Health Care for Older People in Ireland

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Despite a low level of popular advocacy for older people, specialist medical and psychiatric services for older people have developed rapidly in Ireland, and geriatric medicine has become the largest medical specialty in hospital practice. Official policy has incorporated significant recognition of the special needs of older people, but implementation of these policies has been variable and inadequate. No significant transfer of funding has accompanied advances in specialist medical manpower, and there are deficiencies in the full complement of rehabilitation therapists available in the hospitals and the community. Community and long-term care services are relatively underdeveloped; it may require legislative initiatives similar to the Older Americans Act to prompt the profound improvement required in these areas. **J Am Geriatr Soc 51:1280–1286, 2003.**

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In pre-Christian Irish civilization, there was a strong tradition of supportive age-specific care for older people under a system of laws known as the Brehon laws.[1] With colonization by the Normans in the 12th century, these laws fell into disuse, and care of older people (≥ 65) was probably of the same nonspecific nature as practiced in the rest of Europe. There was little differentiation between the care for the indigent of all ages and older people, and during the great potato famines of the middle of the 19th century, a series of workhouses were built. These became the basis for state-funded institutionalized care of older people until the later part of the 20th century.[2]

This article focuses on health care for older people in the Republic of Ireland. The health service in Northern Ireland is part of the National Health Service of the United Kingdom. Nevertheless, there are strong personal and institutional links between medicine on the two sides of the border. The Irish Gerontological Society is an all-Ireland organization. Conversely, most geriatricians in the Republic of Ireland belong to the British Geriatric Society (BGS), and the BGS has twice held its bi-annual scientific meeting in the Republic.

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A COUNTRY OF YOUNG PEOPLE?

By European standards, Ireland is a relatively youthful nation; the proportion of older people in the population is 11.5%, compared with a European Union (EU) average of 15%. However, this proportion is set to grow to 14% by 2011.[3] Of the current population of older people, 21.9% are aged 80 and older, and this will increase to 24.9% by 2011. As elsewhere in the world, there is a preponderance of older women to men.

Irish men and women have the lowest life expectancy at age 65 of all countries in the European Union; 65-year-old men can expect to live another 13.7 years and women another 17.4 years.[4] The life expectancy of older Irish men has shown little improvement over the last 40 years; it has only improved by 1.8 years between 1952 and 1994. The life expectancy of Irish women at age 65 improved by 4.1 years over the same period. Irish men at birth can expect to live for 73.2 years and Irish women for 78.7 years. A major contributory cause of the low life expectancy is the high rate of cardiovascular disease; the standardized mortality for ischemic heart disease of 194.4 per 100,000 population is almost twice the EU average of 114.5 per 100,000 population. Genetic and lifestyle issues, such as a high fat intake relative to other EU countries (although cigarette and alcohol usages are at average levels for the European Union), may in turn contribute to this excess mortality.[4] The vast majority of older Irish people live in the community, with fewer than 5% of residents in long-stay care institutions in 1995.[4] A relatively low number of older Irish people live alone: 25.8% as opposed to the European average of 40%. This increases to 29.7% for people aged 75 and older, with the majority being women. Social supports are strong; a recent survey showed that 44% of the respondents received informal help from one or more people on a regular basis.[5]

Elderly Irish people are less likely than the general Irish population to experience basic (lack of food and clothing) or secondary (lack of lifestyle or household items) deprivation. This is presumably because all are entitled to at least a noncontributory old-age pension; in 1999–2000, this was IR£79 ($88) a week (Ireland changed from the

0002-8614/03$15.00

Irish pound (IR£) to the Euro (€) on January 1, 2002, at a conversion rate of €1 = IR£0.787. For convenience, all money figures are quoted in IR£). The average industrial wage was IR£376 per week ($420) for men and IR£256 per week ($286) for women at this time, but older people are more likely to have low quality housing, and their income has lagged behind that of younger people so that they are at greater risk of subsisting on incomes below the poverty level.[5] The background trends in income are not encouraging; older people's incomes deteriorated between 1987 and 1997. In 1997, about 60% of older people were living on less than IR£100 ($112) per week, and 90% were living on less than IR£200 ($224). Many older people depend almost completely on the state old-age pension, due to reach a minimum of IR£106 ($142) a week for those with no other means in 2002; the purchasing power parity of this sum is $142. Noncash benefits available to all older people include free bus and train travel and free telephone rental, but their relative worth is probably overestimated, because many older people are unable to avail of these public transportation services.[6]

