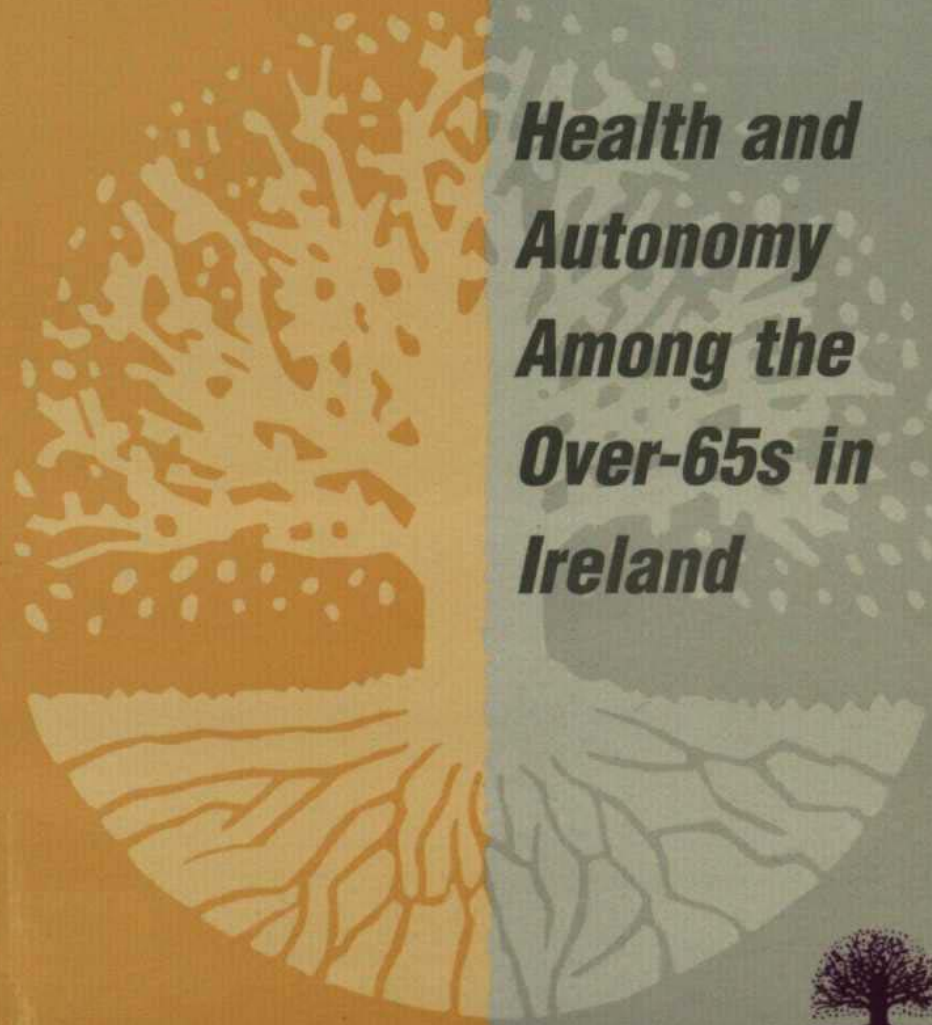
National Council for the Elderly

Health and Autonomy Among the Over-65s in Ireland



NATIONAL COUNCIL FOR THE ELDERLY

The National Council for the Elderly was established in January 1990 in succession to the National Council for the Aged which began in June, 1981. The terms of reference of the Council are:

To advise the Minister for Health on all aspects of ageing and the welfare of the elderly, either on its own initiative or at the request of the Minister, and in particular on

- *— measures to promote the health of the elderly,*
- *— the implementation of the recommendations of the Report,* ***The Years Ahead - A Policy for the Elderly,***
- *— methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for the elderly,*
- *— ways of encouraging greater partnership between statutory and voluntary bodies in providing services for the elderly,*
- *— meeting the needs of the most vulnerable elderly,*
- *— ways of encouraging positive attitudes to life after 65 years and the process of ageing,*
- *— ways of encouraging greater participation by elderly people in the life of the community,*
- *— models of good practice in the care of the elderly, and*
- *— action, based on research, required to plan and develop services for the elderly*

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HEALTH AND AUTONOMY AMONG THE OVER-65s IN IRELAND

HEALTH AND AUTONOMY AMONG THE OVER-65s IN IRELAND

By
Tony Fahey
and Peter Murray

NATIONAL COUNCIL FOR THE ELDERLY

REPORT NO. 39

This Report has been prepared by Dr. Tony Fahey and Dr. Peter Murray
of the Economic and Social Research Institute

for

THE NATIONAL COUNCIL FOR THE ELDERLY
CORRIGAN HOUSE
FENIAN STREET
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Foreword

Introduction

The National Council for the Elderly has maintained a continuing interest in the subject of promoting the health and autonomy of older people. In 1988, following research on attitudes of young people to old age and qualitative research into the world of older people in rural and urban areas, the Council initiated a National Day on Ageing to promote the concept of adding Life to Years by placing the emphasis on what older people can achieve, given an opportunity. This initiative later became *Age and Opportunity*, a national programme for promoting positive attitudes to ageing and older people. *Age and Opportunity* has successfully highlighted the potential of older people for leading a fuller life as a vibrant part of the community.

While there is no escaping old age, and with it the increased, probability of illness or disability, it is nevertheless the case that most old people are relatively independent and capable of participating fully in the life of their community. A minority of the elderly at any one time require care either at home or in an institutional setting. Though this proportion increases as people reach greater ages, at a given time only a minority of those over 80 years are in hospital or institutional care.

More recently the Council has been concentrating on the need to identify strategies and measures which would improve the health and well-being of our elderly population. In 1990, the Council established a Consultative Committee to oversee a detailed review of literature and data sources on measures to promote the health and autonomy of older people prepared by the Special Projects Unit in the Eastern Health Board (Hynes *et al.* 1992). On the basis of this work the Council commissioned a position paper from Professor Cecily Kelleher of the Department of Health Promotion Studies, University College, Galway. This paper was published under the title *Measures to Promote Health and Autonomy for Older People: A Position Paper* (Kelleher 1993). It summarised current thinking in what is a relatively new field. It provided an overview of the relevant factors involved in health promotion and outlined strategic policy directions to

follow if we are to improve the health and well-being of older people in the future.

At the end of 1992. the Council commissioned the Economic and Social Research Institute to undertake new research on the health and well-being of older people based on a national survey of those over the age of 65. It is very pleased to present the findings of this research in the present publication, *Health and Autonomy Among the Over-65s in Ireland.* Together with the work already completed and listed above we are confident that a solid foundation has been laid for practical measures to promote the health and autonomy of the elderly in Ireland.

The Council organised a two-day conference on this topic on 30th September /1st October 1993 based on the progress made, including preliminary findings from the national survey and contributions from members of the Council's Consultative Committee on Measures to Promote the Health and Autonomy of the Elderly in Ireland, and other people with expertise to offer from a national or an international perspective. The proceedings of the conference have been published and are available on request (National Council for the Elderly 1994).

One of the international contributions to this conference came from the European *Ageing Well* network, which is being co-ordinated by Eurolink Age. As a Council member of Eurolink Age. the National Council for the Elderly has been contributing to the *Ageing Well* programme and to the development of a *European Action Plan on Healthy Ageing.* The *Action Plan* aims to highlight healthy ageing issues for public policy, to stimulate research, to encourage education/information networks and to learn from self-help and local community action across the European Union. These issues are being taken up by the *Ageing Well* network in other European countries in the context of the additional health competencies of the European Union. It is hoped that they will be taken up in Ireland also and that they will form a component part of the proposed Second European Programme on Older People up to the end of this century.

Acknowledgements

On behalf of the Council I would like to thank all those who helped to ensure the success of this project. Firstly, may I thank the authors. Dr. Tony Fahey

and Dr. Peter Murray of the ESRI for their professional work in the execution of the research, and Professor Brendan Whelan of the Survey Unit in the ESRI for his work in co-ordinating the fieldwork.

I would also like to thank all the members of the Consultative Committee for their support and advice to the researchers through meetings and correspondence, and their assistance to the Council in formulating its views on this subject. The Committee was ably chaired by Dr. Rosaleen Corcoran and. in addition to the authors, it included Mr. Eoghan Brangan. Dr. Anna Clarke. Dr. David Clinch. Mr. Jim Cousins. Ms. Laura Fargher. Mr. Chris Fitzgerald. Dr. Mary Hurley. Dr. Mary Hynes. Professor Cecily Kelleher. Dr. Marie Laffoy. Mr. Patrick Madden. Ms. Catherine Rose and Dr. Emer Shelley.

I would like to thank Mr. Bob Carroll (Secretary) and Mr. Joe Larragy (former Research Officer) for their role in defining the research brief and providing documentation, guidance and liaison to the Council, to the Consultative Committee and to the research team.

I would also like to thank Ms. Trish Whelan (Projects Officer) for her work in preparing the report for publication and Ms. Céline Kinsella and Ms. Carol Waters for their secretarial support throughout the course of this project.

Finally. I would like to thank the 909 respondents to the survey who gave generously of their time, often despite evident problems of ill health. With their help we now have a better understanding of the health and well-being of the many more thousands of older people they represent and we have valuable data on which to build policy and practice in promoting the health of older people in Ireland in the years ahead.

Michael White

Chairman

December 1994

National Council for the Elderly Comments and Recommendations on Promoting the Health and Autonomy of Older People in Ireland

1. Introduction

The present study is a further important contribution to the Council's work on promoting the health and autonomy of older people. It follows a detailed review of literature (Hynese/o/. 1992) and a position paper (Kelleher 1993) and seeks to provide empirical data on the health and well-being of the over-65 population in Ireland. Such data provide a touchstone for more concrete discussion and debate and more precise definition of health policy objectives, targets and measures to be implemented. The current emphasis among policy makers is correctly on the goals of *health gain* and *social gain,* as opposed to level of health service activity (Department of Health 1994). In so far as it reflects progress in improving the health and well-being of older people, information of the kind reported here will become increasingly important as an index of the outcome of policy and investment in services.

The principal source of data for the present study is a survey of 909 people aged 65 years or more carried out in 1993. This survey is set in the context of an examination of Irish trends in mortality and life expectancy. It examines the health and social circumstances of older people in some detail, covering demographic trends, physical health characteristics, psychological health and well-being, incomes, living circumstances, social networks, lifestyles and health behaviour. It is a valuable addition to our knowledge and is intended to provide baseline information to inform future policy and strategy for intervention in this area. Survey data of this kind have characteristic limitations, principally due to the heavy reliance on self-report of health and social circumstances by respondents without the corroboration of a separate medical examination, and the lack of a longitudinal dimension. However, where possible and useful, additional

research and official sources of information have been used to complement the survey data.

The principal focus of the research is the physical and psychological health and well-being of older people. In line with health promotion thinking, the concept of health used in the study is a broad one. drawing on many indicators of a physical, psychological, social, economic and environmental nature. It is also a positive one which identifies health as a resource. Describing the state of health and well-being of older people, it also seeks to explore some of the different factors often associated w·ith good or poor health - age. gender, social class and lifestyle. It also explores the very important relationship between psychological well-being and physical health status, and the findings indicate that there are strong associations between these.

The study was designed with a view to making comparisons with other studies, in particular a survey of the elderly carried out in 1977 (Whelan and Vaughan 1982). which included a number of health and well-being indices, and the Poverty Survey carried out by the ESRI in 1987. which also included sections on psychological health and other relevant topics in a more general sample of the Irish adult population (Callan *el til.* 1989). This approach, we felt, would add considerable interest to the findings, which can be compared w ith previously measured indicators of some 25 years standing, and relatively recent research on a general population sample. This in turn would provide a better idea of trends in the health and well-being of elderly people over time as well as differences within the population that may be related to age. gender, socio-economic class and other factors. Such comparative information should contribute to our understanding of the determinants of health in old age and identify policy priorities and measures in this complex area.

2. Health Inequalities

The concept of health inequalities usually refers to *international, socio-economic and gender* differences and is an important starting point. The World Health Organisation (WHO), in its first *Health for* /I//Target for the European region, calls for a reduction, *by the year 2000, of 25 per*

cent in the differences in health status between countries and between groups within countries (WHO 1985).

We need to establish those dimensions of health status where our performance is poor relative to other comparable societies. And. within Irish society, we also need to identify which social groups have the worst health status. In time, addressing health inequalities in the whole population, or among specific socio-demographic groups, would probably filter through and result in improved health status among older people through a cohort effect. A consideration of health inequalities is helpful in any discussion of promoting the health of the elderly because it highlights sources of health variation other than ageing itself which health promotion measures could address.

2.1 International inequalities

Although survivorship up to middle age in Ireland is comparable with other OECD countries, life expectancy at older ages compares very poorly with other countries. If people at age 65 have relatively poor life expectancy it is evident that on reaching this age a greater proportion are already in poor health than is the case in other countries. Moreover. Irish life expectancy at birth is below average for the EU. suggesting that when cohorts reach 65 years their health is already poorer than in other EU member states. Irish age-standardised death rates from heart disease, although declining, are still more than twice the EU rate, while deaths from cancer, particularly cancer of the lung, are well above the EU average. Significant improvements in stroke mortality have brought Ireland into line with the EU average (Department of Health 1994: 18-19).

The Council believes that the relative gap between life expectancy in Ireland and other member states of the EU and of the OECD at various ages should be eliminated. The Department of Health, (through the Health Promotion Unit and in consultation with all rele\ ant agencies) should agree the precise schedule for eliminating this gap.

2.2 Gender inequalities

Gender differences are evident, though not in a simple way: the study confirms that men have higher age specific rates of mortality than women.

that life expectancy is much lower among males and that the gap is widening between males and females. In fact, the life expectancy of older men in Ireland has actually deteriorated over long periods during this century. Paradoxically, the present study found that male respondents were more likely to report better self-rated health status than female respondents. This is in line with international studies which suggest that older men rate their overall health better than women: older men's self-rating of health varies little with each successive age sub-group, whereas older women in each successive age sub-group report a more gradual worsening of self-rated overall health (WHO 1989: 19). Research in the UK revealed that although older women have better mortality rates than men, their morbidity rates, standardised by age, were consistently worse than those of men (Victor 1991: 32). But there are at least some indications that men experience earlier onset of serious illness. Nolan (1991: 63-4) found that greater percentages of men than women in each of the age groups 55-64,65-74 and 75 plus, respectively, reported having a major illness. The present study too appears to indicate earlier onset and little variation in the experience of serious illness among older age sub-groups of male respondents while providing some evidence of an age gradient in this variable among female respondents (see Chapter Three. Table 3.1). Measures of functional incapacity showed the clearest gender differences, with more women than men experiencing disability in each age group. A key research issue therefore is to explore the nature of these gender differences among older people in Ireland, and to identify as clearly as possible the factors involved.

Evidently, there are varying patterns to the relationship between gender, age. self-rating of overall health, presence of serious illness, disability and mortality rates. The overall impression is that ageing women exhibit a stronger tendency to become incapacitated and have poorer overall health self-rating than ageing men. On the other hand, fatal illnesses have an earlier onset among men: we know this from the mortality statistics and - although somewhat difficult to interpret - the data on serious illness in our survey and elsewhere seem to reflect this. While further detailed analysis is necessary, the picture that emerges so far suggests that:

a) increasing frailty, possibly allied to chronic conditions such as osteoporosis, affects ageing women more severely than men.

b) the patterns of serious illness which lead to higher rates of mortality among older men. are more erratic and less related to age in men than in women, and

c) the more positive self-rated overall health of older men reflects relatively less a process of gradual senescence and relatively more a dichotomous state of being well or ill than is the case among older women.

2.2.1 Nature or nurture?

Gender inequalities in health status and mortality of the population are particularly relevant for older people. However, such gender differences are not principally attributable to biological or genetic differences. The consensus among researchers appears to put socio-environmental explanations to the fore, with factors such as smoking and lifestyle very prominent among these (Victor 1991; Verbrugge 1989; Gee and Veevers 1985; Waldron 1976). In Ireland the fact that more women have been dying from lung cancer in recent years points in the same direction: in 1992 there was an increase - to 500 - in the number of female deaths from lung cancer, most of these directly attributable to the higher incidence of smoking among women over recent decades (Department of Health 1994). These findings suggest that there is considerable potential for improvement in health among all older people of both sexes but. in particular, improvements in health and longevity among older men.

The Council believes that the widening gap between male and female life expectancies could be narrowed, by means of appropriate measures to raise the life expectancy of males, and recommends that suitable targets be adopted by the Department of Health in consultation with the relevant agencies.

2.3 Health and socio-economic inequalities

There is much international evidence that life expectancy and health vary with socio-economic conditions within each age group. In the UK, Victor found that 'consistently, those elderly from the professional and managerial classes experience better health than their contemporaries from the manual

occupational groups" (Victor 1991: 33). The present study confirms that, among older Irish people, there is a significant class and standard of living gradient in overall health, with poorer health in manual occupational groups and those suffering material deprivation. Nolan (1991: 65) provides evidence of a strong relationship between social class and physical illness in each major age group, even if it is less pronounced among those over 65 years: we would expect this, however, as differential mortality across social class categories prior to age 65 probably erodes the morbidity differences among those who survive beyond 65 years.

2.3.1 Deprivation and the quality of life

The present study provides information on many aspects of socio-economic deprivation among older people. This dimension appears to affect physical health directly, and psychological health indirectly. Basic deprivation (of food. heat, clothing, money to pay bills etc.) is not as pronounced as housing deprivation among the sample respondents in the study. Deprivation of household amenities continues to be relatively more pronounced among single or widowed elderly people living alone in rural areas. While the report shows that considerable progress has been made in recent decades, and now less than 10 per cent of older people are affected by the lack of basic housing amenities listed below, it is unacceptable that any elderly person should have to do without such basic amenities.

We recommend that policy targets should include

a) the complete elimination of deprivation of such basic amenities as adequate heating, a dry, damp-free dwelling, an indoor toilet, a bath or shower. Over 76 per cent of those respondents who had no indoor toilet or bathroom said that the reason for this was that they could not afford to pay the cost. Financial assistance should therefore be provided where required to provide these facilities.

b) ensuring that no elderly household will be without a telephone on grounds of cost, which is the reason offered by 43 per cent of respondents without a phone for not having one. Apart from the usual uses of a telephone, allied new technology will increasingly make it possible to provide support and emergency help for frail elderly people living alone who wish to remain in their homes.

Moreo\ er, the \·alue of a phone may not be fully appreciated by some elderly people. Therefore, specific educational measures could help to address this problem, particularly among elderly people living alone in rural areas.

Another important source of deprivation among sections of older people, which the study investigated, is transport. The study found that those in rural areas, particularly those living alone, were at a considerable disadvantage: almost one quarter of the elderly respondents who were living alone in a rural area, and who were without cars, had no access to public transport of any kind. This is a particularly important issue in the context of centralisation of acute hospital services.

One of the most distressing findings of this study is the increasing concern about crime and rising level of crime experienced by older people. This applies to all areas but the proportion concerned about or experiencing crime is much higher in urban than rural areas. This trend is part of a wider trend in rising crime rates from which elderly people are not immune. The solutions to this problem must be found principally at the wider level through economic and social policy as well as policing policy.

However, the Council believes that we also need to evaluate the success of programmes such as Community Alert and Seighbourhood Watch, and in particular their effectiveness or relevance to older people. The experience of crime and its effects on older people should be examined in more detail in order to identify- preventive measures which older people might take and the support needs of elderly crime victims who may be severely traumatised by the experience.

2.4 Health inequalities between age groups

It is not usual to consider using age group for the purposes of reducing health inequality between 'groups'. It is generally accepted that with increasing age there is an inevitable rise in morbidity and disability rates. In acknowledging this, however, we need to separate the unavoidable biological consequences of ageing from the pathological processes which, while more often experienced in old age, are preventable, curable or manageable. Too often ageing has been perceived as an undifferentiated syndrome involving disengagement, and physical and mental decline. This

in its turn can lead to a fatalistic view of the ageing process on the part of older people and service providers and an unwillingness to view the prevention or treatment of health problems in old age with sufficient vigour.

We have seen above that international, gender and class differences influence the relationship between ageing, illness and mortality. But we also need to emphasise that ageing itself is a socially defined process as much as a biological one. By promoting a positive view of the potential for the increasing numbers now reaching the "Third Age' much can be achieved in redefining expectations and motivating older people to maintain their level of health and vitality.

Moreover, as far as the elderly population as a whole are concerned, this study reports that the majority of respondents describe themselves as being in good general health. The study shows that psychological distress - a vital measure of overall well-being - is not significantly related to age but is related to functional incapacity and self-reported health status. Thus it is not ageingper *se* but morbidity and disability that give rise to psychological distress in older people. There are very important personal benefits to be gained, therefore, from measures promoting physical health and maintaining independence because, in increasing health and social gain, they reduce the psychological distress of the elderly individual.

It is vital that we build on this premise by emphasising that - in addition to the potential long-term benefits of general improvements in social conditions and lifestyle in all age groups, which can be passed on as cohort effects in the form of healthier 65 year olds - there is much that can be done by individuals, families, voluntary organisations, professionals and service providers in all sectors to reduce the health inequalities between today's older people and younger age groups.

In addition to the personal health or social gain there are potentially other economic and social benefits if the demands placed by major illness and disability on informal carers and on formal health care and social service provision can be reduced. In the case of informal carers previous research (Blackwell *et al.* 1992; O'Connor *et al.* 1988b) has shown that they experience very high levels of psychological and physical distress, financial costs and loss of economic opportunity. In the case of formal service provision, there is a correlation between age specific service utilisation and age specific illness and disability. But such service utilisation might be

reduced by a range of preventative measures. Housing, income, social deprivation, safer environments, healthier lifestyles, promoting positive attitudes to ageing and older people, and particularly towards disabled elderly people and their carers, constitute important areas for intervention.

The Council wishes to emphasise that reducing the gap in morbidity and disability between older and younger people should be included as a focus for reducing health inequalities and increasing health and social gain. Where disability and dependency exist, the emphasis should be on support for carers and disabled elderly people in coping with day-to-day life.

3. Health Gain: Adding Years to Life and Health to Years

Health promotion objectives include the reduction of avoidable or premature mortality. The WHO advocates that by *the year 2000, life expectancy at birth in the European region should be at least 75 years* (Target 6. original version). Improvements in average life expectancy at birth are affected more by the addition of many years to the shortest lives than by a few years to the longest ones. Not surprisingly, therefore, the WHO concentrates on achieving mortality reductions in younger age groups, and specifically target a reduction *in infant mortality, and maternal mortality* (Targets 7 and 8). It also refers to improving the survivorship to age 65 by reducing mortality from certain forms of disease. For example. Target 9 says that *by the year 2000 mortality in people under age 65 from diseases of the circulation should be reduced by at least 15 per cent* and Target 10 states that *by the year 2000 mortality in people under age 65 from cancer should be reduced by at least 15 per cent.*

All of the above WHO Targets serve explicitly to improve the potential of surviving to age 65. and indirectly, such as in relation to cancer and circulatory disease, would imply improvements in both health status and life expectancy at or over the age of 65. This is a vital foundation for the medium and long-term improvement of the health of older people. We accept that mortality after age 65 cannot be postponed indefinitely, and we must concede that even the reductions targeted by the WHO in mortality from specific causes among those *under* the age of 65 years are modest. Thus, only very modest targets might be suggested for reducing cause specific mortality in age sub-groups over 65 years.

However, there is a danger here, and more generally in discussions of health promotion, of devoting little attention to improvements in life expectancy in older population segments. Indeed in some circles it is openly advocated that raising life expectancy among the elderly population as a whole is not a priority whereas improving the quality of life should be. This is a complex and controversial issue, particularly in relation to medical interventions which are life-saving but not likely to ensure the quality of the extended lifespan (Institute of Bio-Ethics 1994). *But, in the broader context of health promotion policy, a normative target for extending lifespan among the elderly, for example by reference to a theoretical lifespan of 85 years, would, in the Council's view, counter tendencies to 'write off' ill elderly-people for implicitly ageist reasons.*[1]

There is some additional justification for a target of raising life expectancy over age 65 in Ireland. As the present report points out, our ranking in terms of survivorship to age 45 years among the 23 OECD states is about average but Irish life expectancy ranks bottom of the OECD by the age of 65. for both sexes. In comparison with other EU member states, Ireland's life expectancy at birth is below average. The report also points out that the long-term trend in life expectancy in Irish males has not been very encouraging: between 1926 and 1986 life expectancy at all ages above age 50 scarcely changed, and at ages 65 and 75 life expectancy in 1986 was marginally below what it was in 1926. Despite some recent signs of improvement, since 1986. this evidence suggests that, very particularly in Ireland, there is scope for measures to promote the health of middle-aged and older adults - particularly males - which could be measured by adding years to life. *We should therefore define improvements in life expectancy at or even above age 65 as a specific target. In Ireland, where we lag behind other countries, this is less contentious than in a country which might rank higher.*

Through the study of morbidity patterns and the associated social, economic and lifestyle factors, we need to identify clearly and target the relevant causes of poor life expectancy at older ages. Diseases of the circulatory system and cancers play a major part in avoidable mortality, and some of

I The figure of 85 years is al (he conservative end of current estimates of the theoretical lifespan. For a useful discussion see F. Mesle' *The Future of Mortality Rates'* in *The Future of Europe's Population.* Council of Europe Population Studies No. 26 edited by R. Cliquet Strasbourg: Council of Europe Press 1<W3.

these can be related to cultural, environmental and lifestyle factors. We should carefully review existing targets on reducing mortality by specific cause among those under *and over* 65 years. We also need to pay particular attention to the best approaches to the propagation of healthier lifestyles, for example through the piloting of health promotion initiatives among older people.

4. Potential for Health Gain Among Older People

Improving life expectancy is not merely an end in itself. Life expectancy is frequently quoted as an indicator of health status in a population in the absence of complete and precise data on underlying morbidity patterns. It is widely used in making international comparisons and is the most striking reflection of the dramatic transformation in health status internationally during the 20th Century. Because death is usually caused by disease, improved longevity is usually an indirect consequence of measures to 'add health to life" by reducing the prevalence of illness. To that extent improvements in life expectancy mirror improvements in health. On the other hand many diseases are not fatal - at least in the short term - and chronic diseases which can be disabling also become increasingly prevalent as the population ages. To that extent, as a useful indicator of the trend in the health of a population, life expectancy is incomplete, and in some respects misleading, and research must now focus increasingly on measuring the prevalence of morbidity and disability in the older population.

The Council therefore welcomes the fact that the WHO has adopted an amended version of its original Target 6, *cited above, which now reads 'By the year 2000 life expectancy in the region should be at least 75 years* ***and there should be sustained and continuing improvement in the health of all people aged 65 and over'.***

4.1 Disease and service utilisation among over-65s

The present study uses a number of conventional approaches to provide data on physical health and illness in the survey sample. Among the key findings are the following:

- Almost 47 per cent of respondents reported that they had at least one long-standing major illness or disability which was troubling them for at least one year and was likely to continue in the future. Eleven and a half per cent said that they had at least two such conditions and almost two per cent had three or more.
- Diseases of the *circulatory system* were the most frequently reported (35 per cent of first mentions), followed by diseases of the *musculo-skeletal system* (27 per cent) and *respiratory* diseases (10 per cent). Together these three categories of disease also accounted for a majority of any second (63 per cent) or third (67 per cent) major illness mentioned by a respondent.
- Less than seven per cent of respondents were confined to bed at some time over the previous four weeks, on average for between five and six days.
- Just 11 per cent were unable to carry out their daily routine for some period over the previous four weeks, on average for just under 13 days.
- Over 39 per cent visited their GP at least once over the previous four weeks, i.e.. 1.5 visits per person on average.
- Less than nine percent of respondents received home visits from their GP, with an average of two visits each over the previous four weeks.
- Eleven per cent of respondents went as an outpatient to hospital over the previous four weeks, with an average of 1.6 visits each.
- Four per cent were in hospital over the previous four weeks for an average of 7.8 days each.
- Almost 58 per cent of respondents were on prescribed drugs, with an average of over two different types of medication each.

These figures testify to the considerable extent of disease, confinement, service utilisation and use of medication among elderly people living in the community. While we may not seek a reduction in all of these figures, since they reflect treatment and preventive measures as well as the prevalence of disease, we would wish to reduce avoidable confinement and illness and ensure that health service utilisation results in health gain for older people and a narrowing of the health inequality between them and younger people.

4.2 Lifestyle and health and illness behaviour

It has been suggested that we now suffer increasingly from the diseases of civilisation, i.e.. that the diseases of underdeveloped societies (due to inadequate basic nutrition, sanitation, immunisation, and widespread poverty) have given way to new patterns of disease arising against a background of relatively improved living standards. Lifestyles, occupational risks, sedentary work patterns, chemical, nuclear and other man-made environmental hazards, crime, drugs and stress are thought to affect our morbidity patterns, particularly in later life. Therefore, the more positive concept of promoting healthy lifestyles must be brought to the fore. Below, some consideration is given to these issues.

4.2.1 Weight

Lifestyle was studied in some detail in the present survey. Information on weight, using an index which takes the person's height into account (body mass index. BMI), suggests that only 48 per cent of respondents had acceptable body weight. While some 10 per cent were underweight. 35 per cent were overweight and six per cent were obese. Despite this, most respondents, regardless of their BMI score, believed that they were eating about the right amount. More men than women appear to be overweight and. ominously, the proportion of those overweight appears to be least in the sample respondents aged over 75 years. *Potential for counselling, information and education exists here.*

4.2.2 Smoking

Smoking also varies significantly between male and female respondents and between the younger and older elderly. Among those aged 65 to 74 years, slightly more than half the proportion of females (19 per cent) as males (34.6 per cent) said that they currently smoked. Among those over 75 years 11.3 per cent of females compared to 31.4 per cent of males were currently smokers. *Again, given what we know about the consequences of cigarette smoking for health, this seems an obvious area for advice, information and education.* In the context of today's elderly population there needs to be a special focus on the benefits to men. However, as the study points out. evidence from other research on smoking patterns shows

that younger women are increasing their consumption of cigarettes, with consequences for their future health, particularly as they age. Also, smoking patterns are related to income, education and social inequality and this should be taken into account in developing a health promotion strategy.

4.2.3 Other lifestyle issues

In addition to diet and smoking, the study examines aspects of lifestyle such as alcohol consumption patterns and activities such as exercise undertaken in order to improve or maintain health. In relation to alcohol, gender and age differences are in evidence, though the picture is more complicated, because the causal chain between alcohol and physical disease is less clear than with smoking and diet. Excessive consumption of alcohol has serious consequences for physical health. But alcoholism is itself a major mental health problem, responsible for about one-quarter of psychiatric admissions in Ireland.

In the short-term healthier lifestyles among older people can have important if limited benefits. It is vitally important, however, that healthy lifestyles are adopted among younger people too because the most significant effects of improved health behaviour are medium-term and long-term and the illness patterns of today's elderly people are heavily influenced by the lagged effects of lifestyle factors from early life. Apart from gender differences in lifestyle there appear to be differences associated with income and deprivation. Particular account must be taken of these differences too.

The Council believes that there is very- significant evidence from this study that older people are willing to consider a healthier lifestyle, and many are already engaged in health promoting activities. On the other hand there are many aspects of the evidence in this report - such as the level of smoking and proportion who are (often unwittingly) overweight - which call for health education initiatives and counselling. We believe therefore that there is a solid basis for the introduction of initiatives, which should be piloted and evaluated, in health counselling among older people. There is also considerable potential for older people in taking the leadership role in such counselling initiatives.

4.2.4 Health and illness behavour

Health behaviour refers to action taken by people to maintain and improve their health while illness behaviour describes action taken in response to symptoms or perceived illness. Cultural or social factors and gender are thought to be related to health and illness behaviour variation. Age may also be important. Older people, as we know, are much more frequent users of health services than young people. Nevertheless, this fact may conceal attitudes to illness - and illness behaviour patterns - which lead to under-utilisation in relation to need. Such attitudes may be a function of fatalism and the belief in the inevitability of illness in old age. This issue should be further investigated. Variations in illness behaviour among the sample in the present study could be the starting point for this investigation.

The study, for example, finds evidence that the usage of health services by older people is higher among women than men. possibly reflecting greater morbidity but also indicating more positive 'illness behaviour*, i.e.. a more active response to symptoms and more pro-active use of GPs by women. Confirmation of this has been provided by McCluskey (1989: 153-155).

Men may be less attentive than women to their own morbidity, either because it follows a different pattern by not producing warning symptoms, or because men do not see the significance of symptoms to the extent that women do. Consequently they may not seek check-ups as often as women do to allow a GP make a timely and professional diagnosis. Most diseases can be more successfully treated or managed if detected early. Such gender differences in illness behaviour may be part of a continuum with the poorer 'health behaviour", i.e.. taking action to stay healthy, of men compared to women.

What applies in relation to gender differences also may be applicable to differences based on other factors such as income and education level, and social class. These aspects of illness and health behaviour also need to be investigated.

The Council believes that patterns in mortality and morbidity in later years, patterns of health behaviour and illness behaviour and different perceptions of health among older people need to be further explored and understood because they are an important base for the development of concrete measures to promote health and autonomy. Special attention

needs to be paid to gender, class and other factors affecting differences in health and illness behaviour. Without a clear understanding of these issues measures to promote health and independence will founder.

4.3 Ageing, morbidity and incapacity

There is much in the data on morbidity patterns in this study that requires further analysis, and there are many difficulties with existing morbidity measures. What is inescapable, however, is that ageing itself is not the only condition required for the onset of most disease. Even in the case of the onset of disability which is correlated with age there is inevitably an intermediate morbidity factor. Factors other than age. some of which we have already mentioned, such as socio-economic class and material deprivation, but also lifestyle, health behaviour and life history, play a crucial part in determining whether and when a person becomes ill. In very old age the onset of an illness is more likely to combine with other ailments in reducing physical capacities and the ability to carry out tasks of everyday living, but even in very old age there are many people who suffer neither incapacity nor major disease.

Measures to reduce the prevalence of chronic, and often disabling, conditions are increasingly important now. but they are also worthwhile. Firstly, it is evident that more people are reaching old age. Although Ireland falls behind other countries in life expectancy at older ages the probability is that this will change, giving way to the challenge of reducing the percentage of older people with an illness and the duration of illness. Reductions in morbidity will in turn reduce the extent of functional incapacity and allow more older people to maintain their autonomy for longer. Secondly, this will make life easier for those who will potentially be called upon to provide care for the dependent elderly. Thirdly, as the authors of this study have pointed out. there is a strong correlation between physical health and psychological well-being.

***In** this connection, the WHO has set out a very broad objective for European populations which the Council endorses, of increasing the average number of major disease- and disability-free years by at least 10 per cent by the year 2000* (Target 4). In this context specific attention is given to the fact that both the distribution and the main causes of disease and disability vary

with age. The distribution of disability found in the present report in Irish elderly people echoes what has been found elsewhere. The WHO point out that although acute infectious diseases have been drastically reduced in most European countries in the 20th Century, there is an increased prevalence of disabling conditions of the brain, cardio-vascular system, respiratory system, musculo-skeletal system and connective tissues, and certain forms of cancer. These disabling conditions are most frequently found in old age.

4.4 Early diagnosis, treatment and restoration of independence

Not all disease can be prevented, particularly in an ageing population. However, early diagnosis and intervention can immensely improve the health of older people and restore them to their own home as soon as practicable. We therefore recommend a strategy for the health services which focuses adequately on those who are already elderly. Such a strategy will demand a re-orientation of health services to provide for the early diagnosis and treatment of age-specific disease or syndromes. Opportunistic screening by GPs. early and sophisticated assessment and intervention through geriatric specialists, high quality acute and follow-up care in nursing homes or at home and efficient and flexible domiciliary support services must all be given greater priority in the interests of promoting the health and autonomy of older people in this country.

We endorse the target of the Department of Health in its Health Strategy of maintaining at least 90 per cent of those over 75 years in their own homes through a strengthened role for GPs, other primary health care workers and particularly Public Health Nurses and Home Helps. The ability to remain at home will depend increasingly on the adequacy of domiciliary care and the achievement of this target will hinge on the adequacy of provision in these areas. (Lundström *et al.* 1994J. *We also welcome the commitment in the Strategy to providing a geriatric medicine department, or access to one, in all general hospitals* (Department of Health 1994). *Access to the full range of secondary care services should never be denied or limited on grounds of age alone. The secondary and primary care systems therefore need to be better integrated through effective and efficient co-ordination arrangements.*

5. Caring for Disabled Elderly People

The WHO has called for *better physical, social and economic opportunities for the disabled, by the year 2000* (Target 3). This target was drafted with the general disabled population in mind, covering access to schools, work, social and creative activity and social participation. Disabilities dating from early in life, if not from birth, are more than likely the specific focus of attention here, rather than the progressive disabilities often associated with old age. Nevertheless, two points are important to emphasise: firstly, disability is disproportionately concentrated among older people and. secondly, certain categories of disabled people who, in former times, were unable to survive into old age will now be able to do so. Thus, policies must address the need for fulfilment for disabled older people throughout their longer lifespan. both in the context of early and late onset conditions.

In the context of ageing populations the issue of late onset illness and disability assumes increasing importance. While every effort must be made to prevent and cure disease, it is still inevitable that many older people will experience episodes of - sometimes prolonged - disability. A particularly challenging task will be to add life to years in the case of the seriously ill and disabled elderly segment of the population. Indeed, it is probably the greatest challenge of all. requiring practical help, personal care, supportive environments, medical, palliative and therapeutic intervention to minimise pain and discomfort, and humanistic approaches to the maintenance of morale and dignity.

The WHO draws our attention to the importance of family care for the disabled elderly, noting that such care should not simply be negatively perceived as a burden but also, potentially, an expression of self-determination whereby the disabled person has more control, freedom and privacy than under a formal system of care. Notwithstanding the laudability of this view, it is now well established that while most disabled elderly people prefer an informal care setting, and most relatives appear to share this preference, the level of psychological distress experienced by carers is well above average (Blackwell *etal.* 1992) and is itself an important focus for preventive intervention: most carers are middle-aged women or are themselves elderly.

In addition, as the present study concludes, not chronological age but poor health and disability are by far the strongest contributors to psychological

distress among those surveyed. Older people appear to be able to cope - somehow - with common aspects of ageing, such as retirement, or even bereavement, but with the onset of disability or serious illness they experience great distress. The majority of elderly disabled people are cared for by informal carers. Thus both those cared for and those providing care are in the highest risk groups for psychological distress. *The Council therefore believes that it is imperative that the formal care services be directed to the provision of care and support for the informal system of care, to provide practical assistance, to enable the disabled elderly to cope with living with their disability, and to relieve the carer of the distressful aspects of caring.*

WHO Target 29 is that *by 1990, primary care should be based on co-operation between formal providers, community groups, individuals and families (informal carers).* This is essential in relation to disabled older people, who often require multi-disciplinary support and a combination of informal and professional care. One of the key weaknesses identified in many countries has been the lack of flexible and comprehensive formal support for informal carers (O'Connor *et al.* 1988b: Blackwell *et al.* 1992). This report adds further weight to the argument for policy intervention in this area.

6. Accidents and Suicide Among Older People

Accidents, in addition to causing disability which can be carried into old age by ageing cohorts, are also a significant contributor to mortality in old age. The WHO has called for a *reduction in accidents at home, at work and in traffic by 25 per cent by the year 2000* (Target 11). In Ireland the overall number of fatal accidents has fallen by 37 per cent over the past 20 years. The Department of Health intends to set a target for accident reduction in line with the Health Strategy following consultations with interested sectors (Department of Health 1994: 21).

Older people suffer fatal accidents at home, on roads and to a lesser extent in certain workplaces. In many instances accident prevention requires the same type of strategy regardless of age group and there are agencies specifically devoted to specific safety areas, such as in the workplace. In other instances there is a need to address the specific situation of older people, for example in relation to accidents in the home.

6.1 Road accidents

Road accidents are the most important category. While older people accounted for only 6.1 percent of all road casualties in Ireland in 1992. they figured more prominently among those killed: 12.7 per cent of males and 24.4 per cent of females killed on our roads in 1992 were over 65 years (Environmental Research Unit 1992).[2] While older people are less likely than the general population to be involved in all types of road accident they are equally likely to be involved in pedestrian accidents (Dept. of the Environment 1993).

The present report also provides information on the perceived dangers from traffic and actual experience of being knocked down among older people. Between 1977 and 1993 there has been a notable increase in the number of older people who have been knocked down, from 1.6 to 3.9 per cent, but as high as 6.2 per cent in urban areas in 1993. The proportion of older people perceiving traffic as a problem has increased from 12 to 18 per cent over the same period[3]

The Council believes that there is a ease for reviewing the special hazards to elderly pedestrians and vigorously promoting road safety through improved traffic regulation and physical structures, such as paths, lighting, road-crossings, sub-nays etc., as well as educational measures.

6.2 Domestic hazards

Older people are also particularly vulnerable to accidents at home. They are particularly at risk from domestic fire hazards: although older people account for only 11.4 per cent of population, in 1989 some 22.6 per cent of all casualties and 41.2 per cent of deaths in fires were people aged over 65 years. The reduction of domestic accidents therefore has particular relevance for older people.[4]

The Council recommends that - particularly through health and housing authorities and social senice agencies and personnel - the issue of domestic

2 Quoted in *The Irish Times* 22 12 93.

3 This is a disturbing finding since the *Published Road Accident Fads* of the Department of the Environment for 1977 and 1993 indicate some overall improvement in the rate of pedestrian casualties among older people and the overall population.

4 *See Fire Prevention and the Elderly* National Council for the Elderl) unpublished 1992.

hazards should be highlighted among older people and where appropriate practical assistance should be provided to elderly people at risk.

6.3 Workplace accidents

Accidents at work may not be directly relevant to older people but do take a toll indirectly, as the cohort of working age grows older. Also, many people continue to work well into old age in the agricultural sector, which carries the highest death rates from accidents of all Irish industries. And older people figure significantly among these deaths and injuries.

The Council, in drawing attention to the sometimes disproportionate risk to elderly people from certain accidents, particularly fatal accidents on the roads, in the home and on farms, recommends that statutory and voluntary agencies address these matters with appropriate measures, whether in rendering the traffic or home environment safer for older people or in providing advice and assistance to older people, reminding them of the kinds of precautions they might consider.

6.4 Suicides

The WHO also seek a *reversal of rising suicide trend by the year 2000* (Target 12). In Ireland, the most noted rise in suicides in recent times is among younger adult age groups. However there has been an increase in suicide among the elderly. Measurement of this phenomenon is difficult and the extent of suicide in older people may be under-represented by official statistics.

The reasons for suicide in the elderly may differ from the reasons for younger adult suicides and the methods used could mask the cause of death. This needs to be further explored if we are to consider how to achieve a reversal of current trends and also because suicide may be an index of distress and social fragmentation affecting the elderly population on a wider scale (O'Shea and Larragy 1994). Suicides in the elderly population may be associated with depression and or alcoholism, which in turn may have roots in a poor quality of health or social life. Indirectly, there may be ways to prevent some of the circumstances giving rise to suicide through initiatives of the voluntary sector focused on improving the quality of social contact and identifying and providing support for those at risk.

The Council believes that additional research into suicide patterns and trends among the elderly population in Ireland is needed. The development of support services for ill elderly people and their carers, including earlier detection of depression by medical professionals, and the development of counselling initiatives through voluntary and statutory agencies for those confined to home, could play apart in reducing suicide among older people.

7. Adding Life to Years: Social Gain

Under the motto, *Add Life to Years,* the WHO have defined as a target the development of the health potential of the whole population through the fullest use of their functional capacity, so that *by the year 2000, people should have the basic opportunity to utilise their health potential to live socially and economically fulfilling lives* (Target 2).

This applies to all age groups. It is particularly applicable to older age groups against a background of beliefs that added years of life will be accompanied by increased levels of chronic morbidity and disability among the older population. The WHO has stressed however that, for the most part, disempowerment of older people and policies which impose retirement on them or limit their participation and level of social contact, are a more plausible explanation of the absence of 'life' from later years than any intrinsic mental or physical incapacity on the part of older individuals. The present study demonstrates, consistent with other studies, that the majority of elderly people are living independently without any major physical or psychological impairment.

