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Social Policy and Ageing-related Care in Ireland:
An Exploration from a Social Constructionist Perspective

by

Maria Pierce

Thesis submitted to the
School of Social Work and Social Policy
Trinity College Dublin
In fulfilment of the requirement of the
Degree of Doctor of Philosophy

April 2010
DECLARATION

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Maria Pierce

April 2010
Summary

In the context of population ageing and increasing demands on welfare state spending, issues relating to the care of older people are at the forefront of social policy debates at national, European and international levels. Ageing-related care policy involves policymakers making political choices and taking administrative decisions about what is most appropriate for older people in need of care and their families. Ageing-related care policy is also about what happens on the ground to older people and their families when policies are implemented. At one level, studying social policy is about what these ageing-related care policies are, how they are developed, administered and implemented. However, it is also about arriving at a better understanding of the relationship between social policy and the ways in which ageing-related care is construed.

This thesis explores social policy and ageing-related care through the lens of social constructionism. The thesis takes much of its inspiration from Foucauldian constructionism. One of the ways in which the thesis applies Foucault’s work is by focusing on discourse. This thesis explores policy discourses on ageing-related care. A focus on discourses is necessary because the way in which issues are ‘talked about’ forms the basis from which policy decisions about ageing-related care stem. In other words, they shape ageing-related care policies. This thesis also explores discourses that take place alongside or outside the confines of policy discourse, that is, older people’s discourses. This is important because it attends to the voices of older people, who are the target population of such policies. In this way, this thesis draws to some extent on a key concern of scholars working within a micro social constructionist perspective of ageing, which is to hear the voice of older people.

This thesis relies on a qualitative research approach. The empirical data comes from four different sources: (1) official policy documents; (2) interviews with policymakers; (3) focus groups with older people; and (4) newspaper reports. The thesis employs a grounded theory approach to guide the data analysis. The analysis is organised around three discursive themes: family, care and ageing; ageing and formal care providers; and ageing, care and opportunities for social interaction and participation in social activities.
This thesis presents a recent history (1968-2005) of social policy and ageing-related care in Ireland through discourse in relation to each of the three discursive themes. The thesis shows that multiple discourses coalesce around each of the themes, but are fragmented and dispersed through policy documents. Over time, they are characterised by discontinuity, continuity and transformation.

Through a constant comparison with the dominant discourses identified in official policy documents on ageing-related care, this thesis shows that the discourses of policymakers can be understood as multiple discourse mixtures. With respect to policymakers, dominant discourses and conformist transformations of dominant discourses can be identified but these are sometimes challenged by one or more oppositional discourses as well as being juxtaposed with traditionalist discourses. This thesis shows that although there is never complete harmony and consensus amongst policymakers, some areas of social policy and ageing-related care are characterised by more unsettlement than others.

This thesis argues that the discourses of older people would also be better understood as 'multiple discourse mixtures'. It shows that older people live in a world that is rich with discourses and that older people are able to draw on them in complex and creative ways when discussing social policy and ageing-related care at a macro level. Older people are able to assert their preferences for different ageing-related care policies and are able to engage with, question and contest diverse discourses to which they are exposed. This thesis, thus, maintain that older people have considerable agency.

This thesis raises the question of the potential transformative effects on ageing-related care policies of hearing the voices of older people. In other words, if the discourses of older people were elucidated and then taken seriously in the policymaking process, policies in relation to ageing-related care would look remarkably different from the policies already in situ, particularly if they were built around a 'dominant' discourse of many older people, that is, that 'older people are social beings'.
ACKNOWLEDGEMENTS

I am extremely grateful to many people for their help and support over the last four years. I was very privileged to have two accomplished supervisors, Dr. Virpi Timonen and Prof. Patricia O'Brien, to guide me through this thesis. I would like to express my sincere appreciation to them for their help, support and encouragement as well as their confidence in me. It has been an arduous journey at times but a very rewarding one and I have learnt a great deal.

During the course of undertaking this thesis, I was affiliated to the Social Policy and Ageing Research Centre (SPARC) in Trinity College Dublin. I would like to acknowledge the financial support I received through SPARC, which enabled me to complete this thesis. I was very fortunate to have a very comfortable working environment there. More importantly, it was my colleagues and fellow Ph.D. students at SPARC who made my working days there so pleasant. In particular, I would like to thank Ana Diaz, Sarah Donnelly, Martha Doyle, Colette Garry, Marita O'Brien, Clara O'Dwyer, Andrea Borbersky, Treena Parsons and Dr. Emer Begley for their friendship, for their interest in my work and for their constant encouragement and support. I was very lucky to be surrounded by such great and knowledgeable people. I thoroughly enjoyed my time as a Ph.D. candidate at the Centre.

I would like to thank my former colleagues at the School of Social Studies in University College Dublin who encouraged me to commence this thesis. A special word of thanks goes to Dr. Patricia Kennedy for her friendship, encouragement and inspiration.

I am very grateful to all of my friends who have supported me over the last four years. I am particularly grateful to my family. My parents, David and Elsye, have always given their unwavering support to whatever endeavours I choose to pursue and for that I am grateful. Special thanks go to my brothers and sisters and their partners, John and Pauline, Suzy and Andy, David and Mary, and Emma and John and to members of my extended family, Margaret and Jack, and Karl and Emer for all their kindness, patience and thoughtfulness.
It would not have been possible to complete this thesis without the help of two women and their families. Over the past four years, Bernie Dunne and Barbara Lawless have looked after my two young sons when I was working on this thesis. I am very grateful to them for their care and kindness and for the fun times my boys had with them. It was very reassuring to know that my boys were so happy and in such capable hands. My family too stepped in to help with the children whenever there was a need and much thanks to them for that.

This thesis would not have been possible to complete without the policymakers who very generously gave up time from their very busy schedules to speak so openly about social policy and ageing-related care. Neither would it have been possible to complete the thesis without the participation of the older people who took part in the focus groups. I very much enjoyed meeting them and hearing what they had to say. I hope that this thesis accurately reflects how the policymakers and the older people I met ‘talked about’ social policy and ageing-related care.

The biggest word of thanks goes to my husband, John, and my remarkable boys, Cal and Oisin, for being there for me and for all the laughter and fun.

I would like to make a special mention of my grandmother, Mary (Molly) Pierce, who has always been a significant person in my life. She sadly passed away in January 2010 in her 101st year. This thesis is dedicated to her.
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LIST OF ABBREVIATIONS

DWS  The Developmental Welfare State
HCG  Home Care Grants Scheme
HeSSOP  Health and Social Services for Older People
NCDPNM  National Council for the Professional Development of Nursing and Midwifery
NESC  National Economic and Social Council
NESF  National Economic and Social Forum
OECD  Organisation for Economic Co-operation and Development
PD  Progressive Democrats
PHN  Public health nurse
PRA  Prescribed Relatives Allowance
UK  United Kingdom
UN  United Nations
WHO  World Health Organisation
CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

This thesis is an exploration of the multiple discourses embedded in social policy and ageing-related care in Ireland. It also examines the multiple discourses on ageing-related care that take place alongside or outside the confines of policy discourse, that is, older people's discourses and discourses in the news media. In exploring this topic, the thesis adopts the key assumptions and concerns underpinning social constructionist approaches. The main purpose of this chapter is to explain why this research topic was chosen. This chapter is divided into four sections. Section 1.2 provides the background and rationale for adopting the research topic of this thesis. Section 1.3 addresses the research design and thesis aims. Section 1.4 introduces the methodology. Section 1.5 provides an outline of the thesis chapters.

Before going on to provide the background and rationale for adopting the research topic, I will first define the term 'ageing-related care' adopted in this thesis. Social care is a primary focus of the thesis. It refers to the work involved in looking after and supporting older people, and encompasses personal care, such as bathing, toileting and dressing, practical assistance including help with housework and preparation of meals, and opportunities for social and leisure activities (Blackman, 2001). Social care is usually distinguished from health care (Blackman, 2001; Victor, 2005). For example, in their studies on the use of health and social services by older people in Ireland, Garavan, Winder and McGee (2001) and O'Hanlon et al. (2005) distinguished between the more 'medical' services and those with a more 'social' emphasis. For example, day hospital and day care centres, places where recipients may receive services such as physiotherapy, chiropody, or blood pressure checks, fall into the former category, whereas day centres or day clubs offering a range of social activities and providing a meal or a bath are classified in the latter. However, care for older people encompasses both health and social care. Health care services are designed to cater for those with health problems and in need of medical or
nursing care, whereas social care services are designed to cater for people's need for personal care and practical help.

Making a distinction between health and social care is not always helpful (Blackman, 2001; Victor, 2005). While the majority of older people with care needs continue to live and receive support in their own homes, older people receive care in a variety of settings (Higgins, 1989). The degree to which any care setting - in 'a home', at home and from home - offers social care vis-à-vis health care is difficult to assess. In a hospital setting, for example, social care may be subsidiary to medical treatment (Baldock and Ely, 1996). In addition, in Ireland, unlike Britain, health care and social care services are organised and funded from within the same administrative department (Convery, 2001; Munday, 1996; Quin, 2008), that is, the Department of Health and Children, so that the boundary between the two tends to be blurred. Furthermore, good long-term care requires attention from both social care and health care sectors (Kane and Kane, 2005). Moreover, although it may be usual for policy analysts to make a distinction between health and social care, it is not always customary for policymakers, older people or journalists to make this distinction, as I found during the course of undertaking the research for this thesis. As it both encompasses health and social care, this thesis intentionally adopts the term ageing-related care.

1.2 BACKGROUND AND RATIONALE

This section is divided into three parts. First, it explains the reasons for choosing to focus on ageing-related care as opposed to another area of ageing-related social policy. Second, it gives the background to adopting key assumptions and concerns underpinning social constructionist approaches as a way to explore social policy and ageing-related care. As mentioned above, this thesis has a particular focus on and seeks to gain an understanding of the multiple discourses underpinning ageing-related care policy. The third part of this section offers a rationale for making this a focus of the thesis. In other words, it makes the case for focusing attention on discourses embedded in social policy.

1 Care in 'a home' refers to care in an institutional setting such as a hospital or nursing home.
1.2.1 Social policy and ageing-related care

The area of social policy and older people is wide-ranging. Each of the five main areas of social policy – income maintenance (Prunty, 2008), housing (Norris and Winston, 2008), education (Field, 2000; Withnall, 2000), health (Quadagno, Reid Keane and Street, 2005; Quin, 2008), and social care (Brennan, 2008; Pierce, 2006) – is relevant to the situation of older people, as are the other areas to which social policy stretches including the labour market and retirement (Fahey, 2008; Marshall and Taylor, 2005; Taylor, 2002) and mental health (Drury, 2005), to name just two. It would be beyond the scope of this Ph.D. thesis to address all of these areas in a meaningful way. To give it a greater focus, this thesis concentrates on the area of ageing-related care.

There were a number of reasons for choosing ageing-related care as the focus. Older people have for a long time been one of the main subject groups of long-term care policies (as shown in Chapter 2, Section 2.2, which provides the historical context to social policy and ageing-related care in Ireland). Today, the majority of older people lead active and independent lives and are not in need or in receipt of care services. Nevertheless, in old age people's welfare is likely to be reduced, so that older people may become major users of care services. Care for older people, being poorly resourced and largely provided by unqualified workers, has traditionally been one of the 'Cinderella' areas of social policy (Dominelli, 2009: 48). It has received less attention than other ageing-related areas of social policy, particularly pensions policy. However, in the context of population ageing and increasing demands on welfare state spending, issues relating to the long-term care of older people are now at the forefront of social policy debates (Bernard and Phillips, 2000) at national, European (European Commission, 1999, 2009) and international levels (WHO, 2002). At an international level, several OECD studies (Fujisawa and Colombo, 2009; Lundsgaard, 2005; OECD, 2005; Oxley, 2009) have addressed the implications of ageing for long-term care policy over the past few years. For all of the above reasons, this thesis focuses on ageing-related care.
1.2.2 Adopting a social constructionist approach

Social constructionist studies might be defined as:

those [studies] that seek, at least in part, to replace fixed, universalistic, and sociohistorically invariant conceptions of things with more fluid, particularistic, and sociohistorically embedded conceptions of them (Weinberg, 2008: 14).

My intention in undertaking this Ph.D. was to examine social policy and ageing-related care in this light. The inspiration for adopting the key assumptions and concerns underpinning social constructionist perspectives (outlined in Chapter 3, Section 3.4 of this thesis) in approaching the research topic of this thesis comes from a number of sources. My interest in social constructionism stems in part from an interest in women and social policy, and feminist approaches to social policy. As Marshall (2008: 688) points out, '[a]ll varieties of feminism are constructionist on some level, as none would accept that extant gender arrangements are either natural or unchangeable'. For example, feminists have questioned why caring is viewed as women's 'natural' responsibility (Baines, Evans and Neysmith, 1998: 9). Those coming from a political economy perspective would argue that the construction of caring labour as predominantly women's work stems, primarily, from a capitalist and patriarchal society (Arber and Ginn, 1991; Baines et al., 1998).

The idea that the lives of older people and the problems of ageing may be seen as socially constructed has been widely developed in social gerontology (Estes, Biggs and Phillipson, 2003; Estes and Associates, 2001; Quadagno and Reid, 1999) (see Chapter 3 of this thesis). For example, Estes, one of the earliest proponents of the political economy of ageing perspective in the US, suggests that:

The major problems faced by the elderly in the United States are, in large measure, ones that are socially constructed as a result of our conceptions of aging and the aged. What is done for and about the elderly, as well as what we know about them, including knowledge gained from research, are products of our conceptions of aging. In an important sense, the major
problems faced by the elderly are the ones we create for them (Estes, 1979: 1).

The Care of the Aged Report (Inter-departmental Committee on the Care of the Aged, 1968) published in Ireland in 1968 offers a case in point. The report was prepared by an Inter-departmental Committee on the Care of the Aged, appointed by the Minister of Health in 1965. The Care of the Aged Report is particularly noteworthy because it was one of the first official documents to clearly articulate the policy preference for domiciliary and community-based care in Ireland (Timonen and McMenamin, 2002). It stated that 'it is better, and probably cheaper, to help the aged to live in the community rather than to provide for them in hospitals or other institutions' (Inter-departmental Committee on the Care of the Aged, 1968: 49). The report is considered to represent at least in principle a radical shift in Irish policy towards the care of older people at and from home, as prevailing policies of care were based on institutionalisation (Blackwell et al., 1992). For this reason, it has been heralded as 'ground breaking' (Brennan, 2008: 130). Furthermore, it dominated government policy towards older people for 20 years until the publication of The Years Ahead: A Policy for the Elderly (Working Party on Services for Older People, 1988).

On a closer reading of the Care of the Aged Report, I was curious to note that the report appears to encourage the view that older people in need of care represent a social problem for society. Throughout the report, there are references to the 'enormous', 'growing' and intractable problem of older people in need of care (Inter-departmental Committee on the Care of the Aged, 1968: 13, 45, 50, 101, 107). For example, the report states that:

the total number [of persons aged 65 years and over] is so great that the provision of services for the proportion in need of help still presents the community with an enormous and a growing problem [emphasis added] to which there is no ready or simple solution (Inter-departmental Committee on the Care of the Aged, 1968: 13).

The Care of the Aged Report was undoubtedly prepared with the best of intent and for the best motives. It recommended many significant reforms and improvements to the system of care for older people in Ireland. At the same time,
the *Care of the Aged* Report promotes the view that older people, especially those in need of care, represent a problem for society. This construction of older people as a social problem is not entirely surprising. The Inter-departmental Committee was asked in its terms of reference 'to examine and to report on the *general problem* [emphasis added] of the care of the aged and to make recommendations regarding the improvement and extension of services' (Inter-departmental Committee on the Care of the Aged, 1968:). Moreover, ageing and old age have habitually been seen as a social problem in Western society (Fennell, Phillipson and Evers, 1988).

The perception of ageing and old age as a social problem can also be found in the narratives of policymakers (Powell, 2001; Victor, 2005). According to Victor (2005: 300), 'at both the individual and the societal level, old age is seen by policymakers (and often policy deliverers) as a tragedy which requires a response'. However, the perception of older people as a social problem is one amongst many social constructions of ageing and old age. Johnson's (2005) review of the life history of old age reveals the huge variety of attitudes and social constructions of old age at different historical times, in different religions and cultures. Optimistic and pessimistic constructions of ageing can be identified (Walker, 1999), both of which have found expression in policy terms in the Irish context since the 1990s (Pierce, 2008).

The view of ageing and old age as a social problem led me to further explore social constructionist approaches to social policy, particularly in the area of ageing-related care. The constructionist perspective, with its focus on symbols, interpretation and discourse, has had a very useful impact on the study of social policy generally (Schneider and Ingram, 2008). This particular approach is a distinctive way of seeing and questioning social policies and considering the profound effects that they have on citizens (Saraga, 1998). As distinct from a realist perspective, which would attempt to explain how and why the problems of old age occur, a constructionist perspective starts by asking how older people came to be defined or construed as a social problem (Clarke, 2001).
1.2.3 Importance of discourse in social policy analysis

As Chapter 3 makes clear, social constructionism puts forward the proposition that 'reality' is socially constructed in and through language and interaction between people. Language gives meaning to the social world. Social constructionism is concerned with discourse or the discursive meanings of language (Burr, 2003; Clarke and Cochrane, 1998). In other words, there is a strong conviction within social constructionism that discourse is of central importance in constructing the ideas, social processes and phenomena that make up the social world. The term discourse is often used rather vaguely and has been used in varying ways (Potter and Wetherell, 1987; Fairclough, 1992; Fairclough, 1995). Discourse can be defined as 'a set of ideas, practices and beliefs which coalesce to produce an over-arching picture of reality' (Symonds, 1998: 8). It can also be used to refer to 'the manner in which individuals and institutions communicate through written texts and spoken interaction' (Lupton, 1992: 145). Policy discourse can be defined as 'what policymakers say to one another and to the public in their efforts to generate or legitimate a policy programme' (Schmidt, 2002: 210).

Social policy is made up of language, and, as Marston (2004) argues, on one level, social policy can be understood as a public discourse, that is, discourses are the principal medium through which the politics of social policy is conducted and they exist in the public domain. Social policy is a contested public discourse (Marston, 2004). Social policy involves policymakers making political choices and taking administrative decisions about the actions that are most appropriate for our individual and collective wellbeing. For instance, choices and decisions have to be made about the appropriate division between public and private responsibility in relation to long-term care for older people. Policy processes involve institutions and actors reaching welfare settlements on all sorts of issues (Hughes, 1998a). For example, social policy in Britain in the mid-twentieth century, the period to which the emergence of the Beveridgean welfare state is dated, might be held up as a distinct era of widespread consensus in British society. The orthodoxy is that in Britain after the Second World War a consensus emerged among academics, political commentators and much of the public about the need for the state to

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2 Hughes (1998a: 4) refers to 'settlement' as 'a kind of framing consensus that becomes established which sets limits within which compromises over what and how, and by whom and for whom, welfare services and benefits are delivered'.

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Intervene in a positive way in the lives of its citizens. Ideologically, the British welfare state came to represent the relationship of the state to its people as one of solidarity and unity (Hughes, 1998a).

Concepts in social policy, such as the ‘welfare state’, are institutionalised ideas that have a powerful symbolic foothold on the public imagination (Clarke and Cochrane, 1998; Marston, 2004). Yet, the meaning of these ideas is often assumed rather than defined by those who espouse them. According to Lewis (2000: 9), unsettling or interrogating the taken-for-granted assumptions underpinning social policy concepts is an important part of the process of ‘rethinking social policy’. This type of analysis involves focusing on the meanings that are internal to discourses embedded in social policy that come to represent the social world (Hughes, 1998a; Lewis, 2000; Marston, 2004; Watson, 2000).

Despite the conventional view that there was consensus in British society about the state being the dominant provider of welfare, there was never complete harmony and consensus about how and for whom welfare should be provided during the post-war era (Hughes, 1998a). Rather, there were competing conceptions about the proper role of the state in the provision of welfare. In other words, multiple perspectives are involved in interpreting and understanding social policy. All aspects of social policy have a particular meaning for different people. Burr (2003) refers to the divergent meanings that different groups attach to an aspect of policy as a ‘struggle after meaning’.

Marston (2004: 2) argues that ‘language use is a field of social and political action that often escapes the attention of social policy analysts’, which he attributes to the legacy of a positivist paradigm. The positivist paradigm continues to exert a considerable influence over social policy analysis (Marston, 2004) and over social gerontology in western societies (Katz, 1996; Powell and Biggs, 2000). But because it denies the constitutive role of discourse, the positivist paradigm is not ‘an adequate position for researchers and policy analysts aiming to explore and understand how policy meanings are discursively constructed … and how policy actors and citizens represent and articulate problems and solutions’ (Marston, 2004: 14). Such criticism of the positivist paradigm is not intended to distract from

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3 According to Hughes (1998a: 4), welfare settlements are a set of positions negotiated by the most powerful groups in society. They create a temporary period of stability or equilibrium, even while they remain complex, contested and fragile.
the crucially important role that positivism has played and continues to play in social policy research and analysis.

Moreover, other schools of thought play a key role in promoting the importance of discourse in social policy research and analysis (Marston, 2004). Compared to a positivist paradigm, the various strands of critical social theory and post-structuralism are areas of theorising that offer social policy analysts different ways of thinking about language (Lewis, 2000; Marston, 2004; Watson, 2000). For instance, policy researchers and analysts have highlighted the critical importance that the use of words and language and their discursive meanings have in specific areas of social policy, for example, housing policy (Jacobs and Manzi, 1996; Marston, 2004). Feminist scholars have drawn attention to contested concepts of gender in social policy as well as the gendered meanings of key concepts in social policy such as care and work (see, for example, Bacchi, 1999; Hobson, 2002; Lister, 1997). Academics and disability rights activists have examined the role of discourse in the construction of disability (see, for example, Corker, 1998; Hughes, 1998b; and Oliver, 1990). Shakespeare (2000) has challenged the discourse of burden that underlies social relations of care built on a medical model of disability, for silencing receivers of care. Based on an analysis of historical social policy documents, Jean Carabine (2000; 2001) has examined the relationship between discourses of poverty and sexuality and argues that ideas about sexuality, particularly heterosexuality, play a significant role in social policy whether as a discipline or a practice.

Biggs (2001) contends that commonly held sets of ideas can have a significant impact on ageing policies and argues that discourses in social policy need to be taken seriously as they exist in the public sphere and have the power to shape the way that older people live. Social gerontologists have highlighted the critical importance of discourses in the area of social policy and ageing. For example, Angus (2003) has examined the public discourse surrounding the enactment of the Aged Care Act of 1997 in Australia, and, in particular, how the public discourse had a constitutive role in shaping and regulating people's lives. In a New Zealand study, Ng and McCreanor (1999) found that three key discourses - society's obligation to older people, discourse of anti-ageism, and old age as a positive resource - were prominent in submissions to a Royal Commission on Social Policy in New Zealand on issues relating to older people and showed how discourses can be used by older people and their representatives to defend and
advocate the position of older people. With a focus on work and work-like activities, Biggs (2001) has explored the effect of discourses embedded in positive ageing policies on the public legitimacy and personal identities made available to older people. Katz (2000) has undertaken a similar exercise but focusing on leisure.

1.3 RESEARCH DESIGN AND THESIS AIMS

This thesis draws on four different sources of discourse for data analysis. The research design essentially comprises three parts to reflect the main aims of the thesis. First, by selecting official policy documents on ageing-related care for analysis, the thesis aims to identify predominant policy discourses on ageing-related care in Ireland. The thesis also aims to investigate how these discourses have developed and changed over time. Second, by conducting interviews with policymakers and focus groups with older people and analysing the transcripts, the thesis aims to identify the predominant discourses on ageing-related care held by policymakers as well as those held by older people; and to identify how far these correspond or conflict with each other and with discourses embedded in official policy documents on ageing-related care. Third, by selecting newspapers for analysis, the thesis aims to identify patterns of discourse on ageing-related care issues and policies in one type of news media.

1.4 METHODOLOGY

This section introduces the methodology. It notes that a qualitative approach has been adopted and specifies the sources of data selected for analysis. It outlines the research design, its aims and provides a rationale for selecting official policy documents, policymakers, older people and newspapers as the four sources of discourse in this thesis. It refers to ethical issues relating to the research and introduces the grounded theory approach used to guide the analysis of data in this thesis.

1.4.1 A qualitative approach

This thesis relies on a qualitative research approach to explore the multiple discourses embedded in and surrounding social policy on ageing-related care using Ireland as a case study. As Chapter 4 outlines in greater detail, qualitative
research is the most appropriate approach for exploring the research topic of this thesis.

1.4.2 Data sources

Qualitative research draws on many alternative sources of data. The empirical data on which the thesis is based comes from a combination of four different sources, namely: (1) official policy documents on ageing-related care; (2) interviews with policymakers (politicians as well as senior civil servants in a Government department and senior public servants in state agencies with a responsibility or a particular interest in the area of ageing-related care) (N = 14); (3) six focus groups with a total of 41 older people; and (4) newspaper reports and commentary on ageing-related care issues and policies. It is an extensive dataset, which consists of both written text and speech. Chapter 4 discusses the data sources in more detail and outlines the techniques and procedures used for gathering the data.

1.4.3 Selecting official policy documents as a source of discourse

According to Freeman (2006), governments produce and communicate ideas, suggestions, proposals and plans through texts such as official policy documents. Of course, there are many other documentary sources of such texts, for example, legislation, speeches, press releases, background papers, and parliamentary debates. However, it would be beyond the scope of this thesis to examine all of these. I have chosen to draw on official policy documents for the following reasons. The production of official policy documents and reports is an important activity of governments (Potter and Wetherell, 1987; Jupp, 1996; Tonkiss, 1998). They are written by policymakers for public consumption, easily accessed by the public (and, therefore, by researchers and policy analysts), and often reported on and debated in the media. At one level, official policy documents provide a written statement of the policy intent of government. For example, on the surface the 1968 Care of the Aged Report may seem simply to indicate a shift in government policy towards community care for older people. However, at another level official policy documents are also expressions or carriers of social meaning and as such offer a lens through which to explore multiple discourses underpinning ageing-related care policy.
In addition, discourse is historically located. Discourses are embedded in history and therefore need to be considered in relation to time. In order to understand how a policy has been constructed it is necessary to explore how and where discourses emerge and to describe how they change (Marston, 2004). Official policy documents offer a way of understanding the historical development of discourses. Focusing on official policy documents on ageing-related care from three different periods covering the years 1968 to 2005 allowed me to do this.

1.4.4 Selecting policymakers and older people as sources of discourse

I have already explained that official policy documents are expressions or carriers of social meaning and discourses are the medium through which these meanings are communicated. A narrow focus on official policy documents would fail to capture whether policy recommendations are supported or opposed (see Marston, 2004). Therefore, the second part of this thesis focuses on the perceivers of the meanings communicated in official policy documents. More specifically, it explores the (multiple) discourses on ageing-related care held by two different groups. The first group is policymakers. The second group is older people. Drawing on Yanow (2000), policymakers and older people may be thought of as two different interpretive communities (also known as communities of meaning, communities of practice, speech or discourse communities). By exploring the multiple discourses held by these two groups, the thesis is designed to identify any point of consensus as well as any point of conflict, the latter of which would suggest that different groups attach divergent meanings to some aspect of ageing-related care policy. Thus, the thesis intentionally incorporates the perspectives of policymakers and older people to reflect the fact that ageing-related care is a domain that can be shaped by a range of different and possibly competing discourses.

Policymakers were chosen as the first interpretive community as they are highly involved in the discursive practices of policy debates and decision-making about what they define as the most pressing ageing-related care issues and problems. Policymakers can actively draw on dominant models of ageing and care, which in turn can influence their behaviour and social attitudes towards older people (Estes et al., 2003). Policymakers may have a 'very great' impact on policy even where they unconsciously draw on a particular perspective in formulating ageing-related policy (Wilson, 1991: 37). For example, the widely held view that ageing is a time
of inevitable decline can be taken by policymakers (Wilson, 1991). Similarly to people in society generally, policymakers hold and use information that is 'taken for granted, or simply assumed without any particular conscious thought' (Wilson, 1991: 37). Unconscious assumptions are determined by commonly held societal attitudes towards ageing and form part of the environment in which policymakers operate. The impact of the perspectives of policymakers is all the more important because they usually go unacknowledged and unquestioned (Wilson, 1991). In turn, policies and practices, historically and contemporarily, influence the quality of life and opportunities of older people and the actual experiences of ageing and old age by older people.

Older people were selected as the second interpretive community and source of discourse for this thesis. Although ageing-related care is inextricably bound up with social policy, little attention has been paid to 'deciphering the world of older people as subjects' (Hazan, 1994: 5). O’Loughlin (2005) identifies this as one of the key challenges facing policymakers. Hearing what older people have to say about care is one of the leading concerns of writers for whom a central focus is the social construction of ageing at a micro level. Hazan argues that:

Most of the professional literature on ageing is aimed at the know-how-oriented reader, whose interest is in information about the state of the elderly as an object. Only a smattering of research is dedicated to deciphering the world of old people as subjects, and even less attempts to understand the ways in which knowledge about ageing is produced and reproduced (Hazan, 1994: 3).

According to Marston:

... members of the public are often assumed to be a trifle gullible and portrayed as empty vessels waiting to be filled up with meaning ... This conception fails to acknowledge a capacity for agency and the institutional factors that affect how policies are interpreted (Marston, 2004: 75).

Increasingly, researchers are examining older people’s understandings of care as part of the ageing experience (see, for example, Begley, 2009; Murphy et al., 2007). However, what is missing from the social policy literature is an understanding of older people and their interpretation of public discourse on
ageing-related care. Some researchers have analysed the perspectives of national organisations representing older people (Feltenius, 2008). National organisations representing older people could have been chosen as an interpretive community for this thesis. However, for the following three reasons, older people were chosen as a source of discourse instead. First, the majority of older people are not members of national representative organisations of older people. Second, these organisations frequently lack formal channels of representation for their members. Third, many older people with physical or intellectual disability as well as those on low incomes are less likely to participate in organisations representing older people, while others face obstacles due to age, gender and race discrimination, and (sometimes) full-time caring responsibilities (Walker, 1999).

As well as national organisations representing older people's issues, it is possible to identify other interpretive communities that have an influence on policymaking on ageing-related care such as representatives of national organisations of nursing home owners, academic and policy analysts and the medical and nursing professions. From an interpretive research perspective, non-elite policy actors such as these are also seen to play a role in shaping policies, especially by contesting or rejecting 'top-down' policy perspectives. Interpretive researchers seek to understand their perspectives as well (Yanow, 2007). However, it would be beyond the scope of this thesis to address all of these.

By including policymakers and older people, this thesis looks at both public and popular discourse. Public discourse refers to the use of language by elites that occurs in a public context, for example, in debates that takes place in the public realm as well as written text in the public domain, whereas popular discourse refers to everyday language such as conversations and interactions amongst the general population (Blaikie, 1999; van Dijk, 1993b). Blaikie (1999) believes that although policy perceptions of elites differ from policy perceptions of older people, there exists sufficient common ground between their interpretations. van Dijk (1993b) points to a dialectical relationship that exists between the discourse of elites and non-elites. While popular discourse or discourse of non-elites may influence the perspectives and actions of elites, public discourse or the discourse of elites plays a role in shaping the production and interpretation framework underlying popular discourse (van Dijk, 1993b). Despite this dialectical relationship, it is public or elite discourse, according to van Dijk, that plays a
leading role in constructing many of the arguments about ageing-related care. This thesis is especially interested in comparing and contrasting the public discourses held by policymakers and the popular discourse of older people in relation to social policy and ageing-related care.

1.4.5 Selecting newspapers as a source of discourse

This thesis also focuses on the relationship between policy discourses, older people’s discourse and the news media, more specifically newspapers. Much attention has been given to the key role that the media play in the portrayal of older people. Social scientists have examined the portrayal of older people, including ageist and stereotypical images of older people, in many areas of the media. In particular, the portrayal of older people on television has been well researched (Bell, 1992; Bishop and Krause, 1984; Dail, 1988; Elliott, 1984; Kessler, Rakoczy and Staudlinger, 2004). The portrayal of older people in film too has been the subject of research. For example, Markson and Taylor (2000) have examined current and past portraits of older people and gender roles in feature films. Similarly, researchers have examined images of older people in the print media including magazines (Featherstone and Hepworth, 1995), cartoons and birthday cards. Researchers have also examined images of older people in literature, including children’s books (Piesse, 2004, 2005 and 2007) and crime fiction (Hepworth, 1993; Woodward, 1991). In Ageing and Popular Culture, Blaikie (1999) examines shifts in the representation of ageing in various popular images in Britain. In particular, he explores visual images including cartoons, film, television, popular magazines, photographs and family snapshots.

Forming part of the mass media, newspapers have a focal position in contemporary society (Fairclough, 1995; Marston, 2004). The analysis of newspapers is important because, like other media of mass communication, newspapers ‘reflect social images and views on ageing’, but, in comparison to other areas of the media, there have been few studies of images of ageing and older people in newspapers (Gibb and Holroyd, 1996). Nevertheless, several studies have highlighted the negative portrayal or under-representation of older people in the press. For example, Kennelly and O’Neill (2004) found a significant underreporting in newspapers of ageism compared to other forms of discrimination. Martin, Balding and O’Neill (2004; 2005) found that reporting of older drivers in 15 national and regional newspapers in Ireland and the UK was
largely negative in content. The authors reported that this is at variance with the evidence.

While newspapers are designed as entertainment to some extent, a large part of newspapers deals with public affairs, which includes reporting about ageing-related health and social care issues, as well as other social policy issues. They have a critical role to play in representing and constructing meanings about social policy issues. The study mentioned above on the reporting of older drivers in newspapers serves to illustrate this point. Newspapers, like other forms of mass media, have the power to influence audience's attitudes, beliefs and behaviours (Kessler, Rakoczy and Staudlinger, 2004). The media reflect and shape public opinion, including the public's perception of health and social care related issues. Martin, Balding and O'Neill (2005) warn that, given this, a potential consequence of representing older drivers as a threat to other road users rather than highlighting the issue of access to transport (which is a major concern with transport and health for older people) is to distort the political and social context within which doctors practise medicine and within which doctors, geriatricians and transport policymakers promote healthy ageing.

As well as reflecting wider public opinion and discourse, it is through newspapers and other media of mass communication that the policy discourses and opinions of governments are primarily channelled (van Dijk, 1993a). Fairclough (1995) developed the notion of 'mediatised political discourse' to refer to the space where political messages are mediated by the media. An example comes from Marston (2004) and his study of Australian public housing reforms influenced by neoliberal ideas. Marston (2004: 98) found that a discourse of 'bad tenants' was embedded in government policy documents and that newspapers, for the most part, were complicit in reproducing the government's preferred representation of tenants in their reporting of the public housing reforms. At the same time, he found that there were ideological tensions and critical contradictions within newspaper discourse, evidenced by oppositional political voices and 'tenant friendly' visual images in the newspapers. Marston (2004: 98) concluded that there was evidence in newspapers of 'conservative transformations' but also of 'critical transformations' of government source documents on housing reforms.

The third part of this thesis is designed to explore discourses used by newspapers to 'frame' ageing-related care issues and policies. More specifically, the thesis
explores the representation of discourses of policymakers and older people. By exploring the mediatised discourses on ageing-related care of policymakers and older people, this thesis seeks to contribute to an understanding of this complex dimension of policy discourse.

1.4.6 Ethical issues

There are a range of ethical challenges presented by qualitative research (Patton, 2002). To take account of this, I developed a framework for dealing with ethical issues related to the research process. The set of protocols developed were used to guide the research. These include protocols on informed consent and confidentiality to safeguard the interest of both policymakers participating in one-to-one interviews and older people participating in focus groups. The major principles underpinning the practice of ethical research and the ethical considerations in relation to interviews with policymakers and focus groups with older people are described in greater detail in Chapter 4. I sought ethical approval from the Research Ethics Committee, School of Social Work and Social Policy, Trinity College Dublin. Approval was granted in June 2007.

1.4.7 Data analysis: a grounded theory approach

Qualitative analysis is 'a process of examining and interpreting data in order to elicit meaning, gain understanding and develop empirical knowledge' (Corbin and Strauss, 2008: 1). There is a vast array of interpretive methods of analysis (Yanow, 2007). Among them is grounded theory and this is the method of analysis used in this thesis. Grounded theory was developed by Glaser and Strauss (1967) for the purpose of building theory from data (Corbin and Strauss, 2008). It can be defined as 'theory derived from data, systematically gathered and analysed through the research process' (Strauss and Corbin, 1998: 5).

Powell and Edwards (2002) stresses that the bedrock of grounded theory is that it advocates an inductive approach through a purposeful discovery of concepts from the data. In this way, it offers a challenge to 'the dominant methodological paradigm concerned with the logical deduction and verification of prior theory through hypothesis testing' (Powell and Edwards, 2002: 11).

In a grounded theory approach, the data analysis essentially follows four stages, as explained in Chapter 4. Chapter 4 also outlines and discusses the techniques
and procedures such as line-by-line analysis developed by Corbin and Strauss (2008) to guide the data analysis. Some researchers, according to Charmaz (2008), emphasise a narrow and rigid application of the techniques and procedures of the grounded theory method. However, Charmaz (2008: 398) argues that the intention of grounded theory from its beginnings was to offer ‘explicit guidelines that promise flexibility and innovation’ and that social constructionist approaches to grounded theory encourage innovation. As Gubrium (cited in Powell and Edwards, 2002: 8) puts it, ‘there are no rules for data analysis except one, that the analysis draws heavily on the language of the persons studied ... that it is grounded’. As Chapter 4 shows, a grounded theory approach has been applied to the study of social policy and ageing.

As a means of analysing the four sources of discourse selected for this thesis, this thesis focuses on three discursive themes, namely, family, caring and ageing; ageing and formal care services; and ageing, care and opportunities for social interaction and participation in social activities. An explanation of how these themes emerged from the data is given at the beginning of each of the three findings chapters.

1.5 THESIS OUTLINE

Chapter 2 seeks to give some contextual background to this study. It does this in the following ways. The first part of the chapter traces the evolution of Ireland’s policy relating to the care of older people in the nineteenth century and in the first half of the twentieth century, thereby placing social policy and ageing-related in Ireland in the historical context. There have been sweeping social and economic changes in Irish society since the 1960s, which have had an impact on social policy and ageing-related care in Ireland, and the second part of this chapter covers the most notable of these changes. The third part of the chapter seeks to place Ireland’s system of long-term care for older people in a comparative context using existing welfare state regime classifications.

The theme of Chapter 3 is social constructionism. Social constructionism is ‘a rubric for a mosaic of research efforts with diverse — but shared - theoretical, methodological, and empirical groundings and significance’ (Gubrium and Holstein, 2008: 5). Chapter 3 provides an overview of social constructionism. It sketches out the conceptual backdrop to social constructionism. It discusses key
developments in social constructionist approaches. It identifies the key assumptions and elements of social constructionist approaches. There is a growing body of work studying ageing from a social constructionist standpoint and reference is made to contributions in this area.

Chapter 4 presents the methodological approach adopted for the thesis. The chapter comprises four parts. First, it provides a rationale for adopting a qualitative research approach. Second, it outlines the four-pronged approach to data selection and collection that has been adopted for this thesis. Third, the chapter presents the major principles underpinning the practice of ethical research and outlines the procedures adopted to deal with ethical issues arising. Fourth, the chapter discusses grounded theory, the primary analytical approach adopted to inform the data analysis in this thesis.

Three discursive themes are used in this thesis to explore multiple discourses embedded in social policy and ageing-related care in Ireland. The three findings chapters are organised around these themes. Chapter 5 is the first of the three findings chapters. The discursive theme of this chapter is family, care and ageing. The chapter provides a critical exploration of the prominent discourses about the ‘family’ that are embedded in official policy documents relevant to ageing-related care in Ireland between 1968 and 2005 before going on to explore the discourses about the ‘family’ held by policymakers and older people as well as the mediatised discourses of policymakers and older people in newspapers.

Chapter 6 focuses on the theme of ageing and formal care providers. It presents the findings in relation to the multiple discourses about the formal care providers - public, private and voluntary - involved in mixed economy of care in ageing-related care policy in Ireland. The analysis includes a focus on policy relating to long-term care in institutional settings and social care services for older people living in the community. Similarly to Chapter 5, this chapter presents the findings from the analysis of official policy documents on ageing-related care between 1968 and 2005, transcripts of interviews with policymakers, transcripts of focus groups with older people, and newspapers.

The theme of Chapter 7 is ageing, care and opportunities for social interaction and participation in social activities, which similarly to the two preceding chapters is used as a way of exploring the multiple discourses underpinning social policy
and ageing-related care in Ireland. As with the other two findings chapters, this chapter presents the analysis of key official policy documents relevant to ageing-related care between 1968 and 2005, transcripts of interviews with policymakers, transcripts of focus groups with older people, and newspapers, in relation to this theme.

Chapter 8 provides an overall conclusion to the thesis. It considers the approach to social constructionism that that is adopted in this thesis. It reflects on the methodology chapter. It provides an analytical commentary on the findings, in particular, the conceptualisation of multiple discourses and how it relates to the idea of discourse. It considers why the exploration of multiple discourses is interesting and potentially important. It provides some reflection on implications of the findings from this thesis for social policy and ageing-related care. The empirical, methodological and theoretical strengths of this thesis as well as its weaknesses are considered throughout the chapter.
CHAPTER TWO

SOCIAL POLICY AND AGEING-RELATED CARE IN IRELAND: THE HISTORICAL DIMENSION AND THE SOCIO-ECONOMIC AND COMPARATIVE CONTEXTS

2.1 INTRODUCTION

According to Titmuss (1976), social policy cannot be discussed in a social vacuum. Governments may be the instigators of policies, but a wide range of factors come into play to influence and shape social policy. This chapter addresses this point by providing the contextual background to this thesis. To understand social policy and ageing-related care, we need to see it in its historical context. Section 2.2 outlines the development of social policy and ageing-related care in Ireland to provide the historical dimension to this thesis. Developments in the nineteenth century and in the first half of the twentieth century are covered. Social policies on ageing-related care are not shaped in isolation from the economic context, which is one of the most obvious factors influencing social policy in Ireland. Section 2.3 identifies the main economic changes shaping social policy and ageing-related care that have occurred during second half of the twentieth century. Section 2.4 draws on existing welfare state regime classifications to place Ireland’s system of long-term care for older people in a comparative context.

2.2 THE HISTORICAL DIMENSION

Hensey (1979: 1) has stated that ‘one cannot pick a single point of time and say that the modern trend towards the development of health services commenced then’. The same could be said of the development of ageing-related care services. However, present day provisions of long-term care for older people have their roots in the Irish Poor Law of 1838. This section examines the nineteenth century origins of the current system of care provision for older people.
and traces the main developments in ageing-related care policy in Ireland through
to the 1960s. Particular attention is paid to the dichotomy between institutional
solutions to the care of older people, on the one hand, and community care
solutions, on the other. As Blakemore (1998) points out, it would be difficult to
understand institutional care of older people without reference to the alternative,
community care. Consideration is also given to the 'mixed economy of care', a
term that can be used to describe the balance between the state, the voluntary
sector, the private sector and the family who represent the supply side of care
(Fanning, 1999; Symonds, 1998). The Irish state, which has developed a
piecemeal approach to welfare, is characterised by a mixed economy of welfare
both in general and in specific areas of welfare (Good, 2003). In the area of care
for older people, welfare in Ireland has clearly been characterised by a mixed
economy, with respect to both institutional and community care. Indeed, Ireland
can be described as having a public/voluntary/private mix of (formal) care
services for older people living in nursing homes and in the community both in
financing and delivery. Bearing in mind that the care of older people in Ireland
has always been characterised by a 'mixed economy of care' (Pierce, 2006),
consideration is given to how demarcations within the mixed economy of care
have changed over time in Ireland, particularly with regard to changes in the
balance of responsibility between the informal and formal care systems.

There are a range of factors that have shaped ageing-related care policy in the
period under review. One important factor is the economy. But there are others.
For example, it would imprudent to disregard the influence of political and
religious ideologies on the shaping of ageing-related care policy in the nineteenth
century and the first half of the twentieth century. The ideological role of religion,
especially Catholicism, is emphasised, as is the ideological legacy of liberalism,
which Fanning (2004: 13) argues 'warrants analysis in an era when neo-liberalism
has proved to be a strong influence on social policy'.

For the purposes of this chapter, social policy and ageing-related care in Ireland
in the nineteenth century and in the first half of the twentieth century is broken
down into three distinct periods:

(1) the nineteenth century (1838-1900);
(2) the early part of the twentieth century (1900-1939); and
(3) post World War II developments (from 1945).
2.2.1 Ageing-related care in the nineteenth century (1838-1900)

The origins of social policy towards older people in Ireland, from which much of the present day pattern of long-term institutional care for older people has emerged, might be dated to Poor Law or the Act for the more Effectual Relief of the Destitute Poor in Ireland, which passed into law in 1838. It was the first statutory provision for the poor in Ireland. It was introduced by the British administration, operating from Dublin Castle and adapted from the New Poor Law system introduced into Britain in 1834. While *laissez-faire* was the preferred policy up to 1800, the British administration adopted a more interventionist approach to policy in Ireland following the Act of Union in 1800. This illustrates the way that social policy in Britain has influenced the development of policy and services in Ireland.

The workhouse system, otherwise known as ‘indoor’ relief, formed a central feature of the Irish Poor Law. Relief was initially only administered in the workhouse. The debate as to who was deserving of relief was intensive and ongoing during the nineteenth century. This debate extended to the ‘aged’ (Thane, 2000: 192). Under the Poor Law there was no officially recognised definition of the ‘aged’ and reaching a certain age did not give people a right to receive poor relief. Rather, incapacity for work was considered a more important indicator of need than old age (Thane, 2000). As the normal test of eligibility was incapacity for work, the principle of discriminating between the aged, deserving poor (able-bodied aged) and aged, non-deserving poor (non-able bodied aged) underpinned the provision of relief in the nineteenth century (Thane, 2000).

Under the workhouse system, preference was given to those who fell into the category of ‘deserving poor’ (Burke, 1987); to the destitute non-able-bodied ‘aged’ (and others such as the sick and children) unable to provide for themselves through their own labour or from other resources.

Outside of the workhouse (or in the community) a meagre and restricted form of ‘outdoor’ relief was introduced in Ireland as a response to the Great Potato Famine of 1845-9. Under the Poor Relief Extension Act of 1847, money or food was distributed to millions of people. Notwithstanding this, prevailing policies of formal care in the nineteenth century were clearly based on allocating welfare in the workhouse, as has been noted by Blackwell *et al.* (1992). In Ireland, the State
was the dominant provider and funder of institutional care, which historically was designed to act only as a safety net. As relief was initially granted only in the workhouse, it provided an institutional solution to the problem of providing relief for destitute older people who could not provide for themselves from their own resources. There were no pensions in Ireland until 1909 when the non-contributory old age pension was introduced. Incidentally, it was 1961, more than 50 years later, before the state introduced a contributory old age pension. In the nineteenth century, if the family could not care for their older relatives, then institutionalisation was likely to be the main recourse. In other words, a policy of allocating welfare to poor older people in institutions was practised in Ireland when care by the family did not exist or where family for some reason were not in a position to provide care. This construction of Irish social services was noted in the *Care of the Aged Report*:

> In the past, services for the aged, other than those provided from their own resources or with the help of relatives and friends, were confined almost entirely to the destitute (Inter-departmental Committee on the Care of the Aged, 1968: 48).

A counterpart to the state’s policy of allocating welfare to older people within the workhouse (and later the County Homes) was the tendency to rely on the family as the primary provider of care for older people (as well as other groups in need of care) outside of the workhouse. This policy was bound to place responsibility for care upon individuals and their families as the principle of familial responsibility, whereby the ‘aged’ should be cared for first and foremost by the family, was engendered in the Irish Poor Law. Traditionally, it has been the family who has taken most responsibility for the care of older people in Ireland (Convery, 2001). Ireland does not impose a legal responsibility for caring and the duties of the state are not clearly defined (Millar and Warman, 1996) but the limited provision of formal care services for older people in Ireland has traditionally been based on the widely held assumption that much of the care required would be provided informally by the family (Fahey, 1997; McGlone and Cronin, 1994). The conventional view has been that first and foremost the family had responsibility for looking after their older relatives. As Timonen and Doyle (2008: 79) put it, ‘all care and help in the private sphere of a home was assumed to originate in the kin

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4 The non-contributory old age pension introduced by the Old Age Pension Act, 1908, was a strictly means-tested pension for people over 70 years of age.
and neighbourhood network'. Despite this, in the nineteenth century religious orders and congregations emerged as providers of social services in addition to their role of disseminating and safeguarding the faith (Fahey, 1998).

2.2.2 The early part of the twentieth century (1900-1939)

At the beginning of the twentieth century new liberal welfare entitlements were introduced. The old age pension established in Ireland in 1908 was an extension of the old age pension system established in Britain at the time, as Ireland was still under the rule of the United Kingdom of Britain and Ireland (Cousins, 1995). This was strictly means-tested. It was only for those over 70 years of age. However, the early years of the twentieth century saw no fundamental change in the system of care for older people. A policy of allocating welfare to the 'aged' within institutions continued into the twentieth century, coexisting with second wave liberalism. There was, however, increasing awareness of the need for reform. One indication of this was the formation of the Irish Workhouse Association in 1896. Another indication is the recommendation by Commissions on Poor Law Reform in 1903 and 1909 that the infirm and the aged be removed from workhouses and placed in separate institutions. However, their recommendations were not implemented (O'Loughlin, 2005). Although most people in their old age were cared for and died at home, by the beginning of the nineteenth century, private nursing homes attached to voluntary hospitals were increasingly becoming popular with the middle classes who could afford the fees (Barrington, 1987).

In the 1920s, the new Irish Free State had to deal with the aftermath of a civil war. Poverty in Ireland, especially in remote rural areas, was exceptional by contemporary Western European standards (Foster, 1989). Economic constraints were heightened by a world wide economic recession. There was no money to spend on health and other social services. The old age pension was actually cut by a shilling a week in 1924. However, after gaining independence, the Irish parliament began to abolish the workhouse system. A reorganisation of the Poor Law system resulted in the closure of some workhouses. The majority of the remaining workhouses were converted to hospitals and came to form part of a

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5 With the signing of the Treaty of 1921, independence was gained from Britain and the Irish Free State was founded in 1922.
very basic hospital service throughout the country, which eventually grew into the state hospital system. In each county of Ireland, a workhouse was selected to accommodate people from the workhouses who were not considered to need hospital or other special treatment and designated the 'County Home' (O'Loughlin, 2005: 225). The 'general impression or implied intention' was that the County Homes would be reserved for the 'aged, infirm poor and chronic invalids' (Barrington, 1987: 93; Department of Health, 1951: 7). There was an expectation that any residents who should require medical or nursing care should be removed to a hospital (Department of Health, 1951). However, the County Homes remained the main provision not only for 'the aged, whether sick or infirm' but also for 'the aged' who were 'in need only of shelter and maintenance' (Interdepartmental Committee on the Care of the Aged, 1968: 30).

It is pertinent to consider the significance of the principle of subsidiarity as a factor influencing Irish social policy, which has been the subject of recent debate. In simple terms, the principle of subsidiarity dictates that the State should not intervene in the relationship between Catholic institutions and the family. The notion of subsidiarity is a basic principle underpinning Catholic social teaching, which was widely adopted across Europe (Johnson, 2005). It was first advanced in a Papal encyclical in 1891, Rerum Novarum, which held that ‘the domestic household is antecedent, as well in idea as in fact, to the gathering of men into a community’ (Pope Leo XIII, 1891, § 10). It was with this publication that the Catholic Church first ‘acquired anything approaching a formal body of social thought’ (Fahey, 1998: 417). The principle of subsidiarity was further developed in the 1931 Papal encyclical, Quadragesimo Anno (Pope Pius XI, 1931). When applied to the context of care for older people, the principle of subsidiarity would dictate that care should be provided in the first instance by the family and by other informal carers, such as neighbours and friends. Where this is not possible, Church and voluntary organisations should step in to provide care. Only when the family and these organisations had reached their limit should the state intervene (Timonen and Doyle, 2006; 2008).

Fahey (1998: 419-20) argues that although the doctrine of subsidiarity did lead to some resistance on the part of the Catholic Church to the expansion of state social service provision, the actual impact of Catholic social teaching on social policy in Ireland was ‘smaller than the level of interest and comment it generated would suggest’. Furthermore, religious congregations providing social services
acted much the same way after the publication of Papal encyclicals in 1891 and 1931 as they had done before (Fahey, 1998). However, it is held (Barrington, 1987) that the principle of subsidiarity was a central tenet of Irish social policy from the 1930s and that in accordance with the principle of subsidiarity, the Catholic Church in Ireland, with its influence through social service provision in a range of areas including health and social care, actively opposed a broader role for the state in these and other areas such as education.

The Catholic Church was also concerned to stress the importance of the family. It might be argued that Catholic Church has had a major influence on the development of policy on ageing-related care through its promotion of the concept of familial duty and responsibility which draws strength from Catholic social teaching. Historically speaking, the roots of the conventional Christian view of filial duty and responsibility can be found in the Old Testament of the Christian Bible, in which there are many references to the need to cherish parents in old age (as well as to their wisdom and honour status) (Johnson, 2005). Similarly, filial duty and responsibility is also articulated in other religious (including Islamic) and philosophical codes (Johnson, 2005). Furthermore, there is no conflict between liberal policy and the principle of subsidiarity that underpinned Catholic social teaching.

While state provision in the area of ageing-related care (and others areas) in Ireland was not generous (Fahey, 1998), there was a gradual development of formal (non-state) care services for older people living in the community. In the absence of state provision in the area of formal community care services for older people living at home and in the context of the principle of subsidiarity, voluntary (and in many cases religious) organisations played a pioneering role in the development of health and social care services for older people in Ireland, as they had done in other areas such as disability (Quin, 2003). It was voluntary initiatives that led the way in setting up and providing domiciliary nursing services at the end of the nineteenth century and in the decades that followed with the establishment in 1890 of the Queen Victoria’s Jubilee Institute for Nurses and the founding in 1903 of the Lady Dudley Scheme (Government of Ireland, 1998; Timonen and Doyle, 2006). The first formal domiciliary or home-based social care services that were offered to older people in Ireland were also established and provided by voluntary organisations (Timonen and Doyle, 2006; 2008), although they were not aimed at meeting the needs of older people in particular...
(Convery, 1987). The emergence of voluntary (religious) organisations had the considerable effect of increasing the overall level and standard of health and related service provision.

2.2.3 Post World War II

(i) The reconstruction of County Homes

As mentioned earlier, with the break-up of the workhouse system, some of the workhouses were converted into County Homes to accommodate those who were not considered to need hospital or other special treatment. However, in the late 1940s nineteenth century conditions still prevailed in some of the County Homes (Foster, 1989). In 1949 an Inter-departmental Committee recommended the reconstruction of the County Home to house the aged and chronic sick. A White Paper in 1951 accepted these recommendations and grant-aided the work. Although the County Homes remained the main provision for ‘the aged, whether sick or infirm or in need only of shelter and maintenance’ until the Inter-departmental Committee on the Care of the Aged reported in 1968 (O’Loughlin, 2005: 224-5), a more liberal code for the governing of county homes was introduced under the Health Act, 1953 (Hensey, 1979: 27). The break-up of the workhouses thus laid a tradition of providing care to older people in institutions that are entirely distinct from hospitals.

There has been a long tradition of private nursing home care for older people in Ireland (Barrington, 1987; Working Party on Services for Older People, 1988). Nevertheless, the first formal reference to state responsibility for care of older people in private residential units was made in the Health (Homes for Incapacitated Persons) Act, 1964. The Act made provisions for the Minister for Health to introduce regulations to govern the registration and operation of private (for-profit) (but not voluntary) nursing homes in which older people resided in Ireland. In 1966 regulations were introduced, which set minimum standards for accommodation, food and care in private nursing homes (O’Shea, 2002).

(ii) Welfare state expansion

Right across Europe, the 1940s was the start of a period of expansion of health and social care services for older people (Walker, 1999). Ireland was no
exception. After the Second World War the role of the state in the provision of domiciliary nursing care gradually expanded (Hensey, 1979; Timonen and Doyle, 2006; 2008). Section 102 of the Health Act, 1947, gave health authorities the power to appoint nurses for district duties.

A health authority may, with the consent of the Minister, make arrangements for the provision of a nurse or nurses to give to any person requiring the same, advice and assistance on matters relating to health and to assist sick persons.

There was no obligation on the health authorities to provide a nursing home service and it was the 1950s before the authorities commenced the development of this service (Hensey, 1979). By the end of the 1960s, domiciliary and midwifery nursing services and district nursing services provided by health authorities and voluntary organisations had amalgamated so that public health nursing came under the remit of the statutory authorities. The title of ‘district nurse’ which had been used by health authorities was changed to ‘public health nurse’ and a more clearly defined role for the PHN was outlined in a Department of Health Circular No. 27/66 of 1966. As stated in the circular the broad aim of the ‘district nursing service’ was to make PHNs ‘available to individuals and to families in each area throughout the country’, while one of the more specific roles of the PHN was to provide ‘general domiciliary nursing, particularly for the aged’ (para. 7) in all income groups - lower, middle and higher (para. 15) (NCPDNM, 2005: 9).

The voluntary sector is considered to play a residual role in the provision of social care services for older people in Ireland in comparison to the family (Convery, 2001). Notwithstanding this, local and national voluntary sector organisations have played an important and longstanding role in the provision of both community-based and home-based social care services for older people. According to Convery (1987), it was during the 1950s that (denominational and non-denominational) voluntary organisations were first established to meet the specific (non-nursing) needs of older people. Convery (1987) provides an account of how the Dublin Old People’s Committee came into being in 1950. It

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6 In Britain, ‘formal health visiting expanded in the early years of the twentieth century, having emerged as part of the philanthropic response to situations of extreme poverty and deprivation in communities’ (Kelly, Mabbett and Thomé, 1998: 157).
was also during the 1950s that the state’s role in financing and supporting a range of community care services provided by sectors other than the statutory authorities began to develop. Under Section 65 (1) of the Health Act, 1953, health authorities were given the power to afford grants and other forms of aid to voluntary agencies providing services ‘similar or ancillary to’ the services of the health boards:

A health authority may, with the approval of the Minister, give assistance in any one or more of the following ways to any body which provides or proposes to provide a service similar or ancillary to a service which the health authority may provide:

(a) by contributing to the expenses incurred by the body,
(b) by supplying to the body fuel, light, food, water or other commodity,
(c) by permitting the use by the body of premises maintained by the health authority and, where requisite, executing alterations and repairs to and supplying furniture and fittings for such premises,
(d) by providing premises (with all requisite furniture and fittings) for use by the body.

Under the provisions of the Act, health authorities could make grants on a discretionary basis to voluntary organisations towards the costs of providing a range of services (Hensey, 1979; Timonen and Doyle, 2006; 2008). Although the services were not specifically mentioned in the legislation, they included home help services, meals services and laundry services as well as para-medical services such as occupational therapy, community physiotherapy, chiropody services and day care centres. In some cases, the health authorities approached voluntary organisations and asked them to provide social care services such as a meals service (Convery, 1987). Convery (1987) also provides an account of how around the mid-1960s County Medical Officers were asked by the Department of Health to call a meeting of leaders in each parish to ask them to set up an Old Folks Committee in their parish.

