

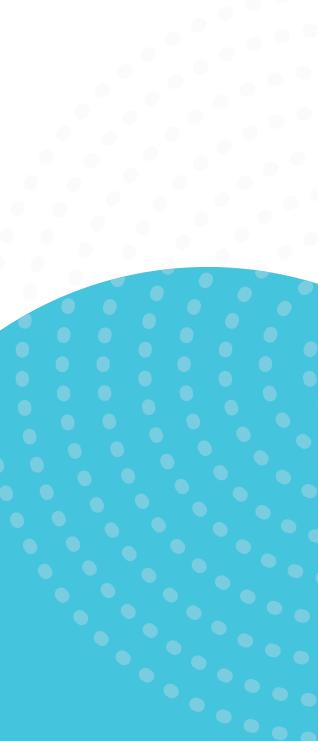
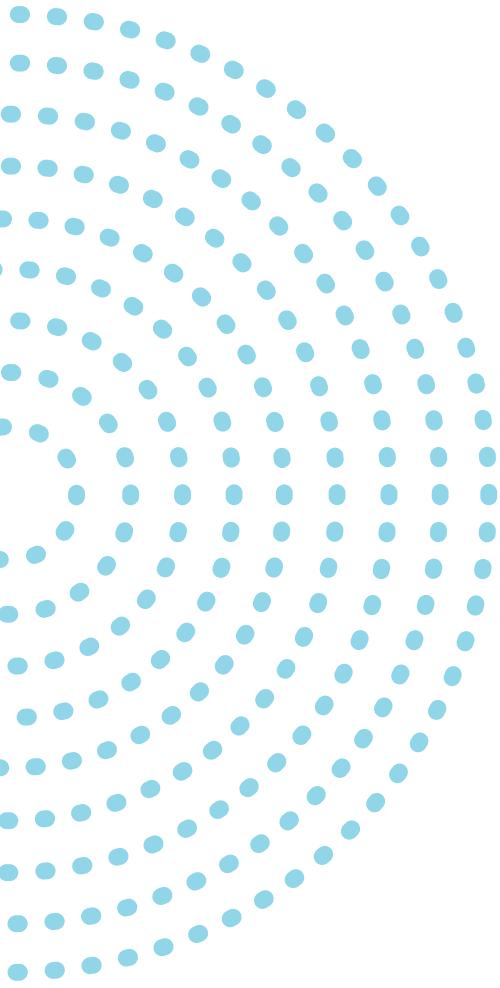


"WHAT CAN YOU EXPECT AT YOUR AGE?!"

AN INVESTIGATION OF RECENT
EXPERIENCES OF AGE DISCRIMINATION BY
OLDER ADULTS ACCESSING HEALTH CARE

INVESTIGATORS: AAKRITI CHHETRI & NATALIE KANAWATI





**This is a joint publication of the Older Women's Network NSW
and Health Consumers NSW.**

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Designed by Melissa Adams

Ebook ISBN: 978-0-6489149-1-4

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FOREWORD

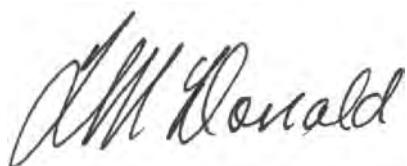
Professor Tracey T. A. McDonald

I am pleased to introduce this report on Ageism in Health Care because, throughout my long career in health and education, I have been acutely aware of the issues that this report raises. As a clinical gerontologist, I have a deep understanding of the various health professions and health services and how they operate and are regulated. Government and organisational policies guide how that interaction should occur but as they trickle down to the interface between patient and practitioner, too often the spirit and intent of the policy are lost.

For many who desire a world where all people are treated equally, and where the wellbeing of others is a motivating force for good, the struggle to persist in our efforts to achieve that health service nirvana can be discouraging. It is affirming to realise that so many smart and dedicated people are working to build a better, equitable future. I commend the Older Women's Network NSW and Health Consumers NSW for producing this report and the platform it establishes for education, training and policy reform into the future.

This report makes a credible addition to a vast body of research and knowledge about ageism, how it corrodes older adults' rights and affects their capacity for living a full and joyful life.

I commend the report to you.



Professor Tracey T. A. McDonald AM PhD FACN GAICD



OLDER WOMEN'S NETWORK NSW

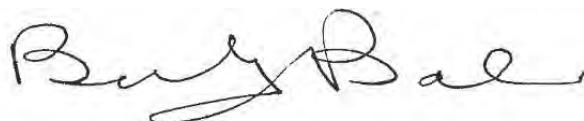
Beverly Baker

The Older Women's Network NSW is pleased to present this report jointly with Health Consumers NSW. Although small in scale, this investigation into ageism in health care touches on an important aspect of how older people view their interactions with the medical world. The Royal Commission into Aged Care has highlighted that ageism is alive and well in Australia, and that older people are not accorded the respect they deserve. This investigation reveals how ageism in health care is experienced by older people.

We hope this report will prompt all medical professionals to question how deeply ingrained the unconscious bias against older people influence their interactions with older patients. While the impact of ageism in the delivery of health care may appear to be superficial at times, there are also instances where the wellbeing and quality of life of older people are compromised because of ageist attitudes.

We look forward to the training module being developed jointly between Health Consumers NSW and OWN NSW to be rolled out in medical schools, and we urge you to get in touch with us if you would like to have this free resource when it is ready.

Older people matter, and it is time that we take ageism in the delivery of health care seriously.



Beverly Baker
Chair
Older Women's Network NSW



HEALTH CONSUMERS NSW

John Garbutt

Older people are, not surprisingly, the largest users of health services. Older people often report high satisfaction with health services, but sadly many experience disrespect or loss of dignity when receiving health care.

This report brings together over 100 people's experience of being treated differently in health care because of their age. People's experience of ageism varied. For some older people it meant being disrespected or patronised, others felt ignored by health providers, while others were denied clinically appropriate care and were told, incorrectly, that nothing could be done for them because of their age.

This is, sadly, not a new problem. In 2017 the *EveryAGE Counts* campaign released their report *The Drivers of Ageism*. This research showed that older people identified health care as one of the main settings where people experienced ageism. Health Consumers NSW, as an organisation dedicated to improving health care in NSW, knew we had to join our efforts to change this. We were very excited to be able to work together with the wonderful team at the Older Women's Network in working to challenge this insidious problem.

Ageism is, at its core, about not listening to older people and excluding them from the decisions that affect them. Health Consumers NSW will continue to assist older people to tell their stories, this report is the start of that, and we also will work to create opportunities where older people are involved as both equal partners in their health care, and in being meaningfully engaged in designing care that is supportive and nurturing of older people. We have already started work with local universities about how they can integrate anti-ageist teaching into the education of health providers.



John Garbutt
Chair
Health Consumers NSW





RATIONALE FOR THE INVESTIGATION

In 2017, research released by the EveryAGE Counts campaign demonstrated that health care settings were the second most likely of places mentioned by older people reporting experiences of ageism.

The first most likely was in aged care (The Benevolent Society, 2017). This report has its genesis in the anecdotal evidence from the many members of Health Consumers NSW and Older Women's Network NSW, about instances of ageism they experienced in their dealings with the health care sector. The two organisations partnered to further investigate the issue of ageism in the health sector using a survey and in-depth interviews to determine how ageism is experienced by older people today, particularly in NSW, and what impact it has on them afterwards.

DEFINITIONS

Ageism: Ageism is the negative or positive stereotypes, prejudice and/or discrimination against (or to the advantage of) elderly people based on their chronological age or based on a perception of them as being 'old' or 'elderly' (Donizzetti, 2019).

Health Consumers: Healthcare consumers are the key stakeholders in a patient-centred practice. Healthcare consumers possess the power and influence to accelerate changes in the delivery of care. They play a critical role in medical decision-making processes, influencing choices that ultimately impact the quality and effectiveness of care delivered to individuals and society as a whole (Yong, Saunders and Olsen, 2010).



CONTEXT

Between 1999 to 2019, Australians aged 65+ years increased from 12.3% to 15.9%. The percentage of those born between 1946 to 1964 turning 65 will increase rapidly over the following few decades (ABS, 2019).

Much of this extension of average lifespan is due to improvements in environmental hygiene, health services and medical science. Late age is often accompanied by the need to live with chronic and complex health issues that, if managed well, enable an acceptable quality of life to be achieved. As a result, older Australians are the largest client group who access the health care system regularly (Wyman, Shavit-Ezra and Bengel, 2018) with 24.5 million medical practitioners (GP) consultations alone being for older people (AIHW, 2016).

Issues of universal access to the public health system have been raised regularly since the implementation of Medicare, the universal health insurance scheme (as retitled throughout this period). Most of the issues relate to setting limitations on access under this scheme to ensure that those who need a hospital and primary health care can do so without the system becoming overloaded with patient demands for admission and patients in long-stay situations. Both of these drivers affect the waiting times for treatment in the public health system which has, from time to time, been used as a political measure of system efficiency. Rationing of access by local administrators and health practitioners is not supported by government policy and therefore goes unreported along with the service level rationale used to restrict access by certain people or groups.

For the growing numbers of older Australians, their experiences with the health care system are important to their health, wellbeing and productivity as well as that of their families, networks and communities. Our investigation clearly reveals that age discrimination has health implications when it compromises patient care, access to health care and adequate support services.



**Older Australians
experience ageism in the
healthcare system when
they are negatively
stereotyped as being
'too old' or 'bed blockers'
or a 'waste of resources'.**

Ageism refers to prejudice or discrimination against a person or group based on age. It is pervasive across all levels within society. Older Australians experience ageism in the healthcare system when they are negatively stereotyped as being ‘too old’, ‘bed blockers’ or a ‘waste of resources’. Attitudes such as these, from health practitioners and administrators, who may or may not be aware of their prejudices against older adults, influence their diagnosis and treatment recommendations. Similar to other forms of discrimination, ageism can be implicit and explicit and directed from the external or internalised by the self (São José, Amado, Ilinca, Buttigieg, & Taghizadeh Larsson, 2019).

Our society’s social norms, values and attitudes as well as policies and practices do not always appreciate the value of older people and often discriminate against them (The Benevolent Society, 2017). Employers and businesses with normalised ageist values can pressure skilled and experienced older adults out of employment, into inappropriate work, or set them up in competition with younger unskilled applicants. Similar bias can occur among providers of general and community services because normalised ageism is not well understood, leading to widespread inequity and practical disadvantage accumulating within a society (McDonald 2017).