Most older people in Ireland live in their own homes, and the rate of owner-occupied dwellings (86%) is the highest in the European Union. Of the rest, 3.6% live in privately rented accommodations, and 7.3% live in social housing (a somewhat euphemistic phrase encompassing everything from ordinary municipal housing to sheltered housing). The not-for-profit sector provides about 2.7% of the housing, most of which can be loosely categorized as sheltered housing.[7] The degree of oversight of this type of sheltered housing program is variable, and an underlying concern of many health professionals is the failure to adequately plan health and social services and eventual need for nursing home care for the vulnerable groups who tend to live in sheltered accommodations.[8]

Public advocacy for older people is relatively underdeveloped. It is divided among five groups with relatively modest political effect; these include the Irish Association of Older People, Age Action Ireland, the Irish Senior Citizen's Parliament, the National Federation of Pensioners, and the Federation of Active Retirement Associations. The government has instituted a national organization to promote positive attitudes toward aging called Age and Opportunity, which has had a modest effect and low profile. Its most visible activity is a month-long festival of aging and the arts, Bealtaine, which is held each May. The underdeveloped state of popular advocacy on aging issues may explain the low level of outcry at deficits in community care and long-term care and the indifference to some of the overt ageism in the healthcare system. These include a breast-cancer screening program[9] that has an upper cutoff age of 65 (despite protestations from geriatricians) and clear evidence of less-aggressive treatment for older people with many forms of cancer.[10] It is a tribute to the foresight and determination of a handful of individuals in Irish public life who have been instrumental in the positive developments have taken place in this context.

HEALTH STATUS

A 1993 study of older people in the community found that the health of older Irish people was generally good.[11] More than half of respondents reported no major illnesses, and 57% considered their health to be good or very good. Similarly, in a 2000 study of older people in the community, 80% rated their quality of life as very good or good.[12] As in many other countries, the level of disability rises with advancing age. In a community survey in 1993, 46% of older people reported having at least one major illness, 12% had at least two conditions, and almost 2% said they had three or more. There is also evidence from Irish epidemiological surveys that mental health problems increase with later life.[13] A community study of dementia using the computerized version of the Automated Geriatric Examination for Computer Assisted Taxonomy suggested a prevalence rate of 5%,[14] and an earlier study using the Mini-Mental State Examination suggested a rate of cognitive impairment of 16%.[15]

STRUCTURE OF THE HEALTH SERVICES

Describing the Irish healthcare system to a wider audience in a brief and meaningful way represents a significant challenge. Built on foundations of private medicine,

Table 1. The Irish Healthcare System Profile in Numbers[4,18]

Total population, n	3,626,087
– Men	1,800,232
– Women	1,825,855
Total population aged ≥65, %	11.4
– Men	4.9
– Women	6.5
Total population aged ≥85, %	1
– Men	0.3
– Women	0.7
Life expectancy at birth, years	
– Men	73
– Women	78.7
Life expectancy at age 65, years	
– Men	13.7
– Women	17.4
Life expectancy at age 80, years	
– Men	5.9
– Women	7.6
Total health care expenditure (% of gross domestic product)	6.8
Physicians (per 100,000 inhabitants)	230
General practitioners in public system (per 100,000 inhabitants)	45.4
General practitioners (estimate[44]) (per 100,000 inhabitants)	74.8
Consultant geriatricians (per 100,000 inhabitants)	1.13
Registered nurses beds (per 1,000 inhabitants)	16.5
Acute care hospital beds (per 1,000 inhabitants	10.1
Nursing home beds (per 1,000 inhabitants aged ≥65)	45
Residential home beds (per 1,000 inhabitants aged ≥65)	0.26

charitable initiatives, and a public health service, the convoluted history of its development has been best captured in the title and text of a compact history by a former senior civil servant in the Department of Health entitled *Health, Religion and Politics*.[16] It is only in the last decade that the Irish Department of Health has articulated explicit global strategies for the whole health service.[17,18]

Perhaps one of the most puzzling features of the health service to outsiders is the relative lack of statistical data on its operation, as can be seen by gaps in international surveys such as the Organization for Economic Cooperation and Development (OECD) *Health at a Glance*.[19] For example, public access to family doctors is by way of a capitation system, and no record is kept of the number of visits made to family doctors. General hospitals are funded based on historical spending, and efforts to link reimbursement to the numbers of patients treated and case mix have been circumscribed. This paper has drawn on the limited official health statistics[4] and reports from a range of agencies.

