing organisations provided more housing for older people and disabled than local authorities. To facilitate this expansion of the role of voluntary organisations the Working Party also recommended that the capital grants available to them should be increased. Maximum grants were increased in 1991 and 1995, though not to the degree recommended. In view of the substantial increases in housing costs in recent years a review of the grants is urgent.

The Working Party identified sheltered housing as one of the key housing options for older people and recommended that it be considered as a first choice for older people who cannot be maintained in their own homes. Most new sheltered housing projects are provided by
voluntary/non-profit housing organisations. Such organisations provide a range of on-site care and social support services in sheltered housing projects with communal welfare facilities, including services equivalent to home help and domiciliary care. However, there is no funding mechanism to assist them in meeting the costs of such services.

The Working Party also recommended health board-local authority liaison, especially with CSEs in the planning of sheltered housing, but few formal procedures are in place to facilitate this. In view of this, and the enhanced role of voluntary/non-profit housing organisations, it may be timely to consider funding procedures and other arrangements which would adequately reflect the contribution and responsibility of health boards, local authorities and voluntary/non-profit organisations in providing housing for older people.

The Working Party recommended that more information about the housing circumstances of older people should be sought. Some progress has been made in this regard. For example, under the 1988 Housing Act older people constitute one of ten categories of housing need, and the 1996 statutory assessment of housing need took account of housing applicants suited to measures other than local authority housing. However, the comprehensive survey into housing conditions of the elderly, recommended by the Working Party, was not undertaken, and it is not clear that existing information collection procedures regarding the housing needs of older people are sufficiently proactive or comprehensive.

Elderly people living in conventional housing can benefit from a variety of grants schemes, loans, remedial works, and other programmes. The Special Housing Aid for the Elderly Scheme, the only such scheme exclusively addressed to older people, expanded considerably in recent years. The value of grants paid under this scheme in both 1995 and 1996 was more than double the value of such grants paid in 1988. However, the existing schemes have not been replaced by a comprehensive and flexible repairs and adaptations scheme as was recommended in The Years Ahead.

A comprehensive housing policy for older people should take a longer term view of all environmental design and construction. A ‘designing for life’ approach would consider the
requirements of people over the entire life cycle. It could identify opportunities and avoid costly mistakes.

**Comprehensiveness of acute hospital care**

All of the health boards have made some commitment to the appointment of geriatricians since *The Years Ahead*; the numbers employed having increased from 11 in 1988 to 24.5. A source of concern, however, is that in many instances geriatricians are not dedicated full-time to older people but are also involved in general patient care. Geriatricians have a powerful role to play not only in the physical care of older people, but also in acting as lobbyists for them within the hospital service to ensure they get the services they require. All acute hospitals need access to at least one geriatrician who should work full-time on medical care for older people. This may not be possible in the smallest hospitals, but there should be enough support there to ensure that at least half of their time is with older people. Indeed, where this is the case a specialist geriatric department may not be wholly necessary as outreach can be provided effectively once specialised support staff and equipment are available to a geriatrician.

Geriatricians need designated beds. No health board has reached the recommended norm for assessment beds (2.5 per 1000 older people) and only two have reached the norm of three per 1,000 older people for rehabilitation beds.

Geriatricians also need day hospitals and dedicated day hospital places in order to provide effective medical care for older people. Day hospital places are not dedicated at present and only £0.2m has been provided annually for day hospital facilities since 1989 instead of the recommended annual £0.5m.

While six health boards have admissions and discharge policies for older people in acute hospitals, follow-up procedures on the discharge of vulnerable older people need to be made more effective. The average length of stay by older people in acute hospitals is falling. Regular assessment and other follow-up procedures need to be systematised so that the older patient does not get lost only to surface again with similar problems.
Comprehensiveness of long-stay care

Long-stay care was discussed by the Working Party in terms of two options: the community hospital and the nursing home.

The development of community hospitals has been slow and the level of services provided within these units has not met the scale envisaged in *The Years Ahead*. As the funding allocated by the Department of Health has been substantially below the level recommended, not surprisingly funding is noted as one of the main constraints on the development of the community hospital. Not all community care areas in all health boards have community hospitals located in them and there is scope for improvement in the level of services provided such as assessment and rehabilitation, paramedical, specialist and geriatrician support.

The demand for long-stay beds is expected to grow and although the recommended norm of 10 beds per 1000 older people has been exceeded by all health boards, these beds are not dedicated but are generic in designation. The issue of dedicated beds needs to be urgently addressed so that the different needs of older people are met.

The demand for beds is also being met by nursing homes which have increased in number since 1988. Relationships between nursing homes and health boards have improved since the *Health (Nursing Homes) Act 1990*, but nursing homes cannot be regarded as the panacea for all long-stay care problems. A range of options must be available to older people.

Dedicated places are also required in the area of welfare accommodation. While there has been a move away from welfare homes, and health boards have responded to the recommendation for more flexible options, there has not been a corresponding increase in dedicated alternative welfare accommodation. All health boards fell way below the norm recommended by the Working Party, which indicates that not only does the issue of dedicated beds and places need to be addressed, but a comprehensive and co-ordinated response is required to the issue of welfare accommodation.
Comprehensiveness of psychiatric care
Psychiatry of Old Age services are poorly developed with, at present, only four consultants in post in two health boards. The 1996 recommendation of Keogh and Roche of one consultant per 10,000 is a long way from realisation. A developed Psychiatry of Old Age service would ensure essential early screening and assessment, which at present are in need of improvement. It would also address the current geographical inequity which prevails.

Dedicated day hospital and day care places are both required, as day care centres can provide an essential support to the day hospitals. Dedicated places are also required in high support hostels for those with functional mental illness as most boards do not provide dedicated places.

Older patients with dementia are poorly served at present. A national Psychiatry of Old Age service would provide some help in ensuring better treatment and accommodation for those who suffer from dementia. Rather than the recommendations made in *The Years Ahead*, as welfare and high support hostel accommodation is unsuitable for those with dementia, safe secure accommodation is required. *The Years Ahead* norms could be redesignated, with six dedicated places per 1000 older people in a non-psychiatric nursing environment for those with dementia and no associated behavioural problems. Three places per 1000 older people could be dedicated in long-stay psychiatric units for those with dementia and associated behavioural problems. Under funding, however, needs to be urgently addressed.

Comprehensiveness of support for carers
Although the Working Party acknowledged the role of informal carers, there is a perception among carers’ organisations that carers’ needs were not adequately covered in *The Years Ahead*. This Review corroborates the findings of previous research that major needs of carers, such as education and training, information and advice, adequate financial support, domiciliary support and respite, are not being adequately addressed and that carers require much greater public support than they are currently receiving. Among both health board management and service providers it is acknowledged that failure to provide adequate support services for carers is one of the major deficits in current care provision for older people. An
indication of some progress in this regard is that *Shaping a Healthier Future* does promise to strengthen home support services for carers, while the national Health Promotion Strategy also plans a specific programme of health promotion for carers.

There appears to be an assumption that family members will continue to provide care and that family care is always the best care. Both these assumptions need to be challenged; a dysfunctional family, for example, is clearly not the best environment for care of a frail older person. *The Years Ahead* also seems to assume that supportive neighbours and communities are available to carers; again this assumption needs to be tested.

**Is the care provided equitable and accessible?**

**Equity and issues of eligibility**
Moving on from comprehensiveness, the next question to be answered from the findings is whether the care provided is equitable and accessible. The Review indicates that there are still issues of inequity in the current care system. One of these issues relates to eligibility for services. While eligibility for most of the major health services is specified in legislation, there are certain very important community services, such as home help, day care and paramedical services for which there are no set eligibility criteria. *Shaping a Healthier Future* promises that national guidelines on eligibility and charges, which will be applied in a uniform manner in all areas, will be introduced for those services without legislative provision at present.

**Equity and discretionary nature of core services**
The Working Party identified certain services, such as home help and day care services, as so important that health boards should be obliged by law to provide them. Similarly, the National Council on Ageing and Older People considers Home Helps, meals-on-wheels, day care and sheltered housing as 'core services' that are so essential to the quality of life of older people that they require to be underpinned by legislation and appropriate statutory funding.

To date, the recommendation on legislation has not been implemented. The Department of Health suggests that the health boards are already fulfilling their responsibility to provide
such services and it is unnecessary to impose a legal obligation.

This Review shows, however, that while the level of provision of these core services has improved since 1988, their discretionary nature has led to a situation where older people in different areas of the country experience considerable variations in extent of provision, in scope and nature of provision and in eligibility criteria. It is clearly inequitable that an older person's access to an essential service should depend on the area in which she or he happens to live. The approach taken to the care of older people differs markedly from that adopted toward the care of children where the *Child Care Act 1991* imposes a clear statutory duty on the health boards to provide a range of child care and family support services. In the interests of equity, the same awareness of need and commitment of resources must be devoted to older people.

**Equity and voluntary provision of core services**

Over-dependence on voluntary organisations to provide certain essential services is another factor which can lead to inequity in the care system. Dependence on voluntary organisations does not in itself necessarily lead to inequitable provision, but equity requires clear-cut partnership arrangements that allow for effective joint planning and that ensure standards are maintained and a quality service is provided in all areas. Formal contracts were seen by the Working Party as a key element of partnership but the Review shows that contracts of more than one year are rare and, moreover, many voluntary organisations appear resistant to such arrangements. *Shaping a Healthier Future* has promised the development of a legislative framework for working relationships between voluntary organisations and the health authorities.

**Equity and information on services**

Another dimension to equity is access to services through provision of information on them. In view of the major changes proposed by the Working Party, it is remarkable that the provision of information on services was not addressed in *The Years Ahead*. As a consequence, one of the deficits in the current care system identified by organisations representing older people, is lack of information. *Shaping a Healthier Future* promises that
the Department of Health and the new health authorities will ensure that people have ready access to information about their entitlements and how to avail of them. Assessment of the extent to which the proposed new structures will enable this to happen awaits research.

There are also several voluntary organisations, such as Age Action Ireland, Age and Opportunity, National Federation of Pensioners Associations, which are committed to the provision of information to older people. Inequity of access due to lack of information is a fundamental problem which must be eliminated. Pathways to care must be clearly signposted so that older people know the options available to them, so that they have the information they need to decide on the best option for their particular circumstances, and so they know how to access that option.

**Equity and transport**

A final and critical dimension to equity is access to services through provision of appropriate transport. This Review reveals continuing widespread concern among both older people and managers and service providers about transport facilities. Unfortunately, no one Government Department appears to be taking clear responsibility for the problem. As a result none of the recommendations of the Working Party for action at Departmental level has been fully implemented.

At health board level few attempts have been made to carry out the kind of review of transport resources recommended by the Working Party. This has hindered identification of options and possible solutions. Attempts at providing transport have been made in all health boards but not all see it as their responsibility to ensure transport and see it instead as a problem for the public transport authorities. Indeed the most innovative and active proposals for addressing the problem have been put forward by voluntary organisations such as Forum and the Rural Transport Initiative which is due to start a pilot project on ‘systems for advanced management of public transport’ in Summer 1997.

**Are the services provided co-ordinated?**
The third question to be answered from the findings is whether the services provided are co-ordinated. The Working Party made specific recommendations for a co-ordination structure at district, community care, regional and national levels. It emerges from the Review that while attempts at co-ordination have occurred, the recommendations of *The Years Ahead* are still far from being realised. The Review also raises questions about certain elements of the co-ordination structure proposed in *The Years Ahead*.

**Co-ordination: district level**
At local level, there are nurses who perform a co-ordination function. They cannot however operate in the manner envisaged in *The Years Ahead* because they are usually not dedicated to co-ordination and their time is not devoted solely to older people. It also emerges that few have the back-up needed to enable them to do their job effectively. For example, few have the support of district teams at local level and not all have the support of CSEs at community care area level. Although there are benefits from having a district team, purely dedicated to co-ordination, it may not be the most important focus for the future improvement of co-ordination. There appears to be some doubt about the feasibility and effectiveness of district teams and questions have been raised about the difficulty of keeping them going and maintaining commitment.

Further research and evaluation are required to assess the effectiveness of teams and to determine principles of good practice for their operation. The absence of district teams and failure to institute an alternative raises questions about how the current system deals with certain co-ordination issues such as the representation of voluntary organisations in service planning and delivery.

**Co-ordination: community care area level**
At community care area level, most boards have made attempts to establish co-ordination structures. Co-ordinators of Services for the Elderly have been employed in most health boards but, in many cases, not to the level recommended in *The Years Ahead*. Again those performing the co-ordination function are not always dedicated to the task and often cater for groups other than older people.
Like the District Liaison Nurses, the CSEs lack the support needed in carrying out their jobs effectively. Important issues in this regard are the current state of flux in many of the health boards due to slow implementation of new management structures, the continuing lack of effective linkages between care programmes and the lack of effective organisational arrangements for liaison between different service providers. A further issue which has to be addressed is the lack of clarity about the role experienced by some CSEs.

Overall while liaison does occur, it is for the most part *ad hoc* and informal. The Working Party was particularly concerned about liaison between GPs and PHNs, but the Review shows that the situation remains much the same as in 1988 with no formal co-ordination arrangements between these professionals. Overall, the lack of formalised structures for liaison within health boards is a source of concern to GPs, PHNs, District Liaison Nurses, CSEs and other professional service providers in the health field and is an issue that must be addressed in any future policy for older people.

**Co-ordination: health board level**

Co-ordination of the different health board care programmes has long been a source of concern. In all the health boards there is an attempt at cross-programme co-ordination by having one particular person (usually a Programme Manager) take overall responsibility for the care of older people. Most health boards also have plans to move from the 'care programme' to the 'care group' approach. The Review highlights the need in the present system for more formal liaison arrangements between hospitals and community services. The absence of dedicated liaison personnel in general hospitals is a significant deficit. The hospital-community barrier needs to be lowered further with effective discharge procedures. Unless effective liaison structures are in place there is a danger that older patients get 'lost' once they are discharged from hospital and that inappropriate re-admissions occur.

**Co-ordination: inter-agency level**

At the level of inter-agency co-ordination, *The Years Ahead* identified the lack of formal co-ordination links between the health boards and local authorities as one of the major problems
to be addressed. It appears from the Review that little has been done to remedy the problem. District Liaison Nurses and CSEs, for example, have very little contact with housing officers even though appropriate housing is a part of the care continuum. This is a continuing source of dissatisfaction for District Liaison Nurses, CSEs and PHNs. The lack of inter-agency liaison at local level is in part due to a lack of liaison at Departmental level. A clearer lead on co-ordination must be taken by the Departments of Health and the Environment to ensure that co-ordination of health and housing services begins to happen at regional and district levels.

While there is evidence of interdepartmental links with regard to some aspects of the care of older people, such as their security needs, nevertheless most existing linkages are informal and *ad hoc*. A potentially important development in this regard is the Strategic Management Initiative which focuses on interdepartmental co-operation and sets out structures for its implementation.

**Co-ordination: challenges involved**

Since the publication of *The Years Ahead*, pilot projects on co-ordination at local level, established by the National Council for the Elderly, have highlighted the challenges involved. Co-ordination is a difficult goal to achieve and the specification of administrative structures, as in *The Years Ahead*, while necessary, is not in itself sufficient to ensure that co-ordination will happen. Apart from the fact that certain elements of the structure proposed in *The Years Ahead*, such as the district teams and advisory committees, may need to be re-evaluated, further developments are needed to support the structures that are effective.

An ethos of co-ordination needs to be created which permeates the entire care system, starting at national level and filtering down to regional and local levels. Accordingly, this Review calls for the development of a national policy on co-ordination. Support, education and training are needed to enable different service providers to work together, and to enable the development of a common mission across agencies with disparate goals and responsibilities. This is particularly relevant at a time when resources are scarce and the setting of priorities is essential. Co-ordination also requires that issues of responsibility and accountability are acknowledged and addressed. This kind of support for co-ordination requires a much greater
commitment of personnel and financial resources than is currently evident. Resolution of these issues is vital as lack of co-ordination seriously hampers the provision of appropriate, flexible and effective care.

**Obstacles to implementation of recommendations**

Thus far, this paper has focused on achievements and continuing deficits in regard to implementation of the Working Party's recommendations with regard to a comprehensive, equitable and co-ordinated care system. Turning now to the second aim of the paper, the next subject of discussion is the obstacles encountered by those attempting to implement the recommendations.

It has to be acknowledged that in some instances lack of implementation reflects not so much failure on the part of the implementing agency but a shortcoming within *The Years Ahead* itself. The main thrust of *The Years Ahead* was the establishment of norms for different services and it allowed little scope for individual health boards to explore the fit between such norms and their own particular needs and circumstances. Variations in care systems across the health boards can sometimes represent an attempt to adapt to local needs. But, while allowing for innovativeness and flexibility in responding to particular circumstances, at the same time there are certain core services which have to be made available to a certain standard to all older people wherever they may live. Where such core services are not being provided, it becomes imperative to discover why this is so.

In some instances failure to implement a recommendation may be traced to ambivalence at management level about its value or effectiveness. This is evident, for example, in regard to services such as community social work, domiciliary paramedical services, boarding out and Care Assistants. Some ambivalence is also evident in regard to delivery mechanisms such as district teams and advisory committees. Ambivalence also arises at Government Department level. This is evident in failure to implement recommendations requiring interdepartmental liaison and collaboration, failure to provide national guidelines for services such as 'at risk' registers, day care facilities and boarding out and failure to produce a model contract for
partnership between voluntary and statutory agencies.

A basic obstacle to implementation which emerged in several instances in this Review was lack of information about the recommendation. This lack of information applied not just to specific recommendations but also to *The Years Ahead* document itself. For example, some agencies outside the health boards, such as local authorities and the Health and Safety Authority, were not aware that any recommendations had been made concerning their area of responsibility.

Perhaps the most important obstacle to implementation is the legal status of recommendations. *The Years Ahead* report had no statutory basis and the recommendations made by the Working Party for the legal underpinning of certain services and of co-ordination structures have not been implemented. At Government Department level it appears that encouragement and support are preferred to legal obligation as a means of ensuring services are provided for older people. However, developments in the field of child care indicate that legislation is considered to be essential to ensure standards of care for other groups. While acknowledging the danger of rigidity in legislating for all aspects of care, the absence of a legislative framework for a certain standard of care with obligatory provision of core services, is an issue which has to be addressed.

Each of the factors identified above has contributed to shortcomings in achieving the objectives of *The Years Ahead*, but the most frequent obstacle in feedback from managers and service providers is failure to provide the funding required. The table below summarises the capital and revenue recommendations made by the Working Party and the amount of finance actually allocated to implement the report.

It can be seen from Table 1. below that some services - Departments of Geriatric Medicine and community hospitals - without taking inflation into account, have received approximately the level of capital funding recommended. In the case of community hospitals, however, it was only in 1996 that substantial funding (£5m) was given which compensated for the underfunding in 1989-1995. It should be noted in respect of these services that the
recommendations applied to the years 1989-1993 only, and it is assumed here that the same level of funding would apply after 1994. With regard to dental services, under the Dental Treatment Services Scheme 1994, £9.8m was made available annually from that year, £6m of which has been spent on older people. The provision for Home Helps increased substantially in recent years and is now estimated to be running at £17.6m for 1996.

Table 1. **Summary of capital and revenue allocations of The Years Ahead report**

<table>
<thead>
<tr>
<th>Capital funding recommended</th>
<th>Funding allocated</th>
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| Day care: £0.5m in each of five years from 1989 | £0.2m 1989-1995  
£0.4m 1996 |
| Department of Geriatric Medicine: £0.1m in each of the next five years from 1989 | £0.1m annually |
| Day hospital places: £0.5m annually from 1989 | £0.2m annually |
| Community hospitals: £2m in each of next five years from 1989 | £1m 1989-1995  
£5m 1996 |
| Facilities for dementia: £1.2m in each of next 20 years from 1989 | Low: little development in area |
| Alarm systems: £0.2m in each of the five years from 1989 | £50,000 annually |

<table>
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<tr>
<th>Revenue funding recommended</th>
<th>Funding allocated</th>
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</thead>
<tbody>
<tr>
<td>Panels of Registered General Nurses and home care assistants: £2m to be given immediately in 1989</td>
<td>£800,000 annually</td>
</tr>
<tr>
<td>Home Helps: additional £6m to be made available to a total of £13.65m annually</td>
<td>In 1995 was £16.4m in 1996 it is estimated that will be £17.6m</td>
</tr>
<tr>
<td>Physiotherapy: additional £0.05m annually</td>
<td>Total of £0.5m since 1989</td>
</tr>
<tr>
<td>Joint replacement and cataract surgery: additional £0.25m per annum</td>
<td>£1.65m approx. allocated since 1995, joint replacement and cataract surgery not categorised separately</td>
</tr>
<tr>
<td>Medical aids and appliances: £0.5m</td>
<td>£100,000 annually</td>
</tr>
</tbody>
</table>
| Dental, chiropody and speech therapy services: £0.75m | Dental: running at £9.8m per annum since 1994 (£6m to older people annually since 1994)  
Chiropody: £300,000 in total since 1989 |
Day care, day hospital places, alarm systems and especially facilities for the mentally infirm have been under-funded. It is unclear whether revenue funding for joint replacement and cataract surgery, chiropody and speech services, or panels of Registered General Nurses and Care Assistants, received the amounts recommended. It is clear, however, that the funding for physiotherapy and boarding out schemes was much less than recommended.

The Working Party acknowledged the constraints in finance operating in the 1980s but had assumed that a decline in births would present an opportunity to redeploy resources towards older people. This redeployment has not happened. Rather there is now a greater focus on children as a client group, a greater acknowledgement of the care needs of children and a new identification of certain needs among this group. The enactment of The Child Care Act in 1991 led to a major programme of investment in child care and family support services, including an additional £10m in each of the years 1993-1996 for new service developments. No such major programme of investment has occurred with regard to the care of older people.

The transfer of resources from the acute hospital sector to community care has also not occurred in line with the principles espoused by The Years Ahead report. As a proportion of the aggregate health budget, community care has remained at approximately one-quarter since 1988. Similarly, community psychiatric services have not increased their proportion of the overall psychiatric budget, which itself has decreased as a proportion of the aggregate health budget. This raises serious questions about the financial commitment to maintaining and supporting older people in the community.

**The Years Ahead: still an appropriate blueprint for the future?**

The third aim of this paper is to address the question of whether The Years Ahead is still an appropriate blueprint and to consider a framework for future strategy for the care of older people.
people. From the discussion of the findings so far it is clear that there are some assumptions in *The Years Ahead* that need to be reviewed and there are certain elements in the care system recommended that need to be re-evaluated. There are also certain orientations and dimensions of care that were not considered or were considered only to a limited degree by the Working Party that need to be included.

The focus now is to build on the achievements of and learning from *The Years Ahead*. The first step is to develop a strategic focus. A possible framework for strategy is presented in the following diagram. The strategy incorporates six key actions which, if taken, would have substantial and significant impact on how people experience ageing and older life. These actions are:

- develop a vision of ageing and older life
- include the consumer in all dimensions of the strategy
- adopt a holistic approach to need and provide for comprehensive needs assessment
- provide comprehensive continuum of options for those in need of health care
- provide for intersectoral input
- evaluate outcomes and carry out more exploratory research.

**A framework for future strategy**

**Framework for strategy on care of older people**
Develop a vision of ageing and older life

Moving on from *The Years Ahead*, the proposed future strategy for older people is grounded in and informed by a positive vision of ageing and older life. In the period since *The Years Ahead* was published there has been a significant move away from the image of the older person as dependent, infirm, useless and passive to a more positive view of old age as a time of opportunity and potential for active contribution to society. *The Years Ahead* did recognise the importance of independence in older life - mainly through its emphasis on the 'staying put' policy - but its major focus was on older people as recipients of care.

A vision of ageing must, in addition to independence, also include the dimensions of social interaction; active participation and contribution; lifelong learning; self-development and self-fulfilment.

A vision of older life must also recognise the heterogeneity among older people. At present,
it can seem that once over the dividing line of 65 years one becomes part of a homogeneous group called 'the elderly'. But people over 65 years of age are just as diverse as those in young adulthood or middle-age and finer distinctions are needed to reflect the different experiences, circumstances and needs of persons in their sixties and those in their seventies and eighties.

A positive vision of ageing would not only ensure quality of life in old age but would also ensure that the potential of older people is released and their knowledge and resources are used for the benefit of all age groups. In this way, older people engage in reciprocal and mutually beneficial relationships with people in other age groups rather than being seen solely as 'receivers of care' from others who are more regarded as resourceful and able. A variety of perspectives must be brought to bear on the development of a vision of ageing and older life but, most importantly, the perspective of older people themselves must be taken into account. Apart from older people there must be input into the vision from most government departments, along with employers and trade unions, service-providers, voluntary organisations, researchers and academics.

**Adopt a holistic approach to need**

The proposed strategy moves on from *The Years Ahead* by adopting a more holistic approach which emphasises that health care is not the only significant need area that has to be addressed in older life. Physical health is but one element of well-being and due recognition must be given to other significant needs including: social participation and contribution, emotional well-being, education and training, work life, social welfare and income security, housing and family relationships. It is a matter of concern, for example, that at present older people are largely absent from the formal education system. There are already some initiatives in this regard that can be built upon. For example, in relation to work life there are initiatives by ICTU such as the Retired Workers Committee, Guidelines on Retirement and the Charter of Rights for Older People.

In the strategy, holistic, comprehensive and reliable assessment of need provides the basis to guide the options and services that must be provided in the different need areas. As with the
development of a vision of ageing, in the assessment of need the proposed strategy assigns a critical role to older people themselves. Specific structures must be set up to enable consumer participation in needs assessment and there must be support structures for it also.

The adoption of a holistic approach demands that policy and action does not remain the responsibility of just one government department or one sector. There has to be intersectoral input and this in turn demands structures and support for co-ordination and integration. Compartmentalisation of needs as being the responsibility of one sector or another is at odds with the interconnectedness of needs in people's lived experience.

**Provide a continuum of care**

In the case of older people requiring health care, the strategy incorporates the provision of a continuum of care options ranging from anticipatory care to long-stay institutional care. It is in this area that *The Years Ahead* provides the most significant lessons. This Review of *The Years Ahead* has identified the significant gaps that currently exist in the continuum of health care and the obstacles that have given rise to these gaps. Through the experience of attempts to implement *The Years Ahead* there is now some feedback available on which health care services are essential, which services are effective, which services are difficult to implement.

**Evaluate outcomes and research solutions**

Building on the knowledge acquired from *The Years Ahead* but providing an advancement on it, the proposed strategy incorporates rigorous procedures for monitoring the quality of all services provided and evaluating the outcomes achieved. At the time *The Years Ahead* was drafted the major focus in the health care system was on the level of provision of services. Accordingly, *The Years Ahead* emphasises inputs into the care system, such as staff and bed numbers, and it makes little reference to outcomes and how those outcomes should be assessed.

With the publication of *Shaping a Healthier Future* in 1994, the focus has been shifted from level of provision to provision of a positive outcome and health services must now have a demonstrable benefit in terms of health and social gain. Outcome assessment requires
systematic and comprehensive data, firstly, on pre-care conditions to provide a benchmark against which gain may be judged, and secondly, on the conditions prevailing after an intervention. Participation by older people at both stages of data collection is of vital importance. It is only now that outcome measures are being developed to assess the health and social gain achieved by the implementation of particular care services. Assessment of gain poses a particular challenge in relation to social outcomes. It is clear that certain outcomes related, for example, to quality of life, do not lend themselves to measurement as readily as certain health outcomes such as care of a physical disease or an increase in mobility but yet are just as important. Evaluation of outcomes does not just apply to healthcare, but must also become an integral part of any initiatives established to meet any area of care.

**Involve the consumer**

Consumer participation is an integral element of each dimension of the proposed strategy. One of the more conspicuous gaps in *The Years Ahead* was the failure to allow for consumer participation but since 1988 there has been an increasing focus on the consumer. Several non-governmental organisations attempting to represent the interests of older people have been active in seeking a consumer voice. One practical example is the Irish Senior Citizens National Parliament. Such initiatives can be built upon to ensure that older people are involved in the decisions that affect them.

**Provide for intersectoral input**

Implementation of a strategy based on a wide-ranging vision of older life requires the input of many different agencies. Traditionally, the main actors in the welfare of older people are the Department of Health at national level, the health boards at regional level and voluntary organisations, neighbours and family members at local level.

The proposed strategy requires partnership among a much wider range of agencies than these traditional actors. At national level, quality of life in old age should be designated as a Strategic Result Area requiring national partnership between government, national voluntary organisations and other non-traditional actors in the field including business, employers, trade unions and researchers and academics. Only in this way can the policy implications of a
positive vision of ageing be taken into account in the areas of health, social welfare, training and education and employment. Within government, while the Department of Health may take the lead role, other departments must also assume clear-cut responsibility for the effective implementation of the strategy.

At regional and local levels partnership is required between, for example, health boards, local authorities, education authorities, social welfare agencies and voluntary organisations. At every level, older people themselves must be given a place as an equal partner. This implies the establishment of a national body representative of the interests of older people and regional and local structures for ensuring the voice of older people is heard at these levels.