There is a considerable educational task to be accomplished here. We frequently read about the burden of old age on a shrinking workforce as though the elderly are unable to contribute. Yet, while we are currently witnessing the widespread introduction and normalisation of earlier retirement, in the long run the whole of our population is ageing and, for both social and economic reasons, there will need to be a re-evaluation of how work is distributed over the life cycle, with the possibility of later, and certainly more flexible, retirement for many, and a greater emphasis on work sharing in society as a whole.

The Council believes that changing labour market conditions, changes in family organisation and general improvements leading to population

ageing should be seen as an opportunity and a challenge to policy makers, statutory bodies and the emerging self-help initiatives of older people to find new avenues for participation. In particular, initiatives offering older people the chance to deploy their skills and experience in a socially useful way should be actively promoted.

In addition, opportunities for adding life to years through voluntary or recreational activities, exercise and cognitive pursuits, and through creating and sustaining a context for friendship and intimacy into old age, will need to be created and exploited to the full. Without wishing to deny ageing or the imminence of death in old age, we have to counter the notion that older people are less entitled than other age groups to experience life to their fullest potential.

The Council sees the potential for a flourishing of projects aimed at drawing out the potential of retired and older people generally. Projects under this heading must be very broad ranging and will vary from one group to another. While many will be geared to the 'fit elderly', they should not be too confined. Volunteer programmes for visiting older people in institutional care or at home are already operating and should be developed, and projects such as reminiscence work and that of Sonas - which stimulates whatever potential remains for a dignified human life among dementia sufferers- are exemplary in adding life to years among even the most forgotten elderly.

Preparation for retirement and, particularly in the case of women who have not participated in the paid workforce, preparatory courses on healthy ageing are also very important and new options need to be explored.

8. A Health Promotion Programme for Older People

The concept of promoting the health of older people has begun to receive the international recognition it deserves. In 1991 the WHO convened a meeting in Lisbon which adopted a programme for Healthy Ageing, and is now working explicitly on the reduction of morbidity among those aged over 65. The EU, following the Maastricht Treaty, provides for additional competency in relation to health promotion, the prevention of diseases, health information and education, and the European Commissioner for

Employment and Social Affairs has identified health promotion as an appropriate theme for a second programme on older people.

In Ireland, the National Council for the Elderly is required to advise on *'measures to promote the health of the elderly'* in its Terms of Reference. This has enabled the Council to initiate a programme of research and conferences on this emerging field and to take initiatives such as the Round Table on *Theories of Ageing and Attitudes to Ageing,* which took place in March 1994. This role has been further underscored in the Government's new Health Strategy, which states that over the next four years priority will be given to promoting healthy ageing with the assistance of the Council and in co-operation with the statutory and voluntary bodies involved with older people (Department of Health 1994).

The Council has provided a link between these different strands at international and national level through its contacts with representatives of the WHO. UN and EU and. in Ireland, with the principal agencies and professionals with an interest in the field. Of particular note among these contacts has been the Council's participation in the launch, in November 1992. of a European programme known *as Ageing Well.* This programme, initiated by Eurolink Age - on whose Council the National Council for the Elderly represents Ireland - involves statutory, voluntary and private sector collaboration around the promotion of health among older people, and includes the piloting of a Senior Health Mentor Scheme involving older volunteers, with professional back-up and evaluation.

/// light of the above and in order to sustain the momentum generated by its initiatives on promoting the health and autonomy of older people to date, the Council recommends that the design and planning of a ***Programme for the Promotion of the Health of Older People*** *be given consideration as a matter of priority.*

The Council considers that the Eurolink Age ***Ageing Well*** *initiative provides a helpful impetus for the design and evaluation of projects under such a programme.*

The Council would be pleased to facilitate the consideration of plans for such a programme, for example through its Consultative Committee on Measures to Promote the Health and Autonomy of Older People, which has successfully overseen the Council's research programme in this area to date.

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CHAPTER ONE

Introduction

Background

Social research in western countries in recent decades has shown a large and increasing interest in ageing and the elderly. This is so, in part, because the elderly populations in those countries are growing very rapidly, both in absolute numbers and as a proportion of the total population. This in turn is the consequence of increased longevity among older people and of very low fertility, leading to decreasing numbers of young people in those populations. Concerns about the ageing of the population have arisen in connection with such diverse issues as the economic burden of financing an ever-growing population on pensions, the rising costs of health care for older people, the possible decline in the quality of old people's lives because of the greater scarcity of younger adults and children in their social circles, and the challenge both of extending old people's life spans even further and of improving their day-to-day health and autonomy.

As we shall see further below, some of the concerns just mentioned do not apply to the elderly in Ireland since their situation differs in some basic ways from that of the elderly in most other western countries. The most striking difference from the viewpoint of the present report is that older-age life expectancy in Ireland has not shown the same increases as have occurred elsewhere and is now lower than in other countries in the developed world. Another related peculiarity of the Irish situation is that Ireland's population is not yet ageing to anything like the degree that is common in other countries. Undoubtedly, one reason for the comparative youthfulness of Ireland's population is the fertility surge from the late 1960s to the early 1980s which gave us so many young people. But the other, and less welcome one. is the relative scarcity of older people caused by higher than average older-age mortality rates. If we do not yet have to be worried about the

prospect of an ageing population in Ireland, we do have to be concerned about the poor health profile and high mortality of older Irish people which has helped to keep the population comparatively young.

This suggests, therefore, that the task of keeping middle-aged and older Irish people alive longer is an urgent one for Irish health policy. However, keeping older people alive is not the only issue, in Ireland or in any other country. It is also a matter of keeping older people healthy and active for as long as possible, though that too is clearly a crucial concern. In addition, we have to accept that, no matter how successful we are in staving off decrepitude and death, ageing inevitably leads to physical decline. For some people, that decline begins early (perhaps even well before old age) and persists for a long time before eventual death, for others it emerges only very late in life and is brief. In any event, few people can avoid having to face physical decline in some shape or form, for however short or long a period, at whatever age in life. It matters greatly for the quality of their lives how well they cope with that decline — how they adjust socially and psychologically, and how they maximise their autonomy and control over day-to-day life within the constraints of declining physical capacity. A fatalistic acceptance of ill-health may be detrimental to one's chances of recovery and so may contribute to illness. But equally, a denial of illness or an inability to come to terms with the physical constraints on one's day-to-day activities which it brings may close off coping strategies and may worsen an already difficult situation.

Objectives of Report

It is against this background that the present report focuses on the health and well-being of older people in Ireland. It is concerned not just with health in the narrow physical sense but also with the broader social and psychological dimensions of well-being, and with the many ways in which that well-being may be preserved or reduced in old age. Its chief concern is to present the main findings of a sample survey conducted in 1993 which focused on various aspects of health and well-being among those aged 65 and over in Ireland. In doing so, it has three main objectives:

1. to provide a profile of the physical, psychological and emotional well-being of older people in Ireland and of the main factors likely to influence those aspects of older people's lives;

2. to identify vulnerable sub-groups of older people as far as these dimensions of well-being are concerned:

3. to contribute to the formulation of health promotion policy for older people.

The first of these objectives is dealt with by means of a descriptive account of a number of measures of physical and psychological well-being which were included in the 1993 survey. These measures ranged over physical illness and disability, utilisation of various medical services, various aspects of health lifestyle, psychological distress and emotional contentment. The second objective is met by examining variations of these dimensions of well-being across major sub-groups of the elderly population as defined by age. sex. social class, urban-rural location, income and living standards. Attention is paid also to social engagement and social supports as factors affecting the vulnerability of older people. Analysis of these issues allows us to say which social categories of older people have the greatest risk of low levels of well-being and of inadequate social supports in coping with their difficulties. The third objective is met by drawing out the implications of the preceding sections for health promotion policy for older people.

The Data

The main data source for this report is the 1993 Survey of the Over-65s which was commissioned from the ESRI by the National Council for the Elderly to mark the *European Year of Older People* in 1993. The target population of the survey was persons aged 65 and over resident in private households (that is. excluding those living in institutions). A national probability sample of 909 persons was drawn from that population and interviewed in June-August 1993. Full details of the survey design and sample details are set out in Appendix A at the end of this report.

Data from a number of other sources are also drawn upon. These include the 1977 National Survey of the Elderly (Whelan and Vaughan 1982) and the 1987 Survey of Income Distribution. Poverty and Usage of State Services (Callan *et al.* 1989). A number of the measures of physical and psychological well-being included in the 1993 survey were replicated from these earlier surveys in order to allow for comparison and for some assessment of trends over time. However, it is important to note that the

design of these earlier surveys differed from the 1993 survey and from each other, in that the sampling procedures, data collection instruments and objectives of the research were different in each case. The degree of comparison which is possible between these data sources is thus limited in many ways. At the same time, because of the absence of any better sources of trend data for central topics in the present report, there is considerable interest in drawing on these sources for whatever trend indications they can give us.

In examining the incomes and living standards of the elderly, the report relies more on the 1987 Survey of Income Distribution. Poverty and Usage of State Services than on the 1993 Survey of the Over-65s. The reason is that the 1987 survey contained quite extensive measures of these issues, whereas the 1993 survey, because of its main focus on physical and psychological health, dealt with income questions only briefly and in a relatively superficial way. The 1987 data are the main source in Ireland in the last 10 years or so on national patterns of income distribution. They have been central to recent analyses of poverty patterns in Ireland and have led to a perception that the elderly are no longer at serious risk of poverty. However, no detailed analyses specifically concerned with the elderly have been carried out on this source. The present report makes some attempt to remedy this deficiency by re-examining some of the data from the 1987 survey as far as the over-65s are concerned. Some comparisons are made between the 1987 data and the data from the 1993 survey on incomes and poverty, though again, because questions of incomes and poverty were not the main focus of the 1993 survey, the degree of comparison which is possible is limited.

Characteristics and Limitations of Study

The principal feature of the 1993 survey is its focus on a multi-dimensional concept of 'health' among the elderly. Notions of health can be defined in a narrow sense to refer to the absence of illness or in a broader sense to refer to a combination of physical and emotional wellness. of the states of mind as well as of states of the body (McCluskey 1989). This report inclines as far as it can towards the broader concept of health, largely by utilising a range of indicators of both the physical and psychological dimensions of health. Clearly, one's physical condition and one's mental state are closely

related — to 'feel sick", in a physical sense, is almost by definition to feel some psychological depletion. This is not to say. however, that they are the *same* thing: one may have good physical health and be in a poor emotional or psychological condition, just as physical problems do not always have a dampening effect on a vigorous or positive state of mind.

It is beyond the scope of this report to try to disentangle the complex interactions between mind and body which go to make up good health or the lack of it. However it is possible to describe in broad terms the levels of well-being in the elderly population in Ireland on the basis of the measures applied in the 1993 survey and to identify characteristic combinations of features which can be found in that population. It is also possible to place the indicators of health in the context of a number of circumstances — social class, gender, income and standards of living, health lifestyle, participation in social networks, etc. — which might be expected to mediate or condition the day-to-day impact of the various aspects of well-being for those involved. By presenting a broad-ranging quantitative picture of these interacting aspects of elderly people's health, it seeks to give some sense of the basic contours of well-being in the elderly population and of the socio-economic circumstances which condition that well-being.

While pointing to the quantitative measures of well-being as a strength of the data to hand, we should also recognise their limitations. The first and most obvious one is that the survey data focus on the living and contain no information on those who have died. Death is the ultimate denial of well-being, but our data provide no information on the patterns or correlates of older age mortality. Chapter Two below attempts to take some account of this deficiency by drawing on death registration and census data to highlight some outstanding features of older age mortality in Ireland. However, until the account of well-being among the living, which makes up the bulk of this report, is complemented by detailed analysis of mortality patterns in the older ages, we will have only a partial picture of patterns of physical health and of vulnerability to illness among older people in Ireland.

A further limitation of the data to hand is that the measures of health status they contain are self-reported and so lack the standardised "objective" character of clinical diagnoses. The self-reports are in the form of brief responses to interview questions and so lack the depth and nuance necessary

to capture the texture of individuals" situations — they provide only a limited sense of the *meaning* of health and illness, or of old age itself. The data thus possess neither the consistency of ‘objective" measures nor the richness of "subjective" experience but fall somewhere in between the two. However, these limitations are a well-recognised feature of survey data in this area. Their significance for the present report is assessed at the relevant points in the text below (see especially Chapter Three and Appendix B). and some care is taken in judging how far they can be relied on to give a useful picture of at least certain aspects of health among older people.

Another limitation as far as any analysis of the conditioning circumstances of health and well-being in the population is concerned is the point-in-time nature of the data. The survey focuses entirely on the present-day situation of respondents and so provides no information on their life histories. This clearly limits the extent to which we can trace the origins or principal influences on their present well-being. How old people feel, either physically or psychologically, is obviously influenced by their current circumstances but is also the outcome of their accumulated experience of life. This is true both of basic physical health, which is as much the outcome of lifetime growth and medical history as of present circumstances, and of psychological and emotional resilience, which also carries the marks of past experience.

It is worth remembering in this connection that the respondents in the 1993 survey were mostly born between about 1910 and the mid-1920s (a small proportion, in fact, were born in the late years of the last century). Medical knowledge now suggests that susceptibility to disease in later life may be influenced by health in the earliest stages in life. We have no information on the early-life health of the respondents in the 1993 survey, but some indication of the general health status of children when they were young is reflected in the fact that, according to the Irish life tables for 1925-27. 11 per cent of children died by the age of five. A similar fragility in the social environment of those children is shown by their high risk of orphanhood: in 1926. 22 per cent of 14 year olds (and 11 per cent of all children under 15) had lost at least one parent through death (Census of Population 1926. *General Report).* This indicates that parental deprivation and family breakup were much more common in the childhoods of those who now are

in their 70s and 80s than they are among today's children, despite the much talked of recent upsurge in lone parenthood and marital breakdown.

As they approached adulthood, the age cohort in our survey faced further distinctive problems. The chances of marrying and forming a family in Ireland in the 1930s were among the lowest in human history that we know of. and in the aftermath of World War II. emigration and population decline reached new extremes. These depressing circumstances not only engendered a deep sense of national malaise, they also ravaged and distorted the family patterns and social networks of large segments of the population at the time. At the same time, among those who married fertility rates remained relatively high by the standards of other countries, while infant and childhood mortality fell, particularly from the late 1940s onwards. This combination of circumstances produced a distinctive outcome as far as family networks are concerned. As is documented in Chapter Five below, strong traces of this outcome survived over the decades and are still visible in the family networks of the over-65s of today.

By the time the social and economic revival of the 1960s arrived, our age cohort was on the brink of or well into middle age — able to garner some of the benefits of that revival while not having been exposed to it in their most formative years.

To trace, in full, the residues of these or any of the other life-history circumstances in the lives of respondents in our survey would be an enormously complex task and is well beyond the scope of the present report. General historical conditions in the course of the twentieth century in Ireland clearly indicate not only that today's old people often experienced material hardship in their lives but also that their social environment in both childhood and adulthood was often more disrupted or traumatic than our often nostalgic images of the past would lead us to expect. In any event, we have to recognise that the present-day features of their lives that are tapped in the present survey are the visible surface of a long sedimentation which the survey makes no attempt to excavate. This is not to invalidate the survey or the present report. It is rather simply to remind ourselves of the complexity of the issues it deals with and the very great challenge it would offer any research programme to unravel them in anything like a complete or comprehensive way.

Structure of Report

The remainder of this report is laid out in eight chapters. Following this introduction. Chapter Two sets the context by providing a brief overview of levels and trends in mortality among the elderly in Ireland, keeping in mind that mortality levels and patterns are often regarded as the fundamental indicator of the health and well-being of populations. It also refers briefly to the demographic implications of recent developments in older-age mortality levels in Ireland. Chapters Three and Four provide a descriptive account of those issues which are at the heart of the study — physical health and illness and psychological/emotional well-being. Chapter Three not only looks at a number of measures of physical morbidity but also gives an account of health lifestyle factors such as smoking, diet, physical exercise and alcohol consumption which are intimately connected with physical well-being. Chapters Five. Six and Seven provide an account of a number of background conditioning circumstances affecting health and well-being which were covered in the 1993 survey. In Chapter Five, the focus is on social networks, social interaction and social support. Chapter Six deals with incomes, referring especially to the extensive data on elderly incomes which are available from the 1987 Survey of Income Distribution. Poverty and Usage of State Services. The less extensive data on this subject from the 1993 survey are referred to also for comparison. Chapter Seven turns to living standards and non-monetary aspects of deprivation among older people. Following the review of background factors in Chapters Five to Seven. Chapter Eight turns to an examination of how these background factors relate to patterns of health and well-being. The objective of this chapter is to identify the sub-groups of the elderly population who are particularly at risk as far as physical health, health lifestyle and psychological well-being are concerned. The final chapter draws out the main findings of the report by identifying four priority issues connected with the health and well-being of the elderly in Ireland which emerge from the analysis and by examining some of the implications for health promotion policy.

CHAPTER TWO

Mortality and Demographic Trends

This chapter sets the context for the subsequent examination of 1993 survey data on health and autonomy among the over-65s by providing an overview of some features of mortality patterns in older age groups in Ireland. Mortality patterns are. of course, important as basic indicators of the health of populations and they are looked at here mainly for what they indicate about that issue. They are also important as proximate determinants of population size, including the size of the elderly population. The latter part of this chapter deals briefly with the implications of recent mortality trends in Ireland for the size and structure of the elderly population.

In dealing with these issues, the present account is hampered by the lack of epidemiological or social science research in Ireland on mortality patterns in general and on mortality among the elderly in particular. Cook (1990). in reviewing the literature on health and health inequalities in Ireland, suggests that *morbidity* among the elderly in Ireland has been studied to some extent but he makes no reference to research on *mortality* among the elderly. This chapter does not attempt to make good the deficit in research in older-age mortality, and it is constrained in what it does attempt because of that deficit. It is concerned simply to highlight certain patterns which are important as background to the present report and which require much further study in their own right.

Mortality and Health

Comparative mortality levels

If we examine international mortality patterns as a basic indicator of health status, older people in Ireland emerge as having relatively poor health. This is true particularly by reference to the standards of other countries in the

developed world but also to some extent by the standards of many developing countries (though not of eastern Europe, where older-age mortality rates are generally higher than in Ireland). As Table 2.1 shows. Ireland in 1990 ranked lowest among 23 OECD countries in life expectancy at age 65 for both men and women. Life expectancy for men at that age in Ireland was 13.2 years, compared to an OECD average of 14.9 and headline values above 16 years in Japan and France (see also Appendix C. Table C.I). For women, life expectancy at age 65 in Ireland was 17.0 years compared to an OECD average of 18.9 years and headline values of 21.0 and 21.7 in Japan and France. Indeed. Ireland ranked lower in life expectancy at age 65 than many intermediate developing countries in Latin America and Asia (UN 1993).

Table 2.1: Life Expectancy at 65 and Survivorship* in Selected Age Ranges in Ireland and in OECD Countries (excluding Turkey)

	Ireland	Mean for 23 OECD countries	Ireland's ranking in 23 OECD countries
MALES:			
Life expectancy at age 65	13.2	14.9	23
Survivorship from birth to age 45	95161	94184	6
Survivorship from 45 to 65	80864	82468	18
FEMALES:			
Life expectancy at age 65	17.0	18.8	23
Survivorship from birth to age 45	97105	97030	12
Survivorship from 45 to 65	88741	90826	20

** Defined as the number per 100,000 who survive from the beginning age to the terminal age in the age range.*

Source: Appendix C. Table C. 1

Table 2.1 also gives an indication of mortality relativities between age groups in Ireland and in OECD countries by setting life expectancy at age 65 alongside survivorship rates in the age ranges 0-45 and 45-65. These

indicators show that in contrast to the elderly, mortality among young people in Ireland is relatively low by international standards. Males in Ireland have a better chance of surviving from birth to age 45 than the average for males in other OECD countries, and on this indicator Ireland ranks sixth from the top among the 23 most developed countries in the world. The survival chances for Irish females over the same age range, though better than for males, are just about average for women in OECD countries and Ireland has a middle ranking in Table 2.1 on this score. With the onset of middle age Irish mortality begins to slip down the international rankings, though even in the age range 45 to 64. survivorship rates in Ireland are by no means the worst in the OECD. Set against Ireland's quite poor international ranking in life expectancy at age 65. these comparisons suggest that, insofar as Ireland has a health disadvantage compared to other developed countries, it is very much concentrated on the elderly. Younger Irish people seem, if anything, to have a health *advantage* compared to most other countries, while middle-aged Irish people approximate more closely to "normal" international patterns than do the over-65s.

Long-term trends

When we look back over time we find that the relative health disadvantage of older Irish people is of comparatively recent origin. In the late nineteenth century, mortality patterns in Ireland were exceptionally good by the standards of the day — though doubts have been expressed about the reliability of the data used to measure those patterns.[1] By the early decades of the present century, however, when the quality of the death registration data had improved, mortality patterns among older people in Ireland compared quite well with those of other countries. In the 1920s, male life expectancy at age 60. at 15.7 years, was among the highest in Europe and female life expectancy at the same age. at 16.2 years, was also

1 Life tables calculated on the 1N~1 Census of Population and death registrations for the period ISM-1N" gave Ireland the highest life expectancy in the world at the time — the only country to exceed a life expectancy of 50 years on average for hoth sexes. Infant mortality was also the lowest recorded and was the first to fall below a rate of 1MI per 1MM of the infant population. However. Fcsty (l>74) considers thai these figures must represent gross undcr-registration of deaths. He suggests that the stagnation in recorded Irish mortality up lo the end of the nineteenth century, at a time when mortality was falling generally in Europe, indicates an improvement in registration MI that registered mortality came to approximate more closely lo actual patterns.

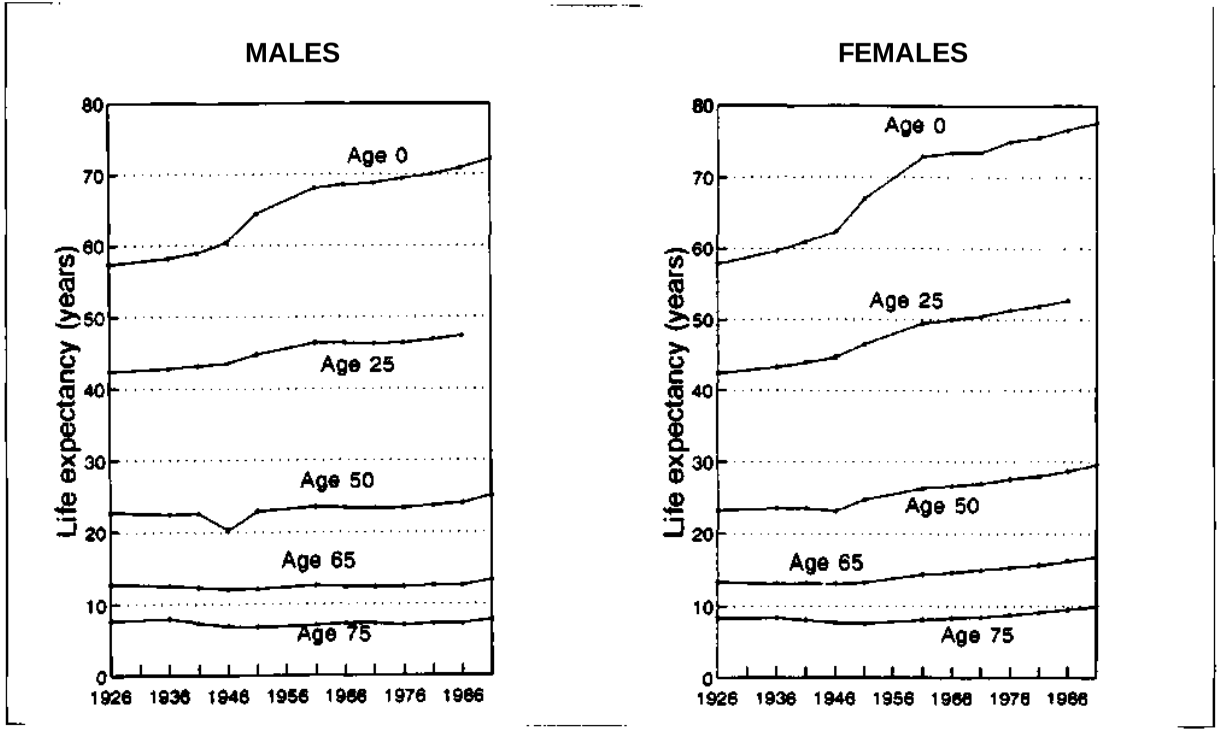
comparatively high (Census of Population 1926. *General Report).* However, between the 1920s and the 1950s, older-age life expectancy in Ireland either stagnated or moved ahead more slowly than in many other countries, so that by the early 1950s older people in Ireland had lost much of their position of advantage.

The sluggish movement in older-age life expectancy in Ireland over the period 1926 to 1991 can be seen in Figure 2.1. which shows trends in life expectancy at various ages from birth to age 75. Mortality rates for male and female infants and for females at age 25 improved slightly between the 1920s and the 1940s, but otherwise mortality stagnated during that period. It is worth noting too that up to the 1940s Irish mortality patterns were quite exceptional in that females had little or no advantage in life expectancy over men (both had a life expectancy at birth of about 58 years). Generally in western countries at that time, women had an average two year life expectancy advantage at birth over men (Preston 1976). In the late 1940s, life expectancy trends began to move sharply upwards at ages 0 and 25 for both males and females, with the female rate of increase somewhat higher than the male rate. The greatest life expectancy gains at these ages occurred between the mid-1940s and the mid-1960s. For middle-aged and older women, life expectancy also increased steadily from about 1950 onwards, with a continuous and fairly steady rate of increase right up to the present. For middle-aged and older men. however, the picture is strikingly different: life expectancy at all ages above 50 scarcely changed over the period 1926-1986. and indeed at ages 65 and 75. life expectancy for men in 1986 was marginally lower than it was in 1926.[2]

The divergence between male and female life expectancy trends since the 1940s has meant that Irish women have gained a substantial and widening life expectancy advantage over men. so that the anomalous lack of such an advantage among Irish women in the decades before World War II has now largely disappeared. On the other hand, we now have a new anomaly: the lack of change in mortality levels among older Irish men from the mid-1920s to the mid-1980s. Periods of stagnation and even temporary disimprovement in older male mortality have been common to many

2 In 1426. men in C'onnaught. Ihe longest lived population group in Ireland at the time, had a life expectancy of 13.4 years, which was a year *greater* than the life expectancy of all men aged <ō in Ireland in 1W6 (Census of Population 1426. *General Report,* pp. 21 "-22(1).

Figure 2.1: Trends in Male and Female Life Expectancy at Various Ages, 1926-1991



Sources: Irish Statistical Bulletin. Data for 1991 are provisional estimates from Eurostat Demographic Statistics 1993.

western countries at various periods around the middle of the twentieth century (Markides 1993). But in Ireland, the period of stagnation has been exceptionally long drawn out. As a result, improvements in older male mortality in other countries have largely passed Ireland by so that at present Ireland lies at the very bottom of the table of western countries as far as older male longevity is concerned. Even among older Irish women, while mortality levels have improved at all ages, the rate of improvement has not been especially high by international standards, so that older women also find themselves faring rather poorly among western countries in the longevity stakes.

Recent developments

While recognising the long-term lack of change in older male mortality levels, and the rather unexceptional rate of improvement in older female mortality, it is important to note emerging signs of advance on both fronts in the 1980s. As can be seen from close inspection of Figure 2.1, the trends in life expectancy for older Irish males show a slight but noticeable upward movement at the very end of the trend lines, that is, between 1986 and 1991.[3] For example, life expectancy for men at age 65 increased from 12.6 years in 1986 to a provisionally estimated figure of 13.2 years in 1991, a pattern repeated to some degree for other older ages. In general, the increases are quite significant given the flatness of the trends for older males since early in the present century. For older women, too, the rate of increase quickened somewhat in recent years.

In order to obtain a more detailed picture of these recent trends, we turn to data on death rates by gender and age group for recent years, though these are available only up to 1990. Figure 2.2 plots annual death rates per 1,000 population among men and women in Ireland for four older age groups (55-64, 65-74, 75-84, 85 plus) over the period 1961-1990. The graphs generally confirm the impression of a new phase in the evolution of middle and older age mortality in Ireland within the last 10 years, especially as far as men are concerned. For men in the age group 55-64, death rates hovered

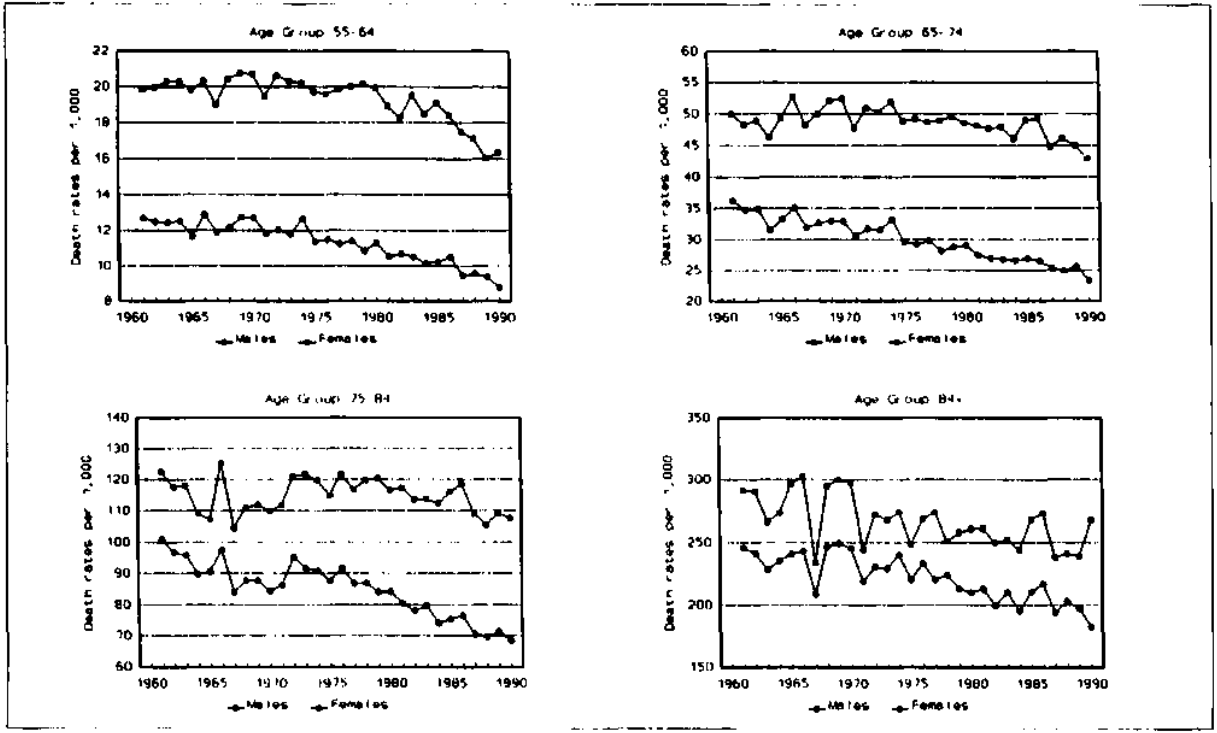
3 Data for 1991 in Figure 2.1 are based on Eurostat rather than CSO calculations. The Eurostat methodology typically produces results which differ slightly from those of the CSO, so that the data for 1991 are not fully comparable with those for the earlier years.

around 20 per 1,000 from 1960 to 1979, then shifted uncertainly downwards up to 1985 before moving quite sharply downwards to a rate of 16 per 1,000 in 1989. The 1989 rate was repeated almost unchanged in 1990, and at that represented a decline of 20 per cent on the rates of 10 years earlier. For men in the age group 65-74, the death rate hovered around 50 per 1,000 up until the late 1970s, but by the late 1980s they had moved down to around (and in 1990 below) 45 per 1,000, indicating something of the order of a 10 per cent decline over about 10 years. In the age group 75-84, the death rate fluctuated quite widely during the 1960s, stabilised at around 120 per 1,000 for most of the 1970s and dropped below 110 per 1,000 in the late 1980s. Only for the age group 85 and over are the signs of decline in the male death rate more uncertain. While there was a sharp decline for males in that age group between 1986 and 1987, there was an equally sharp rise from 1989 to 1990 and the 1990 rate was more or less the same as that which had prevailed during most of the 1970s.

As for women in the four age groups examined, death rates have shown a more continuous and consistent downward trend over the whole period between 1960 and 1990. This is in keeping with the long-term and steady, if unexceptional, improvement in female life expectancy in Ireland noted earlier. Even here, however, the mid-1970s seem to mark a break of sorts in that the decline after that date was generally steeper than it had been before. Indeed for women, in contrast to men, the recent faster rate of decline seems to have occurred in each of the four age groups more or less simultaneously.

The data underlying Figure 2.2 are summarised in Table 2.2 in the form of average annual percentage changes in the death rate among men and women in the four age groups for the 1960s, the 1970s, the first half of the 1980s and the second half of the 1980s. This table brings out more clearly the increased rate of decline in mortality in most of the age-sex groups involved which emerged during the 1980s, especially in the period 1986-90. From 1986 onwards, the annual average decline for both sexes exceeded two per cent for the two age groups between 55 and 74, and only one age-sex group — males aged 85 and over — failed to show a decline. Prior to 1980, by contrast, annual declines of more than one per cent were rare and occurred

Figure 2.2: Male and Female Death Rates in Older Age Groups, 1961-1990



Source: Derived from Annual Vital Statistics Reports

only among women, while there were frequent instances of small but significant *increases* in the death rate.

Figure 2.2 and Table 2.2 together provide evidence of an historically novel improvement in older age mortality in Ireland in the 1980s. Among men, this improvement is most marked in the youngest of the four age groups examined — the 55-64 year olds — and for the latter half of the 1980s. It weakens somewhat as we go up the age scale. This suggests an age-cohort improvement in male mortality which is affecting middle-aged and "younger elderly" first before carrying forward with the ageing of those cohorts into the older age groups. Data for the years since 1990 are not yet available so it is not yet possible to say if the carry-forward effect is still occurring, or if lower death rates are being maintained among newer entrants to these age groups. However, the signs so far are encouraging and could signal the start of a new and more positive phase in the evolution of middle-aged and older men's mortality in Ireland.

Among women, the recent improvement in death rates above age 55 is not as utterly novel as it is for men. However, the rate of improvement did intensify during the 1980s in all age groups over 55. so that for women too. if recent trends continue, health prospects in old age are moving onto a new plane.

In closing on this question of trends in mortality, we should note that the improvements of the 1980s, while significant and welcome, have not been enough to close the gap between Ireland and other countries as far as older age mortality is concerned. The comparative data presented earlier in this chapter, which showed that mortality among older people in Ireland is higher than among their counterparts in other developed countries, relate to 1991 and so take into account the improvements in Ireland of the late 1980s. This suggests, in other words, that Ireland still lags behind, so that there is nothing extraordinary by present day standards about the improvements which have recently taken place. Rather, they mark a step in the direction already taken some time ago in other developed countries.

Table 2.2: Average Annual Percentage Change in Death Rates Among Older Men and Women in Ireland, 1961-1990

		1961-70	1971-80	1981-85	1986-90
		Average annual percentage change			
55-64	M	0.55	-0.34	-0.74	-3.02
	F	0.16	-1.05	-1.94	-2.07
65-74	M	0.67	-0.67	0.22	-2.51
	F	-0.90	-1.14	-1.42	-2.77
75-84	M	-0.83	0.68	-0.08	-1.45
	F	-1.79	0.07	-2.12	-1.86
85+	M	0.98	-0.96	0.64	0.29
	F	0.30	-1.38	0.23	-2.64

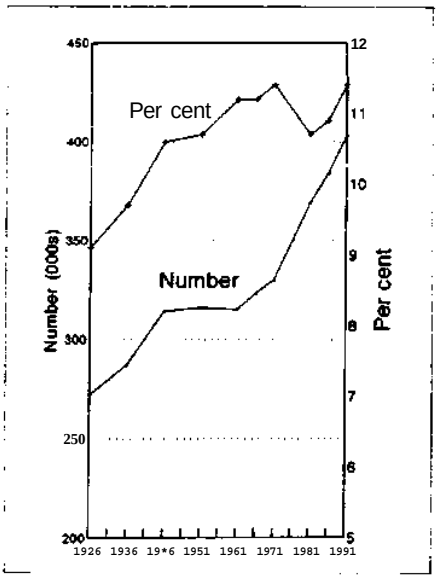
Source: Derived from Annual Vital Statistics Reports

Demographic Implications

A general overview of the demographic characteristics of the elderly population in Ireland has recently has been provided by O'Shea (1993). Here we concentrate on a brief consideration of trends in the size of the elderly population in Ireland, with particular reference to the implications of recent declines in older-age mortality rates for those trends. We also refer briefly to the combined effect of fertility decline and slow population ageing on future age-dependency ratios in Ireland.

As is well known, the "greying" of the population, that is. the increasing proportion of older people in the population, has become common in many western countries. In the European Union, for example, the percentage of the population aged over 65 has increased from around nine per cent in the early 1950s to around 15 per cent in the early 1990s, and many countries are projecting that it w ill increase to above 20 per cent in early years of the next century (Eurostat 1993). Improvement in older age mortality, leading to increased longevity in the elderly population, especially in the population of elderly women, is one of the main causes of this trend. In addition, the fall in fertility in recent decades has reduced the proportion of young people in the population, meaning that the relative size of the elderly population has grown a good deal faster than its absolute size.

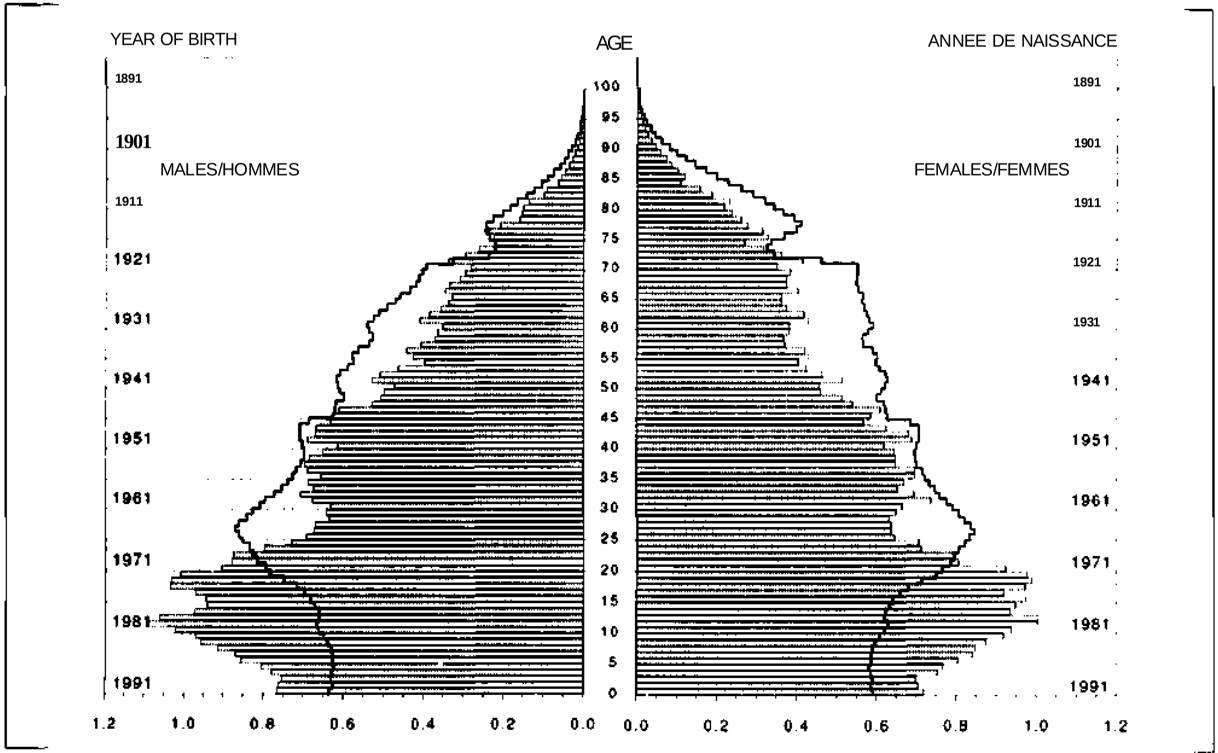
Figure 2.3: The Over-65s in Ireland in Numbers and as Per Cent of Total Population, 1926-1991



Ireland is quite an exception to this trend in that its population has not aged over most of the present century. Though the absolute size of the elderly population in Ireland has increased, its relative size (that is. as a proportion of total population) has changed little since the early decades of the present century. In 1926. 9.1 per cent of the population were aged over 65. a proportion which was large for that time. Since then, however, the percentage aged over 65 has risen only very slowly or not at all. It increased to 11.2 per cent by 1961 but thenceforth it declined slightly over the 1960s and 1970s before rising again to 1961 levels in 1991 (at 11.4 per cent of total population) (Figure 2.3). Absolute numbers aged over 65 have grown from 271.680 in 1926 to 402.924 in 1991. with much of this increase occurring in the years since 1961. However, the population under 65 has grown at a broadly similar rate, thus giving rise to the remarkable long-term stability in the proportion of the population aged over 65.

Three principal factors give rise to this exceptional pattern in Ireland: high fertility, periodic high emigration and the relatively low life expectancy of older people in Ireland. The outcome of the complex interactions between

Figure 2.4: Age-Sex Pyramids for Ireland and the European Union in 1991-1992



Note: Shaded area = Ireland; Black outline = European Union
Source: Reproduced from Eurostat Demographic Statistics 1993

these three factors can be seen when we compare Ireland's population pyramid in 1991-92 with that of the European Union as a whole, as is done in Figure 2.4 (the shaded area in Figure 2.4 relates to Ireland, while the outline pyramid superimposed on it relates to the European Union).

A number of features stand out from this comparison. One is the bottom-heavy shape of the Irish age-sex structure. Ireland in 1991-92 had an exceptionally large teenage population and even though total fertility had fallen very sharply since 1980. the proportion of the population aged under five was still larger than in the rest of Europe. The proportion of the population in the age-range from 20 to the early 30s. by contrast, was small by European standards. Indeed 20-35 was a "bulge" age group in Europe (reflecting both high immigration and relatively high fertility in the 1960s) while it was a pinched age group in Ireland, largely on account of the short but massive surge in emigration which occurred in Ireland in the late 1980s.

The Irish pyramid widens somewhat in the age-range 30-45. reflecting the demographic vitality (and in particular the staunching of emigration) which prevailed in Ireland from the 1960s to the early 1980s. However, it narrows again at the shoulders — that is. roughly from age 40 to age 70 — largely as a consequence of the high emigration of the late 1940s and 1950s which bled off large proportions of the cohorts born in the 1930s and 1940s. The deficit in this age group in Ireland compared to Europe as a whole is particularly evident among women: the Irish pyramid narrows quite sharply as we go from the 40-45 age group to the 55-60 age group while it remains at a near-constant width over the same age-range in Europe as a whole. Irish exceptionalism on this item in part reflects the comparative lack of life expectancy advantage among Irish women over men up to the late 1940s (this lack would have preserved a more even gender balance than is normal during childhood and young adulthood among the age-cohorts in Ireland which are now in late middle age and older). It also reflects the preponderance of women in emigration from Ireland in the late 1940s and of men in return migration to Ireland in the 1970s (though men predominated in emigration in the 1950s) (NESC 1991). The combination of these factors means that the cohort of women aged from about 45 to the early 60s is slightly smaller in number than the same age-cohort among males — a gender distribution which is quite the reverse of the standard European pattern and indeed of the pattern in most other age-cohorts in Ireland. The relative smallness of that female age-cohort also means that it

does not provide the basis for a rapid expansion in the numbers of elderly women over the next 10 to 15 years (and indeed the most recent CSO projections of population (CSO 1988) predicted a *decline* in the numbers of women in the age-range 65-74 over the 1990s). There is little by way of a bulge in the numbers of women until we come down to those in their 30s and early 40s. and these will not begin to hit the 65 year old mark until the period 2005-2010.