The administrative unit for the publicly funded system is the Health Board. There are 10 of these, each with a catchment population of between 250,000 and 500,000; the three health boards covering the area around Dublin have a coordinating agency, the Eastern Regional Health Authority.[20] The health boards provide a wide range of services, many directly provided and others contracted to voluntary (not-for-profit) agencies and hospitals. The small size of these administrative units has led to difficulties in rationalizing specialist services and regional variations in implementation strategies of national policy for older people. There have also been different interpretations of obligations to provide elements of health care to older people. Within the remit of the health boards are certain social services, with the others largely held by the Department of Social, Community and Family Affairs.[21] Health and social services tend to be relatively poorly coordinated. Surveys of the service[22] confirm the perceptions of older people with disability—that access to and availability of health and social services are limited.[12] According to a 2001 report prepared for the Department of Health and Children, an additional 1,300 chartered physiotherapists and 875 occupational therapists will be needed if adequate services are to be provided in the years ahead.[23]

For many years, the Irish healthcare system has been underfunded by international standards. The number of specialists is low by international standards; for example, for the population of 3.8 million, there are only 14 neurologists and 31 cardiologists in the public service and fewer than five in each specialty in private practice.[24] Although healthcare spending has risen with a recent increase in economic prosperity, many areas of health service, including elderly care, remain underdeveloped. In 1998, Ireland spent 6.8% of its gross domestic product on health, compared with an average of 8% for the European Union, 8.2% for the OECD countries, 9.3% for Canada, and 12.9% for the United States.[19] Even the use of gross domestic product may give rise to an overestimate, because many international information technology corporations have their European bases in Ireland. Repatriation of profits inflates gross domestic product, and gross national product may be a more sensitive index of health spending.

There is a strong emphasis on primary care, and access to specialist care can only occur after referral from a family doctor. Older people are frequent users of certain health services; almost half had seen a doctor in the last 4 weeks, and only 11% had not seen a doctor within the previous year.[11] With developments in hospital care, the average length of stay for people aged 65 and older fell from 15.3 to 10.5 days between 1985 and 1996.[25]

ACCESS TO HEALTH CARE

There is a mixed public and private healthcare system in Ireland. Approximately one-third of the population has access to universal primary medical and hospital care, including free medication based on income. This is known as the General Medical Scheme. Recently, this scheme was extended to cover everybody aged 70 and older.

All other adults are entitled to virtually free access to all public hospital services (a maximum annual payment of IR£260 ($291) must be paid), and all medication costs over IR£42 ($47) a month are reimbursed by the state. However, they have to pay for primary care from their own resources and do not have access to (limited) community services. All healthcare expenses are deductible against income tax. One-third of the population subscribes to private healthcare insurance; at present there are only two companies because Ireland insists on a community-rating basis for premiums (i.e., no higher premiums for increased age). This insurance is predominantly directed toward elective hospital care. The main advantage of private health insurance is avoiding the long waiting list for elective surgical procedures in the public system. There is little allowance for the specialist demands of geriatric medicine. No private hospital has a department of geriatric medicine.

There is a nationwide uncertainty as to the extent of entitlement to nursing home care.[26] Although the government provides for a means-tested subvention (i.e., subsidy) toward private nursing home care, this represents less than one-third of the weekly cost of a nursing home in the major cities. Further problems include a shortage of private nursing homes in cities, and there is evidence of a tendency of the private nursing homes to refuse those with significant dependency.[27] Other sources of care include fully subsidized places in private nursing homes and voluntary and health board institutions. There is no clearly stated policy on means testing for these institutions, and older people with severe disability are increasingly being admitted to general hospitals and spend a significant length of time awaiting placement in one of the fully subsidized beds.[28]

SPECIFIC HEALTHCARE POLICIES FOR OLDER PEOPLE

There are three main sources for the development of specific healthcare policies for older people in Ireland. These are a government report, *The Years Ahead—A Policy for the Elderly*; a strong core of specialists in geriatric medicine; and a national advisory body, the National Council on Aging and Older People.