These changes signalled a move away from a strict interpretation of the principle of subsidiarity and a move towards a mixed economy of care characterised by a role for the state as a direct provider of services and as a funder of service
provision by other sectors. According to Fanning (2003), this shift could be used to mark the emergence of a distinct post-war era in social policy in Ireland.

Although the role of the state expanded with regard to the provision and financing of care for older people living in the community, the role of the state as a provider of services for older people within the mixed economy of care remained less developed in Ireland than in other European countries such as Britain. Ireland was a far poorer country than Britain at that time. The economy in Ireland after the Second World War was relatively underdeveloped as the economic resources to support the expansion of welfare provisions that emerged elsewhere in Europe were not available in Ireland. The Irish people had not gone through the same experience of WWII. It was a rural society, and very conservative with a powerful Catholic Church.

2.3 SOCIAL AND ECONOMIC TRANSFORMATION (1958-2005)

The late 1950s have been identified as the point in time when social and economic transformation commenced in Ireland (Kaim-Caudle, 1967). More specifically, the year 1958, which saw the publication of Programme for Economic Expansion for the period 1959-1963, is considered to mark a major turning point in Ireland’s economic development. At this time it was formally recognised that the introspective, protectionist strategy adopted since the 1930s was not working. It was widely accepted that a new approach was needed and that any welfare expansion depended on economic growth. The year 1958 marked the end of protectionism and paved the way for economic and societal openness and participation in the world market. Another aspect of the shift in government policy was a new emphasis on facilitating the implementation of economic planning through the use of consultative bodies and negotiation between the ‘social partners’ - trade union bodies, employer associations, farmers interests and the state - was institutionalised (Breen et al., 1990). Developing the economy and maintaining stable industrial relations dominated tripartite programmes. Around this time, a number of other important social and demographic changes were taking place. During the 1960s Ireland became a predominantly urban society, and dependence on agriculture waned, including as a provider of employment. There was reversal in the population decline.
The Irish economy grew from 1960 onwards, but the pace of growth and expansion was uneven. During the 1970s, there was high youth unemployment and in-migration. There was increasing participation of women in the labour force. There was a demand by women to have choice to continue in paid work while having children, which was aided by Ireland’s accession to the EU in the 1970s. This resulted in the removal of the marriage bar and the institution of equality legislation in the form of the Employment Equality Act, 1977, the Unfair Dismissals Act, 1977, and legislation to protect pregnant workers, the Maternity (Protection) Act, 1981.

The phrase ‘dash for growth’ has been coined to describe policies relating to economic development in Ireland in the 1970s. This period was characterised by increased public spending and high levels of government borrowing to offset inflation. Tansey (1998) argues that the ‘future was mortgaged to pay for the present’. One of the ways in which Government policy sought to provide for employment growth during the 1970s was through the direct creation of jobs in the public sector (Tansey, 1988). The state sector was expanded, marking a change in the role of the Irish State. This was a deliberate policy of government. By expanding the public service, the government aimed to counteract the adverse employment effects of diminishing demands for workers in the other sectors of the economy. This inevitably resulted in an increase in public expenditure.

The 1980s was a period of economic downturn as a result of government overspending and high levels of borrowing. Employment declined sharply. There was a real sense of economic crisis. Unemployment was very high and grew to 17.4 per cent in 1986 and almost two-thirds were classified as long-term unemployed. Emigration increased. A policy shift emerged in the mid-1980s based on competitiveness. This followed the view that government in Ireland could not spend and borrow the country back to prosperity (Fitzgerald, 1994).

In 1987 issues such as tax reform and welfare spending were introduced into negotiations between government and the social partners. From the 1987 onwards, economic expansion took off again under the Programme for National Recovery (1987–1990) – a national collective bargaining agreement which was signed by the government, employer bodies and the trade union movement. Under the agreement, spending and borrowing were curtailed, tax cuts were
introduced to raise the real disposable incomes of workers and a pay deal was agreed. Jobs were created but unemployment levels remained high.

In the mid-1990s, Ireland experienced an unprecedented expansion in employment – the era of the so-called Celtic Tiger. From mid-1990s, the economic boom was coupled with an increase in employment with the addition of large numbers each year to the total workforce and rapid expansion in employment. Employment growth was concentrated in the second half of the 1990s. Agriculture declined, the service sector showed greatest increase and industrial employment grew. There has been an increased participation in the labour market, especially by women, and unemployment fell dramatically (Tansey, 1998). The unemployment rate fell to a low of 3.7 per cent in 2001. However, the expansion of the economy brought with it new challenges (Fanning, 2003).

Traditionally, the focus has been on alleviating unemployment. One of the new challenges was how to alleviate labour market shortages and associated recruitment difficulties. The emphasis was focused on immigration, older workers, up-skilling the least skilled workers, removing barriers facing women who want to enter or return to the labour market and the rights of people with disabilities to participate in the labour market.

2.4 COMPARING AGEING-RELATED CARE SYSTEMS: CONSIDERING THE CASE OF IRELAND

There have been many attempts at both describing and defining the characteristics of the Irish welfare state within a comparative perspective (Cousins, 1997; Gough, 2001; McLaughlin, 2001; O’Donnell, 1999; O’Sullivan, 2004). One of the most ambitious attempts to study the development of welfare state regimes was made by Esping-Andersen (1990) in The Three Worlds of Welfare Capitalism. Within Esping-Andersen’s (1990, 1999) welfare state regime classification, Ireland is situated as a member of the ‘liberal welfare regimes’ (alongside the UK, Canada and the USA).

Ireland’s system of long-term care is an important component of Ireland’s welfare state. Yet, there have been fewer attempts at locating it in a comparative context. One of the reasons for this is that the focus of most comparative research is on state social transfer payment schemes, which emphasises the relationship between welfare and work, with work being defined as paid work on the labour
market. For example, Esping Andersen (1990) chose de-commodification (along with social stratification) as one of his central concepts in considering welfare state regimes. The degree of de-commodification refers to the extent to which state welfare schemes allow people to live without selling their labour in the labour market. However, as Alber (1995) observes, many older people, and particularly older people with care needs, are no longer participating in the labour market. It follows that de-commodification is not the most pressing concern for older people. Rather, the (insufficient) supply of social services, and in particular long-term care services, is more crucial.

Alber (1995) argues that as well as focusing on social transfers, comparative welfare state research needs to study social services, as they are 'increasingly important ingredients of welfare state production'. Accordingly, Alber (1995) proposes a set of variables to map variations in service supply\(^7\) and a checklist of variables which might help to explain such variations.\(^8\) Alber applies this research perspective to a comparative analysis of Denmark, the Netherlands and Germany using the country reports of these countries supplied to the Observatory on Old Age Policies of the European Commission. Ireland was not selected as a country for comparative analysis in this research because evidently of the lack of available data.

There has been much criticism from feminist scholars (most notably, Langan and Ostner, 1991; Lewis, 1992; O'Connor, 1993; Orloff, 1993) and in the work of Taylor-Gooby (1991) of gender-blindness in Esping-Andersen's work and other mainstream approaches to comparing welfare state regimes. One of the major shortcomings in the analysis has been highlighted by Lewis (1992), who points out that a central issue missing from Esping-Andersen's analysis is that of unpaid work. In a similar vein, Orloff (1993) argues that by focusing on the relationship between the state and labour markets, mainstream comparative research has ignored the relationship between the state and the family. This is an issue of importance because unpaid work, primarily carried out by women within the family home, also provides welfare. This is relevant for this discussion as unpaid work includes informal care of older people and, as mentioned earlier, it is the family

\(^7\) Namely, expenditure on social services for older people, the number and staffing of residential care facilities and home care services, and take-up ratios.

\(^8\) Namely, the regulatory structure, financial structure, structure of supply, and degree of consumer power.
who takes most responsibility for the care of older people in Ireland (Convery, 2001), as in most other countries.

According to Lewis (1992), there is a problem with typologies of welfare states that fail to recognise the contribution of unpaid work. She argues that it is crucial to look at the relationship between welfare, paid work and unpaid work. Lewis (1992) suggests that the notion of a male breadwinner model has historically cut across typologies of welfare state regimes. Comparing Britain, Ireland, France and Sweden, Lewis (1992) suggests that there are three variants of the male breadwinner model. Sweden typifies the 'weak' male breadwinner or dual breadwinner model. France offers an example of the 'modified' male breadwinner model. Along with Britain, Ireland's welfare state has historically been characterised by a 'strong' male breadwinner model. The main features of this model are that a dividing line is firmly drawn between public and private responsibility; women entering the workplace do so on the similar terms to men; and it is assumed that women provide childcare and minimal provision is made for leave and pay.

O'Donnell (1999: 80) rightly argues that the 'the usefulness of gender perspectives in the analysis of Lewis and others is undeniable, when such substantive issues as female labour market participation and childcare provision, ignored in other analyses, are considered'. However, the tendency in feminist analysis of welfare state regimes to reflect younger women's concerns about equality of access to and in the labour market and childcare issues has meant that less attention has been paid to the substantive issues facing older women such as long-term care (both as providers and recipients of care), a charge that can be levelled at feminist theorists more generally (Fennell et al., 1988). This is in spite of the fact that women predominate as age increases and feminists 'are well equipped to theorise the position of marginalised groups' (Arber and Ginn, 1991: 28-29). If long-term care issues were to be included in Lewis's analysis, another feature of Ireland's welfare state, as a 'strong' male breadwinner model, would surely be a traditionally low level of social care services for older people and the assumption that women will provide care for older relatives with minimal provision for leave and pay. This, of course, does not address the de-commodification issue for older women caring for other older people, some of whom would have retired from the labour market, and others who would have
either experienced interruptions in their working lives or not engaged in paid work at all because of their domestic roles and responsibilities in the home.

Building on feminist perspectives and drawing on Hobson’s (1990) expression ‘exit out of the family’, Anttonen and Sipilä (1997) take up the question of whether social care services can give women the opportunity to take up a paid job outside the home and become less dependent on the family. Anttonen and Sipilä (1997) focus on statutory social care services, which they understand to be the ‘means of strengthening the autonomy of both service providers and services receivers’, particularly working age women. Anttonen and Sipilä’s work is interesting for this discussion because the social care services they focus on include social care services for older people (as well as day care services for children). They chose Ireland as one of the 14 countries in their research. Furthermore, by describing the quantitative differences in social care services across Europe, Anttonen and Sipilä’s work offers a step towards bringing social care services (for older people) into comparative social policy research, which is an explicit aim of their research.

With respect to social care services for older people, the two variables Anttonen and Sipilä (1997) examine are older people over 65 in institutional care as a proportion of the age group and recipients of home help services aged 65 or over as a proportion of the age group. Anttonen and Sipilä make some crude distinctions between the 14 countries in the research based on the situation in the later 1980s. While a crude distinction can be made along two lines between those countries with abundant (Denmark, Sweden, Finland, Belgium and France) and those with scarce (all the other countries including Ireland) social care services, a somewhat different picture (though not for Ireland) emerges when a crude distinction is made between those countries with abundant social care services for older people (some of which have scarce services for children) and those with scarce social care services for older people (some of which have abundant services for children) (see Table 2.1 below). Ireland falls within the latter group.

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9 However, Anttonen and Sipilä draw upon statistics which do not necessarily make a distinction between public and private services.
Table 2.1: Anttonen and Sipilä’s categorisation of European social care systems

| Abundant Social care services for older people | Scarcle Social care services for older people (and children): | Belgium, France and Italy |
|-----------------------------------------------|-------------------------------------------------------------|
| Countries with abundant social care services for older people: Denmark, Sweden and Finland | Countries with scarce social care services for older people (but abundant services for children): Portugal, Greece, Spain, Ireland and Germany |
| Countries with abundant social care services for older people (but scarce services for children): the Netherlands, Norway and Great Britain |

Source: Adapted from Anttonen and Sipilä (1997: 93).

Drawing on their analysis, Anttonen and Sipilä (1997) identify two distinct models of European social care systems: the public service model, which is distinctive of the Scandinavian countries of Denmark, Sweden and Finland, and the family care model, which is distinctive of the Mediterranean countries of Portugal, Greece, Spain and Italy. They identify two further more tentative models: the means-tested model distinctive of Great Britain and the subsidiarity model distinctive of the central European countries of the Netherlands and Germany and ‘somewhat more remotely’ by France and Belgium. Ireland is an anomaly in that it comes close to two models: the British means-tested model and the Mediterranean family care model.

Timonen’s (2005) work on policy paradigms in the area of long-term care is concerned with considerations of state, family and private sector involvement in the provision of care for older people. Drawing on data relating to developments since the mid-1990s in England, France, Germany, Spain and Sweden, Timonen (2005) identifies three broad paradigms in the area of long-term care services for older people. The first is the ‘statist’ paradigm (Sweden), where the state takes extensive responsibility for financing and providing long-term care, the family plays a secondary role, and use of ‘purely private services’ is still very rare. The second is the ‘familial/individual’ paradigm (England and Spain), where families and individuals are responsible for financing long-term care. When services are available, they are means-tested and limited to a small proportion of the older.
population. In the third, referred to as the 'state pays, others provide' paradigm (France and Germany), the state has assumed responsibility for funding all or part of the costs of care while multiple providers are involved in the delivery of services, that is, family, voluntary and private sectors. Although Ireland was not included in Timonen's analysis, Ireland would presumably lie close to the 'familial/individualist' paradigm, which in all respects is an amalgamation of Anttonen and Sipilä's 'means-tested' and 'family care' models. Arguably, Ireland has some of the elements of the 'state pays, others provide' paradigm, in that Ireland relies on a mix of family, voluntary and private sector organisations to provide care for older people alongside statutory services.

Long-term care policies are not static, and as Kangas (1994) has observed, a limitation of most comparative welfare state analysis is that the relationship of a country to a welfare state regime is contingent on a particular point in time. However, Timonen (2005) examines the extent of policy change in each of the three paradigms and whether there has been convergence between the three models. Despite the lack of significant convergence, a common theme to emerge is 'the increased inclination to turn to the market as a source of care (marketisation). Ireland's long-term care policy would seemingly follow this trend.

Doyle and Timonen (2007) point out that one of the reasons that existing welfare state classifications are not entirely satisfactory in trying to understand variations across social care systems is because the field of social care is more complex and varied than that of social transfer payments. Social care services are one, albeit very important, strand of long-term care systems for older people. Cash benefits are another. As it stands (and as mentioned earlier), older people receive most of their care at home from family members. A topic of on-going debate in national and European social policy is one of how can the state support families in their care-giving role to older relatives (Hantrais, 1996). Several member states of the EU have initiatives in place to support the provision of care to older people by family members, one form of which is financial support. Glendinning, Schunk and McLaughlin (1997) identify four different models of state support in the EU for making payments aimed at encouraging family members to continue providing care to older relatives. Ireland (and the UK) belongs to the social security model. Under this model, allowances are paid directly to the family carer through the national social security/welfare system. The allowance is intended to partially replace income foregone through lost employment
opportunities, which is seen as a cost of caring. The other three models are the social insurance model, of which Germany offers an example, the attendance allowance model, which applies to Italy and France, the social services approach, typified by Finland and Sweden.

Glendinning et al. (1997) conclude that there is no single, ideal system of supporting family caring of older people. There are advantages and disadvantages associated with each model. An advantage of the social security model is that it recognises the independent rights of family caregivers to their own income. As family caregivers are not dependent on the care recipients for their income, it gives them a degree of financial independence. In addition, entitlement does not depend on medical assessments of care needs of older relatives. Furthermore, as the payments are not intended as substitutes for health and social care services, neither family caregivers nor older people are precluded from receiving these services. However, it has been argued that making such payments directly to the caregiver undermines the purchasing power of older relatives receiving care. Payments tend to very low and in reality do not fully compensate the caregiver for loss of earnings. In addition, Glendinning et al. (1997) argue that state financial supports for family carers of older people are developing in the context of cost containment. By providing incentives to families to provide care for older relatives, a major concern is to offload the costs of caring for older people onto their families.

The complexity of social care systems is aptly illustrated by the work of Rostgaard (2002: 53) who argues that 'It is the composition of social services and cash benefits that defines the total care package'. For Rostgaard (2002), the task of integrating social care policies into the debate on welfare state analysis would benefit from incorporating a study of social care cash benefits as well as social care services. Rostgaard (2002) aims to provide a comparative and empirical picture of social care for older people (and for children) in Europe based on an in-depth description and analysis of seven countries in the 1990s. Using a functional equivalence approach, Rostgaard (2002) takes into account the policy objectives of social care, pluralism in the organisation of social care, the actual provision of social care services and the provision of cash benefits as a means of either supporting the informal delivery of care or the purchase of private services. Although Ireland is not included in the analysis, the study is still useful for comparative purposes.
As mentioned above, ageing-related care policies are constantly evolving. A relatively recent development in Ireland, as in several other European countries, has been the introduction of state cash-for-care programmes offering cash payments or vouchers instead of services-in-kind to (older) people. In Ireland the scheme is referred to as the Home Care Grants scheme (HCG). A comparative analysis of cash-for-care programmes in Ireland, England, Finland and the Netherlands shows that in common with the other countries, Ireland’s cash-for-care programme has expanded, it is optional for older people in need of service to choose between the scheme and direct service provision, and private sector organisations and self-employed individuals are the main service providers. Ireland’s HOG programme also differs from the programmes in other countries in many crucial respects (Timonen, Convery and Cahill, 2006). In contrast to the Netherlands and England, the cash entitlement cannot be used to employ relatives as care workers. The proportion of costs of care covered by the programme is low in Ireland, compared to the other countries where it is either moderate or high, placing more responsibility for costs on individuals and families. The quality of services purchased is only haphazardly monitored in Ireland whereas there are either some quality controls or comprehensive monitoring in other countries.

The HCG programme was introduced in Ireland with a view to increasing freedom of choice, independence and autonomy for the care recipient, and shifting care preferences and utilisation from institutional to domiciliary care. However, other rationales were also at play. The introduction and expansion of the HCG programme was viewed as a means of compensating for deficiencies in, or lack of, direct service provision. It also reflected the ‘reluctance to invest more in direct service provision, the ambition to control the growing public expenditure on institutional care, and the view that institutional care is expensive and inappropriate for many older people’ (Timonen et al., 2006: 469). Timonen et al. (2006) predict that the introduction of HCGs is likely to shift the balance of the responsibility for care provision towards private-sector providers and individual responsibility and may lead to an unregulated market in home care services for older people. Furthermore, in sharp contrast to the other three countries studies, the HCG scheme will not offer many older people in Ireland a genuine choice between cash-for-care and direct services, because of the lack of any increase in expenditure on the latter.
Situating Ireland comparatively in welfare state regime classifications is well established and widely applied. However, a recurring theme is that Ireland does not fit neatly into clusters of welfare state regimes, including Esping-Andersen’s typology (Cousins, 1997; O’Donnell, 1999; Reeves and O’Sullivan, 2007). As seen from the discussion above, this is also the case when it comes to considering Ireland’s system of long-term care. Fittingly, Cousins (1997: 226) describes Ireland as ‘a moveable feast’. It also reflects the limitations of comparative welfare state analysis as well as the complexity of Ireland’s welfare state and elements of it (O’Donnell, 1999). According to Cochrane (1993), given that Ireland (and other countries) display(s) a mix of different elements cutting across regime types, it becomes necessary to return to a case study approach with more detailed studies of individual countries or groups of countries (or regime type). Reeves and O’Sullivan (2007: 4) highlight that an ‘extraordinary variety of labels’ have been applied to Ireland over the past two decades or so, which they argue fail to grasp the complexity and nuances of public policy in Ireland. It leads them to conclude that there is ‘confusion in situating Ireland comparatively’. Furthermore, they argue that Ireland’s system of welfare has developed under the influence of unique histories and ideologies, which differ not only from other countries but vary from one policy area to another within Ireland:

The fingerprints of discernibly unique histories and ideologies can be witnessed in different areas of public policy. Therefore, attempts to describe ‘public policy’ per se, are invariably confounded by the variation across policies’ (Reeves and O’Sullivan, 2007: 18).

Both Cochrane (1993) and Reeves and O’Sullivan (2007) provide a justification for adopting a case study approach to considering Ireland’s system of long-term care, before moving on to considering its place in welfare state regimes.

Using a case study approach is also justifiable given that the task of placing Ireland’s system of long-term care in a comparative welfare state context is clearly a complex one. It is widely acknowledged that the field of ageing-related care is inherently more complex and varied than social transfer payments to study (Anttonen and Sipilä, 1997; Doyle and Timonen, 2007; Rostgaard, 2002; Timonen, 2005). Ageing-related care can be provided in a variety of settings ranging from institutional to community- and home-based care. Ageing-related
care can be supported through the provision of direct social services, cash-for-care programmes in the form of either financial supports for informal care-givers or cash benefits to purchase care from private sector organisations. Together with the family, a plurality of organisations – public, private and voluntary – are often involved in the delivery of care. The task of integrating social care systems into the ongoing discussion on welfare state regimes is further complicated given the conceptual and methodological problems as well as difficulties with research data (Anttonen and Sipilä, 1997; Doyle and Timonen, 2007; Rostgaard, 2002; Timonen, 2005).

2.5 CHAPTER CONCLUSIONS

This chapter started with the premise that social policy and ageing-related care in Ireland can be better understood when it is placed into historical, social and economic, and comparative contexts. The chapter placed social policy and ageing-related care in Ireland in its historical context by tracing the development of social policy and ageing-related care from 1838 though to the 1960s. In attempting to do this, it became increasingly evident that there has been considerable analysis of the historical development of social policies in Ireland (Barrington, 1987; Burke, 1987; Carey, 2007; Cousins, 2005; Kennedy, 2004; Powell, 1991). The historical development of some aspects of ageing-related policies, for example, social security policies (Cousins, 2005; McCashin, 2004), has received attention. Timonen and Doyle (2006, 2008) have explored the evolution of care policy for older people in Ireland and several studies that have been commissioned by the National Council on Ageing and Older People (NCAOP) include an historical dimension. Apart from this, social policy and ageing-related care is a strand of Irish social history that has been under-explored.

This chapter offers a brief account of the main economic developments in Ireland from the 1950s when Ireland was served by isolationist and protectionist policies to the era of the so-called Celtic Tiger. This serves as a backdrop to the analysis in the three findings chapters.

The chapter situated Ireland comparatively using existing welfare state regime classifications. In seeking to do this, I was well aware of the complexities inherent in such an exercise and that the use of welfare state regime classifications is
intended to serve merely as a 'useful simplification' (Doyle and Timonen, 2007: 2). Because of the range of complexities referred to above, I follow Cochrane (1993) and Reeves and O'Sullivan (2007) by suggesting that in considering Ireland's system of ageing-related care for older people, a case study approach is required before moving on to considering Ireland's place in comparison to other welfare state regimes.
CHAPTER THREE

THEORETICAL PERSPECTIVES IN SOCIAL GERONTOLOGY: SOCIAL CONSTRUCTIONIST UNDERRPINNINGS

3.1 INTRODUCTION

The study of social policy and ageing generally, or specifically in relation to care, cannot be conducted without drawing on theory, even if implicitly. In approaching the study of social policy and ageing-related care, this thesis explicitly adopts a social constructionist standpoint, and, more particularly, social constructionist underpinnings. The purpose of this chapter is to explain what is meant by a social constructionist standpoint. The chapter does this by presenting a brief overview of the conceptual backdrop to social constructionism (Section 3.2). This is followed by an outline of key developments in social constructionist approaches (Section 3.3) and a discussion of the key elements of social constructionist approaches (Section 3.4). Section 3.5 briefly considers the purpose of social theories of ageing as well as the place of theory in social gerontology in light of concerns about its neglect.

3.2 CONCEPTUAL BACKDROP TO SOCIAL CONSTRUCTIONISM

Social constructionism can be described as a 'movement which has arisen from and is influenced by a variety of disciplines and intellectual traditions' (Burr, 2003: 15). Although it cannot be pinned down to a single starting place (Burr, 2003), the term social construction was formally introduced by Berger and Luckmann (1979) in The Social Construction of Reality. This work, which is a major contribution to social construction, builds on several perspectives (Burr, 2003). These include phenomenology, ethnomethodology and symbolic interactionism.

Social constructionism is clearly inspired by the works of Alfred Schutz (1932) who attempted to develop social phenomenology and set out its basic principles
in *Phenomenology of the Social World*. From his earliest writings, Schutz stressed that ‘the social world is interpreted in terms of common-sense categories and constructs which are largely social in origin’ (Heritage, 1987: 229). Schutz (1932) was particularly interested in ‘ordinary members’ of society and the ways in which they constitute and reconstitute the world of everyday life. He described how social actors draw up social constructs and categories, based on their ‘stream of experience’ of objects through a process of ‘typification’ to build up a ‘stock of knowledge’. They rely upon this ‘stock of knowledge’ in order to make sense of and navigate the world in which they live and must act.

The basic tenets of social phenomenology, as set down by Schutz, provide the basis for ethnomethodology. Ethnomethodology tries to understand the methods that ordinary people use to construct everyday life and make sense of it through the analysis of talk in interaction (Burr, 2003). Garfinkel (1984), who coined the label, drew extensively on Schutz. His work has provided a major stimulus for the development of social constructionism (Sarbin and Kitsuse, 1994). Garfinkel focused on the ‘knowledgeable ways in which, whether consciously or not, social actors recognize, produce and reproduce social actions and social structures’ (Heritage, 1987: 225-6). Ethnomethodology employs methods of participant observation in natural settings to document how people interact in everyday life. However, as Holstein and Gubrium (1994: 264) point out, ethnomethodology is ‘not a mere extension’ of Schutz’s social phenomenology. In contrast to social phenomenology, it argues that shared common-sense knowledge can never be taken-for-granted although we ‘conspire to create the impression’ that it can (Craib, 1992: 102). A distinctive aspect of ethnomethodology is conversation analysis (Heritage, 1987).

Together with social phenomenology, symbolic interactionism, a distinct theoretical perspective in social psychology, contributed to laying the foundations for the development of social constructionism (Sarbin and Kitsuse, 1994). Harold Blumer coined the term symbolic interactionism in 1937 when developing the work of George Herbert Mead at the University of Chicago. Mead (1934) argued that social interaction between humans is symbolic in nature. Because they share symbols, which are embodied in a common language that enables communication, human beings are able to interact and form social relationships. Social relations depend on people’s ability to ‘take on the role of the other’, that is, to imagine themselves in other social roles. A fundamental assertion of symbolic
interactionism is that human beings live in a world of meanings that they themselves create. Meanings are attached to all aspects of social life including ageing and are conferred onto the world by human beings through social interaction. The social constructionist movement has been influenced by Goffman’s *Presentation of the Self in Everyday Life* (1975) and *Stigma* (1963) and builds on labelling theory contributed by symbolic interactionists such as Howard Becker (1963) and David Matza (1969).

In common with phenomenology, ethnomethodology and symbolic interactionism, Berger and Luckmann (1979) considered shared common-sense meanings to be the basis of social organisation. However, in an explicit attempt to combine theories of social action with those of social structure, a major concern for Berger and Luckmann (1979) was with the relationship between the individual and society, and the way in which shared overarching meanings develop out of common-sense meanings. For Berger and Luckmann (1979: 78), the relationship between the individual and society ‘is and remains a dialectical one’. Through social interaction, human beings continually construct the social world, which is then experienced as reality, as something fixed and pre-given, as ‘something other than a human product’.

Berger and Luckmann (1979) have provided the basis for an understanding of how everyday knowledge evolves and the construction of shared overarching meanings in society. Once particular models of the social world are accepted, they become ‘recipes’ that are institutionalised as part of the collective stock of knowledge which in turn ‘reflect some (dominant) variant of the truth’ (Estes et al., 2003: 33). This might suggest that people are constrained by society (to the extent that we must inevitably live our lives within the institutions and frameworks of meaning handing down to us by previous generations). However, understanding the relationship between the individual and society in terms of a dialectical process makes it possible to also think of people as being agentic, always actively constructing the social world (Burr, 2003).

The social construction of reality relies upon a three-stage process of externalization, objectivation and internalization (Berger and Luckmann, 1979). Fundamental to this process is the ability of human beings to create symbols, which carry meanings that can be detached from the ‘here and now’ (Berger and Luckmann, 1979: 51). According to Berger and Luckmann (1979), language is
the most important system of symbols. It allows human beings to attach meanings to objects and externalise or make available these meanings to other people. Externalised meanings are then experienced as objective reality. Through the shared use of symbolic systems, particularly language, social institutions are constructed and 'exist as external reality' (Berger and Luckmann, 1979: 78). This is the process of objectivation. Internalisation is the final phase of the process. The world into which human beings are born has already being fashioned by their predecessors. Through socialisation (primary and secondary) the individual comes to understand the objective world in terms of the meanings conferred on it by society and becomes able to participate in meaningful interaction with other people.

3.3 KEY DEVELOPMENTS IN SOCIAL CONSTRUCTIONIST APPROACHES

Social constructionism has developed in various ways since the early formulations and can be found in a variety of disciplines (Burr, 2003; Clarke, 2001). For social constructionists, the processes of social construction occur at all levels (Estes et al., 2003) the macro, micro and the meso level. Social constructionist perspectives that can be described as micro social constructionism are an important strand and can be distinguished from social constructionist perspectives that focus almost exclusively on the macro level, for example, the intersection between social constructionism and Marxist perspectives. While each lie at rather opposite poles in terms of their analysis, the distinction is not altogether clear cut. The macro-micro distinction is, however, useful as a framework for examining social constructionism. Another key intersection with social constructionism is the work of Michel Foucault. The intersection with social constructionism of these approaches is discussed in more detail below.

3.3.1 Micro social constructionism

Within an interpretive tradition, work on ageing from a social constructionist viewpoint has been developed by social phenomenologists such as Jaber Gubrium (1987). This approach builds on the perspectives of phenomenology, ethnomethodology and symbolic interactionism (Gubrium and Holstein, 1999). It can be referred to as the micro social constructionist perspective as it focuses on
micro and meso level processes by which age-related concepts are socially constructed.

Incorporating human subjectivity into the study of ageing is one of the leading concerns of a micro social constructionist perspective on ageing. The emphasis on the subjective experience is particularly prominent in the work of Gubrium (1993), who is concerned with the manner in which experience is given voice. Social construction of ageing from a micro level perspective seek to interpret the process of ageing in terms of interactions between older people and others in society as well as among older people themselves. For example, a symbolic interactionist perspective underlines that ageing may be socially constructed within interpersonal relations such as between a daughter and mother in a caring relationship, a social care worker and a care recipient, a doctor and patient (Walker, 1999). Adopting a symbolic interactionist framework thus supports the view that 'the emergence of people’s subjective sense of aging arises from a range of communications from those immediately around them, as well as from those arising in the culture generally' (Karp, 2000: 83).

A view shared by micro social constructionists is that context organises meaning (Gubrium and Holstein, 1999). In other words, while all things are meaningful, the particular meaning varies according to the context. Gubrium (1993: 50) uses the concept of 'local culture' to provide a way of conceptualising how context fills ageing with particular meaning. Local cultures such as familial and friendship networks, residential care settings and support groups can each provide a context, albeit changing, for attributing meaning to topics like quality of life and care-giving. For Gubrium (1993: 50) ‘taking account of how the elderly give voice to experience requires that context be given its due’.

Gubrium and Holstein (1999: 292) identify four distinct areas of research in ageing from a micro social constructionist perspective. The first is research that focuses on the social construction of identity. This approach has been used by Sarah Matthews (1979) to examine the management of self-identity among older women. Drawing on symbolic interactionism and Goffman’s (1963) concept of stigma, Matthews (1979) argues that the concept of old age is devalued in contemporary society. She found that the older women she interviewed are continuously subjected to negative stereotypes and images such as infirmity,
senility and worthlessness and uncovered a range of strategies used by the women to sustain positive identities.

A second approach focuses at a meso level on ‘social worlds’ or the settings in which constructions of personal meanings emerge and evolve. This approach argues that organisational and institutional structures and processes influence the experience of ageing. It is also through these organisations that individuals construct personal meanings in their daily lives (Estes et al., 2003).

Narrative analysis comprises a third way of approaching experiences of ageing through the examination of personal stories and storytelling (Gubrium and Holstein, 1999). The fourth approach is research that shows how the category of age can be used in everyday settings to construct backgrounds or contexts for decision-making about older people (Gubrium and Holstein, 1999).

3.3.2 Marxist perspectives and the social construction of ideas

Social constructionism has been influenced by Karl Marx, who theorised the role of social structures in shaping human consciousness and interpretations of reality. Marx’s theory of the social construction of human ideas is based on the view that thinking and the products of thinking are derived from the activities and social relationships in which people engage (Clarke, 2001). From a Marxist perspective, under capitalism the dominant social relationships are based on class. In capitalist societies, the mode of production, which determines the manner in which wealth is produced and appropriated, is characterised by the private ownership of the means of production such as land and labour. The ruling class (bourgeoisie) owns the means of production and the working class (proletariat) owns nothing other than its labour power which it must sell to the capitalist in order to survive (Marx and Engels, 1991 [1848]). According to Marxism, social inequality and class struggle are inherent in the organisation of capitalist production and social relationships established under the capitalist mode of production are characterised by exploitation and conflict (O’Brien and Penna, 1998). For Marx, the relationship between the ruling class and the working class and the way in which the division of labour is organised comprises the economic base of society. This can be distinguished from the economic superstructure of society, which consists of the ideological forms through which class conflict is played out (Marx, 1864 [1859]).
Marx argues that the mode of production determines not only the production and appropriation of wealth, but also determines people's knowledge and understanding of the reality of the situation. In capitalist societies, the dominant ideas are the ideas of the ruling class. They have the power, which stems from the economic base, to influence the production and dissemination of ideas. These ideas and beliefs are widely accepted in society and sanction a reality that serves the interests of relatively powerful groups in society but masks inequitable social arrangements. According to a classical Marxist perspective, because they have a distorted understanding of their position in society, people are therefore said to be living in 'false consciousness'. From a Marxist view, discourses may be seen as ways of talking about our lives, ways of constructing them, living them out and representing them to ourselves and others that mask iniquitous social arrangements. In other words, we may be entering into forms of life which are not necessarily to our own interest.

The Marxist concept of ideology allows social constructionists to take a critical standpoint, to raise concerns about the processes of conflict, social division and power, and to address the question of what social constructions become dominant (Clarke, 2001). However, there are limitations and problems with the Marxist version of ideology (Burr, 2003). For example, the emphasis on structure leaves little scope for individuals or groups to construct their own meanings and destinies. Phillipson (1995) argues that the link between structures at a macro level and behaviour and action at an individual level is unclear and that consideration is not given to the way in which individuals can confront the effect of different forms of institutional control.

3.3.3 Gramsci and ideological hegemony

Antonio Gramsci, an Italian neo-Marxist writer, also wrote about how power was legitimated through the ideological structure of society (Symonds, 1998). However, unlike Marx who gave primacy to economic forces, he emphasised the significance of culture in sustaining capitalist society. For Gramsci (1971), the power of an ideology stems from the power to articulate a set of ideas and to organise the culture of a society into disseminating this view of the world which then appears commonplace. When a set of ideas comes to dominate social and
political discourse and debates are conducted within its parameters, an ideology is said to have gained hegemony. For an idea to gain hegemony, force is not necessary. Rather, political and economic regimes rely on the capacity to orchestrate sufficient consent for an ideology from other social groups. A powerful 'bloc' supporting the interests of the bourgeoisie is thus created. This is achieved by building a web of political alliances, disseminating dominant ideologies and creating a network of institutions. The prevailing ideologies of a culture are a reflection of the dominant social relations.

In social gerontology, the political economy of ageing perspective, which has taken up Marxist ideas (Estes et al., 2003: 17; Estes and Associates, 2001; Quadagno and Reid, 1999; Walker, 1999), is an important strand of social constructionist theories (Blaikie, 1999). It emphasises macro level processes such as the role of the state and the economy in constructing the experience of ageing and the conditions of old age (Estes et al., 2003). A key task of the political economy of ageing perspective had been to explain the role that the state and capitalism have played in the discrimination and marginalisation of older people (Estes et al., 2003). For example, Peter Townsend (1981; 1986) developed the political economy of ageing perspective using the concept of 'structured dependency' of older people. Suggesting that dependency in older age is socially manufactured, Townsend (1981: 9) stated that ‘society creates the framework of institutions and rules within which the general problems of the elderly emerge and, indeed, are manufactured’. According to Townsend (1981), dependency is a consequence of forced exclusion from the labour market, poverty, institutionalisation and restricted roles in the community and the domestic sphere.

3.3.4 Foucault

The work of Michel Foucault, a poststructuralist French historian and philosopher, also provides an important conceptual backdrop to social constructionism (Burr 2003). Using the topics of mental illness, medicine, prisons, and sexuality, Foucault (1967, 1973, 1975, 1976) argued that phenomena in society can be widely represented in particular ways. He referred to representations that make it possible for the world to be seen in a certain way as discourse. As a focal concept for post-structuralism, discourse ‘draws attention to the ways in which forms of knowledge are socially produced and organised’ (Clarke, 2001: 10).
Unlike the Marxist conception of ideologies expressing or articulating social interests, poststructuralists suggest that the intertwining of knowledge and power in specific discourses produces social reality rather than reflects it. By becoming embodied in social institutions and practices, discourses produce ‘realities’ (Clarke, 2001: 10).

Two key themes found in Foucault’s work are the analysis of systems of knowledge and the analysis of forms of power (Davidson, 1986). For Foucault, knowledge, a term he used interchangeably with ‘truth’, refers to the particular common-sense version of a phenomena prevailing in a culture at any one time. Foucault (1980: 97) explained that truth can be understood as ‘a system of ordered procedures for the production, regulation, distribution, circulation and operation of statements’. Employing a specific form of analysis which he called archaeology, Foucault (1972) aimed to provide ‘a history of statements that claim the status of truth’ (Davidson, 1986: 221). Unlike the kind of history that was concerned with describing a series of facts and events and defining the relationship between them, Foucault’s work presents a reordering of events by charting shifts in discourses related to a range of topics (Davidson, 1986; Hacking, 1989). For example, in *Madness and Civilisation* and *The Birth of the Clinic*, Foucault (1967, 1973) traced changes in the way that mental and physical illness respectively were perceived and discussed. Foucault’s approach was based on the assumption that there are systems of anonymous, unformulated and unspecified rules governing the production of a certain version of knowledge as well as its transformations (Davidson, 1986).

For Foucault, knowledge is closely bound up with power. The mutual relationship between systems of truth and forms of power is a central theme in his work (Davidson, 1986). To study how power operates in society, Foucault employed a specific method of analysis, which he called genealogy. Whereas archaeology as a method attempts to identify the rules governing the production and transformation of discourses, genealogy concentrates on the forces and relations of power linked to discourses (Davidson, 1986). For example, in *Madness and Civilisation*, Foucault (1967) traces: first the great exclusion of the mad in the mid-seventeenth century and incarceration of deviants and building of lunatic asylums. Much later with the emergence of a new body of psychiatric knowledge came new ways of talking about and dealing with the insane. The insane are brought under the care of professional experts.
Foucault’s conceptualisation of how power operates in society provides a radically different approach to the Marxist model of power (Davidson, 1986; Hacking, 1989). For Foucault, power is everywhere: ‘No one wields this power’. As Burr (2003: 68) explains, ‘the power to act in particular ways, to claim resources, to control and be controlled depends upon the knowledge currently prevailing in a society.’ Power can be exercised by drawing on particular discourses, which allow our actions to be represented in an acceptable light.

Foucault argued that societies produce ‘regimes of the truth’. Every society at specific historical points produces an all-enveloping ‘truth’ which is accepted by people in that society and brings with it particular beliefs and social practices (Foucault, 1980). As the ‘truth’ or ‘reality’ is a product, which has been constructed by people in that society, it is not fixed or everlasting.

A major contribution of post-structuralist approaches and particularly the work of Foucault is the analysis of social policy as a complex and contradictory space (Watson, 2000; Biggs, 2001). The work of Michel Foucault and the concept of discourse have been used in the analysis of social policy as it relates to older people (Katz, 1996; Powell and Biggs, 2003).

### 3.4 KEY ASSUMPTIONS AND CONCERNS

Lynch (2001) suggests that social constructionism has become so diffuse that it is difficult to have a coherent discussion of the subject. However, the sociological perspectives on which social constructionism is built all understand that social worlds are constructed in and through the meaning making of human actors. As Clarke and Cochrane (1998: 29) put it: ‘what all of the different strands that have contributed to this [social constructionist] perspective have in common is their stress on the way in which collective or shared understandings, interpretations or representations of the world shape our actions within it’. Despite diversity of the field, there are a number of key elements, assumptions and concerns underpinning social constructionist approaches.

Social constructionism puts forward the proposition that reality is socially constructed in and through language and interaction between people (Burr, 2003). The social world is inherently complex and confusing. It is language that
provides us with a system of categories for dividing up our experience and giving it meaning' (Burr, 2003: 44). In the words of Hazan (1994: 13), language ‘functions as a reality-constructing device’: it ‘sets boundaries for our universe of imagery and associations and fuses concepts, myths and symbols into accepted forms of communication’. Because they are socially constructed, the meanings carried by language are never fixed and are always contestable (Burr, 2003). They are mutable and inherently contestable. Meanings are never assumed to be universal and unchanging.

Social constructionism is often contrasted with essentialism. Social constructionist approaches are anti-essentialist in that they move away from the ideas of the naturally given and encourage taken-for-granted assumptions to be questioned and viewed in a new light. For example, social constructionist perspectives reject the view that ageing is a ‘natural’ or pre-given essence (Blaikie, 1999: 3). Even ‘the task of defining old age is considerably ... complex and inevitably involves venturing into the ... territory of social constructions, attitudes and values’ (Timonen, 2008: 7-8). Social constructionists would be critical of conventional theories of ageing such as disengagement theory, which, they argue, take the ‘facts’ of old age for granted (Lynott and Lynott, 1996). They argue that conventional theories of ageing:

treat the subjects studied as more or less ‘subject to’ the variety of conditions, forces and social facts of their everyday world. The interpretation of the so-called forces and their continuing reinterpretation, in the ongoing practice of everyday life, is ignored (Lynott and Lynott, 1996: 573).

Social constructionists are concerned with addressing the question of how or by what processes the ‘facts’ of age and age-related concepts such as dependency, for example, are socially constructed and formulated through language and social interaction and how such concepts are locally applicable. Social constructionists argue that each individual’s experience of ageing is moulded to a high degree by socio-cultural factors and reject the view that ageing is simply ‘natural’, a pre-given essence (Blaikie, 1999: 3).
Social constructionists are concerned with discourse (Burr, 2003). The term discourse stems from the work of Michel Foucault (1975, 1976), who was critical of the notion of ideologies, that is, the view that sets of ideas are used by specific groups to legitimate advantageous position in society (Clarke and Cochrane, 1998). Foucault’s opted for the term discourse, drawing on the everyday meaning of the word, which means ‘to talk about’, to refer to the way in which knowledge about a certain theme or topics is organised and understood. As Clarke and Cochrane (1998: 35) point out, discourse is ‘not just about words’. Discourse gets institutionalised in social policies and in the practices of the institutions through which they work. In this sense then discourse is also about power relations.

Another element of social constructionism is the contested nature of issues or phenomena (Clarke, 2001). For example, the biomedical discourse of ageing, a ‘master narrative of human ageing’ in western culture (Hepworth, 2003: 89; Wilson, 1991: 38), views ageing as a process in which the maturation is followed by a process of decline and decay (Hockey and James, 2003, Wilson, 1991). This discourse of ageing has been widely contested. For instance, by challenging the assumptions that old age is naturally associated with disease and decline and promoting positive images of ageing and old age, the discourse of positive ageing offers an alternative way to construct ageing and old age.

With its strong emphasis on culturally and historically situated knowledge (Gergen, 1973), social constructionism serves as a powerful challenge to a naturalistic approach to the social world (Gergen, 1999). Social constructionists hold that understandings of the world and concepts used to describe it, such as the ways in which ageing and old age are understood for example, are culturally and historically specific (Blaikie, 1999; Burr, 2003; Clarke, 2001; Vincent, 2000). Social constructionists question the social and historical roots of phenomena (Marshall, 1994). For example, their work has shown that understandings and experiences of ageing and old age differ depending on the social context in which they take place (Hockey and James, 2003; Vincent, 2003). Hockey and James (2003) present data from anthropological research conducted at the beginning of the twentieth century, which shows that stages in the life course differ depending on the social context in which they take place. This research, they argue, adds up to ‘a powerful challenge to a naturalistic approach to ageing across the life course’ (Hockey and James, 2003: 27). In more recent research, the differences in the construction of old age in two different cultural contexts, Bosnia and the UK, have
been explored (Vincent, 2003). This includes those concepts and categories used to describe the notion of ageing and old age.

Constructions of ageing also vary historically within particular societies (Hockey and James, 2003). The history of old age now forms an important area of research in the field of social gerontology (Phillipson, 2001). The study of the historical dimension to growing old has been particularly strong in the United States (Phillipson, 2001). While historical research on ageing has been less productive in Britain, there have been important contributions by Laslett (1991), and the more recent studies Old Age in English History by Thane (2000) and The Politics of Retirement in Britain, 1878-1948 by Macnicol (1998). These are considered to ‘represent major landmarks in the study of growing old’ in Britain (Phillipson, 2001: 519). There are also examples of historical studies of old age from other countries including France (Stearns, 1977) and Germany (Scharf, 1998). In comparison, the historical dimension of ageing and how understandings of ageing have changed over time in Ireland have been distinctly under-researched.

3.5 THEORETICAL PERSPECTIVES, SOCIAL POLICY AND AGEING

Social theories of ageing are important. They are important ‘to take us beyond the mere accumulation of facts’ (Marshall, 1995: 12) and are instrumental in raising important issues on ageing (Fennell et al., 1988; Jamieson, 2002). The explanatory purpose of theory is particularly significant (Bengston, Rice and Johnson, 1999; Craib, 1984; Jamieson, 2002; Victor, 2005). Theories explain rather than simply describe the social world. For Bengston et al. (1997: 5) the principal focus of theory is ‘to provide a set of lenses through which we can view and make sense of what we observe in research’, while the principal use of theory is ‘to build knowledge and understanding, in a systematic and cumulative way’. Further benefits of theory are that it can lead to predictions and interventions (Marshall, 1999; Victor, 2005). Theories can also search for meaning (Marshall, 1999).

Traditionally, theoretical issues have played a relatively small part in the field of social gerontology (Fennell et al., 1988; Victor, 2005). Social gerontology or social studies of ageing developed as a scientific discipline, insofar as the methods used to accumulate knowledge were adopted from the physical sciences.
and were largely empirical (Biggs, Hendricks and Lowenstein, 2003). Such an approach to the study of ageing tends to emphasise 'the collection of facts and observations, at the expense of conceptual reflection and theoretical inquiry' (Marshall, 1995: 149).

Since its inception, social gerontology has been closely associated with social policy (Biggs et al., 2003). It is also generally rooted in a very strong positivist tradition (Blakemore, 1998). Fennell et al. (1988: 41) have argued that the tendency to focus on ageing in terms of social welfare policies 'tends to discourage systematic theorising'. In a similar vein, Victor (2005) contends that the applied and policy-related nature of much gerontological research is a major factor in explaining the largely atheoretical character of a great deal of gerontological work. Bengston et al. (1999) point out that from the perspective of 'applied' social gerontology, theory can be viewed as being detached, and a distraction from the more pressing need for practical responses to the problems facing older people. This propensity applies to the field of social policy as a whole and not just social policy and ageing (Fanning et al., 2004a).

However, despite the view that social gerontology has ignored or neglected systematic theorising (Bengston et al., 1999; Harper, 2000; Biggs et al., 2003), the theoretical horizons of both social gerontology and social policy have greatly expanded since the early days of role and activity theories (Cavan et al., 1949; Havighurst and Albrecht, 1953) and disengagement theory (Cumming, 1963). These spawned a range of theories including modernisation theory (Burgess, 1960), continuity theory (Atchley, 1989) and age stratification theory (Riley, 1971). From the 1970s challenges to conventional theories and perspectives within the study of ageing in the form of critical gerontology began to emerge: two major paths of which are the political economy of ageing perspective and the humanities approach (Minkler, 1996). Feminist theories, by complementing and extending

10 Calling these approaches theories is somewhat misleading, as they are generally descriptive in nature (Fennell et al., 1988) and fall outside Jamieson’s (2002) definition of theory as an explanation. Within the literature on these two approaches, the term ‘theory’ is largely absent and theoretical issues were either ignored or a theoretical position was assumed without making the underlying theory explicit (Fennell et al., 1988; Lynott and Lynott, 1996).

11 It is beyond the scope of this thesis to trace the development of social theories of ageing in detail. For more information on the development of theoretical ideas and traditions within social gerontology and the individuals who developed or are linked to them, see, for example, Hendricks (1992), Lynott and Lynott (1996); Bengston, Burgess and Parrott (1997) or Marshall (1999).
critical gerontology, have too made a contribution to theorising in social gerontology (Minkler, 1996), and, indeed, have been described as ‘one of the most significant areas of theoretical development in critical approaches to social policy and ageing’ (Estes et al., 2003: 44). As Section 3.3 of this chapter has shown, micro-social constructionism and post-structuralist perspectives have also contributed to the expansion of social theories of ageing. With respect to the field of social policy, O’Brien and Penna (1998) outline a range of theoretical perspectives through which social welfare systems and provision can be understood. In Theorising Irish Social Policy, the relevance of theoretical and conceptual debates for the study of Irish social policy has been addressed (Fanning et al., 2004b).

3.6 CHAPTER CONCLUSIONS

This chapter has provided an overview of social constructionism. It described the three main perspectives - phenomenology, ethnomethodology and symbolic interactionism - that have formed the foundation stones of social constructionism. It noted the significance of The Social Construction of Reality by Berger and Luckmann (1979) and its concern with the relationship between the individual and society, and the way in which shared overarching meanings develop out of common-sense meanings.

This chapter noted that micro social constructionism is one approach (focusing on the micro level) that has developed since the early formulations. Another strand within social constructionism, political economy, has taken up the ideas of Marxism and Marxist perspectives and focuses on the macro level. A third strand draws its inspiration from Foucault. All of these perspectives have been taken up by social gerontologists and applied to the study of ageing. Despite the diversity of approaches within social constructionism, a number of key elements that they all have in common can be identified and a task of this chapter was the outline the main concerns and assumptions underpinning social constructionist approaches. Much has been made of both the importance and the neglect of theorising in social gerontology. However, this chapter concludes that there are a wide range of theoretical perspectives in social gerontology on which to draw in the study of social policy and ageing.
CHAPTER FOUR:

METHODOLOGY

4.1 INTRODUCTION

This chapter presents the methodological approach adopted for this thesis. The thesis relies on a qualitative research approach to explore the multiple discourses surrounding social policy and ageing-related care in Ireland. Section 4.2 provides a rationale for adopting a qualitative approach. Section 4.3 outlines the research design and the procedures adopted for this thesis. In particular, it outlines the four-pronged approach to data collection. Section 4.4 presents the major principles underpinning the practice of ethical research and outlines the procedures adopted to deal with ethical issues arising in relation to the research. Grounded theory methods were used to undertake the data analysis for this thesis. Section 4.5 outlines the background to grounded theory, describes the specific analytic techniques and procedures used in analysing the data.

4.2 RESEARCH METHODS

There is a wide range of research perspectives from which to choose appropriate tools for answering specific research questions in the study of social policy and ageing-related care. Both quantitative and qualitative research approaches play an important role (Victor, 2005). However, quantitative and qualitative research each represents a fundamentally different paradigm. The approach that a researcher adopts in seeking to understand a phenomenon or research problem is based on the underlying assumptions of each paradigm.

Quantitative research uses experimental methods and quantitative measures to test hypotheses. As Chapter 3 already mentioned, the study of social policy generally is rooted in a very strong positivist tradition. Social surveys are one of
the main methods of quantitative research. Quantitative research methods make use of numerical data and statistics. They are useful for describing the nature, characteristics, circumstances (such as income, living conditions and voting behaviour) and even the views of older people as well as for enumerating specific aspects of the ageing process (Victor, 2005). Two famous early examples of quantitative research are *Life and Labour of the People in London*, a study of the poor between 1889 and 1903, by Charles Booth (1902) and *Poverty: A Study of Town Life*, a social survey of poverty in York by Seebohm Rowntree (1901), which showed an alarmingly high proportion of York's population were then living below the subsistence level. An overriding concern of both of these studies as well as other studies of social conditions undertaken at the time was to discover the 'facts' of poverty. They were strongly motivated by a desire to be scientific in their approach.

The Health and Social Services for Older People (HeSSOP) I study, which was concerned with providing a broad-based assessment of health and social services from the perspective of older people living in the community (Garavan et al., 2001), provides a contemporary example of a quantitative approach to the study of social policy and ageing-related care in Ireland. HeSSOP I was later followed up by a second study, HeSSOP II, which comprised a 'repeat' and a 'longitudinal' component (O'Hanlon et al., 2005: 19). The study was extended to include the views of community dwelling people in Northern Ireland (McGee et al., 2005). These studies largely employed quantitative research methods. They incorporated a standardised survey of a representative sample of older people and used statistical data analysis.

Strauss and Corbin (1996: 11) define qualitative research as 'any type of research that produces findings not arrived at by statistical or other means of quantification'. Qualitative research uses a naturalistic approach (Lincoln and Guba, 1985). It places an emphasis on analysing words, concepts and meanings (Victor, 2005). The bulk of the analysis is interpretive (Corbin and Strauss, 2008). In keeping with social constructionism, it draws on the assumption that the social world is complex and that there are no simple explanations for things. For example, a qualitative approach seeking to capture the perspectives of older people on health and social services might start from the understanding that the

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12 Bryman (2001) has described the main methods of quantitative research as social surveys, official statistics, content analysis, experiment and 'structured' observation.
lives, experiences and views of older people are complex and multi-faceted (Gubrium and Holstein, 2000).

According to Strauss and Corbin (1996), a valid reason for choosing qualitative research is the nature of the research problem. This thesis sets out to explore the multiple discourses underpinning social policy as it relates to the care of older people in Ireland. As this thesis attempts to understand the way in which knowledge about social policy and ageing-related care is organised and understood, it lends itself to getting into the field and finding out what written texts say and what people are thinking about various aspects of this topic. It also lends itself to trying to obtain multiple perspectives about key aspects of social policy and ageing-related care. The concern for different perspectives and different people’s point of view has a strong tradition in qualitative research (Silverman, 2005). Therefore, qualitative research was judged to be the most appropriate methodological approach for conducting the research in this thesis. Moreover, quantitative research approaches would be of limited use for exploring how knowledge about social policy and ageing-related care is organised and understood.

Another reason for choosing qualitative research is that, in comparison to quantitative procedures, which allow for more breadth of information across a large number of cases, qualitative research methods provide in-depth information into fewer cases (Patton, 2002; Silverman, 2005). Therefore, qualitative research ‘typically produce a wealth of detailed information’ and ‘increases the depth of understanding’ (Kreuger, 1994: 28). As Silverman (2005: 9) puts it, ‘qualitative researchers are prepared to sacrifice scope for detail’.

4.3 DATA SOURCES AND COLLECTION

The empirical data on which this thesis is based comes from an extensive dataset. Chapter 1 has already provided a rationale for why the research design explicitly incorporates a wide range of perspectives to reflect the fact that ageing-related care is a domain that can be shaped by a range of different and possibly competing discourses. The empirical data on which this thesis is based comes from four different sources. For each of the four different sources of data, namely (1) official policy documents; (2) interviews with policymakers; (3) focus groups with older people; and (4) newspapers, a detailed explanation is given below (in
sub-sections 4.3.1, 4.3.2, 4.3.3 and 4.3.4) of the sampling techniques and protocols used in gathering the data. As recommended by Schoenberg and McAuley (2007) in their guide for use by authors of qualitative research, these include inclusion/exclusion criteria in sampling, sample size and justifications, recruitment protocols, refusal rates, number of interviews/data collection points, and focus of observations.

4.3.1 Official policy documents relevant to ageing-related care

The thesis draws on official policy documents relevant to ageing-related care as a first source of data. As the source of a great deal of potentially significant information for social researchers, official policy documents play a vital part in social research (Bryman, 2001; Jupp and Norris, 1993). While the state produces a great deal of quantitative data in the form of statistical information, it is also a source of copious amounts of textual material such as official policy documents and other texts. As such, official policy documents offer a relevant source of material for qualitative research.

Relatively few official policy documents in the Irish context are concerned exclusively with ageing–related care policies. The two most significant official policy documents on ageing-related care are the Care of the Aged Report (Inter-departmental Committee on the Care of the Aged, 1968) and The Years Ahead – A Policy for the Elderly (Working Party on Services for the Elderly, 1988). These two reports have dominated official policy towards older people in Ireland for the past 35 years and are considered important for this reason. Therefore, these two reports were obvious choices and it would have been imprudent not to have selected these two reports for analysis.

The Years Ahead continues to underpin official policy on ageing-related care in Ireland. But because it was prepared in 1988, I wanted to include some more recent official policy documents that were relevant to ageing-related care. For this reason, I chose to include an official policy document entitled Care for Older People for analysis. The report has a specific ageing-related care focus and was an obvious choice. It was prepared by a National Economic and Social Forum Project Team and was published in 2005.

The NESF was established by the Government in 1993. It is a government-appointed social partnership body that was established to contribute to the formation of a wider
I also chose the *Study to Examine the Future Financing of Long-Term Care in Ireland* (Government of Ireland, 2002) for analysis. This report was commissioned by the Department of Social and Community Affairs and prepared by Mercer Ltd. The report was chosen because of its focus on long-term care. The report examined long-term care financing and other issues in relation to older and younger people and although it was not exclusively focused on older people, it is highly relevant for social policy and ageing-related care. Another reason for choosing the report was because it was expected to form the basis for future policy strategies in the area of long-term care not only in relation to cost and financing of long-term care but also in relation to service delivery and benefit design. It was also envisaged that the document would act as a starting point for the working group, which was established under the National Partnership Agreement *Sustaining Progress* to examine strategic policy, cost and services delivery issues associated with long-term care. For these reasons, the report was included for analysis.

The fifth report chosen for analysis was *The Developmental Welfare State* prepared by the National Economic and Social Council (NESC) in 2005. The NESC was first established in 1973. It is a consultative body where members of the Oireachtas, civil servants, representatives from trade unions and employer organisations, farming sector, and voluntary and community sector come together to develop strategies for economic and social policy in Ireland. *The Developmental Welfare State* has been welcomed as a ‘landmark’ report (Murphy and Millar, 2007). Although concerned with social policy and welfare state development in Ireland generally, *The Developmental Welfare State* (NESC, 2005) was selected as it offers a ‘major review’ of the welfare state and acknowledges that major social deficits including limited eldercare services are
not being adequately addressed by existing social policies and proposes an alternative framework to guide future reform. The alternative 'developmental welfare state' framework comprises three overlapping domains: core services, income supports and activist measures. With respect to core services, eldercare services are highlighted in the report as a priority area for development.

As mentioned in Chapter 1, the boundary between health care and social care tends to be blurred. In addition, in Ireland social care policy is often subsumed within health policy. Therefore, I chose to select two most important health policy documents for analysis, one from the 1980s and one from the 1990s. These are the *Report of the Commission on Health Funding* (Government of Ireland, 1989) and the 1994 Health Strategy, *Shaping a Healthier Future* (Department of Health, 1994).

