

HEALTHCARE FOR OLDER PEOPLE IN IRELAND

DESMOND O'NEILL, MD, FRCPI

Centre for Medical Gerontology, Trinity Centre for Health Sciences,
Adelaide and Meath Hospital, Dublin, Ireland



D. O'NEILL

Specialist medical and psychiatric services for older people have developed quite rapidly in Ireland, and geriatric medicine has become the largest medical specialty in hospital practice. This advance has not been accompanied by any significant transfer of funding, and there are deficiencies in the full complement of rehabilitation therapists available in both hospitals and community. Community and long-term care services are relatively under-developed; it may require legislative initiatives to prompt the improvement required in these areas.

Key words: Elderly, healthcare, Ireland

In pre-Christian Irish civilization, there was a strong tradition of supportive care for older people under a system of laws, known as the Brehon laws.¹ With colonization by the Normans in the 12th century, these laws fell into disuse, and care of older people was probably of the same non-specific nature as practised in the rest of Europe. There was little differentiation between the care for the indigent of all ages and older people, and during the great potato famines of the middle of the 18th century, a series of Work Houses were built. These became the basis for state-funded institutionalized care of older people until the latter part of the 20th century.²

The **Irish Gerontological Society** was founded in 1947. Helped by their pioneering work, the first consultant geriatrician, Dr. Michael Hyland, was appointed to Cork University Hospital in 1969. This was an important appointment, and Dr. Hyland was a key figure in the subsequent development of policy and services in Ireland.

A COUNTRY OF YOUNG PEOPLE?

Although Ireland is often regarded as a youthful nation, the proportion of older people in the population is 11.4% and is set to grow to 14.1% by the year 2011.³ Of the current population of older people, 21.9% are aged ≥ 80 years, and this will increase to 24.9% by the year 2011. As elsewhere in the world, there is a preponderance of

Dr. O'Neill is a member of the International Editorial Board of this Journal.

Correspondence to: Desmond O'Neill, MD, FRCPI, Centre for Medical Gerontology, Trinity Centre for Health Sciences, Adelaide and Meath Hospital, Dublin 24, Ireland. Tel: +353 1 414 3215; fax: +353 1 414 3244; e-mail: des.oneill@amhnc.ie; web-site: <http://indigo.ie/~arhc>

older females to males.

Irish men and women have the lowest life expectancy at age 65 of all countries in the European Union. The life expectancy of older Irish men has shown very little improvement over the last 40 years: it has only improved by 1.8 years in the period to 1994. The life expectancy of Irish women at 65 years improved by 4.1 years over the same period. Irish men at birth can expect to live for 73.2 years and Irish women for 78.7 years. The vast majority of older Irish people live in the community, with less than 5% residing in long-stay care institutions in 1995. A relatively low number of older people live alone in European terms, 25.8% as opposed to the European average of 40%; this increases to 29.7% for people aged ≥ 75 years.

HEALTH STATUS

A 1993 study of older people in the community found that the health of older Irish people was generally good.⁴ More than half (54%) of respondents reported no major illnesses, while 57% considered their health to be good or very good. As in many other countries, the level of disability rises with advancing age (Figure. 1). The incidence of physical disability increases significantly after 80 years. In a community survey in 1993, 46% of older people reported having at least one major illness, 12% had at least two conditions and almost 2% said they

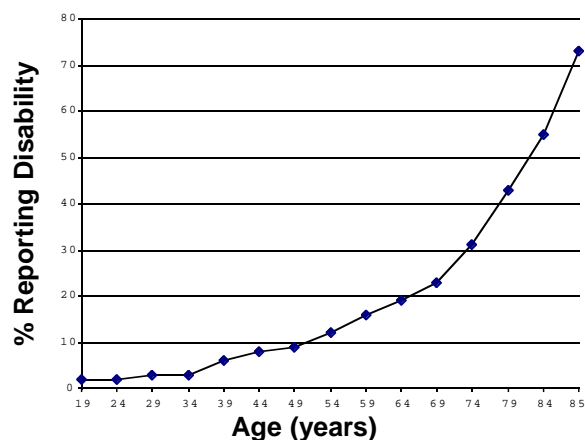


Figure 1. Age vs % disability.