The Years Ahead,[29] published in 1988, was the report of a working group, with input from many disciplines and healthcare administrators, appointed by the Minister for

Health to develop a blueprint for services for the elderly with the goals of maintaining older people at home where possible at an optimal level of health and independence and enabling those who cannot live at home to receive treatment, rehabilitation, and care as close as possible to home. The report made extensive recommendations regarding social and medical needs of older people including the need for adequate housing and income; health promotion; partnership between caregivers, volunteers, and statutory agencies; and development of comprehensive and coordinated services for all older people whether at home, in the hospital, or in institutional care. The special needs of elderly mentally ill patients were also recognized.

The report was adopted as an official government policy in 1993, and although it has been influential in shaping Health Board policies for older Irish people, a review of its effect after 8 years found that many recommendations remained unfulfilled and noted that almost no extra spending had been directed to older people.[25] This is in stark contrast to childcare services, which expanded greatly after specific legislation in 1991. It is the opinion of the National Council on Aging and Older People (and of many geriatricians) that specific legislation will be required to underpin the development of appropriate levels of services for older people.[30] This point was emphasized once again in a new National Health Strategy launched in 2001; the many worthy initiatives for older people were among the only areas whose introduction was circumscribed by the "prevailing budgetary situation."[18]

NATIONAL COUNCIL ON AGING AND OLDER PEOPLE

A vital catalyst in the development of national strategies on aging has been the National Council on Aging and Older People,[31] which was originally founded as the National Council for the Aged in June 1981. Set up as an advisory body to the Irish Department of Health, this council has worked in essence as a center for social and medical gerontology. It has published more than 60 reports on various aspects of aging in Ireland, including health, mental disease, disability, the law, and older people. These are excellent resource books and have provided useful material in terms of developing a positive, constructive, and health-promoting approach to health care of older people.

GERIATRIC MEDICINE

The Years Ahead emphasized the need to provide specialist expertise for older people and advocated the development of geriatric medicine in general hospitals. It was recommended that there should be 2.5 acute assessment beds per 1,000 elderly persons and three beds per 1,000 elderly persons for rehabilitation. A subsequent review recommended a reallocation of beds and facilities in general hospitals toward departments of geriatric medicine, with adequate provision of ancillary staff and, ideally, a day hospital.[25] In general, the government has accepted these arguments, and it is now an official policy that each general hospital should have a department of geriatric medicine. The first consultant geriatrician in the Republic of Ireland was Dr. Michael Hyland, who was appointed to Cork University Hospital in 1969. Dr. Hyland was a key figure in the subsequent development of policy and services in Ireland. There are now 41 geriatricians in the country, the number having more than tripled over the last decade, and geriatric medicine is now the largest medical specialty in the Republic of Ireland. However, provision of the facilities and staff necessary for true multidisciplinary geriatric medical care has lagged behind in many areas.

The expansion of the specialty of geriatric medicine has not always attracted universal approval from other physicians. For example, the Secretary of the Training Committee of the Royal College of Physicians in Ireland (responsible for supervising basic training at the residency level in internal medicine) recently wrote:

> The first mistake was to believe that geriatricians would magically remove older people from acute hospital beds and return them to their own homes or to some low-cost, long-term care setting. On the contrary, specialists in elderly care are much more enthusiastic than other medical specialists when it comes to investigation and active management. People we thought were merely "getting on a bit" are routinely subjected to mental test scores, CT scans, 24-hour ECG, echocardiography, carotid sinus sensitivity, tilting table tests and so on, before eventually landing at the bottom of a long and stagnant list of patients waiting for long-term care.[32]

This comment is not only revealing of negative and reductionist attitudes toward older people, but ironically it also shows that those involved with postgraduate education in internal medicine are absorbing many of the developments in assessment and management of modern health care of older people (albeit with reluctance).

The style and practice of geriatric medicine in Ireland is not dissimilar to that of geriatric medicine in the United Kingdom, where there are 773 consultant geriatricians (full-time equivalents) for a population of 59.64 million, a ratio of 1.3 per 100,000 population, compared with a ratio of 1.13 in the Republic of Ireland. Reduced resources (in the hospitals and in the community) and the persistence of small general hospitals in Ireland explain much of the difference in practice between the countries; for example, solo geriatricians are a rarity in the United Kingdom but occur in 33 of the 38 general hospitals in Ireland. In each country, the discipline is based primarily in general hospitals but has significant liaison with community services, rehabilitation units in nongeneral hospitals, and extended-care facilities. In both countries, access to geriatric medical care is by way of referral from a family doctor (general practitioner). Training in geriatric medicine is implemented through nearly identical structures and processes.