Scott (1990) has developed a set of important distinctions relating to the criteria for assessing the quality of documents. These are authenticity, credibility, representativeness and meaning. These four criteria can be used for assessing the quality of official policy documents relevant to ageing-related care derived from the Irish State. In terms of Scott's (1990) four criteria, the official policy documents can certainly be seen as authentic and to have meaning in the sense of being clear and comprehensible to the researcher. While the question of credibility raises the issue of whether official documents are biased in some way, it is the biases they reveal that can cause such documents to be so interesting to the researcher. The issue of representativeness is complicated when it comes to official policy documents. On the one hand, official documents are unique, which makes them interesting. On the other hand, the question of whether or not an official document is representative is not a particularly meaningful question in the context of qualitative research (Bryman, 2001) as no official document can be representative in a statistical sense. In addition, all of the official policy documents relevant to ageing-related care policy that have been identified as a source of data for this thesis are in the public domain and easily accessible. Therefore, this source of data is readily available and accessible for other researchers to replicate the data analysis at a future date, if they so wish.

A constraint of the thesis is that the dataset excludes official policy documents and reports concerned with ageing-related care that were published prior to 1968 and thus precludes a more historically oriented analysis. Another disadvantage of
the approach adopted is that the analysis of the final documents is undertaken and the process of social interaction of persons involved in preparing and negotiating the documents and reports is missed.

However, the official policy documents selected provide a vast body of text for analysis. It was hoped that by covering the period from 1968 to 2005 any major shifts in discourses on ageing-related care would be identified. The documents selected provided rich textual detail and generated fruitful themes for analysis.

4.3.2 Interviews with policymakers

The perceptions, values and beliefs about ageing-related care held by policymakers will not be easily accessed by means of official policy documents. Potter and Mulkay (1985) highlight the importance of examining a variety of discursive products, both formal and informal. A picture of the values and views about ageing-related care held by policymakers will be more easily formulated by examining the informal commentary of policymakers. Interviews are particularly suited to this kind of research and provide a valuable supplement to the formal literature (Potter and Mulkay, 1985: 268). The second phase of the research, therefore, focuses on discourses of ageing-related care held by policymakers, through the analysis of material based on one-to-one interviews. Qualitative interview studies tend to benefit from a smaller number of interviews as they allow inquiry into selected issues in great depth with careful attention to detail, context and nuance’ (Patton, 2002: 227). They also allow for more time to prepare and analyse the interviews. Therefore, depth as opposed to breadth is emphasised (Kvale, 1996; Patton, 2002). Generalisability is, however, reduced (Patton, 2002).

(i) Identification of interviewees

Identifying policymakers in the field of ageing-related care policy for interview was a consideration in formulating the research design. The selection of interviewees identified draws on the concept of policymakers as ‘symbolic elites’ (van Dijk, 1993b: 44). Van Dijk (1993b: 44) uses the concept of ‘symbolic elites’ to denote ‘groups that are directly involved in making and legitimating policy decisions’ and have the major power resources of having a good education, control of public knowledge, beliefs and discourse (van Dijk, 1993b: 46). Symbolic elites include leading politicians in government and opposition parties.
Policymaking has a vertical dimension (Colebatch, 2002), and as the main adviser to the Minister, government departments have a central role in managing the policymaking process. While it may be the case that Ministers as authorised decision-makers select policies or courses of action and then transmit them downwards to senior officials to implement, it may also be the case that policies selected by authorised decision-makers may have been formulated by senior officials and sent to the decision-makers for authorisation (Colebatch, 2002). The policy-making component within government departments in Ireland is called the Aireacht and is separate from the executive functions of the department. The Aireacht advises Ministers on policy matters. Senior civil servants in government departments directly influencing policy as advisers of policymakers can also be considered to be symbolic elites (van Dijk, 1993b). As well as having a vertical dimension, policymaking also has a horizontal dimension and takes place across institutional boundaries, with many participants in the policymaking process (Colebatch, 2002). Within the framework of the current configuration of policymaking in Ireland, there are a variety of organisations and bodies other than government departments involved in the ageing-related care policy-making process. These include non-departmental public bodies.

Purposive sampling was the method of sampling policymakers adopted for this thesis. Purposive sampling allowed me to choose cases on the basis of their relevance to the research topic. Many qualitative researchers employ purposive sampling, as Denzin and Lincoln (1994: 243) put it, 'to seek out groups, settings, and individuals where ... the processes being studied are most likely to occur'. There was also an element of theoretical sampling as my identification of cases was influenced by social constructionism and, in particular, one of its underlying assumptions that the idea that social policy on ageing-related care is a contested public discourse.

The sampling frame was generated specifically for this thesis. The sampling frame comprised two parts. Part 1 of the sampling frame was drawn up from a list of members of the Oireachtas. It included members of the Oireachtas who were members of Government parties at the time of the fieldwork and who held or had formally held a responsibility (that is, as a Minister or Minister of State) in the area of ageing-related care. It included those from opposition parties who held a responsibility (that is, as a Party Spokesperson on health and/or older people's
issues)\(^6\) in the area of ageing-related care. Three members of the Oireachtas from government and opposition parties were also included in the sampling frame because I was aware that they had a particular interest in the area of ageing-related care. Part 2 of the sampling frame was drawn up to include senior civil servants and public servants with a responsibility in the area of ageing-related care. Senior civil servants attached to one government department were identified and public servants in two government agencies were identified and included in the sampling frame. The sampling frame comprised 24 individuals. All of the 24 individuals who were included in the sampling frame were invited to participate in an interview, as outlined in the next section.

Table 4.1: Sampling frame for policymakers

<table>
<thead>
<tr>
<th></th>
<th>With a position of responsibility in the area of ageing-related care</th>
<th>With a particular interest in the area of ageing-related care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 1</strong> -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members of the Oireachtas:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government Parties</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Opposition Parties/Inds</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td><strong>Part 2</strong> –</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil and public servants:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil servants</td>
<td>3</td>
<td>n/a</td>
<td>3</td>
</tr>
<tr>
<td>Public servants</td>
<td>8</td>
<td>n/a</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>3</td>
<td>24</td>
</tr>
</tbody>
</table>

(ii) Invitation to interview

As outlined above, 24 policymakers, that is, members of the Oireachtas and senior civil and public servants with a responsibility or a particular interest in the area of ageing-related care, were invited to participate in an interview. The invitation to participate in the interview was sent by letter and by email (see Appendix A), which informed the potential interviewees about the research (see Section 4.4.2 below). Invitation to interview included the following information: name, affiliation and contact details of the interviewer, purpose of the research, the nature and expected duration of the interview, the reason for choosing

\(^6\) Some of the opposition parties do not have a spokesperson on older people’s issues.
interviewees, and a statement about confidentiality. The letter of invitation was followed up by a phone call to assess availability and willingness to participate. When consent was given, interviews were arranged at a time that was convenient to respondents and at a location of their choosing.

Table 4.2: Policymakers invited to interview, responses and number interviewed (n)

<table>
<thead>
<tr>
<th>Invited to interview (n)</th>
<th>Responses</th>
<th>Interviewed (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consented to interview (n)</td>
<td>Refused an interview (n)</td>
</tr>
<tr>
<td>Part 1 - Oireachtas members:</td>
<td>毅然</td>
<td></td>
</tr>
<tr>
<td>Government Parties</td>
<td>6</td>
<td>3(^1) 2</td>
</tr>
<tr>
<td>Opposition</td>
<td>7</td>
<td>7(^2) -</td>
</tr>
<tr>
<td>Parties/Inds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part 2 – Civil/public servants:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil servants</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Public servants</td>
<td>7</td>
<td>3(^4) -</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>16</td>
</tr>
</tbody>
</table>

\(^1\) One person consented to an interview but the interview never took place despite numerous attempts to arrange a date, time and location of convenience for them.

\(^2\) One of the opposition parties nominated a spokesperson to participate in an interview on behalf of party spokesperson on health. This spokesperson was not a member of the Oireachtas but consented to and participated in an interview.

\(^3\) It was not possible to use the material from one of the interviews and this was disregarded.

\(^4\) In one case, the public servant invited to interview refused but another member of the same agency was nominated instead.

In many cases, it took numerous attempts to make contact with policymakers after the initial letter/email of invitation was sent in order to assess availability and willingness to participate in an interview. As Table 4.2 shows, out of the 24 policymakers invited to participate in an interview for this thesis, 16 (66%) consented to an interview. There were two refusals from politicians, both of whom referred me to another member of their political party who had already been invited to participate in an interview. There were five non-responses, mainly from public servants. In total, 15 (62.5%) policymakers, out of the 24 invited,
participated in an interview for this thesis. However, one of the interviews was unusable.

(iii) Individual Interviews

The interviews explored policymakers' views on issues relating to social policy and ageing-related care, how they view the problems of care for older people and assess the potential for social policy intervention. Corbin and Strauss (2008: 27) point out that from their experience, unstructured interviews, that is, interviews that are not dictated by any predetermined set of questions, are the 'most data dense interviews'. However, the interviews with policymakers took the form of semi-structured interviews, which is also a mode of interviewing that can be adopted when using a grounded theory approach (Corbin and Strauss, 2008).

The semi-structured interview has been defined as 'an interview whose purpose is to obtain descriptions of the life world of the interviewee with respect to interpreting the meaning of the described phenomena' (Kvale, 1996: 6-7). I opted for semi-structured interviews for two reasons. The first reason was because issues relating to social policy and ageing-related care are wide-ranging and I wanted to focus the interviews with a set of questions derived from the analysis of official policy documents on ageing-related care. Secondly, I had only one opportunity to interview each policymaker. In addition, due to their busy schedules, I was given a limited amount of time by policymakers to conduct the interviews.

The interviews were conducted using open-ended questions and were discursive. They were theme oriented and placed an emphasis firmly on ways in which policymakers perceive ageing as it relates to care and on their views on policy relating to the care of older people in Ireland. The interviews were conversational (Lupton, 1992; Potter and Wetherell, 1995; van Dijk, 1993b). This involves careful questioning and listening with the researcher introducing topics and critically following up the participants' answers to questions. With the permission of the interviewee, the interviews were audio taped using Olympus Digital Voice Recorder DS-2300. Only one of the interviewees refused permission to audiotape the interview. In this instance, the interviewer took detailed notes.
(iv) Interview schedule

Consistent with semi-structured interviews (Kvale, 1996), the interviews were guided by an interview schedule, which contained a general list of topics and themes to be covered in each interview. This approach is particularly suitable to conducting interviews about phenomena where certain topics appear to be important, but are too complex to be defined in detail in advance (Potter and Mulkay, 1985). The interview schedule was based on the following structure. First, the aims of the thesis and the purpose of the interview were briefly explained to the interviewee. The interview requested the respondents to identify the main policy 'problems' that exist in relation to care of older people and the postulated policy 'solutions' to the problems identified. Other topics were then each introduced but in different ways and in a different order at each interview. While the interviews followed the schedule to ensure that each topic was adequately discussed with each interviewee, the interview allowed interviewees to talk freely and at length and allow for interesting lines of talk to be followed up. The purpose of the interviews was to develop a text that represented respondents' public position on ageing-related care. The respondents were not asked to provide any information or views other than those that they would provide in their daily professional activities.

It was anticipated that there might be difficulties in gaining access to and consent of policymakers to participate in an interview. Research protocols (see section 4.4.2 below) to minimise such problems were adopted. Consideration was also given to the issue of reactivity, a situation whereby the reactions of interviewees in a particular setting to the presence of a fieldworker may create distorted responses to interview questions (Patton, 2002). Therefore, less formal interview strategies were adopted, which can help to reduce or even eliminate reactivity among respondents (Patton, 2002).

(v) Transcription of interviews

The recorded interviews were transcribed verbatim with the aid of Olympus Digital Voice Recorder DS-2300. A narrow set of transcription conventions were adopted (see Appendix B).
4.3.3 Focus groups with older people

According to Biggs (2001), the issue of how far different narrative positions in social policy towards older people correspond to the perspectives and experiences of older people has been identified as an important issue for critical social gerontology. The third phase of this thesis explores multiple discourses on ageing-related care held by older people. The thesis adopted a focus group approach to collect the data for this exploration. Focus groups are a form of qualitative research. The primary purpose of focus groups is almost always the collection of qualitative data (Stewart and Shamdasani, 1990). Focus groups have become a frequent feature of qualitative research in the social sciences and, although their use has often been subsidiary to other forms of both qualitative and quantitative research, they have increasingly become a recognised method of collecting qualitative data (Morgan, 1997; Stewart and Shamdasani, 1990).

Focus groups are essentially group interviews. The focus group approach, as used in the social sciences, is a method of studying the views and perceptions of people in the context of a group (Chapman and Johnson, 1995). The researcher relies on group interaction to collect the data. The emphasis is usually on specific topics or themes that are introduced by the researcher who typically takes the role of moderator (Bryman, 2001; Morgan, 1997).

Focus groups are advantageous in that they produce a very rich body of data expressed in the words of respondents (Stewart and Shamdasani, 1999). They are particularly useful, when used independently of quantitative methods, for examining the ways in which individuals collectively perceive an issue under discussion (Bryman, 2001; Morgan, 1997) and when insights and perceptions are of more interest than actual numbers (Kreuger, 1994). A further advantage of the focus group approach is that it facilitates the collection of a large amount of information and interpersonal exchange on a topic in a relatively short period of time (Chapman and Johnson, 1995).

Focus groups have been used by social scientists in research on ageing-related care. For example, Gubrium's (1987) observations of a support group in Old Timers and Alzheimer's are derived from focus groups. Morgan (1992) conducted focus groups to explore how family caregivers for people with Alzheimer's disease made the decision to seek a medical diagnosis, while Morgan and March (1992) used the focus group approach to make a comparison between the impact of
widowhood and caring for a spouse with Alzheimer's disease on networks of personal relationship. In the Irish context, Timonen, Doyle and Prendergast (2006) conducted focus groups with formal care workers engaged by the public, private and not-for profit sectors in Dublin to examine their perspective of domiciliary social care services for older people.

Focus groups with older people are less frequently reported (Quine and Cameron, 1995), but they have been used to explore older people's views of care. For example, Chapman and Johnson (1995) used focus groups as part of a multi-method research approach to gather information about the perceptions of older people (and their carers) in the north west of England of the extent to which their health and social care needs were being met and their degree of satisfaction with the quality of services. In a study examining the feasibility of using focus group as a research methods with older people (75+ years), Quine and Cameron (1995: 454) found that in focus groups with older people with disabilities 'insightful interactions occurred and critical issues emerged' and concluded that the approach could be employed more widely, using certain guidelines. In Ireland, focus groups with older people were used in the HeSSOP studies, although they were primarily employed as a precursor to quantification (O'Hanlon et al., 2005). In other words, they were used a source of preliminary data in a primarily quantitative study to generate survey questions.

The aim of conducting focus groups in this thesis was to enable the views of older people to be made explicit and to gain an insight into older people's ideas about policies and practices relating to care for older people in Ireland. The data from the focus groups was used to compare and contrast older people's discourses on ageing-related care with those embedded in official policy documents and those held by policymakers.

(i) **Focus group types, participants and sample size**

Six focus groups with at total of 41 older people were conducted for this thesis. The focus groups were planned with a view to recruiting a cross-section of older people with a diversity of social positions and experiences, as explained below. The focus groups were organised around six existing groups of older people. The six existing groups of older people were identified with a view to ensuring that the perspectives of a diversity of older people were obtained. The participants of
each of the focus groups were drawn from one of these six existing groups (see Table 4.2)

Table 4.3: Focus groups with older people: type, size, and gender breakdown (n)

<table>
<thead>
<tr>
<th>Focus group</th>
<th>Participants recruited from</th>
<th>Number of participants</th>
<th>Gender breakdown</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>A patient advocacy group in a long-stay care setting in Dublin</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>02</td>
<td>A meals service/day club based in an inner city Dublin area(^1)</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>03</td>
<td>Informal meeting group of older women based in suburban Dublin</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>04</td>
<td>An association of older people in a rural area</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>05</td>
<td>A city based seniors poetry group</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>06</td>
<td>Local active retirement association based in a suburb of Dublin</td>
<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>

Total: 6 focus groups

\(^1\) Designated as a disadvantaged area.

In each of the focus groups, the participants were aged 65 years and over. As Table 4.2 shows, there were between 4 and 8 older people in each group. As had been planned, the participants included women and men, older people living in their own homes as well as those living in institutional settings; those living in urban (designated disadvantaged), suburban and rural locations; older people without need for health and social care services; older people in receipt of health and social care services in both institutional and community care settings; and older people involved in the community. The thesis did not include older people...
with cognitive impairments. Although the aim was to include a diversity of older people, I did not organise a group on grounds other than those outlined above. For example, I did not seek out a group of older people from minority ethnic backgrounds or a group of lesbian, gay and bisexual older people.

In each case, participants were identified and recruited from an existing group of older people with the assistance of a key contact person involved with the group. Initially, key contacts were approached and were given information about the thesis and the sample. After endorsing the research, the key contacts very helpfully gave suggestions regarding the best time and place for conducting the focus group, assisted in identifying potential participants, giving information about the research to potential participants and recruiting participants for the focus group as well as organising the site for conducting the focus groups. Protocols, outlined below in Section 4.4.3, were followed in the recruitment of focus group participants.

A quantitative approach using a large representative sample of older people would have made it possible to measure the responses of a large number of respondents, yielding data that could be used for comparative and statistical purposes (Patton, 2002). However, a disadvantage of using a quantitative survey would have been that the questions asked would have been pre-defined, as would the responses to standardised questions. Using focus groups as a research method meant that responses were limited to a small number of people and provided a small, unrepresentative sample (Stewart and Shamdasani, 1990), which incidentally is also encountered when using in-depth face-to-face interviews. In contrast to a quantitative survey, focus groups allow individuals to respond in their own words, using their own categories and responses, rather than responding to standardised questions (Stewart and Shamdasani, 1990).

Similarly to adopting a qualitative approach to individual interviews, undertaking a small number of focus groups meant that generalisability is reduced (Patton, 2002). Nevertheless, significant information can be gleaned from obtaining the views and perspectives of a few subjects as the participants can provide a vast quantity of observations (Patton, 2002). Furthermore, as in qualitative interviews (Kvale, 1996), questions of representativeness are not so crucial in focus group projects (Morgan, 1997). As this thesis is aiming to collect older people’s perceptions, the question of representation is not an issue. The task is to gain
meaningful information. Morgan (1997: 35) points out that, ‘it is often more useful to think in terms of minimising sample bias than achieving generalisability’. Focus groups are frequently conducted with samples that are purposively selected and with participants that are selected from a limited number of sources. A problem arises only if the interpretation of the data from a limited sample is represented as a full spectrum of views and perspectives (Morgan, 1997). According to Tonkiss (1998), using data that will provide insights into a problem is the most important consideration in selecting data.

Practical issues such as time constraints have a bearing on the small sample size (Kvale, 1996). It is not always possible when designing qualitative research to specify at the outset how many informants will be needed to learn about a particular subject matter (Rubinstein, 1994). For this reason, an exact sample size was not specified at the outset. Rather the sample size was guided by the notion of redundancy (see Patton, 2002) or saturation (Rubinstein, 1994; Kvale, 1996): ‘Inquiry stops when patterns become repetitive and materials are thematically saturated’ (Rubinstein, 1994: 79). In other words, there are:

no hard and fast rules about numbers because ... an adequate sample size in qualitative research is linked to the unfolding conceptual consistency of the data and thematic pattern saturation (Rubinstein, 1994: 80).

(ii) Focus group sessions

The focus groups with older people were based on specific themes in relation to ageing-related care. Each of the focus group sessions was guided by a fairly small set of thematic topics. Open-ended questions were used, making it possible to encourage the participants to explore the complexity of the topic under consideration. Open-ended questions and probes ‘yield in-depth responses about people’s experiences, perceptions, opinions, feelings and knowledge’ (Patton, 2002: 4). I guided the session and intervened only to keep the discussion on track, to prompt the participants to discuss key issues where there are unproductive silences and if there is continuous repetition of the same issue. In addition, I did not delve into areas outside the remit of the thesis and took great care not to raise any issues that might be considered too personal or sensitive.
Each of the focus groups was tape recorded (see Section 4.4.3) and transcribed in full with the aid of an Olympus Digital Voice Recorder DS-2300.

4.3.4 Newspapers

With a view to examining the portrayal of ageing-related care in the press and the role of the press in shaping discourses embedded in ageing-related care policy, newspaper articles comprise the third source of data for analysis in this thesis. Newspaper reporting and articles on ageing-related care in one Irish national newspaper, *The Irish Times*, constituted the data for analysis. The thesis has chosen to examine the representation of ageing-related care in *The Irish Times* as it is both widely circulated and widely read Irish national daily newspapers. According to the Audit Bureau of Circulations, in the second half of 2005, the average daily circulation of *The Irish Times* in Ireland was 115,671 (ABC, 2006). Based on a sample of 7,000 people surveyed for the Joint National Readership Survey (04/05) it is estimated that *The Irish Times* has a daily readership of 335,000. People aged 65 years and older made up 13% and 19% of readers respectively. The European Business Readership Survey suggests that *The Irish Times* is the leading publication for business in Ireland with 79.2% of senior business people choosing to read this daily newspaper (EBRS, 2004). In addition, *The Irish Times* can be accessed through LexisNexis – News and Business, an online news database.

*The Irish Times* in 2006 was issued six days a week (Monday through to Saturday) and each issue of the newspaper during 2006 was included in the search. LexisNexis – News and Business was used to search *The Irish Times* for relevant articles. The focus was on written text rather than visual images. The following search terms were used to identify relevant reports and articles: older people, elderly, ageing, nursing home, and care. The news items identified included news reports, commentary and analysis, editorials, and letters to the editor. The data analysis, which adopted quantitative and qualitative analysis, involved three steps, as follows:

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17 Initially, ‘senior citizen’ and ‘pensioner’ were also used as search terms, but for the most part these terms were not used in relation to ageing and care. It was not usual for the terms ‘older people’ and ‘elderly’ to be used interchangeably in a single news item.
Step 1: All of the news items identified were read at least once. Three classifications of news items were developed. The first included those news items that addressed or mentioned issues relating to family, care and ageing. The second included all those news items that addressed or mentioned formal care sector providers (that is, public, private and voluntary care). The third included those news items that related to the theme of care, ageing and opportunities for social engagement or participation in social activities. Table 4.4 shows the number of news items that were classified under each heading.

Table 4.4: News items in The Irish Times (2006) that address or mention discursive themes (n)

<table>
<thead>
<tr>
<th>Discursive themes</th>
<th>News items that address or mention discursive theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family, care and ageing</td>
<td>36</td>
</tr>
<tr>
<td>Formal care sectors providers</td>
<td>46</td>
</tr>
<tr>
<td>Ageing, care and opportunities for social engagement or participation in social activities.</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>89</strong></td>
</tr>
</tbody>
</table>

Step 2: Each classification was then taken separately. The news items in that classification were each given a number (e.g. 01) and read again (at least once). They were categorised using a framework that I developed for the analysis of newspapers for this thesis (Appendix E provides a sample framework). The following information was recorded in the framework. The type of author (e.g. news correspondent, newspaper editor, representative of national organisation of older people) was recorded. The topic of the news item was recorded. The message that the news item was conveying in relation to the theme was briefly summarised. Any documentary sources cited or sources of opinions (e.g. policymakers, representative of national organisation of older people, medical professional, older person) cited in the news items were also recorded. Finally, I noted if older people views had been cited in the news item. As this thesis is focusing on the discourses embedded in official policy documents, those held by policymakers, and those held by older people, I was particularly interested in finding out if the news items drew on any of these as sources.

Step 3: The third step involved an examination of news items with a view, in particular, to seeing whether or not there was an overlap between the views of
policymakers and older people that were mediated through the news items and those that emerged from the interviews and focus groups.

The findings relating to each of the three discursive themes are presented in the relevant findings chapters that follow.

4.4 ETHICAL ISSUES

This section begins by presenting the major principles underpinning the practice of ethical research and then goes on to outline the ethical issues that arise in relation to this thesis.

4.4.1 Principles underpinning ethical practice of research

There are four major principles – autonomy, nonmaleficence, beneficence and justice - that are relevant to the ethical practice of research and are useful for guiding ethical choices (Gilhooly, 2002; Smith, 1995). Respecting autonomy requires that the researcher respects the decision-making capacities of individuals and allows research participants to make an informed decision about whether they wish to participate in the research or not based on the information provided to them (Smith, 1995). Nonmaleficence is concerned with avoiding harm, risk or wrong to come to those participating in the research and includes guarding against deception (Smith, 1995). The principle of beneficence is concerned with maximising good outcomes for individual research participants as well as for science and humanity (Smith, 1995). Finally, justice refers to the principle that those who bear the risks of research should be those who benefit from it (Smith, 1995). I was committed to and followed these principles, which were used to guide the research.

Interviews with policymakers and focus groups were both key components of the research and each present the researcher with ethical challenges (Patton, 2002; Smith, 1995). To guide the research, a set of protocols were developed to safeguard the interest of both policymakers participating in one-to-one interviews and older people participating in focus groups. These are outlined below.
4.4.2 Ethical considerations and interviews with policymakers

Although policymakers participating in Phase 2 of the research are not classed as vulnerable or powerless participants, it was nevertheless imperative that the interests of each participant in the research were treated with the utmost regard and that ethical issues were considered in every phase of the research. Therefore, in dealings with policymakers, certain protocols were followed in the course of the thesis to safeguard their interests, as outlined below. In particular, the issues of informed consent and confidentiality were considered to be of key importance.

Policymakers were fully informed about the study. Letters inviting policymakers (sent by post and email) to participate in an interview included the following information: name, affiliation and contact details of the interviewer, purpose of the research, the nature and length of the interview, the reason for choosing interviewees, and a statement about confidentiality (see Appendix A). The letter of invitation was followed up by a phone call to assess availability and willingness to participate. When consent was given, interviews were arranged at a time that was convenient to respondents and at a location of their choosing. There was a brief discussion about the thesis before the actual interview began. Interviewees were also informed that any information collected during the course of the interview would be used solely for the purposes of the thesis and would be treated as strictly confidential. It was explained that extracts from the interview may appear in the final Ph.D. thesis and other publications emerging from it, but the name, political affiliation or other identifying characteristics of research participants would not be included.

Before the interview proceeded, permission was sought from participants to audio-tape the interview. In one instance, permission was refused and handwritten notes were taken instead. Where the interview was audio-taped, interviewees were informed of their right to request that the tape recorder be turned off at any point. In addition, interviewees were informed of their right to refuse to answer any questions or stop the interview at any time. At the end of each recorded interview, the interviewees were asked if they would like to receive a verbatim transcript of the interview.
To ensure confidentiality, recorded interviews and handwritten notes were kept in a secure location and were only accessible to me, the interviewer. Each recorded interview was transcribed in full. Electronic copies and hard copies of the transcribed interviews were also accessible to me. For the purposes of supervision, hard copies of the transcribed interviews could be viewed by the Ph.D. supervisors, Dr. Virpi Timonen and Dr. Patricia O'Brien. The recorded interviews and any electronic and hard copies of the transcribed interviews will be kept for three years after the acceptance of the Ph.D. thesis and then destroyed.

4.4.3 Ethical considerations and focus groups with older people

Focus groups, as other forms of qualitative research, present the researcher with ethical challenges (Smith, 1995). The ethical concerns that need to be addressed in focus groups are in many respects similar to those raised in all qualitative research (Morgan, 1997). Of key importance are issues of informed consent and confidentiality (Gilhooley, 2002; Kayser-Jones and Koenig, 1994; Patton, 2002). Building rapport and trust with participants is also an essential feature of the relationship between the researcher and participants in focus group interviewing (Kaufman, 1994).

In addition, some older people may be viewed as vulnerable. As such, the fourth phase of the research presented me with certain ethical challenges. The protocols outlined below (under four sub-headings) were developed and followed in the course of the thesis to safeguard the interests of older respondents and to ensure phase four of the research project was guided by ethical considerations:

(i) Building rapport with participants

As mentioned above, building rapport and trust is an essential feature of the relationship between the researcher and participants. With this in mind, the focus groups took place at a time and location that was convenient to participants. Before the actual collection of data, some time was spent chatting about general matters, explaining why the focus group is important and discussing how the focus group fits into the larger study. Each participant was made fully aware that they were not under any obligation to discuss anything about which they might feel uncomfortable. According to Kayser-Jones and Koenig (1994: 19), 'confidentiality suggests that an agreement has been made that limits access to
private information’. Therefore, the confidential nature of the focus group was discussed with participants prior to the actual collection of data. The focus group itself was informal in style. Every effort was made to create an open and friendly atmosphere and make the experience a positive one for participants.

(ii) Informed Consent

The issue of informed consent is of key importance. Informed consent can be described as ‘providing information about the research, comprehension of the information by potential subjects, voluntary participation and freedom to withdraw at any time without adverse consequences’ (Kayser-Jones and Koenig, 1994: 19). To ensure that the consent of the participants is valid, participants were fully informed about the study. A participant information sheet (see Appendix C) about the research was drawn up. The information sheet included the following information: name, affiliation and contact details of the researcher, purpose of the research, the nature of the focus group, the reason for choosing participants, and a statement about consent and confidentiality. The name and contact details of one of the Ph.D. supervisors was also given. In addition to giving printed information about the research, information was given verbally to those participating in the research. It was clearly explained to each participant that participation in the research was voluntary and participants were given time to consider whether or not they wished to participate in the research. Participants were clearly informed about their right to revoke consent to take part in the research, to refuse to answer any questions or enter into any discussion, or to withdraw from the focus group at any time. Each participant was asked to sign the consent form (see Appendix D), indicating that they had read the participant information sheet, that they understood the thesis and their role in it and that they were fully aware that their participation in the research was voluntary. Both the participant information sheet and the consent form were written in clear language. To ensure that they were accessible to those with sight impairments, clear print was used and the participant information sheet and the consent form were available in large print format.

There were no specific benefits to older people for taking part in the research and participants were made aware of this and were informed that the thesis hopes to make a significant contribution to the study of social policy and ageing-related care.
(iii) Confidentiality

As the interviews were carried out on a group basis, the confidentiality of focus group participants has to be protected. Any information provided by participants during the focus group has been and will be used solely for the purposes of the research and has been and will be treated as strictly confidential. Extracts from the focus groups appear in the final Ph.D. thesis and may appear in other publications emerging from it, but neither the name nor any identifying characteristics of participants were or will be included. A unique ethical issue in focus groups is that what participants say to the researcher is inherently shared with other group participants as well, which raises additional concerns about confidentiality (Morgan, 1997; Smith, 1995). As participants were sharing their views with not only the researcher but with the wider group, it was explained to participants that confidentiality applies to everyone. In order words, they were requested not to share any information or views, that is, the contents of the group discussion, with anyone outside the group, an approach that has been adopted by other researchers concerned about ethical issues arising from over-disclosure by focus groups participants (see Smith, 1995).

With the permission of the participants, each of the focus groups was recorded. The researcher explained to participants that focus group sessions work best if they are tape-recorded and subsequently transcribed, as tape recording is a principle means of capturing observations. Issues regarding confidentiality are especially important whenever tape-recording is used as a primary means of data collection (Morgan, 1997), as was the case in the focus groups. To guarantee confidentiality, the audio-tapes of the focus groups and other personalised data was kept in a secure location. Each recording of a focus group interview was transcribed in full and each transcription used pseudonyms to ensure confidentiality of participants. The recordings of the focus group interview and any electronic or hard copies of the transcribed focus group interview were only accessible to me. As with transcriptions of interviews with policymakers, some of the hard copies of transcribed focus groups were also viewed by my Ph.D. supervisors and will be kept for three years after the acceptance of the Ph.D. thesis and will then be destroyed.
Focus group sessions with older people

The focus group session was designed to provide an opportunity to explore with participants a relatively standard range of topics and themes with respect to ageing-related care issues and policy. Each focus group interview worked from the same basic schedule of previously prepared topics. While the focus groups followed the schedule to ensure that each topic was adequately discussed with each group of participants, I let participants talk freely and at length and allowed for interesting issues to be followed up. However, I did not delve into areas outside the remit of the thesis and took great care not to raise any issues that might be considered too personal or sensitive.

4.4.4 Research ethics approval

I sought approval from the Research Ethics Committee, School of Social Work and Social Policy, Trinity College Dublin. Approval was granted in June 2007.

4.5 DATA ANALYSIS: A GROUNDED THEORY APPROACH

Quantitative and qualitative approaches can be used for data analysis. Quantitative content analysis is an example of the former. It is an empirical method used in the social sciences for analysing communication in a systematic and numerical way through the search for recurring words or themes in the text. It is descriptive and falls within a positivist paradigm (Jupp and Norris, 1993; Lupton, 1992). Qualitative analysis is 'a process of examining and interpreting data in order to elicit meaning, gain understanding and develop empirical knowledge' (Corbin and Strauss, 2008: 1) and it was this that was this approach adopted for undertaking the analysis of data in this thesis.

There are different methods of qualitative data analysis from which to choose. Discourse analysis, which examines language and text critically (Lupton, 1992: 145), falls within a qualitative and interpretive paradigm. Discourse analysis is related to semiotics (Tonkiss, 1998: 246), which attempts to interpret meanings through an analysis of cultural texts that are visual, aural or tactile (Slater, 1998). It is also related to ethnomethodology (Tonkiss, 1998), which tries to understand the methods that ordinary people use to construct everyday life and make sense of it through the analysis of talk in interaction (Burr, 2003). A specific approach to
data analysis within qualitative research is grounded theory and this approach was chosen to analyse the data in this thesis. This section of the chapter presents a discussion and an outline of the grounded theory approach.

4.5.1 About grounded theory

Grounded theory emerged after a study by Glaser and Strauss (1965) on death and dying on a hospital ward. It is a specific methodology that was developed by Glaser and Strauss (1967) for the purpose of building theory from data (Corbin and Strauss, 2008). It can be defined as theory 'derived from data, systematically gathered and analysed through the research process' (Strauss and Corbin, 1998: 12). In other words, it is theory that is generated from the fieldwork and emerges from the data (Patton, 2002). As such, grounded theory argues for inductive theory building in contrast to theory that is developed by deducing hypotheses that are then tested against observations.

Glaser and Strauss (1967) used their research on the care of terminally ill patients on hospital wards as an example of how to use a grounded theory approach. They developed accounts of people's own 'awareness' of their imminent death into accounts of a whole range of 'awareness contexts'. In this way, they moved from an explanation arrived at from one context to greater generality, which they referred to as a move from substantive theory to formal theory.

The epistemology of the methodology stems from and the philosophy of pragmatism inherited largely from John Dewey and George Herbert Mead which later evolved into the Chicago School of symbolic interactionism. A key assumption of both is that knowledge arises through acting and interacting of self-reflexive beings (Corbin and Strauss, 2008). Chapter 3 of this thesis has already discussed symbolic interactionism in more detail and has shown that symbolic interactionism was one of the theoretical perspectives contributing to the development of social constructionism.

Many social constructionists have adopted grounded theory as a research method, although other qualitative and even quantitative methods are equally valid (Burr, 2003). As an approach to social research, grounded theory meets the requirements of social constructionism, since social constructionists insist upon the importance of meanings of accounts and discourses (Burr, 2003). A
grounded theory approach to data analysis is often criticised for being too subjective, as it relies almost completely on a particular reading or interpretation of the talk or text (Lupton, 1992). However, a grounded theory approach does not claim to be objective or that insights produced represent a universal 'truth' (Burr, 2003: 150; Lupton, 1992: 148). In this way, it is closely related to humanistic disciplines, of which interpretation is a feature (Lupton, 1992). Those using a grounded theory approach also question the assumption that quantitative approaches in both the natural and social sciences are scientifically objective and represent the 'truth', based on the argument that no scientific observation is completely objective. Scientific observations will also be influenced by socio-economic and political contexts and values and by power dynamics (Lupton, 1992).

Nevertheless, social constructionists stress that the person interpreting the data needs to make his/her perspective or stance explicit and to acknowledge the influence of socio-political contexts (Lupton, 1992; van Dijk, 1993a). Consistent with social constructionists, those using grounded theory are of the view that meaning is contestable and alternative readings of the same texts can be produced. However, as Charmaz (2003: 249) points out, the grounded theory method consists of 'systematic inductive guidelines' for analysing data and building grounded theories that explain the data. These include thinking comparatively, obtaining multiple viewpoints, gathering data in different ways, maintaining an attitude of scepticism as well as following the techniques and procedures of the grounded theory method as outlined below. At the same time, Charmaz (2006) warns that how grounded theory methods are conducted does not occur in a social vacuum. She offers a list of criteria for evaluating constructionist grounded theory, which she breaks down into four categories: credibility, originality, resonance and usefulness.

Different perspectives and methodological traditions exist within grounded theory. Some researchers, according to Charmaz (2006) emphasise a narrow and rigid application of the techniques and procedures of the grounded theory method. However, Charmaz (2008: 396) argues that the intention of grounded theory from its beginnings was to offer ‘explicit guidelines that promise flexibility and innovation’ and that social constructionist approaches to grounded theory encourage innovation. As Gubrium (cited in Powell and Edwards, 2002: 8) puts it, ‘there are no rules for data analysis except one, that the analysis draws heavily on
the language of the persons studied ... that it is grounded’. A grounded theory approach has been applied to the study of social policy and ageing. For example, a grounded theory approach has been used by Powell and Edwards (2002) to analyse key policy narratives regarding old age and social policy in the United Kingdom.

4.5.2 Techniques and procedures

A simplified model of a grounded theory approach to analysis follows four stages: (1) discovering categories; (2) uncovering relationships between categories; and (3) integrating categories into a ‘core category’ and (4) integrating the core category into a theoretical framework. Categories are discovered through a process of open coding, that is, a process of ‘taking raw data and rising it to conceptual level’ (Corbin and Strauss, 2008: 66). The researcher takes the data and breaks it down into manageable pieces, reflects on the data and delineates concepts that stand for what the researcher thinks the data is indicating. The act of relating concepts/categories to each other is done through axial coding. The next step is to integrate the categories into a central or core category. The final step revolves around refining and trimming the resulting theoretical framework (Corbin and Strauss, 2008).

A set of analytical tools is at the disposal of the researcher to assist in the analysis of the data. Strauss and Corbin have developed some of these analytical tools such as ‘microanalysis’, which is a form of open coding. Others are ‘borrowed’ from other analysts (Strauss and Corbin, 1998; 2008). Some of the most relevant tools for analysis are asking questions and making comparisons – strategy of making constant comparisons. There are many others. One strategy, for example, is to think about the various meanings of a word (Corbin and Strauss, 2008). For example, one of the phrases used by a participant in this study was that ‘the family is all gone’. I focused on the possible meanings of the word ‘gone’ and looked for cues in what other participants were saying. Another strategy is to use the Flip-Flop technique, which involves ‘turning a concept “inside out” or “upside down” to obtain a different perspective on a phrase or a word’ (Corbin and Strauss, 2008: 79). Drawing on personal experience is another strategy (Corbin and Strauss, 2008). Waving the red flag is another example of a strategy that can be used. Certain terms ‘obviously’, ‘always’, ‘never’ should
immediately 'wave the red flag', in other words, they are a signal for the researcher to take a closer look at the data and at taken for granted assumptions.

A grounded theory style of analysis (Glaser, 1978, 1992; Glaser and Strauss, 1967; Strauss, 1987) was used to guide the analysis of data for this thesis. The central techniques of the constant comparative method, openness to evolving theoretical insights and theoretical sampling where questions were generated from previous data were all used.

According to Corbin and Strauss (2008) data analysis is a dynamic process, which involves examining a substance and its components in order to determine their properties and functions and then using the knowledge acquired about the components and their properties and functions to make inferences about the whole. Computer software packages (such as NVivo 8) can be used to facilitate the analysis of qualitative data through the management of data (Kvale, 1996). A computer software package was not used to assist data analysis in this thesis. Non-use of computers is acceptable in qualitative data analysis as software is neither a substitute for data analysis nor does it necessarily ensure rigour (Strauss and Corbin, 1998; Schoenberg and McAuley, 2007).

4.5.3 Incorporating reflexivity

Reflexivity during data collection and analysis is an important consideration in qualitative research (Finlay, 2003; Corbin and Strauss, 2008). Finlay (2003: 4) describes reflexivity as 'the project of examining how the researcher and intersubjective elements impact on and transform research'. Reflexivity is 'an important tool of the researcher' (Begley, 2009: 110), since it allows the researcher to acknowledge the unavoidable influences that life experiences have on understandings and interpretations. To incorporate reflexivity into the research and to apply grounded theory methods to the data analysis, I needed to consider my role in the research process. The first requirement was that I had to acknowledge that I was a central figure in the research with an active role to play in constructing the selection, collection and interpretation of the data. I also had to appreciate that I was not the only figure with an active role to play, but that the research was co-constructed by me, the researcher, and the policymakers and older people participating in interviews and focus groups and the relationship
between us. As Finlay (2003: 5) explains, in being reflexive researchers realise that ‘meanings are negotiated within particular social contexts’.

Finlay (2003) offers a typology of five variants of reflexivity. One of these is reflexivity as ‘ironic deconstruction’. According to Finlay (2003: 14), this perspective sees the world as ‘a babble of competing voices, none of which has privileged status.’ An imperative of this perspective is that the researcher seeks to challenge the view that the researcher is the voice of authority and seeks instead to enable multiple voices to be heard. By including policymakers and older people in the thesis and seeking to hear what they have to say about social policy and ageing-related care, which was often different and sometimes contradictory, this thesis follows this perspective and was, therefore reflexive. More of my reflections on the methodology chapter are offered in Chapter 8.

4.5.4 Reporting the findings

(i) Discursive themes

It has been clearly outlined that this thesis has drawn on four sources of discourse – official policy document, interviews with policymakers, focus groups with older people and newspaper - for analysis. In considering how to undertake the analysis and report the findings, I was aware that if these sources of discourse were to be studied effectively in detail, it would only be possible to focus on a relatively small number of discursive themes.

As Phillips (2007) has pointed out, policy debates on care have centred on a range of issues. These issues include the availability of and access to care, whether good quality care is best provided in the community or institutions, the respective roles of the family and the state in the provision of care, who provides care, the funding of long-term care and its sustainability and the quality, standards, monitoring and regulation of care as well as how to maintain health in later life. It would have been beyond the scope of this thesis to focus on all of these issues. Therefore, I chose to focus on three key discursive themes. These are family, caring and ageing; ageing and formal care provision; and ageing, care and opportunities for social interaction and participation in social activities. The three discursive themes emerged from the data. The way in which these themes
emerged is described at the beginning of each of the three findings chapter that follow.

(ii) Terminology

For the purposes of confidentiality (see Section 4.4.2 above), the name, political affiliation or other identifying characteristics of policymakers that participated in interviews will not appear in the thesis. Therefore, each respondent was given a three-digit code number (e.g. 004) and these code numbers were ordered in relation to when the interview was carried out. In the text of the analysis chapters that follow, policymakers who participated in interviews are referred to as ‘respondents’ and where verbatim quotes from the interviews are used, respondents are identified by the three-digit code, for example, ‘Policymaker 004’.

Similarly with regard to older people participating in the focus groups, there is a need to safeguard the confidentiality. Therefore, each focus group was given a two-digit number (e.g. 03) and these code numbers were allocated on the basis of the order in which the focus groups were conducted. For example, the first focus groups conducted was given the code number 01. In the text, older people who participated in focus group are referred as ‘participants’.

(iii) Use of literature

In reporting the findings, this thesis, in accordance with Corbin and Strauss (2008), uses the literature to confirm findings or to illustrate where literature is incorrect, simplistic, or only partially explains phenomena.

4.6 CHAPTER CONCLUSIONS

This chapter has outlined the research methods and procedures used in this thesis. The thesis relied on qualitative research to explore the multiple discourses embedded in social policy and ageing-related care in Ireland as it was judged to be the most appropriate methodological approach for conducting the research. One of the strengths of this thesis is that it draws on four sources of discourse, official policy documents, policymakers, older people and newspapers. Qualitative semi-structured interviews with policymakers and focus groups with older people were used to collect data in order to analyse their understandings of
social policy and ageing-related care. Consideration of ethical issues was a part of the research design and this chapter described the protocols developed to guide the research with both policymakers and older people. A grounded theory approach was used to conduct the data analysis. The following three chapters report the findings that emerged from the application of the research design and methods described above.
CHAPTER 5:

FINDINGS I: FAMILY, CARE AND AGEING

5.1 INTRODUCTION

As Chapter 4 outlined, this thesis considers three different discursive themes as a way of exploring the multiple discourses underpinning social policy and ageing-related care in Ireland. These are family, care and ageing; ageing and formal care providers; and ageing, care and opportunities for social interaction and participation in social activities. This chapter presents the findings of the data analysis in relation to the first of these – family, care and ageing.

Family, care and ageing emerged from the data as one of the three discursive themes in the following way. I was familiar with the literature on the family, care and older people. It has been well documented that the family is the main provider of care for older people in all countries even those such as Denmark with well-developed welfare systems. However, on my first close reading of the Care of the Aged Report for this thesis, I was curious to note that the rhetorical emphasis was on the formal system of care provision. Reading for emphasis and detail is important in a grounded theory approach to data analysis so as to understand the intricate ways in which meanings are shaped as opposed to presenting a simple summary of the main message intended in official policy documents (as well as in the text from other data sources). However, it is also important to ‘attend to silences’ (Tonkiss, 1998: 258), which involves identifying places in the text where important and relevant issues are omitted or ignored. Although the family was mentioned in the Care of the Aged Report, it seemed to me to be in a perfunctory way. I became interested in looking more closely at why relatively little attention had been paid to the family in the report, what the report was saying about the family, and what changes there had been in relation to this in subsequent official policy documents on ageing-related care. Furthermore, when it came to conducting the interviews with policymakers, I was particularly struck by the fact that it was highly unusual for respondents to raise the issue of the family and its role in caring for older people. In most cases, it was halfway
through the interview before there was any mention of the family and it tended to be me, the interviewer, and not the interviewees who raised the issue.

This chapter is divided into four sections to reflect the findings from the analysis of the four different sources of data. **Section 5.2** is based on the analysis of key official policy documents relevant to ageing-related care between 1968 and 2005. **Section 5.3** presents the findings from the analysis of interviews with policymakers. **Section 5.4** examines ideas about the ‘family’ in older people’s discourse on ageing-related care. **Section 5.5** presents findings in relation to the mediatised discourse of policymakers and older people. **Section 5.6** draws some conclusions. As I wanted to explore in depth the sets of ideas about the ‘family’ embedded in official policy documents on ageing-related care and how these have changed over time, and because I compare and contrast these with three other sources of discourse, this chapter is necessarily lengthy.

### 5.2 OFFICIAL POLICY DOCUMENTS

Official policy documents provide a lens for considering how assumptions about and discourses of the ‘family’ are built into social policy (Finch, 1989). This section traces continuities and changes in the main assumptions about and discourses of the ‘family’ that are embedded in official policy documents on ageing-related care and identifies factors contributing to any shifts identified. The exploration begins with an analysis of the *Report of the Inter-departmental Committee on the Care of the Aged* (Inter-departmental Committee on the Care of the Aged, 1968), referred to henceforth as the *Care of the Aged Report*. This is followed by an analysis of *The Years Ahead – A Policy for the Elderly* (Working Party on Services for the Elderly, 1988). Although official policy on ageing-related care in Ireland continues to be underpinned by *The Years Ahead*, the issue of family, care and ageing has been addressed in subsequent official policy documents. Consideration is given to the assumptions about and discourses about the ‘family’ underpinning three key official policy documents published in the new millennium, namely: *Study to Examine the Future Financing of Long-Term Care in Ireland* (Government of Ireland, 2002); *Care for Older People* (NESF, 2005); and *The Developmental Welfare State* (NESC, 2005).
5.2.1 The late 1960s: The Care of the Aged Report (1968)

In the Care of the Aged Report, the ‘family’ (which, conceptually, as a term is ‘taken for granted’) was spoken of in terms of the great sacrifices that families make in caring for their older relatives. Stating that the family could no longer be expected to provide all of the care for older people living in the community, the Care of the Aged Report argued that there was a need for greater public sector expansion as well as a need to encourage greater voluntary sector involvement. The recommendation in the Care of the Aged Report (1968) to expand the public sector’s role represented a step away from a strict interpretation of the principle of subsidiarity, a change that was already underway by the time that the Care of the Aged Report was published (Timonen and Doyle, 2006; Timonen and Doyle, 2008), as discussed in Chapter 1, Section 1.2. This shift was resonant of a wider shift in the mid-1960s from the ‘tradition of viewing all state social intervention as an outsider’s intrusion into the family and the voluntary sector’ (Conroy, 1999: 37). The Care of the Aged Report in 1968 expressed the idea that the state, the voluntary sector and the family should provide complementary sources of care for older people living in the community who are not able to manage independently on their own:

... the fact remains that the vast majority of the aged live in the community and that many families make great sacrifices to look after their aged relatives. Even with such sacrifices it is beyond the power of the family, in most cases, to provide for all the needs of the aged – these needs can be met only with the partnership between the family, public and voluntary organisations (Inter-departmental Committee on the Care of the Aged, 1968: 13).

Similarly, in Britain the political orthodoxy at the time was that community care should incorporate support from both relatives and public resources (Finch, 1989). In Ireland, there were obviously concerns that publicly financed formal care might become a substitute for family care, so much so that the report stressed that the role envisaged for the state vis-à-vis the family was one in which ‘the public authority should endeavour to help the family’ but ‘not take over from it’ and it was considered essential to regard public and family care as ‘complementary—not as alternatives’ (Inter-departmental Committee on the Care of the Aged, 1968: 45).
The emphasis was on the state and voluntary sector complementing family care (albeit only to a modest degree) rather than substituting for it.

Nevertheless, implicit in the *Care of the Aged Report* (1968) and within the policy discourse of 'partnership' between the state, the voluntary sector and the family was the assumption that most of the care for older people would continue to be provided informally by the family. From my analysis, it is clear that there was a firm emphasis on the formal sector's role as provider to those without assistance from family members. Formal community care services were to be particularly focused on providing a safety net for older people who were living alone and did not have the support of family available to them:

> In the case of many old people living in the community, particularly those who are living alone and without regular assistance of relatives, a variety of needs frequently arises and it is important that trained workers should be available to assist them (Inter-departmental Committee on the Care of the Aged, 1968: 66).

The shift away from the principle of subsidiarity in its strict sense that was signalled in the *Care of the Aged Report* and its discourse of 'partnership' must be seen in the context of the moves to transfer older people out of hospital and institutions and into the community. In Britain the consensus that older people should be living in their own homes wherever possible emerged in the 1950s (Means and Smith, 1985). In contrast in Ireland it was the late 1960s that marked (at least in principle) the emergence of a shift in Irish policy relating to the care of older people away from institutional care towards community care. One of the main policy objectives of the *Care of the Aged Report* was 'to enable the aged who can do so to continue to live in their own homes' (Inter-departmental Committee on the Care of the Aged, 1968: 49). It was the first official policy document to articulate this shift towards community care. Because of its explicit policy to move older people out of institutions and into the community, the *Care of the Aged Report* has been described as 'a major catalyst for change' (Ruddle, Donoghue and Mulvihill, 1997: 38).

It is worth noting here the emphasis that is placed on the distinction between medical and social care in the *Care of the Aged Report*. Whilst it was suggested that medical and nursing care would be provided by public health nurses and
general practitioners on an out-patient, community or domiciliary basis to older people with health care needs, it was certainly implied (as an analysis of the Care of the Aged Report shows) that social care in the community would be provided in the first instance by the family and by other informal carers (in accordance with the principle of subsidiarity). It was only when they were unavailable to provide social care that the state (or voluntary organisations) would (where possible) step in or compensate for the lack of family care. For example:

Many of them [patients in a hospital setting] require only the type of care which is normally given at home by relatives, supported when necessary by the district nurse and the family doctor. Where relatives or other suitable persons are not available to provide them with the help which they need in their own homes, it may be possible to meet their needs by home helps or the provision of sheltered housing and where possible this should be done [emphasis added] (Inter-departmental Committee on the Care of the Aged, 1968: 82).

Thus, the 'family' was seen as fundamental to the success of the policy of community care. In addition, it was implied that home care services such as home helps would be targeted at older people living alone and without the assistance of family members.

In addition to supporting older people living alone and without the assistance of families, the involvement in particular of the voluntary sectors (albeit again to an extremely modest extent) was seen as necessary in order to support families to retain their older relatives at home, that is, families who were providing intensive care and heavily involved in personal care. The report expressed concern that without support these families might reach the limits of care-giving and the likely recourse would be to place their older relatives in institutional care:

The handling of soiled bed linen also presents a problem for people looking after incontinent relatives and often results in an effort to have institutional care provided (Inter-departmental Committee on the Care of the Aged, 1968: 69).
Where possible, laundry services should cater specially for the needs of people looking after incontinent old relatives (Inter-departmental Committee on the Care of the Aged, 1968: 70).

Other than this, and notwithstanding the assumption (albeit implicit) that most of the care for older people living in the community would be provided informally by the family, no consideration was given in the Care of the Aged Report to the extent and patterns of family based care for older relatives, which were, it seems, unknown and went unquestioned. Thus, the analysis shows that the Care of the Aged Report promoted the idea that formal care would be mobilised when family care was lacking or when there was substantial need.

Historically, religious and political thinking have emphasised the family’s responsibility with respect to ageing-related care in Ireland. The 1960s was a period which saw the start of a process of disengagement of Catholic religious congregations from social services due to a decline in the numbers of Catholic religious personnel. As a consequence, there was a move away from the Catholic Church in Ireland as a mass provider of social services (Fahey, 1998). According to Fanning (2003), other social changes occurring in the 1960s such as increased access to education as well as an ideological shift within the Catholic Church contributed to a process of secularisation, which to a certain degree supplanted Catholic social thinking and its opposition to welfare expansion that had characterised Irish social policy in the early decades of the twentieth century (as discussed in Chapter 2). Certainly, the discourse of ‘partnership’ and the recommendation in the Care of the Aged Report (1968) to expand the public (and voluntary) sector’s role in community care represented a step away from a strict interpretation of the principle of subsidiarity, which had underpinned Catholic social thought.

Nevertheless, while there may have been less opposition to the expansion of the welfare state in the 1960s, the decreasing influence of the Catholic Church did not completely remove such thinking. Conversely, the principle of familial duty and responsibility continued to prevail in 1968 and underpinned the Care of the Aged Report to a considerable extent. Clearly, the message in the Care of the Aged Report was that care by family should be treated as the normal and desirable state of affairs and that services should be provided by the state or voluntary sector as a supplement when the family was providing intensive levels of care, or
to compensate when there were no family members to provide care. The *Care of the Aged Report* thus promoted the idea that the family is the first and most important source of care for older relatives, despite its discourse of ‘partnership’.

Liberalism, no less than Catholicism, contributed to an emphasis on familial responsibility. Liberalism, according to Fanning (2004) had considerable affinity with Catholic social teaching in that both contributed to an official ideology of the privatised family.

Notwithstanding the ‘great sacrifices’ that many families were understood to make in supporting older people living in the community, there was a sense in the *Care of the Aged Report* that the state had a role to play in encouraging families to accept, retain or take up their responsibility to care for older relatives. The need to encourage families to accept responsibilities for supporting older relatives was seen to arise for the most part when there was the likelihood that they might be admitted to or discharged from long-stay institutional care or acute hospital care, as indicated by the following statements from the report:

> When any question of long-term institutional care arises: She [the social worker] can improve contacts with the relatives and encourage them to retain old persons at home, or to receive them back after a period of institutional care (Inter-departmental Committee on the Care of the Aged, 1968: 66).

> In addition a domiciliary visit [by a specialist physician] has other advantages – it helps considerably the acceptance of the idea that patients are not admitted to hospital except for good and sufficient reasons, it helps to obtain the co-operation of relatives, it increases knowledge of the conditions for which hospital care is regarded as necessary and desirable and it helps the hospital physician to decide whether discharge back to the home is desirable (Inter-departmental Committee on the Care of the Aged, 1968: 80).

> In relation to geriatric assessment units: Close contacts with the relatives should be maintained and they should be encouraged to retain a continuing sense of responsibility for the patient and, from the date of
admission, they should be conditioned as to the idea of his discharge (Inter-departmental Committee on the Care of the Aged, 1968: 80).

Thus, the policy shift towards emphasising care in the community in the Care of the Aged Report is underpinned by a medical/professional discourse in that professionals are given the authority to encourage families to take up their responsibilities to care for older relatives.

One agenda that lies behind the move towards keeping older people in need of care in the community is the problem of escalating costs associated with hospital and institutional care. The Care of the Aged Report (Inter-departmental Committee on the Care of the Aged, 1968: 49) stated that 'it is better, and probably cheaper, to help the aged to live in the community rather than to provide for them in hospitals or other institutions'. Finch and Groves (1980) argue that policy aimed at helping older people to live in the community frequently translates in reality into care by the family, often meaning care carried out by women in the family. The notion that family caregivers are primarily women is a dominant principle underpinning the Irish welfare state (Lewis, 1992) and is reflected in the Irish constitution and in Irish social and economic policies (Kennedy, 1999). It is clear, although not explicitly stated, that the underlying assumption of the Care of the Aged Report (1968) was that it would be the responsibility of women to stay at home and look after older relatives and that the state and voluntary sector could provide care when they were not available. For example, home helps were to take the place 'which frequently is filled by the daughter or daughter-in-law who looks after an aged relative' (Inter-departmental Committee on the Care of the Aged, 1968: 64).

Built into the idea that community care is 'probably cheaper' than hospital and institutional care is the assumption that care provided by family members for older relatives would be unpaid work, provided for the most part, by women in the domestic sphere (Finch and Groves, 1980; Graham, 1997). It is clear from an analysis of the Care of the Aged Report that there was an assumption that married women should provide care for older relatives in an unpaid capacity and that other female relatives should be willing to leave employment to care for an older relative in need of care for a small payment:
The question is sometimes raised as to whether a relative should be employed as a home help. Where a relative is available to help an elderly person, the Committee considers the payment should not be made. Where, however, a relative has to give up employment or is unable to take up employment because of the need to look after an elderly person who does not receive an increase of pension for the relative under the schemes administered by the Department of Social Welfare, the Committee considers that she [italics added] should be paid, but only at the rate and for the time which a non-relative would be paid (Inter-departmental Committee on the Care of the Aged, 1968: 65).

The family is fundamental to the success of a policy of de-institutionalisation

Care of the Aged Report (1968)

The state through professionals has a role to play in encouraging families to accept responsibility for the care of older relatives

Non-working women should provide care to older relatives in an unpaid capacity

The state, the voluntary sector and the family are partners in care for older people living in the community

Families have primary responsibility to care for older relatives

The state (and the voluntary sector) has a role to play in supporting older people living alone and without the assistance of family and friends

Voluntary sector organisations, in particular, have a role to play in supporting family members providing intensive levels of care to older people

Figure 5.1: Logic behind discourses on family, care and ageing embedded in the Care of the Aged Report (1968)
It is worth remembering that the marriage bar was still in operation in Ireland in 1968. Policy initiatives such as the introduction in 1968 of the Prescribed Relatives Allowance (PRA) reinforced the idea that it should be women who provide care for older relatives (Yeates, 1997). The PRA was payable to people with a disability aged 70 years and over who were in receipt of an old age pension and with whom a nominated female relative (a daughter, step-daughter, sister, half-sister, grand-daughter, daughter-in-law or niece) resided for the purpose of providing full-time care and attention. It was paid directly to the care-recipient. While PRA was seen as a means of enabling older people to remain at home rather than enter an institution (Cousins, 1994), it was based on the assumption that female relatives would be willing to remain at home or to leave employment to care for an older relative with a disability. Clearly, the responsibility to provide care to older relatives in families in the 1960s fell primarily on women.

Figure 5.1 above summarises the logic behind the predominant partnership, familialist, medical/professional and patriarchal discourses embedded in the Care of the Aged Report (1968).

