IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

# IMO Position Paper on
# Care of the Elderly

January 2006

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"Long term care shapes where people live, what they do, and the relationships transpiring within families and communities. How we choose to view long term care as a society therefore entails considering subjects as profound as the meaning of life. Long term care is intimate care, and how it is given, when it is given and by whom it is given shapes the biography of the long term care consumer and, by extension, the biography of family caregivers and the collective biography of the whole family."[1]

Dr. Rosalie Kane (American Gerontologist)

## Overview

TERMS AND DEFINITIONS

Discussion of care of the elderly requires some elaboration and definition of the terms of debate. At the most fundamental, how those classified as elderly are defined needs to be decided. Age & Opportunity and National Council on Ageing and Older People, in keeping with established convention, use the chronological age of sixty-five and over as their working definition. This is the age at which the state pays the Old Age Contributory Pension.

Applying this definition does not and should not presume to characterise all those over 65 years as a distinct homogeneous group. Age *per se* is very much a state of mind. Wide disparities exist in life experiences which reflect family, social and economic circumstances as well as each person's physical and mental health status. In framing any policy for older persons it is therefore essential to understand that those described as 'elderly' compose a group of individuals with needs, opinions and concerns similar to any other age group.

Particular care must be taken that the correct parameters are applied when evaluating the effectiveness of elderly care provision. While measures such as overall expenditure on elderly services and bed capacity, occupancy, and turnover by older persons, provide some indication of the resources which are available, they present only a partial picture.

Age & Opportunity, citing the work of the Gerontological Society of America, suggests that a much more comprehensive measure to evaluate care for the elderly is needed.[2] It employs the term 'social gain' which it believes is a term which encompasses 'quality of life'. It is an important concept which forms part of the Health Strategy and formed the basis of the work of the former Office for Health Gain.

HEALTH GAIN AND SOCIAL GAIN

'Health Gain' can be defined quite simply as 'improvements in health status or life expectancy of individuals or populations' which is the definition used by the Office for Health Gain. 'Social Gain' is altogether broader and includes all issues which affect quality of life including health status.

## Benchmark For Judging Policies

The IMO believes that the benchmark against which to judge care for the elderly must be both 'health gain' and the broader concept of 'social gain.' Elderly citizens are entitled to services from the health and social service sectors which are delivered in a fashion which respects their dignity and autonomy, which value the contributions which they have made to building a prosperous society and which reflect their own views and choices.

Doctors have a dual role delivering both health gain and social gain for the elderly. In their professional capacity they must provide prompt, quality and appropriate services to elderly patients. As trusted advisors to the elderly and their families they have duty to act as advocates for older patients both individually and collectively. Doctors are in a particularly powerful position to enhance the 'social gain' enjoyed by elderly citizens.

## Current Immediate Problems

**The Irish Medical Organisation feels compelled to publish this position paper because it believes that the following problems must be tackled immediately:**

- The effects of the A&E Service Crisis on the Elderly
- The inadequate provision of public nursing home beds
- The difficulties involved in relying on private nursing home beds
- The failure of the Health Service to respond to demographic shifts
- The poor co-ordination of primary, secondary and community services
- The correct use of Public - Private Initiatives to fund nursing home provision.

## A&E Service Crisis and the Elderly

Older Irish people are one of the groups most affected by the crisis in access to emergency services in the Irish health services. Not only do they represent about 40% of such admissions, but they present with complex care needs and are particularly ill-equipped for care in settings such as trolleys in corridors. The reduction in acute beds – removing almost 5,000 beds since the 1980's with a 15% growth in population since then - is one of the main factors in this crisis.