In Ireland, two main models of acute geriatric care have developed. The first model is parallel age-related services in large teaching hospitals such as those in Dublin and Cork. In this system, the physicians in geriatric medicine accept patients from the Accident and Emergency service over a certain age, usually 70, until their beds are full. A smaller proportion of patients is transferred for rehabilitation from other services, and an even smaller proportion is admitted directly from the community. The approach of focussing geriatric medicine on acute medical care for those aged 65 and older has been attracting increasing support. One of the major teaching hospitals in

Dublin[33] has decided to invest heavily in this approach, dedicating almost one-third of acute medical beds to acute geriatric medicine. This would be an approximation of the proportion of admissions who is aged 65 and older but an underestimate of their bed-stays, amounting to 57% of bed days in an urban Dublin hospital.[34]

In the second model, which occurs in smaller hospitals, the geriatrician may be one of only three or four specialists in internal medicine, and geriatric medicine is often integrated with internal medicine. The physician in geriatric medicine will do general medical care for all ages and then come to some local arrangement with his or her colleagues as how to develop the specialist care elements of geriatric medicine. The main problem is that the demands of the general medical service (between 1,500 and 2,000 admissions of all ages per specialist) may be such as to severely circumscribe the physician's ability to practice geriatric medicine.

Geriatric medicine in Ireland has been successful in attracting trainees of high caliber. Specialist training is available only to those who have completed basic training in internal medicine and have passed the examination for Membership of the Royal College of Physicians of Ireland (or its equivalency). In the past, Irish graduates wishing to pursue a career in geriatric medicine did much of their training abroad. Training programs at the specialist level in geriatric medicine are now available in six centers in Ireland, although given the small size of the country, experience abroad is still highly valued and indeed is a component of many programs. The structure of the curriculum is similar to that adopted by the Section of Geriatric Medicine of the European Union of Medical Specialists.[35] It is based on 3 years of general professional training (approximating a residency in internal medicine) and then a structured specialist registrar program lasting 4 (for accreditation in geriatric medicine) or 5 years (for dual accreditation in general and geriatric medicine).

The Irish geriatricians formed themselves into a representative body in 1975, the Irish Society of Physicians in Geriatric Medicine. It meets regularly with the Department of Health and tries to ensure that the principles of geriatric medicine are incorporated into healthcare initiatives. The scientific body associated with aging is the Irish Gerontological Society (IGS), which was founded in 1952 and is one of the oldest gerontological societies in Europe. The IGS has an interdisciplinary membership and a strong healthcare orientation.

Psychiatry of old age has developed relatively recently as a specialty, and there are only nine specialist posts in the country. It is an unstated government policy to appoint psychiatrists in old age to each health board area with hospital facilities based in the general hospital (including the day hospital) but with strong community links.

COMMUNITY CARE SERVICES

Community care services, although growing rapidly, have been underdeveloped in Ireland. Approximately 18% of all older people receive some form of ongoing formal care at home.[25] In a 2000 survey, 15% had been visited by a public health nurse and 5% by other home-based services.[12] *The Years Ahead* suggested that there should be coordinators for services for the elderly in each Health Board. The precise role and responsibilities of this post have not been clearly identified, and there is little evidence of positive or negative effect on the service. The cornerstone of community care services is the public health nurse system and family doctors supported by home help services. A small number of older Irish people avail themselves of home help; in 1993, only 3.5% of the Irish older population used this service, compared with 14% in Northern Ireland and 19% in Sweden.[36] There are various models of organization of this service which leads to considerable frustration among caregivers in terms of adequacy and access.