5.2.2 The late 1980s: The Years Ahead Report (1988)

The rhetoric of ‘partnership’, that the state, the voluntary sector and the family should provide complementary sources of care for older people who are not able to manage independently on their own, was carried through to The Years Ahead (1988), which stated that '[a] comprehensive service for the elderly depends on each partner playing its part and complementing the work of the others' (Working Party on Services for the Elderly, 1988: 163).

In contrast to the Care of the Aged Report, there was an explicit recognition in The Years Ahead of the importance of family care for older people, as a key element of community care. Not only does The Years Ahead stress that the family is a major partner in the care of older people, alongside ‘members of voluntary organisations and professionals working for statutory agencies’, it goes so far as to state that ‘families make by far the largest contribution’ (Working Party on Services for the Elderly, 1988: 163).

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10 The Conditions of Employment Act, 1936, placed an employment bar in certain areas, including the civil service, on married women, which was only removed in 1973 after Ireland joined the European Economic Community.

19 Male relatives became eligible for PRA in 1971.
The prominence afforded to family carers of older relatives in *The Years Ahead*, supports Twigg’s (1998) view that the role of the family in caring and supporting older people was rediscovered as an issue across Europe and elsewhere during the 1980s. At the time that *The Years Ahead* was being prepared, research about carers of ‘dependent elderly people’ in the community was underway in Ireland. A study by O’Connor, Smyth and Whelan (1988) focused on quantifying the extent and nature of care for older people living at home. In addition, the formation in Dublin of the Carers Association in the 1980s, a support group for those caring for older people, also contributed to ‘highlighting the needs of carers and identifying ways in which they can be supported’ as *The Years Ahead* (Working Party on Services for the Elderly, 1988: 58) was to point out.

In keeping with the *Care of the Aged Report* (1968), there was a rhetorical emphasis on formal care in the community in *The Years Ahead*. In contrast, however, *The Years Ahead* stressed the inadequacy of support to family carers provided by the public sector. In reviewing the progress of the implementation of the recommendations of the *Care of the Aged Report, The Years Ahead* documented the shortcomings in services to support relatives: ‘Despite progress in developing domiciliary and community services insufficient support is available to thousands of relatives caring for elderly people at home, many of whom have severe disabilities’ (Working Party on Services for the Elderly, 1988: 24). The gap in supports for caring relatives was noted repeatedly in *The Years Ahead*. It stated that ‘persons caring for their elderly relatives at home receive insufficient support from statutory bodies’ (Working Party on Services for the Elderly, 1988: 28), that ‘people caring for elderly relatives at home receive little or no support from health board personnel’ (p. 40), and that ‘... family carers receive little formal recognition and insufficient support from statutory agencies’ (p. 163).

Alongside this, there was a new rhetoric of ‘supporting elderly people and caring relatives’ in *The Years Ahead*. The Working Party recommended the development of initiatives and services that would play ‘a vital role in supporting relatives caring for dependent elderly people at home’. Co-ordination was an issue of central concern. The model for co-ordination of services proposed co-ordination between different government departments, between different agencies within the health board, between different agencies within the public sector and between the public and the voluntary sector. Supporting relatives caring for older
people was considered to be a task that would be best carried out at district level, where it was envisaged that the District Liaison Nurse would take responsibility for co-ordinating the task, amongst others, of supporting caring relatives (Working Party on Services for the Elderly, 1988: 44) and at community care area/county level, where the Co-ordinator of Services for the Elderly would have the task of ensuring that ‘elderly people in need and their carers receive the right balance of support from statutory services to enable them to live in dignity at home’ (Working Party on Services for the Elderly, 1988: 101).

The development of respite care was recommended. In addition to its role in helping older people living alone, it was recommended that ‘the home help service should be expanded in scope to provide evening and weekend relief service for persons caring for elderly relatives at home’ (Working Party on Services for the Elderly, 1988: 97) and that day centres relieve caring relatives, particularly those who have to go to work, of the responsibility of caring for elderly persons during the day (p. 105). Supporting caring relatives also included a recommendation for community hospitals to provide respite care (p. 134) and the provision of a medical appliance or aid, which ‘can make all the difference to their ability to manage at home’ (p. 93). It recommended that community hospitals (which were to be established from some of the existing geriatric hospitals) would develop a range of support services for older people and their families in the districts they served (p. 139).

Developing services so as to encourage relatives to provide care for older people, and to provide information and advice, training and guidance to caring relatives was also proposed in The Years Ahead. The report recommended that, as resources permitted, additional public health nurses would be appointed. Public health nurses were seen to be particularly suited to encouraging families (amongst others) to provide care as well as advising and supporting caring relatives:

She [the public health nurse] must mobilise the resources of the primary health care team, the family and neighbours, advise and support those caring for the patient and help the patient and family when a crisis occurs [emphasis added] (Working Party on Services for the Elderly, 1988: 91).

Physiotherapists also had a role to play in this regard:
The physiotherapists can help preserve mobility and independence of elderly persons by advising patients and relatives on remedial measures. The physiotherapist can prevent hospitalisation by providing treatment for acute conditions such as respiratory infections. He or she can teach relatives and carers how to handle and lift an elderly patient and can educate them on the risks of inactivity. *Domiciliary physiotherapy can ... lead to a greater involvement by relatives or carers in the handling of the patient ...* [emphasis added] (Working Party on Services for the Elderly, 1988: 94).

The emphasis on nurses and physiotherapists highlights the authority attributed to the nursing and para-medical profession and the pivotal role they were expected to play not only in advising, training, educating and supporting families but ultimately in encouraging greater involvement of families in the care of older people living in the community. This is an indication that the medical/professional discourse was embedded in *The Years Ahead*, as it was in the *Care of the Aged Report*.

*The Years Ahead* went so far as to recommend a legal framework for the development of services for the elderly, which would include 'an obligation on health boards to provide services to support dependent elderly people and their carers in the home' (Working Party on Services for the Elderly, 1988: 184). This thinking is largely based on ensuring that the maximum amount of care is provided informally by the family.

Although a new policy rhetoric of 'supporting elderly people and caring relatives' emerged in *The Years Ahead*, in practice the picture that evolved is less encouraging. *The Years Ahead* acknowledged the significant contribution that families make in caring for older relatives. It stressed the inadequacy of support to family carers provided by the public sector. It recommended initiatives to address the shortcomings. Nevertheless, several studies (Finucane, Tiernan and Moane, 1994; Blackwell et al., 1995) as well as a review of the implementation of the recommendations proposed by *The Years Ahead* (Ruddle et al., 1998) found that support to carers fell far short of what was recommended. As mentioned earlier, the co-ordination of the task of supporting relatives caring for older people was considered in *The Years Ahead* to be a task that would be best carried out at
district level and community care area level (Working Party on Services for the Elderly, 1988: 44). In interviews for the review, Ruddle et al. (1998) found that few District Liaison Nurses spoke of their role as including the support of caring relatives.

In addition, Ruddle et al. (1998) found that the home help services did not provide the extent of respite for carers as envisaged in The Years Ahead due to an underestimation of the level of services required, an underestimation of level of funding needed, and the continuing underfunding of the service. The review highlighted the inadequacy of levels of day centre provision and the unevenness of their distribution across the country (Ruddle et al., 1998). It concluded that the levels of PHNs were less than adequate and noted the widespread dissatisfaction among nurses themselves about the ratios of PHNs to the population. In addition, nurses were distanced from their district nursing duties because of the increasing level of managerial work and there was need for a greater level of back-up services such as nurse panels, home helps and care assistants. Domiciliary provision of paramedical services including physiotherapy was extremely limited due to limited resources and, moreover, domiciliary provision of physiotherapy was not always regarded as necessary by health board management. The lack of availability of support services for carers was compounded by a policy of reducing services where a carer was present. The recommendation on legislation was not implemented (Ruddle et al., 1998). The review was highly critical that little has been done and concluded:

This review corroborates the findings of previous research that major needs of carers, such as education and training, information and advice, adequate financial support, domiciliary support and respite, are not adequately addressed and that carers require much greater public support than they are currently receiving (Ruddle et al., 1998: 312).

Despite a policy rhetoric of ‘supporting elderly people and their caring relatives’, what Twigg and Grand (1998: 146) refer to as an ‘absence of alternatives’ meant that the family was to continue to be the key building block of care for older people living in the community. The Years Ahead recognised that improvements were needed and made proposals with respect to supporting caring relatives. However, as Conroy (1999: 43) has pointed out, the proposals came ‘at a bad time’: the 1980s were deeply recessionary and the OECD (1982) warned the Irish
government against making any changes that would involve an increase in government spending. The desire to reduce public expenditure was a central thrust of the government during the 1980s. Thus, in highlighting the gap between policy rhetoric and what happened in practice, the economy cannot be ignored. Taylor (2003: 318) explains the tensions, which were not unique to Ireland, in the following terms: '[t]ax revenues declined sharply while welfare commitments rose as governments sustained periods of structural unemployment'. Furthermore, there was 'an unusual concentration' on the need to resolve the debt crisis in Ireland both within the political process and amongst the electorate (FitzGerald, 2003: 78).

*The Years Ahead* was also criticised for failing to take account of the issue of 'choice', that is, the extent to which there is 'choice' about becoming a carer (Ruddle *et al.*, 1998: 312). Ruddle *et al.* (1998: 312) argue that '[p]olicy-makers must not assume that family members will provide care'. Apart from the affection that family members might feel towards older relatives, Ruddle *et al.* (1998) argue that a range of other factors come into play in a family member’s decision about adopting the role of carer for older relatives including the carer’s availability, proximity to the older person, sense of obligation, the carer’s gender, employment status and household composition. According to Ruddle *et al.* (1998), these and any other options available need to be taken into account by policymakers to ensure that policy initiatives are not based on the assumption that the family will provide care but on the principle that policy initiatives should offer choice both to those who receive the care and those who take on the job of giving care.

A contrast with the *Care of the Aged Report* (1968) is that *The Years Ahead* (1988) addressed the notion of a decline in family support for older people. The report refuted the idea that there was a decline in the willingness of families to take responsibility for older people. Evidently, this view was informed by empirical evidence from research by O'Connor *et al.* (1988), which demonstrated that the caring commitment of families towards older relatives was strong:

While it is often claimed that families are no longer willing to care for their elderly relatives when they become dependent, the evidence before us does not support that claim. A recent survey of those caring for elderly relatives suggests that about 66,000 dependent elderly persons are being cared for by their families, compared with approximately 18,500 elderly
persons in long-term care. Figure 1.1 shows in a simplified way the proportion of the elderly at any one time leading independent lives, being cared for by their families and in long term care (p. 26).

Nevertheless, the belief that some families were unwilling to accept responsibilities for supporting older relatives once they had been admitted to acute hospital care persisted to an extent:

Their [staff in acute hospitals] reluctance to admit elderly patients may be rooted in previous experience of relatives refusing to accept the discharge of an elderly patient or of delayed discharge because of inadequate community care services (Working Party on Services for the Elderly, 1988: 116).

*The Years Ahead* endorsed the commitment to pursuing policies with the intended effect of enabling as many older people who can do so to continue living at home. As with the *Care of the Aged Report*, the idea of enabling older people to continue to live in their own home and supporting caring relatives is connected to the economic pressures associated with hospital and institutional care (see Finch, 1989: 125). Because of the voluntary nature of much of the home help service at the time, it was seen as an extremely cost effective way of helping older people to stay at home. Similarly, with day centres:

We consider that day centres provide an important service in the continuum of services necessary to support the elderly at home, to assist those caring for elderly relatives and to reduce the unnecessary admission to institutional care. *At a fraction of the cost of residential care* [emphasis added], they offer a life line to many old people who live alone and are unable to look after themselves. They support relatives by sharing the task of caring for the elderly persons for at least one day a week. Attendance at a day centre may make the difference between a family continuing to care for an elderly relative and seeking institutional care because the strain of caring is too great. The more comprehensive the service provided by a day centre, the less need there is for institutional care (Working Party on Services for the Elderly, 1988: 107).
As mentioned earlier, an underlying assumption of the Care of the Aged Report was that married women should provide care for older relatives in an unpaid capacity and that other female relatives should be willing to leave employment to care for an older relative in need of care for a small payment. The Years Ahead also drew attention to caring as a women's issue. However, the difference in tone and focus is notable. Bytheway and Johnson (1998: 244-5), who have traced the history of the concept of 'carer', have pointed out that there was an assumption in the 1980s, reinforced by the extensive body of research undertaken in the UK at the time, that informal care is largely about 'the relationship between one carer, a middle-aged woman, and one dependent person – usually an older parent'. Research in Ireland too concluded that women provided by far the greater proportion of informal care (O'Connor et al., 1988) and this clearly informed The Years Ahead:

A recent survey of those caring for elderly persons found that female carers outnumber males by more than 5 to 1. A female carer is most commonly looking after a parent, a spouse or a parent-in-law. The tendency of women to take on this role is influenced by the traditional caring role of women. It is also influenced by the low level of participation of married women in female employment (Working Party on Services for the Elderly, 1988: 33).

The impact on family care giving of the trend towards increasing levels of participation of married women in the labour force was one of the concerns deliberated in The Years Ahead:

In the period 1971-1985 there was a dramatic increase in married women's participation rates in the labour force following the removal of discriminatory employment practices, changes in social attitudes towards married women remaining in the labour force and increased employment in the social services. The extent to which this trend continues will affect married women's availability to care for dependent husbands and relatives. The estimates are that married women's participation rates in the labour force will increase from the current level of 20.4 percent to 42.2 percent in 1996. DKM [Economic Consultants], using more conservative assumptions, suggest that participation rates will be 34 percent in 2011. While these increases are significant, the projected participation rates are
still low by European standards and much of the work involved may be part-time (Working Party on Services for the Elderly, 1988: 33-34).

The Years Ahead concluded that 'although married women will be increasingly employed outside the home, the increase is not expected to have a major impact on the care of dependent elderly relatives' (Working Party on Services for the Elderly, 1988: 36).

Shortly after the publication of the Care of the Aged Report, the Commission on the Status of Women, appointed by Government in 1970, had taken up the issue of the financial costs facing women who interrupted employment to care for an older relative. The Commission expressed concern that the insurance record of women who gave up employment to provide care and attention for an older relative was adversely affected. It argued that there was a strong case for granting credited contributions to female carers of older relatives who were in receipt of the Prescribed Relative Allowance (PRA) (Commission on the Status of Women, 1972). This was implemented in 1972 (Cousins, 1994).

The issue of supporting family carers financially through the social welfare system had also been highlighted as a policy issue in the Report of the Commission on Social Welfare (1986), which had recommended that the Prescribed Relative Allowance (PRA) be replaced with a payment going directly to the caregiver as opposed to the care-recipient. The Years Ahead argued for the implementation of this recommendation – 'that carers be entitled to claim social assistance in their own right and that such entitlement should replace the Prescribed Relatives Allowance' (Working Party on Services for the Elderly, 1988: 165). In 1990, the Carer’s Allowance, a social assistance payment to carers of older people and other people, replaced the PRA. The Carer’s Allowance became one of the main forms of financial support for carers. Its primary aim was to provide a minimum income for carers. By giving the payment directly to the caregiver, it provided carers with an independent income.

The introduction of the Carer’s Allowance in 1990 can be seen as a means of compensating carers in a limited way for any loss of earnings as well as acting as a financial incentive to carers to provide such services (Cousins, 1994). As a tightly means tested payment and limited to those providing constant and intensive care, the Carer’s Allowance is considered to be an income support
mechanism rather than a payment for caring, which many carers were and still are unable to receive (Ruddle et al., 1998; Timonen and McMenamin, 2002). Given that the Carer's Allowance plays a role in encouraging families to provide care to enable care recipients to live in the community, it is consistent with the principle of familial responsibility in Irish social policy, which is predicated on the assumption that the family and not the state will be the principal source of care in the community (Yeates, 1997).

![Diagram](image-url)

Figure 5.2: Logic behind discourses on family, care and ageing embedded in *The Years Ahead* (1988)

The introduction of the Carer's Allowance can also be seen to represent the principle of 'subsidiarity' in a new guise, with it emphasis on access to welfare that
would support women's choice to withdraw from paid employment to care for older relatives.

Figure 5.2 above summarises the logic that has been discussed so far behind the discourses on the family, care and ageing that are embedded in *The Years Ahead*.

### 5.2.3 Official policy documents in the new millennium

As well as recognizing the existence in Ireland of the provision of care through a mixed economy, both the *Study to Examine the Future Financing of Long-Term Care in Ireland* undertaken by Mercer on behalf of the Department of Social and Family Affairs (Government of Ireland, 2002: 32, 45, 51, 89) and the National Economic and Social Forum report on *Care of Older People* (NESF, 2005: 3, 25, 54) explicitly acknowledged the importance of families in providing most of the care for older people living at home in Ireland, and in most countries.

Nevertheless, considerable attention was paid in the *Study to Examine the Future Financing of Long-Term Care in Ireland* to concerns about the future availability of family care, including for 'frail' older people, due to social and demographic changes, especially the impact of women's increasing participation in the labour market, the trend towards smaller family size and the trend towards older people living alone (Government of Ireland, 2002: 34, 51, 54, 82, 89-92). The report noted that the widespread belief that informal care will decrease as a result of such social and demographic changes can be challenged by evidence that family commitment to caring remains high (Government of Ireland, 2002: 54, 89). Nevertheless, it warned that for the future ‘it can no longer be assumed that care will be available from non-employed female family members’, and that the availability of carers was likely to fall in the future (Government of Ireland, 2002: 54, 62, 89-92). The NESF (2005: 28) report reiterated this concern. Of particular concern in the *Study to Examine the Future Financing of Long-Term Care in Ireland* was the likelihood that the numbers of people ‘with a high level of dependency’ going into residential care would rise, which it argued could potentially result in an increase in the costs of residential care:

... if a family carer is not available, an individual with a high level of dependency and limited means will have no option but to go into
residential care, given the lack of provision for personal care costs at home. More and more people are likely to fall into this category in future years, as demographic change and increased labour force participation lead to a reduction in the availability of family carers. This could substantially increase the cost of residential care (Government of Ireland, 2002: 83).

According to the Developmental Welfare State, issued by the NESC (2005: 36), the family's capacity to provide care has been weakened since the 1970s due to increased women's employment, rising house prices, geographical distance, urbanisation and demographic changes such as smaller family size and growing population of older people. It is interesting to note that they fail to note the counterbalancing trend of an increase in spousal care-giving.

Both the Study to Examine the Future Financing of Long-Term Care in Ireland (Government of Ireland, 2002: 92-3) and the NESF (2005: 28) report addressed the question of the responsibility of the family to provide care. The Study to Examine the Future Financing of Long-Term Care in Ireland acknowledged that there are diverging views on who should be responsible for long-term care. However, it noted that the State's objective is to pursue a policy goal of keeping older people in their homes, or in home-like settings, with adequate support for people requiring institutional care. Given this, the Study to Examine the Future Financing of Long-Term Care in Ireland articulated the view that State's role, which fell between two extremes, was to support families in their caring responsibilities:

This view does not see family care as a substitute for care that should be provided by the State and for which financial remuneration should be provided to family carers. It does suggest, however, that formal services and/or benefits should be available to support the role of the informal carer, which for the most part has not been the case heretofore (Government of Ireland, 2002: 93).

It was against this backdrop that the Study to Examine the Future Financing of Long-Term Care in Ireland saw the need to encourage and support informal carers.
The NESF Project Team adopted and reiterated the view expressed in the *Review of the Carer's Allowance* (Department of Social, Community and Family Affairs, 1998) that there are differing and opposing views and a lack of clarity regarding the balance of responsibility of caring, and identified this as a barrier to the development of better community care services in Ireland (NESF, 2005: 28).

The NESF report stated that 'ultimately, it is society's values which determine policy and financial priorities, and the lack of public debate and clarity on the respective caring roles and responsibilities of the family and the State limit the development of policy in this area' (NESF, 2005: 28). The NESF Project Team decided not to focus on carer supports (as full-time carers had been the focus of work undertaken by the Oireachtas Joint Committee on Social and Family Affairs and work on equality for family carers was the subject of work by the Equality Authority (2005)). However, it strongly supported the view that 'carers are a core element of any community care strategy to facilitate older people to live in their own communities for as long as possible', but that 'insufficient attention has been given to this area in the past and what is required now is a national strategy for caring' (NESF, 2005: 55).

As the *Study to Examine the Future Financing of Long-Term Care in Ireland* pointed out: 'For informal care to continue to be the bedrock of home care provision, more extensive support for family carers will be needed' (Government of Ireland, 2002: 62), a view fully endorsed by the NESF Project Team (NESF, 2005: 25). What marks the *Study to Examine the Future Financing of Long-Term Care in Ireland* out from previous reports is an explicit recognition that while there has been a rhetoric of 'supporting older people and their caring relatives', the likelihood is that in practice formal home care services such as home helps are allocated to older people living alone (Government of Ireland, 2002: 43, 93). This, together with the considerable amount of unmet need for services targeted specifically at informal carers such as day care and respite care, amounted to inadequate support for informal carers (Government of Ireland, 2002: 43, 93). The argument for a shift in practice towards directing home care services not only at unsupported older people living alone, but also to family members providing care to older relatives follows policy in some other developed countries. In a 'brief' overview of the direction of policy in relation to the care of older people in selected developed countries, the NESF report (2005: 13, 129) found that one trend that has emerged has been a policy re-think in many countries on the role of informal carers. Research shows that many home care services aimed at
enabling older people to remain living at home have in fact been heavily
dependent on family members. This finding has led to the view that it may be
better to provide services to informal carers looking after older people rather than
targeting directly towards older people.

The *Study to Examine the Future Financing of Long-Term Care in Ireland*
proposed two approaches for supporting family carers, which were not
necessarily exclusive. These are: (1) the provision of cash benefits where care is
provided informally as an alternative to formal care (that is, care provided by
public, private and voluntary sector) and/or (2) the provision of both formal home
care services such as home helps that indirectly support family carers and
services that directly support family carers, such as day care, respite care and
information services. Importantly, it was suggested that benefits and services
would be set at a level 'consistent with the policy of supporting rather than
substituting for informal care' (Government of Ireland, 2002: 87). The NESF
report strongly supported the concept of community-based subventions to
contribute towards the care needs of those in community settings, and argued
that, amongst others, these should be 'part of a package which supports informal
care, where available' (NESF, 2005: 53). It suggested that Carer’s Allowance and
Carer’s Benefit be replaced with a long-term care benefit. This was envisaged to
be a measure to support family care – a mechanism to support a partnership
between the State and families in the provision of long-term care – rather than a
payment for family care (NESF, 2005: 96).

Figure 5.3 below summarises the logic behind the discourses on the family, care
and ageing that are embedded in the *Study to Examine the Future Financing of
Long-Term Care in Ireland* (Government of Ireland, 2002) and the NESF (2005)
report on *Care for Older People*. 
Home care services, services directly specifically at carers and/or cash benefits should be used as measures to support family care of older people who have been assessed as eligible for services/benefits.

The state, the voluntary sector and the family are partners in care for older people living in the community.

The family is the bedrock of care for older people living at home.

The state has a role to play in encouraging and supporting families in their caring responsibilities.

The availability of carers is likely to decrease in the future.

It can no longer be assumed that care will be available from family members.

Figure 5.3: Logic behind discourses on family, care and ageing embedded in Study to Examine the Future Financing of Long-Term Care in Ireland (Government of Ireland, 2002) and NESF (2005) report on Care for Older People.

The Study to Examine the Future Financing of Long-Term Care in Ireland and the NESF report unequivocally promote the family as the bedrock of home care provision for older people. In both reports families are recognised as the principal source of support for older people and continue to be a target of social policy, echoing policy that emerged in the 1980s. There is a concern that if families ceased to care then the state would face a problem of how to pay for the cost of providing care, particularly for the increasing numbers of older people entering into residential care. The solution is once again to support family carers either financially or through the provision of home care or carer support services.

Given the context of the Celtic Tiger economy in the 1990s and in the early years of the 21st century (see Chapter 2), it is interesting that little attention was given in
either the *Study to Examine the Future Financing of Long-Term Care in Ireland* or the NESF report to the issue of combining caring and part-time employment. This is an issue, however, that was taken up by the NESC in 2005, as will be seen below.

The NESC report (2005), *The Developmental Welfare State* (DWS), argues that Ireland is characterised by a hybrid model of the welfare state. It proposes a reform of the existing system, using a model of the developmental welfare state, which comprises three overlapping domains of welfare state activity; core services, income supports and activist measures. The DWS also adopts a three-pronged life course perspective, which revolves around a tripartite distinction between children, working age adults and older people.

Core services include health and social care services for the young, working age and older populations. The report highlights the need to invest in care services, with elder care services identified as one of the priority areas. The report differentiates between income supports for children, working age adults and older people. Income supports for eldercare are discussed in the context of working age adults. One of the key concepts employed in DWS is ‘working age transfers for participation’. According to the DWS, the spread of measures designed to increase the attractiveness of holding employment has been one of the most notable and sustained developments in income support programmes in Ireland (NESC, 2005: 54) and it argues that in the future this would be a condition attached to all income support measures:

> As a long-term goal, the Council envisages the eventual merging into the one programme of the several contingency-based, social assistance payments which currently provide welfare transfers to people of working-age. This could be termed a ‘participation income’ as the underlying purpose would be to ensure that each payment arrangement to people of working age acknowledges that meaningful participation of some form is a legitimate expectation of people of working age (both their expectation of society and society’s expectation of them) and that, only in rare cases, should it be accepted that an individual does not have some capacity to develop a greater degree of self-reliance (NESC, 2005: 219).
The report does not define meaningful participation, but the choice of the term 'working age', as Cousins (2005) points out, is highly ideologically motivated, and implies that people of working age should be at work. The Carer's Allowance, when introduced in 1990, was a major departure from the emphasis on encouraging employment, as the NESC (2005: 54) itself has noted. Under the developmental welfare state model, it seems to be implied that family carers of older people receiving social assistance would be expected to combine caring and employment. This is reinforced by the argument in DWS that there are direct and positive economic consequences to be achieved from higher public social spending to improve social protection in several areas including services. This is because improved services (including eldercare services) not only support people in their caring responsibilities for family members but 'help them maintain an attachment to the workforce and avoid long absences from it during which their skills deteriorate' (NESC, 2005: 33).

As 'the term 'work' is restricted to market based activity and excludes much socially necessary labour' (Levitas, 2001: 450), the NESC controversially promotes labour market participation over other forms of participation including care (Murphy and Millar, 2007). The NESC report recommends that income supports for family care-givers should be reconfigured as 'working age transfers for participation' and proposes a shift towards providing core services to enable family members (of working age) to combine working and caring for older relatives. These recommendations might offer an example of what Murphy and Millar (2007) refer to as the 'productive reordering of social policy to meet present/future economic needs', and 'part of a process of making social policy subordinate to economic policy'.

The NESC report fails to acknowledge that combining work and caring for older people can be extremely difficult or that family carers may have other roles and responsibilities. Besides, there is insufficient analysis of how this relates to gender. Family carers are by and large women and, as Murphy and Millar (2007) point out, forcing working age women into paid work would increase their overall burden of work. Moreover, there is an assumption in the DWS that care-giving within families is exclusively carried out by working age adults, with little or no attention paid to older (retired) family carers.
Figure 5.4 below summarises the logic behind the discourses on the family, care and ageing that are embedded in *The Developmental Welfare State* (NESC, 2005).

Both the *Study to Examine the Future Financing of Long-Term Care in Ireland* (Government of Ireland, 2002: 38) and the report on Care for Older People (NESF, 2005: 62) noted that the practice of taking into account the income of an individual’s children for the purposes of assessment for nursing home subvention has been discontinued. The NESF Project Team pointed out that although this practice had been discontinued, many families in practice have to contribute to home nursing or nursing home charges if their parents could not afford to do so. In the context of a discussion on charging for services, the NESF report went on to raise the issue of what obligation there should be on adult children to contribute to the cost of care for their parents. It raised three points in relation to this: first, that there has never been a comprehensive debate on Ireland about the role of families in supporting dependent members; second, that although there is no legal
obligation on people to support older parents or other relatives, many people recognise a moral obligation to do so; and third, that it is arguable that older people themselves do not want to be dependent on their children for support (NESF, 2005: 62). Furthermore, adult children have no legal right to inherit their parent's estate (NESF, 2005: 62). In the DWS, the question of how services such as elder care services would be financed remains unanswered (Murphy and Millar, 2007).

The next section summarises the core themes that emerged from the analysis of official policy documents. In particular, the section highlights the multiple prominent discourses in relation to the family, care and ageing that have been identified in the official policy documents, the transformation of these discourses over time, and the emergence of new discourses.

5.2.4 Section Summary

Figure 5.5 (overleaf) summarises the dominant discourses on family, care and ageing that are embedded in the official policy documents on ageing-related care that have been reviewed as well as the key changes that have taken place between 1968 and 2005. This section discusses these in more detail.

Ageing-related care policy and practices in Ireland have been built on the premise that the family is the primary unit responsible for the care of older people. Chapter 2, Section 2.2, pointed out that a counterpart to the state's policy of allocating welfare to older people within the workhouse in the nineteenth century was the tendency to rely on the family as the primary provider of care for older people (as well as other groups in need of care) outside of the workhouse (and later the County Homes). This was a fundamental idea underpinning the principle of subsidiarity, which has been incorporated into social policy and ageing-related care in Ireland (as explained in Chapter 2). In accordance with this is the notion that the welfare state has a residual function and acts as a safety net. This might be referred to as a familialist discourse, which is predicated on the assumption that the family and not the state will be the principal source of care for older relatives. Policies based on this assumption have encouraged the view that recognising responsibility for and fulfilling the duty to care
Figure 5.5: Model of continuity and change in prominent discourses on family, care and ageing embedded in official policy documents on ageing-related care between 1968 and 2005
for an older relative is a ‘normal’ or ‘natural’ part of family life (Land and Parker, 1978).

There are contradictory messages conveyed by the Care of the Aged report. One the one hand, the partnership discourse, which promotes the family acting as a partner with and complementing the state and the voluntary sector provision for older people (particularly when it comes to issue of community care), was a prominent discourse about the family that can clearly be identified in the Care of the Aged Report. It was coupled with the recommendation to expand the role of the public (and voluntary) sector in community care. (This represented a step away from a strict interpretation of the principle of subsidiarity, which had underpinned Catholic social thought). There was also an acknowledgement that the family cannot be expected to shoulder all of the responsibility, in recognition that the ‘burden’ can become too much. On the other hand, a familialist discourse can also be identified. The analysis shows that the conception of the ‘normal caring family’ can be readily observed in the Care of the Aged Report (1968), which presented the family as willing to and making ‘great sacrifices’ to provide care for older relatives. In addition, there was an expectation that the family would continue to maintain responsibility for caring. The principle of familial duty and responsibility thus continued to prevail in 1968 and underpinned the Care of the Aged Report to a considerable extent. This is borne out by the extremely low level of supports that were extended to caring relatives over the following 20 years, as outlined in The Years Ahead (1988).

The analysis shows that implicit in the Care of the Aged Report was the belief that the expansion of formal services for older people would undermine the willingness or sense of obligation within families to take responsibility for older people and to provide care for them. Therefore, the report not only encouraged an image of the ‘normal, caring family’ but also a contrasting one of the family as opportunistic and uncaring. The ‘opportunistically uncaring family’, like the ‘normal caring family’, has dutifully provided care for older relatives. However, as the state becomes increasingly involved in providing care services for older people, the ‘opportunistically uncaring family’ feels vindicated in stepping aside and allowing the state (or voluntary sector) to take over all of the care for older people. The shift away from subsidiarity in its strict sense appears to be a major catalyst for the construction of families as ‘opportunistically uncaring family’.
Ireland has traditionally been characterised in terms of a strong male breadwinner model (Lewis, 1992), which prescribes a homemakers role for the wife who cares for the husband, the children and other family members. The orthodoxy in the 1960s was that the responsibility to provide care to older relatives in families should fall primarily on women. Care work was to be carried out in the private sphere of the home outside of the labour market and in an unpaid capacity. The provision of care within families was therefore a private form of solidarity and exchange. The analysis shows that the Care of the Aged Report was underpinned by this patriarchal discourse in that there was an assumption that married women should provide care for older relatives in an unpaid capacity and that other female relatives should be willing to leave employment to care for an older relative in need of care for a small payment.

The analysis shows that the policy rhetoric of ‘partnership’, resurfaced in The Years Ahead and the most of the other official policy documents on ageing-related care that were analysed for this thesis. Therefore, there is continuity in the way that official policy documents on ageing-related care in Ireland have promoted a view of the family and the state as partners in the provision of care for older people. However, little or no consideration has been given in the official policy documents to how the ideal of partnership between the state and the family operates in practice.

The analysis highlighted that there was a somewhat different tone in other respects in The Years Ahead (1988). Whilst the assumption that the family will provide most of the care for older people prevailed, the predominant image was of the ‘caring but unsupported family’. The message that the report conveyed is of the family willing and making great sacrifices and having to shoulder great ‘burden’ with little in the way of state services providing support for either older people or their caring relatives. A number of factors have contributed to the construction of the notion of the ‘caring but unsupported family’. These include the increased visibility given to the issue of family carers of older people through research on carers in Ireland and further afield, the emergence of organisations representing carers. The emergence of the second wave Irish women’s movement in the 1970s would also have contributed to this change. The message in the report conveyed is that supports for caring families are needed. Notwithstanding the new rhetoric of ‘supporting elderly people and their caring relatives’ that emerged in the 1980s, the desire to reduce government spending,
an ‘absence of alternatives’, and a policy of reducing services where a carer was present meant that the family was to continue to be the key building block of care for older people living in the community.

Despite concerns in *The Years Ahead* about the low availability of services for older people and family carers, the representation of the family as opportunistic persisted (albeit to a lesser extent than in the *Care of the Aged Report*) with the belief that some families are unwilling to accept responsibilities for supporting older relatives once they had been admitted to acute hospital care. Clearly, an underlying current that forms a thread through the earlier official policy documents analysed, that is, the *Care of the Aged Report* and *The Years Ahead*, is a *familialist* discourse that constructs families as both ‘caring’ and ‘uncaring’. The contrast between the former and the latter can clearly be seen in the image of the ‘family’ making great sacrifices in caring for older relatives, on the one hand, and the image of the ‘family’ as unwilling or reluctant to take on their responsibility to provide care, on the other. It is indicative of an unresolved tension between the two constructions of the family. Within both constructions, family care is assumed to be the ideal form of care. The ‘normal caring family’ is hard-working and deserving of some support from the state, but social policies should also be concerned with preventing the (undeserving) unencumbered families who abdicate their caring responsibilities to the state and voluntary sector from gaining benefits (financial or in-kind) from the health and social care system. Moreover, families are constructed as a problem. Unwillingness among families to assume responsibility to care for older relatives constitutes a problem. In particular, families are considered to be partly to blame for the numbers of older people in hospital and institutional care. The analysis shows that the *Care of the Aged Report* and *The Years Ahead* were underpinned by a professional discourse in that the solution to the problem is for professionals and voluntary organisations to encourage and indeed instruct families as to their responsibilities, and to advise and educate them in their caring role.

By 1988, the *patriarchal discourse* that had underpinned the *Care of the Aged Report* had been challenged and tempered by second wave women’s movement of the 1970s and its feminist discourse. Ireland’s accession to the European Economic Community in 1973 would too have had an impact. With the introduction of the Carer’s Allowance in 1990 to replace the PRA, there was a change in policy. By making payments to family members caring for older people,
the state adopted a social security model that recognises the independent rights of family caregivers to their own income, giving family caregivers who receive the payment a degree of financial independence (Glendinning et al., 1997). Its primary aim is to partially replace income foregone through lost employment opportunities, which is a cost of caring. However, it is associated with residual welfare and payments tend to very low, which in reality do not fully compensate the caregiver for loss of earnings. Moreover, this way of financially supporting carers tends towards a carer role rather than a mixed carer/worker role as in other countries such as the Netherlands and the UK tends to reaffirm women in their role as carers.

Another prominent discourse in official policy document on ageing-related care in Ireland is a ‘family in decline’ discourse. The issue of changing familial support for older people was absent from the Care of the Aged Report. While the issue was raised in The Years Ahead, the discourse of family in decline was refuted. In reviewing the implementation of recommendations contained in The Years Ahead, Ruddle et al. (1998: 312) warned that ‘[p]olicy-makers must not assume that family members will provide care’. Certainly, in the early years of the new millennium the idea that the family could not be relied upon to provide most of the care for older people had taken hold. A new discourse about the family, that is, the family in decline came to the fore. This discourse about the family was adopted by the Study to Examine Future Financing of Long-term Care in Ireland (Government of Ireland, 2002), the NESF report on Care for Older People (2005) and the NESC report on The Developmental Welfare State (2005). There were calls in the Study to Examine the Future Financing of Long-Term Care in Ireland and the NESF report on Care for Older People for more extensive supports for family carers in the new millennium. However, proposals to support family carers were set against a backdrop of concerns about decline in family support for older people. As such, it is argued that there are two contradictory aims of social policy on ageing-related care in the new millennium. The first is to develop strategies to support to ‘caring but unsupported families’. The other is to galvanise subsidiarity in the face of the ‘family in decline’ if a policy of community care is to be succeed and public expenditure contained.

The traditional view in Ireland of men as breadwinners and women as homemakers has changed very significantly (Hilliard, 2004: 9) and through provisions such as Carer’s Benefit there is some support in Ireland for a mixed
carer/worker role, especially for women. Unlike carers outside the labour market, participation in the labour market guarantees access to Carer’s Benefit, a social insurance benefit to enable family carers to interrupt work in order to provide care. However, as take up remains extremely low, it can hardly be argued that social policy in Ireland promotes a mixed carer/worker model when it comes to family care of older people. While Carer’s Benefit is a form of financial support aimed at encouraging a family member to provide care for an older relative while remaining attached to the labour market, the care/employment interface in Ireland can be said to be ‘a private one, in that choices around how, when and how much to care are left to individuals within the context of their families’ (Daly and Rake, 2003:145).

The next section examines the perspective of policymakers on family, care and ageing, identifies the key discourses held by them, and compares and contrasts these with what has been found in the analysis of the official policy documents on ageing-related care.

5.3 POLICYMAKERS

This section presents the findings in relation to the theme of family, care and ageing based on the analysis of the transcripts of interviews with 14 policymakers (that is, politicians and senior civil and public servants) with a responsibility or a particular interest in the area of ageing-related care in Ireland. It does this by taking the key themes and categories identified in official policy documents reviewed and comparing and contrasting these with what policymakers were saying about the family, care and ageing.

In comparison to the official policy documents reviewed, which promoted the idea of the family acting in partnership with the state and the voluntary sector, the concept of ‘partnership’ was invoked in interviews by just two policymakers (both civil and public servants). One of these respondents used the concept of ‘partnership’ to refer to the perceived imbalance between the state and the family as partners in providing care for older people, albeit in contrasting ways. While one respondent suggested that, in what is supposed to be a partnership, it is the state that takes most responsibility for the care of older people:
... Where is the responsibility of the family? Whose responsibility is it? It is [supposed to be] a joint partnership here, really. (Policymaker, 010)

A second respondent suggested that from her experience the state adopted an ‘all or nothing’ approach, which it was argued is not characteristic of a true partnership.

‘We’ll come in and we’ll take over or we’ll leave you on your own’ rather than a true partnership piece which is ‘we should work together’ (Policymaker, 12)

Both of the respondents were, therefore, contesting the rhetoric of partnership that was identified in official policy documents on ageing-related care. However, they were doing this in conflicting and contradictory ways. A third respondent didn’t use the term partnership but spoke about a ‘social contract’ between the family and the state:

I would … be saying ‘Well let’s say can we get the family to take on some of their responsibility as well’ … sort of a social contract with families which would say ‘Look, if you are prepared to do your bit would you come to us then and say ‘Look we can’t do anymore, please step in’ that the state would be prepared to do so. That sounds a reasonable kind of a contract to me. (Policymaker, 013)

In accordance with the principle of subsidiarity, this respondent adheres to the idea that the state should only step in when the family can no longer provide such care. This has resonance with the familialist discourse, identified in the Care of the Aged Report, which is predicated on the assumption that the family and not the state will be the principal source of care for older relatives

Most of the respondents, however, held that family input into the care of older people is hugely ‘significant’ and ‘immense’ and ‘absolutely immeasurable’. As one respondent put it, the family is ‘a critical unit’ (Policymaker, 004). Another respondent had ‘even tried to translate it into monetary terms just as a very crude way of emphasising its importance’ … (Policymaker, 009). The image of the ‘family’ making great sacrifices in caring for older relatives was also invoked by one respondent:

I would say, of course, families are the first carers and it’s not easy very often for families where both parents are working outside of the home to provide that care but many of them, indeed one [of the] parents sometimes
sacrifice their career in order to do that but they do it willingly and very graciously. (Policymaker, 006)

Following on from that, it was not unusual for policymakers to argue that the contribution of family care-givers needs to be recognised to a greater extent:

I think that family members have done immense work and that needs to be recognised (Policymaker, 008)

The impression that there is a practice of allocating formal home care services such as home help to older people living alone and leaving family carers unsupported is a policy issues that was highlighted in the Study to Examine the Future Financing of Long-Term Care in Ireland (Government of Ireland, 2002: 43, 93), and was raised by one of the respondents:

... from my own experience you’re really on your own ... it’s all or nothing, you either have nobody and the system kicks in and you get into residential care or whatever or the other end if you have family the system seems to take a step back. Now, that’s my personal experience, other people have told me the same (Policymaker, 012)

Another respondent highlighted the relatively small proportion of family carers that are in receipt of income supports:

[There] could be up to 130 to 140,000 ... carers in this country ... and maybe 25-30,000 getting a contribution - carer’s allowance and carer’s benefit - ... I think there is something wrong in relation to that (Policymaker, 007)

One respondent suggested that non-resident as well as co-resident family members are being enforced to take on the responsibility and role of caring for older relatives through what Twigg and Grand (1998: 146) refer to as an ‘absence of alternatives’, driven by a desire to keep public expenditure down:

... a friend of mine ... her mum was ... getting over an illness but ... didn’t need to go into hospital but ... wasn’t able to look after herself. So ... between myself, the local geriatrician, the local health board, we set up to get this woman into two weeks respite in a nursing home and then ... to get a home help to come into her morning and evening when she got home and we basically [organised] a home care package ...we kept this woman out of hospital and it was just a very proactive approach with everyone working together and that ... is what ... we should be doing all the time. Otherwise we have families pulling their hair out, an elderly person sick and miserable and falling and wandering ... the family
stressed and all it needs is a ... primary care team to ... say 'Well OK she's not sick, she's not in any trouble here, this is what we are going to do' and we just did it. But ... we can’t get those resources normally because ... the first thing the bean-counters say is 'Well, does she need to have home help? Does she need this? Would she not just scrape through with her family?' and this is the sort of codology that we have to put up with ... (Policymaker, 005)

The anecdote also indicates that a level of brokerage (Komito, 1984) is in operation in Ireland regarding access to services for older people. The image portrayed by these respondents is of the ‘caring but unsupported family’.

The idea that the caring is a normal part of family life was contested by one policymaker who argued that that ‘the family’ is not always best placed to provide care for older relatives, neither is it always the preferred choice of older people:

Families are individuals and ... some ... are going to be involved in the care but I don’t think [we can talk about] the family en masse ...it is nonsense to talk about this generic family out there that is minding older people. Some people have four to five daughters and sons who are popping in and out like yo-yos and others don’t like their mothers and fathers and their mothers and fathers don’t particularly like them and we know that the level of abuse towards older people is highest from family members. So, I think older people in the community have individuals who support them, and, sometimes that is family and that is great (Policymaker, 014)

A small number of respondents conceived the family in terms of their reluctance to care for older people. An extreme view about family responsibility and ageing-related care is exemplified by the following quote:

I was always taken by the fact that we had significant numbers of the population who were essentially saying ‘It’s the state’s responsibility to look after my aged relatives’ ... and ... I would have come from the old fashioned school who said (laughs) ‘Well, no actually, they are your family members and insofar as you can’t do it the state should then step in, not the extent that you won’t do it’. But, that was again a kind of an indication of the way society was going and social mores have changed. There is no doubt about that (Policymaker, 013)

These words paint a picture of the family as ‘reluctant’ to care for older family members, similar to the ‘opportunistically, uncaring family’ portrayed in the Care of the Aged Report and The Years Ahead. They illustrate that the interviewee believes that many families are of the view that they do not have any responsibility to provide care for older relatives and instead expect the state to
provide comprehensive long-term care for them. This view, which the respondent alleges is prevalent among families, is completely at odds with the interviewee’s own belief that the family has the primary responsibility to care for older people. In a slightly different vein, another interviewee stated the following:

... there is an expectation in Irish society that the state owes everybody something and that ... if somebody is at home we should be providing 24 hour care. There is a certain cohort of people like that but there [are] a lot of people who aren’t like that ... and how do you get that balance...

(Policymaker, 010)

This respondent is suggesting that on the whole families are ‘normal caring families’, but there are ‘certain’ families that are reluctant to provide care for older relatives and it is only when the state steps in that they begin to take on their responsibility to provide care. Similarly to the previous respondent, this respondent also believes that ‘certain people’ in Irish society expect the state to provide comprehensive long-term care for their older relatives. This discourse harks back to a belief implied in the *Care of the Aged Report* there is certain reluctance among some families to accept responsibilities to care for older relatives. This respondent stated that ‘there is an awful lot of caregivers who just need very small amounts of supports to be able to continue giving it’ (Policymaker, 010) and went on to state the following:

... what we found is that if you give nothing families will do nothing and if you give something they’ll all row in and realise the mountain is not so big ...

... We need to try and get in and be flexible when they really need the help and then pull back when they can manage

(...)

... we could really help the family here if we gave them just this little bit extra, try and push that and I suppose our experience is that most families respond ... if you can go halfway, they’ll come halfway and everybody feels much better about it. People don’t want to put their older person into long-term care and we need to help them to stop doing that. (Policymaker, 010)

This solution, therefore, is consistent with the ‘crowding in’ thesis. However, there is a contradiction with regard to the amount of support the state should give in order to ensure that families will continue to provide care. One, the one hand, it is stated hat ‘very small amounts of supports’ are needed, which suggests that the state’s role is to nudge family members into assuming their responsibility for the
care of older people. On the other, it is suggested that the state need to meet families ‘halfway’, which suggested equal sharing of care between the state and the family. Again, supporting carers is seen as fundamental to a policy of preventing entry into long-term residential care.

As the preceding section showed a prominent discourse in official policy documents on ageing-related care in the new millennium in Ireland is the ‘family in decline’ discourse. Only one respondent (a civil servant) contested the discourse of family care in decline and pointed out that empirical evidence indicates that family willingness to care is not in decline despite changing social and economic conditions:

... all of the evidence to date shows that even with increased female participation in the workforce that families are very willing still to provide informal care. There is no evidence of a decline at all. So, it’s about supporting them. It’s about helping them to have those different roles and that the carer profile if you look at our demographic trends is due to keep increasing until 2011 and not taper off until after that (Policymaker, 009).

Many of the respondents suggested that in spite of the multiple roles and the financial and other costs faced by family members, the family is still willing to provide care for older people. Nevertheless, the issue of changing familial support for older people was a common theme to emerge from the interviews with policymakers. The most prevalent view was that compared with the past the family is less available or unavailable to provide care for older people. A widely held belief was that (female) family members are no longer around or no longer available to provide care for older relatives either because of women’s increased participation in the labour market exemplified by comments such as ‘the women are all out at work’ (Policymaker, 002). Another belief was related to changes in family living arrangements.

... society has changed. I think over the years when more people were at home, there were home care ... having older people in your own house and looking after them ... was the model and then very, very badly placed older people went into ... the workhouse ... and with the sort of change in society and the couple working and all these kind of things that option for older people isn’t there, so [it] went ... straight to if you couldn’t live at home you ... had to require residential care and the community based service option is now only developing ... we are lagging behind ... the way society has developed and a whole generation now that actually two people are working, houses are smaller and ... they either haven’t the capacity themselves or they haven’t the physical room to add on a granny
flat for an older person and look after them, whether there is more selfishness or that kind of thing - don't want to go there, don't know quite frankly. But, I suppose society has just changed and we're a bit behind. (Policymaker, 011)

Others expressed the view that informal care is in decline, as a result of social-economic and demographic changes including changes in family living arrangements and structures, greater mobility of families and a shift towards dual earner families.

... our society these days, the extended family is gone. People are living away from the parents and the grandparents. (Policymaker, 004)

... life patterns have changed considerably and probably what our parents, our grandparents before us were able to do and brothers and sisters before us were prepared to do will not happen into the future [and] with the change in lifestyles and two people working and everything like that. So, really it is a major issue. It's not a problem. It's a challenge for us (Policymaker, 007).

One of the consequences of the 'family in decline' discourse is that it led some respondents to perceive the family as 'peripheral' to the care of older people. They argued that older people in need of care constitute the central focus of ageing-related care policy, that older people generally don't have family members involved in their care and that if family members do have an input into the care of older people their involvement is generally 'peripheral'.

... the policy as such won't revolve around the family ... our focus is on the 'caree' as opposed to the carer ... in the context of the community based supports, in the context of respite care services, obviously the family would be factored into all of that and that should be worked out on the ground with whoever the relevant family or carers are, if they have an involvement. A lot of times older people are on their own or the family has a peripheral involvement (Policymaker, 011)

According to this view, the focus of policy is and should be on the 'caree' as opposed to the carer. Arising out of this view is the argument that state's role is to complement family care-givers in a limited way with the focus on developing strategies to substitute for family care:

I mean the whole family change, I mean, there aren't the family supports that you had in the past. That has to be replaced and it is being replaced to an extent (Policymaker, 002).
A consequence of social intervention based on this view would be that the issue of support for family carers would be sidelined. Furthermore, it coincides with official policy documents in the new millennium in that older (retired) family carers are ignored.

While there were concerns expressed by policymakers about women's increased participation in the labour market and the impact of this on family care-giving for older relatives as well as the consequences for the future cost of providing care, the issue of policy responses to enable carers to combine working and caring was not a theme to emerge in the interviews with policymakers.

The majority of respondents were in favour of providing supports to families to care for older people (including many of those who espoused a ‘family in decline’ discourse). A typical comment was that ‘carers need to be supported’. However, respondents gave divergent reasons for supporting families. Some respondents argued that there was a need to adequately support family members in their care-giving role because it is the best form of care; the preferred choice of older people; and often the preferred choice of family members too.

If you can be looked after by a family member who wants to look after you and is happy to look after you that is better than any other care because you have all sorts of other bonds there. To support and help and sustain that I think is critical ... (Policymaker, 004).

I think it is very important that family members are supported in providing care because I would think that most people want to have, would prefer to have, their own family ... members providing care for them or be surrounded by their own family members (Nominated spokesperson for policymaker, 008).

Supporting families was also seen as a way of reducing public expenditure and shifting costs away from the state to the family was raised by several senior politicians:

It is so important that they [family carers] are looked after because their service is immeasurable in Euro terms in the eyes of the state (Policymaker, 006).

I've had people coming in and saying ... 'If you just pay me I'll look after my relative and I'll do it at home I am quite happy to do that. But I mean I have to give up my job and I need help'. Again I think that makes sense because you are saving on the face of it ... (Policymaker, 003)
Totally without any reference to their income to get the benefit full stop because … they are saving the state a fortune because if they were in state care it would cost a fortune and there is an economic reason for doing it … I'm not arguing that that's the prime one … (Policymaker, 004)

Respondents commented on various policy initiatives that would be effective to support and/or promote family care. The focus was primarily on income supports and/or respite (services and/or grants). With respect to income supports, the Carer’s Allowance, an income support measure for carers that is means tested, was a measure that frequently arose in the interviews, with many respondents arguing for change. Suggestions for change included increasing the level of payment and either relaxing the means test or eliminating it altogether:

... the question of the carer’s allowance ... now we are committed to not means testing that ... it should be regardless of income. If somebody is prepared to look after you and you are not well great then … let’s forget whatever money they earn (Policymaker, 004)

... we wanted to do away with the means-testing for carer’s allowance … and we propose to do that … because [families] will continue to provide the type of care (Policymaker, 007)

Expanding respite services and grants were also seen as a way of supporting families:

Respite has been provided through our nursing homes and through the public hospitals … so that the carer sometimes gets that much needed break and also the respite care grant and all of those supports need to be expanded as we have done so in the past and to work upon supporting the carer (Policymaker, 006).

... it is important I think to support [family carers] through an increase in the Respite Grant and allow that to be flexible of course in how it is used whether it is a public bed or if they want to pay somebody they know to come in and give a hand …it is crucial, obviously (Policymaker, 009).

... family members who are carers have the right to respite treatment or … to be allowed to have vacations and holidays and … support, outside support. We feel that there are … far too few carers provided by the agency in hours. So that is a whole issue that needs to be dealt with and we feel that the government has been very lax in dealing with that issue (Policymaker, 008)

Clearly, these respondents believe that families would be in a better position to provide long-term care for older people if they were able to obtain respite, either in
the form of a temporary stay in a nursing home or a respite service where a formal or informal ‘sitter’ would be paid to come to the older person's home and enable the principal family care-giver to have some regular time off and at hours that meet the needs of recipients as opposed to the needs of service providers.

The emphasis on the state's role in supporting families in caring for older relatives though the Carer’s Allowance and respite care services and grants is an example of what Timonen and Doyle (2008: 86) have referred to as 'the arm's length attitude that the principle of subsidiarity recommends the State take'.

Many of the respondents were in favour of abolishing the means test for Carer's Allowance and providing respite services and grants. The strategies were proposed with the intention of achieving diverse goals. They were seen as a means of supporting care as a natural part of family life, supporting caring families who are inadequately supported. They were seen as a way of implementing a policy of community care and reducing public expenditure on long-term care of older people and thus saving the state money. They were also seen as a means of providing incentives to encourage families to be involved in the care of older relatives care in the face of societal change and changing gender roles.

5.3.1 Section summary

With respect to family, care and ageing, some of the views of the policymakers that participated in interviews for this thesis conformed to dominant discourses embedded in official policy documents on ageing-related care. The preceding section showed that the Care of the Aged Report was underpinned by a familialist discourse in that there was an expectation that the family would continue to maintain primary responsibility for the care of older people. It noted a transformation of this discourse in The Years Ahead to a familialist discourse based on the assumption that the family will provide most of the care for older people, but it needs to be supported to do that. This discourse resurfaced in both the Study to Examine Future Financing of Long-term Care in Ireland (Government of Ireland, 2002) and the NESF (2005) report on Care for Older People. It was a prominent discourse held by policymakers. In this way, the discourses of respondents could be said to be conformist. Not all policymakers conformed, however. The views of one respondent in particular conformed to the familialist discourse and the principle of subsidiarity in its strict sense, that is, the familialist
discourse embedded in the Care of the Aged Report. The discourse of this respondent might be referred to as traditionalist.

Another dominant discourse underpinning official policy documents of the new millennium is the family in decline discourse. Again, this discourse was prominent amongst the respondents and is therefore another example of policymakers holding a conformist discourse. Only one respondent contested it by challenging the assumptions upon which the family in decline discourse is based. This might be referred to as an oppositional discourse. A second example of an oppositional discourse comes from respondents who contested the partnership discourse that is embedded in official policy on ageing related care since 1968. The assortment of conformist, oppositional and traditionalist discourses that respondents were found to hold might be referred to as discourse mixtures of policymakers. The points raised in this section will be further addressed in the conclusion to this chapter.

5.4 OLDER PEOPLE

The findings in this section are based on an analysis of transcripts of focus groups with a total of 41 older people drawn from six existing groups. The section presents the main findings in relation to what older people participating in the focus groups were saying about the family, care and ageing. The findings are presented against the backdrop of what has already been discussed about the theme of family, care and ageing in relation to both the dominant discourses embedded official policy documents on ageing-related care and discourse mixtures of policymakers.

The concept of 'partnership' was not invoked in the focus groups with older people. However, the issue of family responsibility for the care of older people was a key theme to emerge from the focus groups with older people. A small number of participants in the focus groups were of the view that the responsibility to provide care for older people lies primarily with the family:

If there is a family there, the family should look after them. I think the family should look after the 'elder lemon' ... in their own home and stay in your own home as long as you can (Participant, Focus group 2, meals service, inner city Dublin).
It's very sad that people have to go into homes and having a family ... when the person isn’t ill, shall we say, that they don’t even do it in turns ... and look after their father or their mother ... to me unless it’s not possible, care should be by the family (Participant, Focus group 4, Active age group, rural area).

However, many of the older people participating in the focus groups talked about the various ways in which families input into the care of older people. This was a thread running through all the focus groups. Care ranged from social support (such as visiting and companionship) and surveillance to personal care.

... my son'll be coming around, so you are not too bad, you know. Well, it's nice, he calls me now. This morning he called me at twenty to eleven ...

( Participant 1, Focus group 02, meals service, inner city Dublin).

Supervision could come from other members of the family, which is what I see next door to me and it seems to be an ideal situation. I hear loads of laughter coming from there and it seems to be a very happy situation (Participant, Focus group 06, active retirement group, Dublin).

One of the participants spoke about caring full-time for her husband at home:

I will be 79 in September. My husband is living at home. He has Alzheimer’s and ... a man comes in and showers, shaves him and usually takes him for a walk. Otherwise, I do everything (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb).

These quotes serve to indicate the diversity of care provided by the family for older members. Some participants spoke about care as being caring and stressed the emotional or love labour for another family member and the kind of responsibility that that brings. For example:

I was telling them ["the girls"] at night-time sometimes when he goes out and he's continent which is, I'm lucky and I know that mightn't, probably won't remain and when he gets back into bed I can often feel his hand coming out and he just touches me and then he turns around and goes to sleep. It's the reassurance (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb).

Others spoke about having been primary care-givers in the past for one or both parents or for a spouse, as the following quote illustrates:

... and about ageing, my mother died of Alzheimer’s as well and I looked after both my parents ... (...) in their last few years ... (Participant, Focus group 5, Seniors poetry group, Dublin city).
What was striking about the focus groups with older people compared with the official policy documents and the interviews with policymakers was that older people, as recipients and providers of care, spoke as much about family input and involvement in the care of older people in residential care settings and hospitals as at home. For example:

My wife she comes up everyday to see me. She helps me with the dinner because I got a stroke and my two legs are paralysed ... (Participant, Focus Group 02, meals service, inner city Dublin)

Similarly to policymakers, a small number of participants tended to conceive the family in terms of their reluctance to care for older people. At least one participant in three of the focus groups, however, was of the view that 'some families don’t bother!' or that families had abandoned older relatives:

Well, I think people that have families and some of them don’t even bother with them. Sad really! (Participant, Focus group 02, meals service, inner city Dublin).

Oh yeah, that’s what they do. They refuse to take ... I know a family and they refuse to take their mother home and the hospital had to organise [care] (Participant, Focus group 3, informal group of older women, wealthy Dublin suburb).

