

Ageism in Health Policy

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INTRODUCTION

In 1998, the Department of Health and Children, in collaboration with the National Council on Ageing and Older People, published a Health Promotion Strategy for Older People, *Adding Years to Life, Life to Years*. This Strategy views health as a positive concept, which can be promoted by attention to social and environmental factors, many of which lie beyond the health sector, in addition to the more traditional focus on illness and illness-related behaviours. It draws attention to the importance of attitudes to older people and to ageing in promoting the well-being of older people.

Negative attitudes to ageing and older people are commonly understood as ageism and widely agreed to be damaging insofar as they are hurtful at an individual level and hinder positive developments, for example in the context of healthy ageing at a societal level. The term ageism is attributed to Butler, an American psychiatrist, reputedly following his criticisms of residents opposing a housing project for elderly persons in their community, on the grounds of the provision of swimming, parking and air conditioning facilities being inappropriate for older people (Glendenning, 1997). Butler described ageism as the 'systematic stereotyping of and discrimination against people because they are old' (Butler, 1969). Scrutton's (1990) definition of ageism is similar: treating older people not as individuals but as a homogenous group which can be discriminated against. Likewise, Arber and Evandrou (1993) claim that the tendency to

see elderly people primarily in terms of their problems and welfare needs, and treat them as a distinct subgroup of the population with different needs and concerns from the rest of society is inherently ageist.

Fear of the ageing process and stigma are often included in discussions of ageism. The 'awesome dread and fear of growing older' is acknowledged as underpinning ageism and thus moves us to distance ourselves from older people who are a 'proxy portrait of our future selves' (Butler, 1996). Stigma has been defined as 'the shame or disgrace attached to something regarded as socially unacceptable', a facet of ageism that poses a substantial threat to the well-being of older people (Braithwaite, 2001). Stigmatising occurs when a person is perceived to have an attribute, which causes discomfiture or distaste, and the perceiver therefore wishes to dissociate from the bearer and perhaps remove the bearer of the attribute from sight. Many aspects of the physical ageing process, for example wrinkles, sagging skin, arthritic knuckles, or loss, forgetfulness and widowhood although not visible in the same way, can elicit stigmatising responses (ibid). Stigmatising results in the exclusion of older people from many activities and aspects of mainstream society. Examples include: poor representation of older people on TV programmes (unless to promote products that reduce ageing); the organising (by others) of activities in the community that segregate or are solely for older people as opposed to inclusion with regular community activities, and the 'removal' of older people into residential care. As such, stigma and stigmatising are clearly intrinsic to an understanding of ageism.

Butler reminds us that our concept of ageism must also include institutional practices and policies, since people who formulate public policy may well hold such attitudes. These, 'often without malice, perpetuate stereotypic beliefs about the elderly, reduce their opportunities for a satisfactory life and undermine their personal dignity'. Therefore, stereotypical attitudes and beliefs held by individual members of the community and institutional practices are related and mutually reinforce one another (Butler, 1980). Braithwaite (2001), in a similar vein, points out that ageist attitudes at a micro level, if unchecked, become organised into a coherent set of cognitions and practices which limit opportunities

and freedom, and ultimately frame policy design.

Evidence of ageist attitudes in varying degrees at the micro level abound. Studies of ageist attitudes have been conducted on small specific populations (e.g. school students, university students, health professionals). However, few studies have undertaken the task of exploring ageism in policy.

This paper explores the extent to which health policy in Ireland can be said to be ageist. Following the identification of key pieces of legislation and related policy and strategy documents, the documents were reviewed, using the definitions and descriptions of ageism (e.g. Butler, 1969; Scrutton, 1990; Arber and Evandrou, 1993; Braithwaite, 2001) as a framework for analysis.

