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Attitudes Toward Ageism Among Home Health Workers: A Cross-Sectional Study

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ABSTRACT

Objective: This study was conducted to determine the attitudes of home health workers serving in home health services units of a province in the Central Anatolia Region toward ageism against elderly people.

Methods: The population of the study included 64 home health workers serving in Home Health Services units affiliated with the Provincial Health Directorate, in line with the records of the Home Health Service Coordination Center in the province in August 2019. Totally 64 home health workers who agreed to participate in the study were included. Descriptive characteristics were collected and the Ageism Attitude Scale (AAS) was used to evaluate toward ageism against elderly people. Analyses were performed with the IBM SPSS Statistics 23 program.

Results: The mean age of the home health workers were 32.64+7.75 years; 59.4% of them were female, and 40.6% had a master's degree. In the present study, 40.6% (n=26) of the healthcare professionals were nurses, 35.9% (n=23) were doctors, 14.1% (n=9) were health technicians, and 9.4% (n=6) were midwives. A significant difference was found between the total score for ageism attitudes and marital status, educational status, occupation, years of work in home health care, and willingness to take courses related to the elderly people (P<0.05). Significant positive correlations were found among the subscales of the AAS.

Conclusions: The total score for home health workers' attitudes toward ageism in home healthcare services was found to be at a medium--high level. In this context, the importance of training healthcare workers involved in home healthcare services for elderly care and ageism has become apparent, and it is recommended that courses and seminars related to the elderly be planned for healthcare workers.

Keywords: Home health services, ageism, elderly, Ageism Attitude Scale, home healthcare

INTRODUCTION

The development of technology and its reflection in the field of health has led to an increase in life expectancy. The increase in the number and proportion of elderly people in the total population has led to the emergence of old age as an important problematic area in modern society.[1] In this direction, it has been reported that by 2050, the global population of elderly people will more than double and reach 2.1 billion.[2] In Türkiye, the proportion of the elderly population in population projections is predicted to be 12.9% in 2030, 16.3% in 2040, 22.6% in 2060 and 25.6% in 2080. [3] Accordingly, geriatric issues need to be addressed with the highest priority for the well-being of the global population.[4] Moreover, the increase in life expectancy has led many older people to experience health problems, disabilities and care needs that prevent them from taking care of themselves, and older people often experience explicit or implicit ageism.[4,5]

The perceptions and attitudes of healthcare professionals toward aging can affect the quality of the service provided. It has been reported that negative attitudes toward older people and aging, especially among healthcare professionals, lead to serious consequences and that older people who encounter such problems experience various types of hopelessness, which not only negatively affects the treatment processes and quality of care but also pushes them into psychosocial loneliness.[6]

It is stated that ageism is made by healthcare professionals in terms of not giving enough importance to elderly people, preferring to provide services to young people, not using explanatory

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expressions in obtaining information, attributing the disease to aging, and neglecting treatment. [7] In this respect, it is necessary to mention the concept of elderly ageism, since older people are more prone to having multiple comorbidities and age-related health problems, and health is an important area in the context of elderly ageism.[4] The concept of elderly ageism is defined as a very comprehensive definition that includes differences in attitudes, prejudices, behaviors and actions shown to a person only because of their age.[7] Moreover, in the literature, age ageism has many effects on the physical, mental and social well-being of elderly people, which leads to decreased life expectancy, social isolation and decreased adherence to preventive health behaviors.[8,9]

Healthcare workers working in home healthcare services can be said to be at risk of elderly ageism since the majority of the groups they serve are elderly individuals. However, there are no studies on ageism against elderly healthcare workers in home health services. For this reason, a quantitative evaluation of the attitudes of home health care workers toward elderly individuals is important in terms of both determining the level of awareness and increasing the quality of service. Moreover, determining the attitudes of home health care workers and organizing new in-service training strategies that encourage positive attitudes toward older people are important for improving the quality of health care provided to older people. For this reason, it is thought that it is necessary to determine the perceptions of employees toward old age.