**Respect heterogeneity**

The proposed strategy respects the heterogeneity within the population of older people while acknowledging that there are certain groups whose frailty or vulnerability requires particular attention. *The Years Ahead* has served to bring greater awareness and knowledge of the needs of ill and dependent older people and the services that are valuable in addressing these needs. The major challenge for strategy in the future is an increased quality of life for all groups within the older population and the full social integration of older people as members with continuing needs not only for physical health but also for fulfilment, contribution, choice and dignity.
National Council on Ageing and Older People Comments and Recommendations on the Review Findings

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Part I: Mr John Browne

The National Council for the Elderly (now the National Council on Ageing and Older People) was established in January 1990 in succession to the National Council for the Aged which began in June, 1981. The Council was asked, as a part of its new terms of reference to advise the Minister for Health on the implementation of the recommendations of The Years Ahead report. Accordingly, the Council commissioned the Policy Research Centre of the National College of Industrial Relations to carry out a review of the implementation of the report. In this paper, the Council comments on the findings of the Review.

Taking the report as a whole, it appears that The Years Ahead, in spite of its undoubted value, can no longer be viewed an adequate blueprint for the development of older people's health and social services. The Review posed four main questions. First, have recommendations been universally implemented in the manner envisaged by the Working Party? The answer here is almost always no. Second, is it likely that the recommendations will, in the near future, be fully implemented in the manner envisaged? Again the answer is almost always no. Third, are there regional variations in the implementation status of recommendations? Where relevant, the answer is almost always yes. Fourth, are the implementing bodies satisfied with the recommendations of the report? Here the study findings are mixed, but real questions have been raised about the value of certain recommendations.
The Council does not wish to question the fundamental value of the report, which was based on excellent principles, and which contained many useful recommendations. There is also no doubt that the report had, and continues to have a major influence on the thinking of service providers. The essential difficulty is the non-statutory status report. Despite its adoption by the Department of Health, the report did not compel the authorities named (mostly the health boards and local authorities) to implement recommendations in the manner envisaged.

The report asked that a legislative framework be put in place for the development of older peoples services. This legislative framework has not been created, and in general services for older people are still provided on a discretionary basis. This would not have been an insurmountable problem if a lead agency had taken responsibility for encouraging the coordinated implementation of recommendations, from 1988 onwards. Unfortunately this did not happen, with the result that older people and their carers remain in a largely powerless state vis-à-vis the health boards and other service providing agencies. It has also allowed regional variations in service provision to continue in a fashion not envisaged by the Working Party. The lack of a unified approach is exemplified by the finding that some of the agencies contacted were not even aware of the recommendations they were supposed to have implemented.

Policy developments in the period 1988-1997 have also impeded the implementation of The Years Ahead report. Most important here is the 1994 health strategy Shaping a Healthier Future published by the Department of Health. Although this document endorsed The Years Ahead report, new principles for service provision were introduced that in some ways contradicted the approach taken by the 1988 report.

The Years Ahead report was strong on detail with numerous recommendations on staff levels, bed numbers, and organisational structures. Shaping a Healthier Future, by contrast, focuses more on the principles behind service delivery. Crucially, services cannot be assumed to have an inherent value (an assumption usually made by The Years Ahead report) but must demonstrate the health and social gain they produce.
Shaping a Healthier Future also stressed the importance of consumer participation in the planning of services and the accountability of service providers; principles largely ignored by The Years Ahead report. Given the number of changes that were recommended by the report, it is remarkable that no thought was given to asking older people about their value or to informing them about the changes proposed.

Shaping a Healthier Future proposed that important decisions about regional services should in future be taken at a regional level and that the Minister and Department should not be involved in the detailed management of the health services. This was confirmed in the Department's 1997 Statement of Strategy. Following the proposals of the 1989 Report of the Commission on Health Funding, Shaping a Healthier Future also contained a firm commitment to replace the existing health boards with regional health authorities who are to be given greater autonomy. This process makes it likely that regional variations in models of service delivery will become the norm. This is contrary to the spirit of The Years Ahead report, which implicitly advocated common organisational structures and service delivery models across the country.

The 1990 Health (Nursing Homes) Act has also created conditions that were not envisaged by the Working Party which considered the community hospital sector to be the most appropriate source of long-stay care. Since the 1990 Act the private nursing home sector has enjoyed a period of rapid growth with close to 7000 beds available in 1994 compared to 5552 beds in 1988. Some of this growth is undoubtedly due to the incentives provided by the subvention scheme introduced in 1990. While there was undoubtedly a need for more long-stay care beds in some parts of the country, it is ironic that the only significant legislation on services for older people since 1988, has lead to a growth in institutional rather than community-based care.

A further difficulty with The Years Ahead report was its significant under-estimation of the growth in the size of the older population. Recent projections prepared for the Council predict that there will be more than 520,000 older people in Ireland by 2011. This compares
to a figure of 437,400 used by *The Years Ahead* report. The unforeseen increase in the older population has obvious implications for the service levels originally recommended.

Turning to the current report on the implementation of *The Years Ahead* report, doubts over the inherent value of some of the recommendations made by *The Years Ahead* report emerge. There seem to be particular difficulties with the relative emphasis placed on ongoing care versus therapeutic treatment services for older people. *The Years Ahead* report placed relatively little emphasis on the treatment of acute illness in general hospitals, and this contrasts unfavourably with the emphasis placed on continuing care services. The implicit message seems to be that illness in older people should normally be considered a chronic problem rather than a treatable episode.

Finally, it is obvious that funding for many developments, particularly in the 'cutback' years immediately following the report's publication, was not made available. Particularly effected were community care services such as day care, day hospitals, community hospitals, psychiatric services, paramedical services and panels of Registered General Nurses. This contrasts unfavourably with the £65m spent on implementing the *Health (Nursing Homes)* Act over the period 1990-1997. As noted in the Review, the low level of resources given to community care raises serious questions about the financial commitment to maintaining and supporting older people in their own homes.

In summary, although *The Years Ahead* report was a progressive force in the development of services for older people, its style, content and status render it an inadequate guide for future developments. The Council therefore believes that a new blueprint is required, building on the ideas of *The Years Ahead* report but in tune with current policy initiatives.

In the remainder of this paper, Dr. John Murphy who is a Council member and a geriatrician in the Western Health Board, discusses this blueprint and the detail of the Council's recommendations on individual areas of service provision.
Part II: Dr John Murphy

I would now like to outline some general recommendations that the National Council on Ageing and Older People wishes to make on the future development of health and social care services for older people in Ireland. Because of the difficulties with The Years Ahead report outlined by John, the National Council on Ageing and Older People recommends that a new and comprehensive strategy for the development of health and social care services for older people be developed under the guidance of the Department of Health. This strategy should have a number of key elements as follows.

First, it should contain an explicit statement of the principles that should underlie the delivery of services to older people, incorporating the values of equity, quality of service and accountability espoused by Shaping a Healthier Future and the guiding values of The Years Ahead report described above. The Council is particularly concerned that any new strategy has a firm commitment to the principle of consumer orientation, with older people and carers involved in the planning and evaluation of services at all stages.

Second, the strategy should provide guidance on the future development of the co-ordination posts and structures outlined in The Years Ahead report. It is now clear that the health boards in particular do not consider the model proposed an appropriate blueprint for their local needs, although some aspects of the 1988 model have been adopted. The strategy should therefore provide guidance to the health boards on the principles governing co-ordination at different levels rather than the detail of particular posts and structures.

Third, the strategy should specify the desired balance between community and long-stay care for older people. The Council endorses the target set in Shaping a Healthier Future that 90 per cent of people over 75 years should reside in their own homes in the community. This target is useless, however, without a plan for ensuring it is met. The Council recommends that national guidelines for the placement of older patients in long-term care be outlined in the strategy. The strategy should specify the desired mix between traditional long-stay accommodation and alternative community accommodation such as sheltered housing, and
outline how sectors identified as inadequate are to be developed. There should also be a
target for the proportion of funding provided in health budgets for home and community care
services designed to support older people at home.

A fourth element of the strategy should be a model for the planning and funding system to be
used with services for older people should be outlined in the proposed strategy. The Council
has previously recommended that a transparent formal mechanism for distributing health and
social care resources in an equitable and flexible manner on the basis of need be developed.
This mechanism should be based on information collected across local areas feeding directly
into the decision making process. The assessment process should have a strong consumer
focus, with older people asked to defined need from their own perspective.

A fifth element of the strategy should be guidelines on the ongoing measurement of health
and social gain following interventions with older people. It is imperative that outcomes
following health and social care interventions are in some way assessed and inform a
scientific resource allocation system. Again the assessments should be directed at the
individual and what they perceive to be important.

As well as the national strategy proposed for service development, the Council also believes
that a legislative framework governing the provision of essential services to older people is
required. In the current climate of devolved decision-making the Council considers it
essential that certain services are provided as entitlements rather than on a discretionary basis.
The Council wishes to state at the outset that it believes the home help service, Meals-on
Wheels, day care, respite care both inside and outside the home, paramedical services and
sheltered housing are essential, with a proven record of providing social gain, that must be
available to older people whenever required, throughout the country.

These services should be designated as core services underpinned by legislation and
appropriate statutory funding. Core services may be defined as:

Support services which are essential for older persons to maintain a quality of life
and a level of functional autonomy which enables them to live independently in the community and, consequently, to avoid unnecessary hospitalisation or admission to long-stay institutions.

Core services should be differentiated from other important community support services provided by voluntary bodies (e.g. social outings, clubs) for the purpose of planning and funding. The home help service in particular should become a statutory entitlement.

As well as designating certain services as core elements of the health system, the Council also believes that the proposed legislative framework should introduce national guidelines on eligibility criteria and charges for health and social care services should also be outlined in the legislation, where these guidelines do not currently exist. A commitment to providing such guidelines was given in *Shaping a Healthier Future*. Three years later they are long overdue.

A third aspect of the legislative framework should cover the involvement of voluntary service providers. The framework would ensure that the same quality and level of service is provided in areas with and without a well developed voluntary sector. It would also standardise procedures for the funding of voluntary services and for the provision of other assistance by statutory bodies where required.

Finally, the Council believes that legislation safeguarding the rights of carers is required. At present carers are forced to work in conditions that would be clearly illegal in the formal workplace, in order to qualify for the Carer's Allowance. The regulations mean that carers are forced to forego their right to training and asked to work at home for 168 hours per week. These conditions are highly unfair given the regulations governing working hours in formal employment. The working conditions of those judged ineligible for the Allowance are also extremely difficult because of the low level of health and social services (e.g. respite care) available from the statutory sector.

In addition to the legislation and strategy outlined above the Council would like to comment
on a number of specific domains of service provision, based on the findings of the Review by the Policy Research Centre of the National College of Industrial Relations. What follows is a brief account of the key recommendations on specific services which the Council would like to see implemented.

Starting with the co-ordination of services, the Council believes that the Review highlights the need for a rethink about a number of the posts and structures recommended in *The Years Ahead* report. The Council recommends firstly that the post of District Liaison Nurse be reviewed by the Department of Health. The Council is increasingly concerned about the need to develop an approach to co-ordination at the individual level and believes that the organisation of services for individual older people at a local level should be a full-time post carried out by a professional with specific training. Here we have in mind the provision of a package of services to those older people identified as being on the margins of institutional care but who might benefit from case management.

We believe that this concept has much to offer and should be further explored through research and piloting as a possible basis for co-ordinated care in the community. Such an approach would not only contribute to overcoming the fragmentation of community services but also to improving community-hospital-institutional care linkages. In Ireland the role of the case manager would have to be introduced in consultation with existing health board personnel with appropriate training being provided. Existing roles and responsibilities would have to be examined and new organisational mechanisms put in place.

The Council also believes that the district team model of local coordination outlined in *The Years Ahead* report should be reviewed. District teams have not been popular with the health boards and have not proved successful in practice. The proposed review should place particular emphasis on ways of ensuring that the efforts of General Practitioners are co-ordinated with others service providers. The most important aspect of co-ordination is the link between the General Practitioner and Public Health Nurse. This becomes particularly important when the older person has been discharged from hospital. An alternative to the district team which could support this type of co-ordination might be an integrated
information system, capable of recording contact at community and hospital levels. The review should also examine alternative ways of involving the voluntary sector in the planning of local services.

At higher regional levels, the Council believes that the post of Co-ordinators of Services for the Elderly has proven successful when created. As a model of good practice the Council advises that this post should be created for all community care areas in the country. The Council also recommends the appointment of full time Co-ordinators of Services for the Elderly at health board level. This post is particularly important for the encouragement of voluntary service provision at a local level, for the co-ordination of statutory and voluntary efforts and for the development of board-wide information systems. The Council would advise against the current system in some health boards whereby overall responsibility for older people's services is carried out at Programme Manager level. This is an essential post which can not be undertaken on a part-time basis.

At Government Department level, the Council recommends that the Departments of the Environment and Health investigate ways of increasing the co-ordination of their activities. There is evidence that co-ordination between health boards and local authorities is poor and without policy guidance from the relevant government departments this is unlikely to change. The Council believes there is an urgent need for an inter-departmental strategic policy committee with executive powers to oversee social housing for those with health needs. At a local level the planning committees of local authorities should have a representative of the health boards.

In relation to health promotion with older people, the Council urges the health boards to further develop dedicated programmes for promoting older people's health and to introduce and evaluate initiatives and interventions likely to produce significant health and/or social gain for older people. The Council also recommends that a comprehensive public education programme on the nature of mental disorders in old age be undertaken by the health boards in conjunction with the Department of Health and other relevant agencies such as AWARE, the Alzheimer Society of Ireland and the Mental Health Association of Ireland.
An equivalent programme for care professionals should also be undertaken. The professionals to be targeted should include general practitioners, public health nurses, social workers, psychiatric nurses, occupational therapists, physiotherapists and nursing home staff. Again the health boards should be the lead agencies, in conjunction with relevant professional bodies.

With regard to housing, the Council believes that the most important issue continues to be the standard of older people’s homes given that most older people live in quite old, privately owned houses in the community. The Council recommends that a co-ordinated approach to repairs and adaptations and the provision of ongoing domiciliary health and social services be developed. The Council believes that the various schemes for adaptations and repairs to older people's homes run by the health boards and local authorities should be streamlined and operated by one local agency to simplify the application process for older people. The schemes should operate as part of a larger package of care, to ensure ongoing health and social services are provided if needed: this will require health board and local authority co-ordination. National guidelines on eligibility and charges should also be developed to eliminate the regional inequities that currently exist.

To ensure that the quality of older people's homes is maintained in the long-term, the Council recommends that planning permission for new private housing developments be granted only when a proportion of the development is suited, or can be easily adapted to the needs of older people. Most new housing is not suited to people with mobility problems and will pose problems for the occupants as they age.

In relation to social housing, the Council believes that a national plan on provision for older people should be developed by the Department of the Environment. A central principle underlying the plan should be that high quality sheltered housing be available to those older people who choose it. Sheltered housing should be an option for all older people before institutional care is considered. To ensure this is possible, there must be a large increase in the number of sheltered housing units available for older people. It is clear from the current
review that the number of sheltered housing units currently available is inadequate, and many of these units do not provide the full range of support services required by the residents. The Council believes that the non-profit/voluntary sector, because of the expertise it has developed in this area, should be the primary providers of additional sheltered housing schemes. To do this they should receive increased support from local authorities through the Department of the Environment.

A further principle should be an obligation on health boards and local authorities to provide visiting and on-site supports to all residents of grouped social housing schemes, when voluntary organisations cannot do so. Home nursing and home help services, paramedical services and on-site wardens should be made available to all residents by the health boards. Where this is not feasible, financial support for the direct provision of services by the voluntary sector should be provided by the local authority. The health boards should liaise with voluntary organisations in the provision of day centres where the size of the development makes such centres feasible. Local authorities should be obliged to provide support to the voluntary sector for the ongoing maintenance and repair of non-profit/voluntary housing units.

The Council acknowledges that the resources available to the Departments of Health and the Environment, and to the health boards and local authorities in turn, will have to be significantly increased if the above recommendations are to be implemented.

As regards the home and community care of older people, the current Review reveals that significant problems exist with current methods for the early detection and surveillance of health problems in older people. The Council recommends that the Office for Health Gain, in conjunction with the Irish College of General Practitioners should carry out a review of the value of case finding and preventive care by General Practitioners as outlined in *The Years Ahead* report. The review should suggest alternative ways of ensuring the early detection and treatment of illness in older people, if the current methods are found to be inefficient or ineffective.
The Council anticipates that the forthcoming review of the Public Health Nursing service will address the difficulties associated with at-risk registers. The introduction of computerised information systems should be pursued with urgency as a possible solution to this problem. The Council also recommends that all older people over 75 years be comprehensively screened by the Public Health Nurse at regular intervals (e.g., every two years) to ensure that health problems are detected as early as possible. Older people who live alone, live in hazardous accommodation and/or have poor self-maintenance skills may require more frequent assessments.

In the current climate of uncertainty surrounding the role and structure of the home help service the Council is particularly anxious to ensure the future of this vital service is safeguarded. As indicated above, the Council recommends that the legislative basis for the home help service be amended to make it the mandatory responsibility of the health boards to provide or have this service provided to designated categories of older person. The home help service clearly provides both health and social benefits to recipients and should therefore be designated as a core service in legislation to ensure its future.

The home help service also requires expansion in both size and scope. In three health board regions there is no emergency service and in four regions no out-of-hours service, weekend service or relief service for carers. The Council wishes to reiterate its recommendation that the home help service be seen as complementary to the efforts of carers rather than a substitute. The home help service should be available to older people whether an informal carer is available or not, and the Home Help should be available to work in tandem with the carer (e.g. in the provision of personal care tasks such as lifting or bathing) and not just as a relief service.

In relation to the Community Nursing service, the Council believes that the current distribution of Public Health Nurses across the country is inequitable and should be standardised. The Council recommends that all health boards should have a ratio of at least one Public Health Nurse (excluding the Senior and Superintendent grades) to 2500 persons of all ages. This should not require a large increase in resources as some health boards already
exceed this ratio. A broader nursing skill mix within the Community Nursing Service should also be developed. Certain services might often be more appropriately provided by professional and skilled carers other than the already overstretched PHNs. The Council recommends a significant increase in the number of Registered General Nurses working with older people in the community to fulfil this recommendation.

The need for a 7-day, 24-hour Community Nursing Service should also be examined. Many problems experienced by older people and their carers require the immediate and specific attention of a nurse. A 24-hour service, with 'on-call' nurses available at all times' would allow for an immediate response to such problems outside normal working hours. Such a service will place a burden on resources, but some developments are required to meet an outstanding need. Immediate priority should be given to the development of an 'on-call' system operating from 8.00am to midnight, seven days a week.

With regard to paramedical services, the Council is concerned that many older people are denied such services. The Council believes that services such as physiotherapy, chiropody and occupational therapy are essential if ill and dependent older people are to continue living in the community, and we recommend that the health boards reconsider their opposition to the principle of domiciliary paramedical services. The Council is also concerned at the absence of a social work service for older people in Ireland. The Council recommends that social work services for older people be developed within health board community care programmes (as has been done in Donegal).

In relation to transport issues, the Council believes that the absence of adequate transport to local health facilities, particularly in rural areas is a major source of hardship in older people. The Department of Public Enterprise, as the Government Department responsible for transport, should therefore re-examine the possibility of using existing public service vehicles in use in rural areas in more creative ways. The use of postal vehicles seems particularly promising. In many European countries, post is delivered between post offices using mini-buses, which double-up as public transport vehicles.
In relation to day care, there is an obvious need for additional health board day care places in areas without a well developed voluntary sector. In health boards with a strong voluntary sector there is a need for greater support from the health boards in, for example, the training of staff and the development of facilities. As already mentioned, the Council recommends that health boards be obliged in legislation to provide day care services of a specified quality, and with a comprehensive range of services, to older people who require them.

The Council believes there is a particular need for special day care units for older people with dementia. Most people with dementia live at home and are looked after by their families, often constituting a heavy burden for them. The day care units would play an important role in giving respite to the carer. Specially trained staff would be required for these patients where services such as chiropody, haircare, bathing and most importantly occupational therapy would be available.

As regards to the general hospital sector, the Council welcomes the developments that have taken place in geriatric medicine since 1988 but sees room for further growth. We believe that all acute general hospitals should have a properly resourced Department of Medicine for the Elderly, lead by a consultant in geriatric medicine, and with access to the investigative and therapeutic facilities available in the rest of the hospital where necessary. The Council disagrees with the view expressed by one health board that specialist geriatric departments are not appropriate for County general hospitals. The benefits of specialist departments include a greater expertise in medicine for older people and greater access to specialist assessment and rehabilitation facilities.

Consultant geriatricians are not just physicians to older people, but also have a significant role in planning services and in advocating their development. Older people are entitled to have full-time consultant representatives, with no conflicting responsibilities or loyalties. The Council believes that all consultant geriatricians in the larger urban hospitals should be appointed on a full-time basis. Geriatricians should be appointed on a part-time basis only where the hospital has a small number of consultant physicians (three or four) and the geriatrician is required for some general medical duties. In the long-term the Council believes
that all geriatricians should be employed on a full-time basis as an enlarged community hospital sector will require significant support from geriatricians if it is to operate properly.

In relation to discharge from hospital, the Council recommends that the hospital liaison role outlined in The Years Ahead report be reviewed by the Department of Health. The Council feels that dedicated hospital-community liaison workers responsible for overseeing discharge of older patients and liaising with Public Health Nurses and General Practitioners, are necessary in all acute general hospitals. The liaison worker should be equipped to respond quickly and appropriately to discharge. A liaison worker should be available seven days per week. The liaison worker should have at least as close a relationship with community care staff as with the hospital staff. They should be prepared and trained to accompany the older person to their home, and to visit and assess home situations where necessary. The liaison worker should have a car for this purpose if an ambulance journey is not necessary.

as regards to the community hospital sector, the Council recommends that the community hospital sector continue to grow in the manner envisaged by the Working Party, replacing geriatric hospitals and welfare homes where possible. It is essential that these hospitals are equipped with assessment and rehabilitation facilities for the disorders associated with old age and that they receive weekly visits from consultant geriatricians.

In relation to other long-term care facilities, the Council recommends that national guidelines on the placement of older patients in long-term care be established by the Department of Health. At local level, these guidelines should then be translated into clear policies for admission to specific public, voluntary and private facilities. Placement guidelines for welfare accommodation should also be developed, taking account of the alternatives advocated by the proposed national plan on social housing for older people.

The Council is concerned at the ongoing growth in the private nursing home sector and the rising costs to the State associated with this increase. While private nursing homes undoubtedly meet an existing need, the Council feels that the long-term solution to the care of dependent older people must be in community care. The Council would urge that more
resources be given to community care services. For older people at the highest risk of institutionalisation the option of sheltered housing should be available.

The Council welcomes the recent establishment of a Social Services Inspectorate within the Department of Health to develop an expertise in promoting high standards of care in institutions. The Council believes that the Inspectorate should have executive responsibility for the organisation of an inspection system of all types of long-term care institutions, public and private, where older people reside. At present there is a clear discrepancy in the system as nursing homes are formally inspected and governed by a Code of Practice, while health board facilities are not. The Inspectorate should have responsibility for the formulation of protocols governing the inspection and intervention process, and the training of those responsible for the inspections at community care area level.

In relation to the care of older people with mental disorders, the Council made a number of recommendations in a 1996 report which it wishes to reiterate. The Council believes that a national strategy for the future of mental health services for older people must be developed by the Department of Health in consultation with all concerned parties in this area. Action on services for older people with mental disorders has been particularly disappointing since 1988 leading to an unacceptably high rate of institutionalisation of older people with mental disorders, and significant regional variations in care policies and the quality of care.

The Council is concerned at the slow rate of progress in the appointment of consultant psychiatrists in the psychiatry of old age. There are currently four old age psychiatrists, three in Dublin and one in Limerick. The Council believes that consultant-led old age psychiatry should be at the core of the development of mental health services for older people. The specialist assessment, rehabilitation and treatment services offered by these consultants, and the ancillary services they develop are recognised as a model for good practice. It is inequitable then that only four districts in the country can avail of these services. In the absence of a feasibility study on the establishment of a national old age psychiatry service, the Council would recommend that the Royal College of Psychiatrists planning norm of one consultant in the psychiatry of old age per 10,000 older people be urgently adopted.
In relation to the community care of older people with mental disorders, the Council recognises that a major investment is needed in all areas but that certain areas are of particular importance to older people with mental disorders and their carers.

These are:

- hour a day, seven days a week community services;
- specialised day centres for people with severe dementia with transport to the centres available when needed;
- day hospitals capable of treating older people with mental disorders, again with transport when needed;
- flexible respite care services, capable of accepting patients at short notice, for day or night care;
- in-home respite care services.

The Council is also concerned about institutional care for people with mental disorders. It is clear from today's report that the supply of designated community residential beds for these people is very low. In a context where patients are being resettled from psychiatric institutions into the community or not being accepted in the first place, there is an urgent need to:

- increase the supply of housing and hostel accommodation for older patients suitable for discharge to the community;
- ensure that older people who are left behind in psychiatric facilities are not left in buildings with falling standards of care as younger patients are discharged (if older patients are to remain, these buildings must be adapted to their needs in accordance with established principles of good design and environment);
- increase the supply of long-stay beds in non-psychiatric facilities dedicated to the care of older people with dementia but without behavioural problems;
- increase the supply of beds in appropriately designed secure psychiatric units for dementia patients with behaviour problems;
- increase the supply of beds in geriatric units and hospitals for dementia patients
In relation to carers for older people there are three main types of support required. Firstly, the vast majority of carers express a desire for direct payment for caring services. This would both recognise the value of the work performed by carers and allow them to purchase other forms of support (e.g. respite care) should they need to do so. Current payment rates through the Carer's Allowance Scheme are restrictive (because of the means test) and low in comparison to the effort involved. As a result, fewer than 9,000 carers received the allowance in 1996.

A Constant Care Attendance Allowance for people caring full-time for dependent older relatives (e.g. those suffering from advanced dementia) would be a fairer alternative. The Allowance would be similar to the Domiciliary Care Allowance which is provided for parents of severely handicapped children, in that it would not be based on an assessment of the carer's means, but on the effort, and opportunity costs involved in providing full-time care at home.

The Allowance would be paid regardless of means, and should not be calculated in the means test for other social welfare payments. As well as providing a just reward for the effort of carers, such an Allowance, especially in the context of recent Nursing Homes legislation, could go a considerable way towards equity in the deployment of limited health care resources and towards a more favourable balance between institutional and community care. To ensure widespread coverage, the conditions surrounding the new allowance should be less restrictive than those governing the Carer's Allowance. The current conditions effectively demand that the carer perform a caring role 24 hours per day. These conditions are highly unfair given the regulations governing working hours in formal employment.

The second support most frequently sought by carers in Ireland is information and advice on health and social services, and on welfare entitlements. Carers also wish to know about the long-term prognosis and treatment options related to the medical condition of the person they are caring for. Information is a relatively low cost method of providing support and it would diminish the burden of care for carers.
The third support most frequently sought by carers is relief care of various kinds. The fact that the carer must constantly remain in the home and is therefore confined on a daily basis is the most frequently cited stress of caring. Carers could benefit from the provision of a range of respite options, including day care places, short-term relief care (for instance through community residential services), night-sitting (freeing the carer for a number of hours in the late evening), and most importantly, domiciliary relief provided by Home Helps during the day. There is also a need for secure night-time beds in community facilities, for older people with dementia. People with dementia often have disturbed sleep patterns which can create intolerable burdens on the carer.

In summary, the Review being published today raises many issues relating to care for older people. Some of these are more important than others and the Council wishes to underline those issues which require urgent attention. The Council believes that home and community care must be the cornerstone of any health and social care strategy for older people. To this end the following services require immediate development:

- the home help service;
- respite services for carers;
- sheltered housing;
- day care centres with transport services where required;
- paramedical services at home and in the community;
- a social work service dedicated to older people;
- all services for older people with mental disorders;
- the community hospital sector.

The Council is particularly concerned that structures responsible for the development and implementation of the proposed strategy on services for older people be established. The
Council welcomes the recent appointment of a Minister of State at the Department of Health with responsibility for Older People. The Minister is in an ideal position to co-ordinate the activities of relevant Departments in the creation and implementation of the strategy.

Finally, the Council is very aware that its recommendations are useless without financial commitments. We believe, therefore, that an increased proportion of the total health and housing budgets should be directed towards services for older people.
Current policy on the development of services for the elderly is based on *The Years Ahead* report which was published in 1988. The principle recommendations of this report were to maintain the dependent elderly in dignity and independence at home with the support of the community care services where necessary and when this was no longer possible to ensure that they had access to the best possible medical or long-term care.

The Health Strategy - *Shaping a Healthier Future* proposed that the reorganisation and development of health services be based on three key principles of equity, quality of service and accountability. The main objectives of the Strategy were to achieve the greatest possible health gain or social gain for the resources that are available and to ensure that treatment or care is provided in the most appropriate setting.

