

Older people and health care: challenging assumptions

It seems that every year at this time in the UK, the media is full of stories about the impact of 'winter pressures' on the NHS. 2017 seems to have got off to a particularly difficult start with more NHS Trusts than ever before reporting 'serious operational pressures', meaning that they were at risk of being unable to provide comprehensive care (House of Commons Library, 2017). Bed occupancy was the highest recorded so far this winter at 95.3%, resulting in some closures of Accident and Emergency Departments. Seemingly inevitably this leads to a discussion of 'bed blockers' (more appropriately termed delayed discharges) in some parts of the media. One group of people in society is often 'blamed' for this state of affairs as the following illustrates: *'over the course of a year more than 680,000 elderly people treated by the NHS languish on wards for weeks, even though they are well enough to be looked after in a care home or at home with social services support'* (Marsh 2016). Such remarks construe older people as a 'burden' to the NHS and can negatively influence or even reflect nurses as well as the general public's attitudes towards this group of people; one function of nurse education is to challenge such ageist assumptions as they can lead to discriminatory care.

People are living longer; with developments in public health and medical advances the proportion of people living to 90 years and beyond is increasing (referred to as the 'very old' by ONS 2016). Whilst many remain independent, 82% aged 85 or more have more than one long-term health condition (UCU et al. 2014) and hence are high users of health services. This background influences how older people (as a social group) are perceived. Using the single characteristic of older age, this label can result in a process of stereotyping whereby usually negative attention is focused on differences from the majority of the adult population. Older age is often viewed as a time of loss and decline and dependency (Age UK 2016). Such stereotyping ignores any evidence that contradicts the stereotype thus reinforcing our view; so for example older people may not be expected to be happy and so symptoms of depression might be seen as 'normal' and overlooked. Of even more concern is when stereotypes lead to stigmatisation; for example older people may unfairly be viewed as a burden to society because they are perceived as no longer productive (Age UK 2016). Such views are based on prejudicial attitudes; unfortunately we are often unaware of our prejudices but these become apparent in our behaviour. In relation to healthcare for example, younger patients could be prioritised over older patients (when the health need is equal).

Whilst it is a facet of being human to categorise people and things in order to help us make sense of the world (Barry and Yuill, 2016), the danger is that people in the 'older people' category become defined by their 'oldness' and we lose sight of them as unique, multifaceted individuals and think about them as a homogenous group. Just as I would not want to be defined by my age, nor would older people. I have several friends who could be placed in the 'very old' category, one of 94 who lives independently in her own home. She would readily agree with the view embodied by the report *'I'm still me'* produced by the National Voices service user campaign group and others (UCL et al. 2014). The preface to the report sums this up wonderfully: *'An older person is not an alien species – simply our (former) selves grown older.'* And in contrast to 'languishing' in NHS wards, *'Older people value today what they valued yesterday – that is: independence; life roles; connections with family, friends and communities; fun; challenges; etc., etc. What needs to be recognised is not the 'oldness' of a person, but their individuality'* (UCL et al. 2014:2). The findings of this report using mixed methods research methodology with older people (average age

84) are expressed as a set of 'I' narrative statements that represent how older people want high quality care to be. This cuts through the stereotypes and captures what really matters to older people themselves and not what we as health professionals *think* matters. For example the theme 'independence is expressed as *'I am recognised for what I can do rather than assumptions being made about what I cannot'* (2014:6). The theme of decision-making is expressed as *'I can make my own decisions, with advice and support from family, friends or professionals if I want it'*.

What is refreshing about this report is that it seems to capture the inside story of being an older person, who not unsurprisingly have similar hopes and concerns as other parts of the population and simply want to be seen as individuals not as a homogenous group and certainly not as burden to society. They contribute much as grandparents, volunteers, guardians of expertise and wisdom. I thoroughly recommend it to you to read; it helps us to think about our language we use about older people and to revisit our assumptions about this diverse group of individuals.

References

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