... because let’s be honest ... one woman had nine in the family and not one ever came to visit her and I thought that was appalling so you see you have the human factor as a very strong element in all of this, don’t you? (Participant, Focus group 05, Seniors poetry group, Dublin city)

Many of the participants offered explanations for why families might not be involved in providing care for older relatives. For example, the message from one woman caring for her husband who had Alzheimer’s was clear: she was willing to provide care for her husband for as long as she was able, and she knew her children would be willing to step in if she could no longer do so, but she would not expect her children to provide the care her husband needed in her place and had told them so. The logic behind her thinking was that there is a completely different relationship between a husband and wife than between a parent and a child:

... I said this to the children yesterday [pause] the relationship between a parent and a child and ... a husband and a wife is a completely different relationship and I wouldn’t expect any of my children to take my husband if
anything happened to me and I said that out he would immediately have to be put into a home and I made that very clear to them. But I'll do it as long as I can ... (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb)

Many of those participating in the focus groups suggested a wide variety of reasons for why family members, which extended at times not only to adult children but also to spouses, would be unable (as opposed to unwilling or not bothering) to provide care for an older relative in their own family. There are parallels here with the concept of 'legitimate excuses', a concept developed by Finch and Mason (1993:102) to refer to the grounds on which someone can establish that they are unable to provide help in the processes of negotiating commitments and responsibilities in their own families. A wide variety of reasons were put forward by older people participating in the focus groups to justify people's or indeed at times their own inability to care for family members. In constructing justificatory accounts, participants sometimes put forward two or more reasons to explain a family member's inability to provide care for an older person. The explanations offered by older people included geographical distance:

My family are away, you know (Participant, Focus group 01, Patient advocacy group, residential care setting).

I can't stay at home. There is only meself and the wife. All our family are all up, some of them are married, and they are away. (Participant, Focus Group 01, Patient advocacy group, residential care setting)

A second explanation offered by participants was that 'families are inclined to be busy with their work, they mightn't have time' (Participant, Focus group 06, active retirement group, Dublin). Other family commitments and responsibilities were also offered as an explanation. One participant put it as follows: 'Well, they all have their own families now, like mine' (Participant 07, Focus group 2, meals service, inner city Dublin), while another stated:

... families ... I know of one particular case [and] they have ... children, the children have children ... and they have to take care of them and they can't be with the mother all day ... and it's very difficult from that point of view. And this particular mother has ended up in hospital because there was nobody to take care of her. They could get carers during the day but they couldn't get carers for night and she needed and does need 24 hour care (Participant, Focus group 04, Active age group, rural area).

Family size was also given as a reason, as the following example shows:
If you have only one or two children and then maybe they are living apart from you then it can be getting very hard to take care and often they have to give up their job and the burden every week and to go to the mother, for example, and look after her and cook. OK, the mother can live alone but it could be the caring person will become worn out ...

( Participant, Focus group 04, Active age group, rural area)

Where an older person needed (or it was implied that they needed) nursing or medical care, this was invoked as a reason why help could not be provided by a family member:

To live at home would be out of the question because I have to be hoisted to bed and to the toilet, you see, and then my family is very small so it would be out of the question now to live at home so a nursing home is the only answer. ( Participant, Focus group 1, Patient advocacy group, residential care setting)

Well, his wife can’t be looking after him because he had two strokes and that. (Participant, Focus Group 02, meals service, inner city Dublin)

I suppose if it would get to the stage where the family can’t cope. If it was a medical thing, you know, and they weren’t able to look after the person properly without medical assistance then I would say yes. (Participant in Focus Group 04, Active age group, rural area)

The idea of competences of family carers coincides with Finch and Mason’s (1993: 107) argument that people are more likely to accord responsibility to relatives when the assistance needed is fairly limited in terms of skills. There were a variety of other competences that participants referred to. These included the difficulties of caring and the stresses and strains that caring can place on carers, especially where time-intensive care was needed:

When it comes to 24-hour care I think we have to just go into a nursing home ... because it’s not fair quite apart from the expense of having someone ... doing everything for you because it is very wearing on them no matter how good they are (Participant, Focus Group 4, Active age group, rural area)

It’s where the person becomes a danger to themselves, which can happen. My husband had Alzheimer’s and I nursed him for what about 10 years until it got to the stage where I couldn’t keep an eye on the door. He wanted to go out and I knew that he wanted to go on (...) he had a bike (laughs) and to get the bike off him was very hard ... because he’d always been ... the one who told everybody else what to do and then for me to suddenly start, you know, it was just very difficult but in the end, you know, he did go into care ... (Participant, Focus group 4, Active age group, rural area).
Not possessing the 'natural' aptitude of a carer would also come under this heading of competence:

... but all family members are not cut out to be carers anyway. That's another thing that they can't do it physically, mentally, they can't cope. I have six children ... and there was only one of them that was a true carer. The others ... they never said it but I knew that when they visited their father they stepped back and looked and I know it was just they couldn't help it ... everybody isn't born to be a carer (Participant, Focus group 04, Active age group, rural area).

Similarly to Finch and Mason’s (1993: 108) findings, there is a gender dimension involved in competence. Both of the quotes below are from women in one focus group, both of whom suggested that women are particularly good at providing personal care and, moreover, that men lack the skills needed to provide care, skills that they would not be able to develop:

... I've had experience of it where the woman had [Alzheimer's]. Now, that man could not cope. She had to be put into a home. The wife will be the stronger if the man gets it but when the woman gets it it's a different story. That man needs care himself as well as the patient (Participant, Focus Group 03, informal group of older women, wealthy Dublin suburb)

A friend of mine actually nursed his wife at home and in the long run it proved to be not the best thing because she ended up with bed sores and all kinds of things because he just wasn't able for it. He didn't know how to look after her but he insisted on keeping her at home and he was ... kind to be cruel or cruel to be kind, I don't know ... (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb)

Thus, in accordance with Finch and Mason's (2000) findings, there is some support for the idea that gender specific norms may come into play where an older women needs care. According to Finch and Mason (1993: 98), '[t]he concept of ability (or inability) to give help seems to be important, at the level of public norms, in constructing justificatory accounts of one's own accounts or other peoples'.

As the following exchange by participants in Focus group 03 illustrates, some older people, even though they believe that their families would be willing to provide care for them if needed, do not necessarily want that because it would mean losing their independence and becoming a 'burden' on the family:

... as you get older you think about being a worry to your family and you don't want that. I mean you want your independence as long as you can
have it. As much as we know the family ... would want to help I'd rather they didn’t have to because they are rearing children and they are at college and doing all sorts of things and if you could be independent as long as possible.

None of us would want to go and live with our children.

Oh gosh no!

We’d worry about it.

We love them ... (laughter) but we wouldn’t want to worry them either or give one particular family ...

... the burden of looking after you.

(Participants, Focus group 03, informal group of older women, wealthy Dublin suburb)

Nevertheless, participants in two of the focus groups tended to agree on one issue: that economic and social changes together with changes in family structures and living arrangements meant that ‘it’s less possible for an old person to be looked after’, as one participant (Participant, Focus group 5, Seniors’ poetry group, Dublin city) put it. Others put it as follows:

Well, I worry for the next generation because, I mean, we all had fairly large families and you know the more you have the better ... the more it can be divided up if you like ... and you’ll always get some better than others but like with smaller families now it’s going to be a terrible problem in the future. Of course, probably by then there will be a lot more nursing home care and that kind of thing. But I mean family support is great in any situation. (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb)

Participants suggested that ‘families are smaller’ (Participant, Focus group 05, Seniors poetry group, Dublin city), that in the past ‘older people tended to live with families’ (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb) or ‘the granny lived with the family automatically and that was it’ (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb) and that there is ‘mobility now of families’ and that there are more ‘people working’ (Participant, Focus group 05, Seniors poetry group, Dublin city). Therefore, changes in family size, a move away from extended family living arrangements, greater mobility of families, and increased employment and participation in the labour market were all identified as factors contributing to a decline in family care.
In suggesting reasons why family members might not be available to provide care for an older relative, the focus group participants at times put forward alternatives. As the quotes above indicate, entry into a nursing home care was suggested as the main alternative when the family was not able to do so. Another alternative centred on family members paying formal carers privately to provide care in the home. As the next comment indicates, the question of the state supporting the family financially to pay for someone to come and live with an older person living alone or to pay for respite care for a caring relative when the family was unable to provide care did arise in the focus groups:

[The state’s role is to] pay for [formal] carers. Now this would be where families can’t (Participant, Focus group 04, Active age group, rural area)

My grandparents when they were old ... they were living in a very isolated spot ... and their daughters, not the sons, ... had to take it in turns to go and live with them and look after them and abandon their own families. So they hit on an idea that instead of doing that they would get a housekeeper and the whole family then contributed to the housekeeper and if you stop and think about that being utilised now it would be a hell of a lot cheaper if the government’s gave the families a grant to pay a housekeeper and keep them out of [a nursing home] ... (Participant, Focus group 06, active retirement group, Dublin)

However, the issue of the state supports for family carers turned out to a contentious issue in one focus group, namely, Focus group 04, drawn from an active ageing group in a rural area. The issue of the state either paying family members to provide care or paying for respite to relieve a family carer was the subject of much debate in this focus group. One view was as follows:

... and so it should for my opinion be a little bit of support for the [family carer]. You can pay, for vacations, another caring person (Participant, Focus group 04, Active age group, rural area)

Participants who were of the belief that the primary responsibility to care for older people lay with the family were particularly opposed to family members being paid to provide care for older relatives.

I know people ... their children are paid to care for them and I find that so very, very wrong. Their children are paid an allowance to be their carer and I think that is so very wrong and I get upset when I hear it (Participant 03, Focus group 04, Active age group, rural area).
Why do you think it is wrong? (Moderator)

I think of my brother looking after my mother ... she had Parkinson’s and the whole of us looking after my father and I see people here looking after their mothers but when I see somebody being paid to look after (...) I think it is wrong. It should never be allowed. I don’t care in what circumstances (Participant 03, Focus group 04, Active age group, rural area).

Other participants in the same focus group contested this by arguing that ‘you need money’:

It helps for a better quality of life though if the carer is paid. If there is a fund they can pay someone out of the money that they are getting. They could pay someone to do another little job if they wanted to go out because to be tied to a sick person permanently (...) the carer needs a break and I think if you’ve got that little kitty of money you can pay someone else to have mum for the afternoon or something ... because strangers do want paying and I think that’s how that money could be spent (Participant 02, Focus group 04, Active age group, rural area).

I suppose you might give up your job and your potential to earn money is limited (Participant 04, Focus group 04, Active age group, rural area).

The first participant then qualified her view by saying that:

Oh sorry ... like B________ up above looking after her mother with Alzheimer’s. I don’t mean that kind of care. I mean somebody who is paid to take her mother shopping, take her mother somewhere and the mother’s at home and cooks her own dinner and does everything but they are paid to do this and that and there are quite a few of them around (Participant 03, Focus group 04, Active age group, rural area).

To me it just seems wrong. No, I don’t mean people who are ill ... I mean there are people that can’t go out obviously and like you say need 24 hour care so ... you do need a break so you have to pay somebody but ... somebody that is paid to look after their mother [who] is able to ... be 80% looking after herself you know I think they are getting what is it 200 or whatever it is that they get. To me, that is outrageous.

Another participant joined in to the discussion to agree with this point by saying ‘It’s unjust’ (Participant 05, Focus group 04, Active age group, rural area).

... I mean as I say when you are paid to just look after your mother and take her to the shop or take her down town or take her to get her hair done that’s not caring but unfortunately that is what they [family members] are being paid for but really that isn’t caring (Participant 03, Focus group 04, Active age group, rural area).
5.4.1 Section summary

There were a small number of participants in the focus groups who were of the view that the responsibility to provide care for older people lies primarily with the family and an expectation that the family should provide care for older relatives, another example of a traditionalist discourse discussed in the previous section. Again, a small number of participants in one focus group believed that the family should carry out that care in an unpaid capacity. This exception was in circumstances where the person being cared for needed intensive levels of care by family members. However, others in the same focus argued that the state has an important role in supporting family members caring for older relatives.

One of the strong themes to emerge from the focus groups was that families do provide care in diverse ways and to older people with diverse care needs and levels of care needs. There was also a strongly held view that ‘you can’t expect’ families to provide care for older people. A wide variety of reasons (or ‘legitimate excuses’ to draw on Finch and Mason, 1993:102) were offered as to why family members might not be expected to provide care for an older relative in families. This offers an alternative discourse to the traditionalist discourse mentioned above, which is based on an expectation that the family will provide care. Moreover, some participants also contested the view of some policymakers who suggested that family care was the preferred choice of older people.

Similarly to policymakers, a small number of participants believed that some families are reluctant to provide care for family members. However, a thread running through the focus groups with older people was participants talking about the diverse ways that families provide care and support for older relatives. In this way, there were participants who strongly contested the idea that the ‘family’ ‘can’t be bothered’ to care. Moreover, these participants suggested that it is misleading to assume that certain family are ‘uncaring’ because they are not providing care for their older relatives and that rather families and family care relationships are complex.

A strong theme to emerge from two of the focus groups was the decline of family support for older people. This is consistent with the dominant discourse of ‘family in decline’ identified in official policy documents on ageing-related care of the new millennium and in discourses of policymakers. In addition, the findings from the
focus show that, for some participants, women were seen as 'natural carers' compared to men who lack the 'natural' skills that caring involves.

Another finding from the focus groups is that older people's knowledge about social policy in relation to family, care and ageing is often grounded in their own or others (family members, neighbours or friends) personal experiences, past and present.

5.5 MEDIATISED DISCOURSES OF POLICYMAKERS AND OLDER PEOPLE

This section presents the findings from the analysis of news items addressing or mentioning the issue of family, care and ageing contained in *The Irish Times* over a one-year period, that is, 2006. As Table 4.4 (Chapter 4) showed a total of 36 news items addressed or mentioned issues relating to the theme. The news items addressed a range of issues relevant to the theme of family, care and ageing, as shown in Table 5.1.

Table 5.2 below shows that the majority of the news items were written by correspondents at *The Irish Times*. However, some 11 news items were written by people who were not news correspondents.

One of the news items written by a correspondent at *The Irish Times* cited an older person as a source in the article. This was a news item written in response to the death of an older woman whose body lay undiscovered for two weeks. In reflecting on why this had happened the correspondent suggested that '[a]n explanation is the crumbling of community in its traditional sense'. The explanation given by an older woman cited as a source in the news items was that older people's children were forced to live at some distance from them due to the escalating costs of residential
Table 5.1: News items in *The Irish Times* (2006) relating to family, care and ageing by issue addressed/mentioned (n)

<table>
<thead>
<tr>
<th>Issues addressed or mentioned</th>
<th>No. of news items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family contribution to the cost of caring for older people</td>
<td>10</td>
</tr>
<tr>
<td>Calls or proposals for enhanced supports for carers</td>
<td>6</td>
</tr>
<tr>
<td>Carer needs and supports available</td>
<td>4</td>
</tr>
<tr>
<td>Family role in blocking discharges of older people from hospitals</td>
<td>4</td>
</tr>
<tr>
<td>Family support in decline</td>
<td>3</td>
</tr>
<tr>
<td>Working age women caring for younger children and ageing parents</td>
<td>3</td>
</tr>
<tr>
<td>Family abuse, neglect of older people</td>
<td>2</td>
</tr>
<tr>
<td>Family concerns about older people in care</td>
<td>2</td>
</tr>
<tr>
<td>Need for research on family including care for older people</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>

Table 5.2: News items in *The Irish Times* (2006) relating to family, care and ageing by author type (n)

<table>
<thead>
<tr>
<th>Author of news item</th>
<th>No. of news items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correspondents at The Irish Times</td>
<td>25</td>
</tr>
<tr>
<td>Senders of letters to the Editor&lt;sup&gt;1&lt;/sup&gt;</td>
<td>6</td>
</tr>
<tr>
<td>Leader of Political Party (edited extract of speech addressed to party’s annual conference)</td>
<td>1</td>
</tr>
<tr>
<td>Representative of national organisation of older people (writing an ‘Opinion’ article)</td>
<td>1</td>
</tr>
<tr>
<td>Social commentator (writing an ‘Opinion’ article)</td>
<td>1</td>
</tr>
<tr>
<td>Public Servant (writing about ‘My Working Day’)</td>
<td>1</td>
</tr>
<tr>
<td>CEO of voluntary organisation (writing about ‘My Working Day’)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>

<sup>1</sup> These included older people (2), a politician (1), a representative of a national organisation of older people (1), an adult carer of an ageing parent (1), and a geriatrician (1).
property in the area. The message of the news items appeared to be that societal changes resulting in community breakdown and families living at a distance from older relatives were factors contributing to why the woman’s body lay undiscovered for so long. This was the only one of the 25 news items written by news correspondents to cite the views of an older person.

In contrast, 13 out of 25 news items written by correspondents at *The Irish Times* cited the opinions of policymakers in their reports. In seven of these news items the views of Ministers were cited, while one cited ‘government sources’. In four news items, the views of spokesperson of political parties in opposition to government were cited.\(^{20}\) Three articles cited the views of spokesperson from a government agency. These news items covered a range of issues relating to the theme of family, care and ageing such as family contribution to the cost of caring for older people; the need for enhanced supports to carers, carer needs and supports available, working age women caring for both young children and ageing parents, family concerns about older people in residential care, and needs for research on the family including its role in care of older people. News items written by correspondents at *The Irish Times* that did not cite the opinions of policymakers covered three issues: family role in blocking discharges of older people from hospitals; family support in decline; and family abuse and neglect of older people. While it was mostly government ministers who suggested that the family should contribute to the cost of caring for older people, politicians from political parties in opposition to the government were more likely to raise the issue of the need for enhanced supports to (older) family members caring for older relatives.

The majority of the news items that were written by people other than news correspondents were Letters to the Editor. From the contents of two of the letters, it would appear that they were written by older people. One of these addressed the issue of delayed discharges of older people in hospitals. This was attributed in the letter to the absence of carers in the home, which was in turn seen as a consequence of the government’s policy in relation to the individualisation of income tax. The second letter focused on the problems and negative aspects of ageing and suggested that this was partly because “[f]amily members have little

\(^{20}\) One news items cited both a government Minister and spokespersons from two political parties in opposition to the government.
time for visits. They are too stressed'. The letter went on to say that even though the family 'may organise a carer for two sessions a week [and] the practical help is needed and may be very good, we cannot pay someone to love us'. By focusing on the absence of family carers for older people, both of these women adopted a family in decline discourse.

As Table 5.1 shows one of the letters to the Editor addressing the issue of family, care and ageing was from a politician. The letter stressed the need for government to support working age women caring for young children and ageing parents. The three remaining letters to the Editor were as follows. The first had been sent by a representative of a national organisation of older people calling for the voices of the 15,000 nursing home residents and their families to be heard in the debate about a nursing home scandal. A second had been sent by an adult carer of an ageing parent who complained about VAT on private home care fees. The third had been sent by a geriatrician in response to a report to the government prepared by a consultancy firm which proposed to charge families for delaying discharges from hospital of older relatives. This had been the subject of two news items written by correspondents at *The Irish Times*. One of these had pointed to a finding contained in a consultants' report that families and carers delay discharges by refusing to accept first place available or condone a move from hospital. A second news item highlighted the proposal in the consultants' report to charge families for delaying discharges of older relatives. In his letter, the geriatrician opposed this recommendation and argued that 'delays in discharge of older patients are not attributable to their relatives "blocking" discharge. Most relatives rightly seek appropriate facilities for those whom they represent'. He went on to outline other contributing factors such as the lack of essential resources. The issue of families delaying discharges from hospital of older people was the subject of three news items written by correspondents at *The Irish Times*. One had cited the views of a GP claimed that the problem of delayed discharges in hospital A&E departments 'is because families know if they take an elderly relative home "the health board will dump the person with them and be gone" without providing the supports required for the elderly person and the carer'.

One news item comprised an extract of a speech given by the leader of a political party in opposition to government. The theme of the speech was about
harnessing economic prosperity to make society fairer. The speech covered a wide range of issues, but mentioned that if that party were to be in government ‘families will receive help in looking after their ageing parents’.

5.5.1 Section summary

On average, approximately three news items per month addressing or mentioning (some only in passing) issues in relation to the theme of family, care and ageing appeared in *The Irish Times* in 2006. The views of older people were rarely cited in news items written by correspondents at *The Irish Times*. The only other way in which older people voices in relation to this theme were mediated in *The Irish Times* in 2006 was through letters to the Editor. In comparison, the views of senior politicians in government in particular but also the views of those in opposition parties were much more likely to be cited by news correspondents. Writing letters to the Editor as a way of getting their views across was also open to politicians as well as other individuals and commentators.

A variety of competing views of the family, some but not all of which were challenged and contested, were conveyed through the 36 news items. These included images of the family in decline, images of the family as problematic (in relation to delayed discharges from hospital of older people), the family as inadequately supported by the state (though calls for enhanced supports for carers particularly by political parties in opposition to the government) and the family and state as partners (in relation to suggestion by mainly government Ministers that the family should co-contribute along with the state in financing the cost of care for older people).

5.6 CHAPTER CONCLUSIONS

This chapter explored the multiple discourses embedded in social policy and ageing-related care using the family, care and ageing as a lens through which to do this. The preceding four sections of this chapter presented the findings based on an analysis of official policy documents on ageing-related care from 1968 to 2005, transcripts of interviews with policymakers, transcripts of focus groups with older people, newspaper reports and articles. This section draws out the main conclusions.
First, this chapter concludes that there are multiple discourses about the family embedded in official policy documents on ageing-related care and that they change over time, which is in keeping with the emphasis in social constructionist perspectives on historical specificity (Gergen, 1973). The chapter shows that discourses that were prominent in the Care of the Aged Report (1968) resurface in subsequent official policy documents. For example, the medical/professional discourse resurfaced in The Years Ahead (1988) while the rhetoric of partnership has continued to re-emerge right through to official policy documents on ageing-related care that were published in the new millennium.

Other dominant discourses, however, were found to have undergone transformation before resurfacing in subsequent official policy documents. For example, the familialist discourse, which viewed caring as a normal part of family life and the family as the primary unit responsible for the care of older people, led to contrasting constructions of the family as the 'normal caring family' and the 'opportunistically uncaring family', was prominent in the Care of the Aged Report (1968). However, in The Years Ahead (1988), the family was largely constructed as 'caring, but unsupported'. The message this conveyed was that if the family is to continue to shoulder the ‘burden’ of care, it must be supported by the state. Although The Years Ahead was still underpinned by a familialist discourse, it has moved away from the familialist discourse in its strict sense that underpinned the Care of the Aged Report. The patriarchal discourse underpinning the Care of the Aged Report (1968) had also clearly undergone transformation. However, while it is no longer assumed that non-working women can be relied upon to provide care for older relatives in an unpaid capacity, this assumption has been replaced by one that assumes that family members providing care for older relatives are mainly working age women. This coincides with Bytheway and Johnson (1998) findings in relation to the social construction of carers in the UK.

The chapter shows that new discourses have emerged since 1968. The most prominent discourse, which might be dated to the 1980s, is one of 'family support in decline'. While this discourse was refuted in The Years Ahead (1988), it was adopted by official policy documents on ageing-related care published in the new millennium. The central importance carried by the discourse of the ‘family in decline’ is its inextricable link with the concern about the erosion of ‘traditional’ family support for older people, that is, the decline of the 'normal, caring family'. The belief is that compared with the past the family is less available or unavailable
to provide care for older people. This raises a major concern that, in the absence of adequate formal support structures, older people would be left older people alone, in need and dependent on formal services. This in turn could lead to an increase in the numbers seeking long-term care in residential settings.

This chapter shows that official policy documents on ageing-related care can contain competing and contradictory discourses. One that competes with the family in decline discourse is that of the ‘worker/carer family’, which was offered by The Developmental Welfare State (2005), the emergence of which might be dated to the 1990s. The discourse of the carer/worker family might be seen to represent an attempt to move away from the discourse of caring as a normal part of family life and constructions of the ‘normal caring family’. This construction of the family is based on the intention of enhancing the participation of family carers in paid work with a view to promoting economic growth.

Second, the chapter shows that policymakers with responsibility in the area of ageing-related care hold multiple discourses about the family, care and ageing. Prominent discourses embedded in official policy documents are not always widely invoked by policymakers. For example, just two respondents invoked the partnership discourse and both questioned the rhetorical emphasis on partnership between family and the state. Other traditional discourses were found to widely invoked, for example, the familialist discourse. Constructions of the ‘normal caring family’, the ‘caring but unsupported family’ were both identified in the discourses of policymakers and are more prominent than the construction of the ‘opportunistically uncaring family’, which, nevertheless, also surfaces. Although the idea of the ‘normal caring family’ was contested, this was unusual. In congruence with the official policy documents on ageing-related care of the new millennium, policymakers tend to direct their attention to one particular category of family carer – working age women. The discourse of family in decline was widely adopted by policymakers but infrequently contested. In contrast, the competing discourse of ‘family as carer/worker’ was not invoked by policymakers. While there were concerns expressed by both policymakers about women’s increased participation in the labour market and the impact of this on family care-giving for older relatives as well as the consequences for the future cost of providing care, the issue of policy responses to enable carers to combine working and caring was not a theme to emerge in the interviews with policymakers.
Third, this chapter shows that familialist discourse is a prominent discourse around which older people ‘struggle after meaning’ (Burr, 2003). On the one hand, some older people regard family care not only as the primary source of care and support for older people, but also that the family should be relied upon to provide most of the care for older people in Irish society as care is a normal part of family life. They were critical of families and family carers who ‘don’t bother’. On the other hand, there were older people who argued that generally speaking families do care and actually provide most of the care, but that caring relationships in families are diverse and complex. It was suggested that family members may not be the ideal form of care, nor are they always the preference of older people themselves, that families are busy with numerous competing responsibilities. They also argued that families cannot be blamed for the numbers of older people in hospital and institutional care. Rather, where older people are in institutional care it is not an indication of abandonment but an indication of complexity and difficulty of caring. A second discourse that is widely held but rarely contested by older people is the ‘family in decline’ discourse. It often co­existed with the previous discourses held by older people.

Fourth, the chapter has identified factors that have contributed to the transformation of some discourses and the emergence of new discourses. For example, factors that have contributed to the transformation of the ‘normal caring family’ to the notion of the ‘caring but unsupported family’ include the increased visibility given to the issue of family carers of older people through research on carers in Ireland and further afield, the emergence of organisations representing carers (O’Connor et al., 1988) and the feminist ideologies of the second wave Irish women’s movement in the 1970s. Social and economic changes, such as increased participation of women in the labour market, smaller family size, the decline in extended family living, greater mobility of workers as well as the perception that social mores have changes and a move towards individualisation, have precipitated the emergence of the discourse of ‘family in decline’. Arguably, the emergence of the issue of changing family relationships of older people in international policy debates in the early 1980s²¹ might be another factor contributing to the emergence of this discourse in Irish policy debates. As the discourse of the carer/worker family is based on the intention of enhancing the

²¹ Aboderin (2005: 469) dates the emergence of the issue of changing family relationships of older people in international policy debates to the early 1980s, particularly to the first UN World Assembly on Ageing that took place in Vienna 1982 and the resulting first International Plan of Action on Ageing (1982).
participation of family carers in paid work with a view to promoting economic growth, it seems pertinent to argue that this discourse has been almost entirely shaped by economic and labour market developments with little consideration for the role of social policy other than as a basic support for economic development, in agreement with Cousins (2005) and Murphy and Millar (2007).

Chapter 1 argued that it is important to focus on discourses because they have consequences for the formulation of social policies. As Clarke and Cochrane (1998: 35) put it: 'Discourses shape and become institutionalized in social policies and the organizations through which they work'. This chapter has noted the consequences of particular discourses about the family, care and ageing for social policy intervention. For example, the family in decline discourse leads to two alternatives proposals for policy intervention. The first is that incentives should be provided by the state to encourage families to get involved in caring for older relatives. The second is that given the decline in the family's role in the care of older people, the state should step in to provide or at least arrange formal care services to support older people living in the community. The second strategy, however, could lead to the needs of family carers being sidelined or ignored.

The inference of the 'worker/carer family' discourse for social policy seems to be that family carers of older people receiving social assistance would be expected in the future to combine caring and employment. The implication of this merits further discussion, not least because it implies a different organisation of work and care in Ireland, and as a consequence, a different organisation of the relationship between paid and unpaid work. This chapter has already identified a range of problems inherent in the 'carer/worker' family. It would seem that rather than focusing solely on macro level policy, it would be necessary to look more closely at what is involved in the 'work' of caring for older people at a micro level.

Whilst this chapter highlights tensions between the competing constructions of the family in policy debates on ageing-related care, it also shows that social constructions of the family are buttressed by taken-for-granted assumptions. This chapter found that policymakers and older people often do not acknowledge or question the assumptions underpinning their discourses about and constructions of the family, which supports O'Loughlin's (2005: 325) contention that 'policy makers hold many assumptions about family obligations, which may or may not be accurate'. This renders predominant discourses and constructions of the
family problematic. For example, an assumption underlying the conception of the ‘opportunistically uncaring family’ is that a strong welfare state reduces the willingness of families to provide care for older relatives. This relationship has been referred to as the ‘crowding-out’ hypothesis. In other words, the state crowds out family obligations and erodes inter-generational solidarity. The empirical evidence related to the crowding-out hypothesis is mixed with many authors reporting crowding-out, some reporting no correlation, and yet others pointing to the opposite direction, that of crowding-in (Künemund, 2008: 105). However, following a theoretical discussion of the motives of support and a review of the empirical evidence, Künemund (2008: 117) concludes:

The available research suggests that although substitution may take place in various settings, the hypothesis of a generalised crowding out of family solidarity in response to an expansion of the welfare state has to be rejected. The opposite effect – crowding in – has more plausibility.

The ‘family in decline’ is a predominant contemporary discourses underpinning social policy and ageing-related care in Ireland. The assumption that ‘traditional’ family support for older people has been eroded has been solidly refuted (Aboderin, 2005: 469), which begs the questions why this discourse continues to be so prevalent in social policy and ageing-related care debates in Ireland and elsewhere. It suggests that perhaps assumptions about the family underpinning social policy and ageing-related care need to be revisited time and time again and clarified by an ongoing review of the empirical evidence.

This chapter found that certain highly salient issues are ignored by the predominant discourses and constructions of the family in social policy and ageing-related care. For example, the construction of the ‘family in decline’ in ageing-related care policy is incompatible with alternative constructions of the ‘carer/worker family’ that pepper policy on the welfare state more generally and it would seem other areas of social policy such as labour market policy. Yet, such contradictions tend to be ignored. On the one hand, family members are assumed to be and expected to be participating full-time in the labour market and not in a position to provide care for older relatives. On the other hand, the proper role for family members is assumed to be combining working and caring.
The constructed accounts of the family given by older people in the focus groups highlight salient issues that are missed by predominant discourses. Three issues in particular were missing from the policy constructions of the family. First, the construction of the 'normal caring family' tends to emphasise the role of the family in caring for older people living in the community. The significant role that the family play in supporting older relatives living in residential care settings is not made visible by these constructions. Yet, this is an issue that is highly visible in the discourse of older people. Second, the love or emotional labour and the relational component of family care (Graham, 1997) are highly salient in the constructed accounts of the family given by older people but they are invisible in policy discourse. Including older people as respondents in this thesis drew attention to these issues and areas where there is a mismatch between policy discourse and the discourse of older people. Third, while the majority of family carers tend to be women, the attention in official policy documents is focused on working age women, but tends to overlook older spousal care (by women and men) within families. Furthermore, official policy documents on ageing-related care tend to overlook the fact that the majority of older people who are receiving care are women. This tendency together with the fact that older spousal care is often overlooked is not a new issue as it has been taken up by sociologists such as Arber and Ginn (1991) and Bytheway and Johnson (1998).

In conclusion, rather than talking about multiple discourses, the assortment of discourses about the family embedded in official policy documents on ageing-related care, held by policymakers and older people and mediatised through newspapers might be better understood as discourse mixtures about the family, care and ageing. This assortment comprises multiple dominant policy discourses (which are at times contradictory) and conformist transformations of dominant discourses. These are often challenged by one or more oppositional discourses as well as being juxtaposed with traditionalist discourses. All are discourses that make up this assortment are vying with each other. Therefore, there are ever present tensions and ‘struggle after meaning’ with regard to the competing discourses and constructions of the family in policy and wider debates on the family, care and ageing. Understanding discourses that underpin social policy and ageing-related care matters because of the social policy interventions associated with a particular discourse. Social constructionists seek to move away from the ideas of the naturally given and encourage taken-for-granted assumptions to be questioned and viewed in a new light (see Clarke and
Cochrane, 1998 and Saraga, 1998, for example). A task of social policy analysis must be to challenge the assumptions underpinning traditional discourses that continue to prevail such as caring as a normal part of family life and to investigate the assumptions underpinning newly emerging discourses about the family such as the ‘family in decline’ and the notion of a ‘carer/worker family’. For some time now researchers have been pointing out that there is little empirical evidence to support the claim that the family is in decline. For example, Shanas (1979) and Brody (1981) referred to the belief that families today are becoming increasingly less willing than families were historically to care for older relatives as the ‘myth of abandonment’. Whether the assumptions underpinning social discourses and constructions of the family in social policy and ageing-related care in Ireland are supported by empirical evidence or amount to ‘myths’ need to be clarified. A task of policy analysts is also to highlight the contradictions between policy discourses and pay attention to the issues that remain hidden by the predominant policy discourses.
CHAPTER 6:

FINDINGS II: AGEING AND FORMAL CARE PROVIDERS

6.1 INTRODUCTION

The question of who provides care is an issue of considerable concern in policy debates on ageing-related care (Phillips, 2007). The term 'mixed economy of care provision' has been used to describe the balance between the state, the voluntary sector, the private sector and the family in the delivery of care to older people. Chapter 5 took the 'family' as the lens through which to explore multiple discourses embedded in social policy and ageing-related care. Care given by family (alongside neighbours or friends) is referred to as informal care. This chapter focuses on the formal providers of care to older people, that is, care provided by public, private and voluntary sectors, as a lens through which to explore the multiple discourses embedded in social policy and ageing-related care.

Chapter 2 presented an overview of the historical development of social policy and ageing-related care in Ireland. It showed that, at least in relation to institutional care, the rhetorical emphasis was on public sector provision even though there has been a long tradition of private and voluntary nursing home care for older people in Ireland (Barrington, 1987). In the area of community care, Chapter 2 highlighted that the gradual development of formal care services for older people living in the community was pioneered not by the state but by voluntary organisations. Although the role of the state in the provision of domiciliary nursing care gradually expanded in the second half of the twentieth century, voluntary organisations continued to play the most significant role in the provision of both community-based and home-based social care services for older people.

The balance between formal care providers was one of the main themes that I bore in mind on my first close reading of official policy documents for this thesis. It was also one of the core themes that I included in my interview and focus group
schedules as I wanted to explore this topic further with policymakers and older people. I was particularly struck with the number of policymakers participating in interviews that raised this issue and who identified the balance between the public and private sectors in the provision of care for older people as the one of the most pressing concern facing policymakers. It was in this way that ageing and formal care providers emerged as one of the discursive themes.

This chapter presents the findings in relation to the theme of ageing and formal care providers in the same way as the previous chapter on family, care and ageing. In order to reflect the four different sources of data selected for analysis, Section 6.2 is based on the analysis of key official policy documents relevant to ageing-related care between 1968 and 2005. Section 6.3 presents the findings from the analysis of interviews with policymakers. Section 6.4 examines ideas about formal care providers held by older people. Section 6.5 presents findings in relation to the mediatised discourse of policymakers and older people. Section 6.6 together draws some conclusions. For the same reasons that were given in Chapter 5, this chapter is also lengthy.

6.2 OFFICIAL POLICY DOCUMENTS AND RELEVANT LEGISLATION

An analysis of official policy documents reveals significant data about ideas regarding public, private and voluntary sector provision of formal care for older people with respect to both institutional care and community care. As with Chapter 5, the exploration in this section begins with an analysis of Care of the Aged Report (1968). This is followed by an analysis of The Years Ahead – A Policy for the Elderly (1988). The analysis in this chapter is also extended to the Report of the Commission on Health Funding (Government of Ireland, 1989) and the 1994 Health Strategy, Shaping a Healthier Future. Consideration is given to ideas about formal care providers in more recently published official policy documents, namely, the Study to Examine the Future Financing of Long-Term Care in Ireland (Government of Ireland, 2002); Care for Older People (NESF, 2005); and The Developmental Welfare State (NESC, 2005).

6.2.1 The late 1960s: The Care of the Aged Report (1968)

The Care of the Aged Report noted that 'a host of bodies, public and private are involved in the provision of services for the aged' (Inter-departmental Committee
With respect to institutional care for older people, the main focus of the Care of the Aged Report was on proposing the development of four main types of public sector accommodation with a view to providing the most appropriate form of care for older people, namely, general hospitals, geriatric assessment units, long-stay units and welfare homes, and not on the balance between the sectors providing the care. Moreover, the Care of the Aged Report was underpinned by a medical/professional discourse in that its main concern was about making a distinction between those older people in institutional care in need of medical and nursing care and those in need of social care. As the report states:

It feels that if those who are in need of hospital care, or can benefit from medical treatment and rehabilitation procedures, are to receive the services they need their care must be separated from the care of those whose primary need is for a home (Inter-departmental Committee on the Care of the Aged, 1968: 75).

Furthermore, medical professionals were given a pivotal role in decision-making and a gate-keeping role. To control the access of older patients to institutional facilities, the Inter-departmental Committee (1968: 80-2) recommended that power of admission should be invested with specified medical personnel. Decisions about admissions to geriatric assessment units were to be made by a specialist physician. Patients could be admitted to long-stay hospital units after investigation and assessment in the geriatric assessment units. The Inter-

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22 This figure excluded 'those in general hospitals and mental hospitals, the mentally handicapped and casuals'.

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departmental Committee recommended that Chief Medical Officers assume responsibility for making decisions about admission of elderly patients to Welfare Homes.

The role of voluntary bodies in providing accommodation for older people was raised in the Care of the Aged Report. The report stated that the many voluntary institutions and homes catering for older people would be suitable and could be recognised by the health authorities as welfare homes. It also recommended that if voluntary welfare homes were to be recognised by the health authorities, they should be open to inspection (Inter-departmental Committee on the Care of the Aged, 1968: 95).

The system of formal health and social care provision for older people living in the community that existed in 1968 was also characterised by a mixed economy of welfare. By 1968 a situation had emerged whereby the State was funding and directly providing some social care services while voluntary organisations were providing others with some contribution from the state. Commercial organisations played a lesser role. A significant feature of the Care of the Aged Report (1968) was its emphasis on this public/voluntary mix in relation to the provision of (formal) social care services for older people living in the community:

Some services should be provided by health authorities, others by voluntary organisations and others as a result of a joint effort by health authorities and voluntary organisations … In all cases the roles of voluntary organisations and public authorities should be regarded as complementary (Inter-departmental Committee on the Care of the Aged, 1968: 58).

The Care of the Aged Report marked a continuation of the model of social care provision that had emerged during the 1950s (see Chapter 2). There was no obligation on the statutory sector to provide social care services. The role foreseen for the State was either to provide social care services directly through health authorities or to arrange for voluntary organisations to deliver social care services on the State’s behalf with health authorities contributing towards the costs involved. For example, the Care of the Aged Report recommended that:
... health authorities should arrange for a home help service. Where the service is operated by voluntary bodies health authorities should contribute towards the cost involved (Inter-departmental Committee on the Care of the Aged, 1968: 65).

Both statutory and voluntary social care services were to evolve. For example, Lundstrom and McKeown (1994) identified six basic models of the Home Help service in Ireland: four in the statutory sector and two in the voluntary sector. However, it was the latter that was encouraged, the operative term being 'to arrange for'. Indeed, the Care of the Aged Report went so far as to identify a range of social care services that were considered as being particularly suited to voluntary sector activity, including home help services, social work services, meals services, laundry services, and day clubs, as shown by the following examples:

The Committee recommends that health authorities should encourage the development of clubs and should give financial support to voluntary bodies which provide them (Inter-departmental Committee on the Care of the Aged, 1968: 69).

The Committee recommends the operation of a domiciliary meals service ... in any area where the number of aged people in need of the service warrants it. It is a service that is best suited to voluntary endeavour. [...] The Committee recommends that health authorities should accept responsibility for organising a service in these [rural] areas and be prepared, where necessary, to make payments to neighbours to supply meals (Inter-departmental Committee on the Care of the Aged, 1968: 71).

The provision of a laundry service is an activity well suited to voluntary effort. The Committee recommends that health authorities should take the lead in having a service introduced in their areas by approaching local voluntary organisations to run the service and offering the use of hospital facilities or financial assistance as appropriate. Where commercial laundries or laundrettes are available it will usually be found desirable to use them, as capital expenditure on equipment and premises is saved. In areas where a health authority institution which has a laundry is situated a
service based on the use of the hospital facilities could be operated (Inter-departmental Committee on the Care of the Aged, 1968: 69-70).

With respect to day (care) centres, which offer a mix of health and social care services, the *Care of the Aged Report* (1968: 68-9) recommended that ‘health authorities should arrange for the provision of Day [care] Centres in populous areas’, ‘some [of which] are operated solely by voluntary workers’.

While social care services could in principle be directly delivered by the public sector as well as been publicly financed by health authorities (Timonen and Doyle, 2006: 82), in practice, voluntary organisations in some areas were the sole provider of formal social care services for older people (Department of Social Welfare, 1997) with the state adopting an arm’s length approach by financing and providing other forms of aid rather than providing care.

In 1968, there was a far lesser emphasis in the *Care of the Aged Report* on the commercial sector, which has been quite limited in the area of social care for older people living in the community. Nevertheless, Duffy (2003: 175) argues that the role of businesses contributing to the voluntary sector should not be overlooked. The following passage from the *Care of the Aged Report* on laundry services offers an early example of social care services to older people in Ireland provided through a mixed economy of public, voluntary and commercial sectors:

Voluntary organisations are providing a laundry service for old people in a number of towns throughout the country. In some towns special centres have been equipped with washing machines and spin dryers and soiled clothing is collected from old people, washed and returned by voluntary workers. In many cases health authorities have helped by providing finance for the equipment of centres by means of grants under Section 65 of the Health Act, 1953. In one city the service is based on the use of a commercial laundrette. Voluntary workers collect the clothing, process it in the laundrette and return it. The health authority meets the charge made by the laundrette. In other areas voluntary organisations have made arrangements with commercial laundries to provide a service for old people (Inter-departmental Committee on the Care of the Aged, 1968: 69-70).
The private sector has a limited role to play in the provision of social care services for older people living in the community.

The voluntary sector is particularly suited to providing social care services to older people living in the community.

The statutory sector has an important role to play in the provision of medical, nursing and social care for older people living in institutional care settings.

Voluntary nursing homes authorised by the state and open to inspection may offer a suitable alternative to public care provision.

The private sector is a provider of institutional care for older people but has a relatively minor role to play as it is not relevant to the state’s area of responsibility.

The statutory and the voluntary sector have an important and complementary role to play in the provision of care for older people living in the community.

Care of the Aged Report (1968)

Figure 6.1: Logic behind discourse on ageing and formal care providers embedded in Care of the Aged Report (1968)

This example again illustrates the arm’s length approach to service provision that was usually adopted by the State with regard to social care services for older people living in the community. At the same time, there was no universally accepted formal standardised assessment in deciding how to allocate services. Rather, there was a wide variation from service to service, from place to place and within and between health authorities in how need and eligibility was assessed. Moreover, there was no attempt to underpin the system of social care provision with legislation. Social care services that were characterised by a public/voluntary mix sat side by side with the public health nursing services, which was publicly financed and publicly delivered, and other community health care services such as GP services that were often publicly financed but privately
delivered in what Barrington (1987: 285) has referred to as an ‘extraordinary symbiosis of public and private medicine’ in Ireland.

6.2.3 The late 1980s: The Years Ahead Report (1988)

Whereas the Care of the Aged Report focused largely on public institutional care and recommendations to reform it, The Years Ahead addressed institutional care across the public, private and voluntary sectors. There are a number of factors that might explain why this was the case. First, there had been a rapid increase in the number of private nursing homes, especially in the Eastern region, where there was a shortage of health board beds for older people. Second, there had been a statutory responsibility on the State to ensure a minimum standard of care in private nursing homes (but not voluntary nursing homes) since 1965, but this had grown considerably in scope with the introduction of new regulations in 1985 which lay down minimum standards and gave health boards the power to inspect private nursing homes regularly. Third, the principle of public subsidisation of private nursing home care had been officially recognised (O'Shea, 2002) and a considerable amount of public funding was going to private and public nursing homes. Fourth, the principle of choice for older people to avail of private nursing home care instead of accepting a public nursing home bed was underpinned by legislation. It was the Health Act, 1970, which encoded the principle of public subsidisation of private nursing homes and the principle of choice in law, as outlined in the next paragraph.

Section 53 of the Health Act, 1970, obliged health boards to make in-patient care available to persons with full eligibility (free of charge) and to persons with limited eligibility (with charges). Nursing home care generally comes within the definition of in-patient care, which was defined under Section 52 as ‘institutional services provided for persons while maintained in a hospital, convalescent home or home for persons suffering from physical or mental disability or in accommodation ancillary thereto’. However, a critical question, and one which remains a contentious issue, is whether the Act confers a legally enforceable right or entitlement for all citizens to be provided with nursing home care (O'Shea, 2002). Notwithstanding this complex legal question, Section 26 of the Act provided for health boards to make use of beds in nursing homes (voluntary and private) as an alternative to providing accommodation themselves. Furthermore, Section 54 of the Act provided for patients eligible for health board in-patient services to be free
to choose to avail of the services of a private nursing home approved by the Minister and entitled them to a grant or subvention towards the cost of their care. Thus the public/private mix as a desirable feature of Ireland’s long-stay institutional care system was enshrined in legislation.

_The Years Ahead_ considered that there were advantages in having a mix of public, private and voluntary beds for older people with care needs. One major advantage associated with the expansion of the private sector was that it offered more choice to older people:

To judge from the rapid increase in the number of private homes in recent years, there is a growing demand for the kind of care they provide ... We see no reason this trend should be discouraged since those elderly people wishing to provide privately for their latter years are entitled to do so (Working Party on Services for the Elderly, 1988: 142)

The positioning of older people as consumers with a right to choose in _The Years Ahead_ can be traced to the 1970s. For instance, the principle of choice of care provider underpinned the Health Act, 1970, which could be said to be the beginning of a consumerist discourse in ageing-related care policy in Ireland. A second advantage was that there were savings to the Exchequer:

The use of subsidies to voluntary and private homes also reduces the amount of money which must be found from public sources to provide and staff extended care beds for the elderly (Working Party on Services for the Elderly, 1988: 145).

This is based on the argument that as the private and voluntary sectors not only competed with the public sector but are also a source of extra capacity for the state, there would be savings to the Exchequer for not having to provide public long-stay facilities. At European and international level, private sector provision was typically proposed in the 1980s and 1990s as an alternative to state services and supports and a means of averting the old age crisis. However, population

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23 In Ireland, the funds of the government are referred to as the exchequer, whereas in the UK, for example, they are known as the Treasury.
24 In the 1980s and 1990s, there was considerable debate at national, European and international level about ageing, which began to focus on the so-called ‘ageing crisis’. One of the main concerns was that with a declining young population there would not be
ageing does not explain the promotion of the private sector in *The Years Ahead*. The report, which devoted an entire chapter to 'Demographic Change and the Elderly', adopted the view that the favourable age dependency ratio in Ireland made it 'easier to support services for the growing number of elderly persons' and argued that 'the decline in births presents an opportunity to redeploy the resources saved in social welfare, health and education to services for the elderly' (Working Party on Services for the Elderly, 1988: 32). Notwithstanding this, there was still concern about the cost implications of institutional care for older people. According to Cousins (1994) and Boyle (1997), this was a factor that contributed to a policy shift from institutional to community-based responses because the latter were believed to be more cost-effective. It is likely that it was also a factor that contributed to the shift towards private sector involvement in institutional care for older people, which, as we have seen, was believed to be more cost-effective than public sector provision.

Despite the advantages associated with a public/private/voluntary mix, a number of difficulties and concerns had arisen by the end of the 1980s. With respect to the public sector, few of the 'health board geriatric hospitals' were purpose built, but were housed in buildings dating from the Poor Law days, and were often very large in size (Working Party on Services for the Elderly, 1988: 131-2). Others concerns centred on the number and use of beds, the cost of provision, and lack of assessment.

A number of difficulties and concerns had also emerged with respect to the private provision of institutional care for older people in the 1980s, as outlined by O'Shea (2002). Earlier, the National Council for the Aged (1985) had raised many of these same issues. In 1980, the Department of Health stopped approving private nursing homes for subvention due primarily to the severe budgetary constraints and financial restrictions imposed on the health services at the time. There were difficulties with the funding mechanism, which took no account of dependency or means of residents. Arising out of the freedom of older people to choose to avail themselves of care in an 'approved' private nursing home instead of public nursing home care, there were concerns about a disproportionate shift of resources from the public sector to the private sector. The decision to stop

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enough people in employment to sustain economic competitiveness and to shoulder the cost of increased public expenditure arising from the growing number of older people needing health care and other social services.
approving private nursing homes for subvention created an additional anomaly as well as confusion and inequities. As O'Shea (2002) points out, the difficulties that emerged from Section 54 of the Health Act, 1970, were a major concern for policymakers towards the end of the 1980s, and these were highlighted and taken up by *The Years Ahead*.

With respect to subsidies for the care of older people in approved nursing homes, *The Years Ahead* (1988: 145) argued that Section 54 of the Health Act, 1970 'offers elderly people eligible for health services a *choice* [emphasis added] which should not be done away with lightly'. However, it recommended that Section 54 should be amended to enable health boards (1) to subvent the care of eligible elderly people, after assessment, in licensed nursing homes and (2) vary the level of subvention according to patient's needs (Working Party on Services for the Elderly, 1988: 146). According to O'Shea (2002), these recommendations had a major influence on the Health (Nursing Homes) Act, 1990, which provided for an enhanced public subvention system for private nursing home care (see Section 5.2.4 below). Along with the annual licensing system, *The Years Ahead* (1998: 46-7) also saw the need for an adequate system of inspection for both public and private nursing homes and raised another issue about the need for better liaison between the health boards and private nursing homes.

Notwithstanding the difficulties associated with encouraging private sector involvement in the provision of care for older people, *The Years Ahead* argued that involvement of the private sector was necessary in order to respond to the demands of the consumer, thereby adopting a consumerist discourse.

The *public/voluntary mix* in relation to the provision of (formal) social care services for older people living in the community was again emphasised in *The Years Ahead*. It noted the development by voluntary bodies and health boards of 'home help, laundry and day care services for elderly people' in the 1970s (Working Party on Services for the Elderly, 1988: 22). Voluntary organisations with much of their funding coming from the state continued to be a main provider with 'as much as half of the home help service, almost all the meals-on-wheels and laundry service and a sizeable proportion of day care centres for elderly people' run by voluntary organisations (Working Party on Services for the Elderly, 1988: 22).
The private sector has a limited role to play in the provision of social care services for older people living in the community.

The voluntary sector is in a weak position because of its dependence on the state for funding to provide social care services which the state has no legal obligation to provide.

The role played by the voluntary sector in the provision of social care services for older people living in the community is vital and cost-effective.

Expansion of public sector nursing homes to provide care for older people should not be encouraged - it is excessive, costly, and buildings in which care and accommodation is provided are often inadequate.

Private sector provision of nursing home care should be encouraged - it is more cost-effective and offers older people choice.

Subsidies should be paid by the state to private nursing homes that provide care for older people with limited means, and should be varied according to patient need.

Figure 6.2: Logic behind discourse on ageing and formal care providers embedded in *The Years Ahead (1988)*

Health boards had been given the power to give grants to voluntary organisations providing such services under Section 65 of the Health Act, 1953, but more specific authority was given to the health boards for home assistance in the Health Act, 1970. Under Section 62, health boards were empowered but not obliged to make arrangements to provide a home help or other supports services to sick or infirm persons either with or without a charge. There was a specific reference to people who but for the provision of a home care service would need to be maintained in an institution. Section 26 of the Act empowered health boards to make and carry out arrangements with bodies (including voluntary bodies) to 'provide services under the Health Acts, 1947 to 1970, for persons eligible for such services'. Thus, there was no legal obligation on the health boards to provide a home help service and eligibility was subject to conditions (Hensey,
1979). Furthermore, despite the emphasis on the public/voluntary mix, there were communication problems between health boards and voluntary organisations (Ruddle et al., 1998).

The Years Ahead (Working Party on Services for the Elderly, 1988: 96, 106, 168) emphasised the cost-effectiveness of social care services provided by voluntary organisations for older people living at home. In particular, it noted the cost-effectiveness of day care centres and home help services. For example, it noted that '[b]ecause of the voluntary nature of much of the home help service, it is an extremely cost-effective way of helping older people at home' (Working Party on Services for the Elderly, 1988: 96). In addition, the report highlighted the vulnerability of social care services in times of cutbacks, especially services for which there was no legal obligation on health boards to provide.

6.2.3 Report of the Commission on Health Funding (1989)

The Report of the Commission on Health Funding (Government of Ireland, 1989: 351) also drew attention to the difficulties associated with the funding mechanism for subsidising long-term for older people in private nursing homes. The Commission welcomed the significant increase in the number of and supported the development of private sector nursing homes. It identified three main potential benefits of private sector nursing homes: wider choice for older people; cost savings as private nursing homes would be smaller, more flexible and have lower overheads and running costs than public sector nursing homes; and savings to the Exchequer from reduced capital expenditure and the reduced need to provide public residential places. The Commission supported the recommendations of The Years Ahead to enhance the public subvention system for private nursing home care, which it argued were justifiable on the basis of cost-effectiveness (Government of Ireland, 1989: 352).

6.2.4 Health (Nursing Homes) Act, 1990, and the Nursing Homes (Care and Welfare) Regulations, 1993

At the end of the nineteen eighties, the government was faced with the choice of expanding public beds for long-term care of older people or developing an enhanced public subvention system for long-term care in private nursing homes (O'Shea, 2002: 60). The latter was chosen, mainly because of the considerable
cost advantages that it held over the former (O'Shea, 2002). The outcome of this decision was the enactment of the Health (Nursing Homes) Act, 1990, and the Nursing Homes (Care and Welfare) Regulations, 1993, which were drafted with the involvement of representatives of private sector providers (O'Shea, 2002). The 1990 Act set out the statutory requirements for nursing homes regarding registration and standards. It outlined the subvention process for certain categories of older people admitted to private long-stay care. It reflects the recommendation of *The Years Ahead* for mandatory assessment of applicants’ level of physical dependency and financial means, and its recommendation to vary the level of subvention depending on need for services as measured by dependency.

In general, the response of nursing home owners and managers to the 1990 Act was positive, although dissatisfaction was expressed about the assessments, particularly the means testing element of assessment (Ruddle *et al.*, 1998). However, Ruddle *et al.* (1998: 254) were highly critical of the direction that policy in relation to residential care for older people had taken. The lack of dedicated public sector beds, on the one hand, and, the increase in the number of private nursing home beds together with the ‘seemingly disproportionate sum spent on subventing private nursing home care’, on the other, meant that there was a high reliance on private nursing home care, particularly in the Eastern region. Private nursing home care, they warned, ‘cannot be regarded as a panacea to cure all long-stay care problems’ (Ruddle *et al.*, 1998: 311).

### 5.2.4 Shaping a Healthier Future (1994)

In the 1994 the Health Strategy, *Shaping a Healthier Future*, identified the voluntary sector as one of the many strengths of Ireland’s health system (Department of Health, 1994: 33-4) and the private sector as playing an important role in complementing the public sector. In the Health Strategy, the Government’s stated its intention to maintain a mixed economy of public/private/voluntary provision in relation to healthcare:

> The intent of the Health Strategy is not, therefore, to alter this mix in any radical fashion, but to enable the private sector to contribute to the achievement of the overall objectives. The Government remains
committed to maintaining the position of private practice, within the well established public/private mix (Department of Health, 1994: 36).

Although the Health Strategy did not make specific reference to the mixed economy of welfare in relation to long-term care services for older people, it can be assumed that this commitment applies to long-term care services, as they are organised and funded from within the same administrative department. A consumerist discourse, therefore, can also be identified in *Shaping a Healthier Future* (Ruddle et al., 1998).

### 5.2.5 Official policy documents in the new millennium

The *Study to Examine the Future Financing of Long-Term Care in Ireland* undertaken by Mercer on behalf of the Department of Social and Family Affairs (Government of Ireland, 2002: 39) commented on some of the difficulties relating to residential care in Ireland. It noted the uncertainties surrounding eligibility for long-term residential care. It drew attention to the relatively high costs of residential care in private nursing home even for those in receipt of subvention in comparison to public long-stay beds, and the resulting inequities in the system.

Notwithstanding the difficulties associated with residential long-term care in Ireland, the *Study to Examine the Future Financing of Long-Term Care in Ireland* embraces the idea of a purchaser-provider split for long-term care of older people and other groups. Whereas the *public/private mix* was enshrined in *The Years Ahead* as a desirable feature of Ireland’s residential care system for older people, the *Study to Examine the Future Financing of Long-term Care* suggested it should be extended to the home care sector (Government of Ireland, 2002: 62, 85). For example:

In Ireland, we already have a mix of public and private residential care providers (although these do not operate on a level playing field). Preferably, the systems should also facilitate a mix of public and private home care providers (Government of Ireland, 2002: 62).

The *Study to Examine the Future Financing of Long-term Care* suggested that the development of a market for independent home care provision would be beneficial
on the basis that it would not only be more cost-effective, but also widen consumer choice and increase flexibility (Government of Ireland, 2002: 152). The report stated that the 'recipient should have a choice of provider where possible' (Government of Ireland, 2002: 87). A spectrum of delivery mechanisms ranging from a fully serviced-based system at one end through to choice of provider, vouchers, direct payments and then pure cash benefits at the other were all viewed as commensurate with a mixed economy of care model. While each could facilitate consumer choice, the extent to which each delivery mechanism promotes consumer choice was a key concern of the report (Government of Ireland, 2002: 55).

There is ... a strong case to be made in favour of a more consumer-oriented approach, whereby people with care needs could choose among providers in accordance with their own unique preferences and circumstances. This should enable new, more flexible, models of service delivery to emerge (Government of Ireland, 2002: 87).

Having considered the spectrum of service delivery mechanisms, the report suggested that benefits for home care services should be offered initially in the form of 'a choice of in-kind services and a cash alternative' so as to widen consumer choice and enable more flexibility.

The rationale put forward in the Study to Examine the Future Financing of Long-term Care for moving towards a 'state pays, others provide' model (see Timonen, 2005), in which provision would be made for independent providers within the system, was the 'likely supply constraints' that could possibly impede any expansion of state services (Government of Ireland, 2002: 87). Nevertheless, concern about whether there would be a sufficient supply of home care provision to cater for increased demand once increased funding for home care became available was addressed in the report. The report suggested that new providers would be attracted into the market once significant additional funding became available and as individual beneficiaries began to exercise choice in the allocation of that funding (Government of Ireland, 2002: 88). However, the report also suggested the state could further stimulate the emergence of new providers by 'encouraging, or even requiring, the Health Boards to use independent providers to deliver a proportion of their own service obligations' (Government of Ireland, 2002: 88).
The report also suggested that a National Long-term Care Authority be established to undertake responsibility for, amongst others, monitoring the supply of independent residential and home care providers, the take up of such provision by beneficiaries, the use of such provision by Health Boards to meet their own service commitments and the quality of provision (Government of Ireland, 2002: 151). The role of government has moved from encouraging a mixed economy of care provision to monitoring not only the quality of care provided by the various sectors but also the supply of that provision. However, the government was to carry out this role at arm’s length through the establishment of a semi-state agency to monitor the quality and mix of services.

Given that its focus was on the existing system of care for older people, it is not surprising that the NESF Project Team upheld the view that a mixed economy of care provision is a desirable feature of long-term care in Ireland (NESF, 2005). Issues raised in the report which are of particular relevance to a mixed economy of care model include promoting choice, the need for a more co-ordinated approach, the implications of a rights based approach, and the application of standards across the various sectors.