KEY HEALTH POLICY DEVELOPMENTS

Irish Poor Law

A House of Industry Act in 1703, and the Poor Law Act of 1838, resulted in the provision of 130 workhouses, intended to house the old and infirm, the poor and destitute (O'Loughlin, 1999). Workhouse relief, inferior to the worst working wage, was designed to discourage those who might become a burden on society. A Poor Relief Act in 1862 allowed for the employment of qualified nurses in workhouses and infirmaries. Despite this, the now legendary appalling and inhumane conditions in the workhouses persisted, and the shame and stigma of being sent there cut a deep channel in our cultural consciousness. In Ireland, it was not only hated as a result of its institutionalisation of poverty but because it was the policy of an alien authority, imposed on the Irish people (Barrington, 1987). Poor Law Reform Commissions (1903, 1909) recommended that older people be placed in separate accommodation (O'Loughlin, 1999). However, in 1921, 127 workhouses remained. The first Dáil Éireann (1918) committed to dismantling the Poor law system, closed many workhouses and re-titled those that remained County Homes (Coakley, 1997; O'Loughlin, 1999). Recommendations for essential living conditions and care standards were made in 1927, although it was not until 1951 that grants were approved to reconstruct county homes (Coakley, 1997).

1968 'Care of the Aged' Report

In 1965 an inter-departmental committee was appointed to explore the necessary development of services for older people. The development was widely agreed to be a landmark report, signaling a shift in policy terms from institutional provision to community provision. The report clearly articulated a policy to enable older people to live in the community either in their own homes or in appropriately similar community-based accommodation and only be transferred to hospital accommodation when community residences were not available. The planning, co-ordination and the integration of housing services, improvements in income maintenance, and the expansion of health and social care services to include domiciliary nursing, medical care, ophthalmic, dental and social work services, home helps, meals-on-wheels and home visiting were all advocated (O'Loughlin, 1999). A systematic system of assessment based on medical needs for entry to institutions was advocated, along with the development of day hospitals in the community (Coakley, 1997).

1970 Health Act

The 1970 Health Act facilitated the development of community-based care with the creation of a programme to complement the acute and special hospital programmes. The programme greatly extended and gave access, at least in principle, to the range of professional services and supports to people in their own community (Gilligan, 1991). Health service access was further increased with the development of the General Medical Service, facilitating the likelihood of home visiting on the part of the GP. The Health Act empowered (but did not legally oblige) health boards to provide a home help service.

1988 The Years Ahead – A Policy for the Elderly

In 1986 a Working Party on Services for the Elderly was appointed, which reported in 1988. The over-arching aim was to enable older people to live in dignity and independence in the community where this is possible and to ensure adequate and appropriate care in an environment close to their home when it is not, and in this it does not deviate dramatically from the 1968 report. It highlights the need for a range of services, and while

housing is included, the focus is primarily on health services. National, regional and local co-ordination structures are detailed and recommended, including the appointment of regional Coordinators of Services for Older People.

1990 The Nursing Homes Act

This act introduced expanded regulation of private and voluntary homes and of subvention arrangements. The provision for inspection focused on basic criteria and did not include any substantial quality of life component. The Act originally contained provisions which allowed for the means of family members to be assessed for consideration in relation to subvention and thus a contribution to the costs of care. Controversial from the outset, these have now been rescinded (O'Loughlin, 1999).

1994 Shaping a Healthier Future

This general health strategy reiterated the objective to facilitate community living through appropriate support services, setting appropriate 4-year targets e.g. 'ensuring that not less than 90 per cent of those over 75 years of age continue to live at home' (Department of Health, 1994).

1997 A Plan for Women's Health

In a section entitled 'Women with Special Needs', this document emphasises the need for more nursing care places, and the promotion of high standards of care for 'dependent elderly'. The document focuses on lifestyle change and disease prevention, but also contains sections on mental health and domestic violence.

1998: Adding Life to Years and Years to Life. A Health Promotion Strategy for Older People

This paper draws attention to social and lifestyle as well as physical factors in influencing health, and draws attention to both physical and mental health. The strategy uses the Ottawa Charter framework¹ for promoting health, setting goals and targets in

¹Promoting health through a range of actions, to include: healthy public policy, strengthening community action, personal skills, creating supportive environments and re-orienting the health service.

relation to specific diseases and conditions, changing lifestyle behaviours such as smoking and exercise, and the social and physical environment, for example housing matters, income, transport and attitudes to older people.

2000 National Health Promotion Strategy

This document contains strategic objectives for enhancing quality and quantity of life for older people. Emphasis is placed on reducing smoking and increasing exercise rates in older people.

