The importance of addressing ageism in Swedish healthcare

Katarina Sjögren Forss

Abstract
Ageism is discrimination against individuals or groups based on their age. In the Swedish healthcare context, the term is uncommon, despite the fact that older people are a significant class of users. One of every five individuals in Sweden is 65 years of age or older, and the proportion of older people in the population is rising. Therefore, ageism in healthcare warrants more awareness and focus. In three recent articles that we have published relating to nutritional, depression and continence care for older people, we found indications of ageism even though we did not aim to study it. There is a need to identify the manifestations of ageism and label them, and to become alert to both the visible and invisible expressions of ageism. This will help in the development of interventions and policies to eliminate ageism in healthcare. With health inequalities growing and seemingly becoming the norm rather than the exception in Sweden and other European countries, it has become imperative to address and eliminate health inequalities through a range of initiatives and mechanisms. Fighting ageism in different settings must be a part of this larger goal.

Keywords
ageism, healthcare, Sweden, social determinants of health

Accepted: 5 May 2020

Ageism is the stereotyping of, prejudice and discrimination against people on the basis of their age. It can manifest in many ways, such as prejudicial attitudes, discriminatory behaviours and institutional policies and practices that propagate stereotypical beliefs. It is a widespread phenomenon based on the inaccurate notion that all members of a group, such as older people, are the same. As early as 1969, Robert Butler coined the term ageism to mean 'prejudice by one age group towards other age groups'. Much later, the term ‘ålderism’ emerged in Sweden. The term is now prevalent in discussions about the labour market. Reportedly, job applicants in their early 40s and above are experiencing the effects of ageism. However, in the Swedish healthcare context, the term is uncommon, despite older people being a significant class of users in healthcare. Approximately 20% of Sweden’s population is 65 years of age or older, and this proportion is increasing. These concerns motivated me to publish this discussion paper and urge attention to recognising ageism in Swedish healthcare.

Many international studies in recent years have focused on ageism in healthcare. These studies have highlighted the impact of ageism on older people’s health and wellbeing and the need for effective interventions to fight ageism. A longitudinal cohort study of 7731 participants aged 50 years and older about the associations between perceived age discrimination and health and wellbeing in England found associations between ageism and adverse health outcomes. In a systematic review that examined the impact of both structural and individual ageism on older people’s health, a strong and consistent association between ageism and adverse health outcomes was found. The authors concluded that ageism must be seen as a social determinant of health. Despite these indications, discussion and literature from a Swedish perspective remains scant.

Discrimination can be along the lines of gender, ethnicity, sexuality and disabilities, amongst other grounds. According to the WHO, ageism propagates the social and economic prejudice of making inequalities between groups legitimate and sustainable, just like discrimination with respect to gender and ethnicity. As such, ageism must be regarded as a social determinant of health, and must be given much more attention. Individuals who already face discrimination because of their gender, ethnicity, sexuality or disability are also getting older. They should not face
yet another mode of discrimination. With health inequalities growing in Sweden and other European countries, it has become critical to implement measures to address and eliminate them. Fighting ageism should be made an essential element of this agenda. In 2017, the WHO adopted its first global strategy and plan of action on ageing and health. The plan called for a global campaign to combat ageism, mandated changes in societal attitudes and recommended more accessible environments and changes to healthcare systems so that they align better with the needs of older people. From a Swedish perspective, the plan is needed.

In three recent papers that we published relating to nutritional, depression and continence care for older people, we found indications of ageism even though we had not set out to study it. All three studies took place in Sweden, had a qualitative approach and were based on interviews with registered nurses (RNs). In the first study, which focused on the perspectives of older people and RNs regarding nutritional care, we found that RNs tended not to involve older people in their own nutritional care.

Our findings indicated that even if RNs were aware of the importance of involving older people in their own nutritional care, this awareness was not reflected in practice. RNs seemed to prefer to give directives, sometimes with a paternalistic attitude, rather than to have a discussion with older people about the best ways to improve their nutrition. The RNs considered nutritional care a challenge. Consequently, nutritional supplement drinks were often their first and main choice of nursing intervention. In many cases, the involvement of the older people was limited to choosing the flavour of the drink.

In the second study, which focused on depression care by RNs who work at care centres for older people, we interviewed RNs regarding identifying and intervening in cases of depression symptoms observed in the older people at these care centres. Our findings indicated that appropriate nursing interventions in response to depression symptoms in older people were not part of routine nursing care. Older people did not have the same access to counselling services, such as cognitive behaviour therapy, that younger people did. Instead, the first-line treatment approach amongst the RNs was to book an appointment with a primary care physician who would mostly initiate pharmacological treatment even though research has shown that the majority of older people do not respond well to treatment with antidepressants.

The third study sought to illuminate RNs’ experiences regarding continence care for older people receiving home care, either in their home or in an assisted living facility. Although RNs stated that urinary incontinence was a common and significant health problem that had a negative impact on the life of older people, our findings indicated that it was not a prioritised area of care, and older people were not given a medical diagnosis for it in the primary care setting. Instead of attempting to solve the problem, the adopted approach was to prescribe absorbent continence pads.

Although the studies were small and therefore their conclusions ought to be viewed with caution, our findings indicated that the healthcare system is not unaffected by explicit or implicit ageism that can negatively impact the health and wellbeing of older people. Admittedly, the areas of care that we studied are challenging and complex, and we acknowledge that time pressures and other practical constraints might have led to some of the decisions made by the RNs. However, although the approach of the RNs in some cases could be considered understandable, it should not be deemed excusable. Our studies show that there is a need to address and resolve ageism in Swedish healthcare.

Our findings, combined with the lack of studies about ageism in the Swedish healthcare context, point to the need to identify the manifestations of ageism and define and label them. Labelling the phenomenon as ageism and defining and labelling other aspects of this issue will help make the phenomenon and its manifestations more noticeable and increase the use of the term in the Swedish healthcare context. In hindsight, we should have used the term ageism in our studies. As a society, Sweden should increase its awareness of not just the conspicuous, but also the subtle forms of ageism. This will help in the designing of effective interventions and policies to eliminate ageism from healthcare. It is crucial that we not only conceive solutions, but also implement them successfully. This effort has to be undertaken in both clinical and educational settings where we can start by identifying the subconscious stereotypes that people may harbour about older people. Changing social norms and behaviours is tricky, but it is possible. The scientific community should research this issue in the field and report findings regarding the health effects of ageism from a Swedish perspective. It is essential that we obtain and integrate the views of older people regarding their experiences of ageism in different healthcare settings and its consequences for their physical and mental health. Equally, we must obtain the perspectives of healthcare professionals. As Robert Butler advised, everything that we do together to fight ageism will benefit all of us, as all of us will grow old.

**Funding**

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

**Conflict of interest**

The author(s) declare that there is no conflict of interest.

**ORCID iD**

Katarina Sjögren Forss https://orcid.org/0000-0002-3594-3944

**References**

2. Jackson SE, Hackett RA and Steptoe A. Associations between age discrimination and health and wellbeing: cross sectional