The NESF report stated that ‘[a] range of service providers (State, voluntary, community and private) is needed to promote choice’ (NESF, 2005: 42). However, extending choice to older people would require that the assessment process aimed at establishing older people’s needs for services would be, amongst other things, informative of the range of services (statutory, voluntary and private) available (NESF, 2005: 75). Thus, the report makes a link between choice and the greater availability of information for older people. The state now had a role to play in providing information to older people so that they can make informed choices about care in their lives.
Notwithstanding any difficulties, providing care through a mixed economy of providers - statutory, private and voluntary - is a desirable feature of care for older people living in institutions and in the community and should be encouraged.

The government has a role to play in monitoring services provided through a mixed economy of care to older people living in the community.

Private sector involvement in the provision of care services to older people living in the community should be encouraged - it is more cost effective, saves the state money, offers choice to older people and is flexible.

Figure 6.3: Logic behind discourses on ageing and formal care providers embedded in the Study to Examine the Future Financing of Long-Term Care in Ireland (Government of Ireland, 2002)

The issue of co-ordinated approaches to planning and delivering care for older people was a key concern addressed in the NESF report. In stressing the importance of a more co-ordinated approach to planning and delivering care for older people, the NESF Project Team recommended a move from a traditional approach to planning and delivering care for older people to a new approach.

Whereas the former approach is characterised by a lack of voluntary and private sectors' input to policy and service development, a new approach would be underpinned by the inclusion of voluntary and private sectors actively involved in the development of policy and service delivery (NESF, 2005: 78). A shift towards the new approach would mark a change in the role of voluntary and private sector care providers in the planning and delivery of care for older people.
In considering a rights-based approach to community care services for older people, the NESF Project Team noted that where older people have rights, services providers have legal obligations, that is, they are obliged to respect, protect and fulfil the rights of service recipients, an obligation to extends to all service providers including private service providers (NESF, 2005: 58). In a similar vein, the NESF Project Team considered that care standards for older people should be applied to public and private sectors (NESF, 2005: 95).

In the Developmental Welfare State, the NESC does not employ the term ‘mixed economy of welfare/care’ but opts for the term ‘service systems’. Notwithstanding this, it is clear that the NESC embraced a mixed economy of care model as a desirable feature of Irish social policy. The view expressed by NESC (2005) is that direct public provision of social services remains one route alongside (wider roles for) non-profit voluntary sectors and for-profit organisation (commercial sector). Moreover, it argued that a combination of strong public sector organisations and competition from private and non-profit organisations is most likely to achieve the best balance between accountability, innovation and efficiency (NESF, 2005: xix)

The NESC notes that there are sharply divergent views on:

Whether the state should remain the key provider of essential social services or whether more public money should be channelled (under new arrangements for accountability) to private and not-for-profit bodies (NESF, 2005: 5-6).

It cautions about a deepening dualism emerging in Ireland’s welfare state between private and public sector provision. This brings us to another key question highlighted by the NESC about which there are also sharply divergent views. This is:

Whether the number of people turning to privately provided social services (eldercare) and with a negative perception of the quality of publicly provided services is now so large that no government in the foreseeable future can expect an electoral mandate to fund more and better public services by raising taxes.
According to the NESC, a consequence of the low public support for public sector provision may be a preference for private sector provision:

In reality, the ability of existing public sector service providers in Ireland to satisfy users and retain the confidence of the public has come under unprecedented strain and there is evidence of a drift of the public from using them where the option exists (NESF, 2005: 162).

The NESC anticipated that the already significant level of commercial providers of services that existed in Ireland could be expected to rise even further. This, according to the NESC, was because of the widespread belief that care provided by the private sector providers is of a better quality and standard than in the public sector and would, therefore, be the choice of those who could afford to pay:

As incomes rise, and in so far as people believe the choice and standards they want are not forthcoming from publicly provided services, the commercial market for social protection can be expected to get bigger (NESF, 2005: 39).

To avert a further deepening of this dualism in Irish social services, the NESC (2005, 159) argues that 'a radical development of services is the single most important route to improving social protection for Ireland’s population in the years ahead'. The principal policy challenge is 'to ensure that every member of Irish society has access to the type and quality of service they need from the system, with quality and equity guaranteed'. The NESC highlights the need to invest in and develop services, with care services for older people (and childcare services) identified as a priority. A subordinate challenge is to identify the appropriate scale and nature of direct public service provision.

Under the developmental welfare state model, the state would undertake responsibility for ensuring a set of core services (including eldercare services) are available, 'at high standards and in ways that are equitable but tailored to people's circumstances (including their ability to pay) rather than uniform'. (NESF, 2005: 155-6). These core set of services would be delivered through a mix of public, private and voluntary sector organisations. The NESC points out that it was neither promoting the idea that 'the public sector is too large and needs to relinquish some of its activities to the private sector ('privatisation')', nor that the
public sector 'has inherent inefficiencies which the introduction of overt or
managed competition can overcome ('reinventing government')'. Rather, the
NESC argues that there is scope for the public sector to play a very positive role
in the 'services system', but in order to do so there are challenges facing public
service providers:

The core challenge to public sector providers is to replace a vicious circle
between slow change, unsatisfactory service standards, declining public
support and low investment with a virtuous one between successful
change, leading standards, strong public support and high investment.

... there can be an important — even leadership — role for public sector
providers within services systems. Specific difficulties attend this scenario
(see below) but their operations can be characterised by low transaction
costs (less need for regulators), equitable access, good working
conditions, high levels of staff commitment and strong public trust. When
these latent characteristics in a public sector organisation are developed,
with neither efficiency nor service quality deteriorating, society has a
particularly valuable asset (NESC, 2005).

Although the report does not refer to or identify the characteristics of 'weak' or
'strong' private or voluntary sectors providers, the NESC sees the need to
harness the 'expertise and diverse contributions' of private and voluntary sectors
in the provision of publicly funded social services:

... as social challenges grow in diversity and complexity, the state is
having to have recourse to the expertise, niche positions, trust with client
groups, flexibility and resources of for-profit and non-profit private bodies
to complement what it is able to achieve by funding direct public service
provision (NESF, 2005: 155-160).

Each of the sectors would be accountable to government under a national
framework of rights and standards. A major role for government would be
collaboration with the wide array of third parties on which it would rely to address
public problems and pursue public goals. The NESC foresees the government's
primary role in relation to the variety of actors involved in delivering its social
services in terms of Salamon's (2002) concept of 'network management'. This,
according to the NESC (2005: 160) involves 'mutual adaptation through bargaining and interaction rather than the command-and-control characteristic of public administration or the independent action characteristic of markets'.

Figure 6.4: Logic behind discourses on formal care providers embedded in The Developmental Welfare State (NESC, 2005)

5.2.6 Section summary

In the area of formal care for older people, welfare in Ireland has clearly been characterised by a mixed economy of public, voluntary and private provision, with respect to both institutional and community care services. With respect to institutional care, reform of services providing long-term care for older people had been ongoing since the 1970s. However, the mix underwent profound changes from the 1980s (see Figure 6.5 on next page). Private residential care for older people has burgeoned since the 1980s, while public sector care has shrunk. A paradigm shift had clearly taken place by 1988, when The Years Ahead was
published. Whereas the *Care of the Aged Report* (1968) focused largely on public institutional care and recommendations to reform it, *The Years Ahead* (1988) addressed institutional care across the public, private and voluntary sectors. *The Years Ahead* (1988) supported the development of private sector nursing home care. It became commonplace in subsequent official policy documents to argue the case for welfare pluralism in the area of ageing-related care. Central to making this care are the ideas that the state cannot and should not provide care in all cases; and that there are merits in encouraging private sector involvement in care, most notably, because of savings to the Exchequer, more choice for older people, and more flexible care services.

The emergence of the private sector in the delivery of community care services to older people and financed by the state is a more recent development. Since 2002, official policy documents relevant to ageing-related care have been making the case for extending private sector involvement in care to home care, again on the basis that it would be more flexible, cost-effective and offer a wider choice to older people. Although the NESC (2005) in *The Developmental Welfare State* embraces a mixed economy of care model, it expresses concern about a deepening dualism between the public and the private sector. Alongside the need to invest and develop services (including eldercare services as a priority), the NESC (2005) stressed the need to avert this dualism intensifying to a further extent. Services for older people would be delivered through a mix of public, private and voluntary sector organisations. This would require investment and reform to create a 'strong' public service which would provide services alongside non-profit voluntary sectors and for-profit organisations and foresees a role for the government in terms of 'network management'.
Figure 6.5: Model of key continuity and changes in discourses on ageing and care

- Care of the Aged Report (1968)
- Factors influencing
- The Years Ahead Report (1988)
- Factors influencing
- Study to Examine Future Financing of LTC (2002)
- The Developmental Welfare State (2005)

Discourse of minimal state intervention: Medical/professional discourse

Consumerist discourse; Economic discourse

Policies and practices on ageing-related care

Consumerist discourse; Economic discourse; Discourse of state as 'arranger of services'

Policies and practices on ageing-related care
Although not explicitly stated in official policy documents, providing support for the private sector so as to offer older people more choice follows a consumer model, which is akin to a policy of so-called ‘consumer sovereignty’ whereby older people are able to choose from what is available, subject to the terms and conditions defined by providers. This falls within an economic discourse, in which (drawing on Grit and Dolfsma, 2002), care should respond to the demands expressed by consumers, the market is idealised and organisations providing care should operate on the principles of the private sector. A key theme to emerge from the analysis is that the economic discourse underpinning official policy documents on ageing-related care in Ireland pitches public sector against private sector (see Figure 6.6 below).

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**Figure 6.6: 'Private sector merits expansion; public sector merits curtailment': logic behind discourse embedded in key official policy documents relevant to ageing-related care (1968-2005)**
6.3 POLICYMAKERS

The preceding section presented the findings from the analysis of official policy documents on ageing-related care. It revealed that the dominant ideas underpinning official policy documents from 1988 into the new millennium were based on consumerist and economic discourses. Having public, private and voluntary sectors involved in the provision of care is a desirable feature of institutional and community care for older people in Ireland, older people should be offered choice of provider and private sector principles should be followed. This section presents the findings from the analysis of transcripts of interviews with policymakers on the theme of ageing and formal care providers.

The analysis shows that in contrast to official policy documents, policymakers express sharply divergent views on the desirability of a mixed economy of formal care as a feature of ageing-related care, particularly with regard to the involvement of the private sector. From the analysis of the transcripts of interviews with policymakers, it was possible to identify four distinct perspectives:

1. The involvement of the private sector in the mixed economy of care provision is a necessary and desirable feature of ageing-related care in Ireland;
2. The predominance of private sector provision over public sector provision (may not be ideal but) is a ‘fact’ or ‘reality’ of ageing-related care in Ireland.
3. While there is room for private sector involvement in long-term care of older people, there is an over-reliance on the private sector and an under-reliance on the public sector
4. There is no room for private sector involvement in the long-term care of older people.

Following the analysis of transcripts of interviews, I assigned policymakers to one of four different groups according to the set of ideas that they held. Each is discussed in more detail below: As the preceding section pointed out, the state has been encouraging private sector involvement in relation to nursing home care since the 1970s and the system has evolved into one in which the private sector is the most predominant provider of nursing home care. State encouragement of
private sector involvement in home based care is much more recent. It is not surprising then that when policymakers talked in the interviews about private sector involvement in the provision of care for older people, it tended to be in relation to nursing home care. However, I did raise the issue of private sector involvement in relation to home based care in the interviews as well. Furthermore, although these four perspectives might be thought of as distinct, there were some overlaps between them. The areas where there was significant overlap are discussed after the discussion of the four perspectives.

Perspective 1: The involvement of the private sector in the mixed economy of care provision is a necessary and desirable feature of ageing-related care policy

The perspectives of two of the respondents fell into this group. Both respondents expressed the view that a mixed economy of care provision for older people is a necessary and desirable feature of ageing-related care in Ireland. However, one of the respondents highlighted the lack of an explicit policy with regard to the balance between the public and private sectors:

... there is no policy in relation to the balance ... because I have tried many times to find it and I have asked what would be a good mix between public and private. I've kind of mixed views on it. First of all, I would like if there was an explicit policy. I would like if people would say this is a reasonable balance but nobody seems to be prepared to do that (Policymaker, 012).

Nevertheless, this respondent supported the involvement of the private sector in the provision of home care services as a means of creating more choice for older people:

... if you said ‘... you had an assessment this is deemed what you need in terms of ... your dependency or your disability’. Now [the older person can say] ‘I'll decide ... I will either purchase that from a [voluntary] home care provider or ... from a private provider ... but I choose so therefore you respond to me as a customer as opposed to a charity’ ... so ... I have no problem with private providers becoming an agency that somebody can actually choose to get care off provided ... they meet certain standards as well and there are safeguards around it (Policymaker, 012)

However, similarly to the official policy documents on ageing-related care that were analysed for this thesis, the respondents did not acknowledge the conditions over which older people have little or no choice or that the system of long-term care
residential care that has emerged in Ireland does not offer older people more choice between public and private care. When commenting on the home care sector, this respondent referred to the choice afforded to older people through more consumer-directed approaches to care, such as direct payments. Here, it is older people who make decisions about their care. In addition, choice was to be supported where older people were unable to make decisions about which alternative to opt for:

... you build ... into your policies ... that you are acknowledging their right to ... make those choices but there are supports to help them ... so that when they need somebody to sort out the money for them and sort out the payment process ... but ... the core element is their choice and their determination being the principle (Policymaker, 012)

In addition to noting the advantages of involving the private sector, the respondent also reflected on whether the present situation in which the private sector predominated was a problem or not and stated that 'I don't actually have a problem with having predominantly private sector care ...' (Policymaker, 012). The respondent had come to the conclusion that it was acceptable for the private sector to predominate because of problems within the public system, characterised by inefficiency, outdated practices, and trade union activities that hampered reform of the sector:

... a lot of the public sector pieces are inefficient ... there is a lot of entrenched union practices, all sorts of stuff really I think are out of date so I wouldn't have a difficulty with the private sector being the main provider (Policymaker, 012)

This respondent suggested that there is widespread concern that private sector provision is based on a business model with the main objective being to make huge profits, which had led to the widely held view that 'private is bad, public is good'. The respondent suggested that the belief that 'private is bad' was misleading on the basis that a caring ethos could be built into a business model and 'probably unfair' because 'there are some very good private nursing homes there'. The respondent argued that the media had unfairly portrayed negative images of private nursing homes by 'lumping' together all of the 400 private nursing homes with the 'seven or eight' problematic ones. The respondent emphasised the advantages of flexibility, learning and responsiveness associated with involvement of the private sector to justify its predominance. The respondent argued that 'some of the public sector are very good but they are not all as good
as they think they are either’ (Policymaker, 012), thereby suggesting that the view that ‘public is good’ is also misleading.

There is nothing wrong with a business model once there is a strong care element to it as well. That sounds heresy ... I can understand why people would say ‘Oh yes, some people are making huge profits at the expense of care’ ... but I just think this ‘public good, private bad’ isn’t ... all real. There are some very good private nursing homes there and the public sector could learn an awful lot from them. They certainly have a lot more flexibility in some of the way they do things. They can switch on things a lot quicker than the public sector (Policymaker, 012).

The respondent added that a stipulation of accepting the private sector predominance in the provision of care should be that the sector is ‘well regulated and well funded’ (Policymaker, 012).

The second of these two respondents argued that the three sectors are needed, that there is ‘a good balance’ between the three and that a mixed economy of care approach was warranted because ‘we have absolutely excellent care in all three for the vast majority of cases’. With regard to the public sector, the respondent highlighted improvements in the built environment and the erosion of stigma that has traditionally been associated with entry into a public nursing home:

... there was a time when it was actually a stigma to be admitted as a patient [to a public nursing home] and it is quite the opposite now. To visit [and] view the state-of-the art building[s] ...it is wonderful that that has changed and it is often now that residents that are there who are now envied by others (Policymaker, 006).

The respondent spoke about the involvement of the private sector in the provision of ageing-related care as ‘a good measure’ and about the important role played by the private sector in providing a ‘back-up to our state services’ and services that the state ‘would never be able to provide fully’ and argued that the private sector played ‘an absolutely crucial role in providing home care of all kinds and varieties to older people’. The respondent addressed the question of private sector providers entering the market solely as a profit-making exercise by saying that although ‘tax breaks were and are an incentive,’ private sector providers did not just enter the market ‘as a calculated profit’. Rather, there was a need for private sector providers and they ‘played an important role in providing quality
care in the vast majority of cases to [older] people'. Nevertheless, the respondent viewed private providers motivated primarily by profit as undesirable:

We would hope that [the private sector] would stay with us and perhaps those who wish to go in another direction, if it is a calculated monetary exercise, well then, we are probably better off that they are in a different area than looking after older people (Policymaker, 006)

In a study of home care providers in Dublin, private sector providers indicated that they would welcome increased regulation (Doyle, 2006). This respondent suggested that new standards and regulations for residential care would raise the quality of care in private nursing homes, and even though they would be faced with increased costs, it is a move that the private nursing home sector would welcome:

In the private nursing home area, there will be lots of changes with the regulations, so the nursing home people may be worried about that because there will be certain standards that will need to be reached [for example] bed capacity may need to be reduced ... we need to work with the private sector to bring them to the level of quality care that ... all of us would expect, and I know the vast majority of them are very willing to do that (Policymaker, 006).

**Perspective 2: The mixed economy of care provision with a predominance of the private sector over public sector is a ‘fact’ or ‘reality’ of ageing-related care in Ireland**

The perspectives of five policymakers (four of whom were civil and public servants) fell into this group. These respondents spoke about the predominance of the private sector over the public sector in institutional care as a ‘fact’ or ‘reality’ of ageing-related care in Ireland:

... the reality at the moment, because I suppose when making policy you have to think of the reality ... is that two-thirds of all long-stay beds are currently in the private sector and only one-third in the public (Policymaker, 009)

Well, I mean, it’s there and it’s a fact and certainly on the residential side it’s the predominant and like I think it’s like 67% is private ... like, these people are all there and they are providing a service (Policymaker, 011)
Two of the respondents highlighted the lack of a clear policy in relation to the balance between the public, private and voluntary sectors in the provision of long-term care for older people:

... we really haven’t had the debate do we want public, private or not-for-profit ... and it really is the Department who has to have that debate. We can have the conversation with them ... but they have to lead out on it (Policymaker, 010).

In the interviews, the respondents in this group noted the advantages of involving the private sector in the provision of care for older people. As mentioned in the last section, one of the main advantages put forward for involving the private sector is that it offers older people choice as consumers. These respondents made that point, for example:

It is important that we offer the public choice [of] which type of arrangement they prefer. Perhaps they are saying the private sector can do better than the public sector and vice versa ... but again it is important to have ... the choice ... ’ (Policymaker, 009).

Respondents falling into this group suggested that having the private sector alongside the public and voluntary sectors meant that they could all ‘learn from each other’. As the preceding section pointed out, another reason often cited for involving the private sector is that it is a source of extra capacity for the state. This argument was articulated by these respondents who stated that the independent (private and voluntary) sectors, and in particular, the private sector, play a very important role in providing a service that the state can’t provide (Policymaker, 011) and backing up the public sector, which does not have the capacity to meet all the demands for long-term care of older people: For some though, the under-capacity in the public sector was not inevitable, but a ‘fact’ that has been created by government. As one respondent, who believed that ‘we need both [public and private] sectors’, suggested a reliance on the private sector had been created due to under-capacity in the public sector that had arisen from lack of investment in public institutions providing long-term care for older people, on the one hand, and government investment in private sector nursing homes, on the other.

I think we need both sectors ... we contract so many beds from them through absolute necessity because the investment has gone to the private sector through tax incentives ... until this year... it is years since
there has been any significant investment [in public institutions] (Policymaker, 010).

The respondents in this group suggested that it doesn’t matter which sector predominates as long as quality of care and cost-effectiveness is safeguarded. These respondents also alluded to a widely held view that ‘private is bad, public is good’, which they also criticised as misleading. As one respondent put it:

This idea that the private is all bad and the public is all good is rubbish ... because ... I’ve seen plenty of private facilities run absolutely fabulously ... it’s not a black and white issue (Policymaker, 005).

They suggested that care in public nursing homes is often believed to be better than in private nursing homes. As one respondent suggested, ‘there is an idea that all the public nursing homes are perfect and they’re not’ (Policymaker, 005). Respondents pointed out that higher levels and training of staff in public nursing homes contribute to this belief and that they probably do mean that there is less chance of problems arising in such facilities. For example, one respondent conjectured that public nursing homes were ‘better resourced, which does help to improve standards’ (Policymaker, 005). However, the respondents believed that faults could be found in both the public and private sectors. As one respondent put it, ‘[n]either system is perfect ... it boils down to the standards of care’ (Policymaker, 005).

Moreover, these five respondents argued that ambiguity exists around public nursing homes because nursing home standards and inspections (at the time of interview) did not extend to public nursing homes. In order words, it is misleading to argue that ‘public is good, private is bad’:

In the public ... system ... staff will be part of a continuous education programme and everything that is on offer, so I do think there is probably more potential in a private [nursing home] for things to go wrong than in a public [one]. I also think we probably grew too quickly in the private sector and that a more balanced approach would have been better ...Our own units, the reality is, they have not been inspected ... We do know the staffing levels are better but that’s all we do know (Policymaker, 010)

For these five respondents, the principles of cost-effectiveness and quality of care were the most important basis on which to formulate policy decisions on long-term care for older people. The issue of which sector is providing the care is secondary:

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... if I was the Minister for Health and I'm looking at the difference between public and private I just simply measure it in terms of cost-effectiveness to the taxpayer and patient care to the patient and I really don't care who provides it after that (Policymaker, 005)

Moreover, all of the respondents in this group suggested that most of the problems associated with the provision of care for older people were not related to shortcomings of the providers but were to do with failings on the part of the state. This discourse sees the state as an arranger of services. As an arranger of services, the state has a key role to play in managing, structuring and organising private sector organisations. However, the view articulated is that the state has failed to fulfil this role. As well as poor planning and decision-making, the state has adopted a hands-off approach and the private nursing home sector has been allowed to develop too quickly and in an ad hoc manner, with the private sector rather than the state driving development.

Unfortunately, [the private sector] hasn't really been [well-managed] and ... the Finance Act [has] encourage[d] people to build nursing homes ... I just feel it has been allowed to be driven ... it hasn't been managed ... (Policymaker, 011).

Problems such as the geographical location and high costs of private nursing homes that can arise from such an approach were also highlighted:

People can build private nursing homes where they want, they can build them in the middle of nowhere and certainly in Dublin that has been a problem because they have ... been built on the outskirts of Dublin and people can't get to them and you are disconnecting people from their communities. But if there was a true proper plan for where care was needed ... I wouldn't have a problem with it on that basis but that isn't the way that it has happened ... the decisions were being made on the basis of where we had land as opposed to where people actually lived ... (Policymaker, 011).

I suppose the difficulty with that then is you could create a monopoly and then they can drive up the prices ... so I suppose you need to have safeguards in against that kind of thing ... (Policymaker, 014)

Nevertheless, most of the respondents falling into this group expressed some reservations about private sector involvement in care for older people. It was not unusual for respondents to suggest that the primary motive of some or all private sector providers was to make profit. As one respondent stated, '...private is obviously profit driven ...' (Policymaker, 005), while another said, 'certainly, you can get private providers who are in it because it is a business and money making,
...’ (Policymaker, 010) One respondent expressed concern that the private sector had perhaps grown too quickly. Others suggested that providing for older people with high levels of care needs does not appeal to private sector nursing homes:

... certainly it would seem that the privates are not that interested in looking after the very high dependent people, [public] units certainly are doing an awful lot of that (Policymaker, 010).

This view was expanded on by a politician who believed that the public sector is more suited than the private sector to providing long-term care for older people with high levels of care needs. The rationale for this was that the private sector is driven by a profit motive and if private sector nursing homes were expected to provide care for older people with high care needs due to uncertainty and unpredictability of care:

... the private sector can deliver low to medium dependency care because... the private sector is about making profit. You can have good standards of care but it is about profit and... the private sector [wants to] measure their inputs and outputs ... what the private sector can’t do is inconsistency or unpredictable outcomes [of] high dependency patients because you don’t know how sick they are going to get, how often they are going to get sick, how much treatment they need, so I would say that the high dependency patient should remain within the public sector because the private sector cherry-pick[s] off stuff that can be predictable and its outcomes can be measured (Policymaker, 005)

Perspective 3: While there is room for private sector involvement in long-term care of older people, there is an over-reliance on the private sector and under-reliance on the public sector

The respondents who fall into this group argued that there is a problem with the current balance of care provision because, on the one hand, there are not enough public sector nursing home beds and, on the other, there is an over-reliance on the private sector. Respondents who articulated this view believed that public nursing home care is the ‘best care’:

... we feel that the best care, and if you meet anyone who can get into a long-term public nursing home, you get the best of service ...(Policymaker, 007)
These policymakers argued that there was, and is, an undersupply of public nursing home beds, which is a problem that needs to be addressed. They supported the provision of more public nursing home beds, particularly in relation to care for older people with high care needs:

There is a big need to provide public community nursing units ... and it's just not happening. I mean, Professor Drumm is now saying that he has provided or is providing a thousand beds but a lot of those are in private nursing homes and that is problematic ... (Policymaker, 002)

... we will provide more public long-stay places, respite and rehabilitation beds. This government made a commitment ... but during the last ten years of this ... Fianna Fáil and PD government, there have basically been no public long-term care units being built (Policymaker, 007).

I think that [publicly funded and provided nursing homes] is the best solution, yes (Policymaker, 003).

A senior civil/public servant who favoured investment in public sector nursing homes pointed out one of the challenges confronting policymakers. As well as being faced with the need to provide additional long-stay public nursing home beds, they were also faced with the need for investment to improve the state of many of the existing public nursing home buildings, some of which were in a very poor state:

Some, in particular, of our public long stay beds were ... really in an appalling state ... A lot of them were County Homes that went back to the nineteenth century workhouse and ... that was again very high on our agenda trying to do something about ... changing that situation (Policymaker, 013).

... in looking at the planning for say up to 2020, 2025, [it was] reckoned that we needed to provide a certain amount of additional beds every year ... it was quite substantial to even kind of stay standing still and to meet the demand ... so there was this recognition that you needed to provide all this additional long stay accommodation ... But there would have been two issues, one was that we needed a lot of additional kind of capacity in the [public] system and then there was also the other one that ... a lot of the existing capacity wasn’t up to scratch and it needed to improve on that as well. So that was a constant battle ... (Policymaker, 013).

These respondents believed that there was room for the private sector to play a role in the provision of nursing home care for older people. However, they expressed a strong concern about a shift towards an over-reliance on the private
sector. This included a concern that government policy was and is underpinned by a neo-liberal political ideology, which favours private over public at all costs:

...there is a role for ... private nursing home. Some of them are excellent and it’s not that I have an ideological problem with the private nursing home. But, what does concern me greatly, though, is that we have a Minister of Health who has a deep-seated conviction ... that everything private is better than everything public and if she has seen it in America it’s really the best of all. And I think that that is a very crude and wrong approach when it comes to healthcare ... In the area of nursing home care though, there is room for the mix and it is important that private nursing homes are part of the provision ... But this over-reliance on private nursing homes, I don’t think is meeting the need... (Policymaker, 002)

These respondents expressed a concern that relying on the private sector care is not a cost-effective exercise and that it was not going to be any cheaper than public sector provision. They expressed unease about the profit-making motivation of the private sector:

... if we rely on private developers to meet our health needs we are in deep ... trouble, because their focus is on making profit. I have no problem with that. That is what they do, but what I have a problem with is the tax payer is paying them to plug holes in the system because they simply will not do it. They will provide services that make money and [the Minister for Health] has this kind of blinkered view, which I think is based on a certain naivety, that if she gets the private developer in that somehow they will provide for the needs that are there and that’s just not going to happen (Policymaker, 002)

There was a concern that over-reliance might put the private sector in a monopoly position with private sector providers having power to dictate the price of long-term care for older people. Through nursing home subventions, this would ultimately have an impact on government expenditure on long-term care:

... the other worry ... was ... the more that the private nursing homes had developed the more the public sector was going to be dependent on it ... If you accepted that we were going to be more and more in need of long-stay accommodation ... and that you were providing more and more of this in the private sector it would seem you were only going to go in one direction and ... you would get to a point where you would be almost completely dependent on the private sector and then they would set the agenda in terms of the price you were paying ... (Policymaker, 013).

Similarly to respondents who believed that private sector involvement was an inevitable feature of ageing-related care, another key concern was that the private sector might not be able or, indeed, might choose not, to provide care for older people with high care needs:
... they would also set the agenda in terms of the type of people they would cater for ... The likelihood then being that the public sector would be left to deal with the heavier end of the market, if I can put it that way ... the more heavily dependent people ... (Policymaker, 013).

... it's just not working because you have many people who are higher dependency than what the private nursing home sector can provide (Policymaker, 002).

A question was raised about the level of medical care available in private nursing homes vis-à-vis public ones:

... I do have this concern that whatever about the public facilities and they do have medical officers available in an awful lot of [them], certainly in the private nursing home sector I don't see any great evidence of a medical input into the care of older people in nursing homes. I would just wonder about that (Policymaker, 013).

Concern was also raised about the lack of a clear and explicit policy regarding the balance between the public, private and voluntary sector provision for long-term care:

... maybe if you said 'OK well that's going to be our policy', perhaps it would stand up if you then had a very clear idea about what it was you wanted the private sector to do [but] I think that that ... it was [the private sector] setting the agenda rather than the public system (Policymaker, 013).

Private sector nursing home care was deemed acceptable 'as long as they are properly inspected' and the state was involved in closely monitoring and inspecting the homes to ensure that good standards of care were being provided:

... we [opposition party] would acknowledge and support private nursing homes, under strict conditions ...(Policymaker, 007)

With respect to home care services, these respondents accepted a role for private sector organisations but again expressed a preference for public sector provision:

[Home care] service should be provided by the state ... I suppose as we develop, there could be a role [for private sector provision in home care] if we were going to go down the road and say 'OK we are going to give you a subvention for staying at home and then you [purchase] that ... if you want to' ... It probably will develop down the line ... but at the end of the day my preferred option would be for the state to provide the service (Policymaker, 007)
The private sector entering into [home care] is a reality. I suppose once you can guarantee that service meets the proper standard and that essentially people are getting what they need from it and if it doesn’t get too prohibitive and that’s the one worry that you would have that if you put yourself in a situation where the private sector is the only supplier in it that you leave yourself open then to being held to ransom essentially (Policymaker, 013).

**Perspective 4: There is no room for private sector involvement in the long-term care of older people.**

Some of the policymakers interviewed had a strong preference for a ‘state services’ model or a ‘state pays, public and voluntary sectors provide’. They were strongly opposed to private sector involvement in long-term care of older people and to the state relying heavily on the private sector to provide long-stay nursing home care. They were strongly critical of the government for taking this policy direction:

> I don’t think that the present government, over the last ten years, really made the right decision to rely on the private sector so much for things like this [long-term nursing home care for older people] ...I wouldn’t have a huge enthusiasm for that policy direction (Policymaker, 001)

> ... we are completely opposed to privatisation ... of services, health, education, in particular, because we feel that those are services to be provided by the state ... (Nominated spokesperson for policymaker, 008)

These respondents argued that older people have a right to choose private care if that is their preference and they can afford to pay for it. Apart from that, they were of the view that the private sector should not be involved in the provision of care for older people, that it should not be necessary for the private sector to be involved. As one respondent stated:

> If people prefer and can afford to use the private sector, I suppose that’s their right, but we feel that that should not be necessary except for those who really, really want that ...I am not going to say there shouldn’t be any private companies or private industry involved at all. But it shouldn’t be necessary (Spokesperson nominated by policymaker, 008).

They challenged the view that including the private sector in the care of older people is advantageous in that it offers them more choice of providers. However, they argued that that choice is often only available to those who can afford to pay for such care and that choice is often not available to older people, and not just those on low incomes:
... people who are on limited incomes who maybe don't qualify for [subvention] ... many of them can't really afford to go for private care ...

(Spokesperson nominated by policymaker, 008)

The discourse that respondents (all politicians) who fall into this group invoke could be referred to as 'public is good, private is bad'. The public sector is positively constructed. Positive aspects of the public residential care sector are its relatively higher staff ratios, better care and that it is well regarded by the public:

The problem is that public nursing homes at the moment are not covered [by inspection system] ... but generally the ... belief is that they are much better because they have a higher number of staff per patient ratio and they are more qualified ... people are not dying to get into them obviously, but they are really, really sought after ... (Policymaker, 004).

... [public nursing homes] tend to have the highest possible dependency of patients who are put out of acute hospitals who ... have no mobility, they are probably doubly incontinent, they are often confused also, they are just at the end of their lives. It's high quality care, which is very acceptable as well. People think it is a great system (Policymaker, 004)

In comparison, the private sector was negatively constructed, as illustrated by the comments of one respondent, who said 'the care in the private nursing homes in my view is totally inadequate I would say in every respect' (Policymaker, 004). The private sector was negatively associated with a profit-making motive.

What motivates them is profit and where they can make money. This is an area where there is money to be made ... we seem to be following [the United States] model, where people come in and people who have no interest whatsoever, they are not from the caring professions, they see this as a money-making exercise and they can make, as they see it, profit. There are tax write-offs for these people, etc., etc. (Policymaker, 003).

We have people now who are literally, literally selling cars, now going into health care services, people who are into the meat industry, beef barons, going into it. I mean these people do not care. They are in just making a quick buck ... They can't lose because of the tax write-offs ... so they are just going to go in and say 'right, hey give me some of this action' ... I think that's what's motivating it. They in turn will contribute handsomely to the parties. So it's, you know, it's 'you scratch my back, I'll scratch yours' situation (Policymaker, 003).

I'm not comfortable when it is a for-profit organisation ... It may be the best in the world but I wouldn't be happy. I would have reservations because ... I know it might sound wrong, but I don't think money should ever be the issue in these things, ever. It should be the quality of care and the motivation. That I want to make money out of that is to me wrong (Policymaker, 004).
The respondents believed that the profit-making motive of private sector organisations was incompatible with providing care for older people with high care needs. It raises the possibility that the high costs incurred in providing that type of care would result in a loss rather than a profit for private sector providers:

It is a problem because I think if people sink their money into a nursing home ... they want to make money out of it. It's their business. All right when we're all sitting around like this and having tea, that's fine. But gradually, as the person goes downhill, the 630 a week won't keep them. The state's subvention of less than another 200, that won't keep them. Now you are into a loss making situation (Policymaker, 001)

Furthermore, it was argued that most private nursing homes do not have the capacity to competently care for older people with high levels of care needs.

... the problem is that the [private] nursing homes cannot sustain the high level of care that is needed ... right around the country it is the high dependent people that are dying unnecessarily before their time because the homes can't provide the quality [of care] that they need and I think that high dependent care needs to be provided by the state or very, very, very ... very highly staffed and specialist nursing homes. The average nursing home ... hasn't a clue how to do that and it isn't equipped to do it ... (Policymaker, 004).

I think that [private] nursing homes are generally looking after post-operative recuperation ... what they call ... convalescence care, respite care, things like that [but] give them the responsibility for high quality high dependent care I don't think they are capable of doing that (Policymaker, 004).

Care in private nursing homes was considered to be inadequate especially in light of the high charges made:

I would be very critical of [private nursing homes] because [they] are charging five star hotel prices for kips ... in many cases ... I feel they should be doing their job and that to be excellent is to me is the foundation mark. You must get an A grade always because that is what you are charging (Policymaker, 004)

Policymakers argued that providing care is not cheap and if private nursing homes are to provide good quality care to older people with high care needs, then they will need to charge very high fees if they are to make a profit:

... I don't think the private nursing homes unless they are astronomically expensive, I know one that charges 1300 a week, ... that they should be expected to deal with highly dependent people because without a doubt you can't do it on 630 or 720, that sort of thing is impossible because you know if you employing even care assistants surely to heaven you are
going to pay them €10 an hour, that's €80 a day and you need a least one per person and to cover nights, holidays, this that and the other, that's 560 a week just on ... care ... assistance before you go anywhere (Policymaker, 001).

The conditions and quality of care in private nursing homes were called into question and believed to be lower than those in public nursing homes:

Some are fairly alright [but] I saw some [private nursing homes] that I could only describe as appalling, people being treated very roughly, restrained when they didn't need it ... and a huge amount of drugs used ... a friend of mine took her mother into a nursing home ... for two weeks ... she came out [and] she had ulcers on her legs ... she went out much worse than she went in. That was a private nursing home (Policymaker, 001).

Policymakers believed the private sector's motive to make profit was synonymous with a drive to cut costs, which would impact on the pay and conditions of employees and on the quality of care received by nursing home residents. As one of the respondents saw it, cutting costs would lead to 'an inferior type of care where corners will be cut, we'll see skimping' (Policymaker, 003). It was also seen as removing power from the state:

If you can produce good committed people in the public service, in a way you have more power ... because if you give it over to multi-nationals and so forth [the state] lose[s] an awful lot of power ... But it shouldn't just be on price, it should be on quality of care. We have billions, what the hell are we doing? (Policymaker, 001).

These respondents challenged the cost-effectiveness of using the private sector to provide long-term care given that the state has to play a major role in monitoring and regulating the sector:

They do argue that ... it is cheaper this way. But, that is a false economy because ... it seems cheaper on one level but eventually the state has to come in and do something. We've seen that over and over again (Policymaker, 003).

Obviously what's driving it is the state is avoiding the costs of providing the care, the overheads, the building, the maintenance, the upkeep, the insurances and all of that, the staff pensions and all of that. They say you'll do that [make savings] ... (Policymaker, 007).

... if there are private companies or private individuals providing services then they need to be regulated and monitored ... which has not been happening (Spokesperson nominated by policymaker, 008)
Overlapping perspectives of policymakers

As the above indicates, the discussion about the mixed economy of care provision in the interviews with policymakers tended to centre on the public sector vis-à-vis the private sector provision. The findings indicated that there were sharply divergent perspectives held by policymakers around the issue of public and private sector provision in the area of care for older people. However, there were other issues relating to the mixed economy of care provision around which there was much congruence. For example, when asked about the role of the voluntary sector, all of the policymakers talked about the voluntary sector in positive terms. It seemed to be taken for granted (in a similar way that the family is sometimes taken for granted) that the voluntary sector has and should have a significant role to play in the provision of care for older people and in contrast to the other sectors. A typical response when asked if the voluntary sector have a role to play in providing long-term care for older people was 'absolutely'. The respondent highlighted the cost-effectiveness of voluntary sector involvement by saying that 'their work is immeasurable in Euro terms' (Policymaker, 006).

The voluntary sector is great. The not-for-profit places are without a doubt the best ... [and we should] encourage them and give support to ... non-profit making organisations. If they have one going very well you could ask them 'if we supported you would you be fit to do another'. Now you don't want to stretch them too thinly because there is only a certain number who will get involved in these organisations. But suppose they would ... that would be very good (Policymaker, 001)

... what I would like to see expanding is the not-for-profit sector ... that is the answer. I read some research which shows in American and Canada that there are less complaints ... and ... better quality of care in the not-for-profit. That doesn't mean that you can't get bad or terrible not-for-profit organisations ... but ... when the motivation is care ... the only objective is to look after people that's the one that I think is the best ... model ... (Policymaker, 004).

I would love to see [the voluntary sector] involved because I think they give credibility ... to the system because they are doing it because they want to do it and because it needs to be done and not that ... it would be a cheap service but all of the profit is invested back ... that ... is a critical and ... people will have confidence in such a system ... when the motivation is commitment (Policymaker, 004).

... the state should be responsible [and] one way ... is by supporting and resourcing the voluntary organisations [which] have provided immeasurable services and very few of them are being actually compensated in any way or supported adequately to provide the services [and they] save this state a lot of money [but] there needs to be ... better
coordination, better support and resources if the state is going to depend on voluntary organisations ... (Spokesperson nominated by policymaker, 008)

This respondent saw a role for the voluntary or not-for-profit sector that was closely aligned to the public sector:

... I think the community or not-for-profit sector must be always closely connected with the public sector ... (Policymaker, 005)

With respect to the not-for-profit sector, one interviewee expressed the view that this would offer an acceptable middle ground between private sector, which was associated with the 'profit motive' and the public sector, which was associated with inflexibility:

... relative to other countries we have very little [not-for-profit sector provision] and I would love to see more of it. I think that ... would ... certainly strike a good balance between ... the fears people have around the profit side of the [private sector] ... and the lack of flexibility of the public sector ... (Policymaker, 012).

The issue of standards was another area over which there was much overlap. A main criticism related to the fact that the then standards and inspection system did not extend to the public sector, as one respondent noted: 'we have no quality standards and no inspection systems for public care' (Policymaker, 007). There was consensus that the inspection system should extend to all sectors involved in the provision of nursing home care:

...it is very important absolutely that the highest quality of standard care is provided right across in both our public hospitals, our community nursing units and also of course in private residential units (Policymaker, 006).

Most of the respondents believed that the existing regulatory system for long-stay care was 'completely inadequate'. There were criticisms of the inadequacy of the standards for private nursing homes, which were 'not nearly good enough' and of the inspection system that were in place at the time of the interviews, which was seen to be 'entirely inappropriate' (Policymaker, 007). Another criticism was that the way in which inspection reports were produced did not allow inspectors to commend private nursing homes when good practices were encountered as well as highlighting any breaches of regulations.
... the inspection system is so under-developed and unsophisticated that actually good practice in nursing homes isn’t being encouraged and supported because it is not just about rooting out the bad practice but it’s also about developing the good practice and I think that’s a particular problem, that we have to keep the two in mind (Policymaker, 002).

6.3.4 Section summary

In contrast to the official policy documents reviewed for this thesis, all of which favoured or accepted a mixed economy of care approach, there were sharply divergent views about the merits of providing care for older people through a plurality of providers and particularly with regard to an approach that promotes the predominance of the private sector over the public sector. Two respondents (one a politician from a government party) were of the view that a mixed economy of care provision for older people is a desirable and necessary feature of Irish ageing-related care policy. Central to this view was the idea that the state cannot provide care to all older people in need of care. Some respondents (mostly civil and public civil servants) accepted a mixed economy of care approach as a ‘reality’ or ‘fact’ of Irish ageing-related care policy. These respondents acknowledged that there were problems with the current system, not necessarily because of problems in either of the sectors, but because the state has failed in its role in managing, organising and structuring the sectors. According to this view, private sector provision is not the problem. The problem as they saw it lies with ad hoc policy development, poor policy planning and poor public management of the private sector. Central to this is a view of the state as an ‘arranger of services’ and move towards what Lester Salomon (2002) refers to as ‘new governance’. This is akin to the approach underpinning The Developmental Welfare State (NESC, 2005).

There were respondents who expressed a preference for a ‘state services’ model. While these respondents felt there was room for private sector involvement in ageing-related care, they expressed major reservations about policy that was over-reliant on the private sector. These policymakers employed largely positive constructions of the public sector. The public sector was considered to provide the best service, the best care, better staff ratios, continuous staff training, better structures, and to have better facilities and better medical care than the private sector. In contrast, the private sector was negatively constructed. It was believed that there was more potential for things to go wrong in private sector, that it was
too costly, that the primary motivation was profit with care a secondary motivation, there was lack of medical care and a risk of sector becoming a monopoly that set the prices for care. Some respondents were vehemently opposed to private sector involvement in the care of older people, on the basis that it was purely a profit-making exercise, with no caring ethos, offering poor pay to care workers, cutting costs, and thereby undermining care for older people. Like the previous group of policymakers these respondents also employed positive constructions of the public sector and negative constructions of the private sector.

None of the policy documents acknowledge the conditions over which older people have little or no choice. O’Shea (2002) pointed out that the system of long-term residential care that has emerged in Ireland does not offer older people more choice between public and private care. As O’Shea (2002: 62) has argued, if given a ‘real’ choice, it is unlikely that any older person in Ireland would choose private care over public care because of the cost and facility advantages associated with public care. The scarcity of public beds in some areas means that the only option available to some people is to accept subvented care in private nursing homes. In such circumstances, there is no choice. In addition, the scarcity of public beds together with the expense of private sector care may mean that older people, particularly those on low incomes, have no choice but to remain at home.

The argument about the merits of private sector relative to public sector provision leads to the question of whether there are savings to the Exchequer as a consequence of involving private sector providers. O’Shea (2002) points out that private nursing home beds are a less costly alternative than public long-stay beds. This is mainly because private beds do not require any capital investment on the part of the state and residents must pay all or a significant proportion of the cost of private care from their own resources. It is also because of higher staffing levels in the public sector and a wider range of services and facilities. Developing private sector nursing homes beds is, therefore, an attractive alternative for the government because it is less expensive, even when the capital tax allowance scheme for private nursing homes is taken into account. However, as O’Shea (2001) points out, the less costly alternative is not necessarily the most cost-effective alternative.
Despite their sharply divergent views, there were issues over which there was consensus, namely, the significant and positive role that the voluntary (or not-for-profit) sector have to play in the provision of care and the role for setting and monitoring standards across all three sectors providing institutional care.

6.4 OLDER PEOPLE

This section presents the findings about the mixed economy of formal care and ageing based on the analysis of transcripts of six focus groups with a total of 41 older people.

The NESC report on The Developmental Welfare state suggested that a dualism has emerged regarding the public and private sectors with low public support for the former. This dualism was not a feature of the discourse of older people. Although one focus group participant expressed a strong preference for private sector nursing home care, participants in general did not state a preference for either public or private sector care. There was a perception amongst participants that private sector nursing homes offered more comfort. Participants suggested that this might encourage older people to have a preference for private rather than private nursing home care. As one participant stated:

Most people, I suppose ... might like to go to a private nursing home ... you are going to have a bit more comfort than you would have in a public nursing home (Participant, Focus group 02, meals service, inner city Dublin).

Nevertheless, participants commented on the very high costs of private nursing home care, suggesting that affordability was a barrier to availing of private nursing home care, even if it was the preferred option:

Private nursing homes ... I often wonder how could it cost so much money to look after one old person for a week ..., they charge astronomical fees (Participant, Focus group 02, meals service, inner city Dublin).

This finding supports O’Shea’s (2002) view that older people generally prefer public beds to private beds because of the financial implications of ending up in private care, even with the maximum subvention. However, participants in the focus groups suggested that private sector nursing home care might be the
preference of older people who owned their own house as they would be in a better position to pay for private nursing home care.

In the focus groups, participants debated whether care in a public nursing home was better than in a private one. Many of the participants were of the opinion that care in a public nursing home is good or very good and often better than in private nursing homes. Many of them drew on their experience of visiting relatives or friends in public and private nursing homes to arrive at their opinion. The following were typical comments:

... [public nursing homes] were called Poorhouses ... where only the poor went and they're now regular nursing homes ... run by the state ... and they often are very good ... in my experience of those two places [I visited] as opposed to visiting people in [private] nursing homes ... (Participant, Focus group 05, Seniors poetry group, Dublin city).

The thing is you wouldn't get any more care in a private one than you would in a public one. You would get more in a public one, I would think (Participant, Focus group 02, meals service, inner city Dublin).

Another participant stated:

M.... K..... is in a public home ... and I defy anybody to say that it's not better and it's spotless really and the care is incredible ... I don't think you could surpass it (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb).

This finding supports O'Shea's (2002) view that older people generally prefer public beds to private beds on the basis of quality of care. Nevertheless, some participants expressed uncertainty about this. For example, one participant commented: 'Who's to say, the public could be very good' (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb).

Participants offered a number of reasons to explain why they thought that care in public nursing homes is better than in private nursing homes. It was suggested that care was a secondary consideration for private providers, who were more concerned with making a profit from the business of providing care. Typical comments were '... money is the primary thing, the care is secondary' (Female participant, rural group) and 'I think the private are in it to make profit' and 'I suppose it is not the best for the patient really, is it?' (Participant, Focus group 04, active ageing group, rural area) One participant put it as follows:
I worked with [the] Managing Director of a company but for his private business he was setting up nursing homes. Now, he was an accountant. He knew nothing about care and he was setting them up purely as a commercial business (Participant, woman, Focus group 05, Seniors poetry group, Dublin city).

Participants surmised that if the primary motive of private sector nursing homes is to make profit, then staffing levels would be reduced as a cost-saving measure:

... in a private nursing home they are going to employ as few staff as possible because they are there to make money at your expense, yeah, I mean we saw with Leas Cross, didn’t we? (Participant, Focus group 02, meals service, inner city Dublin).

Participants suggested that staffing levels have an impact on quality of care and their impression was that there are higher levels of staffing in public sector nursing homes which meant that they provide better care than private nursing homes:

... about enough staff, my stepfather had a stroke and ... he could hardly move, he was in a wheelchair really in very, very bad shape and he was in a care home that had been a Poorhouse and the nurses were so kind and so patient and so good with everybody and I said to them ‘How can you do this? ... how can you be so patient?’ and they said that there were enough of them, that they had enough time off and, therefore, when they were on they could give their all (Participant, Focus group 05, Seniors poetry group, Dublin city).

... [relations of mine] had been in a paying nursing home which was appalling really because I remember it was a matter of shouting for ‘nurse, nurse’ and there was no nurse and there was a big steel door and he actually fell out of his chair and all that sort of thing, left alone in his bedroom so the care was not there whereas it was I thought in these ... public ones (Participant, Focus group 05, Seniors poetry group, Dublin city).

In two separate focus groups, participants suggested that care in public nursing homes might be better due to better supervision and management:

No, I thought the public now might be better, better supervision and better everything than the private. (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb)
I'd say that the public nursing homes are better run than that private ... They have more supervision in them (Participant, Focus group 06, active retirement group, Dublin).

However, participants pointed out that, even if an older person had a preference for a particular private nursing home and could afford the fees, money wouldn't always buy care in that home. This was because they believed that some private nursing homes might not accept older people with Alzheimer's disease or other special care needs. As one participant put it, 'you can't get into any nursing home even if you had the money they wouldn't take you ... when care is needed for special illness' (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb). Another participant who stated a preference for private nursing home care added 'who knows if you'll have the choice' (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb). Therefore, an added concern was that an older person's right to choose between public and private provider might be further limited where they need high levels of care or had special care needs.

Similarly to the some of the policymakers interviewed, older people participating in the focus groups considered that private nursing homes tend to concentrate on providing short-term care for older people such as convalescence after an illness or hospitalisation:

[The local private nursing home] seems to have people when they've had operations or ... hips and knees and whatever ... and they go in probably for two or three weeks and come out and they can go back to their own home when they have recuperated (Participant, Focus group 03, informal group of older women, wealthy Dublin suburb).

Participants also spoke about the proximity of nursing home to their neighbourhood or locality. The perception of Dublin inner city dwellers was that most private nursing homes (at least in Dublin) were located at a considerable distance from their neighbourhood, which was seen as a particular disadvantage:

They [private nursing homes] are all too far [away] ... you go to a private one and they put you out in Bray (Participant, Focus group 02, meals service, inner city Dublin).

The respondents were, thus, highlighting the fact that older people often have little choice over the geographical location of private (or indeed, public) nursing homes. In contrast, the rural dwellers believed that they were well served with a public
nursing home with good standards and accommodation and a private nursing home that catered mainly for convalescence care.

6.4.1 Section summary

The findings suggest that older people participating in the focus groups used a wide range of criteria in their attempts to evaluate private versus public nursing home care. These included levels of comfort, quality and standards of care, staffing levels, caring ethos, cost and affordability, type of care needed, and proximity to neighbourhood or locality. Notwithstanding the comforts that were associated with private sector nursing home care, many of the participants across all six focus groups of older people expressed a preference for public nursing home care over private nursing homes care on the basis that quality and standards of care were better. Although some uncertainty was expressed the respondents considered public sector care to be good and probably better than private sector care. The findings support the perception of staff in one (former) health board (O'Shea, 2002) and some policymakers participating in this study that the majority of older people prefer public long-stay care to private care.

In the focus groups, participants generally constructed public nursing homes in positive terms and private nursing homes in negative terms and as problematic. The main problems that participants associated with private nursing homes were high costs, profit-making motive, lack of caring ethos, lack of medical care and limited facilities, location of private nursing homes, and poor staff ratios and poor supervision of staff. Profit motive of private sector was a cause of unease. The Leas Cross scandal was seen to typify this. There was also concern that private sector nursing home care may not be a choice for people with high levels of care needs. In addition, it is often removed at a distance from the community, both geographically and socially. In contrast, public nursing homes were constructed in positive terms. Quality of care was considered to be better, in that staff levels are higher and there is better medical and nursing care.

The 'reality' of choice (of provider) being available to older people in need of care was questioned by participants. The 'reality' for older people with respect to the right to choose among public and private providers was encapsulated by one older woman participating in a focus groups with the remark 'Who knows if you'll have the choice'. Moreover, there was a sense that if a nursing home could offer
comfortable surroundings, good quality and high standards of care, had adequate staffing levels, adopted a caring ethos, was affordable, could meet their care needs and was in close proximity to their neighbourhood or locality, it wouldn't really matter whether care was provided by the public or the private sector.

6.5 MEDIATISED DISCOURSE OF POLICYMAKERS AND OLDER PEOPLE

As Chapter 4, Section 4.3.4 noted, news items that addressed or mentioned issues relating to formal (that is, public, private and voluntary) care sector providers were placed into a single classification. They were then categorised according to who had written the news item, the general topic of the news item and the message that was conveyed by the news item regarding the theme of ageing and formal care provision. Sources of opinion that were cited by the author of the news item, including policymakers and older people were noted.

The analysis of interviews with policymakers (see Section 6.3 above) shows that respondents expressed sharply divergent views on the desirability of a mixed economy of formal care as a feature of ageing-related care, particularly with regard to the involvement of the private sector and its predominance over the public sector. The four distinct perspectives identified were discussed above.

The views of politicians were reported in news items by correspondents at *The Irish Times* relating to the theme of ageing and formal care providers. These covered three main issues.

The first issue related to the opening of private home care services, illustrated by a news item reporting the launch by the Minister for Health of 'a US-franchised private home help service'. The news item cited the Managing Director of the franchise group who stressed that 1,000 part-time jobs were being created by this initiative. The message from the Minister for Health, Mary Harney, conveyed through the news item was that it was important for older people to have a mix of care providers, in other words choice of provider, and that there were benefits from involving the private sector in the provision of care for older people. She was quoted as saying: "I think you need a combination of initiatives. I think we need to be flexible and innovative. The important thing is to have high-quality care." However, the launch of the private sector home care services was seen by others as a strategy to promote private sector provision and to undermine the provision of home care services through the public system. A spokesperson for a
political party in opposition to the government was quoted as saying "This is an ideologically motivated decision that has nothing to do with the needs of the health service and everything to do with [the Minister for Health] espousing the American model of healthcare provision".

The views of a trade union spokesperson were also reported in the news item. He strongly criticised the Minister for failing to implement agreements on working conditions of home helps in the public system. He argued that the reason for this was that the Minister had 'private sector providers waiting in the wings'. A spokesperson for a national organisation representing older people was cited in the news item as saying there was nothing wrong with private enterprise but warned the Government against concentrating on the private healthcare model while neglecting public health services and posed the question 'to what extent are we allowing private enterprise to be the driving force in providing healthcare?' In a separate news items reporting a Dáil debate on the introduction of legislation that would change regulations about how family homes are taken into account as income for elderly nursing home patients, it was reported that a TD from an opposition party had asked the Minister for Health to confirm "that she proposes to hand the care of our elderly people over to a money-grubbing private American-based franchise" and called on her "to scrap this crass, incredible privatisation".

A separate news item reported the opening of a ‘state-of-the-art’ private nursing care centre, which was also launched by the Minister for Health who was quoted as saying 'this the future of care in Ireland’. The views of the founder and owner of the nursing care centre were also reported as well as the views of one resident on the services provided by the centre. Older people's voices were not cited in any other news item on issues relating to ageing and formal care providers written by correspondents at The Irish Times. There was one letter to the Editor from an older woman (who gave her age as 84) who wrote to express her disappointment at the government for delays in the opening of a ‘community hospital for the elderly’ in the rural area in which she lived due to problems in relation to the HSE’s funding of capital grants for the hospital.

The second issue centred on a major review of tax relief arising from Government-promoted schemes carried out for the Department of Finance. Six news items by correspondents at The Irish Times focused on this issue. They
reported that a Goodbody Consultants' report produced as part of the review has shown that a relatively small group of high-income individuals have benefited in recent years from tax reliefs arising from Government-promoted schemes, and had "strong negative income distributional effects". A second report by Indecon Consultants studied a number of property-based reliefs as part of the review including allowances for investment in private nursing homes. It recommended continuing the scheme that promoted investment in private nursing homes report.

This recommendation was criticised by spokespersons on finance in three political parties in opposition to government on the basis that such tax reliefs bring about economic unfairness and drive up the cost of building nursing home facilities. The Finance spokesperson of one opposition party argued that any extension of tax reliefs such as for private nursing homes should be subject to cost benefit analysis. Furthermore, the Editor of The Irish Times took up the issue in an Editorial and argued that the Government in recent years had effectively withdrawn from the provision of new public nursing homes, leaving it to the private sector to fill the growing demand and there has been little discussion about this direction of Government policy. Another news item by a correspondent at The Irish Times reporting on a Dáil debate highlighted views of politicians that were similar to the Editor. The government was criticised by opposition politicians for its failure to invest in public nursing home beds with one politician, according to the news item, claiming that 'the Government's approach was to try to get as many elderly people as possible into nursing homes, provide as many nursing homes as possible by the private sector in locations far removed from family, community and wider society'.

The third issue concerned the existing system of nursing home inspections. Politicians cited in four news items addressing this issue called for an inspection system of nursing homes that would cover public, private and voluntary sectors, while in two other news items politicians from opposition parties were reported calling for the publication of inspection reports of private nursing homes. Reflecting the findings from the analysis of transcripts of interviews with policymakers, the analysis of news items shows that there was consensus among policymakers with regard to extension of the inspection system to cover the public sector as well as the private and voluntary sectors.
6.5.2 Section summary

The analysis of news items that appeared in *The Irish Times* in 2006 shows that with respect to ageing and formal care providers, the views of politicians that were reported reflect the tensions that had been found between policymakers participating in interviews for this thesis. One the one hand, there were politicians (in government parties) who stressed the advantages of encouraging private sector involvement, while, on the other hand, there were politicians (from political parties in opposition to the government parties) who argued that the promotion of the private sector was not cost-effective but that government was pursuing a neo-liberal agenda at all costs. Their views coincided with those of national representatives of one organisation of older people. However, the views of individual older people in relation to this issue were not cited in the news reports.

6.6 CHAPTER CONCLUSIONS

This chapter explored the multiple discourses embedded in social policy and ageing-related care using ageing and formal care providers as a lens through which to do this. The preceding four sections of this chapter presented the findings relating to this theme, based on an analysis of official policy documents on ageing-related care from 1968 to 2005, transcripts of interviews with policymakers, transcripts of focus groups with older people, newspaper reports and articles. This section draws out the main conclusions.

Three long-established welfare systems provide institutional care for older people in Ireland – the public system, the private system and the voluntary system. From my analysis of official policy documents on ageing-related care, this chapter identified a major shift in thinking particularly about the relevance of the private sector to the responsibilities of the state, first in relation to institutional care and later with respect to community care.