Among men. there is much steadier expansion in numbers as we go down from age 65 to age 40 and so there is greater potential for growth in the years ahead in the numbers of elderly men. The extent to which this potential is realised depends crucially on trends in male mortality. As we have seen, male mortality rates from age 55 upwards improved sharply in the late 1980s, and if this pattern continues, the way would be open for a rapid growth in the number of elderly men in Ireland in the years ahead.

Implications for population projections

It is not the place here to try to move from the general observations just offered to systematic projections of the elderly population in Ireland. However, it may be worth commenting briefly on the most recently available official projections of population — those made by the CSO on the basis of the 1986 Census (CSO 198S) — in the light of recent mortality trends to see how those changes necessitate revisions in the projections.

In the CSO projections published in 1988. the population aged 65 and over was forecast to grow by 2.4 per cent over the period 1986-91. that is. from a base of 384.355 in 1986 to a projected total of 393.600 in 1991. Thenceforth, it was projected to remain almost unchanged in size up to 2001. before beginning a rather steep upward movement over the years 2001-2021. In the event, the 1991 Census returns showed that the population aged over 65 had actually grown by 4.8 per cent since 1986. that is. from 384.355 to almost 403.000. This was double the projected increase and meant that by 1991 the population aged over 65 had grown to a size it was not predicted to achieve until early in the next century.

Without making the necessary detailed calculations it is not possible to identify precisely where and why the actual outturn in 1991 diverged from the projections. However, it is clear that a greater than expected decrease

in mortality rates was the principal cause.[4] The projections of the population aged over 65 were based on the assumption that, over the period 1981-2021. male death rates would decline by 0.3 per cent per year in the 50-59 age group and by 0.5 per cent per year in the 60-99 age group, while female death rates would decline by 0.5 per cent in the 50-59 age group and 0.75 per cent in the 60-99 age group. These modest assumptions were quite reasonable at the time in the light of the mortality experience of preceding decades.

As we saw earlier, however, actual rates of decline for all ages over 55 in the period 1986-90 generally exceeded an annual average of 1.5 per cent, and for some age groups, two per cent. That is. they were generally of the order of at least two to three times greater than the assumed rate of decline. The consequence was a lower rate of loss of population in the affected age groups, leading to an unexpected increase in the totals in those age groups.

Trends in the *relative* size of the elderly population in Ireland are even more difficult to predict than absolute size because they depend also on movements in the size of younger age groups. Those movements are difficult to forecast because of the volatility of both fertility and migration in Ireland. Ireland in the 1980s, for example, experienced both its highest and lowest number of births in the present century (the former in 1980. the latter in the closing years of the decade), while in 1987-89. emigration soared sharply but briefly to levels last seen in the 1950s. It is quite possible that we **will** have similar swings in both fertility and migration in the years to come, so that the likely trend of total population in the years ahead is very much an open question.

Implications for age-dependency ratios

Trends in the proportions of the population aged over 65 should be viewed in the context of changes in the structure of the population aged under 65.

4 Return migration among older people is another possible contributory factor. The IW3 Survey of the Over-65s. which questioned respondents on return migration, suggests that net immigration may have occurred in that age group between 19<S6and 1W1 but not on any great scale. While almost 21) per cent of respondents reported that they li\ed abroad at some time in their li\es. only 1.2 per cent had returned between lVSh and IWI (inclusive). Gi\ en that this incidence of return could ha\ e been counterbalanced by some measure of emigration among older people, it is unlikely that net immigration accounted for anything more than a small share of the recorded increase in the population aged o\er 65 between 1W6 and 1W1.

Ireland has long been a high fertility society by western standards and so has had a large child population. However, since the early 1980s the birth rate has been falling sharply and is now more or less at the same low level as prevails generally in the European Union. In consequence, the population aged under 15 is declining rapidly, and may decline almost by a further quarter in the next 10 years or so (Cantillon *et al.* 1994. pp 32-35). Meanwhile, as the present large youth population ages, the numbers in the working age group 15-65 w ill increase substantially (from less than 60 per cent of the population in 1991 to almost 70 per cent in 2005). Taking these three factors together — sharp decline in the child population, a relatively low rate of increase in the elderly population and a substantial increase in the population of working age — we get a substantial decline in the age-dependency ratio (that is. the ratio between those in the "dependent" age groups — 15 and under. 65 and over — and those of working age). This downward trend in the age-dependency ratio has a number of favourable consequences as far as older people are concerned, especially as far as overall pressure on public spending is concerned.

Conclusions

The mortality data examined briefly in this chapter have presented an unfavourable picture of older people's health in Ireland — unfavourable by comparison with other countries, with the past in Ireland and with younger age groups in Ireland today. Life expectancy at age 65 in Ireland for both men and women is the lowest in the developed world — and is lower even than in many developing countries. For men. astonishingly, it was also lower in the mid-1980s than in the mid-1920s, and for women, while life expectancy at age 65 had improved steadily since the late 1940s, the rate of improvement was only modest. Younger Irish people, by contrast, have relatively good health. Survivorship rates from birth to age 45 are. for Irish males, among the highest in the world while for females they are average for developed countries. Survivorship rates from age 45 to 64 are not as strong by international standards but they are closer to the norm for developed countries than are survival patterns after age 65. So it is principally older Irish people, rather than Irish people as a whole, who have a relative disadvantage in mortality levels.

The positive side of the picture is that during the 1980s, signs of substantial improvement in older age mortality began to emerge in Ireland. After decades of stagnation, older male mortality declined quite sharply over the years 1986-90. while the long-standing but sluggish rate of decline in older female death rates began to intensify. It is too soon to say if this development will persist to form a long-term trend, but it at least raises the possibility of a significant improvement both now and in the future in the underlying health of the elderly population in Ireland.

The chapter also briefly reviewed trends in the size of the elderly population in Ireland, with particular reference to the impact of mortality changes on those trends. Ireland has long stood out among western countries for the fact that its population is *not* ageing — the proportion aged over 65 in 1991 was almost the same as in 1961 and was only marginally higher than in 1926. However, unexpected mortality declines among the elderly in the late 1980s led to a spurt in their numbers in the 1991 Census, so that the mortality patterns necessary to produce a higher than anticipated rate of growth in the elderly population may now be beginning to emerge. This is not to say that an immediate and rapid ageing of the population is now likely, partly because of possible fluctuations in migration and fertility which make it so hard to say what will happen to the size of population aged under 65. and partly because the population losses from emigration in the 1950s have reduced the sizes of the cohorts entering the population aged over 65 in the 1990s. Such increases as will occur in the proportions in older age groups also have to be viewed in the context of falling numbers of young children. The sharp falls in the birth rate since 1980 mean that overall age-dependency will decline in the years ahead, thus placing Ireland in an unusual position among western countries. In the early decades of the next century, when those now in their 30s and 40s begin to join the ranks of the elderly, the combined effect of reduced mortality and a larger population base from which the elderly will be drawn may have a sharp ageing effect on our overall population profile, but the full effects of this will not be realised for many decades to come.

Clearly, mortality trends among the elderly must be a central concern for research on health and well-being in that age group. So far. we have had little by way of such research, despite a relatively high level of research on

other aspects of the personal and social circumstances of the elderly in Ireland. As a result, we know little about the causes and consequences of mortality trends, and particularly recent changes in those trends, or about the differences by region, social class, gender or other basic variables in the levels or dynamics of older age mortality. It would be worth devoting some research effort to this area in the future.

CHAPTER THREE

Physical Health and Health Lifestyles

Introduction

We have seen from the review of older-age mortality patterns in Ireland in the previous chapter that older Irish people have the shortest life expectancy among western countries (apart, that is. from eastern Europe). On that fundamental measure, therefore, the physical health of older Irish people is among the worst in the developed world. However, the fact that older Irish people do not live especially long tells us little about their patterns or levels of illness while they are still alive. The precise nature of the relationship between mortality patterns and morbidity patterns in the later years of life is one of the large unresolved questions of epidemiological research. As populations live longer, do they have more sickness or less sickness in the middle and later years of life? The pessimistic answer to this question is that greater longevity is associated with an *increase* in the level of illness in all age bands from mid-life upwards. The evidence on morbidity trends in most western countries from the 1950s to the 1980s seems generally to support this pessimistic view (see Markides 1993 for a review of the relevant literature). One possible explanation for this paradox is that mortality has a weeding out effect which is weakened as longevity increases: advances in public health and medicine preserve the frail from early death but only to leave them at long-term high risk of chronic illness. A related, but slightly different explanation, is that medical advances have conquered the quick killer diseases which caused so much premature mortality in the past but have been less successful in combating the long slow. degenerative diseases of today.

The opposing, more optimistic, view of how morbidity changes with increased life expectancy is expressed in Fries" well-known "compression of morbidity" thesis (Fries 1989). This thesis suggests that increased

longevity not only defers death, it also defers the onset of serious illness so that illness becomes more and more "compressed" into the very last stages of life. Evidence in support of this optimistic view is relatively weak, though there are some recent indications that morbidity declines may be beginning to emerge in some western countries in the late 1980s and 1990s (Crimmins *etal.* 1994).

It has not yet proved possible to resolve the conflict between these opposing views. This is so largely because of measurement difficulties: while levels and trends in mortality can be quantified quite precisely, quantification of morbidity trends is. as we shall see further below, beset by a wide range of measurement uncertainties. However, even if we cannot be sure whether mortality and morbidity rates have moved in the same direction or in opposite directions in western countries over recent decades, it is clear that, irrespective of the health improvements which are likely to occur among older people in the years ahead, a high incidence of morbidity will be a continuing fact of life. The analysis by Crimmins *et al.* (1994) of the various health improvement scenarios which are feasible for the older population in the United States show why this is so. The most optimistic scenario they explore is that mortality and morbidity will improve by roughly the same proportions in the years ahead. In that scenario, older people will live longer, will make the transition to dependent ill-health at a later age and so will spend a smaller *proportion* of their life-spans in a physically dependent state. However, because of their longer lives, no real decline will take place in the absolute number of years for which they will be in ill-health. A somewhat less optimistic but perhaps more realistic scenario is that morbidity improvements will not keep pace with improvements in mortality. In that case, older people will live longer but will become chronically ill at about the same age as before (or only slightly later), so that the period of dependent ill-health will increase in both proportional and absolute terms.

These patterns suggest that, in present-day populations of older people, morbidity has a dynamic of its own and is likely to swell in scale — or at least preserve its present magnitude — as average life expectancy increases. Even if health improvement efforts succeed in reducing the proportion of their remaining years which the elderly spend in ill-health, it is unlikely to reduce the absolute amount of time they spend in that condition. Thus we have to examine the role of morbidity among older people, not just as the

overture to death, but as a phase in its own right which has major implications for the quality of their lives. We also need to examine those aspects of lifestyle which are intimately related to morbidity. These not only affect the risk of ill-health but also shape people's capacity to cope with illnesses and physical decline when they arrive.

It is against this background of a likely persistence, if not worsening, in the present incidence of morbidity among older people that we now turn to the examination of morbidity and of morbidity-related aspects of lifestyle among older people in Ireland. The remainder of this chapter is laid out in two main sections. The first of these deals with morbidity among the over-65s. the second with health lifestyle. The section dealing with morbidity begins with some general comments on the mortality-morbidity relationship in Ireland and follows that with a brief outline of measurement issues (these are dealt with more fully in Appendix B at the end of this report). It then turns to a general profile of physical health status of the over-65s. referring both to 1993 and 1977 data. This profile limits itself to an account of age-sex patterns in the measures dealt with, since more detailed cross-sectional analysis is contained in Chapter Eight below. The section on health lifestyle gives an account of certain aspects of health-related behaviour and personal characteristics (smoking, drinking, diet, exercise, body mass, etc.) among the over-65s based on the 1993 data, along with limited comparisons with the 1987 data. The chapter ends with a summary and conclusion.

Morbidity

Mortality and morbidity in Ireland

Given the general uncertainty which exists about the relationship between mortality and morbidity, it is not at all clear what the relative shortness of life expectancy among older people in Ireland should lead us to expect as far as morbidity is concerned. If we accept the view that greater longevity leads to an increase in the incidence of illness, we would have to suspect that older Irish people have less day-to-day illness than their counterparts in other countries, perhaps because higher Irish mortality rates may have removed the physically vulnerable from the population stock. The corollary is that if we succeed in reducing older-age mortality in Ireland in the years

ahead, we will thereby increase the proportion of older people with a higher underlying vulnerability to long-term bad health. On the other hand, if we accept the opposing view that shorter older-age life expectancy is associated with earlier and more widespread onset of morbidity, then older Irish people should show high morbidity levels. The corollary in this instance is optimistic: improved longevity in the future would reduce older age morbidity and reduce the proportion of older people's lives which would be spent in dependent illness. Even that optimistic outlook has its dark side, however, since, as noted above, a proportionate reduction in the period of life spent in ill-health, coupled with a substantial extension in the number of years lived, might not mean a reduction in the absolute length of time spent in that state.

Measuring morbidity

A number of measures relating to physical health and health lifestyles were used in the 1993 Survey of the Over-65s and these provide the basic data for the chapter. However, there are considerable methodological difficulties in providing consistent measures of morbidity, largely because illness is a complex and partly subjective entity which can be interpreted differently from person to person (see Appendix B). Like similar measures used in survey research in other countries, the morbidity measures used in the present chapter are limited in the extent to which they can cope with those difficulties. They relate to how people judge their own health and at that are general, lacking in detail and prone to response errors which are very difficult to estimate. The present measures also have some additional limitations of their own, especially in regard to trends over time. Many of the measures in the 1993 survey were replicated from the 1977 Survey of the Elderly, and some were included also in the 1987 Survey of Income Distribution, Poverty and Usage of State Services. However, while for the most part the individual items were replicated closely, the three surveys in which they were applied differed from each other in purpose and design (see Appendix A at end of this report for details), so that the degree of overall replication is far from complete. It is particularly important to note that, apart from sampling and questionnaire design differences, the 1977 and the 1993 surveys were carried out at different times of the year — the 1977 survey in early winter (mainly November-December), the 1993 survey in

summer (mainly June-July). Seasonal variations in morbidity are undoubtedly large, though not yet precisely estimated, so it is difficult to disentangle seasonal effects from genuine time differences in comparisons between these two survey sources. The 1987 survey, which was a much larger exercise than either the 1993 or 1977 surveys, was carried out over about six months between early spring and mid-summer, so that its seasonality characteristics are different yet again from both of the other surveys.

As a result, while the morbidity measures used here do have a value as global, approximate indicators of people's physical welfare, they should not be elevated to the status of precise, comprehensive measures of people's 'objective' health condition (if it is meaningful at all to talk of 'objective' health condition) or of trends in that condition over time.

Morbidity patterns and health status in 1993

With these *caveats* in mind, we now turn to a description of morbidity and health status of the over-65s in the 1993 survey. A number of measures of morbidity and health status, classified by age group and sex, are presented in Table 3.1. The first measures — whether respondents had a major illness or disability — shows that almost half the sample — 47 per cent — had health problems. The age-sex breakdowns on this measure show that, apart from the 65-69 age group, women are more prone to illness than men, though the difference is not especially large. Among women, older age groups have higher proportions with serious illness than younger age groups, but there appears to be no similar age difference among men. This may imply an earlier onset of serious illness among men, which would be consistent with their poorer mortality, though the measures do not seem robust enough to draw firm conclusions on this count (see also Table 3.4 below and accompanying text).

The second measure of health status in Table 3.1 — the percentage of the sample rating their health as good or very good — provides a more positive picture of health among older people in that two-thirds of the sample rate their health in that way. There is no consistent gender difference on this item, nor, surprisingly, is there any significant age-gradient. The two-thirds reporting their health as good or very good is high given that almost half the sample reported having a serious illness on the previous measure.

However, as suggested in Appendix B. this may indicate simply that self-rating of health is implicitly relative: respondents take their age into account and assess their situation in terms of what they think reasonable for people of their age rather than against some absolute standard.

Table 3.1: Various Morbidity Measures by Age and Sex, 1993

	65-69		70-79		80+		Total
	Male	Female	Male	Female	Male	Female	
Per cent reporting major illness	48	39	43	48	50	55	47
Per cent rating health good or very good	65	69	71	63	65	67	67
Average no. of days unable to carry out normal activities in past 4 weeks	0.5	1.6	1.5	1.1	2.2	1.9	1.4
Per cent reporting no functional disability (7-item FCI scale - see Appendix B)	81	74	68	58	37	29	61
Total per cent	14	17	24	25	8	12	100
Number of cases	128	155	220	225	75	106	909

The third health status measure in Table 3.1 is the average number of days in the past four weeks respondents were unable to carry out normal activities because of illness. This measure does show a certain age gradient for men — inactivity days are few for men in the 65-69 age group but increase substantially thereafter. There is no clear age gradient for women nor are women any worse off than the average for men across all age-ranges.

Taking these first three measures together, the overall level of morbidity is hard to assess: by one measure (percentage reporting serious illness) it affects almost half the sample, but by another (self-rating of health) two-thirds of the sample report good or very good health status. However, whatever the overall level, there is a consistent lack of relationship between morbidity and either age or gender. Indications of ill-health are as common among the 'young elderly' as the 'old elderly' and among men as among women. Thus it appears that the risk of illness after the age of 65 is not a steadily rising slope but a plateau which is reached either before or soon after that age, and at a roughly similar time for both men and women.

The fourth and final item in Table 3.1 relates to functional disability, that is. to physical difficulties with washing, dressing, walking, household chores and so on. Unlike the measures of health status just looked at. this measure shows a strong age gradient. A large majority of those aged 65-69 (81 per cent of men. 74 per cent of women) report that they are free of functional disability. These proportions drop substantially for the age group 70-79. but they still well exceed half. However, for the oldest age group, only a minority — 37 per cent of men and 29 per cent of women — are free of functional disability. This item also shows a consistent pattern of gender difference: in all age groups, women are less likely than men to be free of functional disability. These findings suggest that the pattern of functional impairment among older people is somewhat different than the pattern of illness. Functional impairment increases steadily with age and is somewhat more prevalent among women than among men. neither of which patterns holds with illness.

Table 3.2 further examines the pattern of functional disability by setting out the percentages reporting difficulty with each of the 11 items in the full list of activities used in the 1993 survey. The percentages reporting difficulty with key areas of personal care — washing hands and face, dressing, going to toilet — are small at six per cent or less of the total sample and nine per cent or less of those aged 75 and over. A further set of functions (having an all-over wash or bath, reading, hearing, cooking a meal) pose difficulties for between 10 to 20 per cent of the total sample and 15 to 25 per cent of the over-75s. The most widespread difficulties arise with a third set of activities which are more demanding of physical strength, agility or stamina. These include climbing stairs, getting on a bus, walking half a mile and. most of all. doing heavy grocery shopping. On most of this latter set of items, women are considerably more likely to report difficulties than men (for example, almost half of women aged 75 and over report difficulty in walking half a mile, compared to 30 per cent of men in the same age group).

It is from these measures of functional disability, rather than from the previous measures of illness and health status, that we get a clear impression of the physical decline which is associated in many people's minds with old age. This decline is not necessarily linked with illness, though some connection with illness may be there. Rather it appears to be a more generalised narrowing and reduction of one's physical capabilities. This constriction of physical function is particularly evident in connection with

the more physically demanding activities such as walking substantial distances or climbing stairs.

Table 3.2: Difficulties With Physical Activities by Age and Gender, 1993

	Ages 65+		Ages 75+		Total
	Male	Female	Male	Female	Ages 65+
	Percentages reporting difficulty with activity				
Have all-over wash or bath	12	16	20	22	14
Wash hands and face	3	5	5	6	4
Dress oneself	5	6	7	9	5.5
Get to and use toilet	4	6	7	8	5
Cook a hot meal	15	13	23	18	14
Get up and down steps	14	22	22	31	18
Do heavy grocery shopping	26	42	38	58	34
Walk half a mile	18	35	30	49	27
Get on a bus	15	31	27	43	23
Hear a conversation (with hearing aid if necessary)	14	14	19	21	14
Read paper (with glasses if necessary)	9	8	15	11	8.5

At the same time, we should not overstate the patterns involved. Table 3.1 above showed that even among women aged 80 or over, the group with the highest risk of functional disability, a substantial minority (29 per cent) remained fully fit. at least to the extent that they had no difficulty with any of the items in the 7-item FCI scale. Likewise, in Table 3.2. while 58 per cent of women aged 75 and over reported difficulty in doing heavy grocery shopping (the most demanding item in the list), the remainder of that group (42 per cent) reported no such difficulty. Thus, even as we note the association between ageing and loss of physical capacity, we should note also that the association is far from complete, so that large minorities in even the oldest age groups retain a full or nearly full range of physical capacities.

Table 3.3: Utilisation of Medical Services and Medicines by Age and Sex, 1993

	65-69		70-79		80+		Total
	Male	Female	Male	Female	Male	Female	
Per cent seeing doctor within previous 4 weeks	^	^	^	53	5g	5?	48
Per cent not seeing doctor in past 12 months	17	15	16	7	5	4	11
Mean no. of visits to/from doctor in previous 4 weeks	0.56	0.76	0.61	0.90	0.90	0.99	0.77
Mean no. of visits to hospital outpatients dept in previous 4 weeks	0.32	0.20	0.13	0.08	0.07	0.08	0.14
Per cent taking any medicine on prescription in previous 24 hours	47	51	54	65	65	69	58
Total per cent	14	17	24	25	8	12	100
Number of cases	128	155	220	225	75	106	909

A number of further measures in the 1993 survey dealt with the utilisation of medical services and so tap another dimension of health status (Table 3.3). Almost half the sample (48 per cent) had seen the doctor within the past four weeks, while 11 per cent reported that they had not seen the doctor for a year or more. The mean number of visits to or from the doctor over the previous four weeks was a good deal less than one. while the mean number of visits to an outpatients department in a hospital was only a fraction of that again. However, the percentage taking prescription medicines over the previous 24 hours was high at 58 per cent. On almost all of these measures, there was a consistent differential by age and gender: usage increased with age and was higher for women than for men. The only exception was in regard to visits to hospital outpatients departments. Here, although the overall level of usage was low. men were heavier users than women and usage becomes less common with age.

Comparisons over time

As already mentioned, one of the morbidity measures used in the 1993 survey was applied in two earlier surveys — the 1977 Survey of the Elderly

and the 1987 Survey of Income Distribution. Poverty and the Usage of State Services. However, the value of this item as a measure of trends is limited, for reasons which are not entirely clear. As Table 3.4 shows, the proportion of over-65s reporting serious illness fell from 63 per cent in 1977 to 34 per cent in 1987 and rose again to 47 per cent in 1993. Such large movements are not credible, and throw doubt on the robustness of this measure across surveys. It may be more reliable as an indicator of cross-sectional differences within a single survey (for a plausible use of this measure in that way. see Nolan 1991). though it should be noted from Table 3.4 that the age-gradient and pattern of gender differences on this measure are less than fully consistent across the three samples.

Table 3.4: Percentage of 0ver-65s Reporting Major Illness in 1977,1987 and 1993, Classified by Age Group and Sex

	65-69		70-79		80+		Total
	Male	Female	Male	Female	Male	Female	
1977	56	62	56	67	66	68	**63**
1987	36	28	34	38	65	37	**34**
1993	48	39	43	48	50	55	**47**

A number of the remaining health status measures in the 1993 survey are available also from the 1977 Survey of the Elderly, and these are free of the inconsistencies just noted in regard to self-reported major illness (see Appendix B). We now turn to a brief comparison of these. A range of medical utilisation and health status measures from the two surveys is presented in Table 3.5. This table focuses on a particular sub-group of the elderly — those aged 70-79 — in order to minimise age-composition effects on the measures compared.

The first four items in this table — proportions visiting the doctor in the past four weeks, proportions not seeing the doctor within the past year, taking of prescription medicine over the past four weeks and average number of visits to the doctor over the past four weeks — relate broadly to medical service utilisation. These items, at first sight, indicate either little overall change or some increase between 1977 and 1993. The biggest change, in fact, is in the percentages who had not seen their doctor for over

a year which declined substantially over the period. However, the degree of change in utilisation is probably masked by the seasonality factor. The 1977 data relate to winter-time usage of the services in question, which would represent a seasonal high, while the 1993 data relate to summer-time usage, which would represent a seasonal low. It is likely that the smallness of surface change in medical utilisation between the two measures indicates an underlying increase, since corrections for seasonality would undoubtedly have the effect of raising the 1993 measures relative to the 1977 measures.

Table 3.5: Comparison of Various Measures of Morbidity Among 70-79 Year Olds in 1977 and 1993, Classified by Gender

	1977		1993	
	Male	Female	Male	Female
Per cent seeing doctor within previous 4 weeks	41	49	43	53
Per cent not seeing doctor in previous 12 months	25	19	16	8
Per cent who took pills or medicine in past 24 hours	56	67	54	65
Mean no. of visits to or from doctor in past 4 weeks	0.6	0.84	0.6	0.9
Mean no. days unable to carry out normal activities in past 4 weeks	1.53	1.77	1.5	1.1
Mean Functional Capacity Index Score (7-item FCI scale)	1.6	2.3	.72	1.2
Per cent reporting no functional disability (7-item FCI scale)	48	38	68	58
Per cent stating health as 'good' or 'very good'	63	55	71	62

The second set of items in Table 3.5 deal more directly with morbidity and health status. These items include average number of inactivity days due to illness in the past four weeks, mean FCI score (7-item scale), percentage reporting no functional disability on the FCI scale, and percentage reporting health as good or very good. The most important finding from these items is that they give no indication of an increase in morbidity between 1977 and

1993. On the surface, in fact, there is some sign of a decrease, particularly on the FCI measures and on self-rating of health. This surface appearance has to be read with caution given the seasonality influence on the measures which has been referred to before and, in the case of the FCI scales, given that there were some differences in the wording of the items between the 1977 and 1993 surveys (see Appendix B for details). Even with those caveats, however, the general lack of increase in the morbidity measures is notable. It suggests firstly that medical utilisation and morbidity may have moved in opposite directions over the period, with the former rising (as just described) and the latter declining (or at least not rising by the same amount). It suggests secondly that over this period at least, older people in Ireland may not have experienced the morbidity increases which, as mentioned early in this chapter, seemed to have been general among the populations of western countries since the 1950s. Given the methodological difficulties which arise about comparing the two sets of measures, we would not want to over-emphasise this apparent lack of morbidity rise among older Irish people. Nevertheless, it is a significant pointer which merits further investigation.

Health Lifestyle

Putting forward a view that has been echoed in World Health Organization reports (World Health Organization 1984, pp. 44-45, World Health Organization 1989, p. 84) and by other commentators (such as Grimley Evans *et al.* 1992), *The Years Ahead* stated that 'the onset of some disease can be postponed and the disabilities associated with others reduced by action within the capacity of most elderly people. Such action includes stopping smoking, weight control, eating a balanced diet, limiting consumption of alcohol, stimulating mental activity, regular involvement with other people and keeping fit' (Working Party on Services for the Elderly 1988).

Most health education programmes have, however, been targeted at the middle-aged or the young. And, because evaluation of educational interventions has been one of its central concerns, the same emphasis is found in much of the research into health lifestyle (Murray 1992, pp. 183-184). Questions asked in the 1993 survey about smoking, the drinking of alcohol, height, weight and eating habits as well as the actions elderly

people take in order to maintain or improve their health provide a means of beginning to redress this imbalance. Some of this information is comparable with that on the health lifestyle of middle-aged or younger people collected nationally in 1992 by the Happy Heart National Survey (Irish Heart Foundation 1994) or locally during 1990 and 1991 in counties Kilkenny and Offaly by the Kilkenny Health Project (Kilkenny Health Project 1992). Some health lifestyle items included in the 1987 ESRI Poverty Survey also provide a basis for comparison between the elderly and the non-elderly segments of the population. However, items on these issues were *not* included in the 1977 Survey of the Elderly, so longer-term time comparisons are not possible from the sources used in this report. In addition, as with measurement of health status, inter-survey variations in measurement of health lifestyles and accuracy problems in self-reports of such things as weight, smoking, exercise and alcohol consumption make it difficult to draw firm conclusions from the available data.

Relevant material from a range of sources enumerated above is now presented under the following headings: weight and eating patterns, smoking, alcohol and activities undertaken to improve or maintain health. Because of the data limitations just mentioned, the focus is on cross-sectional comparisons within each sample rather than on estimates of trends over time.

Weight and eating

Being overweight is associated with increased risk of adult onset diabetes, hypertension, ischaemic heart disease, certain cancers, gall bladder disease and arthritis. Body Mass Index (BMI), the ratio of weight in kilograms to height in metres squared, is a measure widely used in the analysis of population weight distributions. For the range of values taken by BMI, Garrow (1981) has defined widely accepted cut-off points which divide the distribution into Underweight, Acceptable, Overweight and Obese categories. In the 1993 survey respondents were asked: 'how tall are you?' and 'what weight are you?' and BMI values were worked out on the basis of the replies. Table 3.6 sets out the BMI category distribution broken down by age and sex. Less than half the respondents are found within the Acceptable category. Acceptable BMI values are more common among the older elderly than among the younger elderly and, within both age groups,

there is no difference between the proportion of men and the proportion of women who fall within the Acceptable range.

Respondents" subjective perception of their present weight is compared to the BMI classifications of it in Table 3.7. While there is a good deal of overlap between the two. there is also considerable divergence. Around half of those the BMI categories classify as Overweight regard their weight as "just about right". The same is true of the smaller group the BMI categories classify as Underweight. Even among those classified as Obese, the proportion who consider their weight to be "just about right" is over 15 per cent. The gap between subjective perception and the objective BMI categories is substantially wider for men than for women.

Table 3.6: Body Mass Index Categories Defined by Garrow Cut-off Points* by Age Group and Sex: 1993 Survey

BMI Category	Age Group						All
	65-74			75 and over			
	Males	Females	All	Males	Females	All	
	Per Cent						
Underweight	4.3	11.0	7.8	7.7	19.5	14.3	10.5
Acceptable	43.9	43.4	43.6	53.6	54.8	54.2	48.1
Overweight	44.3	37.5	40.8	35.1	21.9	27.8	35.3
Obese	7.5	8.1	7.8	3.6	3.8	3.7	6.1

** Underweight = < 20; Acceptable = 20-25: Overweight = 25-30: Obese = >30.*

Further tables relating respondents' self-assessment of their eating behaviour to their BMI category classification are contained in Appendix C. The relationship between BMI status and whether a respondent thinks he or she eats 'the right amount of food for you' is examined in Table C.2. In all the 'unacceptable" categories - Underweight. Overweight and Obese — a majority, which ranges in size from 54 to over 80 per cent of respondents, consider they eat the right amount. Divergence between subjective and objective measures in this instance is not consistently related to gender. Table C.3 relates BMI status to the regularity of respondents"

eating pattern. Regular eating, that is having the same number of meals and snacks at roughly the same time each day. predominates in all categories. It is noticeable, however, that 15 per cent of the Underweight indicate that they eat erratically.

BMI values from self-reported height and weight information were also generated from the 1992 Happy Heart National Survey. Table 3.8 sets out distributions across BMI categories from that survey alongside those from the 1993 survey. The published data from the Happy Heart National Survey merge the Underweight category into the Acceptable one: adjustment has been made to the 1993 data to make them comparable with this format. Within the Happy Heart National Survey, gender and age differences are marked: there are more females than males in the Acceptable category at both age levels and a higher percentage of Acceptables in the younger age level than in the older one. When the data on the elderly from the 1993 survey are set alongside this the gender patterning is sustained but the age one is not. Of all the age levels. 75 and over appears as the one in which acceptability is highest and obesity lowest. It should be noted, however, that when the Kilkenny Health Project evaluation surveys carried out quality-assured measurement of weight and height (Shelley *ct al.* 1991. p. 23). a BMI distribution emerged which had more obesity and less acceptability than those reported by both the Happy Heart National Survey and the 1993 Survey of the Over-65s.' Table 3.9 reproduces the Kilkenny Project findings.

1 In a study in four C'alifomian cities, when BMI category distributions based on data on telephone-interview data were compared with BMI category distributions based on physical measurements carried out for a community intervention programme broadly similar to the Kilkenny one. the former were consistently and significantly lower than the latter (Jackson *el al.* 1W2. p. 414)

Table 3.7: Respondents' Body Mass Index Category as Defined by Garrow Cut-off Points by Self-Rating of Current Weight

BMI Category	Self-Rating								
	Men			Women			All		
	Under-weight	Just About Right	Over-weight	Under-weight	Just About Right	Over-weight	Under-weight	Just About Right	Over-weight
Underweight	58.3	37.5	4.2	46.5	53.5	-	49.5	49.5	1.1
Acceptable	5.0	89.1	6.0	3.0	82.5	14.5	3.9	85.5	10.6
Overweight	1.8	65.5	32.7	-	37.8	62.2	0.9	52.7	46.4
Obese	–	32.0	68.0	--	3.3	96.7	–	16.4	83.6

Table 3.8: Body Mass Index Categories Using Garrow Cut-off Points* by Age and by Sex: Happy Heart National Survey and 1993 Survey

BMI Category	Happy Heart Survey				1993 Survey			
	Age Group				Age Group			
	30-49		50-69		65-74		75 and over	
	Males	Females	Males	Females	Males	Females	Males	Females
	Per Cent							
Acceptable	47.1	67.3	39.9	55.0	48.2	54.4	61.3	74.3
Overweight	43.8	25.0	48.2	32.6	44.3	37.5	35.1	21.9
Obese	9.1	7.7	11.9	12.4	7.5	8.1	3.6	3.8

** Acceptable <25; Overweight 25-30; Obese >30. The Underweight category here is merged with the Acceptable.*
Source for Happy Heart National Survey data: Irish Heart Foundation (1994, Table 17)

Table 3.9: Distribution of BMI Categories Defined by Garrow Cut-off Points in Kilkenny Health Project Evaluation Surveys: Sample Age Range = 35 to 64 years

BMI Category	Per cent			
	Offaly		Kilkenny	
	1986	1991	1985	1990
Acceptable'	34.4	25.0	35.7	34.1
Overweight	47.4	48.5	47.9	46.5
Obese	18.2	26.5	16.4	19.4

** Acceptable includes Underweight.*
Source: Kilkenny Health Project (1992. p. 56).

Smoking

Almost a quarter of the elderly respondents in the 1993 survey currently smoke. When the 1993 data are set alongside similar data from the Happy Heart National Survey in Table 3.10. we see that as age rises the proportion of current smokers falls, the fall being somewhat steeper among women than among men. Women over 75 stand out as having the highest proportion of those who have never smoked.

Information which allows the link between age and smoking status to be examined was also gathered in the 1987 ESRI Poverty Survey, although here, among non-smokers, no distinction was made between ex-smokers and those who had never smoked. The age range included is. on the other hand, a wider one. consisting of those 15 and over and not in full-time education. Set out in Table 3.11. these data show a similar fall in the proportion of women smoking as age increases but a higher proportion of men aged 65 and over smoking than of middle-aged and young men. Because people under 30 are included in this survey, the overall smoking prevalence is higher.

Table 3.10: Smoking Status by Age Group and Sex: National Happy Heart Survey and 1993 Survey

Smoking Status	Happy Heart Survey					1993 Survey				
	30-49		50-69		All Respondents	65-74		75 and over		All Respondents
	Males	Females	Males	Females		Males	Females	Males	Females	
Current smoker	40.5	29.7	34.3	27.2	33.4	34.6	19.0	31.4	11.3	23.9
Ex-smoker	22.3	18.1	40.2	21.4	24.5	35.8	24.5	46.2	19.3	30.5
Never smoked	37.2	52.2	25.5	51.4	42.1	29.5	56.4	22.5	69.3	45.6

Table 3.11: Smoking Status by Age Group and Sex: 1987 ESRI Poverty Survey

	Per Cent						
	Under 35		35-64		65 and Over		All
Do you smoke?	Female	Male	Female	Male	Female	Male	
Yes	38	41	30	38	20	44	36
No	62	59	70	62	80	56	64

Smokers were asked the number of cigarettes they smoke per day in the 1993 survey. As Table 3.12 shows, men tend to be heavier smokers than women and over-75s tend to smoke less than under-75s. A similar inquiry was included in the 1987 ESRI Poverty Survey. As Table 3.13 shows, it found heavier smoking among the over-65s than was reported in 1993, with the figure for those smoking more than 20 cigarettes a day at 14 per cent among men. Across the age-range, the tendency to have higher proportions of heavier smokers was most pronounced in the 35 to 64 years age group. Tobacco is. of course, smoked in other forms besides cigarettes. Current pipe smoking was reported by eight per cent of men in the 1993 survey with a quarter or a half ounce of tobacco being the amount per day most commonly consumed.

Table 3.12: Number of Cigarettes Smoked per Day by Those Who Smoke by Age Group and Sex: 1993 Survey

	Per Cent				
Number of cigarettes smoked per day	65 -74		75 and Over		All Respondents
	Males	Females	Males	Females	
Ten or less	44.3	54.9	55.3	69.6	53.0
Eleven to twenty	47.1	41.2	36.8	30.4	41.0
Over twenty	8.6	3.9	7.9	–	6.0

Table 3.13: Number of Cigarettes Smoked per Day by Those Who Smoke by Age Group and by Sex: 1987 ESRI Poverty Survey

Number of cigarettes smoked per day	Per Cent						
	Under 35		35-64		65 and Over		All
	Female	Male	Female	Male	Female	Male	
Ten or less	57	42	47	28	51	38	44
Eleven to twenty	38	47	46	56	48	48	47
Over twenty	5	11	7	16	2	14	10

Alcohol

The 1993 survey presented respondents with five categories relating to frequency with which alcohol is drunk and asked them to indicate which category they fell into. As Table 3.14 shows, 42 per cent were non-drinkers and less than five per cent take a drink virtually every day. Non-drinkers and special occasion drinkers account for nearly 90 per cent of women but less than half of men.

The 1987 ESRI Poverty Survey included questions on whether they ever went out for a drink to a pub or club, on the frequency of visits among those who did and on the amount they usually spent each time they went to the pub. Table C.4 to C.6 in Appendix C break down the responses to these questions by age group and sex. Over 80 per cent of elderly women never made such outings but most elderly men did. Those elderly women who did go to a pub or club did so less often than the women in younger age groups who went, but there was not a marked contrast as regards frequency of visits between men in different age groups. Elderly men tended to spend less per visit to a pub or club than did younger men. Going to a pub or club and spending money there does not necessarily imply the drinking of alcohol on any or all of these occasions: the survey did not specifically inquire into alcohol consumption.

Table 3.14: Frequency of Drinking Alcohol by Age Group and Sex: 1993 Survey

Response Category	Per cent				
	65-74		75 and over		All
	Males	Females	Males	Females	
Non-drinker	22.0	58.5	23.7	58.0	41.7
Drink only on special occasions	22.3	18.1	29.6	33.5	27.8
Drink 2-4 times per month	21.3	8.8	20.7	3.8	13.3
Drink 2-4 times per week	27.6	4.4	18.9	1.9	13.0
Drink 5-7 times per week	7.1	0.7	7.1	2.8	4.2

Activities to improve or maintain health

The 1993 survey asked respondents: 'do you do anything at the moment to keep yourself healthy or improve your health?'. Over 80 per cent reported engaging in activities with a view to improving or maintaining their health. Surprisingly, since women are generally found in studies to be more health conscious than men, a higher percentage of men than of women responded 'yes'. All those answering 'yes' were asked an open-ended question: 'what are the three most important things you do to keep or improve your health?'. Table 3.15 breaks down the activities mentioned by sex. The percentages in this table are based on responses and not on cases: up to three responses per case were allowed for but, even when prompted ('anything else ?'), some respondents named only one or two types of activity. The overall pattern for both sexes is fairly similar with hobby or leisure exercise predominating. The main exceptions are housework, which is one of the activities most commonly mentioned by women but is much less frequently put forward by men, and work or a job, which reverses this pattern.

Combining the information on different facets of health lifestyle which the 1993 survey collected, a Health Lifestyle Index has been developed. On this index, a respondent scores 1 for:

- being a non-smoker

- being within the acceptable BMI range
- having a perception of own weight status that coincides with how the BMI categories classify it
- reporting one action taken 'to keep or improve your health"
- reporting a second action taken "to keep or improve your health"
- reporting a third action taken "to keep or improve your health'

Alcohol drinking has not been included because information on quantities usually drunk over a specified time period was not collected. Without this, it was not possible to draw a distinction between a healthy and an unhealthy pattern along the lines of the "sensible drinking limits" advocated by current health promotion advice.

Table 3.15: Activities Undertaken to Improve or Maintain Health by Sex: 1993 Survey

Activity	Per Cent		
	Males	Females	All
Walking	25.1	24.1	24.5
Gardening	18.0	15.3	16.6
Housework	4.3	20.0	12.5
Takes Medicines	10.0	10.7	10.4
Dietary Habits	4.9	8.0	6.5
Job/Work keeps me healthy	9.2	1.7	5.3
Gets Fresh Air	7.3	3.4	5.2
Stopped or Cut Down on Smoking	5.1	2.2	3.6
Play Particular Sports	3.5	1.8	2.6
Cultivates or Avoids Certain State of Mind	2.9	2.0	2.4
Other	9.8	10.8	10.3
Total	100	100	100

The distribution of scores on the index is shown in Table 3.16: a high score indicates a positive pattern of health lifestyle behaviours and orientations.

The index is one of the measures used in the analysis carried out to identify risk groups among the elderly population in Chapter Eight below.

Table 3.16: Distribution of Scores on the Health Lifestyle Index

Index Score	Per Cent of Respondents
0	1.4
1	5.9
2	12.3
3	18.3
4	27.5
5	21.6
6	13.1

Conclusion

This chapter has focused on morbidity patterns and the related issue of health lifestyles among the over-65s in Ireland. Lying in the background is the evidence of mortality statistics reviewed in the previous chapter. This evidence suggested that older-age life expectancy in Ireland is the lowest in the developed world, implying that on this basic level the health status of older Irish people is comparatively poor. However, the international research literature is not at all clear on what this should lead us to expect about morbidity levels among the over-65s in Ireland, since there is no agreement on the relationship between mortality levels and morbidity levels among middle-aged and older populations in developed countries.

The evidence on morbidity in the 1993 survey gave a number of different indications of overall health status. Almost half the sample reported having a major illness or disability but two-thirds rated their health as good or very good and over 60 per cent reported that they were free of disability on the 7-item FCI scale. These measures clearly relate to somewhat different aspects of health status so it is not possible to give a single summary measure of health status in the sample. The measures do indicate, however, that while impaired health and physical functioning is quite common in old age it is by no means universal. Even in the oldest age groups, there are substantial

minorities who report no health or physical difficulties on any of the measures used.

The pattern of age-sex differences on the various measures suggest that two general dimensions of health status can be distinguished, one relating broadly to what we would normally think of as illness or good health (the lack of illness), the other relating to functional capacity, that is. ability to carry out everyday tasks such as washing, dressing, moving about and so on. The measures relating to the former dimension, despite differences in the overall levels of morbidity they suggested in the sample, are almost uniform across age-sex groups. Among women, there are some indications that the very old were somewhat worse off than the young elderly, but these indications were not consistent. Among men. the evidence of age-gradient was even weaker. Gender differences were not very strong, since male and female scores on these measures were broadly similar. These results suggest that, when we focus on older age groups in the population, there are a number of aspects of health which lack any consistent relationship either with further ageing or gender. There are some indications of decline in these aspects of health with further age for women, but these are not especially strong.

The second dimension of health status relates to functional capacity. This dimension differs from the first in that it shows stronger association with age. and some association also with gender. The proportion of the over-65s who report physical impairments on this measure increases sharply with age and is higher at all ages for women than for men. Ageing is therefore crucial to this aspect of health status and is so in a more intense way for women than for men.