HEALTHCARE FOR OLDER PEOPLE IN IRELAND

had three or more. There is also evidence from Irish epidemiological surveys that mental ill-health increases with later life.⁵ A community study of dementia suggested a prevalence rate of 5%,⁶ whereas an earlier study suggested a rate of cognitive impairment using a simple screening score of 16%.⁷ The true figure probably lies somewhere in between.

STRUCTURE OF THE HEALTH SERVICES

There is a mixed public and private healthcare system in Ireland. Approximately one-third of the population have access to universal primary medical and hospital care, including free medication. This is known as the *General Medical Scheme*. As this is means-tested, a large proportion of older people is covered by this scheme. The main disadvantage of this system is a relatively long waiting list for elective surgical procedures.

All other adults are entitled to virtually free access to all public hospital services (a maximum annual payment of IR£250 must be paid), and will have all medication costs over IR£32 a month reimbursed by the state. All healthcare expenses are allowable against income tax. **A third of the population subscribe to private healthcare insurance,** at present with only two companies, as Ireland insists on a community-rating basis (i.e., no adverse loading for increased age). This insurance is predominantly directed towards elective hospital care, and there is very little allowance for the specialist demands of geriatric medicine. *No private hospital has a department of geriatric medicine.*

There is a strong emphasis on primary care, and access to specialist care can only occur after referral from a family doctor. Older people are relatively heavy users of certain health services; almost half (48%) had a seen a doctor in the last 4 weeks and only 11% had not seen a doctor within the previous year.⁴ Other studies showed that three-quarters of those aged >75 are on medication and adverse drug reactions are not uncommon among this age group.⁸ Older people also have high levels of hospital use in which they are rivalled only by infants under 1 year. With developments in hospital care, the average length-of-stay for people ≥65 years fell from 15.3 to 10.5 days between 1985 and 1996.⁹ The provision of health services is devolved to eight Health Boards in Ireland. The main disadvantage has been different interpretations of obligations to provide elements of healthcare to older people.

SPECIFIC HEALTHCARE POLICIES FOR OLDER PEOPLE

There are 3 main sources for the development of specific healthcare policies for older people in Ireland. These

are: 1) a government report *The Years Ahead – A Policy for the Elderly*; 2) a strong core of geriatric medicine; and 3) a national advisory body, the National Council on Ageing and Older People.

The *Years Ahead*¹⁰ is the report of a working group appointed by the Minister for Health in September, 1986 to develop a blueprint for services for the elderly with the following goals:

1) to enable the elderly person to live at home where possible at an optimal level of health and independence;

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

This was a very extensive working party, with input from many disciplines and healthcare administrators. The policy decisions were divided as follows:

- 1) A comprehensive and co-ordinated service
- 2) Maintaining health including health promotion
- 3) Housing
- 4) Care at home
- 5) Care in the community
- 6) Care in general hospitals
- 7) Care in community hospitals
- 8) Care of the elderly and mentally-ill and infirm
- 9) Partnership between carers, volunteers and statutory agencies
- 10) Implementing the report

The report has been influential in shaping services for older people. However, a review of its effect after 8 years indicated that almost no extra spending had been directed to older people.¹¹ This is in stark contrast to child-care services, which expanded greatly following specific legislation in 1991. It is the opinion of the National Council on Ageing and Older People (and of many geriatricians) that specific legislation will be required to prompt the development of appropriate levels of services for older people (similar to the Older Americans Act).¹²

GERIATRIC MEDICINE

In terms of developing a specialist core of expertise in dealing with older people, the *Years Ahead* emphasized the development of geriatric medicine in general hospitals. It recommended that there should be one Geriatrician for a population of 80,000. This has been found to be insufficient, and in subsequent policy revision *Shaping a Healthier Future*, it became Government policy that each general hospital should have a department of geriatric medicine.⁹ It was recommended that there should be 2.5 acute assessment beds and 3 rehabilitation beds per 1,000 elderly persons. A subse-

HEALTHCARE FOR OLDER PEOPLE IN IRELAND

quent review recommended that these should be sited where possible in the general hospital site and that there should be a re-allocation of beds and facilities in general hospitals towards departments of geriatric medicine.¹¹

It was also stated that each of these departments should be adequately equipped in terms of the multi-disciplinary team and ideally should have a Day Hospital as well. The support of the Government in this matter has been constructive in developing both the discipline and philosophies of geriatric medicine. *There are now 35 geriatricians in place throughout the Republic of Ireland in general hospitals.*

Two main models of care have developed. The first is of a parallel age-related service in the large teaching hospitals in Dublin and Cork. In this system, the physicians in geriatric medicine accept patients from the Accident & Emergency service over a certain age, usually 70, until their beds are full. This is combined with a smaller proportion of patients who are transferred for rehabilitation from other services and an even smaller proportion who are admitted directly from the community.