In relation to services for older people, the Health Strategy builds on the recommendations of *The Years Ahead* and states that priority will be given to strengthening home, community and hospital services to provide much needed support to elderly people who are ill or dependent, and to assist those who care for them.

The Health Strategy listed a number of priorities including the promotion of healthy ageing; the strengthening of community support structures to help older people and their carers; increasing the number of specialist departments of medicine of old age; additional convalescent care places; adequate funds for the implementation of the *Health (Nursing Homes) Act* and the provision of small scale nursing units in the community.
Over the past number of years the Department of Health and the health boards have been developing services for older people along the lines of the policy set out in *The Years Ahead* and the Health Strategy documents.

In the area of health promotion, the Department’s Health Promotion Unit has entered into an agreement with the National Council on Ageing and Older People to develop a health promotion programme for older people. This programme is comprised of three strands:

- the development of a health promotion strategy for older people;
- the development of an information and support network for promoting the health and well-being of older people in Ireland;
- establishing models of good practice for healthy ageing.

This programme will include procedures which will evaluate the effectiveness of initiatives taken in terms of health and social gain for older people.

Community support structures have been strengthened by the employment of additional paramedical staff, nurses and Home Helps and by the purchase of aids and appliances. An extra £7.6m has been provided over the last three years to cover those services. In addition, in the same period an additional £5.8m has been allocated from the general hospital Accident and Emergency initiative to the Eastern Health Board. This money has been used in the main to improve institutional and community support services for older people. The development of the community ward teams in the Eastern Health Board which support people in their homes is a good example of a service that can be of particular benefit to older people.

Notwithstanding these developments, we recognise in the Department that there are many shortcomings in the support provided to older people in the community and the Minister will be concentrating on this particular issue in his review of the service.
On the subject of support in the community, there has been considerable debate about the adequacy of the home help service which is widely recognised as having a crucial role in assisting older people in maintaining their independence. This issue is covered extensively in the Review report. There are currently about 12,000 mostly part-time Home Helps and approximately 20,000 recipients in a service which costs some £17m annually. Given the concerns expressed about the lack of adequate organisation and provision of the service, the Department recently requested the National Council on Ageing and Older People to oversee the commissioning of a study which will advise on how the service can best be developed in conjunction with other community-based services. This study is expected to be completed by the end of the year.

Elsewhere in this report, the Minister refers to the issue of the development of Departments of Medicine of Old Age. In 1988, there were eight such Departments. The number has now risen to twenty five located throughout the country. The Minister also refers to the capital programme of providing small to medium sized community nursing units in various locations throughout the counties. In 1997, we have a capital fund of £6.75m to cover the building costs of these facilities. A contribution to a range of day facilities for older people is also made through this programme.

The Nursing Home Legislation which was introduced in 1993 set down standards of accommodation and care in nursing homes and provides financial assistance based on dependency levels for older people in need of nursing home care. The number of people in receipt of subvention from health boards under the provisions of the Nursing Home Act increased by 72 per cent between 1994 and 1996.

Over 11,000 people have been approved for subventions since the Act came into force. There are approximately 5600 people actually in receipt of subventions and we are currently spending over £17m on this scheme. The major problem currently facing the Department is to find the resources to meet the increasing demand for nursing home places while at the same time developing other support structures for older people.
I think it is clear from what I have outlined that the emphasis in health policy for older people has been on the promotion of healthy ageing; on increasing the number of specialist Departments of Geriatric Medicine; on improving extended care facilities through the health board system and through the Nursing Home Legislation, while at the same time, endeavouring to improve community support structures.

The message coming from the findings of the Review certainly indicates that we have a considerable distance to go in meeting the requirements in each of these areas, notwithstanding the fact that considerable resources are already being allocated to those services. The resolution of the issues raised in the report will to a large extent depend on the availability of resources. While we have been reasonably successful in recent years in obtaining additional resources, greater effort will be required in order to meet the shortcomings identified in this report. Nevertheless, I think it is important to acknowledge the work of many people both in the state sector and the voluntary sector who have made considerable efforts over the last number of years to bring about improvements in services for older people.

Going on to refer to implications of the findings of the report on future policy I can only say at this stage that, given the comprehensive and thorough nature of the report, it is incumbent on everyone involved in the provision of services for older people to study the findings very carefully in order to identify particular service deficits and to proceed in a collaborative way to try and meet these deficits. However, I feel that there is probably a more fundamental issue raised by this report and that is our overall approach towards promoting the well-being of older people which includes the way we view older people and their role in society. There has undoubtedly been a sea change in the manner in which older people view themselves and the fact that they have a major contribution to make not alone to their own well-being but to the betterment of the lives of their fellow citizens.

This message comes across very clearly in the report which points to the need for a clear vision on ageing which gets away from the traditional view of older people as dependent on others. The report points to the need for a holistic approach to services which encompasses
other requirements of older people as well as health needs i.e. social participation and
collection, education and training, employment, social welfare and income security,
housing and family relationships. There is a reference to a lack of consumer input to the
assessment of needs, planning of services and evaluation of outcomes. Older people
themselves need to be involved in this process which is something we have fallen down on
to a large extent up to the present. Quality of service and health and social gain are key
features of the health strategy. Accordingly, greater emphasis needs to be placed on
research and evaluation of particular models of service which would include feedback from
older people themselves. The report points to the need for more research to determine
exactly the constituents of a basic standard of care.

While the report acknowledges that there have been improvements made in services it
points to the need for enhancements particularly in the area of community support services
such as Home Helps, meals on wheels, paramedical services, social work, nursing and day-
care services and the need to take specific measures to support carers. The lack of
development of mental health services specifically geared towards the needs of older people
has also been highlighted.

At an organisational level the report is of the view that there is a lack of co-ordination of
services from national level to local level. The Council has made a number of
recommendations in the report to improve co-ordination which will be carefully examined.

Where do we go from here? From the Department of Health's prospective there are
obviously aspects of policy emanating from *The Years Ahead* which will need to be looked
at. I think we have to try and develop a broader view of the needs of older people. In
conjunction with the health boards we will have to devise ways in which there can be much
greater involvement by older people themselves in the planning and development of
services. My own view is that we should look at the issues raised at a practical level and see
what can be done, on the one hand, in the short to medium term, and, on the other hand,
what can be planned for the longer term.
We will need, therefore, to identify on a priority basis those areas of the service most in need of enhancement and improvements and seek the resources necessary to implement improvements on a phased basis. In this connection, it is quite obvious from the Review findings that there is an urgent need to improve the community's support structures both for older people themselves and for their carers.

We also accept that a particular priority needs to be given to the mental health needs of older people which would involve improvement of services for people with functional mental illness and those with dementia. We have already initiated discussions with our colleagues in the health boards aimed at developing a specialised service in each health board area. The need for proper research and evaluation is also acknowledged and is an issue which we would hope to address.

The National Council has itself identified a number of core services which it considers should be given priority and, as the Minister indicates, this will be particularly helpful in the preparation of his plans. In discussing a broader approach to the needs of older people the question of co-ordination inevitably comes to the fore. While the Minister and the Department have specific responsibilities in relation to the health services, there are many other areas not within the direct responsibility of the Department of Health which effect the well-being of older people and which have been referred to in the Review. Various very worthwhile initiatives have been taken over the years in each of these areas by the relevant Ministers, Departments and agencies and the Minister will be endeavouring to ensure that further initiatives, aimed at improving the health and social well-being of older people, will be delivered in a more co-ordinated fashion at national and at local level.

In summary therefore, as far as the Department of Health is concerned we see the publication of this Review as playing a significant part in the Minister's development of future policy on services for older people. It will not be possible to meet all of the service deficits identified in the Review within the short to medium term. However, as the Minister himself indicates it is his intention to develop a plan which will meet the priority service needs on a phased basis and in this connection he will be consulting with the National Council and other interested
groups. It is also the intention to explore ways of improving the level of co-operation between the various agencies both at Government and at local level for the purposes of developing a more holistic approach to the needs of older people. The experiences of good practices in other countries will also be an important part of the development of policy.
Despite the many competing demands for state resources and the economic uncertainties influencing the capacity for state investment in healthcare, our country has a rich and proud tradition of being to the forefront of healthcare provision for our ageing population. This reputation has been earned thanks in no small way to the social and family values, which have given the care of older people the priority which it enjoys right up to the present time.

It is heartening for service planners and resource providers that while our country has undergone a period of significant social change in which many values have undergone reform, the sense of community responsibility and respect for its more senior citizens has remained undiminished. For that reason, despite the many difficulties identified in this Review, the re-shaping of services in future years presents as much an opportunity as it does a challenge.

This Review has come, I believe, at the best possible time. It identifies how service provision has developed in the nine year period since the publication of The Years Ahead in 1988 and sets that service provision in the context of the national Health Strategy published in May 1994.

It gives service planners and providers the opportunity to take stock of changes put in place, to look at service models developed both in rural and urban settings and to give particular emphasis to the objectives of the Health Strategy, which specifically set the following goals for the elderly population:

a) To maintain older people in dignity and independence in their homes;
b) To restore to independence those older people who become ill or
dependent;

c) To encourage and support the care of older people in their own communities by family, neighbours and voluntary groups;

d) To provide high quality hospital and residential care for older people when they can no longer be maintained in dignity and independence at home.

The time span covered by The Years Ahead report coincides with a period of particular economic difficulty when sustaining existing levels of services became the imperative rather than the planned resourcing of new services. It is to be hoped that the timeliness of this report will see present day economic improvements converted into forward thinking and progressive developments for the elderly.

The population changes amongst the elderly age groupings predicted in the Council’s Report of 1995, Health & Social Care Implications of Population Ageing in Ireland, 1991 - 2011, must be looked at in an urgent way to ensure that service improvements and innovations match the major changes which are emerging in the configuration of the population. The April, 1996 Census returns validate the prediction made in the Council’s 1995 Report that the population would grow in the case of over 65s by 3 per cent between 1991 and 1996 and in the case of persons over 80 years by 15 per cent in the same period.

The Review findings reflect a wide range of opinion expressed by service providers in relation to the implementation of The Years Ahead. In particular, differing models in terms of organisation have emerged in such areas as district and community care teams, co-ordination at district and regional levels, development of community hospitals for the elderly, appointment of liaison staff and establishment of regional advisory committees.

The existence of differing approaches does not, in my view, stem from a lack of confidence in the recommendations of The Years Ahead or the fact that these recommendations have not been underpinned by legislation, but rather the fact that there is a lack of uniformity in relation to the geographic distribution of healthcare facilities leading to an uneven distribution...
of resources. For example, many community care areas have inherited single large-scale institutions provided many years ago which militate against district services serving populations of 25,000 to 30,000 in the years ahead. Where, for instance, an institutional service of this type served a population of up to 100,000, the district organisation proposed has had to be tailored to such a population. This is not to say that service providers do not accept the concept of smaller geographic catchment areas but this type of service can only emerge when resources, in particular capital funding, are provided for locally based residential and support facilities.

The difficulties which have arisen in the development of elderly services in my own board’s area would in large measure mirror similar experiences in other parts of the country and explain why the service responses differ between and even within health board areas.

The table below shows a comparison between the population features of the over 65 population between the counties of Galway, Mayo and Roscommon and the country as a whole.

<p>| Table 1. Comparison of over 65+ population - WHB v State |
|---------------------------------|---------------------------------|</p>
<table>
<thead>
<tr>
<th></th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Population</td>
<td>3,525,718</td>
</tr>
<tr>
<td>Population over 65 years</td>
<td>402,921 (11.4%)</td>
</tr>
<tr>
<td>Population over 80 years</td>
<td>78,764 (2.2%)</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Western Health Board Population</td>
<td>342,974</td>
</tr>
<tr>
<td>Population over 65 years</td>
<td>49,717 (14.5%)</td>
</tr>
<tr>
<td>Population over 80 years</td>
<td>10,154 (3%)</td>
</tr>
</tbody>
</table>

In this table, you can see that the over 65 population in the Western Health Board area is presently 14 per cent of the total population compared with the national figure of 11.4 per cent. The actual census figure is remarkably close to the figure projected by the Council in its 1995 report and would be even higher in percentage terms were it not for the particularly high
level of net inward migration to Co. Galway and Galway City in particular over the past few years. The over 80 population increased by 2000 over the five years between 1991 and 1996 and is considerably higher than the national average.

The fact that the 1996 over 65 population was so accurately predicted in the Council’s 1995 report strongly suggests that the projections of the Council over the next 15 years for our board’s area can be accurately relied upon.

This next table shows the predicted pattern of population growth of the over 65 population up to the year 2010, at which time the percentage in that age category will have increased from its present 14 per cent to 16.6 per cent. Again, the projection shows that that figure will be ahead of the national percentage by 2.5 per cent that is 16.6 per cent as against 14.1 per cent. Similarly, the over 80 population will exceed national trends.

**Table 2: Predicted pattern of population growth of over 65+ population (WHB)**

<table>
<thead>
<tr>
<th></th>
<th>1991</th>
<th>1996</th>
<th>2006 (E)</th>
<th>2010 (E)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population over 65 years</td>
<td>49,717</td>
<td>49,188</td>
<td>51,138</td>
<td>55,404</td>
</tr>
<tr>
<td>% over 65 years</td>
<td>14.5%</td>
<td>14%</td>
<td>15.2%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Population over 80 years</td>
<td>10,154</td>
<td>12,054</td>
<td>14,303</td>
<td>15,301</td>
</tr>
<tr>
<td>% over 80 years</td>
<td>3%</td>
<td>3.4%</td>
<td>4.3%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

The table below shows that the present number of persons over 65 living alone, is 29.1 per cent of the over 65 population as compared with the national average of 25.8 per cent. The increase in our board’s figure from 1991 which was 22.1 per cent can at least partly be explained by the high migration from rural areas of the West of Ireland within the past decade.

**Table 3: Persons over 65 years living alone - WHB and State**
I would like to take you through briefly the ways in which our board has been implementing the main recommendations of *The Years Ahead* report. Referring back to something I touched on earlier, our board endorsed the recommendations of *The Years Ahead*, but our difficulties have stemmed from the fact that the resource base and geographic distribution of services and installations were not available on which to superimpose the model in *The Years Ahead*, and what we have been doing since is largely attempting to develop the infra-structure which would facilitate the full implementation of *The Years Ahead* report.

I should add that a board area such as ours with a population density marginally above half the national average is particularly suited to the concept of a service based on a 25,000 to 30,000 population, given the unique problems caused by factors such as distance and remoteness.

I will now seek to explain something of the difficulties experienced in bringing to fruition a service based on a defined catchment or sector along the lines set out in *The Years Ahead*.

There are fourteen separate residential facilities and on the face of it, you would draw the conclusion, on dividing our population of 352,000, by fourteen that we have an ideal catchment for each installation of 25,000. However, when we examine this further, we find that there are only four of these installations either equipped or resourced for extended care and immediately this presents difficulties of distance, family contact, liaison with local teams, general practitioners, public health nurses, etc.

<table>
<thead>
<tr>
<th></th>
<th>1991</th>
<th>1996</th>
<th>2006</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Health Board</td>
<td>11,005</td>
<td>14,401</td>
<td>15,518</td>
<td>15,702</td>
</tr>
<tr>
<td>Percentage</td>
<td>(22.1%)</td>
<td>(29.1%)</td>
<td>(30.3%)</td>
<td>(28.3%)</td>
</tr>
<tr>
<td>State</td>
<td>96,522</td>
<td>106,943</td>
<td>131,116</td>
<td>137,812</td>
</tr>
<tr>
<td>Percentage</td>
<td>(23.9%)</td>
<td>(25.8%)</td>
<td>(28.1%)</td>
<td>(26.4%)</td>
</tr>
</tbody>
</table>
Within the Western Health Board, long-stay care is presently at a distance of over 60 miles from home for many patients and while welfare accommodation is more locally based, the difficulty is that they are not physically amenable to long-term care. Furthermore, they are in the main run with a minimum of support staff and the staff complement is sufficient only for ambulant and low dependent residents.

In response to this, we have been planning for a more equal distribution of all support services, including day care, day hospital, respite care, dementia care, etc based on the conversion of a number of our welfare homes into community hospitals for the elderly. For instance, in Carraroe, we are presently in the final stages of an extension to provide 20 long-stay beds and this will to a large extent meet the immediate extended care requirements in the Connemara area. We are also actively working with a local voluntary group on the Aran Islands to provide a small scale community nursing unit on Inishmore. Here in Loughrea is one of the last remaining former workhouses in the country and we propose replacing its 240 beds by two community hospitals, one in Loughrea and one in Ballinasloe. In this way, the concept of a geographic based service centred on a catchment area ideally coterminous with the mental health sector areas will become a reality.

In Mayo, the five installations for the elderly are reasonably well dispersed but again only the Castlebar long-stay accommodation is equipped for extended care. In the medium term, we plan for a community nursing unit in Achill, primarily for extended care, to be followed by adaptations to one of the remaining homes for the aged in order to achieve a geographic balance.

In Roscommon, which has a population of 55,000, our aim is to adapt the existing home for the aged in Boyle into a community hospital for the elderly as soon as resources become available. By doing so, Roscommon will be served by two separate facilities, each serving 27,000 approximately.

The table below summarises where our board stands in relation to the more specific
recommendations of *The Years Ahead*.

**Table 5: Service provision -v- norms**

<table>
<thead>
<tr>
<th></th>
<th>Advisory Committee for the Elderly</th>
<th>Yes <em>(meets every two months)</em></th>
</tr>
</thead>
</table>
| 02. | Co-Ordinator (full-time) for the Elderly | Yes in Galway  
No in Mayo & Roscommon |
| 03. | Liaison Public Health Nurse | 1 full-time in Galway Community Care Area  
1 part-time in Mayo & Roscommon |
| 04. | Consultant Physician in Medicine for the Elderly | Yes in each county *(two in Galway)* |
| 05. | District Liaison Nurses | No |
| 06. | Public Health Nurses to general population | 1 : 2,200 |
| 07. | Home Helps | 6 : 1,000 |
| 08. | Day Hospital places (3 locations) | 1.4 : 1,000 elderly |
| 09. | Day Care Centres (9 locations) | 1 : 6,000 elderly |
| 10. | Residential Places (excluding dementia but including subvented beds) | 40 : 1,000 elderly |
| 11. | Dementia Beds | 1 : 1,000 elderly |

Our board has a broadly representative advisory committee representing all disciplines in elderly care and also a nominee of the voluntary organisations in our board’s area. In line with the principles and values contained in the Health Strategy document *Shaping a Healthier Future*, that committee will be extended to include a user’s representative. The committee works with the Programme Managers for Special Hospital Care and Community Care, both of whom have management inputs to elderly care. This committee also has a planning brief and is presently examining initiatives for further development of health education and health promotion for the elderly.

There is a full-time Co-ordinator for the Elderly in Galway as well as a full-time Liaison Public Health Nurse. The Co-ordinator is medically qualified and both work through the elderly assessment team headed by the Consultant Geriatrician which meets weekly. In Mayo
and Roscommon, the service co-ordination is handled jointly between the Matron of the long-stay institution and the Superintendent Public Health Nurse in consultation with the Consultant Geriatrician. Again, the full team in each county meets weekly.

These co-ordination arrangements continue to work satisfactorily and are supported by liaison arrangements adapted to meet local service needs. In Mayo and Roscommon, the liaison function is carried out by a designated public health nurse and at University College Hospital, Galway a full time staff nurse has been assigned to liaise with the community services.

A development in recent months has been the appointment of a Consultant Physician in medicine of the elderly at University College Hospital, Galway. This was a long-awaited appointment and a 20-bedded assessment unit has been made available for the appointee. Consultant Physicians with special interest in medicine for the elderly have been appointed to Mayo General Hospital and to Roscommon County Hospital. In each of these two hospitals, assessment beds for the elderly are integrated with the general hospital beds but in each case, off-site rehabilitation departments beds have been developed close by in the long-stay geriatric institutions. The Sacred Heart Home in Castlebar has a 28 bedded facility and the Sacred Heart Home in Roscommon has a 20 bedded unit.

In Galway, the board has plans for a 20 bedded off-site rehabilitation unit in Merlin Park Hospital as well as a day hospital for the elderly in University College Hospital, Galway and funding of both developments is awaited.

Our board’s ratio of Public Health Nurses to the general population is 1 per 2,200 which is somewhat better that the ratio suggested in The Years Ahead report. However, the deficits of distance, remoteness and travelling time that I referred to earlier, have to be taken into account when looking at this ratio and if the policy objective contained in the Health Strategy document to maintain 90 per cent of persons over 75 years in their own homes for the future is to be realised, then I am in no doubt but that ratio will have to be improved on.

The total number of home help posts in our board expressed in wholetime equivalents is 296,
which is a ratio of 6 per 1,000 population over 65 years. This is somewhat better than the norm set out in *The Years Ahead* but since 1988 there have been significant changes in the make-up of the elderly population as well as the numbers living alone which would justify a figure above the stated norm. We are indebted for the excellent service given by our Home Helps which has contributed in no small way to the significant decline in waiting list numbers for institutional care. Our board promotes in every way the development of this service, including the proposal in the review document to legislate for its provision as well as the suggestion of a care assistant service.

Our existing day hospital service is based at the Castlebar, Roscommon and Loughrea institutions for long-term care and the number of places is 1.4 per 1000 elderly as compared with the 2 places per 1000 elderly recommended in *The Years Ahead*. Day hospital care is, for many elderly people and their families, a viable alternative to hospital or institutional care. The service allows patients to avail of a full range of therapeutic interventions that are not available in day care centres and which reduce the demand for in-patient hospital beds. Furthermore, patients can retain contact with their families and arrangements for their future care can more readily be agreed.

If our modern day aspirations for elderly care are to be met, I firmly believe that a purpose-designed day hospital should be available for every 50,000 of the general population ideally located in close proximity to a general hospital where there would be a full multi-disciplinary team headed by the Physician in Medicine for the Elderly. Apart from our existing three day hospitals, we are presently completing the construction of a purpose-built day hospital adjacent to the District Hospital in Clifden and an application has been made for a similar facility on the grounds of University College Hospital, Galway. These two developments will give us a further 50 places, bringing the total to 120. With these developments, we would also hope to strengthen the para-medical support with the appointment of additional staff such as physiotherapists, occupational therapists, speech therapists and social workers in the community dedicated to elderly services.

An area our advisory committee has been looking at is the whole question of abuse of older
people and I am particularly pleased that the Council is presently conducting research into this. Its findings will be awaited with some interest as there is some concern that the existing protections, such are Wardship of the High Court or Power of Attorney legislation does not adequately provide for the range of potential abuse.

The number of residential places, excluding dementia, in the Western Health Board is 40 per 1000 population and this is very close to the guidelines in *The Years Ahead*. I am including here the present number of subvented beds which is 650 and when I include private nursing home beds which are not subvented, the total number of available is in the region of 50 per 1000 elderly. The additional subvented places which have come on stream over the last few years have largely eliminated the waiting list problem which existed previously but we still find that there is an uneven geographic availability of beds, leading in some cases to residents having to move a long distance from home.

The dependency level of residents in all our institutions coupled with the categorisation of older people going into private nursing homes strongly suggests that the norms for extended care and welfare home places recommended in *The Years Ahead* need significant adjustment. My own analysis of dependency levels amongst the elderly in our board’s area would suggest that the number of extended care beds would need to be at least doubled from the existing norm of 10 per 1000 elderly population with some reduction perhaps in the number of welfare home places.

I wish to mention in particular the growing problem of dementia amongst the elderly but particularly Alzheimer’s disease which unfortunately has occurred in a rising number of families in recent years. The disease is known to multiply greatly in prevalence with advancing years and the traditional type long-stay service is not tailored in any way to meet the special needs of this patient group.

In my own board’s area, we have adapted a ward unit at the Sacred Heart Home, Castlebar for 35 places. This service has some outreach and community liaison but greatly needs specialised resourcing to help out with families. A specialised unit of this type is a much
needed development but can only function properly if the necessary community dimension is provided for. In our case, we were fortunate in that we were able to transfer staff interested in this kind of service from the adjacent St. Mary’s Psychiatric Hospital, Castlebar. The staff concerned, mainly nurses, following re-training, are to be complimented in the way in which they set about shaping and delivering a new service based on a number of values with which they were previously unfamiliar.

We have also made provision for a small number of dementia beds in Castlerea which will be in place shortly. We have proposals with the Department of Health for a new 20-bedded unit in Galway, as well as a day hospital and we are pleased that at this point, the Department of Health has accepted in principle that the new service will be headed by a Consultant Psychiatrist in the Psychiatry of Old Age. A special unit with 20 beds has been adapted in St. Brigid’s Hospital, Ballinasloe and this continues to provide a specialised service mainly for existing hospital residents.

Our board is greatly appreciative of the service given by the voluntary agencies in our area, including the Alzheimers Society of Ireland and the Western Alzheimers Foundation. These include respite care, day care and a home sitting service.

I pay tribute to the work done by volunteers and voluntary bodies in Galway, Mayo, Roscommon, and elsewhere in supporting the elderly. There are in the region of 70 such groups in our board’s area. Not only does this entail transport and travel costs, but the range of services extends to giving advice and support to clients and their families concerning benefits and entitlements. I would particularly ask that our elderly citizens would not only get involved in this way but would make a special effort to make available their knowledge and skills to the younger generations. From our experiences during 1993, the European Year for Older People, it was abundantly evident that young people were eager to share the wisdom and knowledge of their elders.

I would like to refer to the excellent work done in the area of housing by Local Authorities in recent years. Many have special housing units for the elderly constructed so as to provide safe
housing accessible to local services. A formal liaison system between my board and the housing authorities in our area has been established and under this arrangement, there is co-operation in relation to the Special Housing Aid for the Elderly Scheme. Another joint initiative at the present time is a number of One Stop Shops in rural areas. This is being done on foot of the proposals contained in the Department of the Environment document *Better Local Government: A Programme for Change*, and will become useful focal points for providing information and advice.

I cannot let the opportunity pass without making mention of our carers. I was particularly pleased that in this year’s Government budget, the conditions for qualifying for the Carer’s Allowance were relaxed somewhat. We owe a great deal to the many carers who make care at home a real alternative to institutional support.

Our board has also helped financially to support local groups who have made arrangements to provide security systems for the elderly in their homes. This can be an expensive investment for many local communities but well worthwhile nevertheless.

Overall, the health boards have responded very positively to the provision and development of Services for the Elderly in their areas within the resources available to them for which we thank the Minister and his officers. To maintain the momentum, further additional resources will be required and I hope that these will be forthcoming.
The most recent census of population in 1996 showed there were 107,000 pensioners living alone in this country. About one-sixth of the population live alone and half of these are elderly people.

How they are managing, we do not know. Are they living in hardship? Are they lonely? Have they regular visitors? We do not know the answers to these questions because we have no national network which would monitor the circumstances and the welfare of our colleagues.

There are numerous organisations, both statutory and voluntary, which are doing great work in caring for the elderly, but there is no comprehensive, community or parish-based national organisation to provide a satisfactory response to the needs of a growing number of people. The problem in Ireland is not as great as in a number of other European countries where the proportion of older people to the rest of the community is higher at the present time. However the number of people over 65 years of age is growing in this country and it is estimated that in 25 years time it will constitute more than 13 per cent of the population. The European Union recently estimated that the over-60s could account for up to 40 per cent of the EU population by the year 2050. One third of the over-60s will actually be over 80, according to a Eurostat survey which forecasts that Italy and Spain are likely to be easily the oldest nations by that time.

The Chairman of the Irish Association of Pension Funds, Mr Paul O’Faherty, recently forecast that demographic and social trends would boost the number of elderly people needing long-term care. He estimated that there are now 34,000 people over 85 in Ireland and that this
number could increase to 50,000 within fifteen years. A large percentage of these older people would require short or long-term nursing care.

We are fortunate in Ireland that the vast majority of older people are active and are able to make full use of their retirement. Now is the time to face up to what should be regarded as a challenge rather than a problem - how to harness the vast resource of wisdom and experience of this high proportion of the population, not only for their own personal development but for the benefit of the community in general.

As an interested observer I have been looking at the scene affecting the elderly for the past couple of years and I have formed some opinions which I will put to you later in my talk. But first I would like to refer to some of the more obvious problems that came to my attention as Ombudsman.

When I held the post of Ombudsman for eleven years, I had to deal with many complaints involving older people. One of the main problems was the difficulty of getting public officials to appreciate that elderly people required special consideration. Their hearing might not be the best, or their understanding of official language might not be the clearest. Many of the complaints could have been resolved by a better understanding on the official side. I was constantly advising public servants to put themselves in the position of the person on the other side of the desk, because as surely as the sun rises each day, we will all become old (if we live that long) and, inevitably, we will all find ourselves on the other side of the desk. So, always treat the other person in the way you would wish to be treated yourself.