The available time-trend data are insufficient to yield clear conclusions on trends in health status. However, the indications from comparisons with data from the late 1970s are that morbidity has not increased, and may have shown some decrease. Limited availability of data poses an even larger obstacle to identification of time trends in the health lifestyles of the elderly. Smoking is the only lifestyle feature for which the surveys drawn upon for this report provide comparable information at two points in time. Comparing the 1987 and 1993 surveys, overall smoking prevalence among those aged 65 or older is down from over 30 per cent to 24 per cent. Among men the fall is from 44 to 31 per cent and among women is from 20 to 11

per cent. The picture with regard to weight - for which only 1993 data are available - is less satisfactory with over 40 per cent of those surveyed being overweight on the basis of self-reported height and weight data which are likely to be somewhat biased towards the underestimation of obesity. The elderly are not distinctive in this regard, however, as excessive weight has been shown to be prevalent among the middle-aged group in the Irish and in other populations (Shelley *et. al.* 1991, Kilkenny Health Project 1992, pp. 55-57. Grimley Evans *et al.* 1992. pp. 72-73). There is scope here, and probably also in relation to other aspects of lifestyle on which this report has not been able to provide detailed coverage, for targeted educational programmes encouraging health-enhancing lifestyle changes. Audience receptiveness to such programmes seems likely to be high as — with over 80 per cent engaging in activities with a view to improving or maintaining their health — fatalism does not pervade the attitudes of Irish elderly people.

CHAPTER FOUR

Psychological Health and Weil-Being

The 1993 Survey of the Over-65s used two sets of items to measure psychological health and well-being. The first was the 12-item General Health Questionnaire (GHQ) measure of psychological distress and the second was an *ad hoc* 8-item battery of attitudinal measures which could be loosely thought of as tapping into the morale of the elderly. This chapter is devoted to a general description of levels and patterns of psychological health within the sample as reflected in both these sets of items. It also makes some comparisons with data on psychological distress among the elderly from the 1987 Survey of Income Distribution. Poverty and Usage of State Services. More detailed analysis of the correlates of psychological well-being is deferred to Chapter Eight where the focus is on identifying the elderly sub-groups who are vulnerable as far as various dimensions of health and well-being are concerned.

Psychological Distress

Measuring distress

The GHQ measure of psychological distress was initially designed as a self-administered screening test for detecting minor psychiatric disorders in the community and was subsequently adapted for use by interviewers (Bowling 1991, pp. 108-114; Whelan *et al.* 1991). It has been extensively used in international studies to assess the mental and emotional state of respondents, both in the original 60-item version and in shorter 30-item and 12-item versions. The 12-item version is apparently as efficient as the 30-item version and is easily coped with by older people, though both are slightly less sensitive than the 60-item version (Bowling 1991. p. 109). In

Ireland, the GHQ distress measure was used for the first time on a large scale (in the 12-item version) in the 1987 Poverty Survey and the resulting data have been extensively analysed (principally in Whelan *et al.* 1991 and Hannan and 6 Riain 1993). Findings from the Irish data have been generally consistent with those from other countries and have performed plausibly in cross-sectional analyses of the distribution of psychological distress. The account below draws on the elderly sub-set from the 1987 sample for purposes of comparison with the 1993 data.

The GHQ measure consists of questions which ask respondents to assess their *present* mental and emotional condition by reference to their *normal* state. It is intended to identify those suffering bouts of distress which mark a departure from their normal condition. Such bouts can extend over a long time while still being regarded as a temporary deviation from normal by the person involved, since even those who have recurring or long-standing symptoms tend to regard those symptoms as not really normal for them — they cling to the concept of their "usual self as being without symptoms' (Goldberg and Williams 1988. p. 20). While those identified as suffering from psychological distress by the GHQ measure may include those who are seriously psychiatrically disturbed or who suffer long-standing personality problems, the measure is not designed to identify them separately. It is intended rather to identify the much larger segment of the population who experience transient non-psychotic deviations from their usual 'normal' or "healthy" psychiatric state.

The 1993 Survey of the Over-65s used the 12-item version of the GHQ measure. The questions which comprise this version are set out below. Half of the questions are of a negative slant and half positive. The negative questions have one standard set of responses while the positive questions have another. The right-hand figures in parentheses below indicate which response set applies to each question:

HAVE YOU RECENTLY	Response set
1. Been able to concentrate on whatever you're doing?	(1)
2. Lost much sleep over worry?	(2)
3. Felt you were playing a useful part in things?	(1)
4. Felt capable of making decisions about things?	(1)

5. Felt constantly under strain? (2)

6. Felt that you couldn't overcome your difficulties? (2)

7. Been able to enjoy your normal day-to-day activities? (1)

8. Been able to face up to your problems? (1)

9. Been feeling unhappy or depressed? (2)

10. Been losing confidence in yourself? (2)

11. Been thinking of yourself as a worthless person? (2)

12. Been feeling reasonably happy, all things considered? (1)

Response set (1)	Response set (2)
More/better than usual	Not at all
Same as usual	No more than usual
Less than usual	Rather more than usual
Much less than usual	Much more than usual

In constructing psychiatric distress scales from the responses to these questions, the first step is to collapse the possible response categories into two: the first two responses from each response set are taken as indicating a "normal" condition and are coded 0. the third and fourth responses are taken as indicating a deviation from normal and are coded 1. Each respondent then has a score of 0 or 1 for each of the 12 items. The second step is to sum each respondent's scores (0 or 1) over the twelve items so that on the summed scale each respondent has a score of between 0 and 12. In most studies of general populations, the majority of respondents score 0 on all 12 items (and so score 0 on the summed scale) while only tiny minorities score in excess of 7 or 8. Considerable minorities usually score 1 to 3 on the scale, indicating the presence of some degree of distress. This summed scale thus provides a graded measure of distress and is often used in unaltered form in multivariate analyses of the correlates of distress or to compute mean distress scores across sub-groups of the population.

In addition, as a further variant in the use of the GHQ scores, a more simplified version of the summed 12-point scale is often felt necessary for easy presentation of large amounts of descriptive findings. This

simplification involves splitting the 12-point scale in two sections, the first ranging from 0 to 2 and the second from 3 to 12. Tests of the scale involving comparisons between scale scores and clinical diagnoses of psychiatric disturbance have shown that those who score in the higher of those two ranges (3 or over) have at least a 0.5 probability of being clinically diagnosed as psychiatrically ill. while those who score in the lower range (2 or under) have a less than 0.5 probability of being so diagnosed (Whelan *et al.* 1991). In other words, this splitting of the scale in two enables us to dichotomise samples into the 'normal' and the "distressed" — or more accurately, into those quite likely to be normal and those quite likely to be distressed. The dividing line between those two groups, that is. the point lying between scores 2 and 3 on the summed scale, is commonly referred to as the *GHQ stress threshold,* with those above that threshold classified as distressed and those below classified as normal. This dichotomised version of the GHQ scale will be used frequently below for descriptive crosstabulations, while the full 12-point scale will be used for multivariate analyses of the relationships between distress and other variables.

In addition to the GHQ stress measure in the 1993 Survey of the Over-65s. the present account also draws on the GHQ stress measure in the 1987 Poverty Survey for comparative purposes. The two applications of the measure are not entirely identical: the 1987 ESRI Survey of Income Distribution. Poverty and Usage of State Sen·ices made some alterations to the original format of the scale, while the 1993 Survey of the Over-65s went back to the original unaltered format. The alterations made in the 1987 survey appear not to have had any great effect on the measures derived from it: though there is some evidence that the 1987 format had a slightly exaggerating effect on the measured level of distress, the differences were too trivial to have any substantive importance (Whelan *et al.* 1991. pp. 21-25).

Levels of distress

Table 4.1 shows the GHQ distress scores both for the 1993 sample and for the over-65s in the 1987 sample, classified by sex in both cases. As is usual, the distribution is heavily skewed towards 0 in both samples, indicating that the majority of both samples show no real signs of distress. Beyond that, however, women in both samples show higher levels of distress than men.

In 1993. only 49 per cent of women were distress-free, compared to 62 per cent of men in the same sample. In 1987. a similar gap between the percentages of women and men who were distress-free is evident but at a higher level — 58 per cent for women. 72 per cent for men. The higher incidence of distress among women is a widespread pattern: "one of the most consistent findings in the epidemiological literature is that women experience higher rates of distress and disorder than men" (Whelan *et al.* 1991. p. 25). However, as we will see further in Chapter Eight below, the relationship between gender and psychological distress suggested in Table 4.1 weakens greatly when we control for age and health status. Women aged over 65 are more prone to psychological distress at least in part because they are older on average and because they have a higher risk of certain kinds of health problems (see Chapter Eight).

Table 4.1: GHQ Distress Scores Among Over-65s, 1993 and 1987

GHQ Score	1993			1987		
	Male	Female	Total	Male	Female	Total
	%	%	%	%	%	%
0	62	49	55	72	58	64
1	12	14	13	10	13	12
2	8	10	9	7	8	7
3	4	6	5	3	5	4
4	4	5	4	4	7	6
5	2	4	3	1	3	2
6	3	3	3	1	3	2
7	1	1	1	-	2	1
8-12	5	8	6	1	2	2
Total	100	100	100	100	100	100
Mean GHQ Score	1.33	1.8	1.6	0.7	1.3	1.1
N of cases	423	486	909	500	615	1115

From Table 4.1 we can also see that the 1993 sample as a whole shows higher levels of distress than the 1987 sample. This difference between 1987 and 1993 is not easy to account for. Some of it may be due to random

sampling error and to other sampling differences, but the gap is sufficiently wide to suggest that there may have been an increase in distress (albeit perhaps a smaller one than the comparisons between the survey data suggest) in the interval between the two surveys.

These and other patterns can be grasped more easily if we look to the more simplified measure of distress, the percentage scoring above the GHQ stress threshold. This measure is set out for a number of sub-groups in both the 1993 and 1987 samples in Figure 4.1. In the total 1993 sample. 23 percent are above the threshold, compared to 16 per cent in 1987. Allowing for a confidence interval of plus or minus three per cent around both estimates, along with other sampling differences, the difference is barely statistically significant. Of all the cross-sectional comparisons presented in Figure 4.1, the strongest is that associated with illness: in both the 1993 and the 1987 samples, those with a long-standing illness are about three times more likely to score above the GHQ stress threshold than those without an illness (in 1993. for example. 37 per cent of those with an illness are above the threshold, compared to 11 per cent without an illness). The comparisons by gender, age and marital status categories also show significant differences, but not nearly to the same extent.

Table 4.2 shows the incidence of distress as measured in this way for the entire sample in the 1987 survey. For men. it appears that old age is the most relaxed, distress-free stage of life. Men in the 65-74 and 75 plus age groups had the lowest percentages over the GHQ threshold of any age group, while men in the 45-54 age group had the highest percentage over the GHQ threshold. For women, age variations in levels of distress are less marked, but at least it seems that older women are no worse off in this area than women in most of the other age groups. In general, therefore, it seems that old age is *not* a particularly distressing stage of life. This is despite the associations evident in Figure 4.1 between psychological distress and certain features common in old age. such as age itself, widowhood and. most important of all. illness. The most likely explanation is that certain factors strongly associated with psychological distress among those under 65, particularly unemployment and to some extent poverty (Whelan *et al.* 1991). are less significant for those over 65. Thus while the elderly are prone to some things which are linked to distress, they are relatively free of other problems which affect younger adults and as a result, on balance, are neither better off nor worse off than the rest of the population in this area.

Figure 4.1: Percentages Over the GHQ Stress Threshold in 1987 and 1993

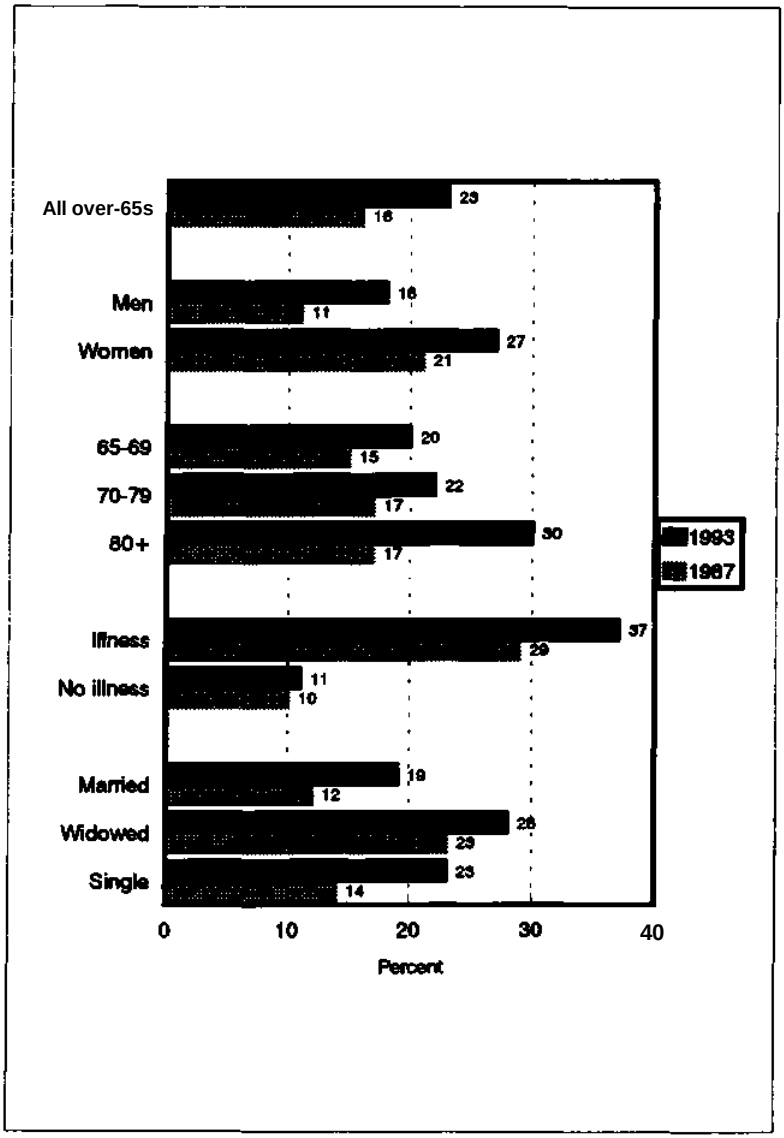


Table 4.2: GHQ Scores, Age and Sex in the ESRI Survey of Income Distribution, etc., 1987

	Percentage of Respondents with GHQ Scores over Threshold		
Age Group	Men	Women	All
15-24	17	13	15
25-34	15	21	18
35-44	14	15	14
45-54	20	22	21
55-64	14	21	18
65-74	11	21	17
75 and over	12	19	16
All	15	19	17

Morale of the Elderly

In addition to the GHQ psychological distress scale, the 1993 survey included an *ad hoc* 8-item battery of questions relating to various aspects of morale among older people. The questions were in the form of statements to which respondents were asked to indicate their agreement or disagreement. Table 4.3 sets out the percentages who were in agreement with each of the statements, distinguishing between men and women.

The pattern of responses to these items suggests that the overall level of morale in the sample is quite good while at the same time there are substantial pockets of unhappiness about particular issues. Three-quarters of the sample (71 per cent of women and 81 per cent of men) agreed that they were generally as happy with life now as they ever have been. A somewhat larger majority (87 per cent) felt that their age had not caused people to treat them with any less respect. Almost the entire sample (94 per cent) felt that they had family members who cared for them very much, and only a small minority (seven per cent) felt that they had to depend on people they did not get on with very well for help with everyday things.

On the other hand, increased loneliness is a problem for many older people. Almost half of the women in the sample and one-third of the men reported that they felt lonely much more often now than when they were younger.

Among women also, almost one-third reported being worried about becoming a burden to other people, though only 18 per cent of men reported similar concerns. There is an indication that many older people already feel themselves to be a burden to some degree: 45 per cent of the sample felt that they were often unable to return favours and help from people as much as they would like. Some degree of boredom was also common: almost half the sample (47 per cent) felt that they often found they had time on their hands.

Table 4.3: Indicators of Morale Among 0ver-65s, 1993

	Male	Female	Total
Statement	Percentage agreeing with statement		
I am generally as happy with life now as I ever have been	81	71	76
I worry a good deal that I am becoming a burden to other people	18	32	26
During the winter. I feel lonely much more often now than I did when I was younger	32	49	41
There are members of my family who care for me very much	94	95	94
Often. I am not able to return favours and help from people as much as I would like	41	49	45
My age generally has not caused people to treat me with any less respect	88	86	87
I often find I have time on my hands	46	47	47
I often have to depend on people I don't get on with very well for help with everyday things	7	8	7

In Chapter Five, we examine the correlates of feelings of loneliness in the sample. This analysis shows that being widowed is the strongest predictor of feelings of loneliness, even among the widowed who live with other family members. It also shows that gender of itself is not linked to loneliness: women are more likely to report feelings of loneliness simply because they are more likely to be widowed. Multivariate analysis of the other items in Table 4.2 showed that poor physical health was the strongest and most consistent predictor of poor morale. Other variables which might

be thought likely to have effects on morale, such as levels of social contact, income and standards of living and household composition, in fact had little or no effects. On the item dealing with older people's sense of having family members who care for them very much, unmarried respondents account for nearly all of those who respond negatively. This reflects the general lack of family networks among the unmarried elderly which is dealt with in Chapter Five below. Otherwise, however, the unmarried elderly do not seem particularly prone to loneliness or any other form of low morale.

Conclusion

The main conclusion of this chapter is that older people do not seem to be particularly prone to psychological distress, at least as far as the GHQ distress measure is concerned. The GHQ distress measures for the over-65s in the 1993 survey were not especially high. While we have only one application of this measure across the whole adult population in Ireland (from 1987). that instance shows no real difference in the incidence of distress between the under-65s and the over-65s. and for men especially, such difference as is present favours the elderly.

A number of more general measures of morale among the elderly in the 1993 sample suggest broadly similar results. Morale in general seems reasonably good, even though there are indications of some increase in loneliness with old age (especially as a result of widowhood) and some problems with being unable to fill up time.

We will return to the question of the social correlates of psychological distress among older people in Chapter Eight below when we examine patterns of vulnerability to various forms of lack of well-being in the 1993 sample.

CHAPTER FIVE

Social Networks and Social Interaction

Introduction

One of the most common themes in discussions of ageing in modern societies is the risk of social isolation among the elderly. This risk is often linked particularly with the growth in the incidence of old people living alone — in OECD countries generally, about 40 per cent of the over-65s live alone (OShea 1993). It is often also linked with the long-term decline in family sizes which has been evident in most western countries for over a century. Smaller families mean that older people have fewer adult children and so are more exposed to being left to their own devices. Other processes connected with ageing contribute to the same risk: contacts with the world of work are lost through retirement: spouses, siblings and same-age friends die: the ability to move outside the home for social interaction is gradually hampered by disability and illness: and. for some old people, poverty leads to the same kind of social exclusion experienced by the poor in other age groups.

In addition to a reduction in the *quantity* of social interaction, it is often also suggested that the *quality* of social interaction declines as elderly people become less active and increasingly dependent on others for care and assistance. Dependency creates imbalances in social relationships, with the result that the elderly person comes to lose dignity and self-esteem, to feel under a compliment or to have anxiety about becoming a burden on others.

However, much of the research on ageing in western countries in recent years has pointed out that the social lives of older people are not nearly so gloomy as this picture implies. Most older people are not socially isolated: they keep up extensive contact with family and friends and. if they live alone, are more likely to do so by choice rather than as the result of rejection by others. Indeed, living alone is often seen by old people as the best way

of maintaining independence and self-respect, so that the growth in the numbers living alone can be taken to reflect an increased freedom of choice rather than a worsening in the social circumstances of older people. Retirement can mean liberation from responsibility and pressing work schedules, not only for those formerly in paid jobs but also for women in the home who had devoted their prime years to the care of children and husbands. Financial pressures can be reduced as children become independent and mortgages are paid off. so that the proportion of income which is freed up for discretionary spending can increase. Even where loss of networks occurs, the consequences may not always be bad since the social relationships involved may have been of doubtful benefit in the first place (as in the case of unhappy marriages).

Generally, therefore, as Whelan and Whelan (1988) point out. the nature and quality of social networks which older people are involved in are as complex and variable as they are for any other section of the population. We cannot make any easy assumptions about the typical features of older people"s social lives, about how ageing affects social networks, nor about how changes in social networks that occur in old age affect other aspects of older people's circumstances. Whelan and Whelan (1988) present some evidence which suggests that social contact, even with family members, can sometimes be a source of distress for older people, just as it is generally a source of benefit and satisfaction. Likewise, loneliness and living alone are by no means the same thing: one can be lonely in a large household, just as one can live alone and have a rich and satisfying social life. Even in cases of illness or disability, we cannot assume that those who live with fit and active relatives will have worked out a better coping mechanism than those who live alone or who live with equally incapacitated partners. All these issues are open to examination, and it is the purpose of this chapter to do so using the relevant data from the 1993 survey.

Demographic background

Before turning to the 1993 survey data on these issues, we should note a number of features in the social networks of the elderly in Ireland which arise from their life-history backgrounds. As mentioned in Chapter One. we have no retrospective life-history data on respondents in the 1993 survey, but it is possible to identify a number of features in their life-histories from

the characteristics of Irish society in which they grew up and lived their prime adult years. These features are especially evident in the Irish family system from the 1930s onwards, that is. in the period in which the present generation of older people were in the family formation stages of the life cycle. Given that family networks are the central part of the social networks of older people, it is worth reviewing here the main features of the family formation patterns which prevailed during the prime adult years of the present generation of older people in Ireland.

The first such feature to note is the exceptionally high incidence of non-marriage. Of the cohort born in 1911-1915. 28.4 per cent of men and 21.1 per cent of women were single at age 50-54. Of the cohort born 10 years later *(i.e.* in 1921-1925). the percentages who were single at age 50-54 had fallen somewhat to 24.5 per cent for men and 17.5 per cent for women, but were still very high by the standards of other countries (Brahimi 1979. p. 673). The consequence is evident in present-day statistics: in the 1991 Census of Population, of those in the age-range 75-79 *(i.e.* the birth cohort of 1911-1915). 20.4 per cent of women and 24.0 per cent of men were single.[1] Among the over-65s as a whole. 21.8 per cent were single. In other words, something in excess of a fifth of the older people alive in Ireland today, and somewhat larger proportions of the very old. either never married or did so too late in life to have children of their own. As a result, they did not create their own immediate nuclear families and so are lacking in what we often think of as the central plank of social support for older people. One of our central concerns below in investigating the social networks of older people today will be to examine the circumstances of that particular group, to ask how far family networks are lacking and to assess if this lack has the negative effects we would expect.

As a counterbalance of sorts to the high proportions who remained single and childless, those of today's elderly who did marry in their prime adult years had relatively large families. Marital fertility declined steadily in

1 As the figures above show, (he percentage of men in the hirth cohort of I'M 1-15 who were -.ingle fell from 28.4 at age 50-54 to 24.0 at age 75-79. while among women, the percentage who were single remained almost unchanged between the same two age-bands. The declining percentage of single men in this and other age cohorts as they grow old may be due in part to a certain incidence of male marriage at old ages. However, it is probably mainly due to higher mortality among unmarried men. a pattern which has been frequenth noted in other countries but not yet documented for Ireland. Unmarried women also have a monality disadvantage compared to married women, but it is not nearly as severe as the mortality disadvantage of unmarried men (Hu and Goldman 1<WO).

Ireland from the 1880s onwards, but pre-decline fertility levels had been so high and the rate of decline so moderate by the standards of other countries that average family sizes were still quite large by the middle decades of the present century (ÓGráda 1991). Fertility decline more or less halted during the period from the 1940s to the early 1970s — a period which includes the child-bearing years of the great majority of the present elderly — so that by 1971 the average completed family size was still in excess of four children (Clancy 1984. pp. 24-5). This placed Ireland at an exceptionally high level of marital fertility among western countries at that time and means that older Irish women of today who were married during their child-bearing years stand out from their contemporaries in other western countries for the large numbers of children they have borne.

It should be noted also that, while marital fertility began to decline more rapidly from the late 1960s onwards, that decline was counteracted by a surge in the marriage rate (the highest annual number of marriages in Ireland in the present century occurred in 1974). As a result, while the average family size was smaller among the children of today's elderly than among the elderly themselves, the total number of children in the country grew during the 1960s and 1970s and reached a new peak in the early 1980s. Thus we would expect most of today's elderly to have large numbers of grandchildren, though this is likely to be less true of the younger elderly whose children began to form their families in the 1980s.

In addition to the high rate *of production* of kin. older people in Ireland have benefitted from a high rate *of survival* of kin. This is true to some extent of lateral kin (brothers, sisters and cousins). As was mentioned in Chapter Two. about 11 per cent of the birth cohorts from which the present elderly are drawn died by age five. While this attrition rate is high by today's standards, it was low by earlier historical standards so that the survival rate of lateral kin for today's elderly was higher than that experienced by any previous generation. The same is even more true for descendent kin (children, nieces and nephews, grandchildren, etc.). Infant mortality improved steadily over most of the present century, especially from the late 1940s onwards. By the early 1950s, deaths by age five had fallen to 6.2 per cent for males and just under four per cent for females, while by 1960-62, the corresponding figures were 3.6 per cent for males and three per cent for females *(Statistical Abstracts of Ireland).* The combination of mortality improvement among children and continuing high fertility among married

couples placed the parental generation in Ireland of the 1940s to the 1960s — that is. the elderly of today — in the unusual position for western countries of having "traditional" family sizes in the midst of 'modern" mortality conditions. This leads to high concentrations of surviving adult children and of grandchildren among older Irish people today — a pattern which we will document further below from the 1993 survey data.

A further factor which is important in shaping the kin networks of older Irish people is the pattern of migration. Migration out of Ireland and from rural to urban areas within Ireland has long been a disrupter of family networks in that it has scattered family members away from their places of origin. The family networks of the elderly of today have been affected by this pattern. As we shall see below, many elderly siblings live at a distance from each other and many children of older people have moved away from their parents to somewhere else in Ireland, if not abroad. However, the timing and pattern of migration surges over the past half century have meant that these disruptive influences, while significant, have not been as extreme for today's elderly as for previous generations of old people in Ireland. Emigration out of Ireland reached a peak this century from the mid-1940s to around 1960. This peak was comprised principally of young adults, that is. those born from the late 1920s to the early 1940s. The majority of today's elderly married between the late 1930s and the early 1950s (the modal year of marriage among the still-married in the 1993 sample of over-65s was 1948). As a result, the great majority of their children were coming to adulthood from late 1950s onwards — that is. at a time when emigration had fallen sharply or had turned into net inward migration (as it did for a time in the 1970s). Indeed, the younger and middle-age ranges of today's elderly were the first generation of parents since the mid-nineteenth century not to have seen very large numbers of their offspring dispersed abroad. Thus, while we should expect to find some dispersal of siblings and children among today's elderly, this is likely to have been on a smaller scale (especially as far as children are concerned) than that experienced by most generations of older people since the mid-nineteenth century.

We often assume that the extended family has shrunk and declined in the course of social and economic modernisation in western countries, and we might easily assume that such a development has occurred in Ireland also in recent decades. However, the demographic background just looked at — the persistence of high marital fertility until the 1960s, the steady

improvements in survivorship among children over the present century, and the decline in emigration since the 1960s — all tend to contradict that assumption in the Irish case, at least as far as the present elderly are concerned. The indications are that the majority of today's elderly in Ireland are likely to have come from large families (and so have relatively large numbers of siblings and cousins), while those who married are likely to have produced large families themselves and to have had their children marry and produce relatively large numbers of grandchildren. In other words, they are likely to have large numbers of lateral and descendent kin. In addition, the decline in emigration since the 1960s means that historically high proportions of their descendant kin are likely to be still living in Ireland (though this is likely to be less true of lateral kin).

These demographic pointers suggest, therefore, that for most older people in Ireland, with the possible exception of the minority who never married, the extended family has never been larger or more extended than it is today. They therefore have a basis for integration into the rest of society which does not exist to the same degree in other western countries. The question now is what role these networks of relatives play in older people's lives, what contribution they make to the health and well-being of the elderly in Ireland, and what difference it makes to certain minorities (especially the never-married) that they do not have such networks to anything like the same extent?

It is with these questions in mind that we turn to an examination of the data on social networks and social interaction from the 1993 Survey of the Over-65s. That survey devoted a good deal of effort to exploring the social relationships of the elderly and the resulting data allow us to fill out the picture of family networks which we can glimpse from background demographic patterns and to explore some aspects of non-family social networks. In the present chapter, we focus on the size and vitality of family and non-family social networks: how large they are, how actively older people participate in them, and (to some extent) what kind of social relationships result for older people. In Chapter Seven below, we take up the question of how participation in various kinds of social relationships affects the older people's psychological well-being and this in turn allows us to draw some general pointers about the significance of social networks and social support in older people's lives.

In examining the quantity and quality of social contact among older people, the present chapter first looks at the extent and structure of the social networks (including family networks) in which elderly people are enmeshed. It then examines the amount of day-to-day social contact they have within those networks, and after that focuses on questions of loneliness, caring, dependence and reciprocity as aspects of the quality of those social networks. Finally it provides a summary and conclusion.

Extent and Structure of Networks

Household size and structure

The most intense social network we routinely engage in is that formed from the people we live with. Co-residence usually means high levels of interaction with the other members of the household, and often — though not always — provides a network of care and support in times of illness or crisis. One characteristic of modern living arrangements, however, is that people increasingly live alone, and such solitary living is especially common among the elderly. In Ireland, the proportion of people over 65 who live alone has increased from 10 per cent in 1961 to 24 per cent in 1991.[2] Despite this increase, however, the rate of solitary living among the elderly in Ireland is a good deal below the average in western countries (which, as already mentioned, is around 40 per cent in OECD countries).

Table 5.1 shows the distribution of the 1993 sample of elderly people by household type, with sub-classifications by sex. marital status and age group.[3] The most common household type, accounting for 33 per cent of respondents, is the two-person household of husband and wife, followed by the lone-person household (26 per cent of respondents). Married couples with unmarried children (12 per cent of respondents" households) and widows or widowers with unmarried children (10 per cent of households) are the next biggest categories, while three-generation households (seven

2 Of the population aged over 65 in private households in I <W1 *[i.e.* excluding the institutionalised elderly). 26.2 **per cent lived alone (CSO *Census 91 Summary Population Report — 1st Series. Table 16).***

3 For the purposes of this chapter, the sample has been re-weighted to conform to the 1W1 Census distribution of the elderly population living alone and not living alone. The unweighted sample over-represents those living alone. See Appendix A for details.

Table 5.1: Household Type by Sex, Marital Status and Age Group

		Household type								Distribution of sample (%)
		Living alone	Couple	Couple with unmarried children	Widow(er) with unmarried children	Couple or widow(er) with married children with or without grandchildren	Siblings	Other	Total	Disbribution of sample (%)
TOTAL SAMPLE	%	26	33	12	10	7	7	5	100	100
	N	236	303	108	90	62	60	49	909	
Sex: Male	%	20	42	21	3	2	7	6	100	47
Female	%	31	26	4	16	11	7	5	100	53
Marital Status:										
Single	%	51	–	–	–	–	36	13	100	15
Married	%	–	70	25	–	3	–	2	100	48
Widowed	%	49	–	–	27	15	–	6	100	37
Age Group:										
65-69	%	20	42	19	8	3	4	4	100	31
70-74	%	23	36	13	11	6	7	3	100	28
75-79	%	33	29	7	10	5	9	7	100	21
80+	%	32	20	5	11	13	9	10	100	20
Average number of persons per household		1.0	2.0	3.7	2.2	5.0	2.3	3.0	2.2	

Chi-square significance for all distributions shown: $p < 0.000$

per cent) and households comprised solely of siblings (seven per cent) account for most of the remainder.

Looking at the distribution of household types by sex. we see that men aged over 65 are more than twice as likely as women aged over 65 to be living with their spouses: couples and couples with unmarried children account for 63 per cent of men compared to only 30 per cent of women, while 31 per cent of women live alone compared to only 20 per cent of men. This is in keeping with the well-established likelihood that husbands will die before their wives, partly because they have shorter life expectancies (see Chapter Two above) and partly because they are usually older than their wives. The distributions by marital status show that about half of single people and the widowed live alone, but most of the remaining widowed persons live with their own children (either married or unmarried) while most of the remaining single people live with siblings or in some other arrangement. The incidence of widowhood, obviously, increases with age and this means that the incidence of persons living alone also increases with age. So too does the incidence of widows or widowers living with their own children. These age patterns reflect the death of spouses and the consequent switch in the elderly person household from a couple-centred to a widow-centred structure as age increases.

The average number of persons per household in the whole sample is 2.2. which compares with an average household size of 3.3 persons for all private households in the 1991 Census of Population.

Kin networks

Outside of the household, the next most significant social network for most older people is that formed by close kin. particularly adult children, grandchildren and siblings. Table 5.2 gives an indication of the extent and location of such networks by presenting the average number of children, grandchildren and siblings among respondents, distinguishing between those living locally *(i.e.* within 10 miles of the respondent's home), those living elsewhere in Ireland and those living abroad. The number of each kin type who are living in the respondent's household are also included to round out the picture of kin networks.

Table 5.2: Average Numbers of Close Kin (Children, Grandchildren and Siblings) Among Respondents Classified by Household Type

	Type of Household					
	Living alone	Couple	Couple or widow(er) with unmarried children	Couple or widow(er) with married children with or without grandchildren	Other	Total sample
	Average number of kin					
Within 10 miles:						
Children	1.3	1.9	2.1	2.5	0.4	1.6
Grandchildren	3.1	4.4	4.8	8.1	0.7	4.0
Siblings	0.9	1.2	1.0	0.8	0.9	1.0
Total:	5.3	7.5	7.9	11.4	2.0	6.6
Elsewhere in Ireland:						
Children	0.6	1.3	1.1	0.7	0.2	0.9
Grandchildren	1.2	2.1	1.9	2.3	0.5	1.6
Siblings	0.6	0.9	0.9	0.6	0.7	0.8
Total:	2.4	4.3	3.9	3.6	1.4	**3.3**
Abroad:						
Children	0.5	0.6	0.5	1.0	0.1	0.5
Grandchildren	O.S	O.S	0.8	2.1	0.2	O.S
Siblings	0.6	0.9	0.7	0.5	0.5	0.7
Total:	1.9	2.3	2.0	3.6	O.S	2.0
Resident in h/hold:						
Children	-	-	1.5	1.1	0.1	0.4
Grandchildren	-	-	-	0.8	-	0.1
Siblings	-	-	-	-	0.8	0.1
Total:	-	-	1.5	1.9	0.9	0.6
Total children	2.4	3.S	5.2	5.3	O.S	3.4
Total grandchildren	5.1	7.7	7.5	13.	1.4	6.5
Total siblings	2.1	3.0	2.6	1.9	2.8	2.6
Total all kin	9.6	14.1	15.3	20.5	5.0	12.5
No. of households	236	303	198	62	109	909
(%)	(26)	**(33)**	(22)	(7)	(12)	(HX))

The picture emerging from Table 5.2 confirms the indications from the demographic patterns referred to earlier that, with the exception of those who never married, older Irish people have dense and extensive networks of close kin. Those who are either married or widowed have of the order of four or five surviving children, of whom around two or three are still living

locally. They also have on average seven or more grandchildren, of whom around four or five are living locally. On top of that, they have two to three surviving siblings, though unlike children or grandchildren, siblings are almost as likely to be living abroad or elsewhere in Ireland as living locally. It seems also that respondents with the largest and most extended household structure — that is. three-generational households or two-generational households where at least one of the adult children has a co-residing spouse — also have the largest kin networks outside the household. This is especially true of local networks, as such households have marginally more children on average and considerably more grandchildren in the locality than do respondents in other household types.

Some indication of how exceptional such large numbers of relatives are by both present-day and historical standards in western countries can be gleaned from Laslett's (1988) estimates of the size of kin networks in England in the 1980s and in pre-industrial times. Using computer simulations of the interacting effects of rates of marriage, births and deaths. Laslett calculates that in England in the 1980s the typical 66 year old had one brother or sister, less than two surviving children and approximately three grandchildren. In pre-industrial times, although today's pattern of small family sizes was yet a long way off. the ravages of early death, combined with the depressing effect on fertility of delayed marriage, kept kin networks down to modest sizes. Even in a relatively favourable demographic regime such as that of England between about 1760 and 1810 (where by pre-industrial standards birth rates were reasonably high and death rates reasonably low). Laslett calculates that 66 year olds on average had only 1.1 siblings. 2.6 surviving children and just over eight grandchildren — and this, in his view, represents the approximate upper bound of pre-industrial patterns rather than the long-term historical standard. From the evidence looked at above, kin numbers among older people in Ireland would seem in general to be a good deal higher than these levels and so would represent something of a long-term historical high point in the size of kin networks. It is possible, though by no means self evident, that in the shorter historical term — that is. since the early twentieth century — kin numbers among older people may have been somewhat higher than today, but this would be simply to extend today's historical high point backwards to form a slightly sloping plateau rather than to deny its existence altogether.

Table 5.3: Average Numbers of Close Kin (Children, Grandchildren and Siblings) Among Never-married and Widowed Respondents Living Alone

	Living alone		Total sample
	Never-married	Widowed	
Within 10 miles			
Children	-	I.S	1.6
Grandchildren	-	4.4	4.0
Siblings	(I.S	1.0	1.0
Total	O.S	7.2	6.6
Elsewhere in Ireland or abroad			
Children	-	1.6	1.4
Grandchildren	-	3.0	2.4
Siblings	1.0	1.3	1.5
Total	1.0	5.9	5.3
Total all kin	I.S	13.1	12.5
Number of households	70	163	909
°o of total sample	7.7	17.9	KM)

While kin numbers are generally high among today's elderly, there are sub-groups for whom they are quite small. The "other" category in Table 5.2 is comprised mainly of unmarried people living with siblings or in some other arrangement and they have much smaller kin networks than the other household types. Respondents in lone person households on average have reasonably large kin networks: the numbers of children, grandchildren and siblings they have outside the household are lower, but not very much lower, than the other main household types. However, these averages represent the mix of two quite distinct categories of people living alone — the never-married and the widowed. Table 5.3 separates these two categories and compares the average sizes of their kin networks both within and outside the local area. This separation of the two categories shows that the widowed who live alone (who account for 18 per cent of the total sample) have just as extensive kin networks outside their households, including local networks of children and grandchildren, as the other major household types. However, the never-married who live alone (who account for eight per cent of the sample), have by far the smallest kin networks of any household type in the sample — no children or grandchildren (as one might expect) but also fewer siblings, either locally or elsewhere. The unmarried elderly who

do not live alone, but live with siblings or in some other arrangement, also have small kin networks outside the household but at least they have the presence of those they live with. Therefore, the unmarried elderly in general, and in particular the unmarried elderly who live alone, form a significant sub-group who have much more limited kin networks than any other category in the sample.

Correlates of kin network size

In order to get a more comprehensive view of variations in size of kin networks among older people, it may be useful to examine the social correlates of kin numbers in the sample in a systematic way. Because these correlates are interconnected, multivariate analysis is necessary to disentangle the links with individual variables. Here we use ordinary least squares multiple regression for this purpose. The data presented in Table 5.4 focus on four dependent variables which measure different dimensions of kin network size — number of children living locally, living elsewhere in Ireland and living abroad and number of siblings living locally. The predictor variables examined are household type, social class, educational level (scored on an eight-point scale from incomplete primary to higher degree), a subjective assessment of the respondent household's ability to make ends meet and a deprivation index (see Chapter Four above), age and urban-rural location. (Estimates of the relationships between these predictor variables and two other dimensions of kin networks — the numbers of siblings living elsewhere in Ireland and abroad — showed negligible predictive power and are not presented here).

The variables examined are not particularly powerful predictors of any of the four dimensions of kin network size examined (the highest percentage of variance explained is in the case of children living locally, at 16 per cent). As already suggested, being unmarried has the strongest effect on numbers of children in the kin network. This effect is captured in Table 5.4 by the household type variable in which single people living alone and persons in the "other' category (comprised principally of single people living with siblings or other relatives) are treated as separate categories. Both of these categories, as one would expect, have strong negative associations with numbers of children, though it is notable also that single people living alone also have slightly fewer siblings on average than other household types.

Table 5.4: Multiple Regression Analysis of the Correlates of Kin Network Size Among Over-65s

	Dependent variables			
	Number of children			Siblings
	Living locally	Elsewhere in Ireland	Abroad	living locally
Independent variables:	Standardised regression coefficients			
Household type:				
Couple	r	r	r	r
Two/three generation	-	-.11*'	-	-
Single person alone	-.24'"	-.21"*	-.16***	-.09*
Widow(er) alone	-	–	–	–
Other	-.21*"	-.25"*	-.16***	–
Social class:				
Upper profVmanag	r	r	r	r
Other non-manual	-	–	–	–
Skilled	.09*	-	–	–
SemiVunskilled	.16*"	-	–	–
Other	-	–	–	–
Educational level	-.08*	-	-	-.12"
Ability to make ends meet	-	-	-	-
Deprivation index	-	-	-	-
Gender	-	–	–	–
Age	-	–	–	-.11"
Urban/rural (urban=1)	.12*"	-.21*"	-	.13"*
R^2	16%	14%	6%	6%
df	864	864	864	864

r = reference category: — non-significant coefficient
**p <05 **p <.O1 ***p <001*

Aside from this marital status effect, there are significant social class and urban/rural effects on numbers of children living locally: the skilled and the semi-skilled/unskilled have significantly higher numbers of children living locally, while urban dwellers have more children living locally than do rural dwellers. For children living elsewhere in Ireland, the urban-rural effect is reversed: urban dwellers have a considerably lower number of children living elsewhere in Ireland than do rural dwellers. This reflects the long-standing pattern of migration to urban areas from rural Ireland which means that rural families become more dispersed within Ireland than urban

families. The combined class and urban/rural effects suggest that the urban working class has the largest *local* kin networks, while rural dwellers generally have larger kin networks living outside the local area in Ireland.

When we look at number of children living abroad, none of the variables examined have any predictive effect except the obvious one of household type/marital status (the never-married generally being without any children). This is interesting in itself since it suggests that levels of emigration among the children of the sample are more or less uniform across social classes and the urban/rural divide. As for number of siblings living locally, the never-married who live alone fare slightly worse than the rest, as do the better educated (the latter is perhaps a social class effect, reflecting smaller family sizes among the better off). Not surprisingly the number of siblings living locally declines with age (siblings die off as they grow older) and is a good deal higher in urban than rural areas (again because of migration effects).

These results suggest, therefore, that in addition to the strong association between being unmarried and having small kin networks, there are some associations also with social class and the urban/rural divide. These latter associations, however, are not very strong, so that despite the differences they reveal, the pattern of large kin numbers is quite general across the main social class or locational groups in Irish society, though again, with the important exception of the substantial minority who never married.

Social Interaction

The existence of social networks does not tell us how actively the elderly person participates in them. While it is clear from the information just presented that most categories of older people in Ireland have large numbers of relatives, we need to ask how active those networks are in the lives of older people, that is, how much contact older people have with their relatives. We have no measures of the level of social interaction between respondents and members of their own household. This is an important gap in our information, since there could be large variations in both the quantity and quality of interaction between household members and these variations could have crucial consequences for older people's welfare. However, we do have indicators of how much respondents interact with kin, friends and neighbours outside the household and also how much they participate in

local social activities. We will now examine the levels of that interaction and the variations in those levels across social groups of older people.