A common stereotype of older people is that they are unable to retain skills, especially new learning, and are viewed as senile, frail, and “old fashioned”. Ageism is perpetuated through such stereotypes, resulting in prejudice and discrimination which can directly affect health service options as well as the quality of health care that older people have access to (Wyman et.al., 2018). Ageism can therefore have profoundly serious consequences for older people and those around them. If older adults are to continue to participate fully in their communities and society, then building the capacity of systems and services to help them improve their health outcomes will ensure their social connection and inclusion, to the benefit of all in our society. The failure of society to adapt appropriately to population change will infringe on older people’s human rights and wellbeing while placing an increased burden of care, treatment and support on health services, taxpayers and families.

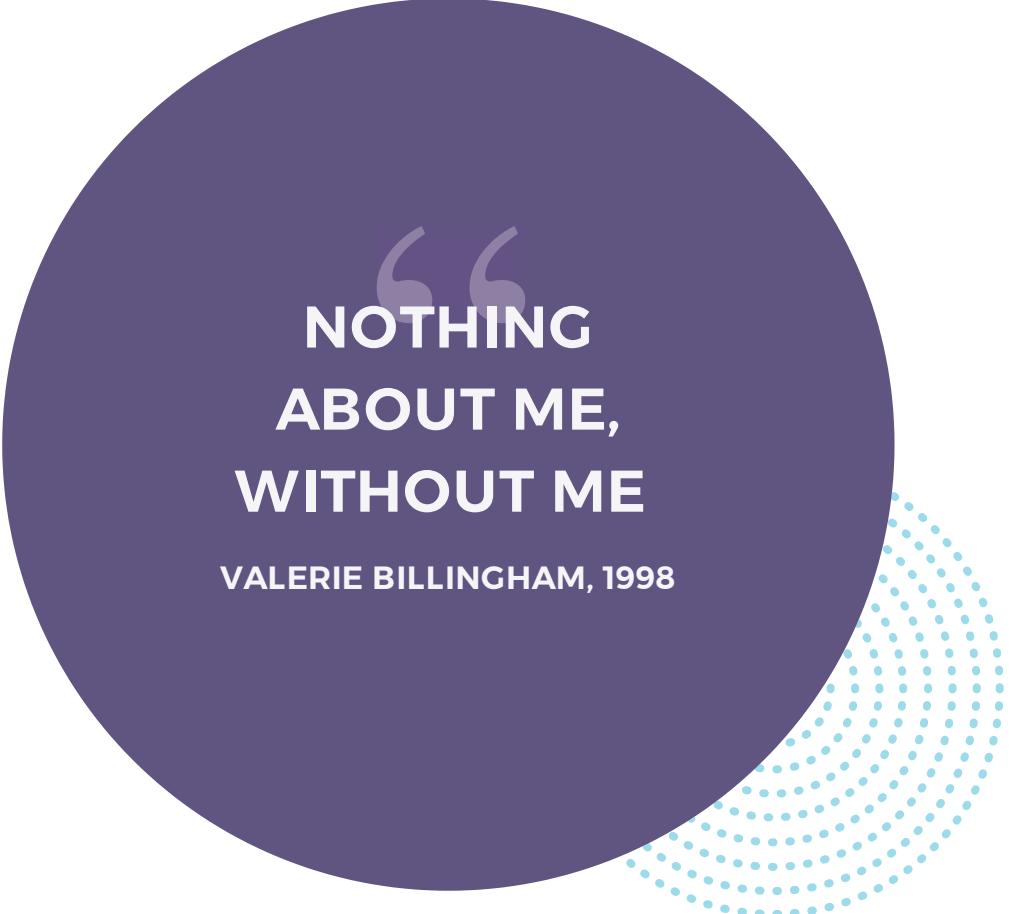
Ageism is a major enabler for the abuse of older adults. In a report to the Ministerial Advisory Council on Ageing in 2018, McDonald & Shaw (2018, page 8) said: “It appears that the mechanism for fostering abuse begins with neglect and social isolation, especially if cognitive capacity is reduced. Then follows psychological and emotional abuse (shaming, blaming and contempt) leading to financial abuse. Physical and sexual abuse may also be part of the abuse cluster used by the perpetrators to torment and exploit older people with whom they have a so-called trust/family relationship that is not scrutinized by others. Indeed, the very nature of this relationship can be used by perpetrators to hide the abuse as a private family matter and deter inquiries and interventions by non-family members.”

When ageism is normalised, that is, when it is accepted as a value or attitude held by most people in a society, perpetrators of elder abuse act with impunity. Ageist attitudes can facilitate society's neglect of older people (Wyman et. al, 2018) and those working in health and aged care services are not excluded from such normalised values. This was highlighted by the *Royal Commission into Aged Care Quality and Safety* (2021). The final report of the Royal Commission showed that so much of the suffering and harm older people have endured in aged care stems from the negative impact that ageist norms among practitioners have on the care of older people and their treatment outcomes. The Royal Commissioners reported that they received submissions from many people concerned about the care older people receive in hospitals. The care of older people outside the aged care system was unfortunately beyond the scope of the Royal Commission. However, its mention in the final report of the Royal Commission highlights that more needs to be done to address the issues of ageism in health care.

Ageism is not an uncommon experience of older people accessing healthcare with 47% of participants in a separate study reporting that they had faced it (The Benevolent Society, 2017). Medical practitioners can compromise therapeutic relationships through condescending behaviour and negative ageist attitudes. Ageism can also prevent patients from being medically treated as they otherwise would have (Malta and Doyle, 2016). Health practitioners subscribing to normalised ageism can succumb to clinical decision-making influenced by prejudice.

Prejudicial bias against older patients accessing the health care sector is well known in Australia. The Australian Institute of Health and Welfare in 2014 noted the slow recognition of ageism as a factor to be addressed in service delivery. At that time, it was assumed to be occurring because of the lack of research into older people's experience of engaging with health and aged care services (AIHW, 2014).

Socio-economic factors also play a part in how health care is delivered and experienced. We know that those from a higher socioeconomic status have more access to medical specialists and can easily engage with multiple health care professionals. In general, people who are well-resourced, educated, and better-off, receive more health care and a higher standard of health care than those people who are poorer and more disadvantaged (Bowden & Donaldson, 2019). With income usually decreasing for Australians aged 65 and over, they have fewer treatment options. It is interesting to note that patient presentations to emergency departments decrease the higher up the socio-economic scale of patients (AIHW, 2016). Unnecessary emergency department visits are a sign of poor access to primary care and GPs (Dalzell, 2019).



“
**NOTHING
ABOUT ME,
WITHOUT ME**

VALERIE BILLINGHAM, 1998

Our investigation's aim is to understand how older people experience ageism in health care. Our purpose is to raise awareness of the issue using information gathered from those most affected by ageism in healthcare and to ensure that our present and future generations of older people are appropriately cared for and respected.

The term 'patient-centred care' used to describe a model of staffing and clinical management approach to service delivery needs to be enacted in reality to centre the experiences and perspectives of older adults in all planning, discussions and decision-making. Shared decision-making is the pinnacle of patient-centred care, along with the rallying cry coined by Valerie Billingham and used by advocates for that movement, "Nothing about me, without me" (Billingham 1998).

METHODOLOGY

An online survey was used to gather quantitative and qualitative data to get a better understanding of ageism in the healthcare sector in New South Wales.

The quantitative survey was done through the SurveyMonkey online platform. The survey questions explored what age groups were most affected by ageism. It also aimed to discover the contexts where health care ageism was most prevalent (e.g., public hospitals, specialists, GPs etc).

Health Consumers NSW (HCNSW) and the Older Women's Network NSW (OWN) invited their members to respond to the online survey through their newsletters and social media. Other older people's organisations were also invited to distribute information about the survey to their members. There was a provision in the online survey where respondents could briefly describe their experiences of ageism in a healthcare context.

The qualitative interview respondents were identified through expressions of interest amongst those who did the online survey. They agreed to share their experience through interviews by video calls or phone calls. In-depth interviews were also conducted with people who responded to OWN's call on Facebook. Due to COVID-19 pandemic restrictions and to ensure safety, all interviews were done using electronic means. Additional case studies were shared by Professor Tracey McDonald.

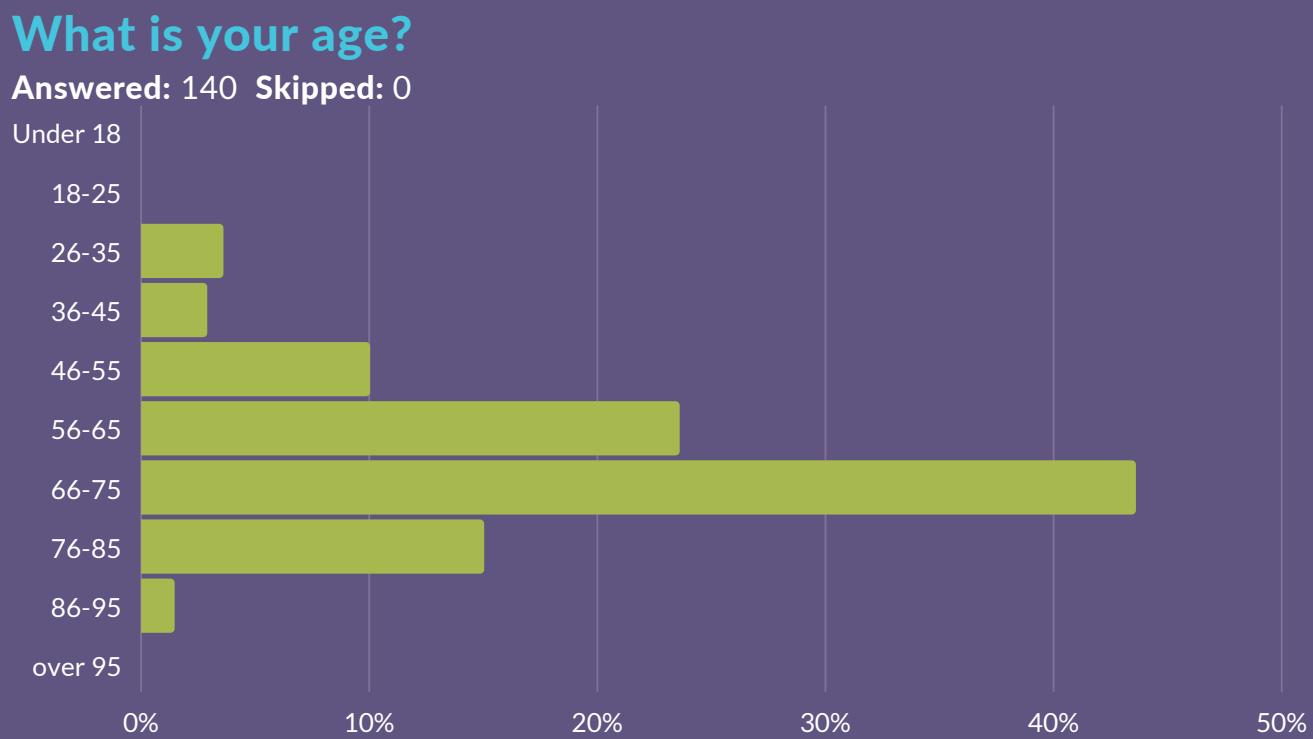
These interviews delved deeper into the stories of the individuals who had experienced ageist treatment in the healthcare sector. The interviews were recorded with the participants' consent. All collected data provided insights into the impact of age discrimination. The interviews also uncovered how ageism affected health consumers and their families. These recorded interviews were transcribed through the Otter.ai application with the consent of the interviewees. All participants were provided with details of the investigation and were assured that their comments would be treated confidentially and that their identities would not be revealed in any future publication of the survey.