METHODS

This study was conducted as a cross-sectional study to determine the attitudes of home health workers toward ageism among health care workers serving in Home Health Services in the Provincial Health Directorate of a province in the Central Anatolia Region. The population of the study included 64 home health workers serving in Home Health Services in the Provincial Health Directorate in line with the records of the Home Health Service Coordination Center in the province in August 2019. All home health workers who agreed to participate in the study were included, and no sample selection was performed. For data collection, the data were filled in by the participants in December 2019 within a period of 10–15 minutes after the purpose of the research was explained. The participants were informed about the research by the researcher, and their consent was obtained. Before starting the study, ethics committee permission was obtained from the Noninterventional Clinical Research Ethics Committee of the Sivas Cumhuriyet University (Date: 09.10.2019, Number: 2019-10/01) in the province where the study was conducted, and written permission was obtained from the Sivas Provincial Directorate of Health, where the application will be carried out.

Data collection tools

The Introductory Characteristics Form and the Ageism Attitude Scale (AAS) were used in this study.

Introductory Characteristics Form was prepared by the researcher and consists of 10 questions. The form includes introductory information about the home health worker and questions about whether the home health worker has received training on elderly health.

Ageism Attitude Scale: This scale has three dimensions: limiting the life of elderly individuals, positive ageism toward elderly individuals, negative ageism toward elderly individuals, and 23 items in total. The item options are a five-point Likert-type scale with a minimum score of 23 and a maximum score of 115. The Cronbach's alpha reliability coefficient of the scale developed by Vefikuluçay is 0.80. The highest score obtained from the scale indicates a positive attitude toward elderly ageism, whereas the lowest score indicates a negative attitude toward elderly ageism.[10] As a result of the reliability analysis applied to the Cronbach's alpha internal consistency coefficients of the AAS and its subdimensions, the elderly ageism attitude scale consisting of 23 items is highly reliable (α=0. 741), the subdimension of limiting the life of elderly individuals, consisting of nine items (α=0.713), and the subdimension of positive ageism toward elderly individuals, consisting of eight items (α=0.601), were found to be highly reliable, and the subdimension of negative ageism toward elderly individuals, consisting of six items, was found to be reliable (α=0.492).

Statistical analysis

The study data were analyzed via transfer to the IBM SPSS Statistics (IBM SPSS Corp., Armonk, NY, USA) 23 program. The frequency distributions were used for categorical variables, and descriptive statistics (Means ± SD) were used for numerical variables. The Kolmogorov–Smirnov normality test, independent sample t test, one-way analysis of variance (ANOVA), Tukey test and Pearson correlation coefficient were used to analyze the data. $P < 0.05$ was set as the threshold for significance.

RESULTS

The mean age of the health care workers in the study were 32.64±7.751, the majority (59.4%) were female, 56.3% were married, and the family type (90.6%) was a core family. In addition, 40.6% had a master's degree, 40.6% were nurses, and 89.1% lived in the province. A total of 70.3% of the healthcare workers did not take any courses about elderly individuals, and 79.7% wanted to take courses about the elderly (Table 1).

Table 1. Demographic Characteristics of Home Health Workers and Distribution of Their Views on the Elderly

	Min.-Max.	Means±SD
Age	22-52	32.64±7.751
Work Year	1-28	8.16±7.132
Home Health Work Year	1-9	2.52±2.265
	Number of Person (n=64)	**Percent (%)**
Gender		
Female	38	59.4
Male	26	40.6
Marital Status		
Single	28	43.8
Married	36	56.3
Family Type		
Core Family	58	90.6
Extended Family	6	9.4
Education Status		
High School	3	4.7
Associate Degree	13	20.3
Bachelor's Degree	22	34.4
Master's Degree	26	40.6
Profession		
Nurse	26	40.6
Doctor	23	35.9
Health Technical	9	14.1
Midwife	6	9.4
Status of Taking Courses on Elderly		
Yes	19	29.7
No	45	70.3
Requesting a Course on the Elderly		
Yes	51	79.7
No	13	20.3

The mean and standard deviation of the total score of the AAS of the home health workers were 87.58±7.83 and 36.95±4.19 in the subdimension of "limiting the life of the elderly", 32.34±3.28 in the subdimension of "positive ageism toward the elderly" and 18.28±3.073 in the subdimension of "negative ageism toward the elderly". The total score for healthcare workers' attitudes toward ageism in home healthcare services was found to be at a medium-high level (Table 2).