Successive governments have recognized the need to increase these bed numbers although the official response so far has been slow and inefficient. The IMO welcomes the emphasis on more efficient uses of existing facilities through innovations such as Acute Medical Admission Units. In 2004 *Comhairle na nOspidéal* published a report on the benefits of Acute Medical Units and their essential contribution as one component to ensuring high quality patient care.[3]

**The National Council for Aging and Older People has found that Health Service usage breaks down as follows:**[4]

- 50%+ of older people regularly attended their General Practitioner
- In 2001,
  - 12% had visited an A&E in the previous 12 months
  - 16% had scheduled inpatient appointments
  - 24% had scheduled outpatient appointments.
- In 2003 4.8% of older people were in Long Stay Care. Reasons for admission were:
  - Chronic Illness (33%)
  - Mental Infirmity (23.9%)
  - Physical Disability (12.3%)
  - Social Reasons (11%)
  - Other (19%)

This research clearly indicates that Health Service Usage by the elderly does not fit readily with the services offered at A&E.

## Deficit in Hospital Bed Provision

The A&E crisis, which as been highlighted by the IMO and other health professionals, has its roots in the drastic cuts in bed capacity made in the acute hospital sector in the 1980s. As the second table below shows the provision of beds for care of the elderly has declined dramatically in the years from 1968 to 2001. It is widely acknowledged that the failure to provide appropriate hospital care for the elderly is a significant cause of the A&E crisis. Table 1 below indicates the level of bed usage divided by age groups compared to the proportion of the relevant age group to the general population.

**Table 1.**[5]

| Age | 0-14 | 15-44 | 45-64 | 65+ |
|---|---|---|---|---|
| % of Inpatient bed days | 16 | 39 | 18 | 27 |
| % of general population | 22 | | | 11 |

Source: *Acute Hospital Capacity – A National Review*

## Public Provision Of Public Nursing Home Beds

**Table 2.** Provision of Public Beds for Care of the Elderly

| Category | Care of the Aged Report (1968) | 2001 |
|---|---|---|
| County Homes / Geriatric Units | 8,057 Beds | 8671 Beds |
| District Hospitals | 960 Beds | 0 Beds |
| Psychiatric Units (>65 years) | 4,577 Beds | 1,396[6] |
| Total Public beds for the Elderly | 13,594 Beds | 10,067 Beds |
| Irish Population (> 65 years)[7] | 323,007 | 432,001 |
| Public Beds for the Elderly per 1,000 population > 65 years. | 42 Beds per 1,000 | 23 Beds per 1,000 |

Source: *Dr. Christine O'Malley, Consultant Geriatric Physician*

Older people consistently state a preference to live their lives in their own homes. Should they develop a disability, they still wish to be supported at home. This is stated aim of government policy since 1993. However, for a significant minority of older people, about 5% of the total, care in the community is no longer possible despite family and state support. At this stage, nursing home care is required. The 5% figure distributed over all 65s conceals the fact that a much higher figure of older people will spend some time in nursing home care before they die. Even if improved community services should develop, evidence from Scandinavia suggests that this proportion will remain at this level or even increase.

If dignified and responsive care for the elderly policy is to be put in place, then the deficit in hospital beds for the elderly – acute, rehabilitation and long-term care beds – must be eliminated.

## PRIVATE NURSING HOME BEDS

Although private nursing homes can manage care for some older people, there is a clear need to provide a significant proportion of care in public nursing homes. Private nursing homes have no obligation to take all who present to them. Current subvention rates will not meet the cost of many nursing homes in Dublin (think how much full board you will get in a three-star hotel for €690 a week, without nursing and other costs included). Geographical location is another factor: relocation to what is a new home at some distance from friends and family is not appropriate. To plan the relatively sophisticated services which this most vulnerable population will require public oversight and input.

## CHANGING DEMOGRAPHY

The Health Service has neglected to match public nursing home care beds with the growth of the population in our large cities. In the 1980s, the bed complement per 1,000 older people in Dublin was only half that available in the rest of the country. This trend has been aggravated with the urbanization of Irish society. Between 1961 and 1996 the population of the Greater Dublin Area increased from 719,000 to 1,056,700 (47%). This has compounded the situation. A significant number of beds have been taken out of the system while only a small number of community units have been built. The collision of urban growth, reduction in existing bed stock, and a failure to develop services at an appropriate rate has caused great distress and suffering to many older Irish people and their families in the Greater Dublin Area. Cork, Galway and other growing urban centres exhibit symptoms of the same problems.