AGEISM IN HEALTH POLICY

The stigma of old age – long-stay care

The practice of removing older people from mainstream society into residential care on the basis of their oldness and frailty is clearly a stigmatising practice. Older people's low level of preferences for long-term care certainly reflect the fact that long-stay residential care is the least acceptable of a range of options (Garavan, Winder and McGee, 2001). In the early part of the twentieth century in this country, the main form of service provision was institutional, in the form of county homes. The county homes provided only the most basic level of care and most of those admitted remained there, in deteriorating health, until they died (Working Party on Services for the Elderly, 1988). Not only was this institutional care stigmatising in itself but use of the former workhouses as county homes further reinforced the stigma.

In Ireland, policy directives since 1965 have clearly been to reduce the tendency to institutional provision. At that time, much of the atmosphere of the old institutions had survived and provision was still very basic, with a tendency to promote dependence rather than independence and without activities or programmes to enable residents maintain links with their community (O'Connor and Walsh, 1986). The number of beds in welfare (state) homes is well below the norm recommended in *The Years Ahead*, and the slack has not been taken up by alternative supports for community living but by an increase in provision in the private sector (Larraghy, 1992; Ruddle et al, 1997), indicating that the stigmatising aspect

has not necessarily been reduced, simply transferred to the private sector. The continued bias in funding toward residential care is clearly perceived by individuals and organisations representing and working with older people (O'Shea 2003).

While long-stay care will always, of necessity, be one element of service provision, ideally it should be based on thorough medical and social assessment. Further, the transition should be managed with respect, consultation and inclusion (Braithwaite, 2001). Braithwaite reminds us that transitions are constantly the concern of policy makers and, all too frequently, they present socially awkward situations in which stigmatising behaviour creeps in. While as a society and as individuals we may wish to minimise the distress of having an older family member or friend move to residential care, the stigma of loss of faculties, mobility, or self-care skills leads us to handle such situations badly. Policy, or more particularly its lack of implementation in Ireland, can be seen to be more likely to be approaching the transition to long-stay care situations disrespectfully, rather than respectfully, from the limited evidence we have.

Both the *Care of the Aged* Report (1968) and the *The Years Ahead* Report (1988) recommended the development of specialist geriatric assessments. However, these recommendations for thorough assessment prior to possible admission to long-stay care have not been fully implemented. Ruddle et al (1997) find, in their review of the implementation of the *The Years Ahead*, that there is still considerable scope for the improvement of assessment at community level. Qualitative evidence from older people resident in long stay care about the transition into that care is limited. O'Neill (1995) outlines for example how failure to inform her of the complexities of and prognosis for her mother's condition led to considerable stress and difficulty for all parties, when having her placed. Evidence from small scale studies suggests that while most older people reported being content to go into care, few feel they had a choice in the decision or in relation to which care facility. Adjustment to life in a nursing home can be very traumatic, and for many long-stay is a dis-empowering experience (O'Connor and Walsh, 1986; Southern Health Board, 1999; Evans et al, 2000).

The stigma of old age – policy non-implementation

It can be argued that the stigmatising process includes putting bearers of the stigmatising attribute out of mind, as opposed to out of sight. By extension, the failure to implement many health policy directives in respect of service provision for older people amounts to stigmatisation.

Implementation is a complex part of the policy process and does not follow a linear, logical sequence (Walt, 1994). Those who formulate policy are not always those who implement it, and implementers are subject to a variety of interacting forces. The forces that intervene between the formulation of policy and the full or complete implementation of it include not only available resources, but the degree of change from status quo required, the amount of 'actors' required to fully implement policy, and the priorities or value base of the implementers. It is at this latter stage that stigma may creep into the process. Putting policy directives that improve the well-being of older persons aside and not implementing them saves us having to confront our own discomfort with the ageing process and the inevitability of old age.

There is ample evidence that policy directives to improve life for older people in Ireland have suffered in this way. The recommendations of *Care of the Aged* (1968) were never fully implemented. While laudable in its aspiration to enable older people to live in the community through provision of a range of social and community supports and services, this hope was clearly not realised when the Working Party on Services for the Elderly was appointed in 1986. While this may have been in part due to the more general failure of the community care programme to live up to its aspirations, specific aspects of service provision such as assessment and rehabilitation for older people were never put in place, leading to a bias toward provision at the institutional end of the care spectrum (O'Loughlin, 1999). It was on this basis that *The Years Ahead* (1988) laid out further detailed recommendations for the development and extension of services, co-ordination and integration of these services and health promotion for older people.