Contact with kin

We look first at the levels of contact with relatives outside the household. Table 5.5 sets out the frequency of contact with relatives among men and women in the sample, showing separate distributions for all contact (including telephone calls) and visiting contact only. These data show quite high levels of kin contact. A little more than one-third of women and a little less than one-third of men have daily visits to or from relatives. When telephone contact is included (80 per cent of the sample have telephones — see Chapter Four above), the proportion in daily contact with relatives rises to 46 per cent of women and 37 per cent of men. If we cumulate the top three categories of contact (daily, every 2-3 days and weekly), we find that 82 per cent of men and 86 per cent of women have at least weekly contact with relatives. Excluding telephone calls, the corresponding percentages are not very much lower at 74 per cent of men and 79 per cent of women. Thus, the overall incidence of regular face-to-face contact is high, and while some additional contact with relatives occurs *via* the telephone, that additional contact is by no means great enough to rank with face-to-face contact as the standard form of interaction with relatives for older people. At the other end of the scale, there is a minority which has little or no contact with relatives. About three to four per cent of both men and women have less than yearly contact with relatives, while a further five per cent have contact only a few times a year.

We have already seen that one household type among older people stands out as having much smaller kin networks than the average, that is, never-married older people who live alone. Table 5.6, which presents levels of visiting contact with relatives by household type, shows that such contact with kin is a good deal lower for that household type than for the other main household types: 18 per cent of the never-married who live alone have daily visits to or from relatives, compared to over one-third in the sample as a whole. At the other extreme, 13 per cent of the never-married who live alone have less than yearly contact with relatives, compared to four per cent for the whole sample. The household type labelled 'other', which is comprised mainly of never-married people living with siblings or in some other

arrangement, also has a relatively low incidence of daily contact with relatives (16 per cent having daily contact). Paradoxically, the second major group of those who live alone — the widowed — have the highest levels of frequent contact with relatives (48 per cent having daily contact).

Table 5.5: Frequency of Contact with Kin Among Over-65s, by Gender

	All contact (visits & tel.)		Visiting contact	
	Male %	Female %	Male %	Female %
Daily	37	46	31	35
Every 2-3 days	26	21	23	21
Weekly	19	19	21	23
Every 2-4 weeks	10	5	14	8
Few times a year	5	5	9	9
Less than yearly	3	4	3	5
Total (n)	100 (423)	100 (486)	100 (423)	100 (486)

Chi-square significance for both distributions: p <0.05

While contact with kin among the never-married is lower than average, we should not conclude that it is completely lacking. If we again cumulate the top three categories of contact (daily, every 2-3 days and weekly) to get the percentage who have least weekly contact with relatives, we find that over half (55 per cent) of the never-married living alone are in that category. Thus the relatively small numbers of relatives possessed by the never-married living alone do give rise to regular contact for a substantial proportion of them, even if that proportion is smaller than for the rest of the sample.

Table 5.6: Frequency of Visits with Kin Among Over-65s, by Household Type

	Living alone		Couple	Two/three generational	Other
	Unmarried	Widowed			
	%	%	%	%	%
Daily	18	48	38	29	16
Every 2-3 days	16	22	27	21	17
Weekly	19	14	20	27	27
Every 2-4 weeks	16	7	12	12	15
Few times a year	18	6	9	8	18
Less than yearly	13	3	5	3	8
Total (n)	100 (70)	100 (163)	100 (303)	100 (260)	100 (112)

Chi-square significance: p < .0001

Correlates of contact with relatives

As we did above with the correlates of kin network size, it may be useful to set out a multivariate analysis of the correlates of levels of contact with relatives. Here we want to find out to what extent contact with relatives is a simple function of network size (the more relatives, the more contact), and how far other factors come into play. We will look at three types of contact—visits *to* relatives, visits *from* relatives and telephone contact with relatives — since, as Whelan and Whelan (1988) suggest, it may well be that the dynamics of each are different.

Table 5.7 shows the results of the regression of a number of independent variables on these three dependent variables. These results show quite clearly that network size, particularly *local* network size, is the most important determinant of contact with relatives. This is especially so concerning visits *to* relatives: having more relatives living in the local area generally does translate heavily into more visiting by older people. The level of visits *from* relatives is also heavily dependent on local network size, though networks living elsewhere in Ireland and abroad also make a substantial contribution. Telephone contact (for those who have telephones) is equally dependent on network size but less dependent on the *location* of networks: relatives living locally and elsewhere in Ireland contribute

equally to telephone contact, though relatives living abroad make a somewhat smaller contribution. These results confirm, therefore, that networks of close relatives are active elements in older people's social lives and the bigger those networks are, the more impact they have on older people's level of social contact.

Compared with kin numbers, the other variables included in the analysis in Table 5.7 have relatively modest effects on levels of contact with relatives. Being unmarried (i.e. a single person living alone or living in the 'other' household type) has an influence independent of kin network size: as we saw already, single people have fewer relatives, but the findings here suggest in addition that they have less contact with the relatives they do have. This reflects the absence of own children among never-married people, children generally being the most frequent and reliable sources of regular contact. There is generally little direct difference between urban and rural areas in levels of kin contact, though the rural elderly rely more on the telephone than do the urban elderly. However, we should recall from earlier in this chapter that the local kin networks of older people tend to be smaller in rural than in urban Ireland, largely because of the higher incidence of dispersal of relatives through migration in rural families. Since the size of local networks is such an important determinant of levels of contact, older people in rural Ireland are at something of a disadvantage in this regard. The higher use of the telephone in rural areas is thus a reflection of the more dispersed nature of kin networks among the rural elderly.

The three variables in Table 5.7 which refer to the health of respondents generally have no effect on contact with relatives. However, there is one important exception in that functional capacity (i.e. physical disability — see Chapter Six below) has a bearing on level of visits to relatives. Physical impairment clearly hampers the older person's ability to move out to visit others, and increasing age has a smaller effect of the same sort. Against that background, it is important to note the lack of any significant relationship between functional capacity or age and either visits *from* relatives or telephone contact with relatives. This suggests that older people who are confined to home by physical impairment do not receive any extra contact from their relatives which compensate for their inability to move out. As a result, we can guess that in addition to the fall-off in contact with relatives which accompanies physical decline, the older person has a reduced capacity to initiate such contact. The shift in the initiative for contact away

from the older person towards his or her relatives could have implications for the quality of contact and this is an issue which we will return to below.

Table 5.7: Multiple Regression Analyses of the Correlates of Social Contact with Relatives Among the Over-65s

Dependent variables:	Contact with relatives		
	Visits to	Visits from	Telephone contact[8]
Independent variables:	Standardised regression coefficients		
Number of relatives:			
Living locally	.51***	.57***	.38***
Elsewhere in Ireland	.19***	.23***	.30***
Abroad	–	.08***	.14***
Household type:			
Couple	r	r	r
Two/three generation	–	–	–
Single person alone	-.13***	-.18***	-.19***
Widow(er) alone	–	–	–
Other	-.14***	-.18***	-.18***
Health:			
Illness (Yes=1)	–	–	–
Functional Capacity Index	-.16***	-	-
Subjective health rating	–	–	–
Living standards:			
Ability to make ends meet	—	—	–
Deprivation index	–	–	.08**
Gender (Female=1)	–	–	–
Age	-.06**		–
Urban/rural (Rural=1)	–		.10**
Social class (five dummy categories: not shown)	-	-	-
R^2	49%	57%	44%
df	864	864	703

r = reference category; — non-significant coefficient
**p<.05 **p<.01 ***p<.001*

[a] Respondents who do not have telephones excluded

Contact with friends and neighbours

In addition to relatives, friends and neighbours also provide a major source of social contact for older people. Table 5.8 sets out the levels of contact with friends and neighbours for men and women and for household types. This table shows that levels of contact with friends and neighbours are similar to. if not higher than, levels of contact with relatives: about half the sample have visiting contact with friends or neighbours every day. and a further quarter have such contact once or more per week. A substantial minority have very little contact with neighbours or friends: seven per cent have such contact less than yearly, while a further seven per cent have it only a few times a year.

The differences between men and women on this item are not statistically significant. However, the classification by household type shows that those household types which have the lowest levels of contact with relatives — never-married people living alone and the "other" category — have somewhat higher than average proportions in daily contact with neighbours and friends (58 per cent and 55 per cent respectively). The difference is not great enough to suggest that contact with neighbours and friends counterbalances the lack of contact with relatives among single people. If contact with relatives and contact with friends neighbours are added together, single people still come out with considerably lower levels of overall contact. In addition, single people living alone have quite high proportions who have very little contact with neighbours and friends — nine per cent have contact less than yearly and a further nine per cent have contact only a few times a year. Thus, despite the overall high levels of social contact among older people, there would appear to be a substantial minority who face a considerable risk of social isolation, having little contact with neighbours, friends or relatives.

As was done above for contact with relatives, the pattern of contact with neighbours and friends is examined further in Table 5.9. where a number of independent variables are regressed on three dimensions of contact with neighbours and friends — visits to, visits from and telephone contact (for those with telephones). The first of the independent variables included in this analysis is contact with relatives, the intention being to examine further if any trade-off or counterbalancing occurs between kin contact and contact with neighbours and friends. The results suggest that there is no such trade-off: contact with neighbours and friends is independent of contact

Table 5.8: Frequency of Visiting Contact with Neighbours and Friends Among Over-65s, by Sex and Household Type

	Sex		Household Type					Total
	Male	Female	Living Alone		Couple	Two/three generational	Other	
			Unmarried	Widowed				
	%	%	%	%	%	%	%	%
Daily	47	50	58	50	41	50	56	49
Every 2-3 days	17	13	10	14	18	16	7	15
Weekly	11	14	3	9	16	14	12	13
Every 2-4 weeks	10	11	10	11	11	7	12	10
Few times a year	8	6	9	6	7	6	8	7
Less than yearly	8	6	9	9	6	6	7	7
Total (n)	100 (423)	100 (486)	100 (70)	100 (163)	100 (303)	100 (260)	100 (112)	100 (909)

Chi-square significance: Sex - not significant; Household type: p <0.1

with relatives, so that those who have little contact with relatives (such as single people) in general do not compensate by having extra contact with neighbours and friends, though neither do they have any less. This pattern is repeated across household types: the level of contact with neighbours and friends does not seem to be related to household structure, meaning among other things that those who live alone are no more and no less sociable with neighbours and friends than those who live in multi-person households.

Table 5.9: Multiple Regression Analyses of the Correlates of Social Contact with Friends and Neighbours Among the Over-65s

Dependent variables:	Contact with friends/neighbours		
	Visits to	Visits from	Telephone contact[8]
Independent variables:	Standardised regression coefficients		
Contact with relatives:	-	-	-
Household type:			
Couple		r	
Two/three generation		–	
Single person alone		–	
Widow(er) alone		–	
Other	–	–	–
Health:			
Illness (Yes=1)	–	–	–
Functional Capacity Index	-.19***	–	-.11**
Subjective health rating	-.09*	-.10*	-.11**
Living standards:			
Ability to make ends meet	-	-	-
Deprivation index	–	–	–
Gender (Female=1)	.08*	.11**	.15***
Age	–	–	–
Urban/rural (Rural=1)	–	–	–
Social class:			
Upper prof/managerial	r	r	-.14*
Other non-manual	–	–	–
Skilled manual	–	–	–
Semi-/unskilled	–	-.09*	-
Unknown	–	–	–
R^2	7%	3%	6%
df	883	864	711

r = *reference category;* — *non-significant coefficient*
**p<.05 **p<.01 ***p<.001*
[a] *Respondents who do not have telephones excluded*

As with visits to relatives, visits to neighbours and friends are quite heavily curtailed by ill-health and physical impairment as measured by functional capacity index and subjective assessment of health. In addition, the other two dimensions of contact with neighbours and friends — visits from and telephone contact — are also reduced to some degree by ill-health and physical impairment in a way that did not occur for contact with relatives. Thus, the loss of contact with neighbours and friends at times of illness and incapacity seems to be somewhat greater than for relatives, suggesting that links of neighbourliness seem to be somewhat less durable and reliable for older people in their declining years than links of kinship.

A further difference between patterns of neighbourliness and patterns of kin contact lies in the effect of gender. As we saw earlier, according to the measures we have used, there is no difference between older men and women in levels of contact with relatives, but the regression coefficients in Table 5.9 suggests that women have significantly more contact with neighbours and friends than do men. This is particularly true of telephone contact — women are more regular telephone users than men. at least for purposes of general sociability. There is also a small class effect, in that even among those who have telephones, those in semi-skilled or unskilled social classes make less use of the telephone for contacting neighbours and friends than average (how much of this is due to the lack of telephones among the friends and neighbours of the semi-skilled and unskilled is hard to say).

Content and Quality of Social Interaction

So far in this chapter, we have described the extent of social networks and the degree to which respondents in the sample participate in them — all of which refers in one way or another to the *quantity* of social interaction. Now we turn to certain aspects of the *content and quality* of social interaction engaged in by elderly people. Here the underlying issue is not how much social contact older people have, but how good or supportive it is. Obviously, questions of content and quality in social interaction are intangible, difficult to define and too elusive to capture easily in survey questionnaires. There has been a flood of research in recent years on social support among the elderly and among the adult population as a whole, but this effort has not produced an agreed, practical set of instruments for

measuring support, and particularly the quality of social support, in questionnaire surveys (Orth-Gomér and Undén 1987).

However, while thorough measurement of the quality of social relationships is well beyond the capacity of the data to hand, we can derive some indirect or partial indicators. These provide rough approximations of the underlying dimensions we are interested in. and even though they do no justice to the full richness of the way people relate to each other, they are sufficiently suggestive to warrant some examination. In this section, we look at a number of such indicators individually, while in Chapter Seven below, which deals with the psychological well-being of older people, we return to the general question of how different kinds and levels of social contact contribute to psychological health.

Loneliness and caring

As mentioned earlier, one of the main reasons social research devotes so much attention to the social lives of older people is the long-standing concern that older people face a high risk of social isolation. We have just seen that, in Ireland at least, while certain minorities (particularly the never-married who have few nuclear family relatives) have much less social contact than average, the great majority of older people are not socially isolated — they generally have large family networks and they keep up good contact not only with relatives but also with neighbours and friends. In turning to questions of the quality of that contact, however, the focus turns to the effectiveness of the social interaction involved in sustaining feelings of belonging and social fulfilment in older people. Two items in the 1993 survey referred to this question directly: one asked respondents if. during the winter, they feel lonely much more often now than they did when younger, the second asked if they had members of their families whom they felt cared for them very much. Both items were presented in the form of statements to which respondents were asked to express their agreement or disagreement.

As Table 5.10 shows, a large proportion of the sample — 41 per cent — reported that they felt lonely more often now than when they were younger. This feeling was more common among women (at 49 per cent) than among men (at 32 per cent). At the same time, a very large proportion of the sample — 94 per cent— felt they had family members who cared for them very

much, so that feelings of total disconnection or abandonment by family members seems to be quite exceptional in the sample.

Table 5.10: Feelings of Loneliness and of Being Cared for Among the Over-65s, Classified by Sex

	Male	Female	Total
	Percentages agreeing with statement		
'During the winter. I feel lonely much more often now than I did when I was younger'	32	49	41
There are members of my family who care for me very much'	94	95	94

The percentages in the sample who give some indication of feeling lonely are large in the light of the high levels of social contact examined earlier. It is worth examining further who is likely to have such feelings by means of detailed cross-sectional comparisons. To this end. Table 5.11 shows the results of a regression of a number of independent variables on responses to the statement about loneliness. These results suggest some striking things about patterns of loneliness among older people. The most important is that, among the factors included in the analysis, being widowed has by far the strongest association with feelings of increased loneliness. The widowed who live alone are more prone to increased loneliness than the widowed w ho live with family members. But even the latter, despite being surrounded (as we saw above) by strong social networks — family members, relatives, neighbours and so on — are more likely to experience increased loneliness than those such as the never-married who have much more limited social networks.

Table 5.11: Multiple Regression Analyses of the Correlates of Feelings of Loneliness Among the Over-65s

	Dependent variable
	Responses to statement 'During the winter I feel much more lonely now than I did when younger' (Scale: 4 — strongly agree. 1 — strongly disagree)
Independent variables:	Standardised regression coefficients
Contact with relatives:	-
Visits to	-
Visits from	-
Telephone contact	-
Marital/residential status:	
Married	r
Never married	-
Widowed, living alone	.26**
Widowed, living with family	.11**
Health:	
Illness (Yes=1)	-.08*
Functional Capacity Index	-
Subjective health rating	.16**
Living standards:	
Ability to make ends meet	-
Deprivation index	-
Gender (Female=1)	—
Age	-
Urban/rural (Rural=1)	-.06*
Social class:	
Upper prof/managerial	r
Other non-manual	-
Skilled manual	-
SemiVunskilled	-
Unknown	-
R^2	16%
df	854

r = reference category; — non-significant coefficient
**p <.O5 **p<.01 ***p<.001*

The importance of widowhood in giving rise to loneliness serves to remind us again that the *quantity* of social contact may have little bearing on loneliness. A single strong bond, such as that between wife and husband.

can be more important than a multiplicity of weaker ones. The breaking of such a bond by the death of one partner may therefore be very hard to compensate for in other social relationships. At the same time, we should not leap to unwarranted conclusions from the link between widowhood and loneliness suggested by the data above. For one thing, the measure of loneliness we use is a relative one which compares present state with that in earlier life. The widowed may be lonelier than they were in their younger days, but that is not necessarily to say that they would rank high on any absolute scale of loneliness or that they are seriously demoralised by loneliness.

Furthermore, widowhood may stand out as a predictor of loneliness simply because it is so easy to measure. Other forms of isolation from others may have equally strong effects but may be much harder to pinpoint. For example. Dean *et al.* (1990). who attempted a more discriminating measurement of social support, found that low support from a spouse who was still present had a more depressing effect on elderly persons than widowhood. Likewise, it appeared that those who never had any children were less likely to be depressed than those whose children had little contact with them. In a similar way. a sense of loneliness may be determined as much by the inadequacy of relationships in which older people are involved as by the complete absence of relationships in the first place. The complex interactions between expectations, habit and what is available to older people are very difficult to measure and make it hard to isolate any simple set of factors which could be clearly identified as primary contributors to whatever degree of loneliness is common among older people.

Apart from the effect of widowhood, an increased sense of loneliness seems to be completely unrelated to levels of contact with family members. The variables which refer to level of contact with relatives show no links with loneliness, while the never-married are no more prone to loneliness than the currently married. Poor health, as measured by the respondents subjective assessment, also contributes to feelings of increased loneliness, but functional disability, which as noted earlier has a considerable inhibiting effect on social interaction, does not seem to have any direct effect on loneliness. Neither does gender have any direct effect: Table 5.10 above pointed to a higher incidence of loneliness among women, but this can be explained as the indirect consequence of the higher incidence of widowhood (and to a much lesser extent of poor health) among women. Living in an

urban area has a slight moderating effect on feelings of increased loneliness but the effect is very slight. The final point to note about the results in Table 5.11 is that the variance explained by the independent variables included in the analysis is only 16 per cent, which means that there is a great deal of additional variations across social groups and personality types which we have not accounted for here.

Physical dependence

A different but equally important aspect of social relationships among older people is the extent to which those relationships provide essential supports to older people in the event of illness or infirmity. The role of social networks in providing care for older people has given rise to enormous interest in social gerontology on the 'care-giving burden" and on the strains that burden places on family members — and the family members involved are usually female, and most commonly the daughters of older people (see *O'Connoxetal.* 1988, O'Connor and Ruddle 1988 and Blackwelle/o/. 1992 for studies of this issue in Ireland).

Table 5.12: Dependence on Physical Care or Assistance Among Over-65s, Classified by Age Group and Sex

		Males	Females	Total
Age Group		Percentages requiring care/assistance		
65-69		10	12	11
70-79		13	23	18
80+		34	45	40
All ages	%	16	24	21
	(N)	(66)	(116)	(182)

Table 5.12 shows that just about one in five (21 per cent) of respondents in the 1993 survey depend on others for some form of physical help or care. The percentage of those aged over 80 who require care is especially high (at 40 per cent). In both the 70-79 and 80 plus age groups, women are more likely to require care then men.

This estimate of the proportion of over-65s who have at least some physical dependency is very similar to that arrived at by O'Connor *et al.* (1988) in the mid-1980s, who put that proportion at 19.4 per cent. Likewise, the pattern of increase in dependency with age and of higher dependency levels among women than among men is broadly similar to that found by O'Connor *et al.*

Table 5.13: Relationship Between Over-65s Receiving Care and Principal Carers

Relationship of carer to person receiving care	Per cent	
Carers living with person receiving care:		**50**
Wife	17	
Husband	5	
Daughter	8	
Son	1	
Daughter-in-law	2	
Brother/sister		
Others		
Carers living in separate household:		
(a) *Relatives:*		**37**
Daughter	13	
Son	6	
Daughter-in-law	8	
Other relatives	10	
(b) *Non-relatives*		**9**
Female neighbour	6	
Paid home help	3	
TOTAL %	100	
(N)	(187)	

The relationship between carers and old people receiving care is a major influence both on how it is perceived by the old person and the degree of strain or burden it causes the carer. Carers who live in the same household as the person they care for often get on less well with that person and feel more strain than carers who are neighbours or friends. This, however, may well be due to the more intense level of care given by carers who live in the older person's household (O'Connor and Ruddle 1988. p. 54). Table 5.13 shows the relationship between the over-65s receiving care and their principal carers in the 1993 survey (given the small sample of persons receiving care in the 1993 survey — 187 cases — the percentages in this

table should be taken as very approximate indicators). The wives of elderly men accounted for 17 per cent of carers, but daughters were the most common category. Daughters who live with their cared-for parent, together with those who live elsewhere, made up 21 per cent of carers, while daughters-in-law accounted for a further 14 per cent. These three groups of female relatives — wives, daughters and daughters-in-law — accounted for half of the carers, while the corresponding male relatives — husbands and sons (no sons-in-law were reported as carers) — accounted for 11 per cent.

The pattern of relationships with carers described in Table 5.13 differs from that described by O'Connor *el al.* (1988. p. 34) for the mid-1980s in that a smaller proportion live with the cared-for person (50 per cent in the present case as opposed to almost 75 per cent in the mid-1980s) and a higher proportion are non-relatives (nine per cent in the present survey as opposed to 2.5 per cent in the mid-1980s). Some of this difference may be due to sampling variability in the two surveys, but it may also reflect a slight move away from relatives and a larger move away from in-house relatives as providers of care. It is clear, however, that relatives, and especially female relatives, remain by far the biggest source of care for those non-institutionalised older people who have physical infirmities.

Conclusion

This chapter has examined various aspects of the social networks of older people, referring especially to family networks. A brief review of background demographic patterns suggested that most older people in Ireland today should have very large numbers of relatives. The combination of high fertility, low childhood and early adult mortality and declining emigration during the family formation stages of the life cycles of the present elderly produce the necessary conditions for large kin networks, not only by present-day standards but also by historical standards in western countries. The data from the 1993 survey confirmed this expectation: most respondents had large numbers of children, grandchildren and siblings, most of them still living in Ireland if not in the immediate local area. The majority of them also had regular contact with their relatives, as well as with neighbours and friends. Older Irish people are also much less likely to live alone than is the norm for other western countries, though the incidence of living alone among older Irish people has increased very rapidly in recent years.

While older Irish people in general have large, active kin networks, the minority who never married are in a different position. This minority is quite large by international standards as a result of the high rates of non-marriage which characterised Irish demographic patterns from the 1930s to the 1950s (that is. the period in which the present elderly were in their prime marriageable years). The never-married elderly have much fewer relatives on average, and they are more likely to live alone and to have little or no contact with other family members. However, the risk of social isolation is still a minority experience even for the single elderly, since the majority maintain regular contact with friends and neighbours, as well as. to some extent, with relatives.

With the partial exception of the never-married, levels of contact with relatives, neighbours and friends was high throughout the sample. However, illness and disability reduced levels of contact: these impediments reduced the capacity of older people to move out to visit others and did not elicit any compensating increase either in visits from others or in telephone contact.

Some indication of the significance of social networks for older people is given by the link, or rather lack of a link, between social networks and feelings of loneliness among older people. The widowed, and especially the widowed living alone, were more prone to loneliness than other groups in the sample. Otherwise, however, indicators of social interaction such as household composition, the size of social networks and the level of participation in social activities seemed to have no bearing on feelings of loneliness. There is. therefore, no straightforward connection between social contact and feelings of loneliness, a finding which will be confirmed further when we consider patterns of vulnerability to psychological distress in Chapter Eight below.

Social networks, especially within the family, are undoubtedly important as sources of care and support for older people who are physically dependent. Over one in five of the sample required care or assistance with day-to-day activities, a proportion which rose to 40 per cent among those aged over 80. Nine out of 10 carers were relatives, with half of the carers accounted for by three groups of female relatives (wives, daughters and daughters-in-law).

CHAPTER SIX

Incomes of the Elderly

Introduction

Although questions of income maintenance did not fall within the terms of reference of the Working Party on Services for the Elderly, its 1988 report — *The Years Ahead* — states that 'it cannot be emphasised too much that an adequate income is a prerequisite for an independent, healthy and enjoyable old age'. While some questions on income were included in the 1993 survey, the main source of data used to explore the subject in this chapter is the 1987 ESRI Survey of Poverty, Income Distribution and Usage of State Services. In general, more recently collected survey information is preferable to a dataset which is several years old. However, collecting good quality data on incomes poses formidable problems of cost and logistics which relatively few surveys are in a position to tackle in a satisfactory way. This is because the household is generally accepted to be the appropriate unit of analysis in relation to income and the household may have a large number of members, each of whom may have multiple sources of income. A complex and exhaustive inquiry is thus needed if a truly comprehensive base of information is to be established.

The 1987 ESRI Survey of Poverty, Income Distribution and Usage of State Services gathered a wide range of information for a sample of 3,300 households which contained over 8,000 adults. In addition to a questionnaire which dealt with the household as a unit, it also administered an individual questionnaire to each household member aged 15 or over and not in full-time education. Key strengths which this dataset can offer to a study of the elderly are, first, that it measures incomes, living standards and deprivation with great accuracy. Second, it offers comparative data on the elderly and non-elderly groups within the population. Third, it allows each elderly person to be viewed within the context of his or her wider household situation. These are strengths which it was not feasible to replicate in the

context of the 1993 survey in which information on income is, by comparison, quite limited. This chapter begins by presenting the 1993 data on levels and sources of income among the elderly in Ireland and then turns to an examination of the more detailed picture presented by the 1987 data. It concludes by commenting on some of the key findings and on the possibilities for further development of some of the conceptual tools with which these findings were generated.

Elderly People's Incomes —1993 Survey

In this section the information on elderly incomes collected in the 1993 survey is presented. Although this information is less detailed and quantified than that collected in 1987. it is more up-to-date and also serves the function of providing part of the set of independent variables that will be used in multivariate analyses of health status indices in Chaper Eight. Apart from a global estimate of household income and a rating of the household's ability to make ends meet on its current income by the elderly respondent, it does not attempt to take in the whole household of the elderly person. Instead the unit it deals with is the elderly person plus his or her spouse where he or she is present: this is referred to below as "the elderly household sub-unit". Here presentation begins with the information that relates to the whole household.

The elderly respondent's assessment of his or her household's difficulty in making ends meet on its current income is set out in Table 6.1. Here a degree of difficulty is reported in close to half of the households and difficulty is most commonly reported in other type households — i.e. other than single person or married couple only types — living in urban areas.

In the survey the elderly respondent was presented with nine income bands and asked to indicate into which of these his or her household's total disposable income fell. Table 6.2 classifies responses to this question by type of household and area. Differences in household size have to be taken into account in analysing household income data since an income adequate to the needs of a small household may be inadequate to those of a larger one. This is done by using equivalence scales which convert each household to a common basis, usually, by convention, to the equivalent of a single adult or a married couple. In the ESRI Survey of Poverty, Income Distribution and Usage of State Services, for example, three such scales were applied.

Table 6.1: Elderly Respondents' Assessment of Households' Ability to Make Ends Meet on Current Income by Type of Household and Area

Ability to make ends meet on current income	Urban Areas				Rural Areas				All Areas			
	Single Person	Married Couple	Other Type	All Households	Single Person	Married Couple	Other Type	All Households	Single Person	Married Couple	Other Type	All Households
	Per cent											
With great difficulty	1.9	2.2	**4.4**	2.8	3.0	3.7	5.2	4.1	2.4	2.9	**4.8**	3.4
With some difficulty	**8.4**	13.7	21.3	14.2	16.3	13.4	18.0	16.2	12.3	13.7	19.1	15.3
With a little difficulty	33.8	25.9	30.1	30.1	23.7	31.3	23.2	25.7	29.1	28.9	26.0	27.9
Fairly easily	41.6	40.3	31.6	38.0	43.7	40.3	41.8	41.9	42.5	40.1	38.2	40.2
Easily	11.7	14.4	**8.8**	11.7	11.1	9.0	9.8	9.9	11.3	11.6	**9.3**	10.6
Very easily	22.6	**3.6**	**3.7**	3.3	2.2	2.2	2.1	2.2	2.4	2.9	**2.7**	2.7
Total	100	100	100	100	100	100	100	100	100	100	100	100

Table 6.2: Band of Household Net Income Reported by Elderly Respondents by Type of Household and Area

Weekly Disposable Income Band	Urban Areas				Rural Areas				All Areas			
	Single Person	Married Couple	Other Type	All Households	Single Person	Married Couple	Other Type	All Households	Single Person	Married Couple	Other Type	All Households
	Per cent											
Less than £50	1.3	-	0.8	0.7	3.8	0.8	1.1	1.8	2.8	0.4	1.0	1.4
£51-100	72.5	9.7	21.1	36.0	82.0	18.3	16.1	36.8	76.8	13.8	17.9	36.1
£101-200	19.5	68.7	45.3	43.6	9.8	69.5	55.2	45.7	14.7	69.5	51.5	44.9
£201-300	4.7	16.4	18.8	12.9	3.8	8.4	19.5	11.4	4.2	12.3	18.9	12.0
£301-400	1.3	1.5	4.7	2.4	0.8	3.1	4.6	3.0	1.1	2.2	4.6	2.7
£401-500	0.7	0.7	5.5	2.2	-	-	1.7	0.7	0.4	0.4	3.3	1.4
£501-600	-	0.7	1.6	0.7	-	-	1.1	0.5	-	0.4	1.6	0.7
over £600	-	2.2	2.3	1.5	-	-	0.6	0.2	-	1.1	1.3	0.8
Total	100	100	100	100	100	100	100	100	100	100	100	100

Each of the scales takes a value of one for a single-person household, or for the first adult in larger households with the following values for additional members:

Scale A: 0.7 for other adults, and 0.5 for children. This is a scale that has recently been used to make cross-national comparisons of poverty in the European Union.

Scale B: 0.6 for other adults and 0.4 for children. This is close to the scale implicit in UK rates of income support (formerly supplementary benefit) and is widely used in studies of poverty there.

Scale C: 0.66 for adults and 0.33 for children. This is close to the scale implicit in rates of unemployment assistance in Ireland, when child benefit payments are also taken into account.

Converting bands of incomes requires an assumption such as the setting of the incomes of all the households in a band equal to the band's middle value. Table 6.3 presents the original income band indications as well as equivalence scale adjustments made subject to this assumption. The adjusted distributions produced by this procedure are similar to one another.

Table 6.3: Household Net Income Band Reported by Elderly Respondents: Unadjusted and Adjusted for Household Size Using Different Equivalence Scales

Weekly Disposable Income Band*	Per Cent			
	Unadjusted	Scale A	Scale B	Scale C
Less than £50	1.4	15.6	13.8	13.6
£51-100	36.4	66.5	68.1	68.4
£101-200	45.3	13.9	13.5	14.1
£201-300	12.1	3.3	3.9	3.3
£301-400	2.7	0.5	0.5	0.5
£401-500	1.4	0.2	0.2	2.2
£501-600	0.7	-	-	-

** The bands £601 - 1,000 and £1,001 or more have been excluded. There were no cases in the latter band: the fonner contained less than one per cent of cases in the unadjusted distribution.*

Table 6.4: Household Net Income Band Adjusted on the Basis of Band Middle Point Values Using Equivalence Scale C (1,0.66,0.33)

Equivalent Weekly Income Band	Urban Areas				Rural Areas				All Areas			
	Single Person	Married Couple	Other Types	All Households	Single Person	Married Couple	Other Types	All Households	Single Person	Married Couple	Other Types	All Households
Less than £50	1.3	9.9	23.2	10.9	3.8	19.1	23.7	16.2	2.8	14.3	23.1	13.6
£51-100	72.5	70.2	55.2	66.4	82.0	69.5	60.7	69.8	76.8	70.3	58.7	68.4
£101-200	19.5	15.3	18.4	17.8	9.8	**8.4**	13.3	10.8	14.7	11.7	15.5	14.2
£201-300	4.7	3.8	2.4	3.7	3.8	3.1	2.3	3.0	4.2	**3.4**	2.3	3.3
£301-400	1.3	0.8	-	0.7	0.8	-	-	-	1.1	**0.4**	-	0.5
£401-500	0.7	-	0.8	0.5	-	-	-	-	0.4	-	0.3	0.2

Table 6.5: Bands of Disposable Income of Elderly Sub-Units by Type of Household and Area

Weekly Disposable Income Band	Urban Areas				Rural Areas				AHAreas			
	Single Person	Married Couple	Other Types	All Types	Single Person	Married Couple	Other Types	All Types	Single Person	Married Couple	Other Types	All Types
Less than £25	-	-	0.8	0.2	1.5	-	2.7	1.6	1.1	-	1.9	1.0
£26-£50	2.7	1.5	1.5	2.0	4.6	3.1	6.0	4.7	3.6	2.3	4.1	3.4
£51-£75	63.9	4.6	49.2	40.3	70.2	7.6	53.3	44.8	66.9	6.4	51.6	42.7
£76-£100	12.2	5.4	5.4	7.9	13.0	9.2	12.1	11.5	12.5	7.5	9.8	10.0
£101-£150	13.6	49.2	26.9	29.2	6.9	64.9	16.5	27.9	10.3	57.0	20.6	28.4
£151-£250	5.4	27.7	11.5	14.5	2.3	9.2	7.1	6.3	3.9	18.1	8.9	10.1
£251-£350	2.0	6.9	3.1	3.9	1.5	4.6	-	1.8	1.8	5.7	1.3	2.8
More than £351	-	4.6	1.5	2.0	-	1.5	2.2	1.4	-	3.0	1.9	1.6

Table 6.4 breaks down the band of Scale C household equivalent income by type of household and by area. Such band distributions and breakdowns could only be interpreted with extreme caution given the assumptions that have had to be made to generate them. They do. however, provide a means of introducing income level variation into the analysis of health status indices which will be carried out in Chapter Eight.

Turning to the elderly household sub-unit, as defined above, the 1993 survey contained information on the variety of sources from which income is received, the most important of these sources and the band into which the sub-unit's disposable income falls. Tables setting out this information can be found in Appendix C at the end of this report. There. Tables C.7 to C.9 break down the variety of sources of income reported for each of the three household types. Within each household type there is a breakdown by recipient's sex and - in the case of one person and couple households - a breakdown by area as well. Tables CIO to C.12 provide the same set of breakdowns for the most important source of income. When the range of income sources is examined, state pensions emerge as by far the most commonly reported one. Among the other sources, occupational pensions are the next most commonly received: these are much more common in the case of urban residents than of rural ones. The most significant non-pension source of income is agriculture: a quarter of elderly males in rural single person households report receipt of this source of income.

When the most important source of income becomes the focus the picture is again dominated by state pensions, although the dominance is somewhat less for men than for women. Non-state pensions are the most important source of income for a sizeable group of elderly urban males and work, or more specifically agriculture, is the principal income source for a sizeable group of elderly rural males.

Finally, in Table 6.5. the bands into which the elderly sub-unit's total disposable income fell are broken down by type of household and area. For couples the figure is calculated on the basis of the combined middle values of the bands indicated for the respondent and for his or her spouse. Close to half of all sub-units are found in the £51-£75 weekly band: breakdown by type shows this concentration to be the product of single person and other type of household sub-units. The largest concentration (57 per cent) of married couple sub-units is found in the £101-£150 weekly band.

Support from the social welfare system for the income of the elderly is next examined. Table 6.6 sets out for 12 categories of social welfare payment the reported pattern of receipt among elderly sub-units, distinguishing between the cases of one and two person sub-units. By far the most important benefits are non-contributory old age pensions and contributory old age pensions.

Table 6.6: Receipt of Social Welfare Payment by Composition of Household Elderly Sub-Unit

Social Welfare Payment	(a) Lone Elderly Person	(b) Respondent and Spouse		
		Respondent	Spouse	Both
	Per cent			
Non-Contributory Old Age Pension	36.0	15.7	9.0	13.7
Contributory Old Age pension	30.9	32.9	10.5	13.0
State Retirement Pension	4.1	4.0	1.5	0.7
Non-Contributory Widow's Pension	4.3	—	—	—
Contributory Widow's Pension	7.5	—	—	—
Carer's Allowance	-	0.2	-	-
Disability/Invalidity Benefit	0.8	1.0	2.0	-
Blind Person	-	-	-	-
Unemployment Benefit/Assistance	-	-	-	-
Disabled Person's Maintenance Allowance	0.8	0.7	0.2	0.2
Supplementary Welfare	-	0.2	-	-
Other	2.2	2.0	-	-

Table 6.7: Concessionary Scheme Take-up by Type of Household and Area

Scheme	Urban Areas				Rural Areas				All Areas			
	Single Person	Married Couple	Other Types	All Types	Single Person	Married Couple	Other Types	All Types	Single Person	Married Couple	Other Types	All Types
Free Electricity:												
Receiving	81.6	64.7	27.9	59.0	88.0	75.4	19.6	55.5	84.7	70.0	23.0	57.2
Not eligible	14.5	31.7	69.9	37.7	10.5	23.9	78.4	43.0	12.5	27.8	74.9	40.0
Free Solid Fuel:												
Receiving	51.7	25.2	20.0	32.9	65.2	45.9	13.5	38.0	58.5	34.8	15.9	35.4
Not eligible	37.7	69.1	75.6	60.0	24.4	50.4	82.9	56.4	31.1	60.1	80.2	58.2
Free Transport:												
Receiving	90.1	89.9	85.3	88.5	88.1	88.6	70.6	80.9	89.3	89.1	76.4	84.4
Not eligible	7.2	5.8	11.0	8.0	5.2	6.1	19.6	11.5	6.2	6.2	16.4	10.0
Free/reduced TV Licence:												
Receiving	80.1	64.5	30.9	59.3	85.9	72.9	20.1	54.5	83.0	68.7	24.8	57.0
Not eligible	13.9	31.2	66.2	36.2	11.1	25.6	74.7	42.0	12.5	28.4	71.0	39.2
Free Telephone Rental:												
Receiving	64.9	25.7	13.4	35.9	66.7	36.4	9.0	33.8	65.4	30.5	11.0	34.5
Not eligible	15.9	69.1	76.9	52.5	12.9	50.8	77.2	50.8	14.3	59.9	77.1	51.6

In addition to social welfare cash payments, the state targets a range of concessionary schemes - relating to electricity, solid fuel, public transport, television licences and telephone rental - at the elderly population. While these schemes do not provide money income, they can be regarded as increasing the discretionary element of elderly people "s incomes by creating the possibility of or increasing the income available for other types of expenditure. Those in receipt of the schemes or indicating that they believe themselves to be ineligible for them comprise over 90 per cent of respondents in all but one case - that of free telephone rental where 12 per cent indicate that they do not want or need the service. Focusing on the schemes' recipients and ineligibles. Table 6.7 provides breakdowns of the take-up patterns of the concessionary schemes by type of household and area. Here the low level of receipt reported by other types of household is striking and this raises the question of whether the current design of these schemes may be excluding a significant number of elderly people with younger co-resident carers.

Differences between the universal or targeted nature of schemes appear to be responsible for the overall level of take-up with targeted scheme benefits being received far more commonly in single person households. Free transport may be. as will be seen in the next chapter, a purely theoretical benefit for elderly people who live in areas where public transport services are sparse or inaccessible. From the 1993 data on elderly incomes we now turn to that collected as part of the 1987 ESRI Survey of Poverty. Income Distribution and Usage of State Services.

Information from the 1987 ESRI Survey

Very detailed information on the income of respondents from various income sources was gathered by the 1987 ESRI Survey of Poverty. Income Distribution and Usage of State Services. This covered income from employment or self-employment (where the latter term is broadly defined to include employers), rent, interest and dividends, private sick pay and pensions, social welfare pensions and other regular receipts such as transfers from other households.

For most income sources information was gathered, first of all. on the amount currently received. For employment income, private pensions, sick pay and social welfare receipts, that is generally the amount received last

week (or fortnight, month etc.. if paid on that basis). For certain income sources which are variable by nature the survey followed the Household Budget Survey and most other surveys in looking for receipts over a longer period, in order to obtain a more reliable estimate of the usual level of income than the receipts in the particular week before the survey would give. Thus, for rent, interest and dividend income, the amounts received over the past year were asked. For non-farm self-employment income the most recent 12-month period for which respondents have information was asked. For farm income the approach adopted was to collect as much information on output and costs directly from the farmer or farm operator as was possible. Farms were classified into a number of "cells" according to farm size, soil type and farm system: this enabled information supplied by An Foras Talúntais (AFT) - now Teagasc - for the average figures on similar farms in their National Farm Survey to be used to estimate those elements of output and cost on which information could not be directly collected. Where income over longer periods of time was asked about, current income was estimated as the weekly equivalent of the amounts received over these periods (for further details, see Callan *et al.* 1989).

Because of the diverse ways in which households containing elderly people are composed, it has not been possible to accommodate them in a satisfactory way within one typology. Instead two typologies of households will be used to examine the survey's data on the incomes of the elderly. The first. Family Type, is essentially a classification centred on the head of household. It encompasses all private households - and not just those containing elderly people - and has five categories:

- family with children under 16 and no elderly:
- household with HOH aged 65 to 74:
- household with HOH aged 75 or over:
- household headed by an under 65 with elderly:
- household without children under 16 or elderly.

The second. Composition of Households containing Elderly, is centred on an age group distinction between elderly (65 or over), adults (14 to 64) and children (under 14). Its categories are:

- elderly person alone:

- 2 or more elderly people;
- 1 or more elderly, 1 adult, no children;
- 1 or more elderly, 2 adults, no children;
- 1 or more elderly, 1 or more adults, with children.

How these two variables stratify the households containing elderly people in the sample is shown in Table 6.8. A couple of points are noteworthy here. First, the great majority of private households in which elderly people are found are headed by an elderly person. Second, where a household contains a combination of elderly and adult persons but no children, an elderly person is head of household in three out of four instances. Where children are added to the elderly and adult combination, however, an adult heads the household in three out of four instances.

Table 6.8: Crosstabulation of Composition of Households Containing Elderly with Family Type, ESRI Survey of Lifestyles and the Usage of State Services

Household Composition	Household with head aged 65-74	Household with head aged 75 or over	Household headed by an under 65 with elderly	Total
Elderly Person Alone	21.5	11.7		33.2
Two or More Elderly People	10.3	8.0		18.3
One or More Elderly. 1 Adult, No Children	13.0	4.5	5.5	23.0
1 or More Elderly, 2 Adults, No Children	10.5	2.5	4.0	17.0
One or More Elderly, 1 or More Adults, with Children	1.8	0.5	6.2	8.6
Total	57.1	27.2	15.7	100.0

Looking first at sources of income, breakdowns of the contributions of different income sources to average weekly disposable household income are given in Table 6.9 by Family Type and in Table 6.10 by Composition of Households containing Elderly.

Table 6.9 shows that social welfare system payments account for 55 per cent of the average weekly disposable income of a household whose head

is 75 or over, 43 per cent of that of a household whose head is aged between 65 and 74 and 26 per cent of that of a household with an elderly member or members whose head is aged less than 65. Occupational pensions contribute their highest percentage of average household income where the head is aged 65 to 74 (15 per cent). For households with a head aged 75 or over their contribution is 13 per cent and for households with an elderly member or members whose head is aged less than 65 they contribute 3.5 per cent. Farming income is proportionately a much more important source of income for the latter category of household than it is for any of the other categories. It should be noted that the data collected refer to the calendar year 1986 and have to be interpreted with some caution as 'this year was a distinct low point for farm incomes* (Callan, *et al.* 1989, p. 49).

