

Editorial

Current Challenges of Ageing and Ageism with a Focus on Healthcare and Long-Term Care

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Editorial

The world population is ageing, and the pace at which this is happening is accelerating. Statistics from the United Nations (UN) predict that between 2015 and 2030, the number of people aged 60 years or over is projected to grow by 56 per cent, to 1.4 billion, and by 2050, the global population of older persons is projected to more than double that registered in 2015, reaching nearly 2.1 billion [1]. The fact that society at large has been alerted by these projections for quite some time, mainly because of their impact on financial and economic sustainability, we do expect a more tolerant society toward older people. Nevertheless, there is evidence that ageism – a multifaceted and often undesirable social construction of old age, is widespread across countries and pervasive across sectors.

There are four main approaches to defining old age [2], namely biological (based on impact of age on physiological systems); chronological (based upon cultural attributions of society with the UN agreed cutoff being 60+ years, while one study [3] classified old age as young-old: 65 to 74, middle-old: 75–84, and oldest-old: 85+); the political economy approach (based on the structural relationship between older people and society, with its institutions and rules within which old age is defined – older people are seen as integral part of society); and as a stage in life cycle (based on the effects of lifelong and social experiences of old age).

Ageism is vaguely defined with complex social roots and broad consequences, and includes a span of intolerant knowledge, values, attitudes and behaviors towards older adults. Additionally, there is unequivocal evidence concerning the negative consequences associated with ageism at the individual, familial, and societal levels. A wide-ranging definition of ageism should be used, as it raises consciousness and conscientiousness of policy makers and society at large on the multiplicity and complexity of the phenomenon. In particular, researchers and practitioners need a comprehensive definition for easier operationalization and emergent conceptualization of ageism.

It was Robert N. Butler, who coined the term “ageism”, referred to it as a “serious national problem” (p.243), and defined it as “a deep seated uneasiness on the part of the young and the middle-aged – a personal revulsion to and distaste for growing old, disease, disability; and fear of powerlessness, ‘uselessness’ and death” (p.

243) [4]. Several scholars entered the debate. Indeed, Iversen and colleagues [5] presented the core aspects of ageism namely: “Ageism is defined as negative or positive stereotypes, prejudice and/or discrimination against (or to the advantage of) elderly people on the basis of their chronological age or on the basis of a perception of them as being ‘old’ or ‘elderly’. Ageism can be implicit or explicit and can be expressed on a micro-, meso- or macro-level” (p. 4). The key dimensions defined by Iversen and colleagues are the three classical components (cognitive-stereotypes, affective-prejudice, behavioral-discrimination); the positive/negative aspect (positive ageism, negative ageism), the conscious/unconscious aspect (explicit ageism, implicit ageism); and the levels at which ageism can manifest (micro-level ageism, meso-level ageism, macro-level ageism). More recently, Levy and Macdonald [6] urged for a deeper understanding of ageism by moving beyond the negative aspect and including the positive aspect that would lead to better understanding of how to improve the lives of older persons and improve cross-age relations.

Additionally, they highlight the lack of agreement in what constitutes old age, and emphasize a lifespan focus by re-evaluating traditional conceptions of age. This focus is a paradigm shift from the mere restricted emphasis on old age to the consideration of a life course from birth to death. They therefore recommend integrating the study of ageism with aging that would endorse this lifespan approach that positions ageism on an analogous course with the aging literature, and that would expand the positive side of ageism. For example, the ageism literature could address the positive and successful aging depictions, namely that “older adults are calm, cheerful, helpful, intelligent, kindly, neat, and stable” (p.11).

I will now turn my attention of this editorial to ageism in health care and long-term care, two contexts that are intensely accessed by old people. The ageing projections show that it is more likely that in the foreseeable future, the need for services by older people in health and long-term care will continue to increase and will present more opportunities for ageism to manifest itself. Nevertheless, there is scant literature on the real needs of care for older people, seemingly a reflection of actual practice – indeed a situation that may be interpreted as ageist. Younger age groups may well be attracting more attention from policy makers, as well as from healthcare administrators and providers [7,8]. Professional ageism is the label used to describe the attitudes shown toward older adults, namely the specific treatment biases that are based on negative misconceptions [9].

But before I delve deeper into discussing ageism in these two contexts, it is of relevance to this editorial to endorse the ISCH COST Action IS1402 (European Cooperation in Science and Technology) entitled Ageism - a multi-national, interdisciplinary perspective, as a rich source of information on the subject [10]. The aim of this Action is to enhance scientific knowledge and attention to ageism so as to inform policy that would help allow older people to realize

their full potential by providing evidence of the practice of ageism across sectors. This COST Action brings together and integrates different disciplines, by developing national, multi-national and international collaborations with public policy officials, non-academic professionals, civil society NGOs and older persons, and by fostering a new generation of researchers. I am an active member of this COST action and involved in Work Group 1 - Healthcare system, which focuses on ageism in various health care settings, and evaluates the healthcare provision and medication management of older adults.

Indeed, healthcare and long-term care represent the pathway of delivery of care related to health and illness for older adults, namely emergency and acute care, chronic and long-term care, community and public health, primary care, and long-term care. Healthcare and long-term care services rely on each other for supporting the efficient running of health and social systems. Despite being complimentary, at the same time they manifest diversity in terms of delivery of services and characteristics of health care professionals caring for older people. Additionally, long-term care facilities tend to care for the vulnerable oldest old, who are more likely to be associated with the negative rather than the positive side of ageism. Furthermore, the rate of patient turnover is lower in these settings, with higher and longer contact with older persons, thereby creating more opportunities for situations of ageism to be reported.

The question that arises is whether or not these services are serving the older people well? For example, emergency departments demonstrate minimal knowledge of the priorities of delivery of care, as well as of the accuracy and efficiency of the medical evaluation in this population [11]. Emergency models of care are disease-oriented and discontinuous [12], and do not sufficiently match the multidimensional needs of frail older patients [13].

Furthermore, older people are the major users of inpatient services, in view of the increased incidence in chronic diseases with acute complications, multiple comorbidities and functional consequences [14]. Despite this, reports of fragmented care for older in-patients persist [15]. Indeed, the contribution of aging to chronic diseases can no longer be toned down [16], and that geriatricians and gerontologists have conceptualized frailty as a diagnosable clinical syndrome characterized by noticeable vulnerability to anxiety, trauma and strain; underlying loss of resiliency; and diminished functional reserve.

Perhaps, even more salient is the tendency for internalized ageist attitudes of professionals to lead them to use condescending talk to older people, potentially resulting in self-fulfilling prophecies that can translate ageist stereotypes into reality with direct impact on older patients' empowerment toward their care [17]. Furthermore, transitioning of care for older people from health to long-term care facilities [18,19] is reported to be highly challenging for both service administrators and older people alike in that the latter are often labeled as 'social cases' [20] or 'bed-blockers' [21]. Even care for older people throughout the last stages of their life may be lacking, with scant literature as regards to which factors enable access to care in this group [22].

In conclusion, the scope of this editorial is to raise awareness on the realities of ageing, as well as on the pervasiveness of ageism. Specifically, in healthcare and long-term care, the negative

consequences of ageism can be overcome through practicing of holistic bio-psychosocial models of care delivered by interdisciplinary healthcare teams. These professionals must be competent in the care of older people, ensure quality and avoid fragmented, chaotic and ageist delivery of care. Only by investing in competency-based education and training of healthcare professionals on how to relate to older people, as well as by promoting healthy ageing to society at large, may we be able to successfully overcome the negative consequences of aging and ageism.

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