RESULTS OF ANALYSIS

1. Quantitative survey results

A total of 140 participants responded to our SurveyMonkey questions. Only respondents who claimed to have experienced ageism (68 people) were included. The other 72 either had no experience or were unsure if they had experienced ageism and so were excluded. Descriptive analysis results are presented below in percentages.

Graph 1: Respondent's age profile

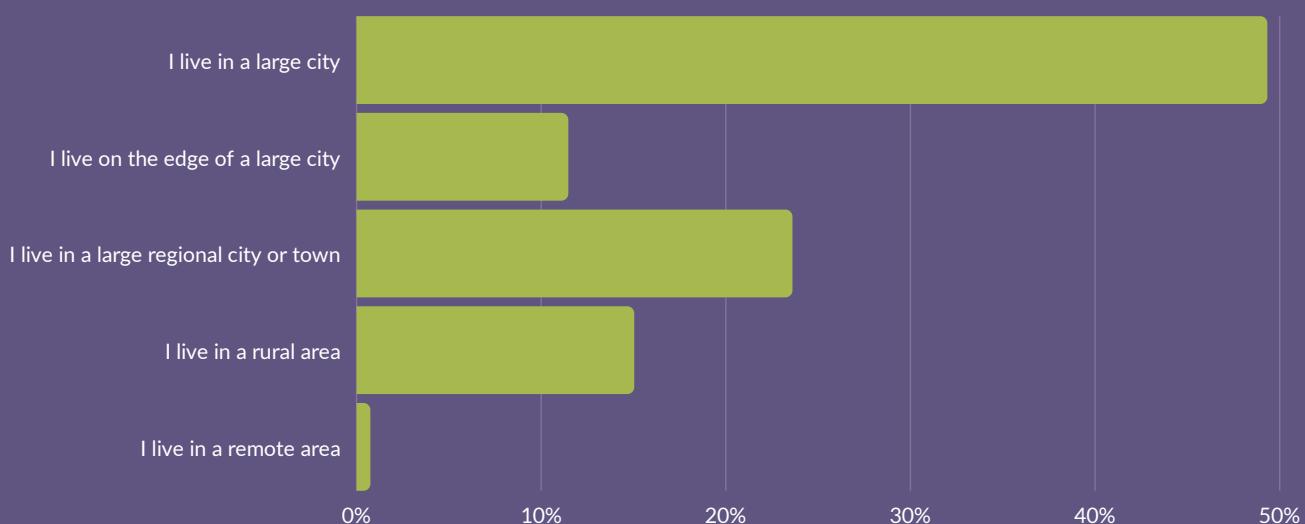


43.57% of the respondents belonged to the age group 66 to 75, making them the majority in the survey pool as demonstrated in Graph 1. Respondents from age group 56 to 65 made up 23.57% of the total survey population. 1.43% of the respondents were aged 86 and above. The number of female respondents was significantly higher than male respondents. 78.57% of the respondents were females.

Graph 2: Respondent's residential location

Which best describes you?

Answered: 140 Skipped: 0



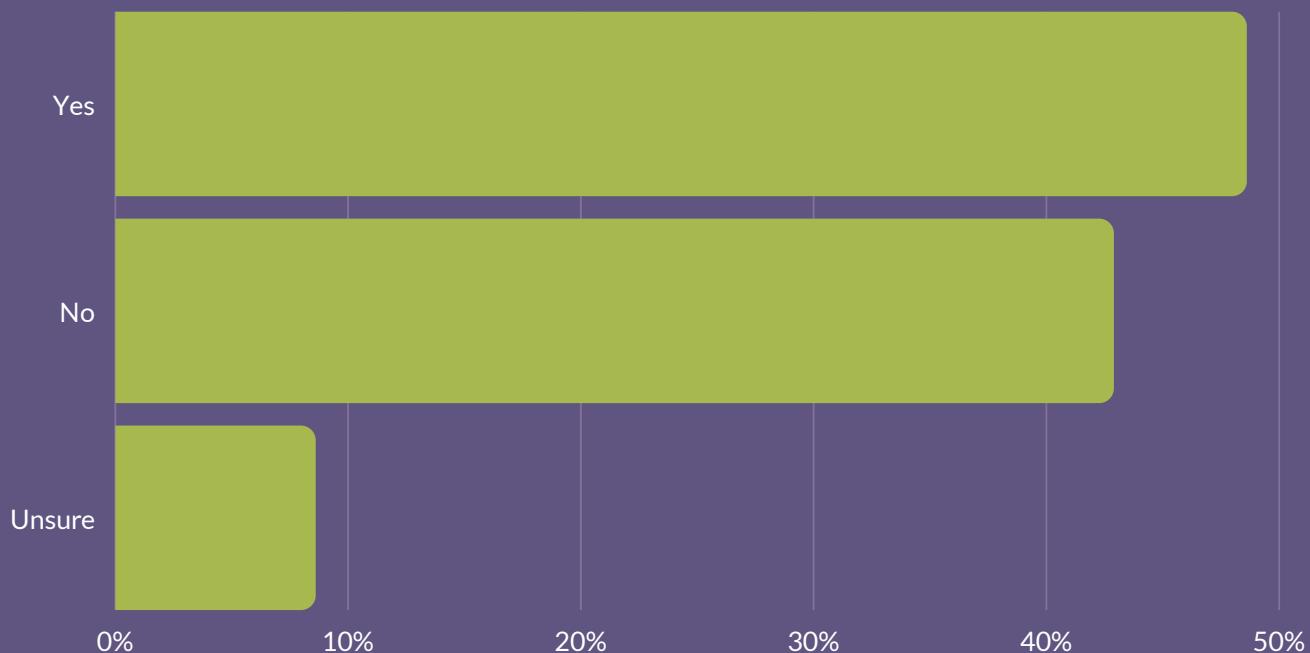
About half of the surveyed participants live in a large city, making up 49.29% of the total respondents as shown in Graph 2. Only one respondent lives in a remote area. 77.86% of the respondents live in New South Wales.



Graph 3: Experience of ageism incidents

Have you ever felt like you received different treatment (compared to other patients) from a health service because of your age?

Answered: 140 Skipped: 0



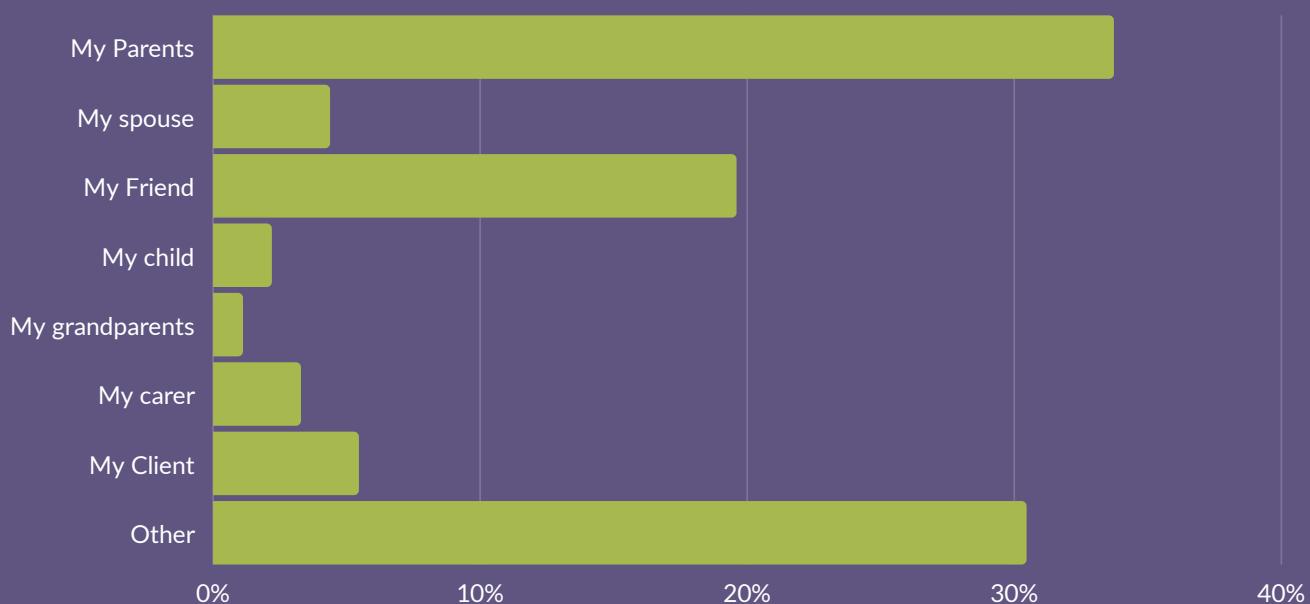
48.57% of the respondents said they had been treated differently because of their age (Graph 3). A further 8.57% of the respondents were unsure if they had ever been treated differently due to their age. 42.86% of the survey respondents felt they had not been treated differently because of their age.



Graph 4: Knowledge of ageism experienced by other people

Has anyone in your surroundings ever felt like they received different treatment from a health service because of their age?