However, it is widely acknowledged that the main aims of *The Years Ahead* remain largely aspirational, and many of its

recommendations have also not been implemented (Blackwell et al, 1992; O'Shea, 1993; Lundstrom and McKeown, 1994; Edmonson, 1997). In order to systematically address this question, in 1997 the National Council for Ageing and Older People commissioned a review of the implementation of *The Years Ahead*. The report concludes emphatically that significant gaps in service provision remain in the spectrum of care options available to older people. Critically, gaps mean that in addition to older people not getting the support they require when they need it, older people may be moved along the spectrum of care options too quickly and admitted to residential care when community based support would have been appropriate (Ruddle et al, 1997). Failure to properly implement policy in this way is not only stigmatising, but is likely to reinforce stereotypes of infirmity and dependence.

The obstacles identified by Ruddle et al in the implementation of *The Years Ahead* were lack of funding and ambivalence of management, both at health board and government level, about the value and effectiveness of certain services. Given that the period following the publication of *The Years Ahead* was widely agreed to be one the strongest economically this country has seen in many decades, and thus that funding was substantially available to develop comprehensive community services for older people, it can only be concluded that health services for older people were not a priority for successive governments. A frequent criticism of *The Years Ahead* is the lack of legislative basis for service provision, despite previous recommendations in the case of the home help service for example.

Despite the publication of *Shaping a Healthier Future* in 1994 and the additional funding dedicated to services for older people that was made available in 1997, *Quality and Fairness* still highlighted gaps in service provision in community support as well as acute and long-stay beds, and reported that 'current funding arrangements do not effectively support home care' (Department of Health and Children, 2001). It is interesting to note that a recent study which consulted with individuals and organisations that represent and work with older people reported a real sense of frustration in respect of the continued weakness of community care across the county (O'Shea, 2003).

VOLUNTARISM

The theme of voluntarism runs through most health policy pertaining to older people. In the *Care of the Aged* report, voluntary work was advocated as a means of complementing statutory provision, a theme which was taken up again in the *The Years Ahead* which saw families and voluntary organisations as partners with the statutory providers (O'Loughlin, 1999). *Quality and Fairness* re-iterates the commitment to volunteering, through the funding of community groups to provide services such as 'shopping, visiting and transport' for older people, through the facilitation of networks between informal carers, and the fostering of programmes to support voluntarism in the community (Department of Health and Children, 2001).

A frequently articulated rationale for supporting and promoting voluntary activity is that voluntarism promotes social cohesion and integration – the much vaunted 'social capital'. The model of voluntarism that underpins the home help service for example, is based on 'good neighbourliness' (Lundstrum and McKeown, 1994). Voluntary activity is seen to provide a type of social contact that is qualitatively different – is superior – to that provided by paid workers (even if these workers would be well trained, paid accordingly, and organised professionally). This remains an untested assumption. Conversely, many commentators caution that volunteers and indeed many 'basic-grade' health service providers are untrained, and the services they provide are unsupervised and unmonitored. While few would dispute the fact that good neighbourliness is a good thing, it is quite another thing to argue that it should be a substitute for health or social care. Relying on 'good neighbours' to supplement or provide much needed community support for older people does not recognise that not all those in need may 'secure' the services of neighbours. Local and family tensions may impede support, issues of land ownership and inheritance may preclude any reliable assessment of need or organisation of voluntary support and, most particularly, no matter how well intentioned the volunteers or basic level workers such as home helps are, most are not trained and may therefore not be adequately equipped to provide appropriate care. Further, the complexities and sensitivities

around the delivery of personal care to friends and neighbours are not addressed. There is evidence that even within families, personal care can present difficulties. Boundaries, taboos and inhibitions are very real in family care. For example, it cannot be assumed that marital intimacy extends into the domain of personal care (Twigg and Atkin, 1994). Older people themselves almost unanimously support the need for training for those who work with older people in the community, either paid or unpaid, on the grounds that it would improve quality of care (O'Donovan, Hodgins, McKenna and Kelleher, 1997).