Community therapists are in general limited to physiotherapists and occupational therapists, with almost no access in the community to speech therapy, clinical nutrition, or social work for older people and their caregivers. Waiting lists can be long for community physiotherapy and occupational therapy. The health boards in the Dublin area have developed units with a more rapid response time, the District Care Unit, but the average delay is still 11.5 working days from referral to commencement of physiotherapy and occupational therapy.[37]

Day centers play a minor but important role. There are approximately 212 day centers, which provide social, nutritional, and community support for older people but not health-based interventions. About 1.8% of the Irish older population receives domiciliary meal services, "Meals on Wheels," whereby meals provided by voluntary organizations, with financial assistance from the regional health boards, are delivered to people's houses.[25]

LONG-STAY CARE

Long-stay care is divided between institutions administered directly by the health boards (9,573 beds, 49% of the total) and private nursing homes (6,209 beds, 32% of the total) and a small but significant proportion provided by the voluntary sector (religious orders and charities) (3,786 beds, 19% of the total).[4] The health board institutions are categorized as geriatric homes and hospitals (6,126 beds), welfare homes (1,056 beds), and district/community hospitals (2,391 beds). There is a widespread perception that care in voluntary sector is of a high standard, and this is often the first preference for patients and carers.

Specialist care in long-term care units has not been well developed within Ireland. As a result, many geriatricians are concerned that such units are likely to contain patients with significant undiagnosed and untreated illness and disability. They have produced a position paper on standards of assessment, treatment, and care in extended care, including the requirement that the medical officer in long-term care should have a Diploma in Medicine of the Elderly.[26] The National Council on Aging and Older People has also expressed its concern about standards of care in long-term care and has advanced proposals to resolve the issue.[38] In 2000, the Minister of Health proposed the use of private nursing home beds for older people supposedly taking up acute hospital beds. Geriatricians strongly opposed this proposal on the grounds that many such patients were in need of rehabilitation and that

many long-stay units lack therapist input. This controversy remains unresolved.

EDUCATION AND RESEARCH

There has been considerable development in teaching various disciplines at undergraduate and postgraduate levels in care of older people. Geriatricians have been in the forefront of the development of specialist services for stroke and, in conjunction with old-age psychiatry, dementia. The first memory clinic opened in St James's Hospital in 1989,[39] and the first acute stroke service was started in Meath Hospital in 1996.[40]

Trinity College Dublin has taken a lead in promoting academic gerontology and has opened the first academic department of medical gerontology (Chair, Professor Davis Coakley) and the first Chair in Psychiatry of Old Age (Professor Brian Lawlor). The Faculty of Health Sciences has selected "Aging and Health" as one of the four key areas of research; the others are molecular medicine, cardiovascular health, and public health. There is an undergraduate course with tutorials for junior medical students and a lecture and tutorial system for senior medical students. Many of the preregistration house physicians will rotate through geriatric medical services, and geriatric medical positions are present on internal medicine and family practice residency programs. Academic geriatricians and psychiatrists of old age in Trinity College Dublin have also helped to develop the national Dementia Services Information and Development Center.[41]

Trinity College also offers diploma and masters courses in gerontological nursing and has established a first module in social gerontology. Academic developments are underway also in Cork and Galway, and the University of Limerick has appointed a geriatrician as the professor of medical science in their postgraduate medical school.

The Royal College of Physicians in Ireland and the Irish Society of Physicians in Geriatric Medicine confer a postgraduate diploma, the Diploma in Medicine for the Elderly.[42] This is directed toward family doctors who have a special interest in older people, particularly those who may be appointed as medical officers for private or state-funded nursing homes.

SUMMARY

Medical and psychiatric specialist services for older people have developed rapidly in Ireland, and geriatric medicine has become the largest medical specialty in hospital practice. No significant transfer of funding has accompanied this advance, and there are deficiencies in the availability of the facilities and staff necessary to provide high-quality multidisciplinary geriatric medical care in hospitals and in the community.

Irish geriatricians and those in allied health professions will continue to develop and strive for improved services. Recent initiatives to improve care of older people in general hospitals include a proposal that the number of geriatricians should be dramatically increased to allow a system of care in which geriatricians will undertake an increasingly large proportion of acute general medicine of later life.[43] It is also proposed that geriatric subspecialty clinics covering areas such as falls and cognitive decline should be developed in each health board area.

If such efforts come to fruition, we may eventually realize the speculative opinion of the *Journal of the American Medical Association* in 1901 that, "Taking all the data together and estimating their significance, it would seem that we ought not to consider Ireland a bad country to live in, but must infer that possibly the green island averages fairly well among the other parts of the earth."[44]

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