Because you understand the language of your Department does not necessarily mean that any outsider understands it. What you consider to be perfectly understandable and lucid language may appear to other people to be unintelligible and complex. Any of you who has ever filled in a claim form of any kind will know what I am talking about. Has any one of you ever succeeded in filling in correctly a census form at your first attempt? Many voters often wonder why people seeking social welfare benefits, for example, feel it necessary to go to their local Dail Deputy for assistance to obtain something to which they are lawfully entitled.
The answer very often is that they have no confidence in filling in the claim form themselves and prefer to put their trust in somebody more experienced.

There has been a major improvement in recent years in the preparation of claim forms but it requires ongoing attention to ensure that unnecessary difficulties are not created for people, often at the most vulnerable time in their lives, when they may be seeking a widow's pension, or benefit of that nature. In the recent general election, all the main political parties produced policy programmes which incorporated provisions for the elderly. Some of the provisions were vague and ill thought out, but others were practical and, if implemented, should lead to progress.

One of these proposals in the Fianna Fail manifesto is certainly capable of promoting improvement if it is implemented in government. It is that a monitoring unit be set up in the public service to oversee the drafting and printing of all official documents so that they will be presented to the public in the most simple and intelligible way. If such a unit is set up, and it is to be hoped that the government will fulfil its election promise, then it would do well to look at all the existing claim documents to revise and rewrite them where necessary.

It is also proposed that future pension increases be held in line with inflation. This was usually the case in the past but there has been an inclination over the past few years to set the increases below the level of inflation. A strong lobby is needed to ensure that there is no erosion of existing benefits, particularly in the area of parity of pensions within the public service. Parity was achieved only after several years of struggle by our predecessors and it would be a sad reflection on this generation if we allowed it to be affected by changes in the methods of rewarding personnel within the present structures. Much unnecessary worry has been created for retired public servants by the fear that they were going to lose out in the context of these changes. I do not think there is any real cause for anxiety because politicians know that we represent a growing and powerful lobby which can be as effective as any other lobby in the country, such as the farming or business community.

Another matter which concerned me as Ombudsman was the new regulations introduced
under the Health Acts which enabled a health board to seek payments for their parents' care in nursing homes from the children of the family. This was a most inequitable development which should never have been introduced and, once its effects were recognised, should have been abolished. The civil service memo on which the decision was made probably made a case for the wealthy sons and daughters of inmates in nursing homes meeting some of the costs instead of having them picked up by the ordinary taxpayer, but the memo failed to take into account the hundreds of cases of sons and daughters struggling to make a living, who felt obliged by feelings of guilt to contribute from their own meagre resources to a cost which should be met by the State. I have come across cases where the spouse of the ill person was reduced to poverty in trying to meet the nursing home costs of the partner and where the issue was further complicated by the health board pursuing other members of the family for payment.

It is necessary that these matters be cleared up now when the numbers of older people requiring residential nursing care are comparatively low rather than later when the numbers will almost certainly increase for the over 85s. A recent British study by the Office of National Statistics found that 71 per cent of men and 61 per cent of women suffer from a long-standing illness, disability or infirmity from 75 onwards. It would be too much to expect that we might fare out better in any corresponding survey in this country.

There are many other matters of importance affecting older people which require attention, such as, adequate tax allowances to assist people in their declining years; allowances for carers who are doing very difficult work under discouraging circumstances and the general question of sheltered housing.

One matter which perhaps requires more immediate attention than any of these is the question of consultation with older people on all issues affecting their welfare. It is difficult to believe in this day and age that many decisions affecting the welfare of older people are being taken without reference to the people mainly concerned. In Denmark, since early this year, all public bodies are required by law to consult with and take into account the views of older people on all matters affecting older people, such as the provision of housing, retirement
activities and, indeed, any project where public policy impinges on the lives of older citizens. But, then, they have in Denmark a most enlightened attitude towards the elderly and it is about Denmark that I want to devote most of this paper in the hope that we can learn from developments there much that we can usefully apply in this country.

One of the things which has struck me most forcefully since I retired from the office of Ombudsman and became involved in work for the elderly is the proliferation of organisations throughout the country concerned with the welfare of older people. This is a wonderful development and the people concerned in setting up and running these organisations deserve our gratitude, but it seems to me after observing the situation in Denmark that much more would be achieved and we would have a much more powerful voice if we all worked under a single umbrella.

The setting up of the National Parliament for senior citizens was a splendid achievement, and there is no doubt that it will be a very powerful voice in the future on behalf of the 100 organisations affiliated to it. As a forceful lobby it will have access to Government departments and, hopefully, to members of the Government, to influence them in the preparation and amendment of legislation and, particularly, in the run-up to the budget preparations each year.

But something more is needed to reach out into each community, each parish, each street throughout the country where elderly people may be living on their own or with an elderly carer, who may be lonely or hungry or ill and be unable to summon help. Many of you will have heard of the Danish organisation, DaneAge, but it is only recently I became aware of the astonishing work it is doing and how it has spread into every community in Denmark to make the lives of older people more happy and secure.

Denmark has a population of just over 5 million people. Its citizens are highly taxed at a rate of some 50 per cent of earnings. In return for this heavy tax burden, people demand and receive a very developed system of social services. But for older people, the widespread system of support is not dependent on State aid. Instead, there is an almost incredible system...
of voluntary aid based on a commitment by the entire community to look after its elderly neighbours.

Of the total population, some 20 per cent are aged over 60 years. In the implementation of social policy, the concept of subsidiarity is fundamental. The responsibility for the implementation of social policy is placed as close to the citizen as possible. All residents are entitled to services, social security payments and benefits, regardless of their affiliation to the labour market. The basic concept in the allocation of services is need. Total social expenditure, including unemployment benefits and health care, amounts to approximately 50 per cent of total public expenditure. In 1995 only 4 per cent of Danish families were categorised as below the poverty line in accordance with OECD guidelines. Because of the growing need for social services by older people and the inability of the public sector to fund this development, it was realised that voluntary organisations would have to play a greater role in this area.

DaneAge Foundation had been set up in 1910 to help older people. It was a non-profit organisation with voluntary workers attempting to provide shelter and food for the elderly. In 1986 the Foundation, which had built up substantial financial resources through gifts and bequests, founded DaneAge Association, a voluntary organisation built on professional lines to extend the activities of the members to the provision of housing, consultancy services, etc.

The Association was launched nationally in October 1986 by means of a magazine distributed to all 2.3 million households in Denmark. There was an astonishing response from the population. Despite the fact that members were required to contribute an annual fee of approximately £15 and engage in quite demanding activity on behalf of the older members of their community, there were 315,000 members by January 1996. This extraordinary number had swelled by another 50,000 to a total of 365,000 by last May, when I saw at first hand the extent of the Association's activities.

The main objective of the Association is to improve the quality of life for older people in Denmark. Self-determination, independence and equality for older people are the motivating
factors. One of its principal tasks is to act on behalf of older people in relation to central and local government and any other agency affecting the quality of life of the elderly. There is no link with any political party, nor is there any religious affiliation. Anybody over 18 years of age may become a member with the result that large numbers of young people in Denmark now give time and energy to older people in the community. They visit them in their homes, they serve them meals, talk to them, take them out on walks and check on them occasionally by ’phone to make sure everything is all right.

The Association is spread over 15 regions and 173 local districts to which members belong according to residence. The National Assembly of Delegates is the highest authority of the Association and comprises elected representatives from the 15 regional committees. Local committees have a governing body of six persons elected for a period of three years by the members. Local activities include the setting up of clubs, the holding of cultural, social and political meetings, lectures, films, study groups, seminars, excursions, entertainment, exercise, educational work, etc. Local committees also arrange counselling, guidance, informative and advisory work, network activities for the lonely and frail. They also organise policy sessions and lobbying at local level.

The nationwide management of the Association consists of an Executive Committee and a Board of Directors appointed by the Executive Committee. There is a central, free-call counselling service which gives members advice and guidance on social and legal matters free of charge. These services are also being developed at the local level. Pamphlets and books offering relevant information are published regularly and a magazine is published six times a year with information on local activities, special offers, travel activities, etc. The Association also arranges conferences and pre-retirement courses for workers and their spouses. Over a 10-year period between 1986 and 1996, the Association became the largest membership organisation in Denmark and entered the Guinness Book of Records as the fastest growing organisation in the world.

One of the reasons for its growth was that it offers certain discounts and concessions to its members. There are special membership benefits in relation to insurance, radio and television
appliances, computers, credit cards, petrol companies and optical treatment. In total, the membership generates in these companies a turnover of more than 20 million pounds sterling per year. New services are constantly being developed for the members and as a means of attracting new members, with the aim of having close to 400,000 members by the year 2000.

The Association receives no public funds unless they are earmarked for a particular project such as a nursing home. Funding comes entirely from the contributions of the members (365,000 members at £15 a year annually comes to almost five and a half million pounds). This enables the employment of high quality administrators and assistants who oversee the general management of the Association's activities. In the city of Copenhagen, for example, there is a huge complex of offices, recreation rooms and workshops where older citizens, for a payment of £5 per month, can have access to reading material, woodwork and ironwork, bookbinding, snooker, a restaurant, a hairdresser and dozens of other activities.

At the national level, the Association has a policy unit and a research unit which work closely together to produce high quality analytical documentation, while a public relations/information unit attempts to secure maximum publicity in the media for the Association's activities and for its viewpoint on political developments of concern to older people.

At the political level the Association has been active in recent years in regard to the question of discrimination on age grounds in the work place; age discrimination in the health sector, the rights of persons suffering from dementia and their carers; the care and service provision for older people at home and in institutions; pensions rights and the whole question of empowerment. Under the legislation brought into operation last February, there is a requirement that local councils and senior citizens be established and that they be consulted on all matters affecting older people. DaneAge is active in the majority of these councils and, where councils have not yet been set up, the Association works closely with local elected officials and civil servants.

The Association's political activity at national level is very similar to the work that will be
undertaken by our own senior citizen's Parliament, making direct contact with members of the Government, party spokesmen and various committees in order to remain abreast of political developments and to ensure that nothing will be done which will adversely affect the wellbeing of older people, and that much will be done to improve their lot.

I think I have said enough about the Danish experiment to indicate that there is a rich source of material here which we might study at some length and consider if it would be possible to apply similar principles and concepts here in Ireland. One would hope that there is as much compassion and care in Irish society for the welfare of elderly citizens as there is in Denmark.

There is another example of extraordinary dedication and commitment here at home to which I would like to draw attention. It is the work of the SHARE community in Cork which, over the past 27 years, has provided modern housing, comfort and friendship for the elderly citizens of the city of Cork. The work is so remarkable that it has attracted international attention, with the prospect of similar organisations being set up in other cities around the world. There would appear to be no good reason why the example set by the young people of Cork should not be replicated in other cities and towns in Ireland.

The founding of SHARE in Cork in 1970 arose from an idea from a member of the Presentation Brothers, Brother Jerome Kelly. The novitiate of the Presentation Brothers at St. Joseph's was becoming largely unused because of the fall in vocations. It was a question of selling off the premises or putting it to another use. Brother Kelly, with twelve young students from the Presentation Brothers schools, put in place the organisation which became known as SHARE, or ‘Students Harnessing Relief for the Elderly’. Over the past 27 years they have provided hundreds of homes for the elderly and, with the co-operation of the local authorities, have wiped out substandard housing for the elderly in Cork. St. Joseph's novitiate was divided between the Brothers and a group of older people, with the Brothers holding on to only one-third of the premises. The twelve young founders started a Christmas Fast to raise funds for the project. Every year since, thousands of students from the 5th Year classes in secondary schools throughout Cork have carried on the fund-raising to provide housing with the result that, over the years, they have succeeded in providing 200 SHARE apartments at 11
different locations throughout the city.

In the House of St. Joseph itself, accommodation has been provided for 42 residents. They share the same facilities that the Brothers have. Those who are frail or confined to their rooms are visited regularly by the Brothers or by the young people to make them a cup of tea, to sit and talk to them, or to listen to their problems. Not only is there a sharing of problems, but there is a great sharing of knowledge and of history, so that the students say they gain more from their visits than the older people. Concerts and musical evenings are provided and the parents of the students known as SHARE mothers, come in each day on a rotational basis to prepare meals.

The organisation is run by a council elected each year by the students, with the assistance of a couple of senior advisors. Work on refurbishing and renovating the two-thirds of St. Joseph's turned over to the elderly has been in progress for years, with the architects consulting with the young people and the elderly residents at every stage. The work was completed in 1993 and the residence is now one of the most up-to-date and comfortable complexes of units anywhere. There is a family atmosphere in the place, and each resident has a small garden plot to tend, with the aid of their young helpers. The net result of this unique achievement is a restoration of dignity to many old people, and the removal of loneliness and fear.

The young people's commitment to their older friends does not end with their deaths. They ensure that their burial takes place in a SHARE community grave, that the funeral ceremonies are attended by the students, who also carry the body to the graveyard and form a guard of honour on the way. Surely, this is an example which might be considered for future development. Is there any good reason why the example set by the young people of Cork should not be taken up by the young people of Dublin, or Limerick or Galway? I put these matters before you for your consideration. It appears to me that they are excellent examples which might be explored for the improvement of the lives of elderly people in this country. None of us, and no organisation, has a monopoly on wisdom. I think we should look closely at any idea which holds promise for a better future.
Equity, Consistency and Comprehensiveness: The Need for a Legislative Framework to Govern the Provision of Essential Services for Older People

Ms Ita Mangan, Barrister and Consultant

The Years Ahead recommended a legislative framework for the provision of services for older people. The main provisions to be included in the proposed framework were:

- a general obligation on health boards and local authorities to promote the well-being of older people and to plan to meet those needs, in consultation with each other and with voluntary organisations;

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

- an obligation on local authorities to provide for the repair and adaptation of dwellings for older people;

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

This latter recommendation was not implemented. The question that arises is, if it were implemented, would the report we are considering here today be substantially different because the legal obligations would have ensured that more of the other recommendations would have been implemented?

I believe that there is a need for a legal framework for the provision of services for older people but I do not believe that the specific framework outlined in The Years Ahead is sufficiently encompassing to ensure that there would be clear and unequivocal obligations on the part of the public authorities and clear and enforceable rights on the part of older people.
I consider that the elements outlined should be included in the legislation but they could be done relatively simply by amendments to the Health Act and the Housing Acts. I think a better solution is to have a separate Services for Older People Act which is much more comprehensive and deals with issues which have never been addressed in law such as the obligations of adult children towards their parents.

While advocating this approach, I also consider that too much reliance can be placed on the existence of a legal framework when, in fact, the major issues are usually resources, administrative and managerial shortcomings and the absence of adequate coordination and review mechanisms when government policy decisions not involving legislation are taken. It must also be recognised that legislation can restrict the development of services so any legislation in this area must be enabling and not restrictive. The only piece of major legislation on services for older people which has been passed since 1988 is the Health (Nursing Homes) Act. Aspects of this legislation provide a good example of how not to provide for clear and enforceable rights - I will return to this issue in some detail later.

On the other hand, the social welfare legislation is relatively satisfactory in that it does provide for clear and enforceable rights. I agree with the stated National Council policy that services such as home help, day care and appropriate housing are so essential to the basic welfare and survival needs of older people that they must be part of core service provision with legal obligations for their provision and appropriate statutory funding. But I would go further and say that, as well as provided a legal underpinning for the services mentioned, the legal framework must also enable the service providers to develop new services, to deliver them in an imaginative way and, most of all, the framework must not provide an excuse for not pursuing initiatives that would benefit individual old people and old people generally.

The question then arises as to whether such a framework can be devised. Legislation is not an exact science. We are all aware of laws which have been used and interpreted in a way which was almost totally different to that envisaged by the original drafters. I recognise that I may be asking more questions than I am able to answer but, while arguing for enabling and rights enhancing legislation, I do want to warn against a tendency to believe that legislation,
in itself, can provide the answer to complex problems and to warn that devising the right kind of legislation will not be easy.

**Government policy decisions**

Did the failure to provide a legal framework fatally damage the prospects of having *The Years Ahead* recommendations implemented? The Council's comments on this report point out that the absence of a legislative framework would not have been an insurmountable problem if a lead agency had taken responsibility for encouraging the co-ordinated implementation of recommendations.

*The Years Ahead* was adopted as official policy by the Department of Health in 1988 and was further endorsed in the Health Strategy document published in 1994. The report we are considering today shows that, in general, efforts have been made to implement it - albeit some not very successfully.

While the report shows that many of the recommendations have not been implemented or have only partially been implemented, it is clear that serious efforts were made by the main service providers to move towards the objectives. However, there are blatant failures to even try to implement it e.g. the Department of Transport (the name has been changed several times but now the Department of Public Enterprise) never even tried to conduct a review of the transport needs of older people. Questions need to be asked as to why Government departments and agencies clearly ignored policy decisions of the government.

The consequences of failure to implement government policy decisions in the areas we are discussing today may not legally amount to a breach of duty but there ought to be some mechanisms in place to ensure compliance with such policy decisions. Otherwise, government policy decisions are meaningless. It would not be desirable to have a situation where the only way to ensure compliance with policy decisions is to have them enshrined in law - not all policy decisions are amenable to or suitable for statutory expression. Perhaps what is needed is a statutory framework governing the status of Government policy decisions.
and the obligations of public servants to implement those decisions.

_The Years Ahead_ was published in 1988. This is the first review of its implementation. All government policy documents should be subject to annual reviews. The Report of the Second Commission on the Status of Women publishes an annual review - this mechanism provides a means by which anyone interested can be aware of what is happening and, perhaps more importantly, can draw attention to what is not happening. The national agreements such as Partnership 2000 all have regular review mechanisms.

**Existing legal frameworks**

There are legal frameworks in existence for certain services and for determining the legal relationships between people. I want to look briefly at how they operate and at how effective they are in meeting the stated overall policy objectives.

**Social welfare**

The social welfare services are, in general, set out in legislation. There are clearly defined rights and entitlements to pensions and other income maintenance arrangements. These rights are enforceable and recent litigation has improved people's rights to fair procedure when dealing with social welfare matters.

Strangely, the ‘free’ services - free travel, free electricity etc. are not enshrined in legislation. However, there is no question of these being discretionary. There are clear rules and, it must be said, there does not seem to be any major disadvantage in not having a legislative framework for them. The absence of legislation does mean that the usual appeals system does not apply but people are entitled to enforce their rights through normal court procedures. The Ombudsman can also review decisions on these benefits. Overall, the social welfare legislation is extraordinarily complex but it does provide for clear and enforceable rights. It places clear obligations on the department of Social Welfare. It must be said, however, that it is much easier to provide for clear rights and obligations in this area than it is in the areas of health and community services and personal social services.
**Maintenance legislation**

There are clear obligations on spouses to maintain each other (even after divorce) and on parents to maintain children. There are undoubted problems with enforcement of this legislation. There are no legal obligations on non-marital partners towards each other nor on children towards their siblings or their parents. Nevertheless, there are areas where the State imposes a *de facto* obligation e.g. in the treatment of non-marital couples in social welfare, in the assessment of board and lodgings in applications for unemployment assistance and in the possible assessment of the income of adult children in the Nursing Homes legislation. Effectively the State is behaving as if a legal obligation exists when, in fact, it does not.

**Nursing homes legislation**

I said at the beginning that the Nursing Homes Act provides an example of how not to have clear rights and obligations enshrined in legislation. In assessing the amount of subvention which the health board will pay for a dependent older person in a private nursing home, one of the circumstances taken into account is the capacity of a son or daughter who is over the age of 21 and living in Ireland to contribute towards the cost of your nursing home care. This gives rise to all sorts of problems.

Only the income of your son or daughter is taken into account - the income of your son's or daughter's spouse is not. This means that there would be no assessment in the case of a daughter (or son) working full time in the home. Income from all sources in the previous year is taken into account including ‘all contributions from whosoever arising provided that the income is personal to the son or daughter’. It is not at all clear what this means; it could mean that maintenance payments made to a separated spouse would be assessed even if normal transfers between a cohabiting husband and wife would not be.

A number of deductions are made from the income, some are clear but some are not e.g. education fees - the rules are not explicit but this may include voluntary contributions as well as fees to secondary and primary schools; it includes higher education fees (which are still
payable in some cases even though undergraduate fees in general have been abolished). There are then a number of allowances: £8000 personal allowance; £5000 for a dependent spouse; £2000 each for children under 21 or in full time education and £2000 each for other dependants living with the son/daughter. In effect, the unfortunate son or daughter has a legal obligation to support his/her children but the health board thinks that £2000 a year is enough for that purpose. He/she has no legal obligation to support the parent but the parent will suffer if he/she does not do so.

If the son or daughter has an income above these amounts then the health board may reduce the subvention which would otherwise be payable. Your son or daughter cannot be forced to pay this amount. There is no legal obligation on children to support their parents. There are no provisions in the legislation for dealing with the situation where a son or daughter does not pay. So, the health board is effectively imputing an income to the parent which he/she may or may not receive.

I want to emphasise that it may well be legitimate for the State to place a legal obligation on adult children to support their parents. I am not expressing a view on that but such an obligation, if it is to be imposed, should be explicit and clear in the way that obligations towards spouses and children are.

The Council also notes the irony that the only significant legislation on services for older people since 1988 - the Nursing Homes Act - has led to a growth in institutional care, in direct contravention to the major aim of The Years Ahead

The report also notes that there is considerable lack of uniformity in the implementation of the regulations under the Health (Nursing Homes) Act. The recent report of the Ombudsman highlighted the fact that the Department of Health and consequently the health boards were incorrectly interpreting the means test provisions of this Act.

**Boarding out**

Boarding out was also put on a statutory basis but it seems to be meeting consumer resistance.
**Lack of context for legislation**

The Nursing Homes legislation was introduced in the absence of overall legislation dealing with services for older people. At one stage in the discussions before the Bill was published it was thought that the whole issue of dependent old.

**What sort of legal framework?**

Can a legal framework be devised which will meet the criteria set out above? I doubt if anyone would dispute the proposition that the provision of services must be equitable, consistent and comprehensive. However, services must also be responsive, flexible, coordinated, planned and cost-effective. Health services must contribute to health gain and social gain. The issue is whether a legislative framework, while it would almost certainly improve equity and consistency, would it do so at the expense of flexibility and responsiveness?

Where services based on individual need are required, would a legislative framework impede this? Can needs be defined in legislation? Especially in circumstances where it is accepted that there is no homogeneity of need. Could assessment of need be adequately dealt with in legislation? Would a legislative framework inhibit imaginative responses? How do you legislate for health gain and social gain? If there is a requirement to provide services - how could we ensure that they would be provided in the most suitable environment; would e.g. physiotherapy services be provided only in clinics with no domiciliary service? Would there be an obligation to provide a transport service as that would be needed in order to avail of the other service?

There is no point in having a legal obligation to provide services if the consumers are unable to use them. These are all questions which need to be carefully considered before any decisions are made on a legal framework. If we could devise an enabling framework which was sufficiently flexible to allow for needs led, responsive services, would it result in even greater concentration of decision making in the service providers and less in the users?
A well constructed legislative framework would mean that the obligations of service providers were clear and unambiguous and that the rights and entitlements of consumers were also clear. Crucially, legislation would give consumers rights of redress for failure to provide services.

Legislation can be designed to obfuscate - you may recall Mr Justice Keane's description of former DPMA Regulations as having been drafted with ‘opacity’. The simple definition of opacity is obscure or hard to understand but the more sinister definitions include ‘impervious to light’, ‘impervious to sense’ and ‘doltish’.

**The legislative approach - is it universally accepted?**

Differences of approach to legislative underpinning of services were clear in the case of the Education Bill. The recent debate on the now defunct Bill revealed a significant difference of view between the current and the previous governments on the role of legislation in the provision of services. The attempt to provide a legislative framework was seen by the current government, while in opposition, as a further bureaucratic interference in an area which was doing fine without legislation. There is a strongly held view that legislation is costly to implement, gives rise to endless litigation and is not, in general, the best way of finding solutions to problems.

Legislative provisions which are not absolutely clear are probably worse than no provisions at all. The most obvious example of such lack of clarity until recently was the legislative arrangement for children where many of the children most at risk were not accepted as the responsibility of any agency.

**Litigation on health services**

There has been relatively little litigation in the whole area of health services and older people. This is possibly because major constitutional issues have not arisen. There is even less
legislation on the area of education services than there is on services for older people. Yet there are clearer rights - this is mainly because of the constitutional rights to education.

The relative absence of litigation is surprising in view of the almost total absence of legally based appeals mechanisms in the health services. At this stage, the promise to have a statutory appeal system for medical card services must be competing with the Shannon Drainage for the title of ‘Unrealised Promise of the Century’. There does seem to be a quite inexplicable aversion among health/social and community service providers to an independent statutory appeals system. In this context, it must be noted that the Social Welfare Appeals system is widely regarded with respect and it has undoubtedly contributed enhancement of the rights of social welfare users. The presence of legislation does, undoubtedly, give rise to litigation. Sometimes this is desirable in that rights are clarified, erroneous interpretations of laws by statutory agencies are put right etc. However, the criterion by which the courts will judge an issue will not be health gain or social gain but the precise wording of the legislation. Drafting legislation is not a precise art and there are numerous examples of legislation which resulted in quite unexpected consequences.

**Resources**

Legislation, of itself, will not guarantee resources but if the obligations are clear and there is a clear right of redress for the older person, then resources must follow. In practice, national agreements such as the PESP, the PCW and Partnership 2000 have been significant in increasing service provision in recent years - some would say that the allocation of resources has been substantially decided in that particular forum.

**Co-ordination**

Lack of coordination is recognised as a problem in service provision; would legislation improve that coordination? Perhaps coordination could be better achieved through good management; training etc. Absence of an ethos of coordination; can legislation deal with this or is it really an administrative matter? Are the ABPs contributing to improvements in
this area? Is coordination mainly an administrative matter? There is a long standing philosophical argument as to the effects of legislation on ethos. If we want to create an ethos of coordination, legislation by itself will not do it but it could certainly help.

**The Child Care Act**

The legislative framework underpinning the child care services is often mentioned in contrast to the absence of such legislation for older people. Significantly increased resources have also been made available to this sector in recent years. Was it the fact that legislation was there that forced the increased resources to the sector or was it simply that public perception of needs changed? I do not know the answer to that question but I think it likely that the discussions about the legislation and the lobbying for it contributed to the increased public awareness of the problem and the two combined to have extra resources allocated. Legislation on services for older people could have a similar effect.

I would warn, however, about using the *Child Care Act* as a model for legislation on services for older people. The *Child Care Act* imposes an obligation on health boards to identify the children who are not getting adequate care and protection and to coordinate information from all relevant sources.

In general, the Act obliges the health boards to provide services - there are relatively few discretionary elements in the Act. It does allow the boards to make arrangements with voluntary organisations for certain services but there are certain obligations which it may not delegate - it may not delegate the duty to take children into voluntary care or to apply for the various care orders. Care order decisions are made by courts, not health boards. I do not think that this type of approach is at all appropriate in the case of older people. All children are in need of care and protection; all older people are not. Even if others would consider an older person to be in need of care, it is not for others to make that decision. If respect for the dignity and independence of older people means anything, it means that the decision on need for services rests with the individual older person. The same principle does not necessarily apply to children.
Categorisation of an older person as ‘at risk’ is actually quite a risky thing to do. It is fine and appropriate to have registers of child abusers and of other criminals and to keep such information on computer and have it exchangeable between agencies. It is quite another to have this information about a person whose perception of him or herself bears no resemblance to the official categorisation.

Maintenance of an official register of old people at risk has far reaching implications about control over one's own life, choices etc. The compilation of information about individual adults has implications for privacy, for liberty and for freedom of information. There are considerable differences in the assessment of ‘at risk’. There is also the not inconsiderable consideration that dependency may be increased.

I do not think that it is appropriate to have a legal obligation to maintain a register of old people at risk. I fully recognise that the absence of information makes it difficult to deliver services but it must be recognised that the primary decision on whether or not an old person needs a particular service is a matter for that person. While the health argument for anticipatory care would seem to be irrefutable, the legal problems are considerable. Again, they hinge around personal rights, freedom of choice.

**Problems with formulating legislation**

The report touches on some of the problems which must be faced if comprehensive legislation is to be drafted. One issue which arises is that of the relationship between the voluntary and statutory sectors. Does the considerable reliance on voluntary services make a legislative framework more difficult; is there a need for a legislative framework for the relationship between the voluntary and state sectors? *Shaping a Healthier Future* considers there is a need for general legislation on this issue. However, research would suggest that the voluntary sector is extremely wary of entering into contractual arrangements with the statutory sector.
**Constitutional issues**

Any enabling legislation would also have some constitutional hurdles to jump - in particular in the areas of right to privacy, family and property rights. I do not think that they would be on anything like the scale of the problems encountered by the Employment Equality Bill and the Equal Status Bill but the issue of religious ethos would certainly raise its head in areas where services are provided predominantly by religious orders.

**Home help**

The report and the Council's comments continually stress the importance of the home help service. I absolutely agree that legislation should require health boards to provide this service and should set out what charges, if any, should apply. However, it needs to be emphasised that the biggest problem of the home help service is not the absence of a statutory obligation, it is quite simple that Home Helps are not paid enough. There are other issues in the drafting of legislation on Home Helps. Should the older person who needs some degree of care be given the resources to employ that care or should the health boards provide it by means of Home Helps, care assistants or other means?