Answered: 92 Skipped: 48



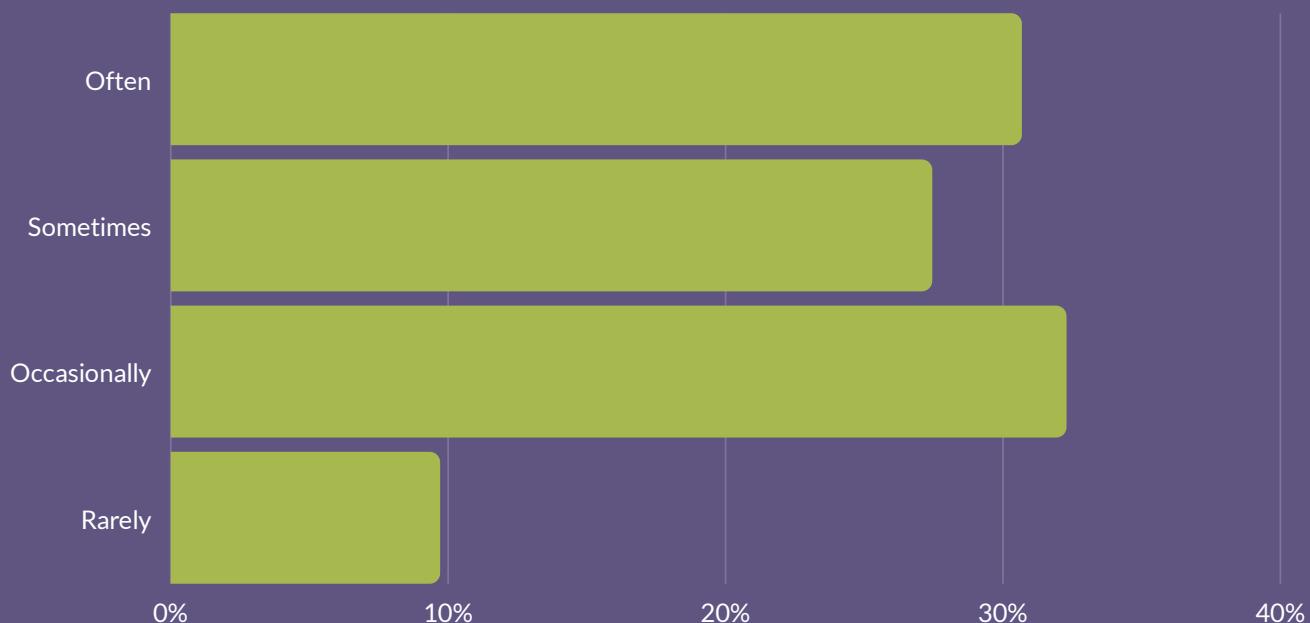
33.70% of the respondents said that their parents were subjected to ageism in a health care setting as shown in Graph 4. Only 92 survey respondents out of the total 140 respondents answered this question. 48 respondents skipped this question. Only 30.43% of the respondents chose to specify their answer, the most common of which were "no", "no-one", "my sibling" and "multiple people". There were about 20 responses for "no" and "no-one".

People who had not experienced ageism or did not know anyone who had encountered ageism were filtered from the responses.

Graph 5: Frequency of personal ageism encounters

How often has this occurred?

Answered: 62 Skipped: 78



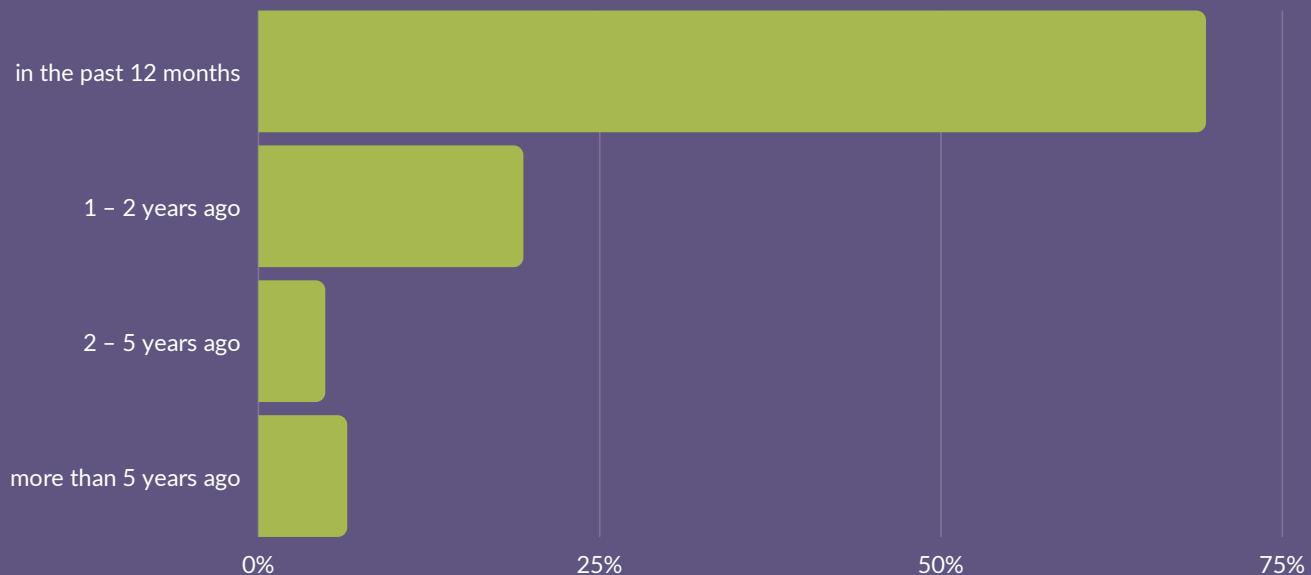
Out of the total 140 respondents, only 62 respondents answered this question. 32.26% of the respondents encountered ageism occasionally, while 30.65% of the respondents encountered ageism “often” (Graph 5).



Graph 6: Recency of ageism encounters

When was your most recent experience of being treated differently?

Answered: 62 Skipped: 78

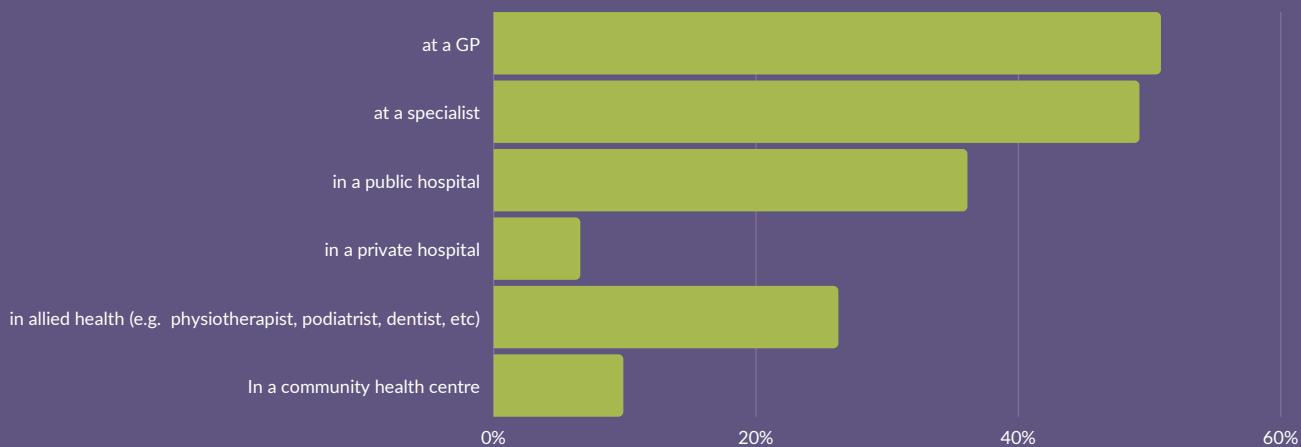


Out of the 62 respondents who answered this question, 69.35% of the respondents had encountered ageism in the past 12 months. 6.45% of the respondents had encountered ageism more than 5 years ago (Graph 6).

Graph 7: Context of ageism encounters

Where did this happen?

Answered: 61 Skipped: 79



The health services where respondents reported being treated differently due to their age were GPs (50.82%), specialists (49.18%) and public hospitals (36.07%) respectively (Graph 7).

Just over half the respondents had experienced ageism at their GPs. People are more likely to visit their GPs at a higher frequency than any other health services because in the Australian healthcare system, GPs act as the first point of contact. GPs then refer the patients to specialists and allied health services according to the needs of their patients.



2. Qualitative interview findings

Eight in-depth interviews were conducted with people who were willing to share their experience of ageism with the public. These interviews were one-on-one and conducted through video calls and phone calls due to COVID-19 pandemic restrictions preventing face-to-face interactions. Four interviewees were drawn from the survey respondents who were willing to share their experience. The remaining interviewees were drawn from OWN's Facebook invitation and Professor Tracey McDonald's respondents.

Analysis

The transcribed interview data was read separately by both investigators who noted broad themes and any sub-themes. Both investigators then read through the transcripts together and checked the themes and adjusted them by consensus as to meaning and threads of information.

Qualitative themes were then compared with the survey results and any alignments and synchronicity identified between the two data streams. Themes combined from both streams were agreed upon following discussions with the editorial team.

Five major themes emerged from the interviews and survey data. These themes are:

1. medical professionals not listening to concerns of older people
2. minimising and dismissing illness concerns
3. patronising language
4. lack of appropriate care
5. intersectionality of various forms of discrimination

Participants reported that their negative experience of using the health care system is often rooted in their health concerns not being taken seriously. They feel they are not being listened to by health professionals.

Other survey participants felt that their medical professionals had a blatant disregard for them and their health, and as a result, felt they were ignored:



[My GP] doesn't care less [that] I have depression, heart attacks, chronic asthma, chronic arthritis and chronic spondylitis.

Another participant reported that she experienced ageism not only with her GP but also in hospital contexts.

She said that when she spoke of her health concerns:

The GP appeared disinterested in what I was saying.

The same participant reported that hospital staff did not believe she was "competent" and:

they ignore everything I was saying.

Many articulated that such disregard for their concerns resulted in an insufficient explanation of medical treatments for them.

One participant stated that either due to their age or because they did not work in the healthcare field:

raising [your concerns] about treatments and the obvious negative side effects are fobbed off.

This was echoed by another respondent who stated that:

[Medical professionals] not explaining treatment properly and when [I] queried, [they] did not listen to concerns.

A major theme that occurred throughout the qualitative survey data was that respondents' health issues were being missed and dismissed on the basis of their age.

One respondent said:

I am post-menopausal and I was bleeding heavily, accompanied by crippling pain. I told my doctor I was over the bleeding and the terrible pain. He told me that young menstruating women would have a worse time than me.

Another respondent reported she had completely lost faith in the healthcare system because of her experiences:

I have given up going to doctors completely.

When I first retired, I decided to have a check-up. I am rarely ill. However, I had about 5 matters of concern.

The young doctor laughed at me and dismissed them all due to age.

I now don't go to doctors at all. I don't do breast scans or bowel cancer screening. It's a waste of my time.

Respondents also reported patronising language and attitudes. Those who are health consumers said that they were being treated as a “*silly old person...with the mentality of a child*” or “*stupid*” because of their age.

Another recounted the use of patronising language such as “*dear*” or “*darling*” which irritated her, as she found it condescending.

Not receiving appropriate care was the most common theme to emerge from the data. Respondents reported that illnesses and injuries were not taken seriously. Many did not receive the appropriate medical care until they actively sought a second opinion. This included being denied access to surgery because they were deemed to be too old.

Went to see an orthopaedic specialist re[garding] a sore knee. Was told basically it was an 80 year old knee. Wasn't offered any other investigations except x-ray which didn't show much. Subsequently sought a second opinion resulting in the need for total knee replacement.