Table 6.9: Average Weekly Disposable Household Income by Family Type

Source of Income	Type of Household					
	Family with children under 16 and no elderly	HOH aged 65 to 74	HOH aged 75 or over	Household headed by an under 65 with elderly	Household without children under 16 or elderly	All types
Employment	129.09	28.53	20.09	94.18	136.81	106.06
Non-Farm Self-Employment	30.52	8.62	2.43	13.01	29.29	23.87
Self-Employed Farming	10.17	11.67	6.01	52.77	15.13	13.43
Occupational Pension	0.53	20.01	15.28	8.67	3.61	5.69
Social Welfare Pension	1.00	49.24	58.58	41.69	5.27	15.88
Other Social Welfare	39.01	8.17	4.66	23.48	22.17	25.85
Rent, Interest, Dividends	3.52	7.69	6.20	12.35	6.26	5.58
Other	1.76	0.93	0.84	0.89	2.16	1.65
Total Income	215.41	134.76	114.11	246.34	220.31	198.06

Note: Social welfare pension payments to households which do not contain elderly people are either Contributory Widow's Pension or Non-Contributory Widow's Pension.

When income source composition is broken down by Composition of Households containing Elderly (Table 6.10). what is most striking is the overwhelming reliance of all elderly households on pension income. Whether they consist of one or more persons, these households on average derive 85 per cent of their income from social welfare payments or occupational pensions. Reliance on the social welfare system is greatest among the elderly living alone: all elderly households with more than one person get 23 per cent of average income from occupational pensions compared with 17 per cent for lone elderly households. With households in which there are elderly and adults, the occupational pension plus social welfare payment contribution represent 48 per cent of the total where there is one adult and no children and 38 per cent where there is an elderly, adult and child combination. An association between a relatively high proportion of farm income and a mixed age household composition is again noticeable.

Table 6.10: Average Weekly Disposable Household Income by Composition of Households Containing Elderly

Source of Income	Composition of Households Containing Elderly People					
	Elderly person alone	Two or people	1 or more children	1 or more elderly, 2 or adult no children	1 or more elderly. 1 or adult children	All types
Employment	2.11	2.07	32.59	117.22	94.60	106.06
Non-Farm Self-Employment	0.57	1.15	11.91	19.22	14.39	23.87
Self-Employed Farming	2.67	3.97	23.63	38.51	35.21	13.43
Occupational Pension	11.43	27.48	16.31	19.23	12.87	5.69
Social Welfare Pension	43.57	71.82	49.07	45.02	47.44	15.88
Other Social Welfare	0.93	1.18	10.58	22.32	33.66	25.85
Rent, Interest, Dividends	4.07	9.65	12.75	8.61	5.94	5.58
Other	0.69	0.10	0.59	2.85	0.39	1.65
Total Income	66.06	117.42	157.23	272.50	244.08	198.06

Table 6.11: Household Disposable Income Decile by Family Type

Gross Disposable Household Income	Type of Household					
	Family with children under 16 and no elderly	HOHaged 65 to 74	HOHaged 75 or over	Household headed by an under 65 with elderly	Household without children under 16 or elderly	All Types
	Per cent					
Bottom	3	20	19	2	14	10
2	4	21	19	7	11	10
3	9	14	24	8	6	10
4	11	10	14	6	8	10
5	13	7	5	8	9	10
6	13	6	8	17	8	10
7	13	7	4	14	8	10
8	12	5	2	12	11	10
9	12	5	2	11	11	10
Top	10	4	2	15	15	10
Total	100	100	100	100	100	100

Turning from sources to levels of income. Tables 6.11 and 6.12 present the decile distribution of gross disposable household income broken down in the first table by Family Type and in the second by Composition of Households containing Elderly. In comparing income levels across households, an adjustment is made to take account of differences in needs arising from variations in household size and composition. Details of the three equivalence scales used to make this adjustment in the analysis of the Survey of Poverty. Income Distribution and Usage of State Services data were also given earlier. Tables 6.13 and 6.14 present the income decile distributions which result from the application of equivalence scale C (i.e., head of household = 1. each additional adult = 0.66 and each child = 0.33). In these tables, equivalent income deciles are broken down by Family Type and by Composition of Households containing Elderly.

Table 6.12: Household Disposable Income Decile by Composition of Households Containing Elderly

Gross Disposable Household Income	Composition of Households Containing Elderly People					
	Elderly person alone	Two or more elderly people	1 or more elderly, 1 adult, no children	1 or more elderly. 2 or more adults, no children	1 or more elderly. 1 or more adults, with children	All Types
	Per cent					
Bottom	43	4	**6**	**3**	3	**17**
2	41	8	10	**3**	3	**18**
3	6	45	**21**	**3**	4	**16**
4	6	21	**14**	**7**	5	11
5	1	8	**14**	**8**	5	**7**
6	1	6	**14**	**13**	14	**8**
7	0	4	11	**14**	20	**8**
8	1	2	**5**	**15**	14	**5**
9	-	3	**1**	**16**	20	**5**
Top	-	-	**4**	**18**	11	**5**
Total	100	100	100	100	100	100

Comparing the distributions before and after the introduction of the equivalence scale, it is clear that the effect of the scale is to disperse the concentration of elderly-headed households and households consisting of a lone elderly person at the bottom of the distributions. The upward movement is predominantly short range in character. After the equivalence scales have been applied, 60 per cent of households with a head aged 65 to 74 and 64 per cent of households with a head aged 75 or over are to be found in the bottom five deciles. After adjustment for equivalence, all types of households containing elderly people are over-represented in the bottom half of the distribution, although the over-representation is concentrated in deciles 3, 4 and 5 and there is under-representation of the aggregation of these types of household in the bottom two deciles. Exceptions to this pattern occur in the case of categories 1 or more elderly, 1 adult, no children and 1 or more elderly, 1 or more adults, with children. Both of these are over-represented in the bottom equivalent decile.

Table 6.13: Disposable Household Equivalent Income Decile by Family Type

Equivalent Disposable Household Income	Type of Household: Family with children under 16 and no elderly	HOH aged 65 to 74	HOH aged 75 or over	Household headed by an under 65 with elderly	Household without children under 16 or elderly	All Types
	Per Cent					
Bottom	13	7	3	9	10	10
2	14	6	3	6	8	10
3	8	12	20	11	9	10
4	7	20	23	10	5	10
5	9	15	15	11	7	10
6	11	12	9	10	8	10
7	12	9	7	14	8	10
8	9	7	12	15	13	10
9	10	8	5	7	13	10
Top	7	4	3	9	19	10
Total	100	100	100	100	100	100

Table 6.14: Disposable Household Equivalent Income Decile by Composition of Households Containing Elderly

Equivalent Disposable Household Income	Composition of Households Containing Elderly People: Elderly person alone	Two or more elderly people	1 or more elderly. 1 adult, no children	1 or more elderly. 2 or more adults, no children	1 or more elderly. 1 or more adults, with children	All Types
Bottom	2	4	11	7	12	6
2	5	5	4	5	9	5
3	31	3	6	5	14	14
4	22	32	16	9	12	19
5	12	27	12	9	12	14
6	12	10	10	9	14	11
7	2	5	12	19	15	9
8	8	6	15	12	6	10
9	3	5	9	15	4	7
Top	3	3	5	9	4	5
Total	100	100	100	100	100	100

From the equivalent income distributions a series of relative poverty lines set at 40 per cent, 50 per cent and 60 per cent of the average household income were calculated by the Survey of Poverty, Income Distribution and Usage of State Services analysts (see Callan *et al.* 1989, Chapter Five for details of the methodology). The 'risk' of poverty for any group is defined in this analysis as the probability of falling below a poverty line faced by the members of that group, as measured by the proportion of that group that actually falls below the income standard. Risks of poverty for the 40 per cent, 50 per cent and 60 per cent relative poverty lines with equivalence scale C adjustment of household income are broken down by Family Type and Composition of Households containing Elderly in Tables 6.15 and 6.16.

Table 6.15: Risks of Property for Different Family Types with Equivalence Scale C

Family Type	Percentage Risk		
	40% Line	50% Line	60% Line
Family with Children Under 16 and No Elderly	7.4	22.2	33.8
Head of Household Aged 65-74	6.7	11.3	24.5
Head of Household Aged 75 or Over	3.7	5.4	22.0
Household Headed by an Under 65 with Elderly	12.9	16.5	27.3
Household Without Children Under 15 or Elderly	7.5	15.6	28.3
All Households	7.3	16.9	29.5

Table 6.16: Risk of Proverty for Different Composition of Households Containing Elderly with Equivalence Scale C

Family Type	Percentage Risk		
	40% Line	50% Line	60% Line
Elderly Person Alone	1.7	4.2	31.1
Two or More Elderly People	5.8	7.4	12.2
1 or More Elderly, 1 Adult, No Children	13.6	18.2	24.9
1 or More Elderly, 2 or More Adults, No Childen	5.8	12.0	19.0
1 or More Elderly, 1 or More Adults with Children	13.5	18.3	32.9
All Types Containing Elderly People	6.8	10.5	24.3

The family type breakdown shows households headed by or containing an elderly member at somewhat lower 'risk' of poverty at the 50 and 60 per cent lines than households in general. Among the family types with elderly, HOH aged 75 or over is consistently at lower risk than the HOH aged 65-74 or household headed by an under 65 with elderly. This latter group is at noticeably higher 'risk' of poverty than households in general at the 40 per cent line.

When the breakdown by composition of households containing elderly is examined, the sharp rise in the risk of poverty among the elderly living alone at the 60 per cent line is striking, as are the consistently high risk at all three lines of the 1 or more elderly, 1 adult, no children and the 1 or more elderly, 1 or more adults, with children categories (which are likely to contain a substantial proportion of households in which there is significant informal care provision).

Conclusion

There is general agreement that incomes of older people have improved significantly over the past two decades. One of the outstanding positive achievements of Irish social policy, this has been due to state transfers of both cash and services, initiated in particular during the 1970s, and also to improved and more widely available occupational pension schemes.

In relation to ongoing policy development, however, a general lack of information on differences in income within the elderly population, a tendency to treat old people as a homogeneous group and the lack of any recent initiatives addressed to sub-groups of the elderly population have been noted by O'Shea (1993), who comments that:

> The worry is that the needs of those old people (admittedly a minority) who continue to live in absolute poverty may be overlooked in the light of the common perception that old people are now relatively well off (O'Shea 1993, p. 39)

The examination of the 1993 and 1987 data carried out above has documented significant sub-group variation in mix of income sources, in levels of gross or equivalent income levels and in the 'risk' of poverty among Ireland's elderly population. Within an overall context of primary reliance on state pension provision, elderly men report a more diversified

income base than elderly women thanks to occupational pension entitlements, which are most commonly possessed in urban areas, and to agricultural self-employment's exemption from a rigid retirement age regime. When the distribution of gross household income is considered, a concentration of elderly-headed households and households consisting of a lone elderly person towards the bottom end of the distribution is apparent. Introduction of equivalence adjustments has the effect of dispersing this concentration. The upward movement is predominantly short range in character, however, so that all types of households containing elderly people remain over-represented in the bottom half of the equivalent income distribution. Moreover, multi-generational households with elderly members continue to be over-represented in the bottom equivalent income decile. When relative poverty lines are introduced into the analysis, multi-generational households with elderly members are a high risk group at all three of the line settings used, while a setting of the poverty line at 60 per cent of the average household income produces a sharp rise in the risk of poverty among the elderly living alone.

This chapter can thus claim to have made a contribution to widening the base of data available on the incomes of elderly people in Ireland even if. within the present context of a broad overview of a multiplicity of issues, this contribution is necessarily a modest one. It is striking that although a wide variety of topics has been explored using the large ESRI Survey of Poverty, Income Distribution and Usage of State Services database (see Nolan and Callan, 1994) for an overview of this body of work), the situation of elderly people has not to date served as a central focus for analysis. This critical gap in research comprehensiveness, and some questionable tendencies in recent social policy commentaries to which it is linked, will be returned to in Chapter Nine. The present chapter concludes by placing the income concept that has been used, and the analytical tools with which that concept has been operationalised. in context. Here there are three important points to be borne in mind.

The first point is analogous to one made in the Introduction to this report - that our data deal with the survivors in the older age group and so provide no information on the characteristics of those who have already succumbed to death. For elderly people, risk of poverty should be viewed alongside another risk of social marginalisation. that of living in an institutional rather than a private household setting. The significance of this risk of

institutionalisation for elderly people is referred to in passing when, discussing the population representativeness of the 1987 ESRI Survey of Poverty. Income Distribution and Usage of State Services database, Callan *et al.* (1989) note that the ESRI sample contains a lower proportion of those aged 75 and over than the Census and attribute this discrepancy to:

> the fact that the sample refers only to those in private households while the Census refers of course to the entire population. Since a relatively high proportion of the elderly are in institutions, the private household population has a significantly lower proportion of this age group than does the population as a whole (Callan *et al.* 1989. p. 45).

An estimate of how the elderly population was distributed across private and non-private households at the time of the 1986 Census — incorporating need for, and mode of provision of, care — has been made by O'Shea *et al.* (1991). This is reproduced in Table 6.17. Second, there is the issue of the provision of informal care — an issue of particular importance in the case of households containing elderly people, as Table 6.17 shows, but one by no means confined to such households — and whether such provision should and could be taken into account in constructing equivalence scales. In principle there is no reason why information on whether or not households are involved in caring for special needs should be excluded. The function of equivalence scales is after all to permit comparison of households of different composition. Moreover:

> Although there is an extensive research literature on the topic internationally, no entirely satisfactory method for estimating or deriving equivalence scales has been identified: as the Canadian statistical office recently concluded "the construction of equivalence scales is, however, an unsettled matter, depending on judgements of an essentially arbitrary character.' (Callan and Nolan 1994, p. 19)

Two studies related to the costs of children provide pointers to how the accommodation of the costs of the informal care of the elderly by equivalence scales might be approached. One is concerned with children in general and with the derivation of equivalence scales which reflect the actual patterns of costs concerned and the welfare implications of these costs at different household income levels (Conniffe and Keogh 1988). The other is concerned with disabled children and with registering, outside the formalised framework of equivalence scaling, the full range of costs

associated with their care within households (Baldwin 1985). However, a constraint faced by any attempt to develop such scales is that work on the costs of informal caring for the elderly in Ireland (such as Blackwell *et ai,* 1992) has to date concentrated on the income side, and the way in which opportunities for paid work have been forgone by carers, leaving additional costs incurred on the expenditure side by households providing care relatively unexplored.

Table 6.17: Estimated Distribution of the 1986 Elderly Population (65 and Over) by Location in Private or Non-Private Households

Location	Population Aged 65+	Percentage of all Aged 65+
Private Households:		
Receiving Care at Home	68,190	17.74
Independent of Carer	283.310	73.71
Total in Private Households	351,500	91.45
Non-Private Households:		
Long-stay Geriatric Units (ex District)	16.034	4.17
Psychiatric Hospitals and Hostels	4.926	1.28
Acute Hospitals (ex District)	4.590	1.19
District Hospitals	1.450	0.38
Other Non-Private Households	5.860	1.53
Total in Non-Private Households	32.860	8.55
Total Population Aged 65+	384.360	100.00

Source: O'Shea etal. (1991, Table 3.7)

Finally, it is generally acknowledged that while current income - the focus of this chapter - is an important determinant of a household's standard of living and quality of living, it is certainly not the sole factor involved. Income-based analysis needs to be supplemented by. and possibly combined with analyses of households' standards of living and quality of life by direct measures of households' activities, possessions and positive or negative experiences of the social environments in which they live. Such supplementation will be provided in the next chapter.

CHAPTER SEVEN

Living Circumstances of the Elderly

Introduction

A recent study of Irish health beliefs and practices found that people saw good food as the major source of good health. The principal cause of illness was unhealthy food, due to preservatives or processing of one sort or another. Physical exercise and sufficient rest were also seen as conducive to physical well-being but the stress and anxiety generated by the pace of life today was viewed as a major contributor to illness. Lack of exercise and environmental pollution were also seen as playing a negative role. Older respondents placed particular emphasis on worry, stress and an immoderate lifestyle (McCluskey 1989. pp. 9. 121).

In McCluskey`s findings the quality of the physical and social environment interleaves with an individual's behaviour pattern to constitute a complex conception of how state of health is determined, in which notions of heredity and innate constitution also play a role. Consciousness of the importance of quality of life for welfare and well-being conceived in a broad sense has been a feature of Irish social research into the circumstances of elderly people. The quality of elderly peoplės physical and social environment was quite extensively explored by the 1977 Survey of the Elderly and this inquiry was repeated in 1993.

Interplay between prevailing standards in the surrounding social environment and behaviour stemming from individual tastes is also central to the attempt currently being made in the field of poverty research to broaden the measurements made beyond the traditional base of income data which was examined in the last chapter and to bring in non-monetary indicators of deprivation. Income tells us only part of the deprivation story because — as Callan. Nolan and Whelan (1994) point out — some people have access to other resources, such as savings or family support, that enable

them to smooth out the effects that income fluctuations would otherwise have on consumption and living standards. At the same time other people, far from having such resources, may have accumulated debts that mean that the impact of income fluctuations are immediate and unavoidable, if not actually magnified. To complement and supplement information on income, researchers have sought to devise means of identifying situations where the lack of what are socially perceived to be necessities springs from a lack of resources on the part of a household. A range of indicators of such deprivation were included in the 1987 ESRI Poverty Survey.

This chapter draws together these three sources of information on the styles of living and levels of amenity enjoyed by the elderly in Ireland. Changes over time in the circumstances of the elderly are examined through the data from the 1993 and 1977 surveys. Contrasts and similarities between the elderly and non-elderly sections of the population are traced by drawing on the 1987 data.

1993 and 1977 Findings Compared

In this section comparison of the situations of the elderly at the two timepoints of 1977 and 1993 are made in relation to the following features of the physical and social environment: neighbourhood conditions, public transport, hazards, housing and household amenities. In both surveys the interviewers who carried out the fieldwork were asked to rate conditions in the respondents" neighbourhoods under the headings of appearance of neighbourhood, prevailing condition of roads and footpaths, and prevailing condition of other properties. These ratings are subjective but they help tap into certain intangible qualities of the social environment. It would, for example, be widely accepted that while the replacement of old areas of sub-standard housing with newly-built stock normally produces a clear improvement in amenities like an indoor toilet or an unshared bathroom, it may also result in the loss of a valued way of life and of close ties defining and binding together a community. The headings under which the interviewers rated the neighbourhoods in which they carried out interviews are proxy measures of the local environment's less tangible, yet vitally important, qualities. Broken down by area and by household type, the full ratings can be found at the end of the report in Tables C.I3 to C.15 of Appendix C. Comparing the 1993 and 1977 assessments a clear pattern

emerges whereby the interviewers were more favourably impressed in 1993 than they had been in 1977 under all three supplied headings. Overall, the most positive rating category for appearance of neighbourhood was chosen in 56 per cent of 1993 cases compared with 38 per cent of 1977 ones. For prevailing condition of roads and footpaths the most positive rating category was up from 47 to 57 per cent and for prevailing condition of other properties the same category rose from 46 to 66 per cent.

Usage of. and satisfaction with, public transport is considered next. The 1993 question on usage differed from that asked in 1977 in that, while both surveys asked, ·do you use public transport for most of the journeys you make?', the 1977 response categories were "yes' and "no" while those in 1993 were 'yes", "no — available but don't use it" and 'none available". The question on satisfaction and the response categories for it were the same on both occasions. Table 7.1 provides details of the responses to the public transport questions broken down by area and household type.

Taking all households in all areas, the proportion using public transport for most journeys has dropped from 46 per cent to 36 per cent between the two dates. A quarter of the respondents report that there is no public transport available to them and. as might be expected, there is a sharp urban/rural contrast here. Unavailability is reported by less than two per cent of urban respondents and by almost 50 per cent of rural ones. How· access to and primary reliance on public transport is related to access to or ownership of private cars in 1993 or in 1977 is explored in Table 7.2: perhaps the most striking figure here is the 23 per cent of rural respondents who live in households without cars and have no access to public transport.

Changes in the extent to which the hazards of burglary, vandalism, assault and danger from traffic impinge on elderly people are shown in Tables 7.3 and 7.4. Taking all areas, the figure for those who have never experienced burglary has fallen from 96 per cent in 1977 to 86 per cent in 1993. In urban areas 10 per cent of the elderly respondents have personally experienced burglary within the last three years whereas in 1977 the corresponding figure was three per cent. Experience of burglary remains less common in rural areas but it is as common there now as it was in urban areas in 1977. The proportion of elderly people for whom burglary is at least ·a bit of a problem" has doubled in the 16 year period between the surveys from 12 per cent to 25 per cent. In urban areas almost 40 per cent of elderly respondents express this concern.

Table 7.1: Percentage of Respondents Who Use Public Transport for Most of the Journeys They Make, Together with Reported Satisfaction with Public Transport Classified by Area and Type of Household for 1993 and 1977

	Urban				Rural				All Areas			
	Single Person	Married Couple	Other Type	All Households	Single Person	Married Couple	Other Type	All Households	Single Person	Married Couple	Other Type	All Households
1993												
Percentage of respondents who use public transport for most journeys	51.9	60.0	57.7	56 4	20.1	21.1	11.4	16.8	36.9	41.3	30.4	35.8
Satisfaction with Public Transport:												
Very Satisfied	39.6	39.5	42.6	40.5	22.0	25.4	26.6	25.0	34.1	34.7	36.2	35.1
Fairly Satisfied	46.5	46.5	45.9	4 6 3	49.2	50.8	51.1	50.5	47.3	48.0	47.7	47.7
Fairly Dissatisfied	9.7	10.9	8 2	9,6	13.6	14.3	14.9	14.4	11.2	11.7	11.0	11.0
Very Dissatisfied	4.2	3.1	3.3	3.5	15.3	9.5	7.4	10.2	7.3	5.6	5.0	6.0
1977												
Percentage of respondents who use public transport for most journeys	73.1	71.3	63.1	66.3	37.8	38.0	30.3	32.3	55.9	53.0	42.3	45.8
Satisfaction with Public Transport:												
Very Satisfied	49.4	48.6	47.6	48,1	27.8	32.4	31.5	31.2	39.1	39.8	37.3	37.9
Fairly Satisfied	31.6	27.3	34.9	33.0	37.5	35.8	36.2	36.3	34.4	31.9	35.9	35.1
Fairly Dissatisfied	8.9	9.9	9.5	9.4	16.7	13.8	20.6	19.2	12.6	12.0	16.4	15.2
Very Dissatisfied	10.1	14.3	8.0	9.5	18.1	17.9	11.8	13.3	13.9	16.3	10.4	11.7

Table 7.2: Elderly Respondents' Usage of Public Transport for Most Journeys by Household Possession of a Car or Cars for 1993 and 1977

	1993			1977		
	All	Urban	Rural	All	Urban	Rural
	Per Cent					
No car, uses public transport for most journeys	22.8	37.4	9.0	34.4	53.0	23.0
No car, public transport available but don't use it for most journeys	16.0	19.1	12.7	25.5	19.9	29.1
No car, no public transport available	12.0	0.9	22.7			
Household has car, uses public transport for most journeys	13.1	19.1	7.9	11.8	13.4	10.8
Household has car, public transport is available but don't use it for most journeys	22.8	23.3	22.5	28.4	13.8	37.1
Household has car, no public transport available	13.3	0.2	25.3			
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table 7.3: Elderly Respondents' Evaluation and Experience of Hazards of Burglary and Vandalism Classified by Area and Sex in 1993 and 1977

	Hazard	Urban Areas			Rural Areas			All Areas		
		Males	Females	All Persons	Males	Females	All Persons	Males	Females	All Persons
		Per Cent								
1993	*Burglary:*									
	Very much a problem	11.4	10.7	11.0	1.7	3.5	2.6	6.0	7.1	6.6
	A bit of a problem	2.9	26.3	27.9	11.3	8.7	10.0	19.3	17.7	18.5
	Not much of a problem	23.9	24.3	24.1	15.6	15.3	15.4	19.3	19.8	19.6
	No problem	34.8	38.7	37.0	71.4	72.5	72.0	55.5	55.3	55.4
	Experienced in last three years	9.1	9.7	9.5	3.4	4.3	3.9	5.9	7.2	6.6
	Experienced more than three years ago	10.2	9.7	9.9	4.3	4.3	4.3	6.9	7.0	6.9
	Never experienced	80.6	80.6	80.6	92.2	91.3	91.8	87.2	85.8	86.5
1977	*Burglary:*									
	Very much a problem	10.5	8.3	9.0	0.0	1.2	0.6	3.2	4.3	3.8
	A bit of a problem	16.5	15.1	15.6	4.6	5.0	4.8	8.2	9.4	8.9
	Not much of a problem	12.7	16.8	15.4	8.7	7.7	8.2	9.9	11.8	11.0
	No problem	60.3	59.8	60.0	86.6	86.1	86.3	78.6	74.6	76.3
	Experienced in last three years	3.4	3.0	3.1	0.9	0.3	0.5	1.6	1.4	1.5
	Experienced more than three years ago	4.8	4.2	4.4	0.2	0.9	0.6	1.6	2.3	2.0
	Never experienced	91.8	92.9	92.5	98.9	98.8	98.9	96.8	96.2	96.5
1993	*Vandalism:*									
	Very much a problem	10.9	6.2	8.2	0.0	1.3	0.7	4.8	3.8	4.2
	A bit of a problem	21.2	24.4	23.0	6.5	3.5	5.0	12.9	14.2	13.6
	Not much of a problem	29.3	26.9	27.9	16.0	13.5	14.8	21.7	20.3	20.9
	No problem	38.6	42.6	40.8	77.5	81.7	79.6	60.7	61.7	61.2
	Experienced in last three years	9.7	4.9	7.0	2.2	2.6	2.4	5.4	3.9	4.6
	Experienced more than three years ago	7.0	4.9	5.8	3.9	3.0	3.5	5.2	3.9	4.5
	Never experienced	83.3	90.2	87.2	94.0	94.4	94.2	89.4	92.1	90.8
1977	*Vandalism:*									
	Very much a problem	10.7	8.0	8.9	0.4	1.2	0.8	3.5	4.2	3.9
	A bit of a problem	21.3	15.8	17.6	3.8	3.3	3.6	9.2	8.7	8.9
	Not much of a problem	12.2	15.2	14.2	6.5	7.2	6.9	8.2	10.8	9.7
	No problem	55.8	61.0	59.3	89.3	88.2	88.7	79.1	76.3	77.5
	Experienced in last three years	6.6	5.7	6.0	0.4	1.1	0.8	2.3	3.1	2.8
	Experienced more than three years ago	2.1	1.0	1.4	0.6	0.3	0.5	1.0	0.6	0.8
	Never experienced	91.3	93.3	92.6	99.0	98.6	98.8	96.7	96.3	96.4

Table 7.4: Elderly Respondents' Evaluation and Experience of the Hazards Assault/Mugging and Traffic Classified by Area and Sex in 1993 and 1977

	Hazard	Urban Areas			Rural Areas			All Areas		
		Malos	Fomalos	All Persons	Males	Females	All Persons	Males	Females	All Persons
		Per Cent								
1993	*Assault/Mugging:*									
	Very much a problem	5.4	3.7	4.4	0.0	0.9	0.4	2.4	2.3	2.3
	A bit of a problem	16.2	15.7	15.9	3.5	0.0	1.7	9.0	7.9	8.5
	Not much of a problem	27.6	30.2	29.0	10.0	12.2	11.1	17.6	21.3	19.6
	No problem	50.8	50.4	50.6	86.6	86.9	86.7	71.0	68.4	69.6
	Experienced in last three years	2.2	2.0	2.1	0.4	0.4	0.4	1.2	1.4	1.3
	Experienced more than three years ago	4.3	4.5	4.4	2.2	2.6	2.4	3.1	3.7	3.4
	Never experienced	93.5	93.5	93.5	97.4	97.0	97.2	95.7	94.8	95.3
1977	*Assault/Mugging:*									
	Very much a problem	3.8	3.8	3.8	0.2	1.2	0.8	1.3	2.3	1.9
	A bit of a problem	9.9	6.7	7.8	1.5	1.5	1.5	4.0	3.8	3.9
	Not much of a problem	19.3	17.5	18.1	6.5	6.1	6.3	10.4	11.2	10.8
	No problem	66.9	72.0	70.3	91.8	91.1	91.5	84.2	82.7	83.3
	Experienced in last three years	1.7	1.0	1.2	0.0	0.0	0.0	0.5	0.4	0.3
	Experienced more than three years ago	0.0	0.2	0.1	0.2	0.5	0.3	0.2	0.3	0.3
	Never experienced	98.3	98.8	98.7	99.8	99.5	99.7	99.3	99.2	99.3
1993	*Danger from Traffic:*									
	Very much a problem	8.1	16.9	13.1	3.5	3.5	3.5	5.5	10.3	8.0
	A bit of a problem	23.2	19.8	21.3	4.3	9.2	6.8	12.6	14.6	13.7
	Not much of a problem	20.0	21.2	20.6	10.4	8.3	9.4	14.5	14.9	14.7
	No problem	48.6	42.1	45.0	81.7	79.0	80.4	67.4	60.3	63.6
	Experienced in last three years	2.7	0.8	1.6	0.0	0.0	0.0	1.2	0.4	0.8
	Experienced more than three years ago	4.8	4.5	4.6	0.9	2.2	1.5	2.6	3.5	3.1
	Never experienced	92.5	94.7	93.8	99.1	97.8	98.5	96.2	96.1	96.1
1977	*Danger from Traffic:*									
	Very much a problem	9.2	8.3	8.6	0.9	1.0	1.0	3.4	4.2	3.9
	A bit of a problem	14.7	12.8	13.4	4.8	4.8	4.8	7.8	8.3	8.1
	Not much of a problem	15.4	14.3	14.6	7.1	7.2	7.2	9.7	10.4	10.1
	No problem	60.7	64.7	63.3	87.2	87.0	87.1	79.1	77.2	78.0
	Experienced in last three years	0.4	0.3	0.4	0.4	0.0	0.2	0.4	0.1	0.3
	Experienced more than three years ago	1.6	2.8	2.4	1.1	0.2	0.6	1.2	1.3	1.3
	Never experienced	98.0	96.8	97.2	98.5	99.8	99.2	98.3	98.5	98.4

The experience of vandalism, and its perception as a cause for concern, has also risen over the period though not quite as steeply as in the case of burglary. Levels of experience and concern differ between urban and rural areas but in each case a rising trend is common to both. From a hazard experienced by less than one per cent in 1977. assault/mugging is reported by almost five per cent of respondents in 1993. The proportion of respondents seeing it as at least "a bit of a problem' has almost doubled in urban areas over the period to stand at almost 20 per cent. Concern remains low in rural areas, with two per cent perceiving assault/mugging as at least "a bit of a problem", the divergence with regard to the concern being much greater than that relating to experience (2.8 per cent in rural areas compared with 6.5 per cent in urban ones). In line with the trends relating to other hazards, the experience of being a traffic accident victim and the perception of traffic as being at least "a bit of a problem" have become more common over the period. Elderly urban males have most experience of being accident victims but concern with traffic dangers is highest among elderly urban females, close to 40 per cent of whom rate it as being at least "a bit of a problem".

Related to this set of issues and included for the first time in the 1993 survey were questions on having experienced "any act of physical violence to yourself* and on having been "regularly insulted, sworn at or threatened in any way". The first of these questions had "since turning 65" as its temporal frame of reference: for the second this frame was "over the past year". In each case, between one and two per cent of respondents reported having had the experience asked about.

The 1993 survey collected less detail in relation to housing than its 1977 predecessor. Housing issues covered by both surveys include tenure, satisfaction with size of dwelling, overall satisfaction with accommodation and desire to move. Table 7.5 sets out the details.

Between the two dates, outright ownership of the dwelling has increased substantially: the percentage of respondents who are in the process of purchasing has risen in urban areas but fallen (against a background of 90 per cent outright ownership) in rural ones. Public authority and private tenancy proportions have both fallen and elderly people living alone in urban areas now stand out as being particularly over-represented among those who rent in a way they did not in 1977.

Table 7.5: Housing Tenure, Satlslfaction with Present Accommodation and Willingness to Move Classified by Type of Household and Area for 1993 and 1977

	Housing Variable	Urhnn Aroas				Rural Aroas				All Areas			
		Single Person	Married Couple	Othor Type	All House-holds	Single Person	Married Couple	Other Type	All House-holds	Single Person	Married Couple	Other Type	All House-holds
		Per Cent											
1993	*Tenure:*												
	Owned outright	69.3	78.3	68.6	72.2	93.9	96.3	84.5	90.7	81.1	87.3	78.0	81.8
	Loan/mortgage being repaid	6.4	15.9	19.7	13.7	0.0	0.7	5.2	2.4	3.4	8.3	11.3	7.9
	Rented from public authority	15.4	5.1	8.0	9.7	3.8	2.2	5.2	3.9	10.0	3.6	6.3	6.6
	Rented from private landlord	7.7	0.7	2.2	3.7	2.3	0.0	3.6	2.2	5.2	0.4	3.0	2.9
	Rent free	0.6	0.0	1.5	0.7	0.0	0.7	1.5	0.9	0.3	0.4	1.5	0.8
1977	*Tenure:*												
	Owned outright	42.5	52.5	50.8	48.5	70.3	79.8	84.2	81.6	55.8	67.6	71.6	68.3
	Loan/mortgage being repaid	7.5	10.7	21.6	16.8	10.8	7.1	8.0	8.3	9.1	8.6	13.0	11.7
	Rented from public authority	21.3	18.3	18.7	19.2	9.5	2.6	6.4	6.4	15.6	9.3	10.9	11.5
	Rented from private landlord	18.8	16.1	8.9	12.0	5.4	5.1	0.6	1.8	12.3	9.7	3.6	5.9
	Rent free	10.0	2.4	1.2	3.4	4.1	5.4	0.9	1.9	7.1	4.8	1.0	2.5
1993	*Satisfaction with Size of Dwelling:*												
	Far too small	0.6	0.0	2.2	0.9	0.7	0.0	4.1	1.9	0.7	0.0	3.3	1.4
	Rather too small	0.6	1.4	3.7	1.9	3.7	2.2	**7.7**	**5.0**	**2.0**	**1.8**	**6.0**	**3.4**
	About right size	76.9	87.8	88.8	84.1	82.2	89.6	83.1	84.7	79.3	88.8	85.3	84.4
	Rather too big	21.8	10.8	5.2	13.1	13.3	8.2	5.1	8.4	18.0	9.4	5.4	10.7
1977	*Satisfaction with Size of Dwelling:*												
	Far too small	0.0	0.6	3.1	2.1	0.0	2.0	4.5	3.7	0.0	1.0	3.6	2.7
	Rather too small	2.5	4.1	11.6	8.7	4.1	2.3	15.6	12.5	3.2	2.5	13.3	**10.2**
	About right size	70.4	82.3	80.9	79.3	75.7	84.2	76.0	77.2	73.4	83.2	78.6	78.5
	Rather too big	27.2	13.0	4.4	9.9	20.3	11.5	3.9	6.7	23.4	13.3	4.5	8.5

Table 7.5 continued

	Housing Variable	Urban Areas				Rural Areas				All Areas			
		Single Person	Married Couple	Other Type	All House-holds	Single Person	Married Couple	Other Type	All House-holds	Single Person	Married Couple	Other Type	All House-holds
		Per Cent											
1993	*Overall Satisfaction with Accommodation:*												
	Very satisfied	65.6	76.4	55.1	65.8	57.8	67.9	62.6	62.7	62.0	71.9	59.8	64.2
	Fairly satisfied	27.3	20.7	37.5	28.4	32.6	26.1	30.3	29.7	29.8	23.7	33.0	29.1
	Fairly dissatisfied	5.2	2.1	4.4	4.0	8.9	3.7	4.6	5.6	6.8	2.9	4.5	4.7
	Very dissatisfied	1.9	0.7	2.9	1.9	0.7	2.2	2.6	1.9	1.4	1.4	2.7	1.9
1977	*Overall Satisfaction with Accommodation:*												
	Very satisfied	66.7	58.5	65.0	64.1	45.9	44.7	46.7	46.3	57.1	51.4	55.3	55.0
	Fairly satisfied	24.7	31.2	25.8	26.6	36.5	39.7	40.4	39.9	29.9	36.2	33.9	33.7
	Fairly dissatisfied	2.5	3.1	5.6	4.6	6.8	10.6	7.7	8.0	4.5	6.9	6.4	6.2
	Very dissatisfied	6.2	7.3	3.6	4.7	10.8	5.0	5.2	5.7	8.4	5.4	4.4	5.1
1993	*Percentage Who Would Like to Move:*												
	Yes, definitely	4.5	2.9	4.4	3.9	5.2	1.5	3.1	3.2	4.8	2.2	3.6	3.5
	Maybe/it depends	9.0	5.7	6.6	7.2	6.7	1.5	5.1	4.5	7.8	3.6	5.6	5.7
	No	86.5	91.4	89.1	88.9	88.1	97.0	91.8	92.2	87.4	94.2	90.8	90.8
1977	*Percentage Who Would Like to Move:*												
	Yes	8.3	13.0	10.5	10.6	12.5	17.9	12.6	13.4	10.5	15.5	10.8	11.4
	No	91.7	87.0	89.5	89.4	87.5	82.1	87.4	86.6	89.5	84.5	89.2	88.6

Taking all respondents in all areas, satisfaction with dwelling size has risen from 78 to 84 per cent between 1977 and 1993, squeezing both the "far/rather too small" and the 'rather too big' responses. Elderly people living alone contribute disproportionately to the "rather too big" response. Other types of household are over-represented among those who find their accommodation too small. The percentage of respondents who are at least `fairly satisfied" with their accommodation is up from 89 to over 93 per cent. In 1977 the percentage 'very satisfied" was noticeably lower in rural than in urban areas. This gap has now to a great extent closed.

The question eliciting desire to move differed between the two surveys. In 1977 it was: "If suitable accommodation were available would you like to move house?" and had "yes" and "no" response categories. In 1993 it was: "In your present circumstances, given the opportunity, would you like to move house or otherwise change your living arrangements?" and had "yes, definitely", "maybe/it depends* and "no* response categories. In spite of these differences the pattern of responses elicited is very similar with around 90 per cent indicating they would not like to move.

The format of inquiry into possession of household amenities also changed between the surveys. The questions asked in 1993 were influenced by recent developments in research into poverty within the European Union context whose background was described at the beginning of this chapter. In Ireland these were principally embodied in the data on non-monetary indicators of deprivation gathered by the 1987 ESRI Poverty Survey. An inquiry as to whether the respondent had a particular item was linked both in 1987 and in 1993 to whether an item not possessed was desired but not affordable or simply not desired. The 1987 survey is the backdrop against which the 1993 data on the position of the Irish elderly are most usefully viewed. Before turning to the 1987 findings, information on the possession of consumer durables or housing amenities which is common to the 1977 and 1993 surveys is set out in Table 7.6.

For all six items covered in Table 7.6 availability has risen substantially over the 16 years between the surveys. The largest rise relates to the availability of a telephone which is up from less than 20 per cent to 80 per cent. It is noteworthy, however, that a quarter of elderly single person households in both urban and rural areas still do not have a telephone. Elderly single person households in rural areas stand out as a group which lags substantially behind the rest of the elderly population across the range of amenity and durable items.

Table 7.6: Possession of Household Amenities and Consumer Durables Reported by Elderly Respondents In the 1993 and 1977 Surveys Classified by Household Type and Area

	Urban Areas				Rural Areas				All Areas			
	Single Person	Married Couple	Other Type	All House-holds	Single Person	Married Couple	Other Type	All House-holds	Single Person	Married Couple	Other Type	All House-holds
	Per Cent											
1993												
Car	22.7	52.1	55.1	42.6	23.0	59.7	75.8	55.7	23.3	55.4	66.9	49.3
Refrigerator	92.2	98.6	98.5	96.3	91.9	99.3	97.4	96.3	91.8	98.9	97.9	96.2
Washing Machine	64.3	90.6	87.6	80.2	51.1	85.8	80.4	73.4	57.9	88.1	83.3	76.6
Telephone	77.5	92.7	82.2	83.9	74.8	88.0	73.8	78.2	75.8	89.8	77.3	80.6
Bath/Shower	92.9	99.3	97.1	96.3	72.6	94.7	88.2	85.5	83.2	96.7	92.0	90.6
Indoor Toilet	96.8	100.0	99.3	98.6	80.0	95.5	91.2	89.2	88.7	97.8	94.6	93.7
1977												
Car	4.9	23.9	35.7	27.0	6.8	32.8	59.1	48.5	5.8	29.0	50.5	39.8
Refrigerator	46.9	67.0	74.0	66.8	24.3	60.0	67.0	60.0	36.1	63.5	69.7	62.8
Washing Machine	9.9	42.2	49.0	39.9	12.2	28.7	46.0	39.1	11.0	34.5	47.2	39.1
Telephone	28.4	27.7	32.0	30.6	6.8	9.7	11.5	10.6	18.1	17.5	19.1	18.7
Bath/Shower	65.4	73.5	79.5	75.5	25.7	48.7	55.4	50.3	46.5	59.4	64.5	60.6
Indoor Toilet	77.8	86.2	87.1	84.8	31.1	55.8	59.6	55.0	55.5	68.9	69.9	67.2

1993 and 1987 Survey Findings Compared

From the wide range of indicators of style of living explored in the 1987 survey. 10 were identified which met the two criteria of being considered a necessity and of being actually possessed by more than 75 per cent of respondents. This group of indicators is broken down by the two classificatory variables introduced in Chapter Six, Family Type and Composition of Households containing Elderly, at the end of the report in Tables C.I 6 to C.35 of Appendix C. Here the pattern which emerges is one in which the elderly are less well endowed with housing amenities and household durables — refrigerator, washing machine, indoor toilet, bath/shower — than the population as a whole, but do not exhibit a higher level of deprivation with regard to having a dry, damp-free dwelling or to the other five heating, food and clothing indicators which make up the rest of the group. On the housing amenity and household durable indicators, households headed by an elderly person are seen to lag behind when the breakdown is by Family Type.

Thirteen style of living indicators were common to 1987 and 1993 surveys. The trend of change in these indicators between the two dates is shown in Table 7.7. The overall trend across the range of indicators is clearly one of change in a positive direction. In interpreting the details of this table the *caveats* with regard to the comparability of the three surveys contained in the Introduction need to be borne in mind. Two issues of comparability are of particular relevance. First, for 1993 the source of information is always an elderly person but this was not the case for 1987 since all Households containing Elderly as defined in Chapter 6 above are included and some of the heads of these households who supplied the information are under 65 years of age. Second, the urban/rural distinction could not be constructed from the same base for the two datasets and, while they may reasonably be regarded as broadly comparable, there is a degree of discrepancy between them.

As noted earlier the format adopted for collecting information on style of living indicators in the 1987 and 1993 surveys makes it possible to distinguish situations where people don't possess an item and don't want to possess it, from those where people would like to have that item but cannot afford it. In this way it is possible to identify consumption forgone because of f resource constraints from that forgone on the grounds of personal tastes.