**Equality of treatment**

As well as equity, the question of equality of treatment also needs to be addressed. While this is very difficult to put into effect, it has to be recognised that there is a quite startling inequality of treatment between a dependent elderly person subvented in a private nursing home at up to £120 a week, and a similar dependent elderly person being cared for in the home of a relative with no financial support whatsoever. I am aware that the private nursing home sector argues that there is inequality of treatment between it and the institutions run by the State. I am not entirely convinced that there is a legal inequality of treatment there but there certainly is in the comparison between private nursing homes and the home of a relative!
WORKSHOPS

ENABLING OLDER PEOPLE TO LIVE WITH DIGNITY AND INDEPENDENCE

Workshop No. 1: Home and Community Care Services

Chair: Dr Finbarr Corkery, GP
Speaker: Ms Deirdre Fitzsimmons, Public Health Nursing Advisor, Department of Health

Before approaching the preparation of this paper I read the summary of the review of findings by the National Council to the implementation of the report *The Years Ahead* 1988. Two particular items caught my eye. The first was number 13 which is the recommendation to provide health education to older people and their carers, a major difficulty being the lack of guidance on the content of health education. Coupled with this is the lack of unstructured organised health education to healthy older people which is rarely carried out.

The second was number 21 relating to the recommendation in the report *The Years Ahead* that greater attention be paid by PHNs to anticipatory care of the elderly at home and the 'at risk' designation of elderly people. The review described this as impractical because of time and resource constraints and poor screening tools.

The following discussion is in the main in response to these two items and suggests that much better use be made of resources and time by the development of properly structured procedures and tools.

The report *The Years Ahead* 1988 identified the objectives of service for the elderly as follows:

- 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 hospital and residential care for elderly people when they can no longer be maintained in dignity and independence at home.

A specific target on services for the elderly, that not less than 90 per cent of those over 75 years of age continue to live at home has been set by the policy document *Shaping a Healthier Future. A Strategy for Effective Healthcare in the 1990s*. The objectives to meet this target are identical to those above. This is our mandate and this is what we must strive for.

A significant proportion of elderly people contribute to the economy of the country by the voluntary work they do, by caring for the dependent young, as resources in the labour market and in the social life of the community. Only a small proportion become dependant on the caring services. With a reducing birth rate it is conceivable that the retired population will be encouraged more and more to contribute their services to those of advanced old age.

The National Council for the Elderly Report *Health and Social Care Implications of Population Ageing in Ireland 1991-2011* by Fahy points out that in Ireland health policy has increasingly committed itself to the goal of healthy ageing. I quote ‘This means that not only should people live longer but that they should do so in a state of improved day-to-day health’. He further states that:

*For planning purposes therefore, in the absence of measurable criteria there seems to be little merit in applying present levels of morbidity and dependence among those aged 65 and older on to projected future populations aged 65 and over as a way of anticipating future health service needs. To do so would be to deny the possibility of real health gain among older people and to reject what is now a central objective of health policy. The same argument can also be applied to the traditional convention of defining age 65 as the threshold of old age*
and again,

As far as health status is concerned, it may be more realistic to view that threshold as a rising boundary which shifts upwards with improvement in life expectancy and in underlying health status.

Potential problems

I would not like to give the impression of too complacent an attitude to the undoubted problems which face us in ensuring that our older people get the best possible care in the community. While the statistics showing increased longevity must be welcome as an indication of improved health and welfare of the population there are potential problems in relation to those who need support as they grow older.

These lie in the increased isolation of older people due to the move away from rural areas of younger people, the decline in average family size, the increased labour force participation outside the home of women who are the traditional carers and the building of homes, particularly in the cities, suitable only for the nuclear family with few opportunities for extensions to accommodate an elderly parent.

Need for effective and efficient service

This brings me to the first issue. Currently the PHN service is obliged under current regulations drawn up in 1966 to provide domiciliary nursing to the aged and the chronic sick, compile a register of elderly persons resident in the district, to visit elderly persons regularly, to advise and assist them, and through liaison with the appropriate officers in the health authority to avail of such health and/or social welfare benefits or services as they may be entitled to or require.

The interpretations of this directive are various as you can imagine and are entirely inappropriate for 1997 not to mention into the next century. Over the years since that
directive the service has of course changed dramatically to meet current needs. There remain however many questions which need to be resolved for a more effective and efficient service if the above objectives are to be met. The numbers of older people who may require services in the future demand that resources are used to the very best advantage.

An explanation is needed here about how the PHN service functions. Those elderly who are sick and need nursing care are referred either by the GP or by the hospital on discharge. Frequently neighbours, relatives or Home Helps will ask the PHN to visit because of illness. In the event of a referral from the latter and where specific treatments or drugs are required the PHN will always refer back to the GP. These cases may be of short duration or become ongoing cases which require long term care until rehabilitated, sent to institutional care or death.

Other cases where very specific problems present and require specific intervention such as the management of continence may not require a continuous service and in this instance the service may be terminated. This service to ill people in the home is independent of age and may be given at any period of a person's life. While this service is vital to keeping elderly people at home and independent it is relatively straightforward and its management poses few difficulties. This nursing service to ill people is different from that of anticipatory care of the well elderly or as described more commonly by public health nurses surveillance of the well elderly. It is this anticipatory care which I would like to concentrate on today.

The responsibility of the PHN service in meeting the targets to maintain the health of the well elderly in the community is three fold and incorporates activities relating to:

- primary prevention of ill health by developing programmes to maintain a healthy lifestyle;
- secondary prevention both in detecting unrecognised ill health through regular surveillance and in the prevention of further deterioration of an existing illness;
- the regulated monitoring of those deemed at risk;
- the development of systems to identify those who might benefit from these
activities.

**Primary prevention**

To take the first item, while there are many communities fortunate enough to have centres where elderly people can join in health promoting activities many thousands of elderly or their carers do not have access to these. This suggests that individual programmes need to be drawn up. The very nature of primary prevention of ill health and disability suggests that the population for whom programmes are required have not yet been exposed to the community health services with the possible exception of the GP service. By the very nature of the ageing process it is likely that sooner or later they will need to visit their GP which makes him or her the first point of access to information on pursuing a healthy lifestyle.

It seems vital therefore that GPs become part of the team in the whole approach to primary prevention of ill health. But it is unrealistic to place the burden of providing a health promotion service on the GPs and a structured programme entails much more than giving information. There must exist a programme at local level to which all those close to or of retiring age can gain access. If lifestyle has to be changed the sooner the better.

This introduces the problem of gaining access to people of retiring age without being intrusive and suggests that a whole range of methods needs to be employed to get the message across. Another and perhaps a more practical suggestion is for the development and distribution of a series of health promoting material freely available to retired people, relatives, voluntary organisations and carers as a focus for discussion with elderly people wherever they meet, either in small groups or with individuals.

The purpose of on-going surveillance properly constructed, should enable early intervention before ill health or adverse social conditions become a problem. A programme of surveillance should result in maximum health and social gain through the use of a system of health and social checks which will detect previously undetected physical, social and mental conditions which without intervention will most probably lead to ill health. While health and
social gain are the goals which guide the system it must be accepted that these are not easily measurable so that evaluation of anticipatory care is made very difficult.

We have been slow to identify what we mean precisely by anticipatory care. What exactly contributes to health gain in the elderly and what intervention can we say with confidence has certain value, or uncertain value or has no value at all? It is generally agreed that anticipatory surveillance of the elderly is a good thing and for public health nurses it is a core part of her work. But ask any number of PHNs for a description of how such a visit is carried out and what she did to provide anticipatory care and each one will be different. Ask a GP what s/he means by anticipatory care and the answer will be different again.

We have little national understanding of those indicators which point to future problems and which are amenable to corrective action. For example, in assessing the value of health screening as part of a surveillance programme, Harris (1992), in the British Medical Journal, posed the question ‘What is the evidence that screening elderly people improves their health...’ and described the evaluation of four random trials. The first showed that screening did not change the prevalence of illness, although patients' morale and referral rates rose and admission rates fell.

The second trial showed that, using health visitors to assess people over 70 in an urban practice, annual screening reduced mortality, though not morbidity. A third Danish study showed that three monthly visits by a nurse to people over 75 reduced admissions, emergency calls and mortality and fourthly that domiciliary visits by a nurse to people over 75 improved morale but no other measures of health. He states that:

*The failure of screening to improve morbidity does not mean that it is a waste of time and effort. Screening improves the quality of life....Screening should not be regarded as having failed if the failure has been in offering effective treatment or advice... The current consensus is that screening is useful in identifying functional disabilities which may have received little or no medical attention. The prevalence of functional problems in the elderly is high.*
Because PHNs take an overview of both health and social conditions, and here I would like to stress the role of the nurse in the provision of a nursing service which incorporates a large social dimension as opposed to a strictly 'medical service', the use of the word 'assessment' is more suitable for the determination of those deemed 'at risk' than the more limited term 'screening'. Assessment can contain both a screening service for clearly defined conditions but will also include the social factors which can impact on a person's well being, take away from the quality of an elderly person's life and which can more productively take place in a person's own home allowing hazardous environmental conditions to be observed.

Risk factors

Our current approach to risk factors which are thought to give rise to health problems needs major evaluation. The purpose of making an assessment is to identify those who are 'at risk' of future health or social problems and to initiate early intervention to prevent or alleviate these problems. But who is 'at risk' and of what?

The professional judgement of 'at risk' varies from nurse to nurse (O'Shea, 1992 in her unpublished study of the elderly at risk in long stay care in Co Galway). This inconsistency and lack of uniformity showed itself across all factors which the nurses themselves considered to be risk factors. This lack of a national approach as to who should benefit from more frequent and focused visiting is important as it means that a proportion of those truly at risk of physical or mental breakdown and the subsequent loss of independence, the very thing we are trying to avoid, are not receiving the attention they need.

The precious resource of time is wasted, and the potential source of valuable information of a rigorously constructed multi-disciplinary assessment tool is lost. O'Shea states that a multi-disciplinary selective screening approach which would incorporate potential functional and social problems has been accepted by the experts as being the most sensible one to follow, particularly in the absence of accurate updated age/sex registers. She makes the recommendation that there is a need to put in place a standardised uniform policy regarding
screening of elderly people living in the community of a particular targeted group who might potentially be at risk, e.g. those over 75.

Freer (1985, Journal of the Royal College of General Practitioners) while mostly discussing screening for medical problems, rightly questions the validity and sensitivity of risk factors citing 'living alone' as a traditional risk factor. This may not be in fact a risk factor as health and social services are involved quickly in a crisis whereas the support provided by relatives for failing elderly individuals living with them may in fact mean that their level of immobility and dependence is very much greater when they do present. He makes the important point that 'elderly people with arthritis visiting their doctor are much more likely to have their level of pain and use of medication assessed than their ability to wash, move about the house freely, go out shopping or attend church'.

Some people living alone may live in a highly supportive community where relatives and friends are frequently popping in and out. If that individual is deemed erroneously 'at risk' by virtue of merely living alone what more can be done to reduce the risk? Nothing. However, a multiplicity of adverse factors common enough in the elderly, such as for example, loss of memory, but which are managed very well by a live-in relative, may place an elderly person living alone in grave danger of accidents or other crisis. Freer states that programmes of screening have tended to concentrate on asymptomatic deviations from the normal range or the existence of an abnormality rather than on the impact of these on the ability of the individual to function normally.

Which brings me to the third issue, that of the development of systems to enable anticipatory care to be offered to targeted groups. Questions need to be answered, such as, At what age should formal assessment take place? Should this be opportunistic or programmed? Should it concentrate on specific age groups?, and, How can the co-ordinators of a formal assessment gain access to those most likely to benefit from it?

Most elderly have medical cards. Should the information from that system be used to offer people over a certain age a formal assessment? What sort of follow-up can be guaranteed and
what criteria should be used to deem that person potentially at risk, also need to be answered by all those involved in caring for the elderly both health professionals, voluntary organisations and representatives of carers.

Prosser's (1993) unpublished ‘Care of the Elderly’ study for the Irish College of General Practitioners makes a strong case for a primary health team approach. Fahy and Murray's (1994) report *Health and Autonomy Among the Over-65s in Ireland* for the National Council, following an extensive study using measures of income and deprivation, social class, household type, social contact and social supports, age, sex and urban-rural location, concludes:

> That the poor are more likely to have bad physical health and the physically unhealthy are more vulnerable to psychological distress. The poor are also slightly more likely to have unhealthy lifestyle characteristics as far as smoking, diet, weight and exercise are concerned. Apart from these associations, very little else matters or at least matters as much.

Later he states and I quote,

> The apparent lack of vulnerability of certain groups is worth noting. The elderly who live alone especially the never married who generally have few relatives are often thought be a highly vulnerable category of older people. This may be true in certain ways. For example, because of their lack of family supports such older people may be less capable of continuing to live in the community when they become ill or physically impaired and so have a higher risk of being institutionalised.

> However as far as the aspects of well-being examined in the present report is concerned there is no detectable difference between those who live alone and those who live in multi-person households, or between those who never married and those who are either currently married or widowed. This is true not only of physical health but also of psychological well-being. It seems in fact that as long as they can
continue to live in the community, family networks make relatively little difference to the well-being of the elderly.

However, lest we feel complacent, he also states that:

The single most striking health-related aspect of life for older people in Ireland is that, on average, they die relatively young. Life expectancy in Ireland from late middle age onwards is the lowest in the developed world and indeed is lower than in some intermediate developing countries in Latin America and Asia. A further remarkable feature of older-age mortality patterns in Ireland is that in spite of improvements in living conditions and massive expenditures on health in recent decades, life expectancy for older people has hardly changed since early in the present century.

I would like to conclude with a recommendation for your consideration. That because of the difference of approach to this subject, each one valid and contributing much to the overall care of the elderly, there nevertheless must be a combined common approach to anticipatory care based on tried and tested tools which will be dynamic in application and be upgraded on evaluation of results.

I am conscious that I have not addressed the subject of combined care to specifically include Home Helps and home care attendants in anticipatory care of the elderly nor indeed any other health professional working in the community. I hope however that they would consider themselves very much part of the team and indeed are key players in contributing to the maintenance and health of elderly people in Ireland. Neither was there time to refer to the carers of older people who are vital to the success of any health policy and who I hope will become much more central to any debate on caring for the elderly in the future.

Summary of Workshop No. 1
As presented by Mr Pádraig Ó’Móráin, Conference Rapporteur
(a) The current focus on a health centred definition of ageing is wrong. The focus instead should be on citizenship. The social dimension of ageing - including kinship and income - should also be given more attention.

(b) Resources should be shifted away from institutions. Targets should be set and under-funding of services addressed.

(c) The issue of difficulties in obtaining information exists at all levels. A solution to these difficulties would be valuable without costing a lot of money.

(d) Issues of equity as between rural and urban communities and between different health boards need to be resolved. There is a need for consistency in service provision across community care areas.
Workshop No. 2: Housing Services

Chair: Mr Matt O’Connor, County Manager, Carlow County Council
Speaker: Mr Bernard Thompson, Director, Irish Council for Social Housing

The following is a summary of a Briefing Paper on Housing Services, presented by Mr Bernard Thompson at Workshop No. 2.

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<th>Republic of Ireland</th>
<th>Tenures</th>
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<tr>
<td>Population</td>
<td>Owner-occupation 81%</td>
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<tr>
<td>Dublin region</td>
<td>Rental 19%</td>
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<tr>
<td>Housing stock</td>
<td>1.15 million dwellings</td>
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Rental Housing

Social rented (Public and Non-Profit) 56% (106,000 dwellings)
Private landlords 44% (80,000 dwellings)

Housing for lower income groups

Social rented housing 1996

Local authority/Public Housing Sector 97,000
Non-profit/Voluntary &
Co-operative housing sector 9000

Local Authority Housing Stocks

(Random sample)
Dublin Corporation 23,000
Cork Corporation 7000
Galway Co Council 1570
Carlow Co Council 565
Monaghan Co Council 387
The average size of housing stock managed by 90 local authorities is 1065 dwellings. The typical size of housing stocks managed by non-profit/voluntary housing associations is 10 to 850 dwellings.

Housing for older people

Care of the Aged Report, 1968
• Suitable housing for the elderly to live in the community

The Years Ahead Report, 1988
• Housing policy should aim to ensure that elderly people have an opportunity to live in accommodation suited to their needs

Shaping a Healthier Future, 1994
• Maintaining older people in dignity and independence at home
• 90% of those over 75 years of age should continue to live at home

Housing and Community Care
• The Years Ahead report recommended that sheltered housing should be the first choice for elderly persons unable to stay in their own homes
• Close liaison between local authorities and health boards is required
• Domiciliary services should be provided in such schemes
• Effective assessment and planning arrangements are needed
• Funding of on-going running costs, e.g. elements of care, staffing in voluntary sheltered housing is required.

Current Trends
• Number of Older persons increasing
• Proportion over 75 years increasing (increased frailty etc)
• General housing standards have improved but needs are changing
Need to provide more supportive/sheltered housing places - intermediate housing and care solutions between ordinary independent housing and institutional/nursing care

Response required
• Need to deploy resources in a co-ordinated and planned way
• National social housing plan for those elderly in need
• Aim for 90 per cent of people over 75 years to live in their own homes
• Role of sheltered housing as an option before institutional care

Summary of Workshop No. 2
As presented by Mr Pádraig Ó’Móráin, Conference Rapporteur

(a) Measures which could prevent the deterioration of people's own homes include: early intervention, information on grants, advisory services on such issues as the installation of grip rails, showers etc, and a campaign to encourage the upkeep of their homes by occupants.

(b) Grants for housing repairs need to be reviewed. Grants which cover only two thirds of the cost may leave a gap in financing which the householder cannot fill.

(c) Housing design could benefit from liaison between health boards, professionals and local authorities. The width of doors, placing of light switches at low level and the use of showers instead of baths are examples of design issues which this would bring to the fore. Another issue related to housing design is that of the integration of older people into the community, what works and what doesn't work in this regard (for instance older people housed in an estate with younger people can be isolated during the day as the younger people go to work). Such liaison should take place at both local and regional level.
Workshop No. 3: Support Frameworks for the Care of Older People in their own Community by Family, Neighbours and Voluntary Bodies

Chair: Mr Michael Dunne, Chairperson, Commission on the Family
Speaker: Mr Frank Goodwin, Chairperson, Carers’ Association

I will focus on the vulnerable, frail and ill older people living at home and their carers. As you know there are about 66,000 dependent older people who are supported by carers in the home. In addition there are many vulnerable older people who are living alone and relatively unsupported due to their manner, their suspicions, their fears, who often refuse services and live marginal lives which leave them at risk.

The lifestyle of many of these people is mostly, and in some situations exclusively, confined to the house compared to the more active older people. Those who can get out can only do so with assistance and door to door transport.

The results can be both a contraction of their contacts with neighbours and friends and with a broader range of interests and activities. They can experience a loss of distinction between the days of the week and the hours of the day. This process can lead to introversion and depression as the person becomes more and more marginalised within their four walls, which become their prison rather than their home. To a large degree this group of people has been bypassed by the concentration on the ‘active older people’. Many of these people are lonely and uninvolved and their interests tend to become dominantly self interest due to the restrictions on lifestyle. Support from outside the home tends to focus on physical needs.

Carers

Many of these vulnerable older people have a carer, frequently a woman who is related, caring for them. They could not live at home without a high level of personal support. About 30 per cent of carers of older people are themselves in the older age range. Other carers range across the age spectrum, some caring full time and others employed outside the home or in
family rearing. The cared-for person's needs, wishes and fears become focused in this one to one relationship with the carer, to an unhealthy and unbalanced degree for both people.

An increasing number of people are now living into advanced old age and the number needing support at home is growing. At the same time there is an awareness among carers about their conditions compared to the paid employed sector.

Unless there is a radical reappraisal of the conditions of carers there will not be sufficient carers and institutional care will be necessary for more people. People will not be willing to put themselves in a position that exploits them, a position where the carer, one person, carries not only his or her own responsibility but also the responsibility of the State and the extended family.

On the other hand, many people would want to provide this caring role at home for their relatives, if they were given a fair deal and the other partners assumed their own responsibilities to complement those of the carer.

It is now well established that many carers are working too hard, too long hours and are under great stress. In other words they are in an exploitative situation compared to every other type of employment. The politicians must be convinced to apply the EU Working Time Directive to carers in the home.

**Carers' health**

We have come across a number of carers whose health goes into serious decline after they finish caring, arising from such working conditions. A number have died from the severity of these illnesses. A combination of work conditions and neglect of their own health appears to suppress any problems until the stress of caring is removed and then the problem/illness appears and deteriorates. Support services for carers are needed as a matter of urgency, including adequate finance, legal entitlement to health and social services, particularly home nursing, home help, home care attendant and social work services as required, as well as
respite care.

While these issues affect many people's lives, there are greater difficulties experienced by those people living in rural areas, where services and even neighbours are some distance removed.

**Family**

To a disturbing extent, the carer is left, within the family, to provide care alone. This happens in situations where there are other family living under the same roof and where they live separately but close by.

This topic of family involvement is a very sensitive one and many carers find it next to impossible to raise it within the family. Yet the family have a role and responsibility as much as the carer and the State to ensure the quality of life of their relative who is highly dependent. There are issues of getting family members involved and also shaping the kind of involvement to ensure that it is constructive rather than an additional stress and expense on the carer.

In addition it is an area that has not been explored or researched to understand the reasons and obstacles behind this lack of family support, to define what could and should be done and how these goals can be achieved. A profile of the family roles should be defined and integrated into a quality of life plan.

What is needed is a focused addressing of this issue through a number of avenues. I suggest that the driving force and co-ordinating role for this family involvement should be with the co-ordination of services for older people. A clearly defined action plan, arising from the profile of the family roles, is required to ensure implementation and evaluation.

**Opportunities for action**
When professional staff are involved, which is usually around a particular need such as hospital treatment, there is an opportunity to get the family together at a time when concern for their relative is high. This opportunity can also be generated in the community by the Public Health Nurse, Social Worker, the GP and by hospital staff if the person is hospitalised.

Another opportunity is available through the local Churches to provide a forum to explore the issues involved and find ways forward, in an atmosphere of caring and support.

Local voluntary bodies providing services for older people are uniquely placed to create an awareness and addressing of family support through, for example, discussions and articles in the local media exploring the details of this involvement, the obstacles and implications.

**Neighbours**

With the process of greater dependency resulting in confinement in their homes and increased reliance on the carer, frequently there is an obvious decrease in the level of contact form neighbours with negative results for both the carer and cared-for-person. To maintain contact with the confined person does require a deliberate extra effort. This is an area that has not been explored to understand the reasons and how the neighbours can maintain contact and thereby support, so that the carer and the dependent relative are not living isolated in their neighbourhood.

There is a need for a sitting service for many confined people and this can be effectively addressed locally by neighbours and voluntary bodies. It requires exploration and definition to allow people to learn the limits and opportunities, the responsibilities and the ways to engage or withdraw from this commitment.

**Other areas of involvement**

Changes that require funding and legal support, such as entitlement to a Home Nursing Service or Home Help Service or financial support for the carer are matters of political
priorities rather than scarcity of resources and can be influenced through the political process, which is controlled by the electorate. Neighbours can be a force for change in conjunction with their elected representatives to enhance the support for dependent older people and their carers. The elected representatives have a key role to play and must be encouraged to give these matters a higher priority on their political agenda, especially at budget time.

The co-ordinating and driving force for neighbour involvement should be the local voluntary bodies concerned with older people's issues, and the national voluntary bodies who can draw together the local issues into the wider perspective.

**Voluntary bodies**

We can see the dynamic role that local and national voluntary support and self help bodies are playing in the interests of older people. At the local tier there are many groups and activities that are essential to the well being of our older, vulnerable people. The issue of the relationship between these bodies and the statutory sector is still unresolved. The Government encourages the roles of many of these groups yet fails to support them with proper planning and resourcing. The annual cycle of applying for funding instead of having a three year cycle places a huge strain on voluntary bodies and detracts from their work with the older people and in some situations has resulted in services being closed down for periods. There is a need for a contractual relationship between the statutory bodies and the voluntary sector to ensure service quality, delivery and accountability.

There are many issues of concern to dependent older people and carers that need to be addressed through these voluntary bodies, because of their unique position outside of the statutory system.

**Hospital treatment**

Hospital treatment frequently does not take an holistic approach and is still focused on medical conditions. The results of this are quite simple and negative - the older person
cannot get into hospital as soon as is needed and is discharged as soon as possible. Their
treatment is often given in the emergency ward with discharge home occurring on the same
day based on a medical assessment rather than the social factors which impinge directly on
the medical condition.

Older people are being discharged home when they are not fit to go home. Community care
services cannot bridge the gap, despite good efforts in some areas with district care teams.
People need a fully supportive convalescent period which they cannot receive at home. The
discharge of older people should be based on their needs and not narrowly on the condition of
a medical treatment. There needs to be a fundamental reappraisal of admission and discharge
procedures and the management of these in conjunction with an evaluation of home services
to ensure continuity of care. There is a case to be made for a manager to co-ordinate total
patient care, with over-riding powers in relation to these decisions.

In conclusion, progress has been made but too little has happened on the home care front for
the most vulnerable older people and their carers. In addition, the long established
institutional services need to refocus their perspectives to look at the total person and his or
her home environment.

Summary of discussions from Workshop No. 3
As presented by Mr Pádraig Ó’Móráin, Conference Rapporteur

(a) The Carer's Allowance is too low and too few carers qualify for the full amount.

(b) Much more needs to be done to support and train Home Helps and to provide more
of them. A FAS scheme being run in conjunction with the Alzheimer Society of
Ireland could provide a valuable guideline in this regard.

(c) Charities would benefit if health boards had contractual obligations to them. One
important area, for instance, is that of lengthy delays in the payment of health board
grants to charities.

(d) A variety of supports needs to be put in place for carers. These would include support groups, a national support network and measures to promote the health of carers.

(e) Day care centres to provide respite for carers should be made available widely.

Workshop No. 4: Hospital Services

Chair: Mr Bernard Haddigan, Programme Manager, Western Health Board
Speaker: Dr Patricia McCormack, Consultant Physician in Geriatric Medicine, Eastern Health Board

Hospital services for the elderly include general hospitals, specialist hospitals, community hospitals and day hospitals. The Working Party suggested that hospital services should be comprehensive, equitable, accessible, responsive, flexible, planned and co-ordinated and cost effective.

This implies that an 'open door' should exist for all sick elderly people. It also implies that all the available services should be well known to the individuals, their family doctors and their carers. It implies that systems exist to bring them to the services or alternatively the services to them. It implies that no barriers exist or are perceived to exist by an older person in need of hospital services.

In making a health policy for the elderly, the Working Party realised that older people had a high demand for acute beds and that they had slow powers of recuperation. In addition, certain negative attitudes existed to older patients in acute hospital beds - 'bed blockers' etc.
In order to achieve the ideals set out above, the Working Party advised that Departments of Geriatric Medicine should be established in the acute hospitals and Comhairle recommended that these should have the 'full time commitment of a whole time specialist'. The recommendation was one specialist physician per 80,000 population.

*The Years Ahead* recommended certain 'norms' or 'quotas' i.e. in terms of numbers of beds. There was also the ideal that these services should be located within a community. It was felt that the hospital services should be part of a continuum of service provision which should link with all the other players in health and welfare planning for the elderly. The Working Party identified adequate resourcing, integration and co-ordination as the fundamental cornerstones on which implementation rested.

There has been an increase in the numbers of geriatricians. There are more departments of Medicine for the Elderly. More elderly patients have access to specialists in Geriatric Medicine. There are now discharge policies, especially in the accident and emergency department.

Does this translate into independence and dignity? In the acute hospital setting an increasing proportion of admissions are unplanned - emergency - admissions, usually through the accident and emergency department. There are now fewer and fewer elective or planned admissions, especially in hospitals that do not have dedicated, protected beds for the elderly.

The average length of stay has reduced from 15.3 to 10.5 for elderly patients. There is increasing pressure to reduce this further, as many hospital managers regard length of stay as the most important indicator of performance. In the instance of stroke where length of stay tends to be long, this discriminates against the older patient. Certain other groups of patients may have difficulties in the acute hospital. These include confused patients especially if they wander and patients with troublesome behaviour. Whilst some hospitals have well developed cross links with psychiatric services, this is not true in all hospitals. This situation may reduce the dignity and independence of the patient.
The role of the Community Hospital has changed somewhat incorporating a number of additional functions. Apart from extended care, many community hospitals now offer respite, terminal care, assessment and rehabilitation, day care and day hospital services. The sites of these hospitals tend to be removed from the acute hospital sites, and hence also removed from the main sites of the Consultant Geriatricians - who may visit on a regular basis.

The development of day hospitals has been slower than anticipated. It is unclear why this should be. The relationships between the geriatrician, the acute hospital, the provision of assessments and rehabilitation, the Community Hospital and the day hospital are not clear. Is assessment occurring in the Community Hospital because of pressure on acute beds from the accident and emergency department? What is the nature of 'assessment' at each site?