Recommendations regarding the development of standards of care, appropriate training for workers, either voluntary or paid, and monitoring arrangements have been made repeatedly for twenty-five years (e.g. Working Party on Services for the Elderly, 1988; Lundstrom and McKeown, 1994; O'Donovan et al, 1997; Hodgins and Kelleher, 1998), yet little has been done at a national level to ensure that a coherent, standardised, training and monitoring programme exists for workers such as home helps or personal care assistants.

In addition to the 'social capital' rationale for voluntarism, economy is never far from the minds of policy makers. Voluntarism is described in the *Care of the Aged* report as representing considerable savings in public expenditure (O'Loughlin, 1999) and in *The Years Ahead* as being cost effective. The 'professional' model of service provision has been resisted by some health boards on the grounds that it might lead to an escalation of costs through demands for higher wages (O'Donovan et al, 1997). The suggestion that cost-effectiveness takes precedence over quality of care is ageist in the extreme.

FOCUS ON THE AGEING PROCESS

Health policy pertaining to older people has an almost exclusive focus on the ageing process. Ageing is clearly seen as a condition, in fact in the eyes of many a pathological condition, which strikes at sixty-five. Sometimes termed the medicalisation of ageing, this static view of ageing underpins all health policy documents, bringing with it an array of related constructions and ideas, many of which, drawing on Butler's definition of institutional ageing,

perpetuate stereotypic beliefs about older people, reducing their opportunities for a satisfactory life and undermining their personal dignity. Both *The Years Ahead* and *Adding Years to Life and Life to Years* preface their recommendations with detailed analysis of mortality and morbidity in old age. The National Health Promotion Strategy (2000) primarily emphasises increasing longevity in old age, while *Quality and Fairness* opens its discussion of services for older people with the statement 'older people often experience a poor level of health, accompanied by pain, discomfort, anxiety and depression' (Department of Health and Children, 2001). Further, all documents focus almost exclusively on service provision; extending services, beds, treatments. This is not surprising, given Oliver's (1990) argument that since, as a society, we view able-bodiedness and able-mindedness as the norm, the natural loss of some physical prowess that comes with either ageing or disability deviates from the norm and is viewed negatively or as abnormal. People who 'suffer' from this tragedy are expected to be pitied, helped, and cared for. Such a view leads us to emphasise the deficits, inabilities, and limitations imposed by age, and thus to consider what services are required to help people adjust to their deficits and losses.

Of course a focus on ill-health and health service provision in health policy documents is not entirely inappropriate. Indeed, for many older people there is a clear perception that health services are inadequate and that better availability of necessary services should be a priority (O'Shea, 2003). That said, in most documents, (with the possible exception of *Adding Years to Life and Life to Years*) the emphasis on biological ageing is not counter balanced by any substantial discussion on broader issues which could promote the health of older people, such as housing issues, transport in rural communities and social inclusion. Consultation with older people, when mentioned, is very much about what services they see as necessary rather than what would promote their health, what way they would like to be involved in promoting their own health and what contribution they would like to make to policy development. Older people, and organisations that represent them, clearly articulate the need for an integrated holistic model of ageing, that transcends current preoccupations

with health care needs and bio-medical interpretations of well-being (O'Shea, 2003).

Focusing on the ageing process influences not only the perpetuation of stereotypical views of old age but can lead to social exclusion and discrimination. Johnson (1993) takes up this theme in a discussion on dependency, suggesting that we exclude and reject those we perceive as dependent, thus damaging self-esteem and engendering depression. He reminds us it is incorrect to assume old age inevitably brings physical decline, or that physical decline brings dependency. Few people are truly dependent or independent, but we are quick to describe a wheelchair user who cannot do his own washing as dependent, but not so the bank manager who cannot iron his own shirts (Johnson, 1993). The 1997 *Plan for Women's Health* is a particularly clear example of this, focusing almost entirely on nursing care for dependent elderly in its section on older women's health needs. Ageist culture and the exclusion and down-grading of older people and their contribution is seen by older people to be a serious problem that requires substantial attention (O'Shea, 2003).