Table 7.7: Style of Living Indicator Comparisons Between 1987 and 1993 by Houshoid Types and Area

Indicator	Urban Areas				Rural Areas				All Areas			
	Single Person	Married Couple	Other Type of House-hold	All House-holds	Single Person	Married Couple	Other Type of House-hold	All House-holds	Single Person	Married Couple	Other Type of House-hold	All House-holds
	Per Cent Possessing Item or Answering 'Yes' to Question											
Refrigerator												
1987	76	98	97	89	84	96	93	91	80	97	95	90
1993	92	99	98	96	92	99	97	96	92	99	98	96
Washing Machine												
1987	66	74	83	75	30	60	75	59	45	66	78	65
1993	64	91	88	80	51	86	80	73	58	88	83	77
Telephone												
1987	55	81	65	64	34	56	61	46	43	66	56	53
1993	77	93	82	84	75	88	74	78	76	90	77	81
Week's Annual Holiday Away from Home												
1987	50	39	50	48	11	14	13	12	28	25	26	26
1993	42	60	46	49	30	34	28	30	37	48	35	40
Dry, Damp-free Dwelling												
1987	92	87	95	93	87	97	81	84	89	87	86	87
1993	97	97	97	97	89	95	96	93	93	96	96	95
Indoor Toilet in Dwelling												
1987	98	88	96	95	72	89	91	85	82	89	93	89
1993	97	100	99	99	80	95	91	93	89	98	95	94
Bath or Shower												
1987	81	91	95	89	65	89	88	81	71	90	91	84
1993	93	99	97	96	73	95	88	85	83	97	92	91

Table 7.7 continued

Indicator	Urban Areas				Rural Areas				All Areas			
	Single Person	Married Couple	Other Type of House-hold	All House-holds	Single Person	Married Couple	Other Type of House-hold	All House-holds	Single Person	Married Couple	Other Type of House-hold	All House-holds
	Per Cent Possessing Item or Answering 'Yes' to Question											
Roast Meat Joint Once a Week												
1987	37	85	85	67	55	79	**81**	**73**	**46**	**82**	**82**	70
1993	61	93	90	81	73	90	**91**	**85**	**66**	**92**	**91**	83
Warm Waterproof Overcoat												
1987	97	98	95	96	81	75	**86**	**83**	**88**	**85**	**89**	**88**
1993	96	99	98	98	96	92	**95**	**95**	**96**	**96**	**97**	**96**
Able to Save Some Income Regularly												
1987	65	60	53	59	35	55	**40**	**41**	**48**	**57**	**45**	48
1993	53	66	53	57	54	56	**63**	**58**	**54**	**61**	**59**	58
Presents for Friends or Family Once a Year												
1987	72	82	87	81	54	75	**67**	**64**	**62**	**79**	**74**	**71**
1993	75	89	80	81	71	81	**81**	**78**	**73**	**85**	**81**	**80**
A day 'when you did not have a substantial meal at all... from getting up in the morning until going to bed' in the last two weeks												
1987	2	-	6	3	2	-	**1**	**2**	**2**	**-**	0	**2**
1993	1	1	-	1	2	1	**4**	**3**	**2**	**1**	0	**2**
Ever Had to go Without Heating During the Last Year Through Lack of Money												
1987	2	-	10	4	1	-	**-**	**0.5**	**1**	**-**	**4**	**2**
1993	4	2	2	3	5	**3**	3	**3**	**5**	2	**2**	**3**

The current breakdown of non-possessors between these categories is set out in Table 7.8: indicators with possession levels of over 90 per cent are excluded from this breakdown.

The ability to save regularly is something almost half the respondents report being without and 86 per cent of this group aspire to. Strong aspiration is also found among the smaller numbers who lack an indoor toilet or a bath/shower. Over a quarter of respondents report being unable to afford presents for friends or family once a year and almost two-thirds of this group aspire to have this ability. For all of the other indicators being without an item is not primarily due to inability to afford it for the majority of respondents. It is noteworthy here that although possession of a telephone has risen fairly dramatically among the elderly over the past 16 years not far off half those still without the telephone would like to have but cannot afford it. Yet the data also indicate that where the level of telephone possession is lowest — among single person households in rural areas — there is also the least frustration of a desire to have the facility by lack of resources.

From the deprivation indicators included in the 1993 survey a sub-set has been chosen with which to construct an index of material deprivation which is introduced as an independent variable into the multivariate analyses of health status measures carried out in Chapter Eight below. These items are:

- having had a day without a substantial meal
- having gone without heating for lack of money
- a dry. damp-free dwelling
- an indoor toilet
- a bath or shower
- a roast once a week
- a warm, waterproof overcoat

Table 7.8: Reason for Elderly Respondents' Non-Possession of Style of Living Indicator Items 1993

Item:	Urban Arons				Rural Areas				All Areas			
Would Like, but Can't Afford	Single Person	Married Couples	Other Typo	All House-holds	Single Person	Married Couples	Other Type	All House-holds	Single Person	Married Couples	Other Type	All House-holds
Washing Machine:												
Yes	17.3	30.8	31.3	22.2	21.0	50.0	34.3	29.6	20.7	40.6	32.7	27.0
No	82.7	69.2	68.8	77.8	79.0	50.0	65.7	70.4	79.3	59.4	67.3	73.0
Telephone:												
Yes	18.8	66.7	54.2	38.5	24.1	78.6	50.0	46.2	22.2	75.0	52.0	43.8
No	81.3	33.3	45.8	61.5	75.9	21.4	50.5	53.8	77.8	25.0	48.0	56.2
Week's Holiday:												
Yes	34.9	45.1	50.0	42.7	28.9	41.0	20.3	28.4	32.2	42.6	31.0	34.4
No	65.1	54.9	50.0	57.3	71.1	59.0	79.7	71.6	67.8	57.4	69.0	65.6
Indoor Toilet:												
Yes	-	-	-		73.1	83.3	76.5	75.5	75.0	83.3	77.8	76.8
No	-	-	-		26.9	16.7	23.5	24.5	25.0	16.7	22.2	23.2
Bath/Shower:												
Yes	-	-	-	-	70.6	100.0	77.3	76.2	73.9	88.9	76.9	76.5
No	-	-	-		29.4	_	22.7	23.8	26.1	11.1	23.1	23.5
Roast Meat Joint Once a Week:												
Yes	23.2	50.0	35.7	288	26.5	16.7	41.2	28.6	25.0	31.8	38.7	29.0
No	76.8	50.0	64.3	71.3	**73.5**	83.3	58.8	71.4	**75.0**	**68.2**	61.3	71.0
To be Able to Save Some of One's Income												
Yes	77.3	84.1	85.0	81.8	92.9	92.9	85.3	90.0	84.6	89.0	85.2	86.0
No	22.7	15.9	15.0	18.2	7.1	7.1	14.7	10.0	15.4	11.0	14.8	14.0
Presents for Friends or Family Once a Year:												
Yes	54.3	85.7	60.0	62.2	61.8	87.0	58.8	67.0	58.6	86.5	59.3	65.1
No	45.7	14.3	40.0	37.8	38.2	13.0	41.2	33.0	41.4	13.5	40.7	34.9

Conclusion

This chapter has presented data from three points in time on a range of indicators of style of living. Taking the elderly separately, the trend over nearly 20 years is in broad terms a positive one as regards housing amenities, household durables and measures of heating, food and clothing deprivation. The single elderly living in rural areas are a sub-group who stand out as being relatively deprived in terms of amenities and durables. When the elderly are examined in the context of the society as a whole as regards this range of indicators at one point in time — 1987 — they are seen to lag behind on housing amenity and household durable indicators but not on the heating, food or clothing deprivation ones. The absence of data on the non-elderly population means that it is not possible to say whether this situation has changed in the intervening period.

The great majority of elderly people perceive their present accommodation as being about the right size for their household and only around 10 per cent indicate they would or even might take up the opportunity to change their living arrangements if it were presented to them. Unwillingness to move prevails to a large extent even among those in poor amenity housing, as Table 7.9 shows. Here an index of defective housing is constructed using the (lack of) an indoor toilet, a bath or a shower and a dry. damp-free dwelling indicators from the 1993 survey. Scores on the index range from 0 where none of the defects is present to three where all three are experienced. Even with the higher index scores, only around 20 per cent of respondents indicate a desire or a willingness to consider moving. While the numbers in the sample experiencing defects is quite small, in terms of public policies to eliminate sub-standard housing, this suggests the utility of an approach primarily based on improving existing dwellings rather than their replacement by newly-built stock.

Transport emerges from the survey as an area in which new policy initiatives are needed. In urban areas danger from traffic is now a more widely experienced and perceived hazard for elderly people than used to be the case. Hopefully the Dublin Transportation Initiative will in the near future give impetus to a greatly increased use of traffic calming measures that will enhance the safety and well-being of elderly people in towns and cities. The elderly nominally enjoy the right to free public transport but 50 per cent of those living in rural areas report lack of access to public transport services.

Almost half of this group live in households without a car. Providing reasonable public transport services in sparsely populated areas is not an easy task. However, research suggests that the absence of such services can have serious negative implications for a population's health. To quote a recent study of North-West Connemara. where the proportion of elderly people in the population is particularly high:

> One of the greatest single problems facing the study area is the need to travel to Galway to avail of many basic health care services. This obviously imposes a massive strain on the resources, both of time and money, of poor families. Many families decide to forgo health benefits to which they are entitled because of the need to travel to Galway to take them up. This is clearly a matter that could be addressed by a straightforward policy of decentralising health care provision and providing much better public transport. (Byrne 1992, p. 83)

Table 7.9: Index of Defective Housing by Whether 'in your present circumstances, given the opportunity, (you would) like to move house or otherwise change your living arrangements'

Index of Defective Housing	Desire to Move		
No. of Defects	yes. definitely'or maybeAit-depends	No	Row Total
0	8	92	100
1	10	90	100
2	22	78	100
3	21	78	100

Perhaps the most disquieting aspect of the 1993 survey findings is the increased experience of burglary, vandalism, assault/mugging and traffic accidents, as well as the more common perception of those phenomena as problems, they record. These findings suggest that, in terms of overall well-being, the benefits elderly people derive from the improvements in income support over the past two decades are being offset by insidious processes of community degradation.

CHAPTER EIGHT

Identifying the Elderly at Risk

One of the themes which has recurred in this report has been the diversity of the elderly population on all matters, including health and well-being. Many of the elderly population fare as well under these headings as the general run of younger people and they do better than some. One implication of this diversity is that if many elderly fare quite well, others fare quite badly. From the point of view of policy on health promotion and care for the elderly, it is important that we identify as far as possible who these vulnerable sub-groups of elderly are. The purpose of this chapter is to contribute to this effort by attempting to identify high risk categories in the 1993 sample as far as health and well-being are concerned. It draws on the data outlined in previous chapters in order to isolate those social and personal characteristics which are most effective in predicting poor scores on the key measures of health and well-being applied in the 1993 survey.

A number of preliminary points should be made about this analysis. Firstly, the purpose of the exercise is to identify predictors of poor health and well-being, not to analyse causes. Predictors can be identified simply by establishing correlations between the variable of key interest and whatever background variables may be thought to be linked to it. Causal analysis requires that we establish the cause-effect relationships which underlie correlations, a more complex issue which is beyond the scope of the present report. Our objective, in other words, is to identify *who* is likely to be vulnerable, not to explain *why* they are vulnerable.

A second feature of the analysis arises from the point-in-time nature of the data being analysed. Vulnerability arises not only from present-day circumstances of the groups being examined but also from their life-history backgrounds. For example, some old people may be vulnerable to ill-health because of present-day low income or poor living standards but these may

be less significant than long-term poverty in the past. However, adequate life-history data are hard to generate and the 1993 survey did not venture into that complex area (this issue is discussed further in Chapter One above). The analysis of risk factors here can thus focus only on present characteristics. In consequence, the effectiveness of the variables examined in predicting vulnerability is likely to be limited.

A final preliminary point concerns the kinds of vulnerability which it is possible to examine here. Clearly, as has been mentioned before, the risk of death is the main threat to the well-being of older people. The survey data at our disposal do not record deaths and do not provide any indications on differing levels of vulnerability to death across various social groups in the elderly population. Therefore, this primary form of vulnerability has to be set aside in our analysis. We are limited to what in effect are risks of a secondary kind — illness, psychological distress, and so on — and while these are important in their own right, they amount to a good deal less than a full profile of vulnerability patterns among older Irish people as far as health and well-being are concerned.

Types of Vulnerability Examined

The analysis of vulnerability focuses on three different aspects of health and well-being. The first is health lifestyle, the second is physical health status and the third is psychological well-being.

Health lifestyle (smoking, body mass, exercise, diet, etc.) is usually thought of as a factor which conditions health rather than as a direct component of health. However, the two are so closely connected that the risk of having a poor health lifestyle is worth investigating in its own right as a component of vulnerability among older people. Health lifestyle is measured here by means of the Health Lifestyle Index described in Chapter Three above. This index gives each respondent a score on a composite 6-point scale derived from smoking behaviour, body mass measures and health improvement activities. A high score on this scale indicates a healthy lifestyle as far as the constituent items in the scale are concerned.

Physical health status is measured in two ways, subjective rating of health (scores range from l=very good to 5=very bad) and 7-item FCI index (a high score on this index indicates a high level of functional disability). Both

of these measures have been referred to in some detail in Chapter Three above. A third measure of physical health status, self-reporting of major illness, is used as a predictor of psychological well-being. In general, however, as is mentioned in Chapter Three (see also Appendix B) it seemed not as robust an indicator of health status as the first two just mentioned so it is not examined here as a dependent variable.

Psychological well-being is measured by means of the 12-point GHQ distress scale described in Chapter Four above.

Predictor Variables

The links between these aspects of well-being and such antecedent factors as gender, incomes, household composition and so on are likely to be complicated by the prior linkages among those factors. For example, women may be more prone to psychological distress than men because they are more likely to be widowed or to have a long-standing physical illness rather than because of any inherent psychological difference between the sexes. In order to take account of such possible prior linkages between predictor variables, we need to employ a multivariate analysis, that is. to examine the effect of each predictor variable while simultaneously controlling for the effects of the others. Ordinary least squares regression is the technique we use for this purpose here.

The principal predictor variables used in the following analyses can be grouped together as follows:

- *Incomes and deprivation.* Three separate measures come under this heading. The first is a household income measure, which is composed using the equivalence scales C described in Chapter Seven above. The second is a deprivation index which is a summed scale based on the measures of non-monetary deprivation discussed in Chapter Seven above (the items comprising this index relate to the lack of: regular meals, heat in the winter, a damp-free dwelling, an indoor toilet, a bath or shower, a roast meat joint once a week and a warm overcoat). A high score on this scale indicates a high degree of deprivation. The third measure is a subjective assessment of the difficulty experienced by the household in making ends meet.

- *Social class. A* 5-category occupational class scale, coded by reference to the respondent's principal lifetime occupation or. in the case of women whose principal occupation was in home duties, to their husband's principal lifetime occupation. This scale is treated here as a nominal scale. The "unknown" social class is comprised mainly of unmarried women whose main lifetime occupation was in home duties.

- *Household type.* A 5-category classification based on the categories of household described in Chapter Five above. Single people living alone and widow(er)s living alone are treated as separate categories. All households containing at least a married couple or an elderly parent and one offspring, with or without a third generation, are grouped together as "two or three generation households". Married couple households are included in the regression as the reference category for the series of dummy variables derived from the classification.

- *Social contact and social support.* This heading is represented by three composite indices, each of which are derived from items discussed in Chapter Five above. The "kin contact index" is derived by adding scores for levels of contact with the main categories of respondents" relatives (daughters, sons, grandchildren, siblings and other relatives). The "social life index' is a summed scale based on reported participation in 10 types of social activity (organised sport, card games or bingo, going to pub. senior citizens club, social day centre, adult education/crafts classes, voluntary work/charity, going to Mass/religious services, other religious activity and other activities). The ‘helping index" is a summed scale derived from respondents' reported incidence of giving three kinds of help to others apart from spouses — occasional large gifts, more regular financial or material support, and baby-sitting or other practical help.

- *Age. sex* and *urban-rural location.* Marital status is not included among these socio-demographic predictor variables because it is partially subsumed into the household type variable described above. Separate analyses not reported here show that where household type and marital status showed bivariate links with dependent variables, the marital status relationship was generally absorbed by the household type relationship in multivariate analyses.

Correlates of Weil-Being

We first look at predictors of low scores on the Health Lifestyle Index as a dimension of well-being. We limit our investigation of predictor variables on this item to the principal socio-demographic measures — incomes and deprivation, social class, household type, gender, age and urban-rural location. The results of the relevant regression analysis are presented in Table 8.1. These results show that the combined predictor variables have only weak links with the Health Lifestyle Index — together they account for less than two per cent of the variance in the index. Such links as are present are confined to three of the variables examined — household income, the deprivation index and gender. These suggest that low income and material deprivation are linked to poor health lifestyle and that men in general have poorer health lifestyles than women. In general, however, these associations are not especially strong and it is the overall weakness of links between health lifestyle and the variables examined which is most striking. This lack of association suggests, in other words, that while there is considerable diversity in health lifestyle in the 1993 sample (see Chapter Three above), diversity is common to all the major socio-demographic categories. The poor, particularly poor men. do have a somewhat higher exposure to poor lifestyle but. that limited exception aside, it is difficult to identify any social group among the elderly with a particular vulnerability in this area.

The second aspect of vulnerability we examine is physical health status. Two dependent variables are used for this purpose, subjective rating of health and Functional Capacity Index. The same predictor variables are examined as in the case of the Health Lifestyle Index except that the Health Lifestyle Index is itself included as a predictor variable. As the results of this analysis show (Table 8.2). Health Lifestyle Index correlates quite significantly with both measures of health status — the healthier the lifestyle the lower the morbidity score. There are also some significant differences across certain socio-demographic categories. Self assessment of health shows some social class differences: the working class generally (skilled, semi-skilled and unskilled) report substantially worse self-ratings of health than do the middle and upper classes.

Table 8.1: Correlates of Health Lifestyle Index Scores

Dependent Variable = Health Lifestyle Index	
	Standardised coefficients
Incomes and Deprivation	
1. Household income	.10**
2. Deprivation index	-.08*
3. Ability to make ends meet	-
Social Class: [Reference category: Prof/managerial]	
4. Other non-manual	-
5. Skilled manual	-
6. Semi-skilled or unskilled manual	-
7. Other/unknown	-
Household Type: [Reference category: couple]	
8. Single person living alone	-
9. Widow(er) living alone	-
10. Two/three generations	-
11. Other	-
12. Gender (Female = 1)	.07*
13. Age	-
14. Urban/rural (Urban=1)	-
R^2	1.6°o
df	813

**p <05 **p <01 ***p <001*
- non-significant coefficient.

In addition to this class effect, there is a substantial poverty effect on self-rating of health: those who score high on the deprivation index rate their health lower than the better off. while those who report little difficulty in making ends meet report higher health ratings. It was already pointed out in Chapter Three above that there was a notable lack of association between self-rating of health and either age or gender. This finding is confirmed here since the coefficients for age and gender are not significant.

The socio-demographic correlates of functional incapacity are somewhat different than for self-rated health. For one thing, functional incapacity increases quite sharply with age and is worse for women than for men (this pattern too was noted earlier in Chapter Three). The class effect which was present for self-rating of health disappears with functional incapacity, though the poverty effect remains. There is an interesting relationship with being a member of a two or three generational household: such respondents

in general have a higher risk of functional incapacity. The cause-effect link here is uncertain, but it may be from functional incapacity to living arrangements: those with functional impairments may be more likely to be taken in by their children or to have children live on with them.

Table 8.2: Correlates of Subjective Assessment of Health and Functional Capacity Index Scores

Independent variables	Dependent variables	
	Subjective assessment of health	FCI score
	Standardised regression coefficients	
Incomes and deprivation		
1. Household income	-	-
2. Deprivation index	.13***	.13***
3. Ability to make ends meet	-.11**	-.10**
Social Class: [Ref. category: Prof/ managerial]		
4. Other non-manual	-	-
5. Skilled manual	.15*"	-
6. Semi-skilled or unskilled manual	.15***	-
7. Other/unknown	-	-
Household type: [Ref. cat.: family household]		
8. Single person living alone	-	-
9. Widow(er) living alone	-	-
10. Two/three generations	-	.11"
11. Other	-	-
12. Health Lifestyle Index	-.13***	-.16***
13. Gender (Female=1)	-	.14*"
14. Age	-	.11***
15. Urban/rural (Urban=1) -	-	-
R^2	7%	10%
df		

**p <05 **p<.01 ***p <.001*
- non-significant coefficient.

Taking the two measures of health status together, we get a strong indication of social inequalities in health among older people in Ireland. Material deprivation and perceived difficulty in making ends meet have consistent negative links with poor health. This is particularly so when we recall that low incomes and poor living standards also contribute to poor health lifestyle, so that as well as their direct effects on health status, these factors have indirect effects through the Health Lifestyle Index. Social class

Table 8.3: Correlates of Psychological Distress

Dependent Variable = GHQ distress score	
	Standardised coefficients
Health Status:	
1. Long-standing illness (1 = Yes; 0 = No)	.09*
2. Functional Capacity Index	.20**
3. Subjective assessment of health	.33**
Material Deprivation:	
4. Household income	-
5. Deprivation index	.06*
6. Ability to make ends meet	-
Social Class: [Reference category: Prof./managerial]	
7. Cther non-manual	-
8. Skilled manual	-
9. Semi-skilled or unskilled manual	-
10. Other/unknown	-
Household Type: [Reference cat.: couple]	
11. Single person living alone	-
12. Widow(er) living alone	-
13. Two or three generations	-
14. Other	-
Social Networks and Social Support	
15. Kin contact index	-
16. Social life index	-.08*
17. Helping index	.07*
18. Health Lifestyle Index	-
19. Gender: (Female = 1)	.07*
20. Age	-
21. Urban/rural (Urban=1)	-
R^2	32%
df	806

*P < .05 **p < .01 *** p <001
- non-significant coefficient.

inequalities are also present, though not in as strong or consistent a way: the working class elderly generally have lower self-ratings of health but there are no social class differences in functional capacity. The picture of gender differences is mixed: women are no different from men on self-rating of health but they show a markedly higher risk of functional incapacity.

We now turn to the third dimension of well-being which we wish to examine, psychological well-being as measured by the GHQ psychological distress scale (Table 8.3). In addition to the predictor variables used in the previous analyses, we include here the three variables under the heading "social networks and social support" referred to earlier.

The predictive power of the variables in this instance is a good deal higher than in the previous analyses, since the percentage of variance explained (R^2) is 32 per cent. Most of this predictive power, however, is accounted for by the health status variables, especially subjective assessment of health and the Functional Capacity Index score. These show quite clearly that ill-health and physical impairment are quite strongly linked to psychological distress. The third physical health variable (the presence of a long-standing illness) also has an effect but this is much weaker than for the other two.

The remaining variables emerge as having only a modest or no effect on psychological distress. In particular, there is a striking lack of association between what we might loosely call sociability and psychological distress. This is so. first, in that the type of household one lives in appears to have no bearing on psychological distress, and it is especially notable that those who live alone are no more prone to psychological distress than those in multi-person households. Secondly, the kin contact index, which quantifies the amount of contact respondents have with their relatives, is not significantly linked to psychological distress. This finding is reinforced when we consider that single people living alone, who have very limited kin networks outside the household (Chapter Five above), show no particular signs of psychological distress as a result of that absence. Two of the social contact variables do have effects, though both are weak. The first of these, participation in social activities such as bingo or going to the pub. slightly reduces psychological distress. The second, however, which measures the giving of help by respondents to other family members.

slightly increases psychological distress. This finding flies in the face of the common view that older people's morale is enhanced by enabling them to continue to make practical contributions to the welfare of their children, grandchildren and other family members. Here, we find that the giving of money or time (for babysitting, for example) has no such positive effect. Rather, it seems, as Whelan and Whelan (1988) also report, that such contributions are more likely to represent a burden on older people.

Poverty, as measured by the material deprivation index, has only a slight effect on psychological distress and neither household income nor the subjective assessment of difficulty in making ends meet has any. However, we should remember that material deprivation and low incomes do have a consistent negative effect on health status, so that they contribute indirectly to psychological distress through their link with poor health.

Social class, urban-rural location and age all have non-significant coefficients (and the same was found to be true of marital status in separate analyses not shown here). Gender has a modest effect, in that women have marginally higher distress scores than men. When the relationship between psychological distress on the one hand and age and gender on the other hand was looked at in isolation in Chapter Four above, the links seemed to be strong. However, these can probably be accounted for by the association between these variables and functional incapacity — being a woman and being old sharply increases the risk of functional incapacity and thus increases the risk of psychological distress.

Conclusion

The objective of this chapter was to identify the social categories of older people who are particularly vulnerable to ill-health, disability and poor psychological well-being. The central conclusions from the analysis can be summed up quite easily: the poor are more likely to have bad physical health and the physically unhealthy are more vulnerable to psychological distress. The poor are also slightly more likely to have unhealthy lifestyle characteristics as far as smoking, diet, weight and exercise are concerned. Apart from these associations, very little else matters, or at least matters as much. It is true that women are more likely to suffer loss of functional capacity than men. and problems of functional capacity increase with age. This in turn feeds through to psychological well-being because of the impact

of functional incapacity on psychological distress. Otherwise, however, neither age nor gender have as strong effects on well-being as one might expect. Neither is there a consistent social class effect: working class elderly do report worse self-ratings of health than other social classes, but this social class effect does not recur on any other measures of well-being looked at here.

The apparent lack of vulnerability of certain groups is worth noting. The elderly who live alone, especially the never-married who generally have few relatives, are often thought to be a highly vulnerable category of older people. This may be true in certain ways. For example, because of their lack of family supports, such older people may be less capable of continuing to live in the community when they become ill or physically impaired and so may have a higher risk of being institutionalised. However, as far as the aspects of well-being examined in the present report is concerned, there is no detectable difference between those who live alone and those who live in multi-person households, or between those who never married and those who are either currently married or widowed. This is true not only of physical health but also of psychological well-being. It seems, in fact, that as long as they can continue to live in the community, family networks make relatively little difference to the well-being of the elderly. Those who lack such networks may experience problems if they become physically dependent, but up to that point they make do without them, while those who have them gain less in well-being than we might expect.

CHAPTER NINE

Conclusion

The present report has been concerned mainly with the health and well-being, both physical and psychological, of older people in Ireland and is ultimately geared to identifying ways to enhance these dimensions of older people's lives. Lying in the background is the concern, not just with individual-level problems of ageing for those who are growing old, but also with the societal-level problem of ageing populations. There is an underlying implication in much of the research literature on the elderly in western societies that the ageing of populations is a societal-level problem, and a serious one at that, since it imposes growing burdens on the rest of society — especially on the 'productive' segments on whom the aged are seen to be "dependent", whether for care or economic support.

In this concluding chapter, our aim is to draw out the main findings and policy implications of the study. This requires that we review the profile of health and well-being among the elderly in Ireland, summarise those factors which contribute to vulnerability among older people as far as health and well-being are concerned and draw out the implications for health promotion policy for older people. In addition, we need to recall the distinctive context of ageing in Ireland by reviewing the somewhat exceptional structural characteristics of the elderly population. These affect both the individual and societal-level implications of ageing and so need to be taken into account in considering health promotion policy for this population segment.

Profile of Health and Weil-Being

Mortality

The single most striking health-related aspect of life for older people in Ireland is that, on average, they die relatively young. Life expectancy in Ireland from late middle age onwards is the lowest in the developed world, and indeed is lower than in some intermediate developing countries in Latin America and Asia. At age 65, men in Ireland in 1990 could expect to live a further 13.2 years on average, which was three years less than the corresponding values for the leading countries. Japan and France, and over a year and a half less than the average for 23 OECD countries. Irish women at the same age could expect to live a further 17 years, which was four years less than Japan and France and almost two years below the OECD average. On this basic indicator, therefore, the health of older Irish people is unacceptably poor, since it falls below the standards prevailing in other western countries (some of which, such as Spain and Portugal, are at lower levels of economic development and have less developed health care systems than Ireland).

A further remarkable feature of older-age mortality patterns in Ireland is that, in spite of improvements in living conditions and massive expenditures on health in recent decades, life expectancy for older people has hardly changed since early in the present century. In fact for men. life expectancy at older ages was marginally *lower* in 1986 than in 1926. Older women's life expectancies have improved somewhat over this period, but at a slow rate by international standards. Life expectancy at birth has undoubtedly improved substantially in Ireland (from 58 years in 1926 to about 75 years now), but practically all of this increase has been due to greatly improved survival in childhood and early adulthood rather than to longer life among older people. In fact, mortality among children and young adults in Ireland is quite good by international standards, in that survival rates from birth to age 45 are among the highest in the world. In Ireland today, in other words, people's chances of surviving to middle age are good by international standards and much better than they were in the past, but once they pass middle age. Irish people's survival prospects fall a good deal below the international norm and are little better than they were in Ireland 60 years ago. Insofar as Ireland has a health disadvantage, therefore, it is

concentrated very much on older people rather than being a general feature of the population as a whole.

There is one encouraging aspect to this otherwise unacceptable picture of older people's mortality in Ireland, in that signs of improvement have begun to emerge in the last 10 years. Having been static for decades, mortality among late middle-aged and older men has shown an historically novel improvement from the mid-1980s to the early 1990s. Among older women too. improvement in death rates, which had occurred at a sluggish rate for a number of decades, began to intensify from the early 1980s onwards. These improvements indicate that older-age survival patterns in Ireland may now be coming closer into line with the standards prevailing in other countries. It is too early to say how far this is so. however, since the improvements which have occurred, though important, have not been large enough nor long enough established to lift Ireland off the bottom of the international rankings as far as older age mortality in the developed world is concerned.

Older-age mortality patterns suggest, therefore, that Ireland is a distinctively unhealthy place to be old in. The improving health of younger people which is evident from mortality decline in childhood and early adulthood since the 1940s may eventually translate into improved health among older people as these cohorts enter old age. Some signs of improvement in this direction have emerged among older people in the 1980s. However, the declines in older age mortality in Ireland in the 1980s have not been sufficient to bring older-age longevity patterns in Ireland up to the standards prevailing in other western countries. This clearly is an area which should be of central concern in future research and policy making in Ireland as far as the well-being of older people is concerned.

Physical health status

Turning from overall patterns of mortality to the physical health status of those elderly who are still alive, the 1993 survey data reveal two broad dimensions of health which have different profiles in the elderly population. The first dimension relates to illness and general ill-health. While estimates of *lewis* of morbidity of this kind among older Irish people are sensitive to the measure used, it is clear that even from the broadest measure included in the present study (self-reported major illness), over half of the elderly

population are free of ill-health. Other measures produce an even more positive picture: for example, when asked to rate their general state of health, two-thirds of older people report that their health is good or very good. In general, therefore, the majority of older people are not ill. or at least not to the extent that they consciously feel themselves to be in poor health. A further notable aspect of these indicators is that they suggest considerable uniformity in levels of morbidity across age and sex groups. The general forms of ill-health they refer to seem to arrive at a plateau at or before the age of 65 and that plateau is at more or less the same level for men and for women. After age 65. there may be some worsening in morbidity rates among women but among men morbidity rates remain more or less stable as they age.

The second dimension of health status to emerge from the findings is physical impairment. This is measured by the physical difficulty (or lack of it) respondents might have in performing daily tasks such as washing, dressing, climbing stairs, walking substantial distances, and so on. This dimension differs from the first in that it is quite strongly linked to both age and gender. Only a small majority of the young elderly (those in the late 60s and early 70s) report difficulties in these areas whereas a substantial majority of those aged 80 and over report such difficulties. In addition, women in all age groups fare consistently worse than men on this measure. Thus, while age and sex differences in perceived levels of ·illness" or "ill-health" among older people are relatively weak, the sense of physical capacity — that is. of mobility, agility, stamina and strength in the conduct of day-to-day physical tasks — declines steadily with age and is generally lower for women than for men. It is in this latter sense that declining health status is strongly associated with ageing, though even in the oldest age groups substantial minorities report themselves free of all difficulties even on these items.

Morbidity trends

It is difficult to draw any firm conclusions on the question of trends in morbidity among the elderly in Ireland because valid and reliable trend measures on this question are very hard to devise. Such measures as have been constructed in other countries (limited though they may be) have not been applied consistently in Ireland over any significant period of time.

From the limited evidence on morbidity trends which is available for Ireland since the late 1970s, it appears, first, that certain kinds of medical service utilisation have increased among the elderly in Ireland, and second, that there is no sign of *increase* in morbidity, even if at the same time there is no clear evidence of decrease.

Such a decrease is unlikely to occur in the future either, if the experience of other countries is any guide. Research from countries where older-age life expectancy has improved in recent decades suggests that increases in life expectancy are not necessarily associated with a later onset of illness or disability in older people's lives. The evidence suggests rather that even if older people live longer, they tend to enter ill-health or physical impairment at much the same age as before (or at only a marginally later age). The result is that older people spend longer proportions of their final years in ill-health or disability, and the total sum of morbidity among the elderly population increases. This link between the extension of life expectancy and the increase in older age morbidity has been one of the great sources of strain on the health systems of many developing countries. We should expect, therefore, that if older-age life expectancy increases in Ireland in the years ahead, there will be a corresponding increase in the total incidence of older age morbidity, leading to substantially increased pressures on the Irish health system.

Health lifestyle

The study of trends and patterns in health lifestyle among the elderly in Ireland encounters similar, and perhaps even more acute, difficulty with regard to reliable measures than is the case with morbidity. This is so not only because of widespread inaccuracies in self-reports of things such as weight, smoking and diet, but also because the focus of such research as has been undertaken in the area in the past has been heavily skewed towards the younger and middle-aged groups. Smoking is the only health lifestyle feature among the elderly for which there is useful trend data and here developments are encouraging with falling prevalence among both men and women. Less than a quarter of respondents in the 1993 survey were current smokers, compared to over 30 per cent in the same age group in 1987.

The picture with weight is less optimistic. Among middle-aged Irish people, there is some recent evidence that the problem of obesity is worsening. We

have no similar trend data for the elderly, but the 1993 survey confirms that weight is a problem for older people too. Sightly less than half the 1993 sample had an "acceptable" body-mass index. Even more strikingly, awareness of excess weight was poor: the majority of those classifiable as "overweight" on body-mass index scores considered their weight to be "just about right" and felt that they ate about the right amount of food. Thus older people in Ireland seem to be a good deal more indulgent regarding their own weight than medical science regards as good for their health.

On the other hand, respondents in the 1993 survey did seem to be conscious of the need to do at least something in the direction of healthy lifestyles and showed little evidence of a passive or fatalistic attitude towards their health. This suggests that well-designed and targeted educational initiatives would find a receptive audience in this age group.

Psychological well-being

In a certain sense it might be argued that questions of well-being, whether of the elderly or of any other population segment, depend not so much on objective conditions — standard of living, social contact, physical health, etc. — as on states of mind. Well-being — how one feels about oneself, one's lifestyle, one's relations with others — may be heavily conditioned by surrounding circumstances but is not wholly determined in that way. Therefore measures of psychological well-being become important to assessing how well off the elderly are in Ireland.

The data on psychological well-being examined in this report suggested that old age is not a particularly distressful or unhappy stage of life. Indeed, there are some indications that adults in mid-life may be more likely to suffer psychological distress than those over the age of 65. so that it is a form of negative stereotyping of older people to assume that they are particularly burdened with psychological distress or low morale simply by virtue of being old. Less than one in four of the over-65s in the 1993 sample showed significant signs of psychological distress.

In so far as psychological distress is present in old age. the major contributing factor is not old age itself, nor indeed low standard of living, social isolation or bereavement. Rather, it is physical health status. Poor health and disability are by far the strongest contributors to psychological

distress and low morale among older people in Ireland. This suggests that the crucial transition older people have to face as far as mental well-being is concerned is not ageing *per se* but the transition from health and fitness to illness and disability. That transition is related to but not wholly determined by age. and of course it can and often does occur before the onset of old age. Low incomes, material deprivation and poor health lifestyle show little or no *direct* relationship with psychological distress. But they are as strongly linked to physical health status as age and through that intermediary have a strong indirect bearing on psychological distress.

Physical decline thus emerges as the crucial issue for older people's psychological welfare, thus enhancing the importance of physical health status as the central plank of the good life as far as older people are concerned.

Incomes and living standards

One further important aspect of older people's well-being is their material standard of living. Older people in Ireland have experienced a sharp improvement in their standard of living over the last two decades, a development which is very much in common with patterns among older people in many other western countries in recent times. This improvement is due largely to extended coverage and higher rates of payment in social welfare and occupational pension schemes. There is now a consensus among policy makers that the elderly are no longer at serious risk of poverty, in contrast to the 1970s when the elderly were the largest segment of the poverty population. While accepting much of the central thrust of this consensus. Chapter Six of this report raises some *caveats* about it and points to some uncertainties in the evidence on which it is based. The principal difficulty lies in the way it lumps together all of the elderly as a single category. This simplifying approach glosses over the marked inequalities in income which exist within the elderly population and so possibly glosses over substantial pockets of deprivation within that population segment. In addition, the choice of the equivalence scales used to generate measures of poverty, which is largely an arbitrary matter, has considerable implications for the way the elderly are placed in relation to relative poverty lines. This is especially so. for example, for the 20 per cent or so of the elderly who are in need of at least some degree of physical care. The equivalence scales

used in poverty research in Ireland have not attempted to take account of the special circumstances of this or any other category of older people, so that the validity of those scales has been assumed rather than demonstrated in their case.

Measures of living standards and deprivation based on indicators other than income, as discussed in Chapter Four above, support the view that the material circumstances of older people have generally improved in recent decades. Again, however, this improvement is by no means uniform across categories of older people and it has been counterbalanced for some older people by disimprovement in such environmental factors as crime and vandalism. More detailed research focused specifically on incomes and living standards among older people is needed to paint a clearer picture on all these issues and to establish if the present optimistic consensus on elderly incomes is as justified as it first appears.

Patterns of Vulnerability

In addition to providing a profile of health and well-being, an objective of the present report was to identify those sub-groups of elderly who were particularly vulnerable in those areas. Patterns of vulnerability are revealed only in a limited way by the 1993 survey data. This is so partly because those data focused only on the present. They did not include information on life-history circumstances which may be as important in shaping vulnerability to poor health or psychological distress as present circumstances. More importantly, since the study dealt only with those currently alive and living in the community, it did not extend to an analysis of the differential mortality risks, nor to the risks of institutionalisation. Thus the most basic forms of vulnerability among the elderly were not included in the analysis.

As far as morbidity was concerned, the most consistent risk factors which did emerge from the data were connected with poor standards of living. Poverty, in other words, is the most consistent source of added susceptibility to illness and disability among older people. Being a woman and increasing age also adds significantly to the risk of poor health status, especially as far as functional disabilities are concerned, but those factors are not as consistent as one might expect.

In regard to psychological distress, as already mentioned, physical health status is by far the strongest risk factor identified. No other factors come close to physical health status as a source of vulnerability to psychological distress. On some measures, widowhood, particularly among widows living alone, does lead to some loss of morale, but that influence is neither as severe nor as widespread as the effect of poor health status. Poverty or material deprivation do not seem to be important as *direct* correlates of psychological distress, but they may have considerable indirect link by way of their relationship with poor physical health status.

In general, there is a striking lack of association between social networks or social contact and psychological distress. It is especially notable that single elderly people living alone, who generally have small family networks and less social contact than others, show no particular vulnerability to psychological distress. This pattern may be coloured by the higher incidence of institutionalisation (and possibly also of mortality) among the single elderly, which would mean that only the robust and psychologically well among the single elderly are likely to continue living in the community (the present study did not include the institutionalised elderly within its scope). Among those who married, by contrast, because of the greater availability of family members (especially spouses, daughters and daughters-in-law) who can provide care and support, the prospect of surviving in the community while either physically or psychologically ill is greater. Thus, on the one hand, the apparent lack of statistical association between being single and various measures of both physical and psychological well-being could be misleading. On the other hand, the findings in this and much other research, both in Ireland and in other countries, suggest that social contact and social support has a much less clear-cut effect on older people's sense of well-being than we would expect. This means, among other things, that the large networks of kin and the high levels of social contact experienced by the majority of older people in Ireland may be less of an addition to the quality of their lives than we would think.

Policy Implications

We now turn to the implications for health promotion policy which emerge from the present report. We will first identify four *priority issues* which are highlighted by the analysis and then we will look at certain aspects of the *context and resources* which need to be taken into account in trying to deal with those priority issues.

Priority issues

/. *Older-age life expectancy*

Undoubtedly, the chief priority concerning the health of the elderly in Ireland which has been highlighted in the present report is the low level of older-age life expectancy. The slow rate of progress over the decades in improving life expectancy for middle-aged and older people is a black mark on the record of social progress in Ireland and the general consensus that the circumstances of the elderly have improved greatly in recent decades. Health promotion policy in Ireland has shown a notable lack of urgency about this problem. The tendency in health promotion has been to focus on •premature' mortality, defined as mortality among those aged under 65. so that mortality levels among those aged over 65 has not attracted the same attention. However, the comparative shortness of life expectancy at older ages in Ireland suggests that many deaths which occur after age 65 are highly premature by today's standards. Improved health at younger ages will eventually translate into better health at entry into old age and so perhaps reduce older age mortality. The present focus of health promotion on the younger population is thus likely to yield eventual returns in older-age life expectancy. This is not to say, however, that health promotion should neglect the possibility of health gains within old age itself — especially in Ireland where long-term improvements in childhood and early adulthood mortality have not yet been followed through by substantial improvements in older age mortality. The present report has also suggested that there are a number of aspects of older people's health lifestyles (especially in regard to body weight and awareness of healthy body weight standards) which seem to call out for health promotion attention.

The whole area of mortality improvement in older ages is a subject, therefore, which requires a great deal more concerted attention from

epidemiological research in the first instance and from health promotion policies based on the findings of adequate research.

2. Ill-health and psychological distress

The second priority for health promotion policy which we would identify arises from the strong links between physical health status and psychological distress among older people which the present study has identified. It is important for health promotion policy to focus not just on the avoidance of illness, disability and death but also on the problems old people have in coping psychologically with ill-health when it comes. This is especially true in connection with physical impairment. Many older people who consider their health quite good nevertheless face steady loss of fitness, mobility and strength as they age. and this has major negative effects on the daily patterns of their lives and on their psychological well-being.

The psychological coping mechanisms which older people need in order to come to terms with declining physical health status thus become an object of concern in their own right. They are especially important given that, in spite of considerable success in raising older-age life expectancy in most western countries, no country seems to have found a way to reduce morbidity among the elderly who remain alive. As far as old people are concerned, therefore, morbidity will always be with us — and so too will the psychological trauma which morbidity brings to the person suffering from it.

The massive resources devoted to the medical treatment of illness and disease reflect the seriousness with which the physical dimension of this problem is regarded. There are no corresponding mechanisms for dealing with the psychological aspects. If health promotion is to take seriously a concept of health which embraces psychological as well as physical dimensions, this basic deficiency needs to be remedied.

Health promotion for older people thus needs to develop a new focus on the psychological implications of declining physical health status among older people. It needs to begin the search for the coping mechanisms which would enable older people to sustain their sense of psychological well-being in the face of illness and disability. In one rather paradoxical sense, this is not an

entirely new issue: much attention has been given in recent years to the burden and strain which disability and ill-health among older people imposes on those who care for them, especially in the case of care that is given informally by family members. Equally however, the cared-for person experiences psychological as well as physical distress from ill-health and disability and from the dependence on others which that brings. Just as there is a need to provide supports to care-givers, there is a need to provide supports to care-receivers, so that the traumatic effects of the transition to dependency are minimised as far as they can be. It is clear that the goal of 'adding life to years' can only be fully achieved by focusing on psychological well-being as well as physical well-being and by incorporating research and education on these matters into the centre of health promotion efforts for older people.

3. Health and standards of living

If physical health status emerges from the present study as the main immediate influence on older people's well-being, then low incomes and material deprivation emerge as significant correlates of poor physical health status. This suggests that improving physical health is not solely a matter of either medical care or of health education. It is also a problem of the broader distribution of material resources in society. Elderly incomes have improved greatly in recent years in Ireland and as a result the incidence of poverty among the elderly has declined. This is not to say. however, that poverty and inequality are no longer problems for older Irish people. The present report has stressed the highly generalised basis of the research on elderly poverty on which recent optimistic pronouncements have been based. Apart from general issues of social equity, therefore, income distribution and material standards continue to be important issues for the physical health of the elderly in Ireland.

We need to have more detailed investigation, therefore, of the extent of inequality in incomes and living standards among the elderly in Ireland, of the degree to which such inequality is linked to inequalities in health (and here differentials in mortality as well as in morbidity would need to be taken into account), and of the precise mechanisms through which those links operate. Until those issues are more fully understood, health care and health

promotion will be in the dark about what may well be key influences on health patterns among older people.