Participants said that doctors perceived themselves as the “experts” who knew better than the patients, and this attitude frustrated the patients:

I know my body pretty well. I have lived in it 72 years and this female doctor who had just met me, [told me she] knew better.

Respondents also identified that the intersectionality of ageism and other forms of discrimination made the situation worse.

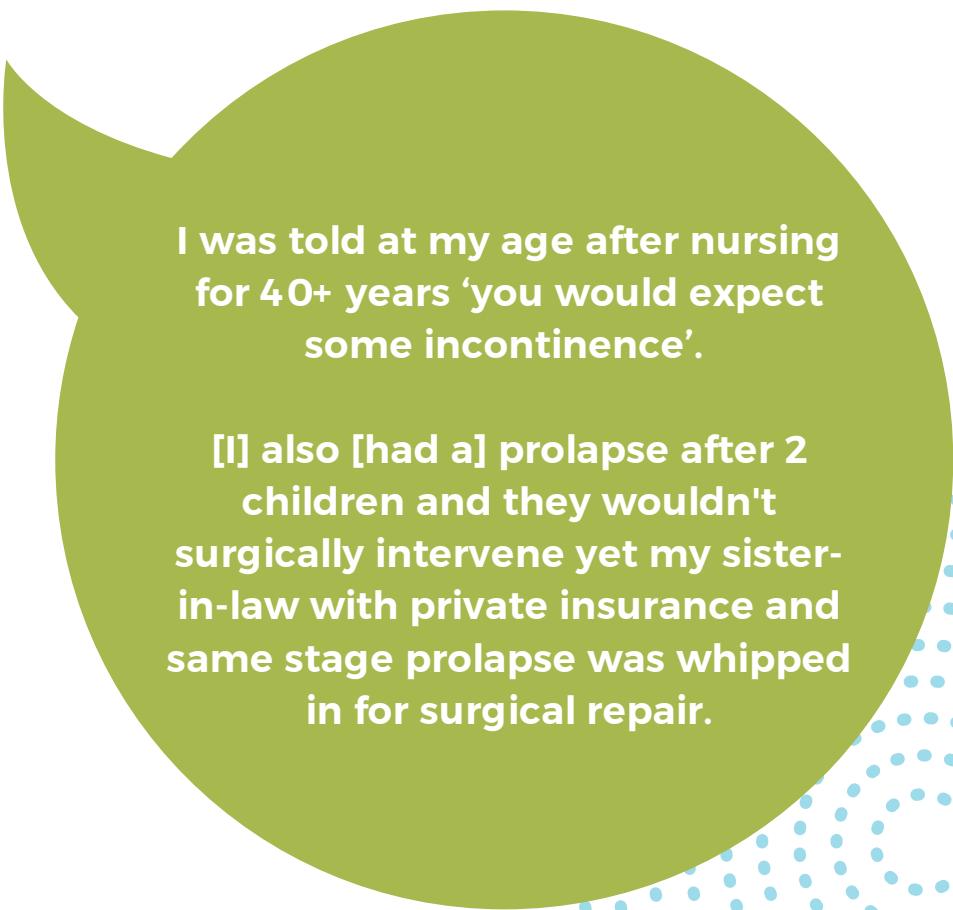
This is especially true of female respondents who reported that ageism was not the only form of discrimination they experienced, with sexism compounding their age discrimination.

One respondent stated that her daughter observed: "*how older women become invisible*". Racism and ageism also intersect:



**Due to my Indigeneity
and being over 50, I
feel racially profiled
when in public and
also by health services.**

The respondents noted that socioeconomic class and ageism directly affected access to health care as well:



**I was told at my age after nursing
for 40+ years 'you would expect
some incontinence'.**

**[I] also [had a] prolapse after 2
children and they wouldn't
surgically intervene yet my sister-
in-law with private insurance and
same stage prolapse was whipped
in for surgical repair.**

SYNOPSIS

It is clear from the analysis that ageism impacts the way older people experience healthcare.

Many felt that health practitioners did not take them seriously. Medical practitioners took on the position of “expert” in determining the diagnosis of the older patients without listening to what they had to say. This made them feel frustrated, as many described how they knew something was wrong with their bodies but their concerns were dismissed and put down to their age. Many doctors interpreted their symptoms as being age-related, as though it was natural and expected that they suffer these diseases despite not all older people having these maladies.

There is a general tendency for health professionals to see ageing as a process of decline. Our respondents highlighted the important fact that their health service providers do not seem to make the distinction between the processes of normal ageing and disease. This is something well understood by older people but which medical practitioners frequently have difficulty assessing. It is therefore common for medical practitioners to dismiss the real concerns of older people who present various symptoms as just the “normal” signs of ageing.

The relationship of trust that should ideally be present between the medical professional and their patients is easily fractured by the manner in which health concerns are dismissed or trivialised. Empathy and compassion are also perceived as missing in these doctor-patient interactions. The credibility of practitioners with these attitudes towards older patients can undermine confidence in prescribed treatments. This lack of perceived care and consideration by the practitioners results in patients being reluctant to seek medical advice in the future as they do not want to be put in a position where their input is not wanted and not respected.

Danger of Ageist Attitudes

Participants said that medical practitioners held ageist attitudes, values and stereotypes which lead to discrimination. They believe that this has negative implications for equitable access to timely and appropriate medical interventions. Medical professionals who stereotype older people may even deny them access to treatment because they are viewed as ‘too old’, in other words, ‘deemed unworthy’. One participant, for example, was told that it was not possible for her to have cervical cancer and that it was not necessary to be tested because she was “too old” to have sex. The in-depth interviews show that ageist attitudes have real consequences that lead to unnecessary suffering for older people.

Neglect and Delayed Diagnosis

Neglect is a form of abuse where a person responsible for care fails to provide appropriate care for someone who is not able to care for themselves (Ying, Poronnik, Usherwood and Reeve, 2020). Neglect can take many forms. When it is practiced by a registered health practitioner who holds themselves out to have certain expertise and receives payment for providing specialised care, they are legally accountable and could be charged with negligence.

A participant of the survey reported that her mother, who was 82 years old, had developed badly disfigured and bent hands as a result of arthritis. Her mother's GP paid no attention to the deteriorating condition of her mother's hands and brushed off any concerns with remarks such as "*what can you expect in your age?!*". When her mother was referred to a specialist, the specialist was shocked to see the condition of her hands. The specialist explained that the pain her mother suffered was unnecessary because there are treatment options, and people no longer have to put up with the pain and disfigurement of untreated arthritis.

This is a clear case of negligence by the general practitioner. Health practitioners have a legal and moral duty of care to their patients. They are meant to conduct a thorough examination and offer treatment plans to reduce pain, suffering and/or further injuries. However, in this case, the GP failed in his duty of care to the mother of the respondent. A breach of duty of care is punishable under the Civil Liability Act 2002 (NSW), however, no legal action was taken in this case because the patient did not know they were entitled to better treatment for their condition. This case is also an example of how internalised ageism can negatively affect individuals' expectations of their health and the negative impacts on their current health condition (Levy, 2009).



Intersectionality of discrimination

Several respondents stated that ageism is not the only form of discrimination they experience. The survey participants and interviewees demonstrated through their stories that the intersectionality of sexism, racism, classism, and ageism makes it much harder for them to obtain equitable access to safe and effective health care. They expressed their frustration and discontent with having to live with the consequences and impact on their health.

The various forms of ageism that respondents have experienced in a health care setting are listed below. The experiences of our respondents are not necessarily gendered and would cause discomfort and distress regardless of whether they are men or women. For instance:

Sentimentalising

- Using patronising words such as ‘dear’ and ‘love’ to address older patients.

Infantilising

- Explaining treatments to the person accompanying and not to the older patient directly, assuming they will not understand medical treatments.
- Assuming help is needed with everything such as offering wheelchairs when it was not requested.

Trivialising

- Dismissing concerns and ignoring what is being said by the patient. Treating an older person as invisible.
- Not believing their experiences and treating older people as “paranoid”, “senile” or “crazy”.

Stereotyping

- Making remarks such as “Oh, you have aged well” or “You do not look like someone who is X years old”.

Inequity based on age

- Not providing certain treatments and referral for tests when he or she is above a certain age.

Prejudice based on gender and age

- Discrimination based on the stereotype that men do not normally access health care services.
- Expecting that men do not care about taking their health seriously.
- Expecting that women will be able to take care of their own health and that of others.

Internalised Ageism

The older generation may have internalised discriminatory attitudes and ageist views themselves as a result of deeply entrenched societal norms that accept age discrimination as typical. It is therefore unsurprising that older people unconsciously submit to stereotypes regarding ageing and do not insist on their rights and entitlements. Their expectations of what constitutes acceptable ways of being treated and what health outcomes to expect at a certain age (Levy, 2009) are changed by their conformity with common social values. Such systematic oppression becomes more problematic when a person believes that their health will inevitably deteriorate as they age and that they should not bother to seek medical help. Their own ageist perspectives are compounded when medical professionals make comments such as, "What can you expect at your age?!".



STORIES & LESSONS FROM THE FRONT

People shared with us their experiences of ageism experienced in health care settings. In recounting these stories, it is important to acknowledge the impact of the COVID-19 pandemic in Australia on a health system that already had issues with ageism affecting local rationing of services by administrators and health practitioners.

In early 2020, the COVID-19 pandemic struck all Australian states and caused widespread emergency responses to control the infection and mortality rates among vulnerable groups, specifically older adults and those with chronic conditions. Three-quarters of deaths from COVID-19 in Australia have been in aged care homes. Australia has one of the highest rates worldwide of deaths in residential aged care as a percentage of total deaths (Cousins, 2020). The Aged Care Royal Commission found that the government's attempts to prepare the aged care sector for COVID-19 was "insufficient", and called on the federal government to establish a detailed national aged care plan for COVID-19.

Observation of the responses in different States and Territories reveals significant flaws in the health system that were exacerbated by the pandemic. Among the many weaknesses of the pre-existing system was the capacity of the health system to manage infectious outbreaks in a timely and efficient manner. The learning curve for system managers and professionals from March 2020 to the current time, has been fast, deep and broad. The counterpoint to health service priorities was the need to address the devastating effect of the pandemic on the economic wellbeing of the nation. Here too, flaws in established policies and systems were revealed as supply chains became unreliable and skilled workers were infected and quarantined while other people were made homeless and dependent on charity and welfare.

Over the past year, people engaged with all sectors and services have come to the view that management according to the 'old ways' of 2019 is no longer acceptable and is unlikely to succeed in supporting Australians into the next five to ten years of living safely with the COVID-19 coronavirus pandemic.