In relation to institutional care, the rhetorical emphasis in the *Care of the Aged Report* (1968) was on the most obvious of the three welfare systems, the public system of institutional care, which was largely focused on the needy. It was taken for granted in the report that the public sector was and would continue to be the most significant provider of institutional care for ‘needy’ older people. The main
focus of the report, therefore, was, not surprisingly, on reforming the public system, which was imbued with a medical/professional discourse. Although the private sector was involved in providing institutional care for older people, the bare mention of it in the Care of the Aged Report (1968) seems to signal that it was regarded as a minor, less significant player. In addition, state intervention in private nursing homes at the time was minimal. It extended to ensuring a minimum standard of care. All of this suggests that private provision of institutional care catering for middle classes who could afford to pay for care was deemed to largely fall outside the scope of the public sphere at the time. In contrast, the Care of the Aged Report (1968) viewed the voluntary sector as a contender in the provision of institutional care for older people.

Thus, there were very different views regarding the relevance of the public, private and voluntary systems to the responsibilities of the state in the provision of institutional care for older people in the Care of the Aged Report (1968). As the most significant provider of care for the 'aged' poor, the public sector was viewed as 'relevant' to the responsibilities of the state in this area. With its role in catering for the middle classes, the private sector was by and large viewed as 'largely irrelevant' to the responsibilities of the state, while the voluntary sector was regarded as being 'possibly relevant' to the responsibilities of the state in the provision of care for the 'aged' poor.

This chapter found that by the time The Years Ahead was published in 1988 there had been a major shift in thinking about the relevance of the private sector to the state's responsibility with respect to institutional care for older people. The Years Ahead (1988) promoted the idea that the provision of institutional care through a mix of public, private and voluntary sectors was a desirable feature of Irish ageing-related care. Clearly, this is in stark contrast to the Care of the Aged Report (1968) and its rhetorical emphasis on the public sector and its significance in providing institutional care for older people. By 1988, the private sector had increasingly come within the remit of the state. Statutory responsibility to ensure a minimum standard of care in private nursing homes had grown considerably in scope with the introduction of new regulations in 1985 that lay down revised standards and gave health boards the power to inspect private nursing homes regularly. Since the principle of public subsidisation of private nursing home care had been officially recognised, a considerable amount of public funding was going to private nursing homes. By 1988, the private sector was, therefore, regarded as
Emerging from this shift in thinking, the focus moved from reform of the public system to altering the balance between the public, private and voluntary sectors in the provision of institutional care for older people in Ireland. In arguing the case for having a mixed economy of formal care, *The Years Ahead* (1988) emphasised the merits of greater involvement of the private sector in providing institutional care. Compared with its bare mention in the *Care of the Aged Report* (1968), support for the involvement of the private sector was viewed in *The Years Ahead* (1988) as merited in that it offered choice, cost-effectiveness, cost savings to the state, and flexibility. In contrast, the public sector as a provider of services was viewed as excessive and outdated. In other words, the private sector was pitched against the public in *The Years Ahead* (1988) as a way to legitimate increased involvement of the private system, on the one hand, and curtailment of the public system of institutional care provision, on the other. The public sector is presented as having inherent difficulties and as disadvantageous whilst the private sector is argued to be beneficial but assumed to be inherently straightforward or unproblematic. *The Years Ahead* (1988) was significant in that it was the first official policy document on ageing-related care in Ireland to communicate such policy ideas about the mixed economy of formal care in this way. The tone of *The Years Ahead* (1988) was in marked contrast to the *Care of the Aged Report* (1968), which shows no evidence of any perceived conflict between the public and private sector, probably because they were both operating in different spheres, that is, the public sphere and the private sphere. Altering the balance between the public and private sector was, therefore, not an issue in the 1968 report.

Between 1968 and 1988 there was a change in state governance of private and voluntary sector provision of institutional care for older people. In 1968 there was minimal state intervention in the private sector. The regulations on minimum standards governing private sector did not apply to voluntary nursing homes. However, the *Care of the Aged Report* (1968) recommended that voluntary nursing homes should become subject to statutory standards and inspections, suggesting that the state was to increase its governance over the voluntary sector. By 1988 the state not only had a role to play in subsidising private care, but regulations adopted by the state in 1985 set down minimum standards and
gave the health boards the power to inspect private nursing homes regularly. This gave the state increased authority over the private sector. Therefore, the state as an ‘arranger of services’ was beginning to crystallize.

With regard to the provision of social care services for older people living in the community, the pitching of the public sector against the private sector emerged much later. Both the Care of the Aged Report (1968) and The Years Ahead (1988) emphasised the public/voluntary mix of provision of community and home based social care services for older people. Although the private sector was involved in providing such care, it was assumed to have a very limited role. One of the main differences between The Years Ahead (1988) and the official policy documents on ageing-related care in the new millennium is that the latter argued or at least accepted the case for extending a mix of public, private and voluntary sector provision to home based care. In a similar vein to The Years Ahead (1988), the Study to Examine the Future Financing of Long-term Care in Ireland (Government of Ireland, 2002) emphasised the benefits of private sector involvement and recommended its expansion on the basis that it would be more cost-effective, widen consumer choice and increase flexibility. Again, the public sector was pitched against the private sector. Whilst the understanding was that the public sector operated under ‘constraints’, the private sector was viewed to be inherently straightforward and beneficial. On this basis, the Study to Examine the Future Financing of Long-term Care in Ireland (2002) sought to legitimate its recommendations to extend the private sector to the field of home based care.

In promoting the view that a mixed economy of care provision is a desirable feature of long-term care in Ireland, the NESF report on Care for Older People (2005) steered clear of positioning the private and public sector as opposites. Rather, the report focused on promoting the concept of informed choice, a co-ordinated approach to policy planning and services delivery by involving the private and voluntary sectors in the development of policy and service delivery, and the application of legal obligations and standards across the three sectors. The emphasis was on state management on an equal basis of the different providers.

The NESC (2005) report, The Developmental Welfare State, pitched the public sector as one player alongside the private and voluntary sectors. As mentioned earlier, the report contended that a combination of strong public sector
organisations and competition from private and non-profit organisations is most likely to achieve the best balance between accountability, innovation and efficiency (NESF, 2005: xix). The report then went on to focus on the difficulties associated with the public sector and positioned it as weak (albeit with potential for reform). In contrast, it assumed the private sector to be inherently straightforward and beneficial. The pitching of the public sector against the private sector is, therefore, also evident in the report. The NESC report (2005) suggested that a deepening dualism in the Irish welfare state between public and private sector provision has emerged, with low confidence in and support for public sector provision and a preference for private sector provision and warned that without reform of the public sector there is a risk that this dualism within Ireland’s welfare state could deepen further. Therefore, an assumption underpinning the NESC (2005) report is that the wider public view public and private sector provision as ‘public is bad, private is good’.

In conclusion, a predominant discourse underpinning policy on provision of ageing-related care since 1988, the emergence of which can be traced to the 1970s, is that having a mixed economy of public, private and voluntary sector providers is a desirable feature of ageing-related care in Ireland. However, this is underpinned by an economic discourse which promotes private sector provision as the ideal way forward as it offers older people more choice, offers cost saving to the state and offers flexibility.

The analysis of transcripts of interviews with policymakers found that, in contrast to official policy documents on ageing-related care, there are sharply divergent views on the desirability and acceptability of having a mixed economy of public, private and voluntary sector providers as a feature of ageing-related care in Ireland. While all accepted that a mixed economy of care is a feature of ageing-related care in Ireland, not all accepted that the predominance of the private sector over the public sector is a necessary and desirable feature. Rather, the analysis identified four distinct, but at times overlapping, views:

1. A mixed economy of public, private and voluntary sector providers is a necessary and desirable feature of ageing-related care policy in Ireland;
2. A mixed economy of care provision (in which the private sector predominates) is a ‘fact’ or ‘reality’ but not a problem of ageing-related care policy in Ireland;
3. While there is room for private sector involvement in long-term care of older people, the over-reliance on the private sector is a problem;

4. Private sector involvement in the long-term care of older people is not necessary and over-reliance on it is a problem.

The first and second views are similar in that respondents argued that a mixed economy of care provision for older people in which the private sector is predominant is not a problem. The main difference was on whether or not the respondents pitched the public and private sectors against each other. One respondent avoided positioning the private and public sector as opposites and emphasised instead the excellent care provided across all three sectors and stressed that difficulties associated with the public and private sectors are being addressed. For another respondent, the predominance of the private sector offered a solution to the difficulties associated with the public sector. The remaining respondents stressed the advantages of private sector involvement but suggested that there was a widely held view that 'private is bad, public is good'. These respondents therefore suggested that a lot of people pitch the public and private sectors against each other but in a way that contrasts diametrically with the pitching of the public and private sectors in official policy documents on ageing-related care. These respondents contested the idea that 'private is bad, public is good', and argued that the idea misrepresents the private sector. Nevertheless, some of these respondents expressed concern about the private sector, particularly the profit-making motive of private providers. Questions were also raised about the suitability of the private sector in providing care for older people with high levels of care needs. But, in general, the problem they identified was failings on the part of the state as an 'arranger of services'. In other words, it is not a matter of altering the balance between public and private, but a matter of governance.

The third and fourth views are similar to each other and different from the preceding two views in that the respondents argued against an over-reliance on the private sector, which they argued is not cost-effective and does not offer savings to the state. The main difference between the third and fourth views is that while some respondents believed that there is room for private sector involvement in long-term care of older people, others were strongly opposed to the involvement of the private sector in the provision of care for older people. These policymakers clearly pitched the public sector against the private sector,
but one that was again diametrically opposed to that identified in the official policy documents. They adhered to the view that ‘public is good, private is bad’. In stark contrast to most of the official policy documents on ageing-related care, these respondents positioned the private sector as inherently problematic and damaging and positioned the public sector as inherently beneficial.

Much concern was expressed by the respondents about the perceived profit-making motive of the private sector, which they believed undermines the quality and standards of care. They argued that private sector care was too costly for older people, was not cost-effective and did not offer savings to the state. They suggested that private sector providers are reluctant or do not have the capacity to provide care for older people with a high level of care needs. They also expressed concern about what they perceived as lower standards of medical and nursing care in the private sector than in the public sector. Furthermore, they argued that difficulties associated with the public sector have been created by government through under-investment. They suggested that the balance between the public and private sectors in the provision of institutional care needs to be redressed through the curtailment of the private sector and investment in and expansion of the public sector. Similarly to the preceding groups of policymakers, these respondents stressed the importance of state’s responsibility and argued that governance matters.

On the one hand, there are official policy documents on ageing-related care that at one level promote the idea that a mixed economy of care provision is a necessary and desirable feature of ageing-related care in Ireland. However, at a second level they emphasise what are assumed to be inherent advantages of private sector involvement and inherent disadvantages of the public sector. Two of the policymakers (those that fall within perspective 1) conformed to this view. On the other hand, there were policymakers (those that fall within perspectives 3 and 4) with an opposing view. Although there were differences of opinion amongst these policymakers with regard to whether there was any role for the private, they tended to emphasise the inherent difficulties associated with the private sector and the inherent advantages associated with the public sector. These diametrically opposing views might be understood as ‘a conflict of opposites’. A third group of policymakers (those falling within perspective 2) lies somewhere in the middle. This group of policymakers accepted a mixed economy of care approach as a feature of ageing-related care in Ireland.
Although they stressed the advantages of private sector involvement in the provision of care for older people, they highlighted concerns in relation to both of the public and the private sectors and did not make the assumptions on which the other groups of policymakers based their views.

From my analysis of transcripts of focus groups with older people, this chapter found that, contrary to the NESC’s (2005) view that there is low support for public sector provision and a preference for private sector provision, the picture appears to be much more complex. Rather than pitching the public sector against the private sector, participants in the focus group used a wide range of criteria to evaluate both sectors in the provision of nursing home care including levels of comfort, quality and standards of care, staffing levels, caring ethos, cost and affordability, type of care needed, and proximity to neighbourhood or locality. Many but not all of the participants across all six focus groups of older people expressed a preference for public nursing home care over private nursing homes care on the basis that quality and standards of care were better. However, there was a sense that older people do not always have a ‘choice’ of provider and, moreover, if a nursing home could offer comfortable surroundings, good quality and high standards of care, had adequate staffing levels, adopted a caring ethos, was affordable, could meet their care needs and was in close proximity to their neighbourhood or locality, it wouldn’t really matter whether care was provided by the public or the private sector. This suggests the need to replace the model of developing ageing-related care policy in Ireland with a model where older people as users would have a role to play in affecting the shape of services.

Taking ageing and formal care providers as a lens through which to explore social policy and ageing-related care in Ireland has shown that providing long-term care for older people through a mixed economy, particularly one in which the private sector predominates, is a highly contentious issue for policymakers. Whilst some policymakers continue to associate private sector involvement with advantages such as more choice for older people, cost-effectiveness, cost savings to the state, these are been challenged by other policymakers. While there has been claim and counter-claim over the relative merits of private sector involvement, this chapter identifies two issues in particular that are the source of much unease amongst policymakers on both sides of the divide. The first concerns the profit making motive associated with the private sector and its compatibility or otherwise with a caring ethos. This is built on the generalisation that all private sector
providers are motivated primarily by profit and that care is a secondary consideration. This was a common-sense understanding of the private sector held by older people as well. The second related question centres on whether private sector providers are ‘creaming off’ older people with low care needs with profit-making in mind, and, if not, whether they have the capacity (and proper supports from the state to facilitate them) to provide care for older people. Thus a common-sense understanding of the public sector held by many policymakers and older people is that the public sector is better placed and more willing to care for older people with high care or special care needs.

There appears to be much disenchantment amongst some groups of policymakers and some older people with the government’s policy direction. However, drawing on Saraga (1998:192) this chapter emphasises the need to be a ‘sceptical stranger’ in considering debates about the mixed economy of care provision for older people and arguments in favour of and against the predominance of the private over the public sector. This chapter has attempted to be a ‘sceptical stranger’ by making explicit the assumptions about the public and private sectors that are implicit in official policy documents on ageing-related care, in questioning the generalisations about the public, private and voluntary sectors that are taken for granted by policymakers and older people, and by scrutinising what older people ‘know’ alongside alternative policy definitions of the problem.

For example, the common-sense understanding of older people is that the public sector provides better care than private. Further work is needed to test, where possible, the assumptions about the private, public and, indeed, voluntary sectors, that are embedded in official policy documents on ageing-related care and those held by policymakers and older people against the empirical evidence that is available.
CHAPTER 7:

FINDINGS III: AGEING, CARE AND OPPORTUNITIES FOR
SOCIAL ENGAGEMENT AND
PARTICIPATION IN SOCIAL ACTIVITIES

7.1 INTRODUCTION

In Chapter 1, I referred to the distinction that is often made between health and social care, and drawing on Blackman (2001) defined the latter as including personal care, practical assistance and opportunities for social and leisure activities (Blackman, 2001). Providing opportunities for social and leisure activities is a key element of ageing-related care policy. Studies of older people's participation in social and leisure activities and their social interaction with others, both of which are strongly associated with a good quality of life, have become of considerable interest to policymakers in recent years (Gallagher, 2008; Pillemer et al., 2000).

This chapter considers ageing, care and opportunities for social engagement and participation in social activities as a way of exploring the multiple discourses underpinning social policy and ageing-related care in Ireland. This topic was chosen as it was a major theme to emerge from the focus groups with older people. Older people participating in the five community-based focus groups conducted for this thesis were recruited from existing formal and informal social groups. In these focus groups, the overwhelming view that came across was that involvement in a social group, participation in social and leisure activities organised by and for the group, and interaction with others in the group was positive and enhanced their lives. They contrasted their experience with older people whose quality of life they believed was undermined by a lack of opportunities for social engagement and participation in social activities. In addition, a main theme to emerge from the focus group with older people living in a residential care setting was the lack of opportunities they had for social engagement and participation in social activities. I decided to explore the ideas
about the theme of ageing, care and social interaction and opportunities for social
tivities for older people that were embedded in official policy documents and
how policymakers talked about it. The findings presented in this chapter follow
the same format as the findings in relation to other two discursive themes
explored in this thesis to reflect the four different sources of data selected for
analysis. Section 7.2 presents the findings from the analysis of key official policy
documents relevant to ageing-related care between 1968 and 2005. Section 7.3
presents the findings from the analysis of one-to-one interviews with
policymakers. Section 7.4 presents the analysis of focus group with older
people. Section 7.5 presents findings in relation to the mediatised discourse of
policymakers and older people. Section 7.6 draws together some conclusions.
This chapter is shorter than the previous two findings chapters. This is because
(as it will be seen) this theme received less attention in the official policy
documents on ageing-related care. It was not a key theme to emerge from the
interviews with policymakers, nor was it as widely covered as the other two
themes in news items.

7.2 OFFICIAL POLICY DOCUMENTS

This section presents an overview of the main discourses about the participation
of older people in social and leisure activities that are embedded in official policy
documents relevant to the care of older people in Ireland based on an analysis of
five reports. As with Chapters 5 and 6, the exploration begins with an analysis of
the Care of the Aged Report followed by an analysis of The Years Ahead – A
Policy for the Elderly (Working Party on Services for the Elderly, 1988), which is in
turn followed by an analysis of three reports published in the new millennium,
namely: Study to Examine the Future Financing of Long-Term Care in Ireland
(Government of Ireland, 2002); Care for Older People (NESF, 2005); and The

7.2.1 The late 1960s: The Care of the Aged Report (1968)

My analysis of the Care of the Aged Report revealed that advancing years is
closely associated with increasing rates of dependency:

As people advance in years their dependence grows greater and few of
those over the age of 75 years will be completely independent and the
It is not, however, only the very old who are associated with dependency and lack of productivity in the report. People over the age of 64 years in general are defined in the report as 'the dependent members of the community' (Inter-departmental Committee on the Care of the Aged, 1968: 46). There is only one reference (at the end of the chapter on community health and social care services) to older people as productive members of the community, when they are identified as a potential pool of voluntary workers:

The aged themselves are a source of particularly valuable [voluntary] workers [in the care of the aged] which probably has not been sufficiently tapped. Many are in good health and have time to devote to voluntary work. They can be very suitable for work among their less able contemporaries, or among those older than themselves (Inter-departmental Committee on the Care of the Aged, 1968: 74).

The report recognised through this one reference that older people are active and make a contribution to society through voluntary work. Nonetheless, the report placed more emphasis on the loss of social roles for some older people. For example, the report noted that '[m]any of the elderly follow the interests of a lifetime, others find new interests in their old age, but some are lonely and feel a loss of status and sense of purpose in life' (Inter-departmental Committee on the Care of the Aged, 1968: 69). It raised concerns about the loss of social roles by many older people upon retirement:

Unfortunately [after retirement] too much opportunity for rest and leisure speedily leads, in many cases, to boredom and the realisation of the less attractive aspects of retirement—a reduction in income, loss of occupation, fewer contacts with other people and, frequently, loneliness and a feeling of no longer having a useful role in life. Hobbies and games learned earlier in life can provide a reservoir of interests which will be of considerable help in reducing the problems met with on retirement, but few have developed sufficient recreational and leisure outlets to fill all the time
which had been devoted to work (Inter-departmental Committee on the Care of the Aged, 1968: 4698).

The *Care of the Aged Report* stressed the importance of finding new roles and activities for older people to reduce 'the problems' of retirement and argued that there was a need for employers, trade unions and voluntary bodies to co-operate on preparing people for dealing with the 'problems' of retirement including the loss of social roles and loss of interests. It viewed voluntary work as a way of offering older people a 'valuable' role and compensating for the loss of social roles and status. It stated that '[v]oluntary work frequently gives the aged an interest and a sense of purpose, so that in helping others they also help themselves' (Inter-departmental Committee on the Care of the Aged, 1968: 74).

The *Care of the Aged Report* also stressed the importance of finding new roles and activities for older people living in the community who were in need of support. To this end, it stressed that occupational therapists have an important role to play in encouraging older people living in their own home to take an 'interest in social activities'. For example, the report stated that 'old people can be introduced to new hobbies and interests which will help them to lead a fuller life' (Inter-departmental Committee on the Care of the Aged, 1968: 63). In addition, the report contended that occupational therapists could ensure that any hobbies and interests acquired by older people in hospitals would continue to be of benefit to them on their discharge from institutions and return to the community. The report suggested that occupational therapists could be employed for this purpose and recommended that occupational therapists should be provided by health authorities on a community basis for 'the aged' who are in need of the service.

As an alternative to occupational therapists, the report proposed that voluntary workers could be encouraged to 'provide occupational therapy of a supportive nature, e.g. to interest the aged in games and social activities' (Inter-departmental Committee on the Care of the Aged, 1968: 63). The Committee also recommended that health authorities should encourage the development of clubs and give financial support to voluntary bodies that provide them, as they were considered to offer considerable benefits to 'the aged':

*Clubs provide leisure activities for many, help them to enjoy companionship and to remain interested in their surroundings ... Clubs*
bring together old people living in an area and encourage them to co-operate in social activities and the development and pursuit of hobbies. They are a most useful means of preserving contacts, fostering friendships, giving the elderly new interests and maintaining a high standard of morale ... they may provide facilities for some or all of a wide range of activities, e.g. for card and similar games, for billiards, for hobbies such as photography, woodwork, arts and crafts, knitting, sewing etc, for various educational courses, for keep-fit classes etc. (Inter-departmental Committee on the Care of the Aged, 1968: 69).

As mentioned in Chapter 6, the Care of the Aged Report, in its discussion on institutional care, focused primarily on the different types of public sector accommodation that could be developed to care for older people, namely, general hospitals, geriatric assessment units, long-stay units and welfare homes. In relation to the latter form of accommodation, which were intended as ‘substitutes for normal homes’, the report raised the issue of social interaction and social activities for older people residing in welfare homes. It suggested that ‘[a] few small sittingrooms are preferable to one large one, where residents are less inclined to form friendships or to share interests’ (Inter-departmental Committee on the Care of the Aged, 1968: 83). The report stated that older residents of welfare homes ‘will not readily form friendships or engage in social activities and they can easily become institutionalised if preventive measures are not taken. They should be encouraged in every way to retain their interests’ (Inter-departmental Committee on the Care of the Aged, 1968: 84). The report stressed the importance of providing occupational therapy for residents and the necessity of providing the services of an occupational therapist or of a teacher of arts and crafts (Inter-departmental Committee on the Care of the Aged, 1968: 85). However, the report did not raise the issue of activities and social contact for older people in institutional care settings other than welfare homes.
Measures should be taken to prevent disengagement of older people living in welfare homes and promote participation in social and leisure activities.

Loss of social roles and inactivity is an inevitable part of the ageing process.

Para-medical experts and voluntary organisations should encourage older people to be active.

Loss of social roles and inactivity amongst older people is a problem.

Volunteering and participation in hobbies are appropriate activities for older people.

Older people must be encouraged to find new roles and to be active.

Figure 7.1: Care of the Aged Report (1968): Logic behind discourse on ageing, care, and opportunities for social engagement and participation in social activities.

7.2.2 The late 1980s: The Years Ahead Report (1988)

The Years Ahead report recognised that the majority of older people are ‘active’ (Working Part on Services for the Elderly, 1988: 27). The report devoted an entire chapter to ‘Maintaining Health’, at the beginning of which it noted Ireland’s commitment through its membership of the UN to the Vienna International Plan of Action on Ageing. As The Years Ahead pointed out, the Plan advocated a broad approach to the promotion of the health of older people and recommended that the care of older people:
... should go beyond disease orientation and should involve their total well-being, taking into account the inter-dependence of the physical, mental, social, spiritual and environmental factors ... Health efforts, in particular primary health care as a strategy, should be directed at enabling the elderly lead independent lives in their ... community for as long as possible instead of being excluded and cut off from the activities of society (cited in The Years Ahead, 1988: 54).

The chapter on 'Maintaining Health focused on the themes of health promotion, health education, professional attitudes, retirement and involvement. The Years Ahead stressed the importance of enabling older people to participate in social activities in its discussions around three of these themes - health promotion, retirement and involvement. It pointed out that health promotion policies aim, amongst others, to add life to years by enabling as many persons as possible to remain healthy and active and argued that a successful health promotion policy would, amongst others, increase the number of people who are healthy and active. The report suggested, however, that, given the unnecessarily high proportion of older people in long-stay institutions for social reasons, there was room for improvement in this regard (Working Party on Services for the Elderly, 1988). The Years Ahead noted that pre-retirement courses can emphasise the scope for new kinds of social participation for retired persons (Working Party on Services for the Elderly, 1988: 60). It stressed that it is important to 'make every effort to develop a social, cultural and economic milieu in which older people can participate and contribute effectively', but argued that this would require some attitudinal change on the part of older people and of society as a whole, along the lines advocated by the Vienna International Plan of Action on Ageing (Working Party on Services for the Elderly, 1988: 61).
In three other chapters, *The Years Ahead* also stressed the importance of enabling older people to participate in social activities and maintain social contact. In a chapter on housing, it recommended that sheltered or special housing should be designed in accordance with the belief that older people should be integrated with the community and in contact with younger people (Working Party on Services for the Elderly, 1988: 75). In a chapter on care in the community, it noted that a main purpose of day centres was to ‘promote social contact among the elderly and prevent loneliness’, by providing a meeting place for elderly people where they could socialise with contemporaries (Working Party on Services for the Elderly, 1988: 105-6). In a chapter on voluntary organisations, it noted the involvement of voluntary organisations in the provision of day centres, visitation and social contact and argued that their involvement should be
supported given the advantages, which included the view that day centres and other such services 'are more appropriately provided by volunteers than by statutory personnel' (Working Party on Services for the Elderly, 1988: 168). Although the idea that institutional care acts as a barrier to older people's participation in social and leisure activities, there is no mention in The Years Ahead of enabling older people living in institutions of any kind to participate in social activities and maintain social contact.

7.2.3 Official policy documents in the new millennium

The Study to Examine the Future Financing of Long-Term Care in Ireland undertaken by Mercer on behalf of the Department of Social and Family Affairs (Government of Ireland, 2002: 32) made a distinction between health care services (that is, paramedical services and medical services) and social care services. The primary focus of the study was on the financing of social care services. The report defined social care as including assistance with the instrumental activities of daily living or practical help and assistance with personal care. As I noted in Chapter 1 and again in this chapter, the definition of social care adopted for this thesis includes opportunities for social and leisure activities (Blackman, 2001). However, the financing of services offering such activities and other broader health and social care services such as assistance with transport fell outside the scope of the Study to Examine the Future Financing of Long-Term Care in Ireland.
In keeping with its terms of reference, the NESF report on *Care for Older People* (NESF, 2005: 2) ‘stressed the importance of older people’s full participation in economic, social and cultural life’. Valuing older people’s participation in society was adopted as a core theme of the report. The NESF report (2005: 11-13) noted that international policy (UN, 2002; WHO, 2002; and OECD, 2005) highlights active participation in society as a major determinant of quality of life for older people. The NESF report (2005: 23) argued that having ‘person-centred, holistic and integrated services’ is central to enabling older people’s participation in society, particularly for those who are cash poor or who may rely more than others on public social services to address their needs and who may not be in a position to access alternative services.

Older people’s participation in social activities and the importance of social interaction for older people were not major themes of the NESF report. However,
The NESF (2005: 43; 50) identified services that offer social activities and networks as one aspect of a person-centred approach, which it argued could improve quality of life and prevent or delay long-term care and help towards 'making living at home possible' for older people. In the report, the NESF (2005: 75) recommended the introduction as a priority of a unified and holistic assessment process of establishing older people's needs for services, which would involve, amongst other things, a comprehensive assessment of an individual's health, social care, housing and other needs. Given the report's emphasis on holistic services, this would presumably include an assessment of an older person's need for services that offer leisure and social activities.

In its brief discussion of social isolation, the NESF report (2005: 85) suggested that having a choice of activities to attend and the development of visiting and befriending schemes were amongst a range of measures to address social isolation, but stressed that such measures must take account of personal choice and preferences. The report used the Summerhill Active Retirement Group, Co. Meath, as an example of the value of community-based responses to counter isolation. While the NESF report (2005: 89) stressed that the majority of older people live active and independent lives, it emphasised the importance of 'active ageing for all, not just for those who are most active or independent'. Drawing on research from the UK and Ireland, the NESF report (2005: 97-9) promoting interdependence and healthy ageing for older people living in the community as well as those living in residential care settings.

25 The Summerhill Active Retirement Group was established in 1988 in the village of Summerhill, Co. Meath, in response to the lack of facilities available to many members of the older community. Its founder, Mary Nally, believed that lack of activities for and isolation of older people has negative health implications. The Group offers a wide range of activities and services, which it categorises under the following headings: day to day support for older people; opportunities for lifelong learning; enhancement of self expression; promotion of positive ageing, health and wellbeing; representation of older people; the contribution of older volunteers; and building links and breaking down barriers. For further details, see www.thirdage-ireland.com.
Active ageing should be encouraged for all older people: for those living in the community as well as those living in institutions; for healthy older people as well as those with a high level of care needs.

The majority of older people live active and independent lives.

A range of person-centred measures are needed to address isolation and encourage social engagement of older people.

Active participation in society is a major determinant of quality of life for older people.

Figure 7.4: NESF report on Care for Older People (2005): Logic behind discourse on ageing, care and opportunities for social engagement and participation in social activities.

As mentioned earlier, the Developmental Welfare State was concerned with social policy and welfare state development in Ireland generally and did not focus specifically on ageing-related care. However, there was one reference to older people and social interaction in The Developmental Welfare State (DWS). The report argued that because of changes in living arrangements in Ireland - smaller family sizes and smaller households, and a growing number of households in which a person aged 70 years or over is living alone, some of whom may need support to assist them to live independently - there may be a need for 'new types
of social interaction ... to be facilitated in neighbourhoods'. However, the report did not define what is meant by this other than to say that it would be additional to the kinds of social interaction traditionally generated across households by children for their ageing parents (NESC, 2005: 37).

The Developmental Welfare State (2005)

The decline in family support for older people state necessitates 'new types of social interaction' in the community

Figure 7.5: The Developmental Welfare State (NESC, 2005): Logic behind discourse on ageing, care and opportunities for social engagement and participation in social activities

The NESC made no explicit reference to older people’s participation in social activities. However, the NESC report (2005: 87) identified ways in which Irish society needs to collectively respond to emerging challenges that have been articulated by ‘neglected minorities and sub-groups of the population’ such as people with disabilities and older people. It argued that, amongst other changes, ‘a ... more holistic approach and much improved amenities are sought for and needed in every type of institution where individuals are the responsibility of the State’. This would include institutions providing care for older people (welfare homes for older people are specifically mentioned in the report). However, the report did not state if ‘improved amenities’ encompasses services and practices
aimed at improving older people’s participation in social activities in such State institutions.

7.2.4 Section summary

The analysis shows that the views of ageing fostered by the official policy documents on ageing-related care changed significantly between 1968 and 2005 (see Figure 7.6 below). The Care of the Aged Report emphasised the loss of social roles and inactivity is an inevitable part of the ageing process, that it is a problem, that new roles and activities must be found, and that this can be done through encouragement by para-medical professionals and voluntary organisations.

In comparison, the logic behind thinking about ageing, care and social activity was that older people are generally active, that activity is associated with healthy ageing, that older people should be enabled to participate in social and leisure activities. The report alluded to the barrier that negative attitudes towards older people play in preventing older people to be active. Although the report does not state it explicitly, a message of the report is that living in the community enhances opportunities for participation in social and leisure activities. The corollary of this is that institutional care acts as a barrier to older people’s participation in social and leisure activities.

Similarly to The Years Ahead (1988), the NESF Report on Care for Older People (2005) reiterated that the majority of older people live independent and active lives. It stressed that activity is a major determinant of quality of life and that a range of person-centred measures are address social isolation and encourage social engagement of older people. A finding that marks the NESF Report as different from The Years Ahead is that the former emphasised active ageing for all older people, for those living in the community as well as those living in institutions; for healthy older people as well as those with a high level of care needs.
Influencing factors embedded in Discourse of ageing drawing on 'role theory' and 'activity theory': Incorporates medical/professional discourse.

Institutionalisation embedded in Policy and practices.

Care of the Aged Report (1968)

The Years Ahead Report (1988)

NFS report on Care for Older People (2005)

Influencing factors embedded in Discourse of ageing drawing primarily on notions of 'healthy ageing' and 'active ageing' for 'young-old'

Institutionalisation embedded in Policy and practices.

Figure 7.6: Model of change in prominent discourses on ageing, care and activity embedded in official policy documents on ageing-related care between 1968 and 2005.
It would seem that often changes in thinking about ageing, care and opportunities for social engagement and participation in social activities that can be found embedded in official policy documents on ageing-related care are closely connected to changes in thinking about ageing that are central to the social theories and concepts of ageing articulated by social scientists and social gerontologists. In other words, official policy documents on ageing-related care may often reflect prevalent social theories of ageing. It would seem that the older people’s interest groups and international discourse are sources of the prominent discourses that policymakers drawn upon in preparing official policy documents. However, sometimes ideas about ageing, care and social activity in official policy documents can be based on assumptions about what constitutes the key areas of concern in relation to social care and assumptions about the family. These points are developed further in the conclusion to this chapter. The next section of this chapter addresses the ways in which policymakers talk about ageing, care and social activity.

7.3 POLICYMAKERS

This section presents the findings in relation to the theme of ageing, care and opportunities for social interaction and participation in social activities based on the analysis of the transcripts of interviews with 14 policymakers (that is, politicians and senior civil and public servants) with a responsibility or a particular interest in the area of ageing-related care in Ireland.

Respondents expressed the view that the majority of older people live active and independent lives and, moreover, that ‘older people like to get together [for] social activities’ such as dancing, cards, exercises and T’ai Chi. Respondents correlated high levels of engagement by older people in social and leisure activities with a higher quality of life.

Respondents were all in favour of services or schemes that encouraged older people’s participation in social and leisure activities, which they argued was much easier to do in groups than as an individual. While one policymaker recommended that: ‘anything that keeps people going ... should be promoted’, others identified specific areas for development such as improved access to
computers, internet facilities and broadband as a means of encouraging social interaction for older people. Some policymakers highlighted day care centres as an example of 'what works well'. As one policymaker put it:

... it's more than just bringing somebody into a day care centre and giving them their medication, there is food, there is activities, there is exercises, there is all these kinds of things which we do consider to be part of a broader care continuum than just medical (Policymaker, 011).

However, a major theme to emerge from the interviews with policymakers on this issue was that ageing-related care policy and practices in Ireland create barriers to social engagement and participation in social and leisure activities for older people living in the community. Many of the respondents suggested that, in policy relating to the provision of care for older people living in the community, opportunities for participation in social activities received little attention in comparison to the emphasis placed on health care and personal care and practical help.

One of the findings of the analysis of the official policy documents in the new millennium was that no or relatively little attention was paid to the issue of older people's social engagement or opportunities for participation in social activities. Although it was mentioned, it was not a major theme of the Care for Older People report (NESF, 2005). An assumption underpinning the Study to Examine the Future Financing of LTC in Ireland (Government of Ireland, 2002) was that this was not central to the debate on the future financing of care for older people. Yet, the issue of financing of this aspect of care for older people was raised by a small number of policymakers participating in interviews.

A few respondents argued that there are the financial barriers facing older people seeking to access social and leisure activities, which need to be addressed. Respondents pointed out that funding is available for community based social and leisure activities for older people from a range of sources including the National Lottery Fund,26 Dormant Accounts Fund,27 local authority grants28, and Dublin Bus

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26 Under the National Lottery Fund, funds generated by the National Lottery are allocated to projects in the areas of Youth, Sports and Amenities; Health and Welfare; Arts, Culture and National Heritage; and the Irish language. For further details, see http://www.lotto.ie/en/Good-Causes/Money-Donated.
27 Legislation on dormant accounts (that is, Dormant Accounts Act 2001, the Unclaimed Life Assurance Policies Act, 2003 and the Dormant Accounts (Amendment) Act 2005) provides for a scheme for the disbursement of funds that are unlikely to be reclaimed for projects and programmes designed to alleviate poverty and social deprivation. The Dormant Accounts legislation targets three
Community Support Programme\(^ {29}\) (Policymakers, 001). However, the impression particularly of one civil and public servant was that it is not easy to make a case to the HSE to get funding for older people to participate in social and leisure activities. Furthermore, a few respondents argued that the system of financing home care in Ireland did not facilitate older people’s social engagement and participation in social activities. One respondent pointed out that some older people might prefer to have financial support to enable them to engage in social and leisure activities outside the home rather than having a home help. This respondent then went on to argue that a problem with Ireland’s home care grant scheme\(^ {30}\) is that, unlike other countries, ‘you certainly won’t get funding to engage in social activities’ (Policymaker, 012) and suggested that more flexibility could be built into home care grants to give older people living in the community the choice to use the funding to facilitate their engagement in social activities, if they so wished.

One respondent highlighted the transport barriers facing older people seeking to access social and leisure activities, arguing that some older people faced barriers arising from poor public transport services, especially in rural areas, which needs to be addressed:

\[
\text{it’s all very fine to come along and say … everyone over 66 has a bus pass}^{31} \ldots \text{when there is no transport and they are confined to the rural areas of north County Dublin … or [other parts of] the country and to get people to link in with each other and … participate in leisure activities generally you need to bring people in} (\text{Policymaker, 007})
\]

This respondent recommended that a scheme be put in place in the form of a taxi service or mini-bus service to enable older people to travel to participate in social and leisure activities and avail of social services.

\(^{29}\) Home care grant scheme – Ireland’s cash-for-care programmes offering cash payments instead of services-in-kind to (older) people.

\(^{30}\) The Dublin Bus Community Support Programme was launched in December 2003. Under the programme, Dublin Bus awards small grants to local charities and voluntary groups working with children, sport, people with disabilities, the elderly, and substance abusers or environmental projects based across the Dublin Bus service network. The grants in the amounts of €5,000, €2,000, and €1,000 are funded from long-term unclaimed change receipts. For further details, see http://www.dublinbus.ie/en/About-Us/Community-Events/Community-Support-Programme/

\(^{31}\) Everyone aged 66 and over living permanently in Ireland is entitled to the free travel scheme under which free travel is available on all State public transport (bus, rail and Dublin’s LUAS service) and on a limited number of services that are operated by private bus transport companies. For further details, see

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\(^{238}\)
One respondent suggested that the state should 'be open more' to projects such as the 'excellent' Summerhill Active Retirement Group in Co. Meath, which 'support [older people] in various ways to do the things they want to do rather than have them pulling from the system all the time' (Policymaker, 013). This respondent suggested that projects such as this contribute to a positive outlook among older people and highlight the contribution that older people can and do make to society. As a result, he conjectured that older people would more likely be perceived 'as a resource rather than a problem', which would help to promote a more positive image of older people.

Respondents pointed out that nowadays older people living in the community are more likely to be living alone. One of the respondents conjectured that some older people do not have strong social supports available to them, especially those whose children have moved away and spouse or partner has died, and that this can become a problem particularly when they do not have strong bonds with their local community. Although he believed that 'it's very hard then to get those people involved with day centres or active retirement groups and basically to partake in society' (Policymaker, 005), he argued that it is important for the state to encourage social and leisure activities for these older people. This idea is similar to the point raised in The Developmental Welfare State, as outlined in the preceding section, that decline in family support for older people state necessitates 'new types of social interaction' in the community.

Respondents also expressed views about opportunities for social engagement and participation in social activities of older people in nursing homes. They agreed that older people residing in nursing homes should be encouraged and enabled to be socially engaged. They stressed the importance of providing stimulus for older people and alerting older people to the world around them in order to provide residents of nursing homes, whether public or private, with a high quality of life. They spoke about giving older people in nursing homes a good life, affirming their worth and importance as a person and bringing out the best in them, and taking an holistic approach to care for older people in nursing homes:

However, one civil/public servant suggested that a commonly held perception of nursing home care is that as a resident 'you’re waiting for your next meal or death and there’s really nothing in between' (Policymaker, 012). This was a view held by many of the respondents. Some of the politicians participating in interviews
believed that the atmosphere in some nursing homes can be very depressing and 'you often have people staring into space' (Policymaker, 004). However, respondents claimed that a nursing home isn't or shouldn't be a place where you go to die and strongly rebuked the alleged practice in some nursing homes where older people are taken from 'the bed to the table to the chair and to the bed again' (Policymaker, 001). As one politician put it:

... there is nothing so appalling [as] some older people in nursing homes ... taken out of their beds at 8 o'clock in the morning ... put in a chair and they are there for most of the day and they get their lunch and ... they are there until the end of the day and that is scandalous ... (Policymaker, 007).

One of the respondents was of the view that passivity in nursing homes was related to the idea of a nursing home as a hospital rather than a home. However, respondents were just as likely to relate passivity to the prevalence in Irish society (including amongst older people) of ageist assumptions about, stereotypes of and negative attitudes towards ageing and older people, especially those with high levels of care needs. For example, one respondent suggested that there is an assumption in our society that if you are in a nursing home 'you’re probably gaga', so you don’t need anything (Policymaker, 011). One respondent suspected that images portrayed by the media of older people in nursing homes as completely debilitated contributed to negative stereotypes. Respondents refuted such negative stereotypes arguing that older people 'still have a life even if they have a dependency and they are frail'.

However, a common view to emerge from interviews with policymakers was that in nursing homes there is too much emphasis on medical and nursing care as opposed to social care. Many of the respondents suggested that care of older people in nursing homes is driven by a medical model, with an emphasis on 'pressure sores or physical care' (Policymaker, 001):

I think it is absolutely a medical model that we work to ... our entire residential care is driven by nursing and physical care and nurses will admit that themselves ... most of the practices we have in residential care come from the acute services, most of the staff in residential care worked in the acute sector so they come through that model ... (Policymaker, 012)

In particular, policymakers considered that nurses tend to adopt a medical model approach to the care of older people in nursing homes by focusing on the physical
Respondents stressed the importance of meeting not only the health but also the social care needs of residents in nursing homes, but many believed that the balance was wrong.

[Health care] is an essential part [of nursing home care]. It has to be met but, I mean, social care that is your life ... This is about where you live so things like people rather than fitting into how the institution runs ... there has to be push at all times to let people have a good life, not be in a waiting room for death (Policymaker, 014).

... if you only look at your physical care it is a pretty awful life to have so there is a huge problem in trying to acknowledge that social and psychological side of care as well as the medical side but I think that people genuinely accept that it is a problem but they just can't see a way out of it (Policymaker, 002).

Respondents suggested that where staff comprises a high proportion of nurses, it is more difficult to promote a social model of care. As one respondent stated: 'the nurse[s] ... will do their best but they will be very focused on the physical stuff and the health and safety stuff and the risk stuff as opposed to the wider pieces' (Policymaker, 012). To address this, the policymaker promoted the idea of a broker or an advocate who would help an older person to access social and leisure activities, amongst other things. This respondent also alluded to the culture of care in nursing homes, 'nurses will say the problem is they are too busy giving the physical care and haven't time to do that [social] piece' (Policymaker, 012). Many of the policymakers believed that proper health care is critical to a good life but there is a danger that if a medical model is adopted the social aspect gets completely lost, which can have a detrimental affect on human quality of life issues for older people.

One respondent suggested that a particular problem is the belief held by managers and staff in some nursing homes that 'a social model [of care] is inappropriate' because residents in their care were 'far too dependent' (Policymaker, 012). Respondents again reproved this belief, stressing that 'we have to find ways to ensure that [older people with physical or mental disabilities] don't get excluded' (Policymaker, 002) and that they can still participate.

Two respondents held a strongly alternative view. A politician suggested that there is a need to 'tilt the balance' more towards medical care so as to 'lead to
better ageing or healthier ageing and ... to delay dependency for as long as possible' (Policymaker, 005). Another respondent expressed a concern that the medical care of older people in nursing homes was not always adequate, especially in the private sector:

... I do have this concern that [while] ... they do have medical officers available in an awful lot of the public long stay facilities, certainly in the private nursing home sector I don't see any great evidence of a medical input into the care of older people in nursing homes (Policymaker, 013).

A small number of respondents highlighted problems with the geographical location of some nursing homes, which could have a bearing on opportunities for residents to engage in social and leisure activities. As one policymaker speaking about private nursing homes stated: 'they have ... been built on the outskirts of Dublin and people can't get to them and you are disconnecting people from their communities’ (Policymaker, 012). They recommended that locating nursing homes near hospitals, churches, shopping facilities, town location would be helpful, and that this should be done in a planned way. These were the only time when talking about the theme of ageing and opportunities for social engagement and participation in social activities that any of the policymaker participating in interviews differentiated between public and private sector nursing home care.

Many of the respondents argued that not doing anything at all, in other words, fostering passivity, in nursing homes was perhaps an 'easy option' (Policymaker, 006), but totally unacceptable. Respondents informed me that ensuring that supporting older people in nursing homes to continue to live a good life is one of the biggest challenges facing policymakers, as well as management and staff of nursing home. Respondents in general considered that 'people genuinely try very hard to introduce the social element'. However, they added that it can be challenging to implement a social model of care 'in a way that is not tokenism' and difficult 'to find innovative ways to stimulate older people'. As one policymaker put it:

... it requires great creativity and innovation and a greater sense of community from the outside being involved, visitations from all age groups, schools should be integrated into that policy of each nursing unit, residential care area so that people are conscious of being members of a community and are not living in isolation in a bedroom for most of the day without good social interaction (Policymaker, 006).
In addition to measures already referred to above, respondents suggested a range of other ways to promote engagement of older people residing in nursing homes in social activities. Some offered examples of the kinds of activities that could be offered such as pet therapy and plant therapy. Others believed that social participation and engagement was likely to come about as people’s perceptions of older people became more positive:

... the more older people are seen as a valuable resource rather than a resource gobbling kind of group, the more we have a chance of overall society’s perception of older people changing and becoming more positive and then the more positive the treatment of older people will be ...
(Policymaker 011)

Amongst some respondents there was a sense that ‘things are changing’ and ‘getting better’. Some suggested that already in many nursing home ‘lots of great work goes on ... art therapy, all kinds of therapies, all the other activities that people like ...’ (Policymaker, 006). Civil and public servants in particular were of the opinion that the HSE is ‘genuinely trying to change the whole model of residential care to a resident directed model of care ...’ (Policymaker, 012) and that a new ethos is now emerging. They gave the example of the existence of resident councils in nursing homes around the country. They spoke about exploring a range of different models and asserted that there are models that show that you can give lots of options and choices to people in residential care. They spoke about drawing on best practice from other countries such as Scotland with a view to having meaningful residents’ councils/committees in every nursing home in Ireland. They informed me that the HSE is ‘actively looking at the whole cultural underpinnings’ and organisation of nursing home care, ‘even for high dependency people’. Although they saw this as a huge challenge particularly for professional staff ‘who are used to making decisions on behalf of [older] people’, they believed that having such a policy in place meant that the message to older people is that ‘even at a very vulnerable, very dependent level, you still have a right to make decisions about your own life’. One respondent suggested that research work on the social aspects of care and quality of life for older people in care that has recently been undertaken in Ireland was another indication of changes for the better. However, there was the view that a lot more research was needed in this area. Respondents welcomed plans to introduce new nursing home standards and reform the inspection system, which they believed would be
better equipped than the previous system for addressing 'the human quality of life issues' that face older people in both public and private nursing homes.

...talking to people, asking them what their life is like, observing, sitting with them ... seeing what a day looks like and ... skilful interviews to elicit views [as some] older people ... especially when they are living in a care home can be loathe to complain ...(Policymaker 014).

Respondents were generally of the view that the state, through, for example, the Department of Health and Children and the HSE, has an obligation to ensure that nursing homes actively encourage residents of nursing homes to interact and participate in social and leisure activities. However, there were differing opinions about the costs of doing so. While some believed that such an approach would not be cheap, others believed that it would not necessarily cost money to reform care provision.

I think as the more positive view of older people and ... the social contribution that older people can make becomes more evident I think that whole funding dynamic and the defensiveness there is about it will change (Policymaker, 011).

7.3.1 Section Summary

The core themes to emerge from the interviews with policymakers in relation to the issue of ageing, care and opportunities for social engagement and participation in social activities were active ageing, the state's role in facilitating active ageing, and barriers to active ageing created by policies and practices. However, although being active was seen an important aspect of older people's lives, respondents also spoke about the importance of giving older people in nursing homes a good life, affirning their worth and importance as a person and bringing out the best in them. This was especially the case when policymakers were talking about older people in residential care settings and was about social connectedness more so than simply being active. In particular, respondents were critical of the medical model of care that many believed underpinned nursing home care in Ireland, which they argued was a barrier to older people's participation in social activities and their social connectedness. Instead, they advocated a social model of care. Between them, the respondents pointed to a range of policies and practices that create barriers to the social integration of older people in the Irish context (see Figure 7. below).
Figure 7.7: Policies and practices that create barriers to social integration of older people (from policymakers' perspective)

- Lack of attention compared to health care, personal care and practical help
- Financial barriers
- Transport barriers, particularly for those in rural areas but also some built-up areas
- System of financing home care
- Negative and ageist attitudes towards older people
- Decline in family support for older people
- Practices in some nursing homes that encouraged passivity
- Negative attitudes towards older people with disabilities and high levels of care needs
- Assumptions about nursing homes residents
- Media images of nursing home residents
- Inadequate medical care of older people
- Geographical location of some nursing homes
- Too little research
- Culture of care in nursing homes
- Inadequate nursing home standards and inspection process

A comparison of the discourses of policymakers and those embedded in official policy documents on ageing-related care shows that the views of policymakers conform to a considerable extent to discourses embedded in the NESF (2005) Report on Care for Older People.

Policymakers, however, had differing views on the cost of strategies to increase opportunities for social engagement and participation in social activities and how much progress was being made in this regard.

7.4 OLDER PEOPLE

The findings in this section are related to older people’s views on ageing and opportunities for social interaction and participation in social activities. The findings are based on an analysis of transcripts of focus groups with a total of 41 older people drawn from six existing groups, as explained in Chapter 4.
As mentioned at the beginning of this chapter, the overwhelming view that came across from the older people participating in the five community based focus groups was that being socially active and interacting with others was positive and enhanced their lives. Over and over again, I found that participants in the community based focus groups described their involvement in the various social groupings and activities as ‘great’, ‘marvellous’ and ‘enjoyable’. Through their involvement in the various social groups, the participants participated in a wide range of hobbies and leisure activities including games such as bingo and bridge, dancing and singing, arts and crafts including flower making, knitting, crochet and painting, educational activities such as computer classes, indoor sports such as table tennis, snooker, bowling and other physical activities such as exercise classes, and special interests such as creative writing and poetry writing and more social activities such as social evenings and coffee mornings. They also participated in social outings, day trips, Sunday lunches, and holidays organised through the social groups. The community based focus group participants stressed that leisure activities were important because they enabled them to be and keep active and stimulated for as long as possible.

Keeping active was only one of the positive aspects of participants’ involvement in the social groups. Socialising and sharing interests with other people were other important aspects of involvement in social groups. The participants enjoyed interacting with people ‘roughly’ their own age. They emphasised the importance of social relationships, which included having company, having friendships and having someone to talk to. They spoke about how they liked having the ‘craic’ and hearing people laugh as well as being able to give out and grumble and having other people act as a ‘sounding board’ for them. Leisure activities involved engagement in the wider society and the wider world. Participants spoke of how they enjoyed ‘hearing snippets of news’ and ‘keeping in touch with the 21st century’. Participating in social and leisure activities was also used by some participants as a strategy for avoiding isolation. Two different participants in one focus group explained it as follows ‘it’s having an outlet. It gets me out of the house, anyway’ (Participant, Focus group 06) and ‘I come down to be a part of the world outside of the four walls of my house’ (Participant, Focus group 06).

Another positive aspect that participants spoke about regarding involvement in both the formal and informal social groups was the strong ethos of helping and
caring that underpinned the groups to which they belonged. Participants cared for and helped each other out in many different ways including helping each other in practical ways and giving emotional support. This coincides with Gallagher's (2008) research on older people living in two communities in Ireland. In addition, participants spoke about the importance of feeling and being cared for in a group. Some of the participants used the terms 'community' or 'family' to describe the group to which they belonged. For example, in one focus group, participants stressed that even if you have no family around 'once you are in a community like this there is always ... someone [to] come to you' (Participant, Focus group, 03, informal group of older women, wealthy Dublin suburb). A participant in another focus group spoke about how she had 'stepped into this family and I feel very much part of a family and I like the support around' (Participant, Focus group, 05, Seniors poetry group, Dublin city).

In both the formally and informally organised community based groups, older people had the opportunity, if they so wished, to get involved in deciding upon and organising the activities that interested members of the group. They often drew on the interest and skills of members of the groups as a means of providing the activities. During the focus groups with older people, participants informed me about the involvement of the group in voluntary work, charitable work, community work and research on the local community. The commitment that individuals in the group gave to teaching and imparting knowledge was also notable.

In one of the focus group, there was a discussion about the reluctance on the part of older people to participate in social groups. One of the participants expressed pity for older people living in the community who did not engage in social and leisure activities:

there are a lot of we'll say proud [older] people living on their own that wouldn't want to ... come into the group. Like we've gone around and ... they'll come once or twice but they won't come again because 'ah, I don't want to go, I'd rather stay in me own house' and it's sad really because they don't have anyone (Participant, Focus group 02, meals service, inner city Dublin).

While others agreed, one participant gave a different explanation:

Well ... they're happy in their own house and with their own company and then there are others who don't know that there is anything on and they
are delighted to come out (Participant, Focus group 02, meals service, inner city Dublin)

Gallagher (2008: 206), in her study of older people living in the community in Ireland, found that some older people described as unconnected present a sufficient and positive outlook despite their disinterest in social engagement and participation in social activity. However, Gallagher (2008: 272) also found that there were other older people living in the community who were restricted from participating in social groups due to poor health.

A key theme to emerge from three of the five focus groups with older people living in the community was the negative association of institutional or nursing home care for older people with lack of social activities.

The food is alright. Maybe the accommodation, but [the residents] are like zombies because there is no such a thing as occupational therapy provided and that's a terrible thing (Participant, Focus group 06, active retirement group, suburban Dublin).

This perspective is akin to Townsend's (1981) concept of 'structured dependency'. Focus group participants stressed that the majority of older people living in nursing homes were intelligent people. However, they suggested that often social activities that were available in nursing home served to infantilise them. Participants gave examples of infantilising activities, including the following practice:

I think there are treated like children ... I've been in there and they give them little books to draw that you would give a four or five year old, painting which ... for an older person's intelligence I think it is bringing them down to their childhood (Participant, Focus group 06, active retirement group, suburban Dublin)

Participants were under the impression that staff in nursing homes were usually too busy and always appeared to be in a hurry, with little time to engage meaningfully with residents. They complained that older people in nursing homes in Ireland, as one participant put it, 'are let sit, sit, sit', 'twiddling their thumbs' with nothing to do. Some of the participants in the community based focus groups suggested that one of the problems contributing to passivity among residents in nursing homes was a lack of staff, while others argued that they had seen plenty of staff but suggested that 'the staff aren't doing anything':

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The nursing staff get through the day as easily as possible, that’s my reading on it having visited ... now this sounds like a blanket sort of condemnation and it’s not meant like that because I’m sure within various staff there are very dedicated people but certainly on the whole ... they stick to a rigid routine and there’s no cognisant taken of each individual person and their needs (Participant, Focus group, 05, Seniors poetry group, Dublin city).

They also suggested that in nursing homes older people can be belittled by the staff:

> You’re patronising them. Pat you on the head ‘You’ll be grand there now’. Four hours later, you know, ‘You’ll be grand there now. Would you like a bikkie?’ (Participant, Focus group 06, active retirement group, suburban Dublin)

In one of the focus groups, participants were particularly critical of the provision of activities in nursing homes that did not take account of the personal choice and preferences of residents. They suggested that staff values were imposed on residents:

> ... all the women were made up and had their nails done, which some of them might of loved and really enjoyed and felt pampered, others of them didn’t ... just being treated on bloc by the staff perceptions of what would be ... a jolly way to pass the morning (Participant, Focus group 05, Seniors poetry group, Dublin city)

This follows the view of the NESF report on Care for Older People (2005) that older people’s choices and preferences should be taken into account when social activities measures are being developed and was a point raised by Murphy et al. (2006) in their study on quality of life of older people in residential care settings.

> Older people have a lot of talents and I think their talents should be brought out because if they show their talents it would make them feel important (Participant, Focus group, 06, active retirement group, Dublin).

Despite constructing nursing home care negatively with regard to social activities and social interaction, some of the participants in the community based focus groups suggested that there are some very good nursing homes that organise lots of different activities and events and have regular outings for residents in the summertime. They argued that it was really important to provide stimulus for residents and made suggestions such as music, plant therapy, pet therapy, and teaching residents gardening. In addition, participants considered that having no
restrictions on visiting times and the locality of nursing homes to be important. In their view, providing nursing home accommodation in close proximity to where the older person had lived enabled them to maintain contact with friends and neighbours. Participants in the community based focus groups were of the view that there were fewer opportunities for older people living in residential care settings in Ireland to engage in social and leisure activities than in many other countries including France, Poland, the USA and Canada, which the participants had either visited or had heard about through family and friends who had emigrated.

My analysis of the focus group data shows that with regard to involvement in leisure activities and hobbies, the picture presented by participants of the focus group based in a residential care setting was remarkably different from participants of the three community based focus groups discussed above. There were a limited range of activities available to focus group participants based in the residential care setting. Although the participants spoke about liking the activities - bingo, arts and ‘occupational therapy’ - that were available to them, a major ‘gripe’ was there was not enough social activities or that they were offered too infrequently leading to boredom. As one participant explained:

I still am *compos mentis* and I would like much more activity. Now, I have been doing painting ... every Wednesday, but ... the last painting I did was last week and I won’t be doing any more [for another month] ... which means I have nothing to do on a Wednesday and the weekends are literally boring except we might have a little bit of bingo on a Sunday ...

( Participant, Focus group 01, Patient advocacy group, residential care setting)

This coincides with the findings of a study by Murphy *et al.* (2006: 169), in which some participants in residential care reported that few recreational activities were provided for them and that the days were long and dull. The participants of the focus groups for this thesis pointed out that they rarely went on social outings, which they enjoyed. During the focus group discussion, it became apparent that activities such as bingo were not available to all residents:

That’s the first I heard of the bingo ... we don’t have anything like that in my suite (Participant, Focus group 01, Patient advocacy group, residential care setting)
This raises the question of whether opportunities for social and leisure activities are offered to all residents of nursing homes, including those with greater levels of physical and mental impairment. Unlike the participants in the community based focus groups who got to know each other very well and did things with and for each other, participants in the focus group based in the residential care setting seemed to be very much dependent on staff for social activities and social interaction. Whereas the participants in the community-based focus groups had been involved or at least had the opportunity to get involved if they so wished in developing and organising activities for the group, the participants in the residential care setting spoke about occupational therapy, bingo and arts as 'the things they [the staff] do for you'. While the participants praised the staff, describing them as 'good' and 'helpful', they pointed out that the staff had little time for doing things with them, which meant that they were left with nothing to do much of the time:

I love a game of scrabble and I only get one when [a staff member] in the kitchen is free and that's not too often, things like that (Participant, Focus group, 01, Patient advocacy group, residential care setting).