The failure to develop public nursing home services causes, to a significant, extent the current A&E crisis. If an illness such as a stroke, fractured hip or delirium finally undermines the persons ability to remain at home, the only route to extended care is through the general hospital. At any one time the number of people awaiting extended care in the Dublin hospitals greatly exceeds the number of those waiting on trolleys, and timely access to augmented community services, specific rehabilitation facilities, and increased numbers of public and private nursing home beds would ease the problem.

The presence of older people awaiting nursing home care in general hospital beds is a system failure. It is pejorative to use terms such as ‘bed-blockers’ for them. Not only have they not caused this situation, but they and their families have often made Herculean efforts to stay at home for many years.

## PUBLIC-PRIVATE INITIATIVES

The promise in 2002 (if realised) of a Public Private Initiative of 850 public nursing home beds in Dublin (450) and Cork (400) represents a beginning. To truly match need, policymakers must plan for a programme that recognises that up to half of all citizens may experience nursing home care during their lives, and that to plan for this in an organised way will yield great benefits. It will maximise general hospital use by freeing beds occupied by those awaiting long term care rather than increase the numbers of more expensive hospital beds. More importantly, it will begin to allow older people to enter nursing home care in a more organised and dignified manner than at present, without spending up to a year in a general hospital bed first.

## Health Service Executive National Service Plan 2005

**The HSE National Service Plan 2005 sets objectives for Services to Older People (>65 years).[8] The IMO endorses these objectives and the principle of:**

- Person-centred, needs-led services, which are responsive the user preferences and choices.
- Service delivery developed in accordance with a population health approach.
- Harmonised and equitable services delivered nationally with improved access to services.

## Primary Care

The General Practitioner has a key leadership role in the delivery of care to the elderly. As stated above 50%+ of older people visit their General Practitioner regularly. The Irish Association of Older People believes that General Practitioners are central to the delivery of health services to the elderly

**The IMO supports the strategy outlined in *Primary Care - A New Direction* (DOHC). The strategy outlines twenty action points which are required to implement the plan. Within these there are three which are of particular importance to older citizens:**

- **No. 4** Primary Care teams will be put in place to meet the health and social care needs for a specific population.
- **No. 10** There will be greater integration between primary and secondary care.
- **No. 19** Mechanisms for active community involvement in primary care teams will be established.

The IMO condemns the failure to implement the Primary Care Strategy which was devised with so much effort and goodwill. The IMO calls on the HSE to explain how it will now achieve the goals set out in that strategy for older citizens.

## Care in the Community

NURSING HOMES AND COMMUNITY AND REHABILITATION SERVICES

Looking forward, an accelerated programme of building and staffing public nursing homes is a key element of catching up on years of neglect. Better community and rehabilitation services are also vital, but they are complementary to, and will never eliminate the need for, an adequate range of public nursing home beds, appropriately resourced and geographically distributed to ensure equity.

COMMUNITY AND REHABILITATION SERVICES

The IMO believes that older citizens value their independence and preference to remain in their homes in the community. They have expressed repeatedly the desire to receive treatment in their homes and to live independently with the support of their families.[9] The increased provision of home-based multidisciplinary professional care, in collaboration with enhanced support from the voluntary services, will do much make this a reality.

**In its position statement *An Age Friendly Society* the National Council on Aging and Older People highlighted the following:**

- In 2003 87% of people questioned preferred to remain in their homes with family members taking care of all needs and health services providing respite care.
- The study stated that the most frequently used Community Services were:
  - Chiropody
  - Optical services
  - Dentistry
  - Public Health Nursing.

Those who need continuing therapy should receive domiciliary services including Physiotherapy, Occupational Therapy, Speech and Language therapy, and mental health.