The age profile of the death rate alone is sufficient to justify greater consideration of the plight of older Australians and their families whose lives are now affected by either trying to avoid infection or trying to recover from it. In doing so, they must engage with service intersections that are linked to policy frameworks at the national, state and local government levels regarding funding and eligibility for services among many other criteria. They also face organisational policy hurdles at the hospital, community centre and local service levels regarding the eligibility of access, length of stay decisions, funding/payment and private insurance and fee-for-service issues.

Negotiating a way through these policy networks is difficult, even for those who work within these systems. For older people and families who are unfamiliar with these decisions that ration access to resources, the task of obtaining effective treatment and services at a time of emergency can be daunting.

Our health and other services tend to be mainstreamed, mostly in order to achieve economies of scale, but not all people in our society have equal access to such services. In any consideration of ageism and health services, we need also to consider the health difficulties experienced by some members of transgender communities on their life journeys, and especially as they age.

People who were assigned male at birth but have undergone the transition to live in their affirmed gender as female may have undergone surgical procedures for their transition. They often retain a prostate and will have been prescribed follow-up hormone therapy which needs to be continued during the ageing process. The competence of nurses, GPs and specialists in geriatric health in addressing these complex ageing issues is limited, especially in regional and rural areas. The story of Lisa below provides an indication of how this impacts on the individual.

A different and equally complex set of health circumstances confront people whose assigned gender at birth is female, but whose affirmed gender is lived as male. They may have undergone complex surgical procedures as well as long-term hormone therapy, to enable them to continue their journey in their affirmed gender. Many may not have undergone genital reassignment surgeries and retain their female genitalia whilst living as affirmed males.

People who have transitioned from their gender (assigned at birth) have unique and complex health issues as they age and their experience of ageism can be unique and devastating, affecting their physical and mental health. Mainstream services set up for gendered patients have an obligation to be informed about those who have special needs that warrant non-mainstream protocols and interventions.

The following stories about personal experiences showcase the variety of issues and contexts that have inherent ageist factors that compromise people's efforts to access safe and effective health services in hospitals, primary care and aged care. The names and other identifying characteristics have been changed to maintain confidentiality. Following each story, some significant factors are identified to provide a basis for further debate and possible action.

PAM

Before Pam retired, she was a physiotherapist with her own practice. She worked with women with complex needs. Years of experience in the field gave her plenty of knowledge of the medical system.

Pam is now 68 years old and has a diagnosis of dementia.

Pam has experienced ageism various times while trying to access health care. Pam has reported that the medical practitioners in the past have “taken no notice of a woman’s pain” and that she has had to “fight tooth and nail” to be listened to.

When Pam’s clinical physician finally ran brain scans, her physician was “gobsmacked” at what he saw. Pam stated that this was because he did not listen to anything she had said previously. These scans finally lead to her dementia diagnosis.

Pam believes that her delayed diagnosis would have been preventable if the doctor had not been both ageist and sexist towards her.

When Pam was having trouble sleeping, she consulted two psychiatrists. These psychiatrists did not refer Pam onwards because they believed her sleeping problem was the cause of her diagnosis of dementia. Hence, she felt reduced to a “68-year-old with a dementia diagnosis”. She was made to feel like a “hysterical silly woman”. Instead, she went to a different specialist who identified the possible causes of her sleeping issues with a “fine-tooth comb” and found that she was not sleeping well because she was not getting enough oxygen to her brain, thus she was given a diagnosis of sleep apnea.

When speaking about the psychiatrists that did not take her seriously, Pam stated that: “I’m just upset about their lack of basic professionalism. It is quite wrong”.

Throughout her years as a physiotherapist, Pam has become no stranger to dealing with discrimination: “I mean, I’ve learned to stand my ground for my clients. Over the decades, I never expected to have to be the one to stand my ground so firmly to get heard by professionals. Yeah, it was a huge shock to realize.”

The treatment that Pam received severely affected her mental health. She stated that the treatment encouraged her suicidal ideation. The way she was treated made her feel “discouraged and worthless” and led her to doubt herself.



Pam is concerned about the serious effects of ageism and sexism in health care. She states that not being listened to is detrimental as people are not “getting the optimal help/support that they need... And they probably go into care sooner than they might if they've been unable to maintain independence.”

Pam encourages doctors to practice with empathy and to engage in new training so they can have the latest practice knowledge.

Significant factors in this case:

Dementia being used as justification to ignore and neglect people: There is poor understanding by health practitioners of the causes of dementia and this compromises the quality of care and outcomes of services as up to 18-20% of dementia cases can be reversed with appropriate treatment. Dementia is not a disease - it is a collection of symptoms from a variety of causes and any treatment success relies on having an accurate diagnosis and expertly selected interventions.

Difficulty in obtaining an accurate diagnosis: Lack of interest in accurately assessing causes of dementia can be attributed to ageism among health practitioners. Those living with these symptoms are further disadvantaged if they fall into groups which receive lower priority for treatment such as being female or belonging to a non-mainstream social group.

'Lucky guess' diagnosis being regarded as sufficient for older patients: Time and effort are required to determine a definitive medical diagnosis and, from the story above, the practitioners avoided that work by trivializing and stereotyping Pam's concerns.

Deterioration of professionalism within health practitioner ranks: Behaviours by professionals that engender trust are well known, as are attitudes and characteristics that undermine trust. Professionals working without peer supervision or who are not held accountable for conduct unbecoming to a professional, need to be reported to their representative organisations where codes of conduct exist with which all members are obliged to conform (APHRA 2002).

MERLE

Merle, aged 96 years, is healthy and getting about independently in Sydney. She recently had an accident on her scooter at a suburban railway station, and suffered six fractured ribs, two fractured femurs and a fractured elbow plus general bruises, including on her face.

She was admitted to a public hospital as an emergency case, and had surgery. She has always been independent, bright and engaged in her community and was pleased to hear that no internal organs were damaged. Two weeks later, she still had a urinary catheter as she was unable to get out of bed. She needed help with feeding as her right arm was in a splint. Her surgeon told her that she would be in the hospital for at least two months.

The following day, and for the next three days, a junior doctor and social worker attached to the high dependency unit aggressively argued that she had to be transferred to a nursing home of their choice. On the third morning they informed her that she MUST leave the hospital as her medical care was now completed. Merle was distraught. The original plan with the surgeon was for her to be discharged when she could stand, and then go to a rehabilitation hospital before returning home. The junior doctor and social worker became increasingly determined to 'move her out' and refused to look for a hospital bed for her in a less critical ward where she could have a few weeks to heal and have her urinary catheter removed before being discharged.

Merle's niece requested a meeting with the surgeon, but the junior doctor and social worker both refused to arrange one for her. Her niece (who has worked in aged care for 20 years) refused to allow an Aged Care Assessment Team¹ (ACAT) review to be done as she feared her aunty would be shoved into an ambulance and taken to the nursing home chosen by the social worker chose and then dumped.

Merle was afraid of getting COVID-19 in the ambulance and also in the nursing home. She was also afraid that if sent to a home, she will be isolated for two weeks and will be unable to walk, feed herself or take care of herself because of her injuries. The pandemic meant that her niece will not be able to visit to help her as she will not be allowed in. The junior doctor and social worker both agreed separately that if a younger person with the same injuries was in their hospital, they would be allowed to remain as an inpatient because they are not eligible for a nursing home placement. When it was suggested that this was an ageist position to take, they denied it and took offence.

¹Aged Care Assessment Team (ACAT) is a team of medical, nursing and allied health professionals who assess the physical, psychological, medical, restorative, cultural and social needs of frail older people and help them and their carers to access appropriate levels of support.



The surgeon was contacted and Merle was admitted to the aged care area of the public hospital where she remained for a further three weeks on complete bed rest to allow her fractures to heal. The staffing on that ward was inadequate and Merle had to use disposable nappies. She received little by way of treatment or nursing care.

Merle finally applied for respite at a nearby aged care facility and she was transferred after completing the ACAT assessment for respite only. She remained in the respite facility for 90 days, receiving some therapy but again, the staffing was poor and she was asked to use nappies rather than being walked to the toilet. As a consequence, she has lost continence control. She also lost muscle and strength and her balance is poor even with assistance. She is now back in the public hospital system in a rehabilitation ward and is receiving physiotherapy daily, walking with a frame and using the toilet normally. She is looking forward to returning home to the flat in a few weeks at age 97.

The callous treatment of a remarkable 96 year old woman who is, except for her injuries, quite capable of resuming her normal life at home if she is given the same access to hospital care as younger people, is a sobering example of ageism at work. Her anxiety about COVID infection risk, being isolated from people she knows and losing her home (a social housing flat) is realistic.

Significant factors in this case:

Equity of service access between older adults and younger people: This was not preserved due to the option of moving an older person out of a state hospital to a Commonwealth-funded placement in order to clear beds for younger patients. The staff involved mistakenly believed that the level of care, skill and treatment in nursing homes was similar to that available in hospitals.

Inconsistent information being provided to patient and family by the senior medical staff and junior staff: Expectations of fair access to services were created during the initial discussion around the length of stay and then contradicted by junior medical staff.

Callous disregard of realistic anxiety about infection risk: When concerns were raised about leaving the hospital environment to go to a nursing home during the pandemic, this was ignored. The pressure brought to bear on the medical staff to force a 96 year old woman with multiple fractures out of the hospital and into a risky environment needs to be investigated as this approach is both unethical and immoral.

Lack of understanding of the needs of older people following trauma: The slower healing time, and fragile mental health consequences of being in an accident, frailty and limited self-care ability following multiple trauma and fractures, risks of social isolation and alienation from loved ones are just a few basic considerations that were not met by the hospital staff.

Regulatory complexity of moving between services was experienced at every transfer: These local, state and federal regulatory processes appeared to have little relationship with each other. The processes involved are repetitive and geared to reducing the status of older patients to that of a nursing home resident. Limits on access to a hospital bed, to funding, to insurance and to care and treatment varies with the different regulatory processes involved.

SUSAN

Louise's mother, Susan, is 82 years old. Over the years, Susan has developed multiple chronic health conditions such as arthritis and decreased immunity to infections. She has been seeing the same GP for many years. Susan's arthritis has gotten progressively worse over the past years, so much so that her hands have developed deformities. However, Susan's GP has not taken notice of the condition of her hands.

Louise had developed some pain in her hands herself, and suspected it could be arthritis. Hence, she visited her own GP to whom she briefly described her mother's arthritis and how it had led to severe hand deformities. Her doctor was shocked to hear about the condition of Susan's hands. At this point, Susie's hands were bent and out of shape. Louise's doctor explained to her that there are medications and treatments available in the market to address arthritis and that such deformities should not have to happen to people with arthritis anymore.

After a conversation with Louise, Susan visited her long-standing GP of many years. When Susan raised concerns about her arthritis and how it was affecting her hands, the practitioner dismissed her concerns saying, "what can you expect in your age?", "you should not expect to be in perfect health in your age", and "at your age, it is quite normal to have such things". These comments were hurtful, and Susan got quite upset. The practitioner then referred her to the hospital to see a specialist.