The almost exclusive focus on the biological ageing process and the questionable assumption that old age leads to dependency, in health policy in Ireland to date, has permitted policy makers to view older people as a group to whom services are provided, to whom things are done, who can 'be consulted' – a less-than-able-bodied population, acquiescent and passive. None of the policy documents reviewed here articulate a vision of a society in which older people are a potentially politicised group, are employable, experienced, active, participants in society.

OLDER PEOPLE AS A SEPARATE AND HOMOGENOUS GROUP

Related to the focus in policy on biological ageing is the view that older people are a homogenous group. Skating over individual differences and assuming that people share certain personality characteristics and behaviours on the basis of their group membership is the core cognitive error at the heart of stereotyping. When we do this with 'older people', our thinking

can only be described as ageist, as exemplified by Scrutton's (1990) definition of ageism: 'treating older people not as individuals but as a homogenous group which can be discriminated against'. Braithwaite (2001) cautions that policy initiatives that fail to highlight the variability in characteristics, interests and capabilities of older people are inherently ageist. Older people are not a homogenous group. A span of thirty years or more separates those leaving paid employment and those in their mid-nineties.

Policy in Ireland to date has indeed largely viewed older people as a homogenous group (O'Shea, 1993; Ruddle et al, 1997). All documents mark out old age as commencing from age sixty-five and discuss the needs of older people henceforth as one group, with occasional exceptions for 'the frail elderly' when discussing highly supported environments and care. The focus on older people as one homogenous group, can lead us to view older people as 'others' (Edmonson, 1997), different and apart from the dominant in-group. Braithwaite points out that the cognitive processes that are associated with in-groups and out-groups come into play such that members of the dominant group, in this case those under sixty-five, can assure themselves that 'problems' associated with the out-group lie within it, and therefore social change will not be needed. This kind of thinking, she argues, perpetuates stereotypes and ageism (Braithwaite, 2001).

Further, by focusing on older people as a group in need of services, it follows then that older people as a group are pitted against other 'needy' groups, such as Travellers or at-risk-youth, for finite resources. Since this can only lead to governments prioritising one group's needs over others, ageist practice or indeed other types of stereotyping is inevitable, at least some of the time. The assumptions contained in *The Years Ahead* with regard to the re-deployment of resources from child care services, and the ensuing failure to do so, due to the emergence of significant information about inadequate service provision in the area of child protection, is a clear example of this eventuality².

²Based on the assumption that the absolute number of older people in the population was set to increase, and that accompanying reductions in the birthrate would mean savings in child care provision, specific recommendations were made for the extension as well as the co-ordination of services. The assumptions

Focusing on problems caused by ageing *per se* obscures other inequalities in society and the structures that create and perpetuate them. Oliver (1990) suggests that the 'personal tragedy' view of disability and ageing draws our attention away from the processes by which the structures and institutions of society disable and oppress. Addressing inequalities that link with ill-health in early life would be a radically different approach to health policy for all, not just older people. Differential access to financial and material resources, carried on the transition belts of gender and class inequality, is carried throughout one's life course, and in fact is more likely to influence a person's attitudes behaviours and expectations – and health – than age *per se*. There is now extensive international literature attesting to the robustness of the relationship between social class and health. Poor health, unhealthy lifestyle behaviours, perceived physical and mental well-being and premature mortality are all linked to position on the social class gradient. Yet, the focus in many policy documents (e.g. *Adding Years to Life, Life to Years, A Plan for Women's Health*, the National Health Promotion Strategy) is on lifestyle change in specific population groups, rather than addressing the broader inequity in society that underlies health inequalities generally and specific behaviour patterns. There are many now arguing that attention to income and resource inadequacies and promoting a fair society are more promising routes to promoting health throughout society (e.g. Lynch et al, 2000; Gwatkin, 2002).