Services must be delivered in partnership with the elderly, their families and carers and a range of statutory and non-statutory voluntary and community groups. The IMO agrees with the Federation of Active Retirement Associations that those over 65 should receive equal treatment in the delivery of health services.

General Practitioners and Public Health Doctors have a key role in the planning of community services. A co-ordinated development of integrated Primary Care Service and Community Health and Rehabilitation Services will be a cost effective and humane. It will deliver the appropriate services to the older citizen in the appropriate place, at the appropriate time.

## Mental Health Services

In the past few decades a shift has occurred in psychiatry which has seen the relationship of the doctor and patient change in emphasis from one led by the doctor to a more equal one in which patient demands are given more weight.

Ireland is poorly equipped to deal with the demands of this shift. Doctors see the deficits in the provision of services in Ireland, the lack of capital resources in hospital beds, out-patient clinics, numbers of psychiatrists and clinical psychologists.

The IMO demands that all psychiatric services for the elderly are genuinely community based and patient focussed.

Psychiatric services for the elderly should focus of treatment within the home and family contexts. Crises and breakdowns must be addressed with flexibility. The burden of social exclusion felt by older people will require more supportive networks.

There are twenty public old age psychiatry services, two private services (Highfield Hospital Group and St. Patrick's Hospital, both in Dublin). However, there are still large areas of the country with no specialised services. Existing services have significant resourcing deficits. Most services have populations in excess of the recommended norm of one consultant per 10,000 people over 65 and there are gaps in the provision of important members of the multidisciplinary teams.

There should be full resourcing of multidisciplinary teams addressing the shortage of professional groups within multidisciplinary teams such as Assistant Directors of Nursing, Community Mental Health Nurses, Occupational Therapists, Psychologists, Social Workers and administrative staff.

People over the age of 65 with longstanding psychiatric illnesses e.g. schizophrenia or recurrent mood disorders (graduates) are the responsibility of General Adult Psychiatric Services. General Adult Psychiatry Services should be adequately resourced to provide for this group of patients including the development of rehabilitation psychiatry teams where none exist and ring fenced access to psychiatric day centres, psychiatric hostels and other long stay psychiatric facilities.

The advent of pharmacological treatments for Alzheimer's / vascular dementia and Lewy Body Dementia in recent years is a much welcomed advance in the treatment of this vulnerable group. The use of these drugs requires specialist assessment, diagnosis, investigation and monitoring to ensure all those most likely to benefit are identified early and treated. It is recommended that memory clinics should be developed where they do not already exist and they should ideally be set up in conjunction with medicine for elderly services and, if possible, Neurology services.

## Conclusion

The IMO believes that services for the Elderly require the full attention of the Health Service Executive which must implement the principles outlined above in its National Service Plan. It is clear that the establishment of the HSE provides an excellent opportunity to improve the coverage and co-ordination of services for the Elderly. The IMO demands that the needs of the Elderly be given the priority and attention they deserve. We can predict with reasonable accuracy the level of demand for services and the types of services which the Elderly need. There can be no excuses for not serving the interests of fellow citizens who throughout their lives have contributed to building the economically successful society we enjoy today.

1. Rosalie Kane, 'Long Term Care and a Good Quality of Life: Bringing Them Closer Together,' *The Gerontologist*, No. 41, pp.293-304
2. *Home from Home? The Views of Residents on Social Gain and Quality of Life: A Study in Three Care Centres for Older People,* (Age & Opportunity, 2003) pp.39-43
3. Comhairle na n-Ospidéal, *Report on Acute Medical Units*, (October, 2004)
4. NCAOP, *An Age Friendly Society*, (Dublin, 2004)
5. *Acute Hospital Capacity - A National Review*, DOHC, Dublin 2002, Figure 4.7, p.46
6. 5th Psychiatric Census
7. 1996 Census and 2002 Census respectively
8. HSE National Service Plan 2005 pp.58-59
9. NCOAP