When the specialist saw the condition of Susan's hands, he was shocked that she was not referred to the hospital at least 5 years ago. It took Susan a long time to change doctors but according to Louise, ever since Susan made the change, there have been improvements to her health.

On another occasion, Susan once had a cat bite that landed her in hospital. The site of the cat bite had become infected, and one of the nurses commented, "What do you want to have surgery for at your age?". Susan was understandably demoralised by the comment.

This had happened right after the COVID lockdowns were announced. Susan still required medical attention for dressing the wound. She is considered at high risk of contracting COVID due to her age and her co-morbidities. She was therefore advised to stay home as much as possible. Susan contacted her local clinic to book an appointment for the wound dressing and she asked the receptionist if she could also receive a flu shot when she was there. The receptionist told her she would have to book another time for the flu shot.

This meant that Susan would have to travel to the clinic twice for appointments lasting less than 15 minutes. The travel alone would have been quite difficult for Susan, plus the potential for exposure of COVID made it more stressful for her. She was very upset by how the receptionist showed no understanding of her situation. Her GP then stepped in and told her they could arrange the flu shot on her wound dressing visit.

Significant factors in this case:

Clinical competence of the GP: The loyalty shown by older patients to their community doctor can open opportunities for neglect and for low clinical standards to occur. Registered health practitioners are registered under the Health Practitioner Regulation National Law Act (2009) each year and must show that they are clinically current, competent and ethical.

Ageist comments trivializing patient concerns and suffering: The motivation for dismissing patient concerns could be ageism or simply an effort to manage workload and rationing their services in ways that disadvantage older patients.

Failure of primary care: Primary care providers, mostly GPs, are expected to manage chronic conditions within the community. Neglect of this duty until the patient is harmed in some way and then referred to the hospital is irresponsible and could be an acknowledgment of the lack of medical proficiency that warrants reporting under the National Act.



LISA

Lisa is a 67-year-old woman who transitioned 40 years previously and has lived in her affirmed gender successfully in a regional community. Lisa began experiencing problems with urination 12 months ago so she went to consult her GP of twenty years and was referred to a urologist for treatment and support.

Lisa had undergone genitalia reassignment, but retained her prostate. The first urologist informed her that “her type” were “lucky to have lived as long as she had”. She was further informed by others that the urologist did not “treat her type”. Lisa also identifies as Aboriginal.

The impact of such discriminatory and ageist comments were devastating psychologically for her. Fortunately, Lisa is a strong and resilient woman and a fierce advocate. So with assistance from a community organisation, she lodged complaints with the Health Care Commission and the Anti-Discrimination Board.

Lisa was then referred by her GP to another urologist located 70 kms away in another city. Her treatment and support from this specialist resolved the urinary matters. Lisa remains sceptical regarding her ongoing care as she ages, and also has a mistrust of the health care system from both an ageing perspective as well as discrimination due to her gender re-assignment.

Significant factors in this case:

Discrimination preventing access to specialist treatment: The comments stereotyping Lisa were intended to be dismissive and clearly caused distress. The callous disregard motivating the comments has no place among health professionals and need to be reported.

Self-advocacy and knowledge of the systems and policies: Holding health practitioners accountable is of benefit for those who are sidelined by prejudice from accessing essential health care.



WALLY

Wally is a gentleman aged 83 years, recently admitted to a public hospital with chest pains. He is also experiencing delirium/psychosis where he knew he was going to harm himself.

He was reviewed by the cardiology team and approved for discharge as there were no cardiac issues. His delirium/psychosis was still present. He was not reviewed by the social worker or mental health team.

Wal's wife, aged 79 years, requested that the hospital not discharge him until their daughter could return later that week from interstate so she could support them both. The hospital declined. Their daughter advised her mother to refuse to accept Wally home. This was the hardest thing for her to do as they had cared for each other during their 60-year marriage, always side by side.

Their daughter, who worked in aged care, contacted an associate from the hospital system who reviewed Wally. Medication was given, and the request was made for Wally not be discharged for 7 days so any medication impact could be reviewed. The family and patient were advised that the daily medication would need to be taken for at least a year. This was late on Friday afternoon.

Wally was transferred to a periphery hospital the next morning, Saturday, where he remained for 5 days. Medication had improved his mood and he did not seem to be a danger to himself any more so he was discharged home. The delirium/psychosis returned over the next week or so. On investigation, it was discovered that Wally had been discharged without the new medication, without prescription and instructions about medication, and no clinical handover to his GP.



Significant factors in this case:

The importance of advocacy: This patient could have easily been inappropriately admitted to a residential facility without the involvement of strong advocacy and pre-existing knowledge of the aged care system. Aged care facilities do not have the staff skill mix, equipment, systems or funding to provide mental health services. All mental health issues involving confusion or cognitive decline are labelled 'dementia' in aged care facilities, and residents with mental confusion are placed in locked sections of the facility with little or no treatment for their often reversible conditions.

Missed care of discharge planning, appropriate patient transfer and medical handover:

Medical responsibility for patient care includes conducting appropriate handover of patient information on discharge or transfer to the care of another medical practitioner. If ageism is at the core of missed care, then the employers of such practitioners are vicariously liable for any suffering, loss or damage. Therefore, administrators of all levels of care services have a responsibility to oversee the plans for any unique circumstances facing each patient being discharged or transferred. Failure of practitioners to adhere to patient management and treatment protocols and to perform competently can result in harm to patients and is a reportable breach of the National Act, and cause for a review of employment status based on clinical competence.



UNA

Una is a 78-year-old woman who has a diagnosis of dementia. Una is quite alert but moderately impacted by confusion and anxiety. She was admitted from the nursing home to the local teaching hospital with a provisional diagnosis of cancer of the cervix, based on the appearance of an unidentified mass.

Surgery was completed and Una returned to a general ward for post-op recovery with the positive news that the surgery had found no active cancerous growth.

The day after surgery, Una was left unattended next to her bed when she was visited by the medical registrar doing his ward rounds. Una attempted to follow the doctor and fell, breaking her arm. Upon her return from having the arm splinted, her mental confusion had increased and she was unable to care for or feed herself.

The hospital nurses and doctors appeared to lack any understanding of how to care for a patient with dementia symptoms. They ultimately decided to move Una to a single bed ward adjacent to the Nurses Station. She was also given various dolls and toys, apparently for her amusement. On the first night in this single bed ward, she was assisted to the bathroom by two nurses and was dropped, causing further bruising to Una's arms and legs.

Again, there appeared little understanding by these nurses of how to assist or manage a person living with dementia. For instance, positioning Una adjacent to the Nurses Station put her in the centre of multiple activities and people movements throughout the full 24-hour cycle so she could not relax. In addition, her broken arm and other problems in self-care did not result in any offers by staff to assist her with feeding, personal care and hygiene. If family members were not present at mealtimes, food was often not consumed.



During a second admission from her nursing home sometime later with a urinary tract infection, the treating medical registrar advised the family that Una would be denied any liquids and fluids, apparently on the assumption she was going to die anyway. The family was very unhappy with this proposed course of action and arranged for Una to return to her nursing home where she was given sustenance, and where she passed away with dignity several weeks later.

Significant factors in this case:

Competency in dementia management: Una's experience is not unique, rather, it is all too common. It highlights the need for hospital systems and staff competency to be upgraded as the number of patients entering the hospital system with a dementia diagnosis is projected to double by mid-century.

Ageist medical prognosis: The assumption by the registrar that the family would agree to cease all sustenance was egregious. The medical staff's attitude towards older adults is that they are a burden on the system, and as they are going to die anyway, causing that outcome a little earlier seemed to them an acceptable 'treatment' option.

Health service equity of access: The case study also reinforces the attitude of hospital staff regarding equivalence of treatment and access by the general community and residents from nursing homes. Again, there is an underlying assumption that nursing homes can provide care almost equivalent to that available in a hospital setting.

REG

Reg is a 71 year old man who is fully independent but has lived with increasing pain for several years due to an osteoarthritic left hip.

His medical history is unremarkable but he uses paracetamol when necessary to alleviate pain. He lives alone in a self-contained unit that is accessed by 13 steps from the front of the unit. Rear access is via a steep, grassy slope which becomes a fall hazard during wet weather.

Reg consulted the exercise physiologist at the nearby university and goes to the gym daily to remain as fit and healthy as possible. In August 2019, Reg's orthopaedic surgeon placed him on the "elective" public health list for a total hip replacement in May 2020. He was referred to the Hip and Knee Clinic for physiotherapy at the Community Health Centre and attended weekly sessions. He continued to attend the gym daily and began using a walking stick for stability and support due to increased decrepitude.

During his assessment with the Community Health service, he asked about accessing rehabilitation at a nearby regional hospital post-operatively due to the risky home access issues and lack of home supports. He was informed that this would not be possible as he is "too fit and healthy". He raised this request several times over the next few months and was told that transfer was not possible for him but that he would be eligible for Compack² home support, which is a 5 day a week up to 6-week support program for personal care, domestic assistance, medical transport and shopping if required.

No weekend support is available for personal care under that scheme. He therefore persisted in his request for rehabilitation at the regional hospital and was informed that hospital physiotherapy would ensure his safety before discharge and, if required, he would be referred for community physiotherapy.

Covid19 lockdown in March 2020 caused all elective surgery to be cancelled.

Reg continued his daily gym sessions. Although his pain increased and his movements became more restricted, he was still mobile. In July, when limited elective operating lists recommenced, Reg was offered a surgery date and admitted to the hospital on 1st September 2020.

Surgery was uneventful and during his post-operative assessment, Reg again broached the possibility of a transfer to the regional rehabilitation hospital. He was informed that there was no need for in-patient rehabilitation, as he would receive a Compack package on discharge for home assistance of 3 days per week.

²Compack is a non-clinical case managed program of community care available for people being transferred home from a participating New South Wales Public Hospital.

He enquired about physiotherapy on discharge and was informed that this could be done in the community but that the referral for community physiotherapy would possibly have a backlog before it could start.

Rehabilitation at Lismore Base Hospital involved a physiotherapist “walking him” using a forearm wheel walker for approximately 10 meters twice daily. Reg also requested assistance from nurses to ambulate on other occasions. He needed assistance with transfers from his bed to the toilet and shower. The supervised ambulation using a forearm walker occurred only when ward staff were ‘free’.

While in hospital, Reg asked the doctors and nurses about being transferred to the regional hospital near his home. They said they no longer had a discharge planner. Reg spent an uneventful weekend, using the forearm walker for ambulation, and being assisted in and out of bed as well as assistance with personal care. No physical therapy was available on weekends for acute patients. Nurses were unable to assist him to ambulate or exercise due to the pressure of other patients’ needs.