At the end of the day what does the consumer feel about the hospital services? Does the older person feel that they have a service that meets their needs? There seems to be much work to be done in improving hospital services for the elderly. The basic services exist in some but not all areas. The specialist services likewise need to be increased. Above all we need to create an environment where the older person can feel that they have access to the hospital, its personnel and its services. They should not be made feel that they are 'bed blockers'. They should have the confidence that the hospital services are there for them, to enable them to live with dignity and independence both whilst they are availing of the services and afterwards.

Summary of discussions from Workshop No. 4
As presented by Mr Pádraig Ó'Moráin, Conference Rapporteur

(a) Existing resources could be better used in two ways. First, the emphasis on private nursing home subventions could be reduced in the future. Second, there could be more emphasis on better assessment, on day hospital services and on rehabilitation. Less emphasis on bureaucracy and on throughput as a virtue in itself which often leads to people being discharged from hospital too early.
(b) More resources are needed in four areas in particular. First, community care should be expanded as a priority and, as part of this, community hospitals and community nursing units should be given priority over new acute hospitals. Second, respite care and other supports for carers should be used to prevent unnecessary admission. Third, better use should be made of anticipatory care and preventive medicine. Fourth, there should be a significant increase in services for dementia patients. These should include secure respite care units for those with behaviour problems, access to geriatric care for those with chronic illness and acute beds for people with acute illnesses.

(c) Issues of equity arise in hospitals in regard to attitudes, infrastructure and knowledge. Older people should be encouraged to take the attitude that acute care is an entitlement. Infrastructure is crucial in that transport difficulties and lack of transport make access to hospitals impossible for some people. Knowledge is crucial too as some older people and carers do not know how to use the system to their benefit.

(d) Four issues were raised which were specific to geriatric medicine. First, day hospitals are needed on campus for assessment. Second, more rehabilitation beds would release acute beds and prevent premature discharge of patients. Third, fulltime geriatricians are needed as advocates for older people and to promote the development of services. Fourth, the Psychiatry of Old Age service, though not a geriatric medicine, must be expanded because it is the most appropriate model for older people with mental disorders.
Workshop No. 5:  Best Practice in Long-Term Care Provision

Chair: Mr Joe Stanley, Chairperson, Irish Registered Nursing Homes Association
Speaker: Ms Celine Phelan, Director, St Joseph’s Centre, Order of St John of God

Earlier this year at the annual conference of the Association of Health Boards in Ireland, Dr Rosaleen Corcoran, Director of Public Health, North Eastern Health Board, said that a more positive attitude to the aged is needed within health care professions where negative and discriminatory attitudes are often held and easily passed on.

Statistics given at this conference estimate that the number of people aged 65 years and over in Ireland is steadily increasing from 403,000 in 1991 to a projected 522,000 in 2001.

The growth in the number of older people is accompanied by a decrease in that of younger persons under 15 years of age. With these calculations we can see that in our country, there is a definite increased population reaching advanced old age who will require health care services.

One recent article in The Irish Times by Dr William Reville, (Lecturer Biochemistry UCC) states that society loses out when the elderly are ignored. He asserts that, because much of our society’s infrastructure is financed and maintained by taxes paid by the working population, obvious problems will arise from a significant and simultaneous decline in the working population and a rise in that of the older person.

Whilst supporting in every way the principles for care recommended by The Years Ahead document, we still must work to be prepared for this expected increase in the population of older persons in our country. If, as expected, this comes to pass, then it follows that there will be an increase also in the percentage of older people who will require care in long-term service provision.
The findings of the National College of Industrial Relations in their review of the implementation of the report, were not exactly positive with an uneven balance of care provision throughout the country.

Recommendations from the Working Party of *The Years Ahead* to have development of community hospitals catering for both acute and long stay care have not come about mainly due to lack of resources, particularly in the Midland, North East, North West and Western Health Boards.

The availability of geriatricians for these community care centres is varied. The provision of geriatricians greatly influences the effective operation of community hospitals. The Working Party recommended a norm of 10 beds per 1000 elderly in the context of 2.5 per 1000 for those in the specialist department of geriatric medicine in the general hospital and 3 per 1000 for those in rehabilitation in general and community hospitals. Beds for assessment and respite care in community hospitals should be met from the norm of 10 beds per 1000 elderly for extended care. They recommend these norms to be reviewed by the Department of Health to ensure their adequacy.

The Review of the implementation of *The Years Ahead* report shows only two health boards who have a positive response to the appropriate and feasible norms recommended by the report. The strategy document *Shaping a Healthier Future* recognised that whilst ‘considerable progress has been made in the past few years in improving services for ill and dependent older people, much remains to be done before the objectives of *The Years Ahead* are achieved’.

Over the last number of years, there have been very significant improvements in the provision of care for older people with a long-term dependency.

*The Health (Nursing Homes) Act 1990* which based it’s legislation on the recommendations of *The Years Ahead* has been a milestone in the upgrading of standards of care delivered by
nursing homes in the country. The ‘Code of Practice’ document 1994 endorsed the legislation and contains excellent guidelines for best practice in care of older people who are dependent, frail and obliged to live their final years in a long-term care centre.

The economic boom from which Ireland is presently benefiting, has to include the most vulnerable in our society, among whom are those older people who become so dependent on others for their daily living needs and a continuation of an accepted quality of life. A person’s quality of life may be dictated by legislation, policy or regulations. The role and influence of human service providers is critical in the development and implementation of such legislation. We must caution against the relentless pursuit of quality of life trends, without thought of their impact on the individual concerned. Enabling and supportive systems must be available to the vulnerable person if his/her quality of life is to be maintained at a satisfactory level.

The persons’ life experience must always promote the persons’ dignity and must be based on respect for him/her as a valued human being.

Older people are the main consumers of nursing care, some only on occasions of ill health and for health promotion advice, but for the increasing numbers who will need continuous care, there is no area of care where nursing skills are as crucial.

In delivering a high quality of nursing care to the older person in this category of need we can bring about an acceptable level of recovery from illness, and help to maintain a lifestyle wherein the person may feel valued with a restoration of dignity and self esteem.

Most nursing homes have specific criteria for admission. It is detrimental to the well-being of both the person and their family if the placement is inappropriate for their need. Admission criteria often exclude referrals, particularly when there is a cognitive impairment, or severe physical disability. It is understandable at times as proprietors/matrons are balancing needs to staff ratios and budgets, but I believe that each person is an individual and deserves individual evaluation.
When I am approached, usually by the family, of a person who needs admission to long-term care, in all cases I make an appointment with them to visit our centre, to listen to their needs and give them information to ensure their decisions are informed. If possible, the prospective resident can also attend this information sharing meeting.

This is a most distressing time for families who may have been caring at home for many months or years and perhaps have no control over incidents which happened and now prevent them from continuing to provide care. Carers/family members need assistance and support at this time of decision-making for their loved ones’ future life. Nurses/nursing administrators who deal with admissions must give time to listen and show empathy for the situation, recognising the hurt and the stress that the family now have and refer them for appropriate counselling and support if needed. Families can be greatly reassured at this interview if properly listened to and positive information given.

Prior to admission to any facility, I deem it an essential part of the care to have an assessment of need carried out by nursing staff in respect of the prospective patient. Two of our senior nursing staff arrange with the family to visit either in the home, hospital or where the patient presently lives.

This pre-admission assessment allows the staff to have knowledge of the patient’s need and is in fact the first part of the individual care plan. It also helps the family to assess our care skills and technical competence by seeing how we interact with the person in need of care.

The pre-Admission Assessment should contain assessment of:-

- physical needs
- physiological needs
- psychological needs
- self esteem
- safety/security
- relationships - (accompaniment)
• social background
• actual self care skills

Dementia:-

(i) Mild dementia with no physical disability
(ii) Severe dementia with no significant physical disability
(iii) Mild or severe with significant physical illness

The GP or hospital doctor is requested to fill out a form which will contain information for the doctor who will care for the patient after transfer. This should contain past relevant medical history and up-to-date medication regime.

On arrival at our centre, because of the pre-admission assessment, the admitting nurse will have a fairly detailed file with essential information. We do not therefore need to descend on the person and family immediately for such procedures as history, vital signs, specimens etc. This allows the family and the patient time to settle in and hopefully feel welcome and assured, and to come to terms, through the support given, with the trauma that the separation can cause.

The first days and weeks after transfer to a facility can be stressful for both the patient and the family. Close support and accompaniment must be given and the family liaised with closely in the ongoing plan of care, particularly when the patient involved may have poor verbalisation due to their condition.

Carers and families may have fears for their loved one, they may fear nihilism that can be present in the care of older people, of which they have heard and read about in the media. Nurses and all employed in a centre who have pride in their work can appease these fears and increase the family security in leaving their loved one in our care.

Good communication is an essential element of care with the patient and the family. Inter-staff communication ensures proper co-ordination of care. Consistency is critical to quality
care. This means that all personnel who are employed in any unit/centre should be given any proper training and instruction in how to communicate with those older people who reside there.

Care plans must be developed, monitored and evaluated regularly by the care team because of the progressive nature of most age-related illnesses and changes that occur because of such conditions. This demands creativity from staff and family. Care conferences with family are most helpful in decision making about ongoing care.

Care goals and methods of attaining such goals should be:

- time Limited
- specific
- understandable
- measurable
- related to observed behaviour
- all staff should have a participative role
- achievable

In the nursing home it is important to maintain a creative friendly climate, using various programmes to diversify away from drudged routines; to nurture good interpersonal relations among staff, as I believe people who work well together improve their communication around work skills.

Staff must be empowered to have an adequate input into their work, therefore organisations, nursing home proprietors must provide opportunities for further development and education of its’ staff to help improve skills and sustain good morale. They must endeavour to provide a staff complement which has the range of skills necessary to meet the needs of the patient population, and be open to piloting proven models of care and treatment in the interest of effective and holistic patient care which brings about improvement in the person’s quality of life.
Section 4 of the document *The Future of Nurse Education & Training in Ireland*, An Bord Altranais 1994, deals with nursing care of the elderly recognises that the elderly, and I quote - ‘include elderly persons with a mental handicap and elderly persons who are mentally ill’... ‘The provision of care facilities and supervision for persons with dementia and mental confusion is emerging as a special need in relation to care of the elderly’.

They go on to state:

*Many nurses employed in care of the elderly have had little opportunity for specialist education and training... and that in light of the evolving patterns of caring for elderly people, recommends that a greater level of nurse education in the care of the elderly be provided.*

Perhaps those who draw up and devise the programmes of training and education for nurses could consider a period of secondment for its’ students, during the learning period, to reputable centres of care of older people in long-term care situations.

For staff, it is important to keep an open mind, to celebrate with the patient and family all small victories and moments of clarity. The key is hope and flexibility. In the process of care, we must research new programmes and ideas, particularly when there is a cognitive impairment, in the area of stimulation.

It is necessary that management foster a good team spirit and motivate staff to achieve high standards. Techniques and strategies must aim to bring about improved effectiveness and quality of life for patients and their families.

In its recent submission to the Commission on Nursing, An Bord Altranais states:

*The mission of nursing in society is to help individuals, families and groups to determine and achieve their physical mental and social potential.*

In long-term care settings, nurses and their assistants must be given adequate information and training in order to enable older frail persons to achieve this potential. It is helpful if staff can
have an initial induction/orientation programme to introduce and familiarise them with the methodology and philosophy of care upheld by the facility. In the contract between employee and employer, an agreed clause should be included which advocates and guards the right of the older residents to excellence in care.

The incidence of abuse of the older person is one which thankfully is not too frequent but we should never be complacent and owners/matrons must be ever vigilant that we do not fail the person in our care and their family who have placed their loved one with us in trust. In The Sunday Times, 31st August last, an article revealed an undercover report of malpractice and abuse in England, and there were recommendations to their Department of Health in order to stamp out such unacceptable practice.

The abuse highlighted was verbal and the over subscribing and administration of medication. One geriatrician had concerns that ‘drugs are being used like a chemical ball and chain to keep patients quiet’ and his concern was that ‘patients are being “switched off” at the same times as the lights’.

In long-term care there are three main components in the holistic care of the patient population.

1. Excellence in physical care

This is one of preventative protocols in place because of the vulnerability of people whose immune systems i.e. resistance to infections, are so impaired that they no longer have the ability to self care and whose either illness or brain failure is progressively deteriorating.

In saying this, each individual’s assessment must note the degree of self help possible, nurses must avoid ‘taking over’ and therefore creating a situation where the person becomes totally dependant before this actually becomes necessary.

2. Pastoral care
There are many definitions for this. I would define it as ‘The Holistic Care of the sick person, whose life as a human being has a God given value and meaning that cannot be taken away by any conceivable circumstance.’

In long-term practice, it should include the accompaniment of the individual person and their family within relationships of mutual respect and trust where there is promotion of quality care at all levels.

3. Psychological care

The provision of positive programming providing support plans which assist staff to deal with challenging behaviours. With the high incidence of dementia among older frail people it must be recognised that what is most problematic in caring for people in this category is the disturbances and distortions that arise in the relationship between the sufferer and the family. There can be a sense of loss of mutuality in the relationship. The loss of reciprocity which ensues is likely to add to the distress experienced by the person and the family.

Those who care for the person must learn to pick up on the non-verbal communication cues of the eyes, our gestures, our facial expressions, through touch and with our hearts.

I believe that it is a given right to provide both physical and holistic care, but these in themselves are not enough. Particularly for those with dementia and confused states, there is observable deterioration of the person if there is sensory deprivation. Therefore, it is essential to have daily physical therapies - not ‘Jane Fonda workouts’, but gentle passive exercises which prevent further immobility and pain.

Social therapies provide stimulation for the thinking mechanism which may not be as yet impaired. In this area nurses/carers need to be reaching outside of their professional training and be creative around such programmes which communicate with the older disorientated person by validating and respecting their feelings, acknowledging their humanity and past
experiences. By doing this we can increase their feelings of self-worth and self esteem.

Spending ones’ final years in a long term care facility should not bring despair and loss of hope but rather create a lifestyle which allows certain freedoms of expression for patients whose love and commitment to their families is unbroken.

An analogy I have used in the past when speaking specifically about people with Alzheimers is that of life as a play (‘all the world’s a stage etc’), but how sometimes it must seem to the sufferer, or in this context the older frail person in need of long-term care, that the curtain has come down before the play has ended.

In the last verse of a well known poem by Robert Frost:

The woods are lovely dark and deep
But I have promises to keep
And miles to go before I sleep

Life can be compared to a journey through the unknown. Life in all its forms is for living. In these declining years, we, who are indeed privileged to care for older people in such need, with the primary carer, the family, must help to light the way for them.

Respect and dignity can only be measured by knowing what these terms mean to the patient, nurses/carers must look forward, working to create the ‘joie de vivre’ that is the right of all human beings. At every stage of life helping to renew the lost inner spirit and bring hope and reconciliation to those for whom they care.

Through compassion and understanding, which becomes tangible through tender tactile communication, and the close presence they can bring to the lives of the person and the family, ensuring an atmosphere of respect, trust and love in which they can live out their lives.
Summary of Workshop No. 5
As presented by Mr Pádraig Ó’Moráin, Conference Rapporteur

(a) Long term care should be holistic by nature and should be made up of three main components - excellence in physical care, pastoral (i.e. spiritual) care and psychological care.

(b) Providers of long term care face a number of new challenges. These include psycho-geriatric patients and aged persons with learning disabilities living in the community. The ageing of the population will, in itself, produce new issues. In this regard, long-term care should, perhaps, be renamed ‘continuing care’.

(c) Participants stressed the need for comprehensive pre-admission assessments and for improved liaison between all the agencies involved. Indeed, there is an urgent need for better working relationships between statutory/voluntary and private service providers in the whole area.

(d) The training and development of all staff involved in long-term care should be regulated and standardised. Participants raised the issue of whether geriatric nursing should be a specialised area.

(e) A quality assurance system should be put in place in all long-term care facilities and this should include an input from consumers.

(f) Unless there are exceptional circumstances, there should be freedom of choice for patients and families in decisions on long-term care.
Friday 12th September

FIRST SESSION: HEALTH SERVICE MANAGEMENT - MEETING THE CHALLENGES IN REGARD TO SERVICES FOR OLDER PEOPLE

Working Together to Achieve Measurable Health Gain: Priorities in Regard to the Promotion of Healthy Ageing

Mr Kieran J Hickey
Director, Office for Health Gain

I would like to begin by commenting briefly on the period immediately following The Years Ahead report in 1988. Due to national economic difficulties this constituted a period of unprecedented challenge to the continued provision of various health services, and certainly to the achievement of any significant development or expansion of services. A period of five years passed before the beginnings of an improvement in that situation occurred.

Yet it is remarkable that the various health boards succeeded in making some degree of progress with their plans for the development of services for older people in the period under review. This was done through a mix of some ear-marked funding by the Department of Health, and internal re-deployment of resources gained from restructuring of services and value-for-money initiatives.

Taking as an example the health board with which I was most familiar at the time, you will see that significant progress was achieved in that period of five years. I am referring to the Eastern Health Board Review of Service Developments for the Elderly 1990 - 1995. 667 additional places for respite, rehabilitation and extended care constitute a substantial development despite the difficulties of the time.

The Community Ward teams have been particularly successful in bringing a range of supports
into the homes of older people and the number of such teams has increased from fourteen at
the end of 1995 to twenty three at present and will increase still further to thirty by the end of
this year.

Since 1995 another three Consultants in Medicine for the Elderly and two additional
Consultants in the Psychiatry of Old Age have come on stream in addition to five new
consultants during 1990 to 1995. Valueable experience was gained in the process of piloting
support groups for carers which will contribute to a new initiative in developing this
important support service.

The annual revenue cost of developments in the period from 1990 required an additional
£15.7 million in revenue expenditure per annum by the end of 1995. The capital cost of
various developments in that period was £2.7 million.

Notably, the main emphasis was on development of treatment and care services with a lesser
emphasis on advisory or support services. This underlines the difficulty of releasing
resources for health promotion and disease prevention services. This dominant focus on
treating and curing disease and providing extended care in the case of older people, militates
against implementation of approaches that stress health maintenance and promotion.

Current environment

Notwithstanding the current favourable state of the national economy there will be continuing
pressure on health boards and service providers to deliver proportionately more services in
relation to the finite resources available. This is because of the ever-increasing expectations
and demands of citizens for more and better services in terms of quality and accessibility, and
supply pressures arising from new and costly medical technologies. Demand pressures will
be added to because of an ageing population.

The Government Health Strategy of 1994, Shaping a Healthier Future uses the concepts of
health gain and social gain to indicate that patients and clients of the health or personal social
services should receive a clear benefit from their contact with the system. The Health Strategy also requires that services should be directed towards achieving the greatest possible health or social gain for the resources that are available.

Under new financial accountability legislation of 1996, health boards are required to have regard to resources available and the need for the most beneficial, effective and efficient use of such resources. This gives rise to the need for a service plan for preventive, treatment, rehabilitation and caring services balancing their impact and return in terms of health and social gain. Not an easy task.

The challenge to the successful development of the health promotion/prevention approach is that any such intervention must be seen and accepted as a better investment than additional treatment and care services if any significant re-orientation is to take place in health and personal social services.

**Health promotion**

Under the Government Health Strategy, health promotion and disease prevention were seen as the obvious starting point for any re-focusing of the health service towards improving health status and quality of life, concentrating in particular on the three main causes of premature mortality in Ireland:

- Cardiovascular Disease
- Cancer
- Accidents

Life expectancy at birth for both males and females in Ireland has improved greatly over the last 40 years but is below the EU average. The picture of life expectancy at age 40 shows that for Irish women it is 39.3 years and this is joint lowest in the EU. Irish men with a life expectancy of 34.7 years at age 40 rank third lowest in the EU. The gap between male and female life expectancy is widening.
Cardiovascular disease is the major cause of death in Ireland and we have the highest death rate in the EU in the under 65 age group for this disease - almost double the EU average. Data from OECD countries show that, whilst the trend is downward, Ireland, after the UK still has the second highest rate in years of potential life lost from heart disease in males under 65 years of age.

It is no surprise then that one of the priorities for health promotion and disease prevention has to be to address this cause of premature death and morbidity in the under 65s.

Accidents constitute the single greatest cause of death in the under 45s age group in Ireland.

Effective health promotion or prevention interventions aimed at redressing some of the unfavourable life expectancy and mortality ratios already outlined for age groups under 65, should of course be of benefit when the recipients become part of the older age groups in due course. Given the financial limits which govern health board service plans and the requirement to make the best use of resources, there is a balance to be struck between investment in health promotion and disease prevention in the younger and older age groups respectively. Another difficult decision.

**Health promotion for older people**

*The Years Ahead* report saw the aim of health promotion as -

*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 causes of illness and accidents and to add years to life by increasing the average life expectancy of the individual.*

It is now accepted that life expectancy as an indicator of the trend in the health of a population is incomplete and morbidity and disability in the older population must also be the focus of attention.
The national Health Promotion Strategy lists a number of priority population groups, including the elderly and puts forwards goals and targets to be supported by all the groups with a stake in their pursuit. The targets of the Health Promotion Strategy can be linked to the target in the Government Health Strategy which is to ensure that not less than 90 per cent of those over 75 years of age continue to live at home, and to restore to independence at home those older people who become ill or dependent.

The plan for women’s health published this year by the Department of Health includes older women amongst those with special needs and identified the challenge of extending the benefits of healthy ageing to more women in the future by:

- maintaining a healthy lifestyle
- actively contributing to the life of the community
- the early detection of disease

Given the widening gap in life expectancy between women and men referred to earlier, there is also the challenge of extending the benefits of healthy ageing to men also. In the meantime, it is the case that more women are surviving into older age and many of them are likely to be living alone.

Older people are the fastest growing segment of our population. There is a clear case for specific health promotion and prevention programmes targeted at older people since they have the highest incidence of most chronic conditions and of certain accidental injuries. The consequences of disability are likely to be more severe than for younger age groups in terms of loss of independence and quality of life. Older people account for about 33.3 per cent of all healthcare expenditure whilst making up 11 per cent of the population as a whole. They are the most likely to need high cost long-term care.

In the view of the WHO, anything that can be done to prevent or delay the onset of disease or disability or minimise its impact whilst promoting the greater independence and well-being of older people, provides multiple benefits both to older people themselves, their care-givers and families, and to the community as a whole. The aim should be to increase active life
expectancy through health promotion and disease prevention and to compress morbidity as far as possible to the end of the lifespan.

As well as prevention of disease and the earlier detection of disabling conditions, the social as well as the health needs of older people need to be considered in terms of support or social involvement. It has been pointed out that the health and welfare of older people is greatly affected by whether or not they consider themselves to be valued members of the community.

Maintaining the physical, social and mental well-being of older people is not just the responsibility of the health sector. In the first place it should be a two-way process involving the views of the elderly themselves and the contribution to positive ageing which can be made by organisations such as Age and Opportunity, Age Action Ireland, the Irish Senior Citizens Parliament and others. As shown by the Eurobarometer Survey of 1993 Ireland was shown to have a relatively positive attitude towards ageing and older people.

Some factors influencing the health and welfare of older people are.

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<th>Treatable Illness/disability</th>
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<td>Accident prevention</td>
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This shows the multi-faceted nature of the problem and the need to involve various other sectors.

In translating various strategy requirements into an implementation plan or programme, interventions that have been evaluated and proven to be effective elsewhere should of course
be considered. This might include learning from the Ageing Well Europe Programme or the similar programme run by Age Concern in the UK, including older people acting as Senior Health Mentors. Proven interventions in relation to accident prevention and vaccination against influenza are also worthy of consideration for inclusion.

**Conclusion**

The Office for Health Gain was established by the Chief Executive Officers of the health boards with the aim of working together to achieve measurable health gain. It has already been addressing in a conjoint way, with appropriate multi-sectoral involvement, some of the main risk factors i.e. smoking, exercise and causes of accidents which underlie the three main causes of premature mortality referred to in the Government Health Strategy.

Under the 1996 legislation referred to earlier, ‘health service’ is now defined as including ‘any service relating to the protection, promotion or improvement of the health or welfare of people’, whereas beforehand health promotion was not so explicitly included. The future development of effective health promotion interventions is likely to be governed by:

- developing clear links between health promotion and health gain through needs assessment, targeted interventions and developing measures of effectiveness for both short and longer term evaluation;
- developing health promotion as a process of defining and re-inforcing the roles and contributions of health promotion specialists, personnel engaged in the delivery of health and social services (including GPs), community partners, and partners from other sectors outside health and social services;
- developing good practice and a network for the exchange of innovation and learning.

The three stands of the Healthy Ageing Programme being developed by the National Council for Ageing and Older people seem to reflect a somewhat similar approach.

There is scope for inter-agency and intersectoral collaboration in the development of a
framework to inform the development of plans for healthy ageing at individual health board level in line with agreed criteria. In this regard there appears to be particular scope for collaboration between the National Council for Ageing and Older People, and the health boards through the aegis of a joint agency such as the Office for Health Gain. Such an opportunity of working together to achieve measurable health and social gain for older people will, I am sure, not go unheeded.
Important though co-ordination is, it is nonetheless, only a means towards a desired result. In the case of services for older people, the desired result, I suggest is, or certainly ought to be, measurable health and social gain. I distinguish between the terms measurable health and social gain and just health and social gain. The words health and social gain describe a concept which enjoys universal approval. Even a sceptic will tolerate it on grounds that some good may come of it and it is unlikely to cause any harm. When we are required to measure the health and social gain on investment in the health and social services and when we develop the tools with which to do so, the concept becomes much more interesting and may be even provocative. When we reach that stage we will have moved to considerations of real substance and issues related to structures and process, for example, will be seen as secondary considerations.

In order to measure health and social gain we need to first ascertain what the current position is, determine goals to be reached by a stated future date, design a strategy, policies and performance measures to achieve the stated goals and then put in place the funding and operational policies necessary to deliver the desired results. Considerations relating to quality, standards, needs assessment, audit and review all need to be provided for.

You are perhaps thinking, ‘all that is a long way removed from where we are at’, and I would not wish to dispute that view. My argument would be, it represents where we need to get to and we ought to be giving consideration to devising ways and means of getting there. Considerable effort and a good deal of time will be involved to complete the change, but progress can be incremental.
The target contained in the health strategy, that not less than 90% of those over 75 years of age continue to live at home is, though crude, capable of serving as a health gain measure or as a social gain measure or as both. Because studies have shown that older people desire to remain at home, for as long as their independence permits, this suggests that the target represents a socially desirable state of affairs. If, however, that were to be the only measure used, many developing countries could be judged to be performing better than we are, but their apparently better performance may be largely explained by the fact that residential care beds have just not been provided.

It may well be that even if the national target is appropriate local circumstances may justify variances upwards or downwards. If the target resulted from an assessment of need, it would be easier to be confident about its achievement. If a health status assessment revealed that residential care provision for more or fewer than 10% of those aged over 75 years was justified then the target should be changed and lead to a review of strategy, policy, service provision and funding. In the Midland Health Board we use seven headings to illustrate the many and varied health care needs of older people.

They are:

i. Health promotion and disease prevention.

ii. Diagnosis and disease management.

iii. Rehabilitation.

iv. Development of a community support network for the frail and disabled and their carers.

v. Provision of palliative and hospice care.

vi. Provision of residential care facilities for those for whom community care is inappropriate.

vii. Provision of day centre care where some functions are not strictly health related.

Lack of funding is likely to be the main impediment to the satisfaction of the health care
needs of older people by the health boards and non-statutory providers. It ought to help in securing funds for the strategy if it is underpinned by a clearly stated set of values. The values which underpin the Midland Health Board strategy for older people are:

- Respect for human dignity
- Responsiveness - respect for the wishes of the client and involve them in decision-making
- Equity in treatment, and equal access based on need
- Effectiveness - evidence based therapies or strategies
- Accepts accountability
- Promotes efficiency in the use of resources
- Strives to deliver appropriate services in the appropriate setting
- Demonstrates farsightedness

Health care is merely one contributor to the achievement of the overall target and even the health care contribution is likely to have been more influential years before the older person reaches 75 years. Other essential supports, such as, income, housing, transport, security and contacts with friends and neighbours, are largely beyond the influence of the health services. However, these two broad areas of health needs and social needs are interdependent.

In Ireland the health boards are cast in the lead role insofar as the achievement of targets, such as ensuring at least 90% of those over 75 years live at home. To perform that role, the boards need to see themselves as co-ordinators, but not just as co-ordinators. They also need to be leaders, facilitators and collaborators. Let us consider what that involves and how the boards can support the development of integrated services for the older person.