Table 2. Distribution of the Mean Scores of Home Health Workers in AAS and Subdimensions

AAS and Sub-Dimensions	n	Min–Max	Mean±SD
Total AAS	64	66-106	87.58±7.83
Sub-Dimensions			
Limiting the Life of the Elderly	64	24-45	36.95±4.19
Positive Ageism against the Elderly	64	23-37	32.34±3.28
Negative Ageism against the Elderly	64	9-25	18.28±3.07

There was no significant difference between the mean scores of the total score and subdimension scores of the AAS and between age group and gender (P>.05). There was a significant difference between the mean scores of the total score and the subdimensions of positive ageism toward the elderly and negative ageism toward the elderly and marital status (P<.05), but there was no significant difference according to the mean score of the subdimension of limiting the life of the elderly (P>.05). A significant difference was observed between the total score of the AAS and the mean scores of all subdimensions and between educational status and occupation (P<.05). A significant difference was observed according to the mean score of the subdimension of positive ageism against the elderly in the working year (P<.05), and the difference was not significant

according to the mean scores of the AAS total score and the subdimensions of limiting the life of the elderly and negative ageism against the elderly between the working years (*P*>.05). The difference between the mean scores of the AAS working year AAS total score and the mean scores of the subdimensions of positive ageism toward the elderly and negative ageism toward the elderly was significant (*P*<.05), and the difference between the mean scores of the subdimension of limiting the life of the elderly in the AAS working year was not significant (*P*>.05) (Table 3).

Table 3. Distribution of the mean total and subscale scores of AAS according to sociodemographic characteristics

	n	Limiting the Life of the Elderly	Positive Ageism Against the Elderly	Negative Ageism Against the Elderly	Total Scores
Age Group		**Mean±SD**	**Mean±SD**	**Mean±SD**	**Mean±SD**
22-26 years	22	37.50±1.994	33.27±2.815	18.82±1.790	89.59±4.250
27-36 years	22	37.73±2.434	31.59±3.487	18.23±3.491	87.55±6.201
> 37 years	20	35.50±6.637	32.15±3.422	17.75±3.697	85.40±11.454
F; *P*		1.810; .172	1.525; .226	.631; .536	1.525; .226
Gender					
Female	38	36.50±4.958	32.05±3.136	17.89±3.091	86.45±8.867
Male	26	37.62±2.669	32.77±3.491	18.85±3.016	89.23±5.778
t; *P*		-1.046; .299	-.857; .395	-1.221; .227	-1.407; .164
Marital Status					
Single	28	37.25±2.429	33.64±2.642	19.18±2.001	90.07±5.938
Married	36	36.72±5.191	31.33±3.397	17.58±3.573	85.64±8.623
t; *P*		.539; .592	2.965; **.004****	2.262; **.028***	2.323; **.023***
Education Status					
High School/Associate Degree	16	33.69±6.610	30.69±2.089	15.81±3.468	80.19±9.432
Bachelor's Degree	22	37.73±2.798	31.09±3.571	18.73±2.453	87.55±5.738
Master's Degree	26	38.31±1.490	34.42±2.469	19.42±2.469	92.15±4.096
F; *P*		8.067; **0.001***	11.986; **0.000****	9.020; **.000****	17.691; **.000****
Difference		**1-2,3**	**3-1,2**	**1-2,3**	**1-2-3**
Profession					
Nurse	26	34.81±5.396	30.38±3.073	17.27±4.143	82.46±8.406
Doctor	23	38.52±.898	35.26±0.449	19.74±.449	93.52±0.898
Health Technical/Midwife	15	38.27±3.369	31.27±2.963	17.80±2.426	87.33±6.466
F; *P*		6.815; **.002***	26.254; **.000****	4.669; **.013***	19.231; **.000****
Difference		**1-2,3**	**2-1,3**	**1-2**	**1-2-3**
Work Year					
1-2 year	24	37.17±1.633	33.75±2.382	19.04±1.706	89.96±4.379
3-10 year	15	38.20±1.821	31.33±3.677	17.87±2.356	87.40±3.942
> 11 year	25	36.00±6.298	31.60±3.416	17.80±4.223	85.40±11.087
F; *P*		1.356; .265	3.895; **.026***	1.185; .313	2.156; .125
Difference		-	**1-2,3**	-	-
Home Health Work Year					
1 year	24	37.92±1.976	34.42±2.225	19.17±1.494	91.50±4.462
2 year	16	37.69±2.272	31.56±3.759	19.00±3.651	88.25±4.851
> 3 year	24	35.50±6.108	30.79±2.797	16.92±3.438	83.21±9.820
F; *P*		2.427; .097	10.295; **.000*****	4.184; **.020***	8.404; **.001****
Difference		-	**1-2,3**	**3-1,2**	**1-3**