On the morning of 4th September, a medical officer unknown to Reg arrived and stated that the hospital was experiencing bed shortage. Reg was asked to consider a transfer to a regional hospital. Reg agreed to this as this has been his request previous. Within 2 hours he was transported to that hospital’s acute ward for admission.

On admission, the admitting doctor asked why he had been transferred to the acute ward and not in rehabilitation which was more appropriate. Rehabilitation therefore commenced on 7th September with an assessment and a rehab plan designed and decided upon with his doctor and allied health team. The intensive rehabilitation therapy progressed well and Reg ceased using pain medications on 10th September, but remained on daily aspirin to prevent clotting, with prescriptions available if pain control was required.

He was discharged according to plan on 21st September 2020 following occupational therapy and physio assessments and referred for follow-up with his surgeon on 8th October 2020. Home care services for personal care and domestics were arranged three times weekly, and community transport if required. Reg was cleared by the surgeon to drive, and home care services were no longer required after two visits. Full recovery has been achieved, and Reg is now attending gym four times weekly, and his progress is being monitored by the team.



Significant factors in this case:

Persistent self-advocacy is required to access services and ensure care continuity:

Reg's experience of taking control of his progress through multiple teams, services and organisations was the only way he could preserve continuity of care and gain access to services needed. His efforts at advocacy were strengthened by his knowledge of the health system, professionals and protocols.

Low staffing models of care compromise treatment goals: The staffing formula for different hospital areas needs to be calculated in terms of the case-mix and interventions required. Without rehabilitation, hip surgery would not be successful. Yet post-operative mobilisation of patients was not considered a priority due to workload. The rehabilitation goal of being fit and healthy under an "enablement" framework enables patients to return to their community faster, and reduces the burden of possible falls and impacts on the health system post-operatively. The consequences of complications of surgery and longer stays in the hospital seem not to be a consideration at the clinical end of health services.

Comprehensive assessments are crucial to older people's successful treatment outcomes: Multiple specialist assessments in isolation from other health assessments can lead to a piecemeal understanding of the circumstances and challenges faced by the older patient in accessing, enduring and recovering from medical interventions. Only when the whole health team communicates and acknowledges the full array of issues facing the patient, can a holistic plan be devised and implemented.



DISCUSSION

Critical reflection for health and medical professionals

This investigation reveals that older people know when they are being discriminated against based on their age. When medical practitioners subscribe to ageist stereotypes, the effort they put into determining an accurate diagnosis and selection of treatment options to offer, and the care and support plan they provide, is negatively influenced. Practitioners' (often) unconscious bias can cause real harm to those they are treating while prolonging unnecessary suffering and allowing patients to languish with reversible conditions that have not been diagnosed and therefore not treated.

To combat this unacceptable situation, all health practitioners need to learn to critically reflect on their practice and routinely evaluate the beliefs that influence their decisions when providing services to others. They must be mindful and aware of any personal biases and the root cause of any prejudices they hold that could affect their competence as a medical practitioner. The identification of practices that are the result of discriminatory attitudes and beliefs holds true not only for ageism but also for all the other forms of discrimination.

Respondents interviewed believed that doctors were less likely to display ageist attitudes if they perceived their patients as the “experts” of their own bodies. In other words, they respected the patient and valued shared decision-making. It is important to the respondents that doctors make treatment decisions using a collaborative decision-making approach and avoid making decisions purely based on age or presumptions arising from age stereotypes.

The issues raised in the stories presented here warrant further discussion and debate but mostly, they require action. Each of these matters is linked to policy or practice around health services and has connections with the education and training of all involved. The degradation of health professions, the compartmentalisation of services and health disciplines, the alienation of people from publicly funded institutions, and the rationing of service access and time by administrators with no accountability for doing so, is shifting the risk of poor health and a miserable existence onto older people who find it difficult to advocate for themselves and others.

Slowing the slide down to lower standards of care requires a groundswell that can only be triggered by people with knowledge of what could be and what should be, and a desire to reverse these trends so that trustworthiness, empathy and competence are re-established as standard practice within our essential services.

Implications for Health Professionals

We acknowledge that while the practice of ageist discrimination is widespread among Australian health practitioners, we also understand that many practitioners are unaware that they have adopted negative societal prejudices towards older adults who have no option but to depend on them for their expertise. The situation cannot continue. A strategy is needed to heighten the awareness of ageism which is causing prolonged misery for older patients, and how it undermines confidence in health services and the medical professions.

The findings of this project will be used to develop learning modules for students studying to become medical professionals and health managers. The learning modules aim to share information about ageism and how age discrimination impacts health care delivery and effectiveness. It is hoped that those exposed to the modules will develop better and more empathic communication, particularly in actively listening and responding to older people's concerns.

The modules, containing real-life scenarios, will help to raise awareness of internal biases and prompt a critical reflection on the practice of healthcare so that steps can be taken to ensure that interactions with older adults needing interventions will be a positive and supportive experience for them.

While this investigation focused on older people's interactions with medical practitioners, the issues of ageist attitudes within the health system are well known. We therefore encourage all health care administration and other personnel who are required to communicate with patients, to educate themselves about ageism and the unfairness that it engenders.

Data strengths and limitations

The strength of the current investigation relates to the collection of personal accounts of experiences of ageism in the context of health services. The small number of respondents were purposefully selected based on their experiences and they were forthright in their responses. However, the data collated cannot be regarded as being representative of all older Australians. The surveys were only made available to those who have internet access, have digital literacy and can communicate in the English language. The data was collected using the internet, thereby excluding those who could not use a computer or get help doing so.

Participant self-selection will have occurred by those who have experienced ageism making them more likely to participate in the survey than people who have not. We did not ask for positive experiences (non ageist) which could have provided a counter-balance to the ageism comments received. As noted, the surveys were only in English and therefore may not have been accessible to a large number of culturally and linguistically diverse populations with limited English proficiency.

However, the value of the investigation is that it provides a snapshot of ageism experiences shared by a capable group who have the means to access the survey. That said, the results strongly indicate that there is a problem that needs to be addressed and warrants further investigation.

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ACKNOWLEDGEMENTS

This investigation was led by Dr Anthony Brown from Health Consumers NSW and Yumi Lee from the Older Women's Network NSW.

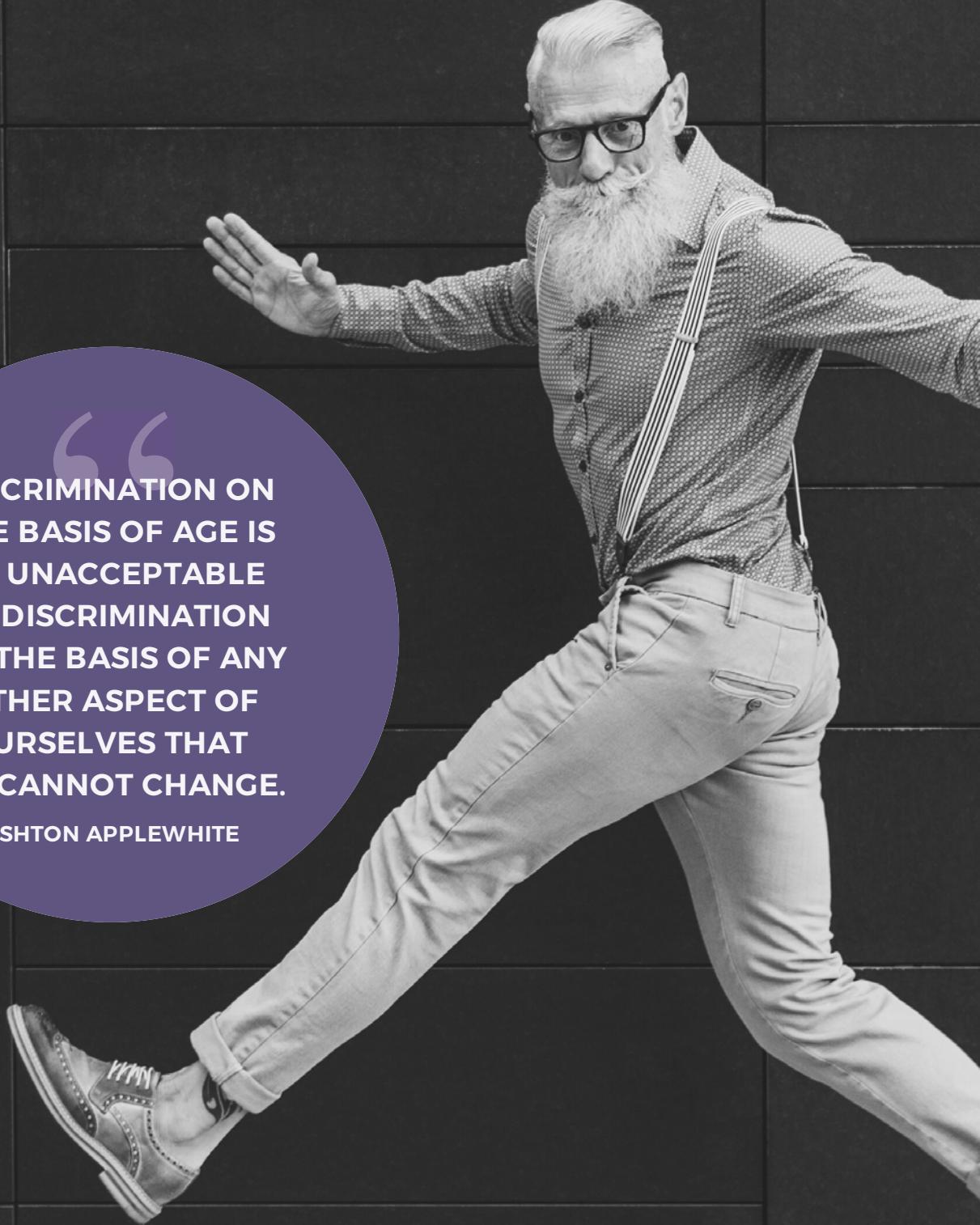
We would like to express our appreciation to the following:

- **Ms Kathryn Greiner AO**, Chair of the Ministerial Advisory Council for Ageing, for launching the report on March 18th 2021 at "Shifting Gears", the first Australian and New Zealand conference focussed on consumer leadership and experience in health care.
- **Dr Tracey McDonald AM**, for generously providing additional material, advice, support and expert guidance for the investigation.
- **Mr Rod Young & Mr Roy Starkey** for contributing to the report.
- The **respondents of the survey** and the interviewees who shared their personal stories with us. We are very grateful to them all for trusting us with their stories.



Health Consumers NSW acknowledges the support received from NSW Health.
Older Women's Network NSW acknowledges the support received from the
NSW Department of Communities & Justice.





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