The Health Strategy *Shaping a Healthier Future* signalled major changes in the future roles and relationships of the Department of Health and the health boards and in the future relationships between the boards and the non-statutory providers of health and personal social services. The future role of the Department of Health was described as follows:

*While the Minister for Health will of course continue to have ultimate responsibility*
to the Oireachtas for all health services, his Department will no longer be involved in the detailed management of individual services. In addition to its roles in providing general support to the Minister for Health and preparing legislation, its principal responsibilities will be:-

- Advising and supporting the Minister in determining national policy
- Strategic planning and management at a national level
- Advising the Minister for Health and the Government in its determination of the annual Health Estimate.
- Determining the financial allocation of the regional health authorities
- Determining the overall personnel policies within which health authorities function
- Monitoring and evaluating the service and financial performance of the authorities against national objectives and standards
- Identifying and supporting the introduction of more effective management practices
- Supporting the Minister in his functions in relation to other statutory bodies under his aegis

The Strategy went on to state that the health boards will be responsible for providing directly or indirectly all health and personal social services in their functional areas. The Strategy advocated more flexibility and autonomy for health boards but emphasised that ‘greater autonomy must be balanced by increased accountability at all levels and there must be independent monitoring and evaluation of the performance of the executive agencies’.

What we call the new Accountability Legislation or to give its full title The Health (Amendment) (No. 3) Act, 1996 is very specific about the way health boards must in future perform their functions. For example:

- health boards must have regard to limitations on resources and are required to secure the most beneficial, effective and efficient use of those resources.
- health boards are required to co-operate with and co-ordinate their activities with those of other health boards, local authorities and public authorities, insofar as the
functions of the other authorities influence the health of the population of the health board area.

The latter requirement is particularly relevant to the topic I have been asked to address and to the issues around the provision of services for older people generally.

The basis of the future relationship between the health boards and the Department of Health will be Service Plans. Service planning has been in vogue for a few years now but is still at a rather underdeveloped stage. When fully developed services plans will be drawn up in respect of the many elements of the services provided by a health board and, in the aggregate, the health board service plans for the many service elements will be the basis of the board's contract with the Department of Health. The plan will set out in financial, personnel and activity terms the services the board will engage in and this in turn will be the basis on which the performance of the board will be judged. Non-statutory providers of health and social services will receive what public money they get from the health boards on the basis that future relationships between the boards and these non-statutory providers will also be based on service plans supported by service agreements.

Health boards are in the process of re-organising and restructuring for the purpose of delivering fully on their new responsibilities. While the new arrangements have not yet been finalised, a number of trends are discernible across all the health boards. One change involves a move away from the programme structure, which has been a feature of health boards since they were set up, in favour of services organised to meet the needs of care groups. The care groups are elderly, children, people with disabilities, people with mental illness and episodic illness or acute care.

Another evident trend is towards separating the assessment of need, the planning of services and the evaluation of services from the delivery of service. The new arrangements are likely to work something like this. Assessment of need, service planning and evaluation of services will be the responsibility of a team working with the statutory and non-statutory providers of health care. The financial resources for the non-acute services will be allocated to a member
of that team, probably a Director of Services, who will allocate the resources between the statutory and non-statutory service providers. The providers, statutory and non-statutory, will enter into agreements and furnish service plans as a basis for accounting, in service and financial terms, for the funding they receive. Statutory and non-statutory providers will compete on equal terms for the funds available and their service performance will be judged against common criteria.

The change from programmes to care groups is intended to shift the emphasis from the services structures on to the recipients of services. The focus will be on assessing need, determining priorities and allocating resources in ways considered most likely to satisfy priorities. In the case of older people the overall aim will be to sharply focus on achieving measurable health and social gain for that group of our citizens. The greater clarity which is expected to result from that approach should be of particular interest to voluntary organisations who perform so many vital roles in providing services to older people. They will be facilitated to bid for funding to provide services on the basis of service agreements. They will be placed on an equal footing with statutory service providers since the main criterion in allocating funds will be ability to satisfy specific service needs.

In future then, overall policy, with regard to health and personal social service provision for the elderly, will be determined by the Minister for Health of the day and the Department of Health. The health boards will be expected to devise policies and action plans capable of effectively implementing Ministerial and Departmental policy and will be required to co-ordinate their implementation plans for the purpose of ensuring that equity applies in the provision of services throughout the State.

Different health boards may very well adopt quite different approaches aimed at achieving broadly similar results and indeed different approaches may well enrich the implementation process. A uniform approach, if inadequate, may well not be self evidently inadequate. Different approaches provide opportunities for comparing and contrasting the effectiveness of each and by sharing the experiences, what has worked well can be emulated and what has not worked well can be avoided in other places. However, structures need to be put in place to
ensure that co-operation and collaboration exist at local level.

In some boards, the sectors which were adopted for the purpose of organising mental health services are now more widely used and in a number of boards, including the Midland Health Board, will be the basic unit for delivering services to the elderly. In the Midland Health Board structures for consultation and collaboration are being established at that level. In addition, the six sectors which make up the health board area will be grouped for the purpose of consultation and collaboration at the highest health board level. When local government is re-organised it may well be that the districts which are formed may be capable of serving as local administrative units for co-ordinating services provided by State bodies also. In the case of services for the elderly, if the approach of all providers were based on achieving measurable health gain by assessing need, setting goals, providing the resources required, measuring outcomes, an involvement of elected representatives would in all likelihood enrich the process.

The sector, serving a population of 25,000-30,000 people, facilitates co-ordination of service planning and delivery. Even in rural parts the area involved is usually not too large and the natural boundaries involved are often well known. The population is usually served by about 10 to 12 general practitioners and about the same number of public health nurses. Others serving the area such as social workers and the area medical officer are usually well known throughout the territory. The older population is likely to be catered for by 5 or 6 local voluntary organisations. Consultation often occurs between health board staff and their counterparts in other organisations but this is often related to particular issues or elements of services. The challenge now is to convince all of the organisations providing services or support to older people that they can enhance their contribution by collaborating with others, in a structured way, to pursue measurable health and social gain for older people.

We have not, in my view, involved older people sufficiently in the planning and co-ordination of services intended to serve their needs. One of the ways of reaching 75 years in good health is to be afforded opportunities to use the skills and experiences acquired during a working career. With more people favouring early retirement the rich resource of experienced people
is expanding. The combination of being given a meaningful role, in the early years of retirement, combined with the vested interest that group have in bringing about improvements in assessing accurately and responding appropriately to the needs of older people represents, in my view, enormous potential.

If older people are to be facilitated to live independently in their own homes for as long as possible, greater collaboration in policy and service delivery will be required from a number of government departments and state organisations. Should not the process of collaborating for the purpose of achieving measurable health and social gain begin at the very highest level?.

The general perception is that advantages have resulted from the assignment of responsibility for children's services to the Minister for Health. A Cabinet Minister with overall responsibility for policy and resource allocation for services for older people would not only facilitate integration of approach by the providers of services to older people but would convey a powerful signal about the importance the government attaches to enabling older people to retain their independence and the support they can expect in order to do so. It would also contribute to increased efficiency and effectiveness through the greater collaboration a Minister with overall responsibility could demand in planning and delivery from all of the support agencies. This suggestion is for co-ordination, not centralisation, at the highest level.

The role of co-ordinator could be performed by one of a number of ministers including Health, Social Welfare, Environment or Equality. Since the key task involved would be to support the often expressed desire of older people to be facilitated to retain their independence and to live at home for as long as possible, the Minister of Social Welfare may be the one best placed to fulfil that role.

In summary then, I believe that a management strategy for the co-ordination of health and personal services for older people recognise that:
• older people make up a sizeable number of citizens
• they are not a homogenous group
• their health and social needs should be fully and professionally assessed
• services should be tailored and adjusted to meet assessed needs.
• planning and service delivery should be locality specific
• service providers should collaborate in service planning and delivery to maximise the social return on their investments
• the potential contribution older people can offer in assessing need and developing policy should be availed of
• a Government Minister should be given responsibility for co-ordinating government policy on the support older people can expect on order to retain their independence and the levels of care and treatment they can expect when they require them.
Ageing is a process we are experiencing all the time. We are, at this very moment, growing older. As we grow older, our abilities, needs and desires can change. Every day, we grow stronger in experience. However, we may also need assistance in areas of our life that previously had presented no problem.

Before dealing with current housing policy as it affects older people, I would like to make a few points about housing output generally and social housing output in particular.

Record levels of housing output have been achieved in successive years 1995 and 1996. The 1996 figure was 33,725 new houses/apartments, an increase of over 3000 on 1995. Another record year, with possibly 37,000 completions, is in prospect for 1997. To put these figures in context, new house completions are more than twice the 1988 level.

In the report, The Years Ahead Report: A Review of the Implementation of its Recommendations, the summary says ‘Local authorities have scaled back their building programmes in the past decade and this has effected housing for older and disabled people’. It then goes on to produce and compare average annual figures of local authority housing output in the periods 1972 to 1987 (736 units) and 1988 to 1995 (236 units).

To the casual reader, the figures quoted would appear to refer to overall provision of local
authority houses, and not simply to the provision of specially adapted houses for older people
and people with disabilities. As the figures for the latter period are significantly lower than
the former, a very negative impression of the scale of the social housing programme in recent
years could easily be generated. Let me put the record straight.

Exceptional numbers of local authority houses were provided in the years up to 1987. This
level of local authority house provision, allied to programmes such as the £5000 surrender
grant (since terminated) for local authority tenants and tenant purchasers moving into private
housing, combined to reduce the local authority housing waiting lists in 1988 to about 50% the
1982 level.

Social housing provision clearly depends on the availability of finance. It competes for this
finance with other important social programmes such as the health and social welfare
services. Social housing provision also generally reflects the level of needs.

Not only were the local authority housing waiting lists at a record low level in 1988, anecdotal evidence was emerging that some local authorities did not have tenants on their books for houses becoming available. Furthermore, difficult economic decisions were being taken in the late 1980s and early 1990s that have arguably sown the seeds for our current Celtic Tiger economy. Accordingly, it is not surprising that social housing provision declined around that time.

Social housing provision has, however, increased very significantly since the early 1990s. The local authority housing programme delivered less than 1500 completions in 1992 - in 1996, almost 3600 houses were completed or acquired. Voluntary housing bodies completed more than 900 houses in 1996 compared to just over 500 in 1992. Taking all the options into account, the number of households assisted under the social housing measures has increased from under 6200 in 1992 to over 10,000 in each of the years 1995 and 1996. 1997 will see about the same numbers accommodated.

When we speak of meeting social housing needs, it is crucial to bear in mind that access to
housing for younger and older people alike is not purely related to the extent of annual social
housebuilding programmes. It is also highly dependent also on the extent of the existing
housing stock and the occurrence of vacancies in those houses.

Local authorities have, over the years, used their house building programmes to provide
substantial numbers of older persons dwellings. They continue to do so. In 1996, they
provided an additional 580 older persons units, bringing the total available to almost 14,000
out of a total rented local authority housing stock of 97,000 houses.

Thus, older persons dwellings represent a very substantial proportion of the local authority
housing stock. This is reflected in the fact that, in 1996, local authorities let over 1,500 older
persons units out of total lettings of about 7000 dwellings. This is an indication of the local
authorities' commitment to meeting the housing needs of older people. And, bear in mind,
this commitment is complemented by output under the voluntary housing schemes.

Moving on to the main business of this session - current housing policy and our policies as
they relate to older people in particular. The overall aim of housing policy is ‘to enable every
household to have available an affordable dwelling of good quality, suited to its needs, in a
good environment and, as far as possible, at the tenure of its choice’.

Housing policy is inclusive. The words ‘every household’ embrace the older people, single
parents, homeless people, families. The policy covers all housing sectors. It encompasses the
provision of new houses and the improvement and adaptation of the existing housing stock.

Turning to older people, we accept that their accommodation needs are important and require
a sensitive and flexible approach to ensure that the needs of each individual are met in the
most appropriate way. This may involve the provision of accommodation specifically
designed to meet the needs of older people or improvement works to their existing
accommodation. In a nutshell, and in common with the views expressed in The Years Ahead,
our policy is that older people should be facilitated to retain independence and live in their
own homes for as long as they wish and are able to do so.
The vast majority of older people in Ireland live in their own homes. It is safe to assume that most of these houses are occupied unencumbered by mortgage and that, in the majority of cases, minor, routine maintenance can arranged by the occupants from their own resources. However, the situation can, and does, arise that works which cannot be afforded by the occupant must be carried out. Given the extent of owner occupation, housing's first priority for older people is to ensure that assistance is available to them to enjoy basic, decent conditions in their own homes. Accordingly, a range of measures is on place.

The Task Force on Special Housing Aid for the Elderly was specifically designed to meet situations such as these. The Task Force is representative of the Society of St Vincent de Paul, ALONE, local authorities, the Departments of Health and the Environment, local government and FAS. Set up in 1982, it enables older people living on their own, if they so desire, to remain in their existing accommodation. The scheme provides for the carrying out by FAS trainees, at no cost to the occupier, of basic works to improve unfit or insanitary housing conditions. Typically, works involve structural/roof repairs or improvement, wiring, damp-proofing, repairs to windows and doors and the provision of water and sanitary facilities.

The scheme is operated at local level by health boards under the direction of the Community Care Programme Managers who have responsibility for decisions in individual cases. There is regular co-ordination between the health board and the local authority in regard to cases which might be assisted under the Task Force or for whom one of the other social housing measures might be more appropriate.

The Department of the Environment and Local Government provides the necessary funding to the Task Force through an annual Grant-in-Aid. We have increased our support to the Task Force considerably in recent years. The 1997 provision is £4.132 million compared to funding of £2 million in 1993. Some 29,000 dwellings have been improved with assistance from the Task Force since 1982, including almost 3000 last year.
The Task Force has been particularly successful in meeting the housing needs of older people. Its success is probably principally due to its operation in an informal manner at local level with the minimum of fuss.

The Task Force is not the only avenue of assistance available to older people to improve their housing conditions. The local authorities provide a range of other social housing options, namely, the disabled persons grants scheme, the essential repairs grants scheme and the scheme of improvement works in lieu of local authority housing.

Bearing in mind that the likelihood of mobility problems increases with age, the Disabled Persons Grant scheme is of great relevance to older people. The scheme enables local authorities to assist, by means of a grant, necessary adaptation works to a house to meet the needs of a disabled person. In the case of a private house, the grant may amount to two thirds of the cost of the work and, generally, local authorities make maximum grants of £8000 available. In the case of a local authority house, the local authority may meet the full cost of the necessary work.

The Department of the Environment and Local Government recoups to local authorities half of their grant expenditure up to a maximum of £4000 per case. Local authorities paid out almost £9 million last year in respect of almost 2200 disabled persons grants.

The Essential Repairs Grant scheme is a long established social housing option. It is a modest but very worthwhile measure as it enables people in accommodation which cannot be made fit in all respects at a reasonable cost to have basic repairs carried out to their houses so that they can continue to provide an acceptable standard of accommodation for the occupants. Under this scheme local authorities advance grants which are, in turn, partly recouped by the Department of the Environment and Local Government. The scheme is generally used to secure essential repairs to dwellings occupied by older people, often in isolated rural areas. Grants totalling almost £1.3 million were advanced by local authorities last year under this scheme in respect of almost 750 houses.
The scheme of improvement works in lieu of local authority housing holds great potential for meeting the housing needs of older people. It enables local authorities to improve or extend privately owned houses occupied or intended to be occupied by an applicant approved for local authority housing. The authority can arrange to have all necessary works of improvement carried out to the house at no cost to the occupants other than a small weekly or monthly charge, based on the cost of the works, for a maximum of 15 years.

Indeed, the scheme can go further than just providing adequate accommodation for existing residents in the house. In certain circumstances, necessary improvements to a house may be carried out under the scheme, where for example, a young family on a local authority housing waiting list intend to move in with an older relative. Such an arrangement might hold great benefits for both parties - for the older person, from the point of view of care, security and companionship and, for everyone, decent housing conditions. Equally, the scheme can apply in cases where older people in housing need wish to move in with members of their family.

Clearly, not all older people have ready access to private accommodation. In such cases, the social housing programme provides custom built accommodation. Accommodation for older people may be provided under the local authority housing programme or the voluntary housing Capital Assistance Scheme. Local authorities carry out assessments of housing needs on a regular basis, including the needs of the older people. They have regard to the level and composition of housing needs in their areas when making their schemes of letting priorities and when determining the type and scale of additional accommodation which they should provide. The 1996 assessment of needs revealed that 2140 elderly households were in need of housing from a total net need of 27,427 households. This represents just under 8 per cent of the total and was very much in line with the 1993 assessment.

The provision of additional accommodation to meet the needs of the older people who are identified in the assessment are primarily a matter for the local authority who can meet these needs either directly in their building programme or indirectly through the voluntary housing programme. As I said previously, the total local authority housing stock now stands at about 97,000 dwellings. Of these, almost 3000 are suitable for people with a disability and almost
14,000 are for older people. Thus, 17 per cent of the rented local authority housing stock caters for older people or people with special needs.

Clearly, therefore, the local authorities have been mindful of the need to provide rented accommodation for older people. And, bearing in mind what I said earlier about the influence of the size of the existing housing stock in meeting needs, you will be happy to hear that the intention is that the current stock of older persons units will be retained as rented housing as will any such new stock which becomes available.

While local authorities have provided significant numbers of dwellings for older people, it has also been recognised that the voluntary housing sector has a special role to play in meeting such needs. The voluntary housing sector brings life to the phrase ‘small is beautiful’. Apart from providing housing, they can also make a personal commitment in their projects, a commitment which local authorities may find difficult to deliver. This type of commitment is especially important in projects which cater for special needs such as those of some older people.

The Capital Assistance Scheme has traditionally catered principally for people with special needs - older people, people with disabilities, homeless people. In the period 1988 to date, almost 2,200 units for older people have been provided under the scheme. In 1996, a total of 501 units were completed under the scheme. Almost half of these, 246, were for older people.

Housing output from the voluntary housing sector is additional to local authority housing. Particular attention was given to the desirability of expanding voluntary sector activity in the housing field in the 1991 policy document *A Plan for Social Housing* and its 1995 successor *Social Housing - The Way Ahead*. Progress has been good to date and, by 1995, output from the sector had almost doubled over the 1991 level. Output has, however, slowed down somewhat in recent times. It is recognised that the capital cost limits etc. under which the voluntary housing sector operate are in need of adjustment following recent rises in building costs etc. The matter is currently being pursued with a view to increasing the various limits and restoring output.
So what does the future hold? What changes to housing policy for older people are now appropriate? Will we see any new directions being taken?

Nothing in life is ever perfect. However, given the what I have been saying, I think that our housing policy is responding well to the needs of older people. The fundamental policy of ensuring that older people can remain in their own homes for as long as they wish and are able to do so is unquestionably correct. It is in line with the views expressed in *The Years Ahead*.

What about service delivery? Is sufficient funding being provided for the schemes which aim to improve the housing conditions of older people? These issues can only be dealt with in the context of our future economic performance. Thankfully, the outlook appears good.

Could the available funding be better applied or be better utilised? I would think that we will inevitably see some changes in the service we provide and the manner of its provision. Change is normal and is to be expected. Better co-ordination of services between local authorities and health boards will, doubtless, be a priority. Hopefully, we will see continued output from the voluntary housing sector and local authorities meeting the housing needs of older people.

In the private housing market, I think we may see houses being designed at the outset to enable them to more adaptable and to better meet the changing needs of people as they grow older. We may also see private developments being specifically designed for older people and marketed accordingly.

I am sure, however, that the broad thrust of our housing programmes for older people - appropriate support for owner occupiers and social housing for those who cannot afford it from their own resources - will remain virtually unaltered.
**Recent Social Welfare Policy Initiatives Relevant to Older People, their Families and the Voluntary Sector**

Deirdre Carroll  
Assistant Secretary-General, Department of Social, Community and Family Affairs

**Pensions background**

The most obvious manner in which the Department deals with older people is through the payment of pensions. Well over a quarter of a million people over 65 years of age receive a weekly pension from the Department. The Department also has responsibility in relation to Occupational Pensions which is not as widely understood.

**National Pensions Board**

In 1986 the National Pensions Board, an advisory body was set up. That body issued a number of important reports, including reports on:

- the priority requirements for regulation of occupational pension schemes and on the most suitable method of ensuring that the proposed regulatory requirements are effectively monitored
- the extension of social insurance to the self employed
- the tax treatment of occupational pension schemes
- equal treatment for men and women in occupational pension schemes

Following their advice, the *Pensions Act, 1990* came into effect. This Act was a particularly important one as it was the first piece of Irish legislation which was exclusively devoted to occupational pensions and the first major pension legislation since 1972.

The Pensions Board was set up under the terms of this Act to monitor and supervise its operation and pension matters generally. I think it is reasonable to say, that to date, the
Pensions Act has been successful in its aims, the primary one of which is to safeguard the rights of the individual members of pension schemes and to ensure that their pension rights are secured and safeguarded.

In 1993 the National Pensions Board published its Final report Developing the National Pension System which set out the aim that there should be a national pension system which would provide pension benefits which would maintain a reasonable relationship with previous income levels, so that established standards of living could be maintained. This report was of great significance in shaping views about national pensions policy and could be said to have laid the groundwork for the current Pensions Initiative which I will speak about shortly.

Survey of Occupational Pensions

One of the recommendations of the National Pensions Board was that a survey of occupational pension schemes should be carried out to establish their coverage and adequacy. The last major survey related to 1985 and it was essential that up-to-date information should be available which would be of considerable assistance when proposals in relation to pensions were being formulated.

Accordingly, the Department and the Pensions Board jointly commissioned a report from the ESRI. This report entitled Occupational and Personal Pension Coverage 1995 was published in October 1996.

The report shows that pension coverage is roughly the same now as it was over ten years ago. The overall coverage for those at work stands at 46 per cent while the coverage rate for employees has fallen from 54.4 per cent in 1985 to 52 per cent.

National pensions policy initiative

Having considered carefully the findings of the report, the Department in conjunction with
the Pensions Board, sponsored a National Pensions Initiative. The purpose of the Initiative is to facilitate a national debate on how to work towards a national pension system consistent with the aim of providing pension benefits which maintain a reasonable relationship with previous income levels so that established standards of living can be maintained.

This Initiative is a two-stage process. Stage 1 involved the production of a consultation document which was published in February of this year and which formed the basis for general discussion among all interested parties, the social partners and the general public. This document set out the information and data currently available on pensions coverage in Ireland and the key issues that need to be addressed. These issues include coverage, the delivery of this coverage, its efficiency and fiscal and economic implications. The document also describes the alternative models of pension provision that exist in other relevant countries. The document notes the international context in which many countries are reforming or reviewing their system of providing for older people. The context includes:

- the so-called demographic 'time-bomb' arising where the proportion of older people is set to increase rapidly relative to the proportion at work, and

- the fact that existing systems, in particular social welfare pensions paid out of current revenue, are facing severe financing difficulties due to demographic pressures and/or previously made pension 'promises' which are difficult to meet as they mature.

Even though similar concerns will arise in Ireland, their timing will be more delayed and their likely extent significantly less than in many other countries. While careful policy choices need to be made now regarding these longer term matters, there is no basis for alarm about an imminent financing shortfall in any area of pension provision. Thus, the present review of policy is not a response to a crisis, as is the case in many other countries, but a timely consideration of policy options to ensure that in the longer term this country will not face the difficulties being experienced elsewhere. Responses to this consultation document were invited and more than 130 were received.
Stage 2 of the Initiative is now well underway. This involves:

- processing and analysis of the responses to the consultation document
- reviewing critically selected pension models from other countries, relating these to Ireland and developing options in the Irish context
- preparation of a report including the formulation of recommendations on the actions that need to be taken to achieve a National Pension system in line with the aim of the National Pensions Board as articulated in their Final Report.

The deadline for the completion of this stage is the end of this year. A team of consultants, Peter Bacon and Associates are assisting in the process. The position of pensions (both Social Welfare and Occupational) and pensioners generally will arise for consideration in this context.

**Actuarial Review**

The final report of the National Pensions Board also recommended that an Actuarial Review should be carried out at least every 5 years. The first such review is almost completed and will be in time to feed into the National Pensions Policy Initiative. This will facilitate projections and discussion as to the levels of Social Welfare pensions that can be provided in the decades ahead and the costs of different options.

This is a very important time for pensions policy. We need to look comprehensively and very carefully, over a relatively short time frame, at the present position. We then need to make decisions and, most importantly, to carry those decisions through so that we face up to, and deal with the medium and long term issues so as to ensure that the living standards of future generations of pensioners are safeguarded. This National Pensions Policy Initiative is the first step to achieving this.

I would now like to mention some recent improvements in the pensions area. One of these is in relation to gaps in insurance.
Qualifying conditions for Old Age (Contributory) Pension

In relation to Old Age (Contributory) and Retirement Pensions at present, to qualify for an Old Age Contributory Pension there are three main conditions. A person must:

- have entered social insurance at least 10 years before reaching pension age
- have at least 156 contributions paid
- thirdly, have a yearly average of at least 20 contributions (paid or credited) registered since January 1953 or the time they started insurable employment, if later.

Gaps in insurance

The yearly average condition gives rise to particular problems for people with gaps in their insurance records and as a consequence can result in a person's yearly average being diluted with a person only qualifying for a reduced pension or, indeed, in some cases no pension at all.

Measures taken to alleviate problems caused by gaps in insurance

In recent years some measures have been introduced to alleviate some of the anomalies caused by gaps in insurance.

- In 1988 special partial old age pensions for people who became compulsorily insured for pension in 1974 but failed to qualify because of gaps in their insurance record caused by the operation of the remuneration limit were brought in. Under these arrangements pensions were granted for averages of between 5 and 20.

- In 1991 pro-rata pensions for people with 'mixed insurance' records were introduced, the rate of pension payable being in proportion to the periods of insurance completed at the rate appropriate for old age/retirement pensions.

- The 1992 Social Welfare Act makes provision for the introduction of an alternative
‘yearly average’ test for entitlement to the maximum rate of Old Age (Contributory) and Retirement Pensions. This allows a person to qualify for full pension if he/she has an average of 48 since 6 April, 1979 when the present PRSI system came into operation.

- From 6 April 1994 periods of time spent by homemakers out of the workforce caring either for children aged up to 6 years (increased to 12 years from April 1995) or incapacitated people will be ignored or disregarded when calculating a person's pension entitlements.

- For any year to be disregarded for this purpose a homemaker must be out of the workforce for a complete year (52 weeks) in any given year from 6 April 1994. The maximum period which will be disregarded is 20 years.

'New' pro-rata pensions

A new pro-rata pension was announced in this year's Budget and given effect in the 1997 Social Welfare Act. This provides that, from 21 November this year, new pro-rata pensions will be introduced so that in future, people who have a yearly average of between 10 and 19 contributions, and who currently would not qualify for any Old Age (Contributory) Pension will now qualify for a pro-rata pension. The present system, as I have already indicated, requires you to have a minimum yearly average of 20 contributions over your working lifetime, in order to qualify for a minimum contributory pension.

A yearly average of between 15 and 19 will, from November, give a pension of £58.50 (75 per cent of the £78 maximum rate) while an average of between 10 and 14 will give a pension of £39 per week (50 per cent of the maximum rate). Depending on personal circumstances a person may also qualify for a Qualified Adult and Dependant Child Allowance, Living Alone/Fuel Allowance and the various Free Scheme Benefits.

To qualify for this new pro rata pension, persons with an average of between 10 and 19 will
require to have 260 paid contributions, as opposed to 156 at present. The reform will be of particular benefit and help to groups such as:

- women who may have spent long periods outside the paid workforce, working in the home, and who may not benefit from the 1994 homemakers provisions which are not retrospective
- returned emigrants who entered the workforce here for a short spell before working abroad for a long period and then returning to take up employment here again
- people who entered Social Insurance at an early stage and then were self employed for a long period before 1988 when Social Insurance for the self employed (Class S) was introduced.

Costs/statistics
We estimate that this measure could immediately benefit up to 4000 people who will qualify for a pension for the first time, at a cost of £6 million in a full year and it is estimated that some 1300 persons per year will qualify after that. In addition an estimated 4500 people, who currently have a reduced rate pension, will qualify for the new pro rata at a higher rate of payment than their current pension.

Changes in paid contributions rule

Another change was in the number of paid contributions required in relation to Retirement and Contributory Pension entitlement conditions. This will take effect in two phases as provided for in this year's Social Welfare Act -

- an increase in the paid contribution requirement from 156 at present to 260 paid contributions in 5 years time (from 6 April 2002),

  and

- a final increase from this 260 to 520 paid contributions in 15 years time (from 6 April 2012).

The purpose of this change is to ensure a stronger relationship between paid contributions and
entitlement to a pension on reaching retirement. Over a normal working life of, say, 40 years, it is not considered unreasonable that a person would be required to have 10 years of paid contributions. The paid contributions conditions should be easier to satisfy in the future as virtually all people in employment and self employment now pay Social Insurance, which was not the case in the past. At this stage, I should say that the changes introduced in this year's Social Welfare Act are broadly in line with the recommendations made by the National Pensions Board some years ago. In fact, that Board recommended slightly more restrictive conditions but I think what we now have is a good balance.

**National Anti-Poverty Strategy**

I would now like to refer to the National Anti-Poverty Strategy. At the UN World Summit for Social Development in Copenhagen in March 1995, the Irish Government together with other Governments, agreed a programme of action geared to a substantial reduction of overall poverty and inequalities everywhere.