**P< .05 **P< .01 ***P< .001*

1= High School/Associate Degree 2= Bachelor's Degree 3= Master's Degree

1=Nurse 2=Doctor 3= Health Technical/Midwife

1=1-2 years 2=3-10 years 3=11 years and over

1=1 year 2=2 years 3=3 years and over

While the difference between the mean score of positive ageism against the elderly subdimension and taking a course about the elderly was found to be significant (*P*<.05), the difference between taking a course with the elderly and the total score of the AAS and the mean scores of the subdimensions of limiting the life of the elderly and negative ageism against the elderly was not significant (*P*>.05). Accordingly, the mean score of positive ageism against the elderly subdimension of those who took a course about the elderly was significantly lower than the mean score of those who did not take a course. The difference between wanting to take a course about the elderly and the mean scores of the total score and all subdimensions of the AAS was significant (*P*<.05). Accordingly, the mean scores of those who wanted a course about the elderly were significantly higher than the mean scores of those who did not want a course (Table 4).

Table 4. Distribution of the mean total and subdimension scores of the AAS according to some characteristics related to the elderly

	n	Limiting the Life of the Elderly	Positive Ageism Against the Elderly	Negative Ageism Against the Elderly	Total Scores
Status of Taking Courses on Elderly		**M±SD**	**M±SD**	**M±SD**	**M±SD**
Yes	19	37.00±2.728	30.95±2.656	17.16±3.005	85.11±3.900
No	45	36.93±4.702	32.93±3.360	18.76±3.009	88.62±8.822
t; *P*		.058; .954	-2.289; **.026***	-1.942; .057	-1.664; .101
Requesting a Course on the Elderly					
Yes	51	37.98±2.293	33.06±3.042	18.90±2.138	89.94±5.293
No	13	32.92±6.946	29.54±2.665	15.85±4.741	78.31±9.402
t; *P*		2.590; **.023***	3.811; **.000*****	2.266; **.041***	4.291; **.001****

**P<.05 **P<.01 ***P<.001*

Table 5 shows that when examining the relationship between subscale scores, there is a low level of positive correlation (r=0.295; *P*<.05) and a moderately positive linear relationship (r=0.551; *P*<.001) between limiting the elderly person's life and negative ageism against the elderly person. However, no significant linear relationship was observed between positive ageism against elderly people and negative ageism against elderly people (*P*>.05).

Table 5. Examination of the Relationship between Ageism Attitude Scores

		1	2	3	4
1) Attitude Toward Ageism (Total Scores)	r	1			
	P				
2) Limiting the Life of the Elderly	r	.875	1		
	P	**.000****			
3) Positive Ageism Against the Elderly	R	.601	.295	1	
	P	**.000****	**.018***		
4) Negative Ageism Against the Elderly	r	.714	.551	.064	1
	P	**.000****	**.000****	.614	