PROBLEMATISING OF OLD AGE

The construing of age as a social problem often takes the form of emphasising the increase, absolute and relative, of older people in the population (Coleman et al, 1993). Edmonson (1997) points out that the practice of introducing any discussion of older people or ageing with an analysis of demographic trends should be viewed with caution as it, presumably unwittingly, suggests that older people are a threat by virtue of their numbers. Recent policy

about the re-deployment of resources proved incorrect as high profile cases exposing the failure of the state to provide adequate protection to vulnerable children led to the finalising of a long over-due Child Care Act in 1990.

documents have indeed made reference to the increase in the number of older people in the population. It has to be acknowledged however that, as policy is essentially about planning, policy makers would be negligent if they did not take due cognisance of the projected demographic trends. Yet, how this increase is viewed is relevant to any discussion of ageism.

The Years Ahead outlines projected demographic changes and suggests that there will be increased demand for health services and state pensions – hinting at a problematising view. However the document does state that the increase in the proportion of older people in the population is a positive and favourable development, meaning as it does that more people will live longer lives. *Quality and Fairness* refers only to the increased demand in services created by growth in the population over sixty-five years and *Adding Years to Life, Life to Years* also discusses increased numbers in the context of increases in service needs. Neither of the latter documents mentions the positive implications of an ageing population, for example the increased potential for drawing on the life experiences of those retired, the potential positive influence on young children of grandparents, or the boost to the economy from increased longevity at all ages. On balance, increased numbers are viewed as problem, rather than as an opportunity.

CONCLUSIONS

The past century has seen some radical changes to the way in which we provide for and promote the health of older people. We have moved from the highly pejorative practice of condemning people to pauperdom at the start of the last century to a system that contains a variety of community-based and acute services, and is increasingly encompassing a view of health that accommodates its wider determinants. Despite this, it is apparent that health policy is underpinned by substantial ageist thinking.

The existence of policy documents and directives that focus exclusively on older people, or select older people for special mention in generic policy, is inherently ageist. This approach to policy making flows from assumptions that older people are a separate 'other' and homogenous group. This is a clear example

of ageism, as defined by Scrutton (1990) – ‘treating older people not as individuals but as a homogenous group which can be discriminated against’.

It is also apparent that health policy is ageist in its strong focus on the biological ageing process. Assuming that ageing is ‘only’ a series of biological degenerations leads to the related assumption that old age leads inevitably to infirmity and also dependency. Further, older people are thus easily perceived as a passive group, to whom goods and services are provided, treatments are administered, things are done. Most particularly however, the focus on biological ageing leads to an almost exclusive focus in health policy on illness, disability and service provision. The vast majority of health policy documents outline the need for disease prevention, nursing care, the expansion of services generally, beds in particular and access to services. This tendency conforms to the definition of ageism offered by Arber and Evandrou (1993) – ‘the tendency to see elderly people primarily in terms of their problems and welfare needs, and treat them as a distinct subgroup of the population with different needs and concerns from the rest of society’.

However, although clearly ageist, many might overlook or tolerate this at least to some degree, if policy directives for service provision were in fact implemented. The basis of much service related policy has been to promote independent, dignified community-living. Many commentators agree that the aspirations are laudable. However, perhaps the most distressing and frustrating aspect of the analysis of policy undertaken here is the consistent non-implementation of policies that aim to provide comprehensive, equitable, responsive community services. This reflects Butler’s definition of ageism: ‘the systematic stereotyping of and discrimination against people because they are old’ (Butler, 1969). There is evidence that people see the long-promised development of community care as a priority and a necessary first step in any serious move to promote healthy ageing (O’Shea, 2003). Limited and ageist as a service development focus is, if policy in this area were implemented, perhaps through giving it a legislative basis as some have suggested, it would serve as a signal that the stigma accorded to, and low prioritising of, older people and their needs is finally being eradicated. At least then,

older people would and could remain in their communities and other aspects of ageist thinking could be addressed.

Although procedures for monitoring the implementation of social policy are not commonly found in Ireland, there are important developments in this direction. Implementation committees now exist to assess progress on the implementation of the report on the *Commission on the Status of Persons with a Disability*, and on Traveller policy commitments. *Quality and Fairness* does contain a commitment to develop a national implementation team within the Department of Health and Children and independent evaluation of selected service areas (Department of Health and Children, 2001). Clearly, a body to monitor policy implementation of policy on older people would be a significant positive development in the reduction of ageist non-implementation of policy.

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