In the other hospitals where there are often only three specialists in internal medicine (one of whom is the geriatrician), a more integrated system within internal medicine has developed. The physician in geriatric medicine does general medical take for all ages and also has some local arrangement with his/her colleagues as how to develop the specialist care elements of geriatric medicine. The main problem is that the demands of the general medical service may be such as to severely circumscribe the physician's ability to practice geriatric medicine. There has also been reluctance on the part of some healthcare administrations to provide the multi-disciplinary team: this further hampers attempts to ensure adequate multi-disciplinary geriatric medical care.

Geriatric medicine is now the largest medical speciality in the Republic of Ireland and has been successful in attracting trainees of a high calibre. An important policy decision was made quite early in the development of specialist services for older people. This was that jobs would not be advertised until there were candidates suitably trained to take them on. This has proved to be a useful policy. The Irish geriatricians have formed themselves into a representative body in 1975, the **Irish Society of Physicians in Geriatric Medicine**. It meets regularly with the Department of Health and tries to ensure that the principles of geriatric medicine are incorporated into healthcare initiatives. The scientific body associated with ageing is the Irish Gerontological Society, which is one of the oldest gerontological societies in Europe and which has an interdisciplinary membership and a strong health-

care orientation.

Psychiatry of Old Age has developed relatively recently as a speciality, and there are four posts in the Dublin area. It is unstated Government policy to appoint psychiatrists in old age in each health-board area with hospital facilities based in the general hospital (including the Day Hospital) but with strong community links.

NATIONAL COUNCIL ON AGEING AND OLDER PEOPLE

A vital catalyst in the development of national strategies on ageing has been the National Council on Ageing and Older People, which was originally founded as the National Council for the Aged in June 1981. Set up as an advisory body to the Irish Department of Health, this council has worked in essence as a centre for social and medical gerontology. It has published over 50 reports on various aspects of ageing in Ireland, including health, mental disease, disability, the law and older people. These are excellent source books and have provided useful material in terms of developing a positive, constructive and health-promoting approach to healthcare of older people.

COMMUNITY CARE SERVICES

Community care services, although developing rapidly, have been underdeveloped in Ireland. Roughly 18% of all older people receive some form of ongoing informal care at home. In the *Years Ahead*, it was suggested that in each Health-Board should be a Co-ordinator for Services for the Elderly. The precise role and responsibilities of this post have not been clearly identified, and there is little evidence of positive or negative impact on the service. The cornerstone of community care services is the public health nurse system and family doctors supported by home help services. A relatively small number of older Irish people avail themselves of home helps: in 1993 only 3.5% of the Irish older population availed of this service compared to 14% in Northern Ireland and 19% in Sweden.¹¹ There are various models of organization of this service, which leads to considerable frustration among carers in terms of adequacy and access. Nurse/older person ratios vary significantly; the best ratio occurs in the Midland Health Board region (1 to 1,946), and the worst ratio occurs in the Southern region (1 to 3,334).

Community therapists are in general limited to physiotherapists and occupational therapists, with almost no access in the community to speech therapy, clinical nutrition and social work for older people and their carers. Waiting lists can be long

HEALTHCARE FOR OLDER PEOPLE IN IRELAND

for community physiotherapy and occupational therapy. One health-board has developed units with a more rapid response time, the *District Care Unit*, but the average delay is still 11.5 working days from referral to commencement of physiotherapy and occupational therapy.¹³

A minor but important role is played by Day Centres. There are approximately 212 Day Centres which provide social, nutritional and community support for older people but not health-based interventions. Meal services are available and delivered to peoples houses, provided by voluntary organizations with subventions from the regional health-boards. About 1.8% of the Irish older population receive domiciliary meal services, described as '*Meals on Wheels*'.¹¹

LONG-STAY CARE

Long-stay care is divided between state-funded and private nursing homes, with a small but significant sector provided by the voluntary sector (religious orders and charities), as illustrated in Table 1.