**P<.05 **P<.001 r= Pearson correlation coefficient*

DISCUSSION

In this study, the differences between the attitudes of home health workers working in home health services toward elderly ageism and the mean scores of elderly ageism attitudes with respect to education level, occupation, total working years, duration of service in home health, receiving and requesting training for the elderly and marital status were significant. However, the mean total score of the home health workers was 87 indicating that the employees had positive attitudes toward elderly ageism. In terms of the subdimensions of the scale, employees have a positive attitude, and the mean scores are "limiting the life of the elderly" in the first place, "positive ageism against the elderly" in the second place and "negative ageism against the elderly" in the third place. In studies conducted with nursing and medical students, the scale scores are similar.[11,12] This may be due to social value and positive attitudes toward old age. In fact, a positive attitude toward elderly ageism is influenced by the effects of traditional structures, such as respect for elderly individuals, adoption of elderly individuals, the importance of providing services to the elderly in the society in which they are located, and the cultural perspective toward the elderly people.[13]

In general, home health services are defined as the provision of health services and social services by qualified and competent personnel or family members in the person's home or living environment with the aim of protecting, promoting and restoring the health of the person.[14] However, the majority of individuals who benefit from home health care services are 60 years of age and older.[15-17] In this vein, the fact that healthcare professionals working in home health services interact with elderly individuals, who constitute the majority of the individuals they serve, and their attitudes toward the elderly appear to be a critical element in terms of health service quality. In this study, the significant differences between favorable ageism toward the elderly and years of employment, years of home healthcare services employment, taking a course about the elderly and requesting a course about the elderly support this situation. Moreover, good workplace conditions and having received training in the field are

among the factors associated with positive ageism toward elderly individuals.[13]

In this study, a significant difference was observed between the total score and subdimensions of the scale and educational status. The fact that the majority of the health care workers had master's degrees (40.6%) and bachelor's degrees (34.4%) is similar to the literature. In fact, in the literature, studies have shown that an increase in the educational level of employees positively affects their attitude toward elderly people, but other studies have shown that the level of education does not significantly differ.[18-21] Moreover, the difference in the status of taking a course about the elderly and requesting a course supports the significant difference in educational status. There was a significant difference between the attitudes of ageism against elderly home health workers and their marital status, and the mean scores of single workers were higher. A study of nurses working in primary care reported that the total scores of elderly ageism attitudes were higher and significantly different among single nurses. In the same study, there was a greater and significant difference in the total scores of elderly ageism attitudes between married nurses working in secondary care and single nurses.[22] In studies conducted with medical students and academic staff, no significant difference was found between marital status and elderly ageism.[12,23] The differences in the results may be due to sampling differences and the situations of encountering elderly individuals in the work environment. In the literature, it is emphasized that social and social interaction may be important in the formation of attitudes toward elderly individuals.[21] In fact, the way both society and professionals perceive old age, their perspectives and prejudices affect the quality of the service provided in the provision of health services.[13] In this context, the study revealed a weak positive correlation between limiting the elderly person's life and positive ageism and a moderate positive correlation between limiting the elderly person's life and negative ageism; these findings suggest that elderly individuals may be exposed to both protective and restrictive approaches at the same time. On the other hand, the absence of a significant relationship between positive and negative ageism suggests that these two dimensions operate independently of each other. In this sense, healthcare professionals may exhibit overly helpful and protective behaviors toward older adults without simultaneously holding negative judgments, or they may hold negative stereotypes without exhibiting positive ageism. The fact that positive and negative ageism operate independently of each other suggests that ageism cannot be considered a one-dimensional structure; rather, it is a multidimensional phenomenon in which different tendencies can emerge together or separately.

CONCLUSION

Since the majority of the group served in home health services is elderly, it is recommended that studies be conducted on the subject in larger samples. Moreover, the fact that the majority of the findings included the situation of wanting courses about the elderly in the majority can be said of among the recommendations to organize training activities on this subject. As a result of this study, suggestions were presented in the form of developing training programs and conducting studies with large samples. In this direction, the high demand of participants for training in communication and care with elderly individuals reveals the necessity of developing structured and continuous training programs for healthcare professionals in this field. Considering that a large proportion of individuals who benefit from home health services are elderly individuals, quantitative and qualitative studies should be conducted in different regions and with larger samples to increase the generalizability of the findings on ageism among elderly individuals.

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