In April 1997 *Sharing in Progress - The National Anti-Poverty Strategy* (NAPS) was launched. The launch marked the end of two years of widespread consultation, in particular with those experiencing poverty and with their representatives. The top priority of the NAPS is to reduce the 9-15 per cent of the population, identified as consistently poor in the 1994 *Living in Ireland Survey*, to under 5-10 per cent by the year 2007.

Ireland, in common with most countries in the developed world, recognises poverty in relative terms. An understanding of relative poverty recognises that poverty involves isolation, powerlessness and exclusion from participation in the normal activities of society, as well as a lack of money. In developing the NAPS the definition of poverty was agreed as follows:

*People are living in poverty, if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living which is regarded as acceptable by society generally. As a result of inadequate income and*
resources people may be excluded and marginalised from participating in activities which are considered the norm for other people in society

The NAPS provides a broad framework through which issues relating to poverty and social exclusion can be discussed and progressed in an integrated and coherent fashion. It also details the position of various groups - including the elderly - in terms of their income and risk of poverty. The 1987 Living in Ireland Survey carried out by the ESRI showed a very significant improvement in the position of the elderly though some remained at risk of poverty. This related to increases in the real income of pensions from the mid-1970s to the mid-1980s due to increased coverage under occupational pension schemes, and from greater coverage and higher rates under social welfare pension schemes. However, in 1994 (the latest year for which data is available), the risk of poverty for retired heads of household had slightly increased at the 50 per cent relative poverty line, from 9% to 11%; but had increased from 21% to 39% at the 60 per cent relative poverty line.

It should be noted that there is substantial overlap between retired households, single adult households and households headed by someone working in the home. Single adult households and households headed by someone working in the home have also shown an increase in their risk of poverty between 1987 and 1994.

A key factor in explaining the increase in the risk of poverty for elderly households, especially single adult elderly households and those headed by women is the changing relationships between the poverty lines and the rates paid under different social welfare programmes. Support rates for the elderly and widows increased by a good deal less than incomes between 1987 and 1994.

As a result, those relying entirely on means-tested old age or widows' pensions were on incomes at or about the 50 per cent poverty line in 1994 whereas, before that they had been above that level. The elderly are therefore vulnerable to an increasing risk of poverty, especially those who are dependent on Non-contributory Old Age Pension. This is borne out by examining income and deprivation information combined where the proportion of the
retired among the poor has more than doubled. Using this criterion the retired group made up 13% of the poor in 1994 compared to 6% in 1987.

The NAPS sets out a number of strategic aims which have direct effect on older people. The strategy recognises the rights of people to an income that provides for essential needs, as is currently provided by social welfare pensions. Occupational and personal pensions are a means of topping up the social welfare pension to allow people to maintain their established standard of living. While currently only 46% of those at work are covered by Occupational Pensions, the objective is to increase that percentage so that all people will have adequate replacement income in retirement.

In the area of income adequacy there is a commitment to increase social welfare rates, including pension rates. The strategy notes, however that there are problems in deriving an estimate of income adequacy in a way that will be acceptable and convincing to everyone.

The NAPS provides a forum public debate on these issues. From the outset it was recognised that the effectiveness of a National Anti-Poverty Strategy - no matter how good its proposed policy actions - could be undermined if the right support structures or mechanisms were not in place. The implementation of the Strategy will be assisted by the following structures:

(a) The establishment of a Cabinet Sub-Committee on Social Inclusion and Drugs (including Local Development) which will deal with issues of poverty and social exclusion to be chaired by the Taoiseach, and include Ministers whose brief includes policy areas relevant to tackling poverty. The Minister for Finance will be a member of the Sub-Committee.

(b) The Minister for Social, Community and Family Affairs to have responsibility for the day to day political oversight of the NAPS and to appear before the Social Affairs Committee to update the Oireachtas on developments with NAPS. Individual Ministers will have responsibility for development in areas under their remit.

(c) The continuation of the NAPS Inter-Departmental Policy Committee chaired jointly by
the Department of the Taoiseach and the Department of Social, Community and Family Affairs. The members of the Committee comprise senior officers from key Departments who are designated as having responsibility for ensuring that the NAPS provisions relevant to their Departments are implemented. This Committee is the focus for addressing issues where co-ordinated effort is required and for agreeing future plans and programmes of activity.

(d) The establishment of a Strategic Management Initiative (SMI) team (known as the NAPS Unit) in the Department of Social, Community and Family Affairs with core staffing to co-ordinate the implementation of the Strategy and to include, on a full- or part-time basis, representatives from other relevant Departments augmented as necessary with appropriate external expertise.

(e) The Combat Poverty Agency - a statutory agency - apart from working closely with the NAPS Unit, provides a key advisory, educational and monitoring role. It will particularly provide advice on anti-poverty strategies in areas which have not been directly involved so far in the Strategy, such as that of local government reform. Perhaps most importantly of all, it will oversee an evaluation of the NAPS process and will present the results of the evaluation to the inter-Departmental Policy Committee.

(f) The National Economic and Social Forum has responsibility for monitoring the social inclusion element of the current National Agreement, Partnership 2000 and, in that context, will be asked to report regularly on the progress of implementing the NAPS.

(g) Continued consultation with and the involvement of the voluntary and community sector including users of services and those with first hand experience of poverty. Continued involvement also with the social partners. The ongoing involvement of those directly affected by poverty and social exclusion will be an essential element.

**Carer’s Allowance**

I would like to discuss briefly developments in relation to carers. The Carer’s Allowance is a
social assistance scheme which provides an income maintenance payment to people who are providing elderly or incapacitated pensioners or certain disabled persons with full-time care and attention and whose incomes fall below certain limits.

The *Social Welfare Act, 1997* made improvements in the scheme by:

- making provision for the payment of an additional amount, equivalent to 50% of their existing entitlement, to carers who are providing full-time care and attention to more than one person.
- a relaxation of the condition in regard to the provision of full-time care and attention so as to cater for situations where care-recipients are attending approved courses of rehabilitation.

In line with the Government's commitment to improve the position of carers in our society, the question of progressively relaxing the qualifying criteria for the Carer's Allowance, to ensure that more carers can qualify, will be examined.

As with other social assistance schemes, a means test is applied to the Carer's Allowance Scheme so as to ensure that limited resources are directed to those in greatest need. The means test has been eased significantly in the past few years, most notably with the introduction of disregards of the income from employment and other sources of the carer's spouse. The complete abolition of the means test, however, would have substantial cost implications and these could only be considered in a Budgetary context.

The question of developing provision for carers through the social insurance system will be examined in an overall review of the Carer's Allowance which is being carried out in the Department of Social, Community and Family Affairs. This review will take account of the findings contained in the report of the Oireachtas Joint Committee on Women's Rights on *Long-term Support for Female Carers of Older People and People with Disabilities* and in the Report of the Commission on the Status of People with Disabilities. It will also consider the purpose and development of the Carer's Allowance Scheme; the potential for its future
development both in terms of the current operation and in the wider context of health care provision in the home generally.

**Commission on the Family**

The Commission on the Family was set up by the Government to examine the needs and priorities of families today and to make recommendations as to how they can be strengthened and supported for the future. The Commission's work will assist in providing the basis for the development of an integrated policy to help families to provide support and development to their individual family members.

The Commission will complete its final report for the Government over the coming weeks. The contribution of older people to society and to continuity and stability in family life is an important issue in the Commission's examination of what needs to be put in place to better support families for the future. The work of the National Council on Ageing and Older People has been most helpful to the Commission in its analysis of the changes which are taking place in society. The outcome of this seminar will also be of interest to the Commission in finalising its recommendations in this area.

It is expected that the Commission's final report will make a further positive contribution to a more informed public debate on the impact of social and economic changes on family life in general, and assist Government with formulating policy in this important area.

**Scheme of community support for older people**

A special Task Force on Security for the Elderly was established by the former Minister for Social Welfare on 24 January 1996. The purpose of this task force was to consider the security needs of the elderly and, in particular, those on low incomes who could not benefit from tax incentives introduced in the 1996 budget. The Task Force, among other things, recommended that consideration be given to the extension of the tax relief measure announced in the 1996 Budget and that it be specifically extended to relatives who install
security systems in the homes of elderly people living alone and to elderly couples or households composed of elderly persons.

These tax incentives, as recommended by the report, were subsequently made available and local Tax Offices can provide further information in this regard. The Task Force also recommended that resources be made available to voluntary groups to support the installation of security equipment and monitored alarm devices in the homes of elderly people identified as at risk. Arising from this the Scheme of Community Support for Older People was introduced in 1996.

Under the scheme funding can be provided for small-scale physical security equipment (such as strengthening of doors and windows, window locks, door chains, and locks and security lighting) and socially monitored alarm systems. Funding is not available for conventional intruder alarms under this scheme.

The Scheme of Community Support for Older People is administered by the Department of Social Community and Family Affairs through its regional structure. Grants are made to voluntary organisations such as Muintír na Tire, Neighbourhood Watch and Community Alert, who have undertaken to identify the people in need of the schemes services and to ensure that the appropriate locks and alarms are provided for them. The involvement of voluntary organisations in the scheme ensures the greatest level of local involvement and represents the best opportunity for meeting individual needs of older people in the community.

Strong links were also forged with An Garda Síochána. They, along with a number of the voluntary organisations concerned and officers of the DSCFA, comprised a National Advisory Committee which was established to advise on the administration of the scheme.

In 1996 grants totalling approximately £2.6m were made to voluntary organisations involved in the scheme, ultimately providing assistance to almost 15,000 older people countrywide. A further £2m was provided in the Budget for the scheme in 1997. However, following
advertisements for the scheme, applications for funding totalling in excess of £5m were received from the voluntary organisations. The Minister for Social, Community and Family Affairs, recognising that a great demand for such assistance still exists among the vulnerable older people in the community, recently secured an additional £3m, raising the total funding for this scheme in 1997 to £5m. It is envisaged that this level of funding will enable the Department to assist some 21,000 older people under the scheme this year.

The Minister proposes to undertake a review of the scheme in conjunction with Dr Tom Moffatt, Minister of State with responsibility for Older People at the Department of Health and Children. This review will seek to ensure that the scheme is achieving its aims, that it is being operated in the most effective and efficient manner and that the security needs of the most vulnerable older people in society are being met in the most effective way.

**Green Paper on voluntary activity**

The Department published a Green Paper on Voluntary Activity earlier this year. The objective of this Green Paper is to discuss a framework for the future development of the relationship between the State and the community and voluntary sector and to facilitate a debate on the issues relevant to that relationship. The publication of the Green Paper provides an opportunity, following discussion and debate, to put in place a more permanent set of policies relevant to this area. The voluntary sector has a long and valued tradition of meeting social needs in Ireland. Many essential services are provided by voluntary organisations, and the voluntary and community sector is playing an increasing role in the areas of social service delivery, combating poverty and community development.

The important role of the sector is reflected in the substantial amount of funding - approximately £487 million annually - which it receives from the Irish State and EU sources. The Green Paper acknowledges that the Government greatly values the vital role played by voluntary and community organisations and welcomes the enormous contribution made by them in assisting individuals in need, the communities in which they live and work and society as a whole. Without the input of this energy and commitment to the task of building a
better society for citizens, social problems and the distress following in their wake, would be all the more difficult to address.

The Green Paper identifies and discusses a number of key issues which should be taken into account in the development of a policy covering the relationship between the State and the voluntary sector. These include - clarifying the responsibilities of different Departments in relation to the sector; examining the effectiveness of existing programmes and support structures; establishing formal consultative mechanisms involving the sector within Government Departments; introducing Customer Charters in relation to specific social services; providing training for the statutory sector; and the need for sensitive management of the integration of local government and local area-based partnerships. It also considers the possibility of setting up independent Community Trusts, issues relating to charitable status and support of volunteering.

Community Trusts or Foundations play an important role in resourcing the voluntary sector in other countries. Essentially the concept is of an independent foundation which raises donations from the private sector and also from Government. Government funds can be significant initially as seed money in allowing a trust to become established and build up a stream of private sector donations. The objective is to build up a sufficient capital base to generate an income for disbursement to the community and voluntary sector. The application of the Community Trust concept to Ireland could open up the possibility of generating significant additional income from the private sector for community and voluntary groups, including those working with older people.

The Green Paper is intended to stimulate further debate and to facilitate further engagement between the statutory and voluntary sectors in relation to the issues involved. The debate to be facilitated by the Green Paper will help shape future Government policy in relation to the voluntary community sector. My Department will undertake a consultative process in relation to the issues discussed in the Green Paper over the winter months, with a view to moving to the publication of a White Paper by the middle of next year.
Conclusion

In concluding I would like to raise a few general concerns which I feel society should address in relation to older people, which do not necessarily fit into any one Department's or Agency's brief.

I feel that 'ageism' is a very real problem affecting Western societies particularly. It affects the way we feel about people, how we categorise them, how we relate in groups, and indeed as individuals. It affects not only how we shape State policies but also our advertising industry, the way we conduct our social life, indeed all aspects of life in modern, so-called 'civilised' societies. There is very little civilised in my view about the way we personally relate to our older citizens many of whom lead lives of extreme loneliness, of a kind which has probably not been experienced by previous generations who are regarded by us as 'deprived' because they had less material prosperity.

The almost ‘epic’ nature of the phenomenon of loneliness among older people today deserves a very serious societal response. It calls for policies and behavioural changes affecting all areas of life, particularly areas affecting community and social supports, housing, employment, family policies and even policies affecting recreational and social life.

Gradually we should strive for a society which will pay less attention in a publicity sense to what are perceived as the disadvantages of ageing but will, on the contrary, cherish and indeed reward and encourage older citizens to fully participate in the activities which society at any given time regards as useful and worthy. These activities include not only employment and activities associated with family life but also social and leisure pursuits. Current obsessions with youth and physical perfection must be modified. We should also become obsessed in the same way with the wisdom and experience of older people, the stories they have to tell, the history they want to write, and the contribution to living which they still have to make. This requires a range of imaginative responses which regrettably we are only at the early stages of considering.
THIRD SESSION: THE WAY FORWARD

Do We Need a New Strategy for Quality in Health and Social Welfare Services for Older People?

Dr David Clinch
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The Review of the Implementation of The Years Ahead Report is most thorough and those who conducted the report are to be thanked. However it must be stated that many of us working with the ill and incapacitated elderly have serious reservations about some of the conclusions and emphasis in the Review.

Was The Years Ahead a good report?

From the Review presented this week there was a distinct impression given that while The Years Ahead was an honest attempt to develop Health and Welfare services in 1988, its time has passed. The Review concludes that it can no longer be an appropriate blueprint for health and welfare planning for the elderly in 1997.

Such an apparently major revision would concern many of us working at a clinical level. While recognising the need for updating and revision, it must be noted that key recommendations of The Years Ahead have been vindicated in practice in this and other countries. These recommendations are established as standard for any modern country that aims to keep its elderly well and living outside institutional care if at all possible.

In Irish terms, The Years Ahead was a breakthrough. For the first time at policy levels the old negative ‘workhouse’ attitude to illness in the elderly was discarded and a modern approach adopted. The previous negative approach was usually well intentioned. However, if you were old and unable to look after yourself you ended up very dependant on institutional care if you survived. There was little questioning of how the old person had ended up
incapacitated. It was felt there was little point in taking analysis any further. If they could still walk they were given food and if they became immobile bed care was the main treatment. Many inmates of the former workhouses lived as long as 20 or 30 years in institutional care before their death. This was the case up to quite recently.

In 1988 *The Years Ahead* formally grasped the modern positive and incisive approach to incapacity in older people. This had been started in the first half of the century by medical pioneers in Britain and elsewhere. The growing knowledge of difference in physiology and illness in old age developed into the speciality of Geriatric Medicine (Medicine for the Elderly). Instead of an institutional approach to any old person having or causing problems, there was a questioning analytical approach, Why was the old person not coping?, Why were they immobile?

Despite the expanding information on medical conditions in the elderly no new diseases have been discovered. However there are major differences in illness occurring in older patients.

**How are older people medically different?**

*Multiple Pathology*: Several diseases tend to occur at the one time

*Atypical presentation*: The same illness can present in the elderly very differently to the same condition in younger people

Though only two in number these broad differences can result in a need for a special approach to diagnosis and treatment. For example the exact same type of pneumonia which causes high temperature and chest pain in younger people, may have no such features in the older person. Instead they may become immobile or confused. Once established in the older person the pneumonia may cause further problems with a heart strain and cardiac failure resulting. Then treatment of the cardiac failure can result in gout. The overall pattern will be complex and needing a very different insight from the standard medical one.

Hence the need for the development of the specialised Geriatric Medicine (Medicine for the
Elderly) so strongly advocated in the original *Years Ahead* report. This medical approach is very rewarding for a patient in terms of shortening the illness as well as decreasing the cost to the health service. You start with unusual presentations of illness in the elderly. If you proceed to investigate, bit by bit, being careful not to over-use technology that would exhaust the patient and bankrupt your health service, you will be particularly effective. For example, if you find that the social crisis is because the older person cannot walk and the carers are becoming over-wrought, you wonder why? You analyse why the person can't walk instead of just putting the older person into a long-stay bed.

So you proceed towards specific diagnosis. Say, for instance, in the case we are discussing clinical examination suggests a pneumonia. A simple chest x-ray may tell you which antibiotic to use. If this approach is adopted in a specialised ward for the elderly (Assessment Unit) then it will be particularly effective. The staff will have no other priority than the elucidation of the older persons problems unlike a standard medical ward. In addition to nursing and medical expertise, there will be a practise of establishing close links with community services to find out the social background against which the illness has occurred. While there will be a tendency to minimise investigation in such experienced units, it is essential that these have access to full diagnostic facilities. The elderly with their lesser reserve cannot afford delay.

This approach was implemented in the nine years since *The Years Ahead* was published in several units throughout the country as well as in the pre-existing units in Cork and Dublin. Though often units were smaller than the 20 bedded minimum advised in the report, the actual results vindicated this positive approach to illness in the elderly. Needless to say this active approach to illness in the elderly of early diagnosis in treatment can also be carried out by family practitioner and nursing services in a home setting.

**If The Years Ahead approach was vindicated, why wasn't it implemented?**

In the Review valid excuses are offered for the failure to implement some of the recommendations. It can be accepted that the community service developments were
dependant on new resources being allocated. The same cannot be said for the failure to implement the key recommendations on specialist hospital services. The norms of provision failed to be implemented with depressing consistency in region after region. This did not need new resources to implement as outlined so clearly on page 123 of *The Years Ahead* ‘we recommend the reallocation of beds and facilities for assessment and rehabilitation of the elderly...facilities need not be additional to those existing in general hospitals’.

Anyone looking at international patterns of disease and hospital usage in modern society would have to agree with this recommendation. Patterns of illness in the elderly means that admission of younger people is now required far less often than in previous decades. There is a welcome emphasis on outpatient investigation and treatment. No modern society could be expected to allocate new resources for acute hospital beds for older patients in addition to the historical requirement for younger patients in previous years.

However, the reallocation advocated by *The Years Ahead* has not taken place to anything like the required degree. The fact that the elderly are now the chief users of medical and surgical services in our acute hospitals has apparently not impacted on a recognition at local level of the need for appropriate size of specialised facilities. Instead small units, often of token size, are the pattern. The appointment of new geriatricians is welcome. However, the failure to implement the hospital recommendations has meant they have not been able to fulfil their full service potential.

The norms of provision for hospital services to the elderly are now recognised and established internationally (2.5 acute hospital beds under care of a geriatrician and 3.0 rehabilitation beds). A recent 1997 document accepted internationally advised that these are minimum figures. For the National Council's 1997 Review not to emphasise such norms of provision as core facilities is worrying. These beds are the ones that older people need to guarantee so that they remain independent in the community if at all possible.

The need for acute rehabilitation hospital beds is a standard requirement no matter what country or county of Ireland you are in. Other provisions such as the balance between long-
stay and community care can be more a question of what suits the local situation. The concept of measurable health and social gain can be the watch-words when deciding.

The assessment and rehabilitation beds advocated for the elderly should link with the Community Services in a way that no other acute hospital beds do. It is indeed strange that because a good policy, now internationally vindicated, was not implemented in Ireland leads to a conclusion that *The Years Ahead* may have been wrong to be so prescriptive. Surely we should look to why correct policy was not implemented?

**Why was *The Years Ahead* not implemented even when there were no resources implications?**

From the perspective of somebody working at clinical level it seems that the cause may have been divided responsibility. This appears to have been at the level of implementation. Even when policy was correct and after due consultation, it failed to be implemented at local level. The divisions between Voluntary Hospitals and community services run by health boards may be a factor. Even in areas where the health board provides the full range of Acute Hospital and other services, national health policy on the elderly has to divide into two or three sections of the various programmes:

- acute hospitals
- special hospitals for the elderly
- community services

The impact of the policy is often weakened along the way as is the overview of how an initiative in one programme can help another. For example, in the question of the implementation of national policy in the Acute Hospital. In the decision-making progress there, the geriatrician may be the only one fully committed to the national policy for the elderly. All the other specialities will understandably be pursuing their own interest. Pressure for expenditure on high technology and the pharmaceutical industry will also be presente through their legitimate lobbies. Even the nurse manager or matron and hospital managers, though they may be sympathetic to the needs of the elderly, will tend not to be
totally guided by *The Years Ahead*. They will have to deal with all other specialties. In this setting the needs of the elderly will always tend to lose out. When set on a one-to-one basis up against the needs of other groups (children, surgery etc) there is no doubt who will win and that the elderly will lose out.

The contradiction of course is that the elderly are the chief users of the Acute Hospital. It is to the benefit of the hospital as a whole that the elderly should be dealt with sympathetically and discharged appropriately as soon as possible. Otherwise they will spill over on to other speciality areas. At present this need for an overview is often lost. Similarly the affects of acute hospital policy on community services will often tend to be ignored.

**Would the care group approach to implement health policy help?**

Certainly this would seem to mean particular consideration in view of the difficulties outlined above. However it would be important not to reproduce the same error of divisions within the care of the elderly that exist now. A recent announcement suggested the following care groups:

- Elderly
- Children
- Mental illness
- Acute and Episodic illness

While the approach is welcome it would seem to ignore the fact that the elderly form the chief group with acute and episodic illness which requires Acute Hospital admission. There does seem a danger of splitting continuing care and rehabilitation for the elderly away from the acute care of elderly people say in the surgical wards. The large numbers of elderly patients there may particularly need a specialised medical input or rehabilitation.

The great problem of the present split between the Acute Hospital Programme and Special Hospital Programmes would then be reproduced.
**Would introduction of a consumer approach help?**

The elderly certainly need an effective lobby on their behalf. This is not just for more resources but for the application of these resources in a way that is sympathetic to the requirements and sensitivities of older people. It is very welcome to see development of associations of older people advocating on their behalf as well as societies that help those with specific illness such as The Alzheimer’s Disease Society. However it is always likely that other groups in society will be able to carry more force in the quest for their specific needs and older people particularly when they are sick.

Most elderly people either live alone or with an elderly spouse. Dementia rates as high as 20% in the population over 70 have been reported. Even highly articulate older people when they become ill will lose this ability to fight their corner. In addition they will certainly be less likely to have articulate relatives around them at the time of the illness.

Although it may be changing at present, most of the elderly now come from a time when self advocacy/litigation and other forms of exerting pressure were unheard of. Thus health policy for the elderly must be specific in terms of requirements for the health and welfare of older people and undertake to monitor the implementation of these at local level. Whoever is suited by vague aspirations, it is not the elderly, particularly when they are ill or incapacitated.
Creating a Culture of Positive Ageing in Ireland: Priorities for the Future

Dr Margaret Mac Curtin
Dominican Sister and Historian

My mother's generation transformed the Irish Revolution 1916-1923 into the modern Irish state. Born in 1899 she was left a widow at the age of 56 having married an idealistic nationalist who entered public service in the 1920s and died in the middle of his work which was the education of Irish children at primary level. She was left with one year's salary to face widowhood at the age of 56. There was a hefty mortgage on a house as well as a determination to pay fees for the last two at university. Of course she went back to work and though it was part-time she worked until her early seventies. When she died in her ninety first year, the elderly had a range of benefits which were unimaginable thirty five years previously.

It has been one of the triumphs of the Irish State that despite, or perhaps because of fierce self-criticism, we have produced a state-based welfare system which is responsible, humanitarian, person-centred and draws on an unremembered tradition and philosophy of public philanthropy that goes back to the 18th century Irish parliament. Because in the last analysis as The Years Ahead report reiterates, and this conference has stressed, there has to be government commitment not only to community care but to identifying and following up health and other needs for those groups in society which demographic analysis exposes. Here this week we are taking part in a comprehensive review by the National Council on Ageing and Older People of an important report.

My contribution to this review is to suggest how we can create a culture of positive ageing in Ireland at a period when our demographic pattern is experiencing a growth in the elderly population and our culture, both at popular and elite levels, pays homage to youth. Youth is all about us, creating an illusion that we have a youth culture on this island but the predictions are that the baby boom which produces such unprecedented numbers of young people going to third level education, or being visibly unemployed, have levelled out. These statistics you
have looked at this week.

Thus I argue it is vital that we start creating a culture of positive ageing for a young generation who will be the legislators and taxpayers quite early on in the next century. We need to look at them more appraisingly and we need to put strategies in place to ensure that public service and the pursuit of politics are not reduced to pragmatic and self-serving agendas of different political parties and interest-groups in the beginning decades of the next century.

The beginnings of centuries are always times of high ardour and yet we find ourselves in a period of troubling transition because it is also a new millennium. If we fail this generation of young people now coming into adulthood and into their teens, then history will be unkind to us and older people in the next century will suffer from our neglect.

A community psychiatrist who works with young people remarked to me recently that young people in their twenties and under in the 1990s were what she called ‘self-relating’. By this she meant that they related everything to themselves; it is not the same as self-regarding. In some ways if it is a true generalisation it is more alarming because it means we are not giving our young people the skills of lateral thinking and I want to say something more about this and our post-primary education in a minute.

‘Self-relating’, this community psychiatrist explained, has to do with undue attention being focused on the wants (not the needs) of young people and this she linked to small family units and the decline in the extended families. Many of us in this hall grew up in large families with a retinue of uncles and aunts and grandparents. Our lives consisted of keeping eagle eyes on siblings about our notions of equal opportunities and we were expected to do our share of child-minding and granny-minding. Possibly it was rural-based, or there were summer holidays in the country and, let's face it, pocket-money and treats were valued and used wisely. Now we have the two or three child family and extended families are scattered, sometimes in different parts of the world. We also have the one-parent family with one child or more and the efforts to compensate for a normal family life.
The consequences of this developing situation for the older population are startling, even worrying. Our present system of education with its emphasis on points puts pressure on schools to over-scholasticise their out-of-class activities, visits to museums, art galleries, Paris, Rome, Stratford-on-Avon, and in the summer exchanges and the Gaeltacht: all admirable and behind the projects, self-sacrificing parents.

But there is a widening gap between young people and the issues that create community, both rural and city. How do you educate the young to be involved in looking after the less fortunate? Giving generously of money is a duty the late Ronald Knox, university chaplain to Oxford students, used remind to them of as he passed round the collection box for different charities. But isn't there more required?

In some countries community tasks are required of school children before they leave school. For example New York State requires pre-school leavers to be certified by their school that the students have done a term of community work in the previous years i.e. teaching literacy, visiting hospital or being a hospital ‘runner’, taking an older person shopping etc. A lot of religious orders, the Jesuits come to mind, used do this kind of education with their pupils and the much-maligned Legion of Mary did it at an early period for schools that certainly were not elitist. Now that religious no longer are present in schools and in a time where State Schools will be the norm, should we be looking at inserting community training schemes into the curriculum? Should we be evaluating the ‘transition year’ and demanding that it widens the experience of pupils to expose them to the needs of the elderly, the lonely, the incapacitated?

Finally, that works both ways. Are we also creating a culture of ‘self-relating’ elderly? In what new ways are we devising definitions of citizenship and providing models of citizenship where we too are building community, providing opportunities for the caring communities everyone longs for?

It is here that I believe ageing religious communities might be recruited. Religious orders
everywhere have had to reassess their identities and aims and all sorts of new models of community life have emerged worldwide. The monolithic institutions of the past are being replaced by local, community-based units. As microcosms they are oases in inner-city and suburban wildernesses and they are potentially a huge reservoir for bringing cheer and hospitality and a special kind of affirmation to the old and lonely. They also have a lived spiritual and prayer life and, in the values of religious life, old age is traditionally respected and even reverenced. It is seen as a ‘time of deeper transformation, spiritual growth, gentling, stripping away of masks and defences. and an awesome mystery’. What can we learn from each other? How can we exchange ideas, stories, insights?

My concluding remarks are from Paul Tournier, the renowned psychotherapist:

_The fact is that in order to make a success of old age, we must raise our culture level: and this must be done well before we are old. But that necessarily implies a value-judgement about culture, about the meaning of culture, and lastly about the meaning of our lives - a religious question, par excellence._