Murphy et al. (2006: 169) too found that some of their study participants in residential care suggested that staff were busy and had little time to organise activities. In this thesis, participants in the community based focus groups suggested that having someone to talk to is highly important. However, my analysis of the focus group data found that participants in focus groups based in a residential care setting expressed disappointment that there were few opportunities to engage with the staff in more informal ways:

They don't really listen to you that much ... They don't have the time to sit down and talk to you, you know (Participant, Focus group 01, Patient advocacy group, residential care setting)

7.4.1 Section summary

The core theme to emerge in relation to the theme of ageing, care and opportunities for social engagement and participation in social and leisure activities is the marked difference between older people participating in the community based focus groups and those participating in the institutional-based focus group. The remarkably different perspectives of these two groups suggests
that the 'social worlds' or settings in which they lived, in the community, on one
hand, and in residential care, on the other, had a huge influence on their
opportunities for social engagement and participation in social activities. The view
of ageing fostered by the participants in the community based focus groups was
based on active and productive ageing but also on the notions of social
connection and solidarity. In stark contrast, the view of ageing fostered by
participants in the focus group based in a residential care setting was one of
structured passivity and structured unconnectedness. This resonates with the
view that participants in the community based focus groups had of ageing in a
residential care setting. These participants believed that barriers to meaningful
social engagement and participation in social activities facing older people were
created by care policies and practices in nursing homes, and, therefore, could be
changed (see Figure 7.8). Participants gave examples of what they considered to
be good practice in this regard.

Figure 7.8: Policies and practices that create barriers to social integration
of older people (from perspective of older people)

- Transport barriers in rural areas
- Reluctance of some older people to engage with groups
- Infantilising practices/activities for older people in nursing homes
- Lack of opportunities for meaningful engagement in nursing homes
- Practices in some nursing homes that encouraged passivity
- Account not taken of personal choice and preferences of residents
- Imposition of staff values on older people residing in nursing homes
- Geographical location of some nursing homes
- Nursing and care staff too busy

7.5 MEDIATISED DISCOURSE OF POLICYMAKERS AND OLDER PEOPLE

As Chapter 4 pointed out that, based on a search (following the steps outlined in
Chapter 4, Section 4.3.4) of each day's edition of The Irish Times issued in 2006,
seven news items addressed or mentioned the issue of ageing, care and
opportunities for social engagement and participation in social activities.
Table 7.1: News items in *The Irish Times* (2006) relating to ageing, care and opportunities for social engagement and participation in social activities by author type (n)

<table>
<thead>
<tr>
<th>Author of news item</th>
<th>No. of news items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correspondent at The Irish Times</td>
<td>5</td>
</tr>
<tr>
<td>Editor of The Irish Times</td>
<td>1</td>
</tr>
<tr>
<td>Representative of national organisation of older people</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>

Table 7.1 above shows that these news items had been written by either a correspondent at the newspaper, the editor of the newspaper or a representative of a national organisation of older people. The opinions of older people were cited in two of the five news items written by correspondents at The Irish Times. The opinions of policymakers (a Minister and a senior public servant, both with a responsibility in the area of ageing-related care) were cited in two of the five news items (see Appendix E).

The first of the two news items citing an older person was about complementary therapies and practices in day and residential care settings for older people. The message of the news item was that creativity amongst older people attending day centres and residing in residential care settings is enhanced by art, music and reminiscence therapy, while complementary practices such as T'ai chi, reflexology, aromatherapy, hand and foot massage and yoga are life-affirming and life-enhancing. The views of the older person who was cited in the news items supported this message. The views of a T'ai chi instructor were also cited.

The second was a news item about the opening launch of a nursing care facility catering for adults, which drew on the idea of a 'real' village, where 'people live full, vibrant lives with the support of the community'. This news item pointed out that the 'state-of-the art' nursing home centre included residential care and day care facilities that offer various social activities ranging from chess and bridge lessons to pottery classes as well as other services that might be found in a village such as a cinema. The resident who was staying at the nursing care centre for respite care was reported to 'appreciates space, quietness and privacy' and 'enjoys watching "pictures" in the cinema upstairs'. The resident was quoted as saying "There's company here, the other patients are very nice and the staff are lovely and friendly - they can't do enough for you. We are very well looked
after, we need for nothing. Visitors can come at any time, there are no visiting hours and they can book a meal in the restaurant." The Minister for Health who was launching the nursing care centre was quoted as saying: "I don't think you would get better facilities in a hotel, never mind a nursing home. I have never seen a nursing care facility as developed before in Ireland. This is the future of care for the elderly." The views of the founder and owner of the 'nursing care centre' and a senior chef working at the centre were also cited.

The views of older people were not sought in the other three news items written by correspondents at *The Irish Times*. However, two of the news items reported research that was based on the views of older people. One of these was reporting a study of the lives of older people in an inner city community. The other was reporting a study based on the views of older people in residential care settings that had been commissioned by the NCAOP and undertaken at the National University of Ireland, Galway. This study also prompted the editorial mentioned above. The third of these news items was a news report about a music programme for older people in residential and day care settings, based primarily on an evaluation report of the Music in Healthcare Programme. The main message of the article was that music workshops for older people in residential and day care settings have positive outcomes but are under-funded and overlooked. Although the news item didn’t include the voices of older people, the views of a Director of Services to Older People (Dublin/Midlands), a senior public servant with responsibility in the area of ageing-related care, was sought and was quoted as saying 'the project’s participative workshops have enhanced the quality of life of older people and also created a new phase of learning for the staff'. The views of the Chief Executive of Music Network, which operated the Music Programme, as well as a clinical nurse specialist, were also cited in this news item.

7.5.1 Section summary

The analysis of *The Irish Times* in relation to the theme of ageing, care and opportunities for social interaction and participation in social activities shows that this is a theme that receives very little coverage in the newspaper. In one year, only seven news items were found to have addressed or mentioned issues in relation to the theme. Although the views of only two older people were cited in these news items, both support the view that older people enjoy opportunities for
social engagement and participation in social and leisure activities and that this improved their quality of life. This was also the view of one of the policymakers who was cited in one of the news items. All seven of the news items were essentially making this point. The news item on the music programme, the news item complementary therapies and practices for older people in care settings, and the news item on the opening of the 'state-of-the art' nursing care centre appear to support the view of some of the policymakers participating in interviews for this thesis that some good work is going on. However, there was a suggestion in two news items analysed that issue of ageing, care and opportunities for social engagement and participation in social activities is overlooked, under-funded and there is a greater need for public investment in relation to community based services and those in residential care settings. Although this is based on a tiny sample, it nonetheless contests the assumption underpinning The Study to Examine the Future financing of Long-term Care in Ireland (2002) that providing opportunities for older people to participate in social and leisure activities in not central to the debate on the future financing of social care services.

7.6 CHAPTER CONCLUSIONS

This chapter explored the multiple discourses embedded in social policy and ageing-related care using ageing, care and opportunities for social engagement and participation in social activities as a lens through which to do this. The preceding four sections of this chapter presented the findings relating to this theme, based on an analysis of official policy documents on ageing-related care from 1968 to 2005, transcripts of interviews with policymakers, transcripts of focus groups with older people, and of news items in a national daily newspaper in 2006. This section draws together the main conclusions.

The most striking finding from the analysis of official policy documents on ageing-related care is that there were significant changes in discourse about older people's social engagement and participation in social activities between 1968 and 2005. The official policy documents fostered very different views of ageing. As noted in Chapter 3, a wide variety of social theories and concepts have been developed and used to view and provide insights into aspects of ageing. Concepts that are central to particular social theories of ageing can be identified in the official policy documents analysed.
The Care of the Aged Report (1968) associated ageing with dependency. It emphasised loss of social roles and inactivity of older people. The view of ageing fostered by the Care of the Aged Report draws on the concepts of social role, individual activity and individual adjustment. These concepts originated in the sociological literature of the 1940s (Lynott and Lynott, 1996) and are central in works such as Personal Adjustment in Old Age (Cavan et al., 1949) and Older People (Havighurst and Albrecht, 1953) that became known as role theory and activity theory. Role and activity theories suggest that inactivity is a normative pattern of behaviour for older people and is a problem for the individual because of its impact on social and psychological well-being. The response of the Care of the Aged Report to the problematisation of older people as unproductive and inactive was to prescribe a role for occupational therapists and voluntary organisations in encouraging older people either to continue to maintain their existing activities or to find new ones to replace the ones that they have lost and so overcome loss of social roles and inactivity. The Care of the Aged Report is, therefore, underpinned by a medical/professional discourse.

A completely different tone was evident in The Years Ahead, which recognised that the majority of older people are active, and emphasised healthy ageing and promoted active ageing. The report’s emphasis on policies aimed at maintaining health and promoting activity was clearly influenced by the UN Vienna International Plan on Ageing (UN, 1982). The view of ageing fostered in The Years Ahead is based on the theoretical position described as ‘successful ageing’, which has been defined as including three main components: low probability of disease and disease-related disability; high cognitive and physical functional capacity, and active engagement with life (Rowe and Kahn, 1997a; 1997b). The emphasis on ‘healthy ageing’ and ‘active ageing’ in The Years Ahead thus marks a move away from the view of older people portrayed in the Care of the Aged Report as roleless and inactive.

Whilst The Years Ahead addressed the issue of social interaction and participation in social activities for older people living in the community, it did not raise the issue in relation to older people living in residential care settings. It has been argued that successful ageing approaches divide the population of older people into the ‘young-old’ and ‘old-old’ (Featherstone and Hepworth, 1995) or what Moody (1991) has referred to as the ‘wellderly’ and the ‘illderly’. The silence on the issue of social interaction and participation in social activities for older
people in institutional care settings seems to suggest that *The Years Ahead* focused (albeit not intentionally) on the ‘young-old’, that is, older people for whom successful ageing is most likely. A consequence of this might be that the ‘old-old’, those older people for whom successful ageing (as defined by Rowe and Kahn, 1997a; 1997b) might be impossible (or at least more difficult) to achieve tend to be ignored. As Vincent (2003: 167) points out, differentiating between the ‘young-old’ and the ‘old-old’ does not overcome the problem of old age; ‘it merely postpones it’. One of the problems associated with the successful ageing discourse is that images of older people as healthy and active can at times be overly exaggerated and may not adequately reflect the reality of the day-to-day lives of many older people. A second problem is that while it promotes the image of old age as a period of health and activity, but fear and anxiety of and hostility towards ‘deep old age’, which is associated with decline, dependency and death, remains (Featherstone and Hepworth, 1995). Vincent (2003: 167) contends that focusing on biological failure in the ‘very old’ leads to a construction of ageing that ‘generates and prolongs its low esteem’. Moreover, there is also the possibility that people will be blamed for failing to age successfully and not continuing to lead fit and active lifestyles (Vincent, 2003). Vincent (2003) calls for a construction of ageing that values old age in all its diversity, including in its final state.

According to Estes et al. (2003: 67), ‘the debate over successful ageing goes to the heart of ageing studies ... because it suggests a means of countering negative stereotyping of older people and increasing their social inclusion’, but that it also raises questions about wider ideological structures. *The Years Ahead*, in contrast to the *Care of the Aged Report*, highlighted the problem of negative attitudes towards older people and how they can act as a barrier to older people’s participation in social and leisure activities. By raising this problem, the report inferred that there are wider ideological structures in Irish society that need to be address if older people are to be better integrated into society.

There are some notable differences between *The Years Ahead* and the NESF report on *Care for Older People*. First, whereas *The Years Ahead* promoted healthy ageing and active ageing, the NESF report on *Care for Older People* stressed the importance of older people’s participation in social activities as a major determinant of quality of life. Second, the NESF report on *Care for Older People* stressed the importance of taking account of older people’s personal
choice and preferences. Third, in contrast to *The Years Ahead*, which focused on community-based responses to promote active ageing, the NESF report on *Care for Older People* report adopted the idea of 'active ageing for all, not just for those who are most active or independent', thereby including older people with cognitive and physical impairments, and those living in residential care settings. In promoting 'active ageing for all', the report attempts to move away from associating the 'old-old' with frailty and inactivity. There are some interesting overlaps between the view of ageing fostered by the NESF report on *Care for Older People* and researchers such as Gallagher (2008), who has developed a 'model of connectedness' based on her study of older people living in the community in Ireland, and researchers affiliated to the Cornell Gerontology Research Institute who have discussed the implications of social integration, or its converse, social isolation, for health as well as the range of interventions including transportation, volunteering and peer support, through which future policy could seek to enhance integration through connectedness to others (Pillemer *et al.*, 2001).

Policymakers participating in interviews frequently adopted active ageing, healthy ageing and successful ageing discourses. Some of the policymakers invoked the notion of productive ageing and promoted strategies aimed at giving older people the choice to remain in the workplace for longer. Policymakers often tend to use these notions in a perfunctory way. However, when reflecting on how these notions of ageing account for older people with care needs, especially those in residential care settings, policymakers tend to modify their view. Between them policymakers highlighted the wide range of existing structural and ideological barriers that impede their social engagement and participation in social activities (see Figure 7.6) and there tended to be a consensus amongst policymakers that it is important to promote active ageing for all older people, but that social connectedness is also important including for those in need of care and that this needs be organised within a social model of care. This suggested a need to remind policymakers that older people are not one homogenous group, but are a diverse group of people with diverse circumstances and needs.

From the focus groups, the images of older people living in the community conflicted greatly with the images of older people living in residential care. While there was some criticism in the focus groups of older people living in the community who were reluctant to engage, the image generally was of busy, active
and productive older people who were socially connected and well-integrated into society. Their sources of activity were wide-ranging. A different image is portrayed of older people living in nursing homes as bored, inactive and much less connected than those living in the community. However, it must be remembered that Gallagher (2008) found poor health placed a restriction on older people living in the community from participating in social groups. Many of the participants in the community-based focus groups identified inactivity and passivity of older people in nursing homes as a particular problem. Similarly to the policymakers, they suggested that the cause of the problem did not lie with older people but with a range of structural and ideological barriers (see Figure 7.8), particularly for those living in residential care settings. In conclusion, these findings suggest that there is great imbalance between opportunities for social engagement and participation in social activities for older people living in the community when compared with those for older people living in residential care settings. Older people living in the community and older people living in residential care settings might be thought of as living in two very different ‘social worlds’ (Gubrium, 1975). While there was a tendency for older people participating in the focus groups to make generalisations about institutional care settings, some participants highlighted practices in nursing homes that promoted social and engagement and activity for older people.

To conclude, this chapter has highlighted that views of ageing based on notions of active ageing, healthy ageing and successful ageing are embedded in official policy documents on ageing-related care in Ireland. A focus on strategies that encourage the active engagement of older people in society is to be welcomed. However, policymakers and older people tend to be highly aware of the need to promote policies and practices that seek to break down structural and institutional barriers that impede older people’s opportunities for participation in social activities and that seek to enhance their social connectedness. Developing policies and practices that promote a social model of care (Oliver, 1990) and a model of connectedness (Gallagher 2008, Pillemer et al., 2000) for older people living in the community as well as for those living in residential care would go some way towards reaching this objective. Moreover, developing such policy and practices is not an optional extra but must be attended to in all social policies relevant to ageing and ageing-related care.
This chapter, therefore, shows that it is not only academics that engage in theorising about ageing, but that this is an activity of policymakers and older people. In other words, policymakers and older people engage in ‘everyday theorising’ (Gubrium and Wallace, 1990) about ageing.
CHAPTER EIGHT

CONCLUSIONS

8.1 INTRODUCTION

The purpose of this chapter is to provide an overall conclusion to the thesis, which explores social policy and ageing-related care in Ireland through the lens of social constructionism. In Section two, I consider the version of social constructionism that this thesis encompasses. In Section three, I offer some reflections on the methodology chapter. In Section four, I provide an analytical commentary on the findings. I discuss the conceptualisation of multiple discourses and consider how it relates to the idea of discourse. In Section five, I consider why the exploration of multiple discourses is interesting and potentially important and reflect on the implications of this idea for social policy and ageing-related care. Throughout the chapter I consider the empirical, methodological and theoretical strengths of this thesis as well as its weaknesses.

8.2 ADOPTING AND ADAPTING SOCIAL CONSTRUCTIONIST APPROACHES

Chapter 2 outlined three key approaches within social constructionism that have developed within social gerontology: the political economy of ageing perspective, Foucauldian gerontology, and micro social constructionist perspectives of ageing. I now turn to a consideration of the ways in which this thesis is influenced by and draws on concepts and ideas from each of these three perspectives. I consider what is distinctive about the version of social constructionism used in this thesis and how it extends social constructionist ideas on which I have drawn. I also reflect on the strengths and limitations of the social constructionist approach taken.
8.2.1 The political economy of ageing perspective

The political economy of ageing perspective, with its focus on the influence of the state and the economy on conditions of ageing, and, more specifically, the suggestion that the lives of older people and their experience of ageing as well as definitions of ageing are determined to a large extent by social policies, had a bearing on this thesis, particularly in the early days of doctoral work. It focused my attention on the role of social policies in the construction of concepts relating to care for older people. It also drew my attention to the way (at the macro level) that understandings of ageing and related concepts change over time within welfare systems. For example, Walker (1999) has reviewed how social constructions of ageing through social policy have shifted from regarding ageing as a social problem in the period from the 1940s to the 1970s and toward seeing it as an economic one from the mid-1970s to the late 1980s and as both an opportunity and a burden since the 1990s.

As I explained in Chapter 1, the Care of the Aged Report (Inter-departmental Committee on the Care of the Aged, 1968) constructed older people as a social problem for society. This Irish policy document is an example of the kinds of authoritative writings that have provided a focal point for scholars working within the political economy of ageing perspective. Thus, the use of official policy documents on ageing-related care in this thesis fits with a political economy of ageing perspective. The political economy of ageing perspective also draws attention to the relationship between power and social constructions of ageing (Estes et al, 2003). Scholars working within this perspective argue that some groups in society have the power to impose their particular constructions of reality on others such as older people through, for example, the agencies of the state (Walker, 1999). For example, Estes and Associates (2001) argue that policymakers and the media (as well as experts) have a disproportionate influence on the dominant definition of ageing. Thus, the political economy of ageing perspective played a part in focusing my attention in this thesis on policymakers and the media. Although the political economy of ageing perspective is an important approach within social constructionism, it focuses primarily on the macro level and has been criticised for overestimating the role that social policy plays in shaping constructions of ageing. In addition, it ignores how older people shape their own experiences outside of the policy domain (Powell and Longino, 2002). Because I was interested in questions of agency
and as I planned to include the voices of older people in the research, this thesis departed from the political economy of ageing perspective to draw on Foucault's work and to take inspiration from micro social constructionist perspectives, as explained below.

8.2.2 Inspirations from Foucauldian constructionism

Foucault has been described as a 'masked philosopher' because he deliberately sought to avoid being aligned with any particular school of thought (Powell, 2006: 90). But, as Miller (2008: 251) writes, 'anyone who knows anything about Foucault knows that he was a social constructionist'. This thesis draws on Foucault's version of constructionism in the following ways. It draws on one of the key assumptions of Foucault's work: that knowledge is profoundly historical. There is an emphasis in Foucault's work (similarly to the political economy of ageing perspective) on authoritative writings such as official policy documents, and these are one of the focal points of this thesis. The interdependence between power and knowledge is central to the work of Foucault. For Foucault, discourse stands as evidence of underlying power relationships. Focusing on discourse is a key way in which this thesis applies Foucault's ideas about power-knowledge. This thesis is inspired by Foucault's argument that the analysis of power must go beyond the state and by his emphasis on the micro politics of power. The question of agency is a perennial concern of scholars drawing on Foucault's work (Miller, 2008) and is a concern of this thesis. These points are discussed in more detail in the three subsections (8.2.3, 8.2.4 and 8.2.5) that follow.

8.2.3 Social policy and ageing-related care: a history through discourse

This thesis has taken up Foucault's assumption about history. As discussed in Chapter 3, Foucault was not interested in writing the comprehensive history of a period or an institution based on describing a series of facts and events and defining the relationship between them (Davidson, 1986; Hacking, 1989). He was more interested in providing a critique of mainstream or conventional approaches to history. Foucault's discursive analytical tools of 'archaeology' and 'genealogy' provide a methodology for analysing discourses embedded in policy documents. Foucault's 'box of tools' can be used to 'dig into the past' and 'excavate' discourses. In this thesis, this took the form of seeking out the
dominant discourses on (as well as paying attention to what is not said about) ageing-related care embedded in Irish official policy documents and shedding light on the ways in which these discourses have shifted between 1968 and 2005. The thesis used a grounded theory approach, which stems from symbolic interactionism (one of the intellectual traditions on which social constructionism was built), to excavate the discourses.

Foucault’s historical critique could have been used in this thesis to excavate a particular discourse embedded in ageing-related care policy documents, such as biomedical discourse, discourse of dependency or neoliberal discourse. However, one of the concerns that I had was that if the thesis focused on one particular discourse other discourses would be obscured. Hence, the approach taken was to adopt three discursive themes: family, care and ageing; ageing and formal care providers; and ageing, care and opportunities for social engagement and participation in social activities and to excavate all of the discourses around each of these three themes (I return to a discussion of ‘multiple discourses’ later in this chapter). By focusing on these three discursive themes, the thesis adheres to Foucault’s emphasis on the micro-physics of power. For Foucault, history is the best tool for challenging existing orders. The first part of the three findings chapters draws on Foucault’s historical critique to identify major discourses at particular points in recent social policy history and chart shifts in discourses in relation to three different discursive themes, thereby presenting a reordering of social policy and ageing-related care.

Official policy documents are one of the material traces left behind by a particular historical period and culture. However, there are limitations attached to using official policy documents on ageing-related care to excavate discourses. As mentioned in Chapter 4, relatively few official policy documents in the Irish context are concerned exclusively with ageing-related care policies in the past 35 years. There was a twenty-year gap between the publication of the Care of the Aged Report (Inter-Departmental Committee on the Care of the Aged, 1968) and The Years Ahead – A Policy for the Elderly (Working Party on Services for the Elderly, 1988), the two most significant official policy documents on ageing-related care in the Irish context. It was the new millennium before other important policy documents with relevance for ageing-related care were published. The gaps in time make it difficult at times to provide a detailed exploration of ‘ruptures’, to coin a phrase used by O’Brien and Penna (1998: 111), in discourses. For instance, in
relation to the provision of care services to older people in the community there was a shift away from the use of the term ‘commercial organisations’ in the Care of the Aged Report to the use of the term ‘private providers’ in official policy documents in the new millennium. However, it is not possible from an analysis of official policy documents to identify when this shift actually came about or say more about what it meant. Thus, the analysis of material traces other than official policy documents, for example, records of parliamentary debates, would help to provide a more detailed assessment of the emergence of new discourses.

Furthermore, while a Foucauldian methodological standpoint informs the analysis of official policy documents on ageing-related care in Ireland between 1968 and 2005, the historical context presented in Chapter 2 is largely descriptive and takes a very conventional approach to trace the development of ageing-related care in Ireland in the nineteenth century and in the first half of the twentieth century. The intention here was to provide readers unfamiliar with the development of ageing-related care policy in Ireland with some historical context. As Chapter 4 (page 64) points out, the thesis dataset excludes official policy documents concerned with ageing-related care that were published prior to 1968 and thus precludes a more historically oriented analysis using a Foucauldian approach. This is a limitation of this thesis.

Adopting a Foucauldian approach would represent an attempt to read the history of social policy and ageing-related care in Ireland from the beginning of the nineteenth century through discourses. Using Foucault’s work, Katz (1996) identified the Poor Law Reform Act of 1834 in Great Britain, a significant benchmark for the origins of institutionalised care for older people, as the beginning of the authoritative control in managing the masses of vagrants, homeless and the poor, many of whom were older people (Powell, 2006). As Ireland’s Poor Law was adapted from the New Poor Law in Britain, this work suggests that a Foucauldian approach could be used to trace the history of ageing-related care policy in Ireland through discourses of managerialism. However, to keep with the discursive themes of this thesis, it would be more fitting to adopt a Foucauldian approach and seek to reconstruct what, for example, ‘the family’ meant in the past and how it was used, in the context of policy relating to the care of older people. Reading the history of social policy and ageing-related care in Ireland is an area that warrants future research. However, there are few official policy documents concerning the care of older people from the nineteenth
and the first half of the twentieth century. For instance, the main policy
documents published during the first half of the twentieth century (all of which
focus primarily on institutional care) are the Commissions on Poor Law Reform in
1903 and 1909 (the recommendations of which were not implemented) and the
White Paper on the Reconstruction and Improvement of County Homes
(Department of Health, 1951). A Foucauldian 'archaeology'/genealogy of social
policy and age-related care during this period of history would, therefore, need
to be extended to material traces other than official policy documents.

One way in which Foucault's work on discourse and power relations is applied by
social gerontologists is to consider how discourse gets institutionalised in social
policies and in the practices of the institutions through which they work. Although
the three models of discourse continuity and change presented in Figures 5.5, 6.5
and 7.6 (Chapters 5, 6 and 7 respectively) suggest that the dominant discourses
embedded in official policy documents on age-related care between 1968 and
2005 may have become or may in the future become institutionalised in social
policy and practices, this thesis does not address the extent to which and the
processes by which discourse gets translated into policies and practices. While
this was beyond the scope of this doctoral work, it is one of the limitations of the
thesis.

8.2.4 The 'Expert' gaze of policymakers

In addition to his interest in the analysis of authoritative writings such as official
policy documents, Foucault was also interested in the analysis of the discourses
of experts, which have been referred to as 'serious speech acts' (Powell, 2006:
92). These are what experts say when they are speaking about a given issue
within a discipline of thought or practice. Social gerontologists have taken up
Foucault's insights to focus on the 'gaze' of the helping professions such as social
work, nursing and medicine and the intermeshing of care and power. One of the
ways in which this thesis extends the Foucauldian gaze is to draw attention to
discourses of policymakers and the expert gaze through which they view age-related
care issues. Another important way in which this thesis extends
Foucault's work is by exploring the complex interplay between dominant policy
discourses (as articulated through official policy documents) and the discourses of
policymakers. This led to the conceptualisation of the discourses of policymakers
as 'multiple discourse mixtures' (which will be discussed later in the chapter).
8.2.5 From subjugated knowledge and subjective experience of older people to older people’s agency

This thesis is informed by debates relating to Foucault’s discussion of subjugated knowledge. In conjunction with his interest in the discourses of powerful voices, Foucault was concerned about how human beings are made subjects (Millar, 2008). When they are made subjects, human beings are subjected, that is, they are constructed as objects of power. Social gerontologists have used Foucault’s work to explore how older people are made subjects or constructed as objects of power. For example, Katz (1996) and Green (1993) emphasise the disciplinary power of social policies to classify and regulate the experiences of older people.

Social constructionist approaches that emphasise Foucault’s concept of disciplinary power, which remains a ‘formidable’ conceptual tool for research, can be understood as a ‘top-down, totalizing and deterministic model of the relationship between discourse and the actor’ (Miller, 2008: 255-6). In other words, the actor or the subject is entirely constructed by discourse. This view presents dominant discourses as all-pervasive and a picture of older people with limited freedom or agency. This interpretation of Foucault’s constructionism implies a weak concept of older people as actors (Miller, 2008).

From the outset, I was interested in including an exploration of the discourses and agency of older people in this thesis. However, Foucault did not look at the narratives of individuals (Powell, 2006). This is one of the weaknesses of Foucault’s work. As Longino and Powell (2009: 386) put it, “[i]t is inadequate for gerontologists to view older people only as “objects”.” It is here that I turned to micro social constructionism for some insights. As Chapter 3 points out, hearing what older people have to say is a key concern of scholars for whom a central focus is the social construction of ageing at a micro level. This approach places an emphasis on older people’s subjective experience of ageing-related care and constructions of ageing-related care within interpersonal relationships. But, while this approach strives to give voice to older people, it does so at a micro level. As this thesis is concerned with what older people have to say, it is inspired by micro social constructionist perspectives. However, by purposely setting out to gain an understanding of how older people construe social policy and ageing-related care at the macro level, this thesis moves beyond micro social constructionism.
Insights from micro social constructionism have led to an understanding of Foucauldian constructionism that is different from the deterministic thesis described above. This is an understanding that Foucault had always insisted that power was a relationship and that whenever power was exercised resistance was also always present. Katz (2000), for example, has drawn attention to everyday acts of resistance by older people living in residential care settings. Others have accepted Foucault’s argument that the subject is constructed by discourses but have set out to explore the limits of agency within a discursive framework (Miller, 2008). For example, Twigg (2002) has taken up questions of discourse, meaning and the agency of the subject through the exploration of the personal care of older people who need help with bathing.

Micro social constructionist perspectives have given voice to older people at the micro level and those, such as Twigg, drawing on Foucauldian constructionism have led to a fuller understanding of older people’s agency. However, what ordinary older people themselves have to say about social policy and ageing-related care (at the macro level) has been neglected in the perspectives of micro social constructionism and Foucauldian constructionism. Each of the three findings chapters in this thesis provides views about social policy and ageing-related care according to the older people who are themselves often the subjects and recipients of these policies. By centring on how older people themselves discern and interpret social policy and ageing-related care, this thesis both builds on and extends each of these two constructionist perspectives.

8.3 REFLECTIONS ON ‘METHODOLOGY’ CHAPTER

One of the strengths of this thesis is that it has a rich and complex empirical focus. However, Chapter 2 took a very conventional approach to give an account of the thesis methodology. As Silverman (2005) points out, the methodology chapter can be a much more interesting affair than a formal description of the data studied, how it was obtained, what claims are made about its representativeness, the methods used to gather the data, why these methods were chosen, how the data was analysed and the advantages and disadvantages of using the method of data analysis chosen. To draw on Silverman (2005), there are three main ways in which the methodological discussion in this thesis could have been made more interesting: first, by explaining the actual course of decision-making rather than presenting a series of blunt assertions in the passive
voice; second, by giving an account of the history of the research, including responses to the various practical difficulties that were encountered in conducting this complicated piece of work; and third, as Silverman suggests, renaming the 'Methodology' chapter 'The natural history of my research', which would inform the reader about such things as the personal context of the research topic, the reasons for the research design, how they developed through trial and error and the methodological lessons learned (Silverman, 2005: 306). In retrospect, the approach suggested by Silverman would have make a more interesting and lively methodology chapter.

The following example, which explains the reasons for my decision to use focus groups as a method of data collection rather than one-to-one interviews to gain an understanding of how older people construe social policy and ageing-related care, serves as an illustration. I began by considering the advantages and disadvantages of conducting focus groups as against one-to-one interviews. One of the reasons for choosing a focus group approach was the practical advantage of being able to collect a large amount of information in a relatively short time. My decision was also partly influenced by my interest in exploring the ways in which older people agree with or contest each others views and focus groups are good for capturing exchanges between people. It was also partly informed by the emphasis within micro social constructionism on the centrality of context for attributing meaning to topics such as ageing-related care (Gubrium, 1999). I had no indication at the outset how well older people would engage with the topic of social policy and ageing related care. I guessed that older people might talk more easily about social policy and ageing-related care in a group than in a one-to-one conversation with a researcher. In addition, the concept of 'local cultures' (Gubrium, 1993) influenced my decision (more so than the concept of diversity) to organise focus groups with older people in different contexts including a residential care setting, a community based meals service in an inner city, a friendship network in a suburban area, an association of older people in a rural area, a seniors poetry group and an active retirement group. As it transpired, one of the main benefits of the focus group approach was that the older people participating had the opportunity to discuss topics, which resulted in lively debates and was useful in revealing competing discourses in a population often assumed to be homogeneous.
One of the drawbacks of choosing a focus group approach is that I did not include older people living in the community who were confined to home due to illness or disability. Although I had considered involving them in the research, I was faced with the practical difficulty of organising a focus group of older people confined to their own homes. An alternative would have been to conduct one-to-one interviews. However, I was already coming to grips with a very extensive dataset of policy documents, transcripts of interviews with policymakers, transcripts of focus groups with older people, and one whole year of newspaper articles and reports. Conducting one-to-one interviews is rather labour intensive and time consuming and these constraints were taken into account in the decision not to do so. In retrospect, it would have been beneficial to the research to hear what older people confined to their own homes have to say about social policy and ageing-related care. In my opinion, their views in relation to ageing, care and opportunities for social engagement and participation in social activities would be particularly interesting. The exclusion of older people confined to their own homes is, thus, a limitation of this thesis.

Chapter 2 included essentially a review of existing literature that attempts to both describe and define the characteristics of Ireland's system of long-term care within a comparative perspective. It is limited. The analysis presented in Chapters 5, 6 and 7 of this thesis provide a fuller understanding of different aspects of ageing-care in Ireland. In retrospect, it would have been much more interesting and fruitful to start with this detailed analysis of social policy and ageing-related care in Ireland and use it to investigate the commonalities and differences in understandings comparatively with other countries. Although it was beyond the scope of this thesis, another way in which it could be strengthened would be to give consideration to the intersection between multiple discourses on ageing-related care in Ireland and those at the supranational level, using Foucault's ideas of disciplinary power, resistance and freedom.

One of the strengths of the methodological approach adopted in this thesis is that it allowed the three discursive themes to emerge from three different sources of discourse – policy documents, interviews with policymakers and focus groups with older people. This is a novel approach. The findings suggest that social policy discourses are multiple, complicated and fragmented. The next section takes up the issue of multiple discourses.
8.4 CONCEPTS EMERGING

I mentioned in Chapter 1 that the Care of the Aged Report has been heralded as 'ground breaking' because it signalled a radical shift away from a policy of institutionalisation towards a policy based on domiciliary and community care. I also mentioned that ageing in the Care of the Aged Report was constructed as a social problem. However, this discourse of ageing as a social problem was only one amongst a myriad of discourses that criss-crossed the report – others that noticeably stand out include a discourse of dependency, the language of frailty, patriarchal discourse and biomedical discourse, to name a few. In this thesis, I set out to explore the concept of 'multiple discourses' by way of an exploration of social policy and ageing-related care in Ireland. By doing so, this thesis extends beyond previous work on social policy and discourse, which tends to emphasise one particular discourse at a time. An example comes from Fraser and Gordon (1994) who used Foucault's historical critique to provide a genealogy of dependency; to sketch the history of the term dependency and explicate the assumptions and connotations it carries in US debates about welfare.

I started with a close reading of official policy documents on ageing-related care, following which I identified a number of potential discursive themes, and, after interviewing policymakers, I selected one of these initially for analysis. Chapter 5 explains how the theme of 'family, care and ageing' emerged. I used a grounded theory approach to examine discourse in relation to that theme. By adopting this approach, I was able to show in Chapter 5 that multiple discourses (partnership, familialist, patriarchal and medical/professional) coalesce around the theme of the 'family' in the Care of the Aged Report. This is true for the other discursive themes of Chapter 6 and 7 that emerged from the interviews with policymakers and focus groups with older people respectively. It is also true at different points in time. This thesis shows that there isn't one overarching discourse about things such as the 'family' in official policy documents on ageing-related care. Rather discourses about things are multiple or multifaceted, fragmented and dispersed through official policy documents.

This finding is important because it suggests that official policy documents on ageing-related care are very complex documents that are in part made up of a string of multiple discourses that coalesce around a range of discursive themes. Katz and Green (2002) draw attention to the detail (of, for example,
law, administrative provision, statistics, previous actions and present discontents) with which official policy documents on ageing are routinely saturated. In a similar vein, this thesis shows that official policy documents on ageing-related care are saturated with multiple discourses. Multiple discourses on one discursive theme such as the ‘family’ are entwined with a string of multiple discourses on other discursive themes such as ‘the public sector’ or ‘the private sector’, all of which are fragmented and scattered throughout the documents. Official policy documents are in turn filled with a surfeit of other detail (Katz and Green, 2002). Thus, although official policy documents can be easily accessed by policymakers and citizens (including older people) and are regularly debated and often reported upon in the media, it is difficult for readers to ‘process, decode, interpret and judge the political significance’ (to draw on Katz and Green, 2002: 161) of discourses threaded through them. This is because the successions of multiple discourses in official policy documents to which readers are exposed are not readily apparent to them. Katz and Green (2002) relate ‘saturation with detail’ in policy documents to Foucault’s notion of governmentality. To follow, Katz and Green (2002), it might be argued that saturating official policy documents on ageing-related care is ‘a communicative and a moral practice that situates senior citizens as subordinate and dependent’.

I regard multiple discourses threaded through official policy documents as dominant discourses. Therefore, official policy documents on ageing-related care are saturated with multiple dominant discourses. I used the official policy documents on ageing-related care to chart changes over time in the multiple dominant discourses in relation to the three discursive themes. While this thesis has focused on charting shifts in dominant discourse, it does not pinpoint exactly the timing of discourse changes nor does it adequately address how changes in discourses can be explained.

Discursive institutionalism (Schmidt, 2008), from political science, provides useful insights from which to draw on to explore the processes by which some discourses fade and new ones come to the fore and why certain discourses are taken up rather than others. For instance, in addition to focusing on the timing of change, discursive institutionalism suggests that agents of change, the content of change, the discursive dynamics of change, and the context of change need to be considered. The importance of focusing on each of these is discussed by
Schmidt (2008). For example, Schmidt (2008) states that ‘focusing on the agents of change [the carriers of the discourse who bring about change] is important, because it emphasizes the fact that who is speaking about what makes a difference’. Agents of change are manifold. With respect to this thesis, an exploration of the processes by which, for example, the idea of ‘caring, but unsupported families’ came to the fore in *The Years Ahead* (see Chapter 5), would require a consideration of, amongst others, agents of change. Drawing on the analysis in Chapter 5, the agents of change would include policymakers, researchers, carer support groups and feminist activists but they could include others such as the media.

One way of understanding the discourses of policymakers is to define them as expert discourses (Fraser, 1989). Fraser (1989) who used Foucault’s work to investigate needs discourses in social policy identified expert discourses, which she associated with the major institutions of knowledge production and application (such as the Oireachtas, government departments and state agencies). Fraser (1989) also identified oppositional discourses which were closely associated with active social movements (such as older people’s interest groups). While Fraser’s division between expert and oppositional discourses is a useful device for investigating political struggle over meaning, it begs the question, as O’Brien and Penna (1998: 219) point out, ‘Can an expert representative of an official institution of knowledge-production expound an ‘oppositional’ discourse …?’ This thesis shows that they can and do. This brings me to a discussion of the concept of ‘multiple discourse mixtures’, which emerged from the analysis of the transcripts of interviews with policymakers for this thesis.

I developed the concept of ‘multiple discourse mixtures’ through a constant comparison of the discourses of policymakers in relation to the three discursive themes with the dominant discourses identified in official policy documents on ageing-related care in the new millennium as well as those from earlier periods in the second half of the twentieth century. From the analysis, it became apparent that some of the discourses of policymakers were similar to the dominant discourses found in contemporary official policy documents on ageing-related care. I adopted the term ‘conformist’ to denote this similarity between them. It also became apparent that at times the ‘conformist’ discourses of policymakers took on a slightly different nuance to the dominant discourses in official policy documents, hence, the term ‘conformist transformations of dominant discourses’.  

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I adopted the term 'oppositional' discourses to refer to discourses of policymakers that were clearly a contestation of the dominant discourses in official policy documents. Finally, it became clear that some of the discourses of policymakers could not be aligned (either as conformist or oppositional) with the dominant discourses of contemporary official policy documents, but instead echoed dominant discourses that I had found in earlier official policy documents but had since faded. I opted for the term 'traditionalist' to refer to these long-established discourses.

The concept of 'multiple discourse mixtures' is useful because it shows that the discourses of policymakers and other authoritative powers in the field of policymaking cannot be understood simply as dominant discourses. They are much more complicated. Policymakers can expound dominant discourses and as such are carriers of dominant discourses but they are also interpreters of discourse and as such can bring about transformations of dominant discourses. It shows that policymakers can and do contest the dominant discourses of official policy documents and thus answers the question posed by O'Brien and Penna (1998). Chapter 6 illustrates this point particularly well. It also demonstrates that there can be divergence across 'oppositional' discourses. The idea that the discourses of policymakers are characterised by multiple discourse mixtures suggests that policymakers might be understood as both agents of continuity and agents of change.

This thesis argues that the discourses of older people would also be better understood as 'multiple discourse mixtures'. Applying this concept to the discourses of older people is useful as, on the one hand, it moves away from the deterministic version of Foucault's work which emphasises the power of discourse to construct older people as 'docile bodies' and, on the other hand, beyond the association of older people with oppositional discourses, which draws on Foucault's insistence that whenever there is power, resistance is exercised. The concept of 'multiple discourse mixtures' suggests that the discourses of older people, just as those of policymakers, are more complicated and more fragmented than that.

As Chapter 1 explains, I drew on the concept of interpretive communities or discourse communities, as developed by Yanow (2000), to design the research for this thesis. I conceptualised policymakers and older people as two distinct
interpretive communities. This conceptualisation suggests, albeit implicitly, that:
(1) the discourses of a particular interpretive community such as policymakers are
in harmony and settled; and (2) the discourses of an interpretive community such as
policymakers are diametrically opposed to the discourses of another
interpretive community such as older people, although there may be points of
consensus. The concept of ‘multiple discourse mixtures’ challenges this notion of
an interpretive community as a group with similar discourses by drawing attention
to the complexity and fragmentation of discourses amongst policymakers and
older people. It brings to light the fact that taken-for-granted concepts in ageing-
related care policy are subject to persistent contestation and conflict not just
across interpretive groups but within interpretive groups. There are implications
for interest groups representing older people in debates about social policy and
ageing-related care as the concept of ‘multiple discourse mixtures’ draws
attention to the mixtures of discourse within interest groups and the extent to
which and the ways in which some discourses may come to the fore while others
remain in the background.

As they talked about social policy and ageing-related care in the focus groups,
older people drew on dominant, oppositional and traditionalist discourses. But
they also draw on other discourses, such as a ‘discourse of legitimate family
excuses’ (Chapter 5) or a ‘discourse of older people as social beings’ (Chapter 7)
when discussing different aspects of social policy and ageing-related care. Twigg
(2002) explores questions of discourse and agency of older people through the
everyday example of bathing and personal care. This thesis also explores
questions of discourse and agency but through the example of older people at the
micro level talking about social policy and ageing-related care at the macro level.

The analysis presented in the findings chapters is potentially significant for the
development of social policy and ageing-related care. This thesis demonstrates
that older people cannot be simply understood as objects of power or as ‘cultural
dopes’. Despite its distinct approach, the analysis in this thesis resonates with the
work of Twigg (2002). This thesis, however, extends Twigg’s (2002) work by
arguing that older people live in a world that is rich with discourses and that older
people are able to draw on them in creative ways not only when talking about the
care experience but also when discussing social policy and ageing-related care at
a macro level. Older people are able to assert their preferences for different
ageing-related care policies and are able to engage with, question and contest
diverse discourses to which they are exposed. Thus, based on the analysis presented in the findings chapters of this thesis, I argue that older people are not passive subjects but questioning and resisting subjects and, along with Twigg (2002), I maintain that older people have considerable agency.

The findings chapters suggest that older people have a particular ‘way of knowing’ about ageing-related care that is often distinct from that of policymakers. The findings presented in Chapter 7 – on the discursive theme of ageing, care and opportunities for social engagement and participation in social activities, which emerged from the focus groups of older people – are particularly significant as they point to a predominant discourse of older people, that is, ‘older people are social beings’. If focus groups with older people had not been used to identify the third discursive themes of this thesis, it is unlikely that this theme would have emerged as it was not a predominant discourse of official policy documents on ageing-related care or in the discourses of policymakers.

Furthermore, this thesis develops Gubrium and Wallace’s notion of ‘everyday theorising’. Theory can be defined simply as ‘attempts to explain’ (Bengtson et al., 2009: 4). But, as Marshall (2009: 573) points out, ‘to invoke a theoretical perspective is to say “look at it this way”.’ By asking the question ‘who theorises age?’, Gubrium and Wallace’s (1990) intention is to draw attention to the everyday theorising about age and ageing in which ordinary older men and women are engaged. Ordinary older people may neither be aware of their theoretical perspective nor make it explicit. However, when discussing social policy and ageing-related care they are implicitly saying “look at it this way”. This thesis opens up older people’s discussions about social policy and ageing-related care to view. In this way, it draws attention to the ‘everyday theorising’ about social policy and ageing-related care in which ordinary older people engage. In a similar way, this thesis draws attention to the ‘everyday theorising’ about social policy and ageing-related care in which policymakers engage. It also highlights the commonalities and differences between the ‘everyday theorising’ of the two groups.

Gubrium and Wallace (1990) note that there are striking parallels between the ‘everyday theorising’ of ordinary older people and theorising of professional theorists (or academics). Thus, Gubrium and Wallace (1990) argue that we need to extend theorising in social gerontology to older people’s own theories about
aging, to their own ideas and explanations for what it means to grow old and be old in today's world. Similarly, it might be argued that we need to extend theorising about social policy and ageing to take account of older people's own theories about social policy and ageing-related care. This would direct research towards the broad question of the ways in which ordinary older people theorise or 'look at' social policy and ageing-related care. This may in turn contribute to a development of social policy and ageing-related care according to the views of those who are often the subjects and recipients of such policies. In addition, there is a need to take account of the ways in which policymakers theorise or 'look at' social policy and ageing-related care and any underlying assumptions.

8.5 IMPLICATIONS FOR SOCIAL POLICY AND AGEING-RELATED CARE

This thesis has implications for social policy and ageing-related care. This thesis suggests that to reach a fuller understanding of social policy and ageing-related care, it is necessary to read official policy documents (as well as other products of government) through discourse. Such a reading emphasises that social policy and ageing-related care is an extremely complex and fragmented domain. The socially constructed nature of social policy and ageing-related care, as demonstrated by this thesis, draws attention to the fact that ageing-related care policies could have developed in a very different way than they did and highlights the potential for change in the future. Another implication of this thesis is that it challenges policymakers as well as older people to question and acknowledge the assumptions underpinning their common-sense views of various aspects of social policy and ageing-related care, for example, the view that family support is in decline (as discussed in Chapter 5).

This thesis demonstrates that older people's views about social policy and ageing-related care are as well-founded as those articulated through official policy documents. The discourses of older people are as logical as those of policymakers. However, the preferences that older people state for long-term care policy demand an approach that is often quite different from that taken by policymakers and endorsed in official policy documents. This raises the question of the potential transformative effects on long-term care policies of hearing the voices of older people. In other words, policy in relation to the long-term care of older people could be very different if the perspectives of older people were taken seriously in processes of policy formulation. If the discourses of older people
were not only elucidated but taken seriously in policy-making, ageing-related care policies would look remarkably different from the policies already in situ, particularly if they were built around older people's 'dominant' discourse that 'older people are social beings'.

Foucault has argued that dominant discourses maintain their power by a process that actively excludes other 'disqualified' ways of knowing. This thesis demonstrates that certain discourses are privileged in official policy documents on ageing-related care at the expense of the distinct discourses of older people. The power of the expert gaze of policymakers is illustrated in this thesis through an analysis of the mediatised discourses of policymakers and older people in newspapers. The findings show that compared to policymakers the voices and perspectives of older people in relation to ageing-related care issues and policies are poorly represented in this media. While this thesis does not address the processes by which certain discourses become privileged over others, it emphasises the importance of amplifying the multiple discourses of older people in relation to social policy and ageing-related care. There is, therefore, a case to be made for elucidating the discourses of older people and for these to be taken seriously in the development of social policy.

This thesis suggests that it is not only entirely legitimate but important to involve older people in policy formulation on ageing (including ageing-related care) as well as other policy areas. However, little is known about the multiple discourses that coalesce around the theme of older people's involvement in the formulation of policy, either generally or in relation to the specific area of ageing-related care. There is great potential to further analyse the thesis dataset to: (1) provide a history through discourse of social policy around the theme of ageing, care and the involvement of older people in policy formulation; and (2) explicate the multiple and complex ways in which official policy documents, policymakers, older people and newspapers construe the theme of older people's involvement in policy formulation on ageing-related care. Furthermore, Gubrium (1993: 61) points out there are many diverse ways and contexts within which 'speakers and listeners formulate, communicate, and respond to interpretations of life'. To draw on this point, there are many distinct ways in which older people can be involved in formulating, communicating and responding to interpretations of social policy and ageing-related care. These include the traditional routes of voting and lobbying through interest groups (which has become a firmly-entrenched feature
of policymaking in several countries) as well as newly emerging consultation mechanisms that aim to include older people from the wider population and not just the perspectives of older people's interest groups. But, they could also extend to alternative modes such as ordinary poetry, which has been used to communicate experiences of ageing (Gubrium, 1993). The thesis findings suggest that an important area for future research is to investigate older people's voices in relation to social policy and ageing-related care in diverse contexts.

8.6 CONCLUDING REMARKS

Foucault's work has had a significant influence in a variety of social science disciplines. The influence of Foucault on social gerontology, however, has not been as significant as its influence in other areas of social science such as criminology (Powell, 2006). Foucault had little to say about ageing (Katz, 1996). Nevertheless, Foucault's insights are of great relevance to social policy and ageing. Chapter 3 mentioned that social gerontologists have drawn on Foucault's concepts and ideas to develop an understanding of ageing, but, to date '[o]nly a tiny handful of international gerontologists have used Foucault's work to shatter taken-for-granted assumptions centred on aging' (Powell, 2006: 93).

This thesis seeks to add to this body of work by offering a contribution to the endeavour of rethinking social policy or, as Lewis (2000) put it, a way of expanding the 'social policy imaginary' as it relates to the area of ageing-related care. It does so in the following ways. It demonstrates that Foucault's work can be used and combined with insights from micro social constructionism to explore social policy and ageing-related care. It portrays social policy as a space that is more complex than the ongoing contestation between dominant discourses and marginalised discourses. It shows that discourses in official policy documents are multiple, fragmented and dispersed so much so that they are not readily apparent to the reader, speaker or listener. It conceptualises discourses of policymakers and older people as 'multiple discourse mixtures'. It draws attention to the considerable agency of older people. It highlights older people's distinct ways of knowing about social policy and ageing-related care and the significance of taking into account the views and preferences of ordinary older people in the formulation of social policies.
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APPENDIX A:
LETTER INVITING POLICYMAKERS TO PARTICIPATE IN AN INTERVIEW

Social Policy and Ageing research Centre (SPARC),
School of Social Work and Social Policy,
3rd Floor, 3 College Green,
Trinity College Dublin, Dublin 2.
Tel: (01) 896 2913

Name and address

Date:

Dear

I am a Ph.D. student affiliated to the Social Policy and Ageing Research Centre (SPARC), School of Social Work and Social Policy at Trinity College, Dublin. The topic of my Ph.D. is on The Social Construction of Ageing in Ireland, with a particular focus on ageing as it relates to social care. I am especially interested in the ways in which Irish social care policy changes as a result of shifts in dominant ideas about ageing.

As a key part of my Ph.D., I am inviting central policy-makers (politicians and senior civil and public servants) with responsibility or with a particular interest in the area of ageing-related social care policies to participate in one-to-one interviews. The interviews will be conducted by myself, Maria Pierce, an experienced researcher. I am writing to ask if you would be willing and available to participate in a short interview of approximately one hour to take place at your convenience. Any information given in the course of the interview will be treated as strictly confidential and will be used solely for the purposes of the research.
With a view to arranging an interview, I will get in contact with you again next week. In the meantime, if you would like further information about the interview or have any other enquiries about the Ph.D. research, please do not hesitate to contact me at the Social Policy and Ageing Research Centre, 3rd Floor, 3 College Green, Trinity College, Dublin 2; Telephone: (01) 896 2913; Email: piercem@tcd.ie. Alternatively, you can contact my principal supervisor, Dr. Virpi Timonen, Director of SPARC, School of Social Work and Social Policy, Trinity College, Dublin; Telephone: (01) 896 2950; Email: timonenv@tcd.ie

Yours sincerely,

________________________

Maria Pierce

Social Policy and Ageing research Centre (SPARC),
School of Social Work and Social Policy,
3rd Floor, 3 College Green,
Trinity College,
Dublin 2.
Tel: (01) 896 2913
Email: piercem@tcd.ie
APPENDIX B: TRANSCRIPTION CONVENTIONS
(adapted from Silverman (2005))

[ ]

P01: quite a [while Left bracket indicates the point at
P06: [well which one speaker's talk is
which one speaker's talk is
overlapped by another's talk
overlapped by another's talk

=

Equal signs, one at the end of one
Equal signs, one at the end of one
line and one at the beginning of the
line and one at the beginning of the
next line indicate no gap between
next line indicate no gap between
the two lines
the two lines

( )

P01: I think ( ) the first thing Empty parentheses indicate
that there is a pause between words
that

REALLY

P06: I REALLY don't think Capitalised words indicate
that the talk is especially loud in
that comparison
spoken
to the rest of the words

(???)

P03: People don't (???) Question marks in parentheses
indicate that the transcriber was
un able to hear what was said

(word)

P02: Parenthesised words are possible
hearings

((word))

P05: ((laughs)) Double square brackets contain
author's descriptions rather than
transcriptions

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APPENDIX C: FOCUS GROUP PARTICIPANT INFORMATION SHEET

Title of Ph.D. Research Study:
‘The Social Construction of Ageing-related Care in Ireland’
Maria Pierce

Participant Information Sheet

You are invited to take part in a research study entitled *The Social Construction of Ageing-related Care in Ireland*. The study is being undertaken by Maria Pierce, a Ph.D. student affiliated to the Social Policy and Ageing Research Centre (SPARC), School of Social Work and Social Policy, Trinity College, Dublin.

The study is seeking to gain an insight into older people's understandings of care as part of the ageing experience and to investigate their views on policies and practices relating to care for older people in Ireland. With this in mind, the study is carrying out a number of focus groups with older people. Focus groups are essentially group interviews. Each focus group will comprise approximately 5 to 6 participants along with the researcher.

If you would like to take part in the study, you will be asked to participate in one of the focus groups. Each focus group will last approximately one hour and will take place at a time and a location that is convenient to participants. You do not have to take part in the study if you do not wish to. Participation in the study is entirely voluntary. If you do agree to participate, you are free to withdraw from the study at any time.

The focus group will be conducted by me, Maria Pierce, an experienced researcher. Participants will be asked to take part in a group discussion about key issues relating to care as part of the ageing experience and policy on care for older people in Ireland. You are free to decline to answer any questions posed or comment on any issue raised during the course of the focus group. You are not under any obligation to discuss
anything about which you feel uncomfortable and you are free to withdraw from the focus group at any time.

Any information provided during the course of the focus group will be used solely for the purposes of the research and will be treated as strictly confidential. Extracts from the focus groups may appear in the final Ph.D. thesis or other publications emerging from it, but neither your name nor any identifying characteristics will be included.

It is intended to tape-record each focus group session. The recordings of a focus group or any other personalised data will be kept in a secure location. The recordings of the focus group interview and any electronic or hard copies of the transcribed focus group will only be accessible to the interviewer, Maria Pierce. For the purposes of supervision, hard copies of the transcribed focus groups may also be viewed by Ph.D. supervisors, Dr. Virpi Timonen and Dr. Patricia O’Brien. Each focus group recording will be transcribed in full and each transcription will use pseudonyms to ensure confidentiality of participants. The recordings and transcribed copies of the focus groups will be kept for three years after the acceptance of the Ph.D. thesis and will then be destroyed.

There are no specific benefits to you for taking part in the study. However, the study hopes to make a significant contribution to the study of ageing and care in Ireland.

If you would like further information about study or the interview, please do not hesitate to contact me (Maria Pierce) at the Social Policy and Ageing Research Centre, 3rd Floor, 3 College Green, Trinity College, Dublin 2; Telephone: (01) 896 2913; Email: piercem@tcd.ie. Alternatively, you can contact one of my Ph.D. supervisors, Dr. Patricia O’Brien, Director of the National Institute of Intellectual Disability (NIID), School of Social Work and Social Policy, Trinity College, Dublin; Telephone: (01) 896 3879; Email: obrienc3@tcd.ie
The study has been approved by the Research Ethics Approval Committee, School of Social Work and Social Policy, Trinity College, Dublin.
APPENDIX D: FOCUS GROUP CONSENT FORM

Title of Ph.D. Research Study:
‘The Social Construction of Ageing-related Care in Ireland’

Consent Form

This form has been drawn up to ensure that you understand the study and that you have given your consent to participate in it. Before signing the form, please read the following:

• I have you read or listened to the researcher read the participant information sheet

• I know enough about the project to participate in it and have been given the opportunity to ask questions

• I understand that my participation in the study is entirely voluntary and that I do not have to take part in the study

• I understand that everything I say will be treated as strictly confidential and my name will not be associated with anything included in the Ph.D. Thesis or any publications emerging from it.

• I understand that I can withdraw from the study at any stage and that I can refuse to answer any questions or withdraw from the focus group at any stage.

If your answer to all of the above is yes and you agree to participate in the study, please sign below:

Name:_____________________________ Date: ___________________
APPENDIX E: SAMPLE FRAMEWORK FOR ANALYSIS OF NEWS ITEMS IN THE IRISH TIMES (2006)

Categorisation of news items identified in *The Irish Times* (2006) relating to theme of ageing, care and opportunities for social engagement and participation in social activities

<table>
<thead>
<tr>
<th>News Item</th>
<th>Author</th>
<th>Topic of news item</th>
<th>Message (of relevance to theme of ageing, care and social engagement and activities)</th>
<th>Documentary sources cited</th>
<th>Cited sources of Opinions (policymakers and older people in bold)</th>
<th>Older people as source of opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Representative of national organisation of older people</td>
<td>Opinion to Ministers in advance of their formulation of a strategy for 'elderly care'</td>
<td>Ageing as a period of opportunity ... 'even in the fourth age as we face the dying of the light'</td>
<td>No. However, news items written by representative of a national organisation of older people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Correspondent at <em>The Irish Times</em></td>
<td>News report about research study on lives of older people carried out by Dublin-based Council of Services for Older People</td>
<td>There is a need for greater public investment in services for older people (such as day centres) focused on enhancing their sense of being part of a community</td>
<td>Research study on lives of older people carried out by Dublin-based Council of Services for Older People</td>
<td>Chairman of the Council Dublin-based Council of Services for Older People</td>
<td>No. However, research study reported in news item was based on a survey of older people</td>
</tr>
<tr>
<td>3</td>
<td>Correspondent at The Irish Times</td>
<td>News report about a music programme for older people in residential and day care settings</td>
<td>Music workshops for older people in residential and day care settings have positive outcomes but are under-funded and overlooked</td>
<td>Music in Healthcare - Evaluation report</td>
<td>Chief Executive of Music Network; Clinical nurse specialist; Director of Services to Older People (Dublin/Midlands)</td>
<td>No</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>4</td>
<td>Correspondent at The Irish Times</td>
<td>News report on NCAOP study on the quality of life for older people in long-stay care</td>
<td>Residents in residential care want more opportunities to keep in contact with family and friends and meaningful day-to-day activities that take account of their interests</td>
<td>NCAOP study on the quality of life for older people in long-stay care</td>
<td>Director, NCAOP</td>
<td>No. However, study reported in the news item was based on qualitative interviews with older people</td>
</tr>
<tr>
<td>5</td>
<td>Editor of The Irish Times</td>
<td>Editorial in response to NCAOP study on the quality of life for older people in long-stay care</td>
<td>Therapeutic activities for older people living in residential care settings needs to be increased</td>
<td>NCAOP study on the quality of life for older people in long-stay care</td>
<td>No. However, editorial was based on qualitative interviews with older people</td>
<td></td>
</tr>
</tbody>
</table>
6  Correspondent at The Irish Times

News report about opening launch of a nursing care facility catering for all adults drawing on the idea of a 'real' village, where 'people live full, vibrant lives with the support of the community'.

This 'state-of-the art' nursing home centre includes residential care and day care facilities that offer various social activities ranging from chess and bridge lessons to pottery classes.

Founder and owner of 'state-of-art' nursing home facility; Minister for Health; Senior chef; Resident receiving respite care at the nursing home

7  Correspondent at The Irish Times

News item about complementary therapies and practices in day and residential care settings for older people

Creativity amongst older people attending day centres and residing in residential care setting is enhanced by art, music and reminiscence therapy, while complementary practices such as t'ai chi, reflexology, aromatherapy, hand and foot massage and yoga are life-affirming and life-enhancing.

T'ai chi instructor; Participant (75) in T'ai Chi class in day centre

Yes