There is widespread perception that care in the voluntary sector is of a very high standard, and is the first preference for patients and carers. Specialist care in long-term care units has not been well developed within Ireland and is the subject of some concern among those involved with specialist care of older people. The particular concern is that they represent a repository of significant illness and disability and require specific specialist input. Many units do not have therapist input, and this is a serious deficiency.

EDUCATION AND RESEARCH

There has been considerable development in teaching various disciplines at both undergraduate and postgraduate levels in care of older people. Geriatricians have been to the fore in the development of specialist services for stroke and dementia. The first Memory Clinic opened in St James's Hospital in 1989,¹⁵ and the first acute stroke service was started in the Meath Hospital in 1996.¹⁶

Trinity College Dublin has taken a lead in promoting academic gerontology and has the first academic department of medical gerontology (Chair, Professor Davis Coakley) and the first Chair in Psychiatry of Old Age (Professor Brian Lawlor). There is an undergraduate course with tutorials to junior medical students and a lecture and tutorial system for senior medical students. Many of the pre-registration house

Table 1. Percentage of older people in long-stay care by type¹⁴

Statutory	57%
Private nursing homes	28%
Voluntary	15%

physicians will rotate through geriatric medical services, and geriatric medical posts are present on internal medicine and family practice residency schemes.

Trinity College also offers Diploma and Masters' courses in **Gerontological Nursing**, and has established a first module in social gerontology. Academic developments are underway also in Cork and Galway, and the University of Limerick has appointed a geriatrician as the Professor of Medical Science in their Postgraduate Medical School.

The Royal College of Physicians in Ireland and the Irish Society of Physicians in Geriatric Medicine confer a postgraduate diploma, the **Diploma in Medicine for the Elderly**. This is *directed towards family doctors* who wish to take specialist interest in older people, particularly those who may be appointed as medical officers for private or state-funded nursing homes.

REFERENCES

1. Robins J. Fools and Mad. Institute of Public Administration, Dublin, 1986.
2. Coakley D. The Irish School of Medicine. Town House, Dublin 1988.
3. Fahey T. Health service implications of population ageing in Ireland. National Council for the Elderly, Dublin 1995.
4. Fahey T, Murray P. Health and autonomy among the over-65s in Ireland. National Council for the Elderly, Dublin 1993.
5. Keogh F, Roche A. Mental disorders in older Irish people: incidence, prevalence and treatment. National Council for the Elderly, Dublin 1996.
6. Lawlor B, Radic A, Bruce I et al. Prevalence of mental illness in the community dwelling elderly in Dublin using AGE-CAT. *Irish J Psychol Med* 1994; 11:157-60.
7. O'Neill D, Condren L, O'Kelly F et al. Cognitive impairment in the elderly. *Irish Med J* 1988; 81: 11-3.
8. Nolan B. The utilization and financing of health services in Ireland. Economic and Social Research Institute, Dublin 1988.
9. Department of Health. Shaping a healthier future: a strategy for effective healthcare in the 1990's. Stationary Office, Dublin 1994.
10. Working Party on Services for the Elderly. The Years Ahead – A Policy for the Elderly. Stationary Office, Dublin 1988.
11. Ruddle H, Donoghue F, Mulvihill R. The Years Ahead report: a review of the implementation of its recommendations. National Council on Ageing and Older People, Dublin 1997.
12. Coakley D. No Room for Complacency – Services for the Elderly in Ireland. *Irish Med J* 1997; 90: 208.
13. Durkin J, O'Neill D. Rehabilitation, an audit of the hospital community interface. *Irish J Med Sci* 1997; 166: 17-20.
14. National Council on Ageing and Older People. Long-stay care. National Council on Ageing and Older People, Dublin 1997.
15. Swanwick GJ, Coen RF, O'Mahony D et al. A memory clinic for the assessment of mild dementia. Mercer's Institute for Research on Ageing, Dublin. *Irish ZMed J* 1996; 89: 104-5.
16. Collins DR, O'Neill D, McCormack P. Potential for treatment with thrombolysis in an Irish stroke unit. *Irish Med J* 1999; 92: 236-8.