4. Gender and health

The final issue we wish to point to is the fundamental question of gender. The importance of this question is obvious first of all from the puzzling pattern of gender differences in health — women live longer than men but seem, on some measures at least, to be more prone to illness. These differences suggest that gender is a significant element in patterns of vulnerability to ill-health, but in ways that are complex and as yet poorly understood. More generally, of course, there are basic gender differences in the nature and meaning of ageing. For example, married men are likely to be older than their wives, to have their wives available to care for them when they become ill or infirm and are less likely to experience widowhood. They are also more likely to have to adjust to the transition from working life to retirement when they cross the threshold into old age. Women, on the other hand, are more likely to be widowed, to spend a number of years living alone, and to depend on the next generation, or on paid care-givers, for care when they become infirm and to experience family transitions as more central to the ageing process than transitions connected with work.

As far as health promotion is concerned, the implication of these and many other gender differences in patterns of ageing is that health promotion needs to be gender sensitive. At a minimum, it needs to recognise that women and men may have different biological vulnerabilities to ill-health and that they certainly are different in the way their socially structured roles and experiences in life lead them to relate to health and illness. There are various differences also in patterns of psychological well-being, income and living standards, patterns of care-giving and care-receiving — in fact, in most of the issues which have been dealt with in the present report. It is not always clear from the present state of knowledge precisely how those differences should be understood. This lack of understanding sometimes reflects the inherent complexity of the issues (as in the case of gender differences in mortality and morbidity) but it often also reflects a lack of concern for gender issues in examining the patterns of older people's lives.

While it is beyond the scope of the present report to provide detailed prescriptions as to how the priority issues just outlined should be dealt with, it is possible to refer to some important contextual factors which affect the range of policy options that can be considered in Ireland. These have a bearing especially on resources — both the resources that are *needed* for improving the circumstances of the elderly and that are *available* for that purpose in Ireland at present. Two of these factors we will highlight here — the trend in ageing and age-dependency in the population of Ireland and the distinctively large size of family networks for most categories of older people in Ireland.

Non-ageing of population and declining age-dependency

Policy debates on the elderly in other countries have been heavily influenced by concerns about 'grey pressure' (the rising proportion of older people) on public expenditure, on health care systems, on pension schemes and on economic distribution in general. Whatever about the nature and validity of these concerns, it is clear that they do not yet arise to the same degree in Ireland. Population ageing in Ireland, though present to some degree, is occurring from a lower base and at a slower rate than in other countries. The proportion aged over 65 is among the lowest in the western world, is more or less the same now as in 1961. and indeed is only marginally greater than in 1926. Population projections suggest that it will be well into the first decade of the next century before ageing on a scale common in other western countries begins to take place here. In addition, because of falling fertility, the size of the child population is declining. As a result, the overall age-dependency ratio (the ratio between those in the ·dependent" ages — 15 and under. 65 and over — and those aged 16-64) is likely to decrease in the immediate years ahead. Thus. Ireland is in the rather exceptional position of having less growth in its elderly population as a proportion of total population than other developed countries, along with decline in overall age-dependency. As a result, while certain factors (such as increasing older age morbidity and the increase in the absolute numbers of older people) may increase resource pressures on public policy for the elderly in Ireland, the trends in ageing and age-dependency mean that these will be less severe than in many other countries. This should make an

increase in effort on behalf of the elderly in Ireland more feasible to attain than elsewhere.

Family networks

A further distinguishing feature of the situation of older people in Ireland is the very strong support base they have in the younger-adult and child population (Chapter Five above). Not only do these younger people exist, they are tied to older people by dense and extensive kin networks. Older Irish people have exceptionally large networks of close kin — siblings, children and grandchildren — with many of those kin living either in the same household or in close proximity to their elderly relatives. The extent of these networks give the lie to the common belief that the extended family has declined in modern Ireland, and indeed it could plausibly be argued that, at least for older people, the extended family has never been stronger than it is today.

An important exception to this general picture of large family networks among older people in Ireland is found among those older people who never married. Over 20 per cent of those aged over 65 in Ireland today are single. a legacy from the exceptionally high incidence of permanent non-marriage which prevailed in Ireland during the decades when the present elderly were in their prime adult years. The single elderly stand out from the rest of the 1993 survey sample for having few relatives and. largely because of their small networks of kin. lower overall levels of social interaction. They do. therefore, experience a marked absence of extended family contacts.

For the ov er-65s who did marry and form their own families, the large size of family networks is the result of a quite distinctive conjuncture in Irish social history during the life-span of the present elderly which never occurred before and may never occur again. This conjuncture was made up of a combination of quite high marital fertility among today's elderly during their child-bearing years, new historical lows in rates of mortality among their children and. from the 1960s onwards, generally low emigration rates and high marriage rates among those children in their adult years. The high rate of production of kin which derived from high marital fertility could be regarded as "traditional", the high rate of survival of kin which derived from low mortality rates is undoubtedly 'modern', while the combination of the two in the lives of the present elderly is neither traditional nor modern but a distinctive transient circumstance in recent Irish history.

Obviously, family networks are an important resource for older people, and it is quite a positive feature of the position of older people in Ireland that that resource is present in such abundance. It is especially important as a source of care for the infirm elderly, thus helping to reduce the incidence of institutionalisation and dependence on state resources among that category of older people. However, although this resource is present on a comparatively large scale in Ireland, two points need to be remembered in considering its relevance for policy. One is that it is unevenly distributed: the never-married elderly generally have quite small family networks, and to some extent, because of migration, the rural elderly may lack relatives in the immediate locality. This is one further dimension of the heterogeneity of the elderly population which has been referred to repeatedly in the present report.

The second point is that, if the full benefit of this resource is to be reaped by those older people who have it available to them, its precise character needs to be understood and its strengths and limitations as a source of support for older people needs to be better taken into account by policy makers. Some things have been done which reflect awareness of these points — for example, the development of the Home Help service for those elderly who lack family supports or whose available supports are inadequate to their needs. There is also increasing awareness of the need to nurture and support informal family care within the overall system of care for infirm older people. However, informal family care is likely to be as diverse in quality and reliability as any other aspect of family life, and to be as mixed in its implications for older people. Sometimes it may provide the ideal solution to the care needs of older people, but equally sometimes it may fall far short of that ideal, for both carer and the cared-for person. In many cases the shortfall may be financial or material, especially where carers have to forgo paid work in order to provide care for older relatives. In others the difficulties may arise in the area of interpersonal skills, caring abilities, or the psychological strain either of caring for older people or. in the case of the older people themselves, of being dependent and being a burden on those who are providing the care. There is thus scope for educational support for family members so that both they and the older people they care for will derive maximum benefit from the caring relationship.

APPENDIX A

1993 Survey of the Over-65s

This appendix gives an account of the design of the 1993 Survey of the Over-65s and of the sample on which it was based.

Target population and sampling method

The target population for the 1993 Survey of the Over-65s was the population aged 65 and over who were living in private households. In the 1991 Census of Population, there were 402,924 persons aged 65 and over in Ireland, of whom 34.370 or 8.5 per cent lived in institutions. This left a total of 368.554 persons aged 65 and over in private households. It is difficult to achieve a strict probability sample of this population as no complete, separate listing of those who comprise it is available to serve as a sampling frame. In order to overcome this absence, the sample was drawn by *screening* a much larger sample of names drawn at random from the Electoral Registers, that is. a sample representing the entire population aged 18 years and over. A total of 9.300 names were drawn from the Electoral Registers by means of a two-stage clustered sampling procedure using the ESRI's RANSAM programme. These names were issued to interviewers who then contacted them or other members of their households to establish if they were in the target age-range. Those of the original named sample who were identified in this way as being aged 65 or over were then asked for an interview. Screening and interviewing were carried out in the period June to August 1993.

The outcome of the screening of the initial sample of 9.300 names was as follows:

	No.	%
Total sample issued	**9,300**	**100**
Address vacant	31	0.3
Could not locate	84	0.9
Deceased	234	2.5
Moved	408	4.4
Not available throughout fieldwork	248	2.7
Refused	144	1.5
Ill	55	0.6
Aged under 65	6.887	74.1
In institution	120	1.3
Other non-available	180	2.0
Interview completed	**909**	9.8

Because of the aim to achieve a complete representative coverage of the target population, interviewers were instructed to make particular efforts to complete interviews in respect of older or more infirm persons in the sample who might otherwise be unwilling or unable to participate. For infirm people who had difficulty completing the interview themselves, information was accepted from proxy respondents (in nearly all instances other members of the respondent's household) for those segments of the questionnaire which could reasonably be completed by an informed third party. The breakdown of completed questionnaires between sampled respondents and proxy respondents was as follows:

	No.	%
Sampled respondents only	832	91.5
Sampled respondents plus proxies	57	6.3
Proxies only	20	2.1

Response rates

Given the nature of the sampling procedure, the ages and residence (private household or institution) of those who were deceased or who were otherwise not contacted were not established. As a result, the proportion of the original

sample of 9.3(K) names which was valid for the purposes of the survey — that is. which consisted of those aged 65 and over living in private households — was not established. This in turn means that while it is possible to express non-contacts, refusals and other non-completions as a percentage of the original sample (as is done above), it is not possible to identify the non-completions within the *valid* sample or to calculate a response rate for the valid sample. On the face of it. it would appear that the proportion of interviews completed from the initial sample, at 9.8 per cent, was low. since the non-institutionalised population aged 65 and over in the 1991 Census of Population amounted to about 15 per cent of the non-institutionalised population aged 18 and over (sufficient detail from the 1991 Census is not yet available to allow for anything other than an approximate estimate of this proportion). However, the proportion of the original sample which was under 65 (74 per cent) was also low. The underlying problem is that at least seven percent of the original sample was inaccurate or invalid, mainly because of death and changes of address, and a good proportion of those about whom no information of any kind was established was also likely to have been inaccurately listed in the Register. Non-completions arising from such things as refusals and illness were quite low. (and some of these may have been aged under 65). It is likely, therefore, that the sample conforms acceptably well to the usual standards of randomness in sample selection.

Representativeness of sample

The 1991 Census of Population is the most useful independent bench-mark against which to check the representativeness of the achieved sample in the 1993 survey. Apart from the passage of time between the 1991 Census and the survey date, the usefulness of the Census for this purpose is limited somewhat by the fact that nearly all of the tabulations available from it on the population aged 65 and over relate to the *total* such population rather than to the population in private households (as already mentioned, 8.5 per cent of the total population aged over 65 are recorded in the Census as resident in institutions). Only one tabulation is available from the Census returns so far published which provides an internal breakdown of the 65-and-over population who live in private households: this arises from the count of those in that age group in private households who live alone, classified by sex (Census 91 Summary Population Report — 1st Series.

Table A.I compares the Census distribution on this item with the corresponding distribution in the present sample.

Table A.1: Percentages of Those Aged 65 and Over Who Live Alone According to the 1991 Census of Population (Private Households Only) and the 1993 Sample

	Male	Female	Total
	Percentages living alone		
1991 Census	20.3	30.8	26.2
1993 Sample	25.5	38.3	32.3

As the proportion of elderly persons living alone has been increasing rapidly in Ireland in recent decades (it rose from 21 per cent in 1986 to 26 per cent in 1991), it is to be expected that the 1993 sample would report a slightly higher percentage in this category than the 1991 Census. However, the gap between the two as revealed in Table A. 1 is too large to be accounted for by real changes in the population since 1991. The 1993 sample, therefore, somewhat over-represents those living alone and under-represents those living in multi-person households.

Age-sex distributions are available from the 1991 Census for the total (private and institutionalised) population aged 65 and over only. However, the Census does report that of the 65s-and-over in institutions, approximately two-thirds are female and one-third male. We also have an estimate from O'Connor and Thompstone (1986) for the early 1980s which suggests that the age-breakdown of the 65s-and-over in institutions is roughly as follows: five per cent in the age-range 65-69. 10 per cent in the age-range 70-74. 25 per cent in the age-range 75-79 and 60 per cent aged 80 and over. Using these figures as a basis, we can estimate the age-sex distribution of the 65s-and-over living in private households in 1991 from the Census distributions for the total population in that age-range. The resulting estimated distributions derived from the 1991 Census are compared with the corresponding distributions in the 1993 sample in Table A.2.

Table A.2: Age-Sex Distribution of Those Aged 65 and Over Living in Private Households According to the 1991 Census (Estimated) and the 1993 Sample.

	1991 Census		1993 Sample	
	Male	Female	Male	Female
	°o	%	O,0	%
65-69	37	32	30	31
70-74	30	27	30	25
75-79	20	19	22	22
80 and over	13	22	18	22

The comparison in Table A.2 shows that there is a generally close match between the age-sex distribution in the sample and in the 1991 Census (as estimated). The exceptions are the two extremes of the male age groups: the sample under-represents males aged 65-69 (these account for only 30 per cent of the male sample compared to 37 per cent of the corresponding male population in the Census) and over-represents males aged 80 and over (these account for 18 per cent of the sample compared to 13 per cent of the corresponding male population in the Census).

Re-weighting of the sample to correct for the deviations from population measures of both the proportions living alone and the age-sex distribution were experimented with. However, as the deviations were not very great (particularly in the case of the age-sex distribution, where in any event the population measures used as a bench-mark were themselves only estimates), and as the re-weighting for the proportions living alone slightly worsened rather than improved the representativeness of the age-sex distribution, re-weighting was not generally applied to the data for the main body of the report. The only exception is in connection with Chapter Five, which deals, among other things, with the patterns of co-residence among respondents. The tabulations in that chapter are based on a re-weighting of the sample which makes it conform to the Census percentages of the elderly population living alone.

APPENDIX B

Measures of Morbidity

Characteristics of Morbidity Measurement

Measurement of patterns of health, illness, physical impairment and disability in general populations (as opposed to populations encountered in clinical settings) has relied heavily on questionnaire survey methodologies, that is, on self-reports of health and physical condition by individuals in population samples. Research in many countries has shown that certain self-reported health measures have considerable value in predicting serious illness and mortality, so that the general idea of relying on self-reports by samples of individuals as a means to assess the health status of populations has acquired a good deal of credibility (Bowling 1991).

At the same time, survey methodologies have a number of limitations in measuring morbidity and health status. The most often cited is that the measures used have to be simple enough to be easily administered through self-completed or interview-based questionnaires (Bowling 1991. Nolan 1991. pp. 77-78). Health and illness are complex things which cannot be captured adequately by simple measures. They are composed partly of physically observable conditions and partly of more intangible but equally important psychosomatic factors. They are thus difficult to define and even more difficult to quantify in a consistent, valid way. Even the "objective" diagnostic techniques used in clinical medicine do not always produce consistent results (Bowling 1991). If doctors can differ in their assessments of people's health, it is scarcely surprising that there will be some looseness and inconsistency in measures derived from simple questions in survey questionnaires. Therefore, while social survey methods do have value in morbidity research, it cannot yet be said that they have come up with practical effective ways of producing fully valid and reliable measures of morbidity or health status.

Because of these so-far unresolved measurement problems, epidemiological studies of morbidity and health among older people are still hampered by inadequacies in the available data. Good quality morbidity time-series data are particularly hard to come by. even in countries such as the United States which have a long tradition of work in this area. The consequence, as Markides (1993. p. 13) states, is that, despite a very large increase in research effort on morbidity trends, "it is difficult to draw firm conclusions about what is happening to the health of older people in western societies, particularly because of the relative scarcity of adequate trend data".

Morbidity Measures in the Present Report

Of the morbidity measures used in the 1993 Survey of the Over-65s. three were replicated from the 1977 Survey of the Elderly. The first of these simply asked respondents if they had a serious illness or disability:

> "Do you have any major illness, physical disability or infirmity that has troubled you for at least the past year or that is likely to go on troubling you in the future?"

Respondents who answered ·yes" to this question were asked what the nature of their illness or disability was. This measure was used also in the ESRI's 19S7 Survey of Lifestyles and the Usage of State Services, so that this measure of illness levels in the elderly population in Ireland is available for three points in time since 1977.

The second measure replicated from the 1977 survey asked respondents to give an overall assessment of their state of health:

> "All things considered, how would you rate your present state of health? Would you say it is very good. good. fair. bad. or very bad".

The third measure replicated from 1977 consisted of a short battery of items relating to illness and health behaviour in the previous four weeks. Over that four-week period, respondents were asked how many days they were kept in bed at home, how many days they were unable to carry out normal activities because of illness or injury, how many visits they had to or from a doctor and to or from a hospital on their own account, how many nights they spent in hospital, and when they last saw their doctor. An immediate

follow-on item asked them whether they had taken any prescription pills or medicine in the last 24 hours. The first two items in this set (days in bed and inactivity days) relate fairly directly to health status and the remainder relate to health service utilisation. While health status and health service utilisation are correlated, the correlation is far from perfect since many factors other than health status (cost, accessibility, awareness of services and willingness to use them, etc.) bear heavily on patterns of health service utilisation (Nolan 1991). Thus these measures of health service utilisation should be read at most as indirect and somewhat remote indicators of health status.

In addition to these three measures, a measure of functional capacity was used in the 1993 survey which was similar but not identical to a measure of functional capacity used in the 1977 survey. In each of the two surveys, respondents were asked, with reference to a list of activities, whether they could carry out each activity. The versions of this measure used in the two surveys differed in that the lists of activities had some but not all items in common and there were differences also in the wording of the response categories. The list used in the 1993 survey was as follows:

1. Have all-over wash or bath
2. Dress oneself
3. Walk half a mile
4. Get up and down stairs
5. Get on a bus
6. Hear easily (with hearing aid if necessary)
7. Read a newspaper (with glasses if necessary)
8. Wash hands and face
9. Get to and use toilet
10. Cook a hot meal
11. Do heavy grocery shopping

Items 1-7 on the list above were used in the 1977 version of this measure. The wording of the response categories in the two surveys differed in that the 1993 response categories were ' without difficulty, with difficulty, only with help or not at all", while the 1977 response categories were "no difficulty, a little difficulty, considerable difficulty, impossible for you'.

These differences in detail, which are additional to more general differences between the two surveys, reduce the comparability of the two sets of items. Nevertheless, a Functional Capacity Index (FCI) has been constructed from the seven items in common in the two surveys and used in Chapters Three and Eight above. For each of the seven items, respondents are scored 0 if they report no difficulty and 1 if they report any degree of difficulty. These scores are then summed across the seven items to give an FCI score of between 0 and 7 for each respondent. Some analysis of these scale scores from the two surveys is reported below.

Quality and nature of measures

No systematic testing of any of the above measures has taken place in Ireland, so it is difficult to provide assessments of their relative merits. From the uses of the measures which have been made in Ireland, only some general comments can be made.

Firstly, on the face of it, two of the general measures of health status just outlined — whether respondents had a serious illness or not and their self-assessment of their general state of health — would seem to relate to broadly similar dimensions of health. However, the pattern of responses in both the 1977 and 1993 surveys suggests that the former is a broader, more inclusive measure of illness or poor health than the latter. Many people who report having a serious illness consider that they have good overall health. As Table B. 1 show s. in both the 1977 and 1993 surveys. 41 per cent of those who said they had a serious illness rated their health as either "good* or 'very good", while only 11 or 12 per cent with a serious illness rated their health as 'bad* or ·very bad". Clearly, therefore, for many people having a serious illness and being in poor health are by no means the same thing. It may be that self-rating of health is an implicitly relative measure: it may reflect the respondents' views of their health compared to others of the same age and circumstances. At the same time, none of those who were without a serious illness considered their health to be "bad* or "very bad' so that the two measures are not totally out of joint.

Table B.1: Crosstabulation of Self-Assessed State of Health With Whether Respondents Have Serious Illness/Disability

Self-assessed state of health	Has respondent serious illness or disability?			
	1977		1993	
	Yes	No	Yes	No
	%	%	%	%
Very good	11	54	10	49
Good	30	34	31	41
Fair	48	12	48	10
Bad	9	—	10	—
Very bad	2	—	2	—
Row percentage	63	37	47	53

As noted in Chapter Three above (see esp. Table 3.4). the other general measure of morbidity used in the 1993 survey — self-reported major illness — shows considerable fluctuation in overall level and age-sex distribution among the elderly population when compared with the two other Irish surveys in which it was applied (1977 and 1987). In addition, when included in the regression analyses of the type reported above in Chapter Eight, this measure showed little or no relationship with a number of variables with which it might be expected to have a connection. For example, as we saw in Chapter Five, self-reported major illness did not correlate with levels of social interaction whereas other health status measures — subjective assessment of health and FCI index — did. The same is true in connection with psychological well-being as reported in Chapter Four above: subjective assessment of health and FCI index correlated strongly with psychological distress while self-reported major illness did not. For these reasons, the validity and reliability of self-reported serious illness as a measure of health status is open to some doubt, especially as far as inter-survey comparisons are concerned.

In the present report, we place more reliance on respondents" self-assessment of their overall state of health than on self-reported major illness as an indicator of health status. We also make use of the measures of functional capacity used in the 1977 and 1993 surveys. Functional

capacity refers to a different, though over-lapping, dimension of health status than either major illness or self-assessed state of health (many chronic illnesses — e.g.. asthma — do not necessarily cause any diminution in day-to-day functioning, while some physical impairments — e.g. lameness or poor eyesight — might not be thought of as illnesses or reflections of poor health). Like subjective assessment of health, the measure of functional capacity proves to be quite a strong predictor of a number of aspects of behaviour and measures of well-being in the 1993 sample.

APPENDIX C

Additional Tables

Table C.1: Mortality Indicators for 23 OECD Countries Around 1990

	MALES			FEMALES		
	Survivors per 100.000		Life Expectancy at age 65	Survivors per 100.000		Life Expectancy at age 65
	From birth to age 45	From 45 to 65		From birth to age 45	From 45 to 65	
Japan	96258	86089	16.6	97821	93489	21.0
France	93279	81390	16.1	96993	92365	20.7
Switzerland	93969	85208	15.6	97145	92710	20.1
Iceland	95547	85445	15.6	97903	91434	20.0
Canada	94533	83471	15.5	97176	90808	19.9
Sweden	95388	85322	15.5	97449	91901	19.4
United States	92135	80230	15.3	96143	88451	19.2
Spain	93527	83225	15.5	97054	92732	19.2
Netherlands	95855	83961	14.4	97322	91205	19.2
Australia	94096	83197	15.0	96920	90589	19.1
Italy	94994	82763	15.0	97367	91982	19 0
Norway	94833	83444	14.6	97310	91316	18.7
Luxembourg	92894	81207	14.5	96517	90404	18.6
Austria	93875	81048	14.9	97048	91072	183
Belgium	93978	80766	14.1	96598	90534	18.3
Greece	94816	85162	15.8	97114	92952	18.3
Finland	92836	79294	14.1	97177	91551	182
New Zealand	93128	82118	14.3	96399	88405	18.1
Denmark	94504	81056	14.4	96984	87057	18.1
U. Kingdom	95355	82609	14.3	97268	89253	18.0
Germany	94255	80065	14,1	96936	90096	17.8
Portugal	91027	78827	13.7	95950	89958	17.1
Ireland	**95161**	**80864**	**13.2**	**97105**	**88741**	**17.0**
MEAN	94184	82468	14.9	97030	90826	18.8
Ireland's ranking out of 23	6	18	23	12	20	23

Countries arranged in descending order of female life expectancy at age 65.

Source: Derived from WHO. World Health Statistics Annual 1992. Table C-2.

Table C.2: Body Mass Index Categories Defined by Garrow Cut-off Points by Respondent's Rating of Whether He or She Eats the Right Amount of Food

BMI Category	Per cent		
	Yes. the right amount	No. too much	No, too little
Underweight	76.6	3.2	20.2
Acceptable	92.6	2.9	4.5
Overweight	80.8	18.3	1.0
Obese	53.7	44.4	1.9
All	84.3	10.9	4.8

Table C.3: Body Mass Index Categories Defined by Garrow Cut-off Points by Whether or Not Respondent Eats Regularly (i.e., has the same number of meals and snacks at roughly the same time each day)

BMI Category	Per cent		
	Yes	No	Varies
Underweight	83.2	2.1	14.7
Acceptable	90.8	2.1	7.1
Overweight	91.5	2.8	5.6
Obese	92.7	-	7.3
All	90.4	2.2	7.4

Table C.4: Percentages Who Go Out for a Drink to a Pub or Club in the Evenings by Age Group by Sex: 1987 ESRI Poverty Survey

	Under 35		35-64		65 and Over		All
	Female	Male	Female	Male	Female	Male	
	Per cent						
Go	75	81	49	72	17	57	63
Don't go	25	19	51	28	83	43	37

Table C.5: Frequency of Going Out for a Drink by Age Group by Sex: 1987 ESRI Poverty Survey

How often do you go to the pub?	Under 35		35-64		65 and Over		All
	Female	Male	Female	Male	Female	Male	
	Per cent						
Most days	1	1	-	2	1	7	1
2 to 3 times a week	22	30	9	28	5	28	23
Once per week	35	42	34	39	20	42	38
Once or twice a month	28	19	32	21	43	15	24
Less frequently	14	7	25	10	30	9	13

Table C.6: Usual Spending Each Time Respondent Goes Out for a Drink: 1987 ESRI Poverty Survey

Amount spent	Under 35		35-64		65 and Over		All
	Female	Male	Female	Male	Female	Male	
	Per cent						
Nothing	17	0	30	0	29	1	10
Up to £2	5	2	8	4	13	**6**	5
£2 to £4	16	10	15	14	24	34	15
£4 to £6	**30**	27	28	**39**	14	42	32
£6 to £8	**6**	10	3	**9**	2	-	-
£8 to £10	19	31	12	**24**	18	13	22
Over£10	7	20	4	**10**	2	1	10

Table C.7: Frequency with which Different Sources of Income are Reported as Being Received by Single Person Elderly Households by Area: 1993 Survey

Source of Income	Per Cent Reporting Receipt								
	Urban Areas			Rural Areas			All Areas		
	Males	Females	All	Males	Females	All	Males	Females	All
	Per cent								
Wages or Salaries	-	1.0	0.7	5.7	-	2.3	2.9	0.6	1.4
Self-employment Income	7.8	1.7	4.0	6.4	-	2.0	9.6	3.9	6.3
Income from Agriculture	2.1	-	0.7	24.5	5.3	13.2	13.6	2.3	6.5
Social Welfare/Old Age Pensions	80.4	80.2	80.3	84.9	88.5	87.0	83.2	83.8	83.6
Public Servant's Retirement Pension	19.1	10.0	12.9	10.7	6.7	8.2	10.7	6.2	7.8
Occupational Pension	17.0	9.9	12.2	5.7	2.6	3.8	10.7	6.7	8.2
Other Private Pension	8.5	4.0	5.4	-	2.5	1.5	3.9	3.4	3.5
Property Income	6.4	1.0	2.7	3.8	1.3	2.3	4.9	1.1	2.5
Other Sources	2.1	15.0	10.9	3.8	13.3	9.4	2.9	14.3	10.1

Table C.8: Fraquancy with which Different Sources of Income are Reported as Being Received Within Married Couple Elderly Households by Area: 1993 Survey

	Per Cent Reporting Receipt													
	Urban Areas				Rural Areas				All Areas				All Rspndnts	All Spousos
	Male Rspndnt	Female Spouse	Female Rspndnt	Male Spouse	Male Rspndnt	Fomalo Spouse	Fomale Rspndnt	Malo Spouse	Male Rspndnt	Female Spouse	Fomalo Rspndnt	Male Spouse		
Wages or Salaries	-	**3.8**	1.8	1.8	-	2.6	1.3	3.9	0.6	**3.2**	**1.8**	2.7	1.1	3.0
Sell-employment Income	2.5	-	-	3.6	5.3	-	2.0	-	3.8	-	**0.9**	1.8	2.6	0.7
Income Irom Agriculture	-	-	-	-	7.9	-	3.9	17.6	3.8	1.8	-	8.2	3.0	3.4
SocialWelfare/Old Age Pension	86.3	40.5	46.4	76.8	91.1	56.3	83.0	86.8	88.1	48.8	64.3	81.3	78.3	62.1
Public Servant's Retirement Pension	17.5	–	1.8	14.3	6.4	1.3	3.9	2.0	11.9	0.6	**2.7**	**8.2**	**8.2**	**3.7**
Occupational Pension	29.1	1.3	3.5	24.6	9.2	-	–	5.8	19.2	**0.6**	1.8	15.2	12.0	**6.7**
Othor Privato Ponsion	15.2	1.3	1.8	5.4	5.3	1.3	-	2.0	10.3	1.3	0.9	3.6	6.4	2.2
Income from Properly	2.5	–	–	1.8	2.6	-	–	3.8	2.6	–	–	2.7	1.5	1.1
Other Sources	6.3	1.3	**5.5**	5.7	10.5	1.3	4.1	-	9.0	1.3	5.6	3.8	7.6	2.3

Table C.9: Frequency with which Different Sources of Income are Reported as Being Received by Elderly Sub-Unit Within Other Types of Household: 1993 Survey

Source of Income	Per Cent Reporting Receipt								
	(a) Respondents With Spouses				All Rspndnts	All Spouses	(b) Respondents Without Spouses		
	Male Respondent	Female Spouse	Female Respondent	Male Spouse			Males	Females	All
	Per cent								
Wages or Salaries	1.1	3.3	–	3.8	0.9	3.4	1.8	1.4	1.5
Self-employment Income	12.2	–	–	3.8	9.5	0.9	–	2.1	1.5
Income from Agriculture	17.8	2.2	–	11.5	13.8	4.3	16.1	4.2	7.5
Social Welfare/ Old Age Pension	74.2	23.1	57.7	80.8	70.6	35.9	73.2	85.3	82.1
Public Servant's Retirement Pension	11.0	–	3.8	7.7	9.4	1.7	3.6	6.9	6.0
Occupational Pension	11.0	1.1	3.8	19.2	**9.4**	**5.2**	**5.4**	**2.1**	3.0
Other Private Pension	6.6	-	–	7.7	5.1	1.7	3.6	4.2	4.0
Income from Property	1.1	-	–	–	0.9	-	7.1	2.8	4.0
Other Sources	7.7	2.2	–	–	6.0	1.7	10.0	3.1	4.1

Table C.10: Most Important Source of Income of Single Person Elderly Households by Area and by Sex: 1993 Survey

Income Source	Per Cent of Nominations as Most Important								
	Urban Areas			Rural Areas			All Areas		
	Males	Females	All	Males	Females	All	Males	Females	All
	Per cent								
Income from work	2.1	2.1	2.1	19.2	2.6	9.3	10.7	2.3	5.4
State Pensions	81.3	82.5	82.1	76.9	88.3	83.7	79.6	85.1	83.0
Other Pensions	14.6	4.1	7.6	-	6.5	3.9	6.8	5.2	5.8
Other Sources	2.1	11.3	8.3	3.8	2.6	3.1	2.9	7.5	5.8

Table C.11: Most Important Source of Income of Partners In Married Couple Elderly Households: 1993 Survey

Income Source	Urban Areas				Rural Areas				All Areas				All Rspndnts	All Spouses
	Male Rspndnt	Female Spouse	Female Rspndnt	Male Spouse	Male Rspndnt	Female Spouse	Female Rspndnt	Male Spouse	Male Rspndnt	Fomale Spouse	Female Rspndnt	Male Spouse		
	Per cent													
Income from work	1.3	5.7	-	4.1	6.3	4.3	2.2	12.5	3.8	4.9	2.3	8.0	1.9	6.6
State Pensions	73.4	82.9	86.7	79.6	83.8	93.5	95.7	87.5	78.1	89.0	92.4	83.0	82.8	85.7
Other Pensions	20.3	5.7	3.3	10.2	6.3	2.2	-	-	13.1	3.7	1.3	5.0	9.2	4.4
Other Sources	5.1	5.7	10.0	6.1	5.8	-	2.2	-	5.0	2.4	5.1	4.0	5.0	3.3

Table C.12: Most Important Source of Income of Elderly Sub-Unit Within Other Types of Household

Source of Income	Per Cent of Nominations as Most Important								
	(a) Respondents with Spouses						(b) Respondents Without Spouses		
	Male Respondent	Female Spouse	Female Respondent	Male Spouse	All Respondents	All Spouses	Males	Females	All
	Per cent								
Income from work	19.6	14.8	6.3	18.2	17.6	16.3	14.3	5.3	7.7
State Pensions	69.6	77.8	93.8	68.2	73.1	73.5	73.2	86.8	83.1
Other Pensions	8.7	3.7	–	13.6	7.4	8.2	1.8	2.6	2.4
Other Sources	2.2	3.7	-	-	1.9	2.0	10.7	5.3	6.8

Table C.13: Interviewers' Ratings of Appearance of Neighbourhood Classified by Household Type and Area for 1993 and 1977

Interviewer's Evaluation of the Appearance of Neighbourhood	Urban Areas				Rural Areas				All Areas			
	Single Person	Married Couple	Other Type of House-hold	All House-holds	Single Person	Married Couple	Other Type of House-hold	All House-holds	Single Person	Married Couple	Other Type of House-hold	All House-holds
1993						Per cent						
Plenty of trees, shrubs or grassed open space (including gardens)	36.5	40.3	35.0	37.3	76.3	76.1	72.8	74.8	54.4	57.4	57.2	56.4
Moderate amount of trees, shrubs or grassed open space etc.	32.1	36.0	35.0	34.3	18.5	18.7	23.6	20.7	26.2	28.2	28.4	27.6
Only very few trees, shrubs or grassed open spaces etc.	12.2	17.3	15.3	14.8	3.0	3.0	2.1	2.6	8.2	10.1	7.5	8.5
No trees, shrubs or grassed open space	19.2	6.5	14.6	13.7	2.2	2.2	1.5	1.9	11.2	4.3	6.9	7.5
1977												
Plenty of trees, shrubs or grassed open space (including gardens)	16.0	21.6	16.8	17.2	47.3	50.5	53.5	52.3	31.0	38.0	39.8	37.9
Moderate amount of trees, shrubs or grassed open space etc.	35.8	24.3	29.1	30.1	31.1	32.6	33.5	33.0	33.5	29.0	31.8	31.8
Only very few trees, shrubs or grassed open spaces etc.	24.7	24.1	26.7	25.9	14.9	12.3	10.8	11.6	20.0	17.4	16.8	17.4
No trees, shrubs or grassed open space	23.5	30.0	27.4	26.8	6.8	4.5	2.2	3.1	15.5	15.5	11.7	13.0

Table C.14: Interviewers' Ratings of Prevailing Condition of Roads and Footpaths Classified by Household Type and Area for 1993 and 1977

Interviewers' Evaluation of the Prevailing Condition of Roads and Footpaths	Urban Areas				Rural Areas				All Areas			
	Single Person	Married Couple	ther Type of House-hold	All House-holds	Single Person	Married Couple	Other Type of House-hold	All House-holds	Single Person	Married Couple	Other Type of House-hold	All House-holds
1993	Per cent											
In good condition	62.2	68.6	54.7	61.9	45.2	56.0	53.6	51.8	54.1	62.2	54.1	56.6
Generally in good condition but some repair work necessary	34.6	26.4	39.4	33.5	33.3	33.6	30.4	32.2	34.0	30.2	33.9	32.8
Quite a lot of repair necessary	3.2	5.0	2.2	3.5	17.8	8.2	10.3	11.9	9.9	6.5	7.2	7.8
Large amount of repair necessary	0.0	0.0	3.6	1.2	3.7	2.2	5.7	4.1	2.0	1.1	4.8	2.8
1977												
In good condition	46.2	69.5	61.6	59.0	36.5	40.6	38.8	38.7	41.6	53.1	47.4	47.0
Generally in good condition but some repair work necessary	46.2	22.8	30.7	33.3	35.1	30.5	37.1	36.1	40.9	27.2	34.6	35.0
Quite a lot of repair necessary	6.3	6.7	6.3	6.3	12.2	18.4	16.0	15.7	9.1	13.3	12.4	11.9
Large amount of repair necessary	1.3	1.1	1.5	1.4	16.2	10.5	8.0	9.5	8.4	6.4	5.6	6.2

Table C.15: Interviewers' Ratings of Prevailing Condition of Other Properties in Neighbourhood Classified by Household Type and Area for 1993 and 1977

Interviewers' Evaluation of the Prevailing Condition of Other Properties	Urban Areas				Rural Areas				All Areas			
	Single Person	Married Couplo	Othor Type of Housohold	All Households	Single Person	Marnod Couple	Other Typo of Housohold	All Households	Singlo Porso	Marnod Couplo	Othor Typo of Housohold	All Households
1993												
Well-maintained and tidy	64.7	72.9	61.3	66.3	64.7	72.9	61.3	66.3	61.6	74.8	62.3	65.9
Generally well-maintained and tidy but some poor maintenance and untidiness	27.6	22.9	30.7	27.0	27.6	22.9	30.7	27.0	23.1	17.3	26.3	22.5
Quite a lot of poor maintenance or untidiness	5.1	4.3	5.8	5.1	5.1	4.3	5.8	5.1	6.8	4.7	3.9	5.1
Generally poorly maintained and untidy	2.6	0.0	2.2	1.6	2.6	0.0	2.2	1.6	4.4	0.7	2.4	2.5
Respondents's dwelling isolated - no comparison possible	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.1	2.5	5.1	4.0
1977												
Well-maintained and tidy	54.3	59.4	54.4	55.0	32.4	45.9	40.1	39.6	43.9	81.6	45.5	45.9
Generally well-maintained and tidy but some poor maintenance and untidiness	27.2	28.4	35.3	32.5	35.1	36.0	32.8	33.5	31.0	32.6	33.7	33.1
Quite a lot of poor maintenance or untidiness	11.1	8.9	7.1	8.3	6.8	3.6	12.2	10.4	9.0	5.9	10.3	9.5
Generally poorly maintained and untidy	7.4	3.3	3.2	4.2	18.9	7.3	7.9	9.4	12.9	5.5	6.1	7.3
Respondents's dwelling isolated - no comparison possible	0.0	0.0	0.0	0.0	6.8	7.3	7.1	7.1	3.2	4.4	4.4	4.2

Table C.16: Possession of a Refrigerator by Family Type, 1987

Possession of Refrigeration	Type of Household					
	Family with Children under 16 and No Elderly	Head of Household Aged 65 to 74	Head of Household Aged 75 or Over	Household Headed by an Under 65 with Elderly	Household Without Children Under 16 or Elderly	All Types
	Per Cent					
Has	98	92	83	96	96	**95**
Does Not Have	2	8	17	4	4	**5**
Total	100	100	100	100	100	100

Table C.17: Possession of a Refrigerator by Composition of Households Containing Elderly, 1987

Possession of Refrigeration	Composition of Households Containing Elderly People					
	Elderly Person Alone	Two or More Elderly People	One or More Elderly, 1 Adult, No Children	One or More Elderly, 2 or More Adults, No Children	One or More Elderly, 1 or More Adults, With Children	All Types
	Per Cent					
Has	80	94	93	98	98	90
Does Not Have	20	6	77	2	2	10
Total	100	100	100	100	100	100

Table C.18: Possession of a Washing Machine by Family Type, 1987

Possession of Washing Machine	Type of Household					
	Family with Children Under 16 and No Elderly	Head of Household Aged 65 to 74	Head of Household Aged 75 or Over	Household Headed by an Under 65 with Elderly	Household Without Children Under 16 or Elderly	All Types
	Per Cent					
Has	94	68	48	82	74	80
Does Not Have	6	32	53	18	26	20
Total	100	100	100	100	100	100

Table C.19: Possession of a Washing Machine by Composition of Households Containing Elderly, 1987

Possession of Washing Machine	Composition of Households Containing Elderly People					
	Elderly Person Alone	Two or More Elderly people	One or More Elderly, 1 Adult, No Children	One or More Elderly, 2 or More Adults, No Children	One or More Elderly, 1 or More Adults, With Children	All Types
	Per Cent					
Has	45	61	72	87	89	**65**
Does Not Have	55	39	28	13	11	**35**
Total	100	100	100	100	100	100

Table C.20: Possession of a Dry, Damp-Free Dwelling by Family Type, 1987

Possession of Dry, Damp-Free Dwelling	Type of Household					
	Family with Children Under 16 and No Elderly	Head of Household Aged 65 to 74	Head of Household Aged 75 or Over	Household Headed by an Under 65 with Elderly	Household Without Children Under 16 or Elderly	All Types
	Per Cent					
Has	92	86	90	90	89	90
Does Not Have	8	14	10	10	11	10
Total	100	100	100	100	100	100

Table C.21: Possession of a Dry, Damp-Free Dwelling by Composition of Households Containing Elderly, 1987

Possession of Dry, Damp-Free Dwelling	Composition of Households Containing Elderly People					
	Elderly Person Alone	Two or More Elderly people	One or More Elderly, 1 Adult, No Children	One or More Elderly, 2 or More Adults, No Children	One or More Elderly, 1 or More Adults, With Children	All Types
	Per Cent					
Has	89	**86**	86	88	85	87
Does Not Have	11	**14**	14	12	15	13
Total	100	100	100	100	100	100

Table C.22: Possession of Heating for Living Rooms When It is Cold by Family Type, 1987

Heating for Living Room When Cold	Type of Household					
	Family with Children Under 16 and No Elderly	Head of Household Aged 64 to 74	Head of Household Aged 75 or Over	Household Headed by an Under 65 with Elderly	Household Without Children Under 16 or Elderly	All Types
	Per Cent					
Has	97	96	98	97	96	97
Does Not Have	3	4	2	3	4	3
Total	100	100	100	100	100	100

Table C.23: Heating for Living Rooms When It is Cold by Composition of Households Containing Elderly, 1987

Heating for Living Room When Cold	Composition of Households Containing Elderly People					
	Elderly Person Alone	Two or More Elderly people	One or More Elderty. 1 Adult. No Children	One or More Elderly. 2 or More Adults. No Children	One or More Elderty. 1 or More Adults. With Children	All Types
	Per Cent					
Has	96	97	98	99	93	97
Does Not Have	4	3	2	1	7	1
Total	100	100	100	100	100	100

Table C.24: Possession of an Indoor Toilet by Family Type, 1987

Possession of Indoor Toilet	Type of Household					
	Family with Children Under 16 and No Elderly	Head of Household Aged 65 to 74	Head of Household Aged 75 or Over	Household Headed by an Under 65 with Elderly	Household Without Children Under 16 or Elderly	All Types
	Per Cent					
Has	97	89	85	92	92	93
Does Not Have	3	11	15	8	8	7
Total	100	100	100	100	100	100

Table C.25: Possession of an Indoor Toilet by Composition of Households Containing Elderly, 1987

Possession of Indoor Toilet	Composition of Households Composition Elderly People					
	Elderly Person Alone	Two or More Elderly People	One or More Elderly. 1 Adult. No Children	One or More Elderly. 2 or More Adults. No Children	One or More Elderly. 1 or More Adults. With Children	All Types
	Per Cent					
Has	82	87	92	95	96	89
Does Not Have	18	13	8	5	4	11
Total	100	100	100	100	100	100

Table C.26: Possession of a Bath or Shower by Family Type, 1987

Possession of Bath or Shower	Type of Household					
	Family with Children Under 16 and No Elderly	Head of Household Aged 65 to 74	Head of Household Aged 75 or Over	Household Headed by an Under 65 with Elderly	Household Without Children Under 16 or Elderly	All Types
	Per Cent					
Has	97	86	76	92	90	91
Does Not Have	3	14	24	8	10	9
Total	100	100	100	100	100	100

Table C.27: Possession of a Bath or Shower by Composition of Households Containing Elderly, 1987

Possession of Bath or Shower	Composition of Households Containing Elderly People					
	Elderly Person Alone	Two or More Elderly People	One or More Elderly. 1 Adult. No Children	One or More Elderly. 2 or More Adults. No Children	One or More Elderly. 1 or More Adults. With Children	All Types
	Per Cent					
Has	71	87	90	93	95	84
Does Not Have	29	13	10	7	5	16
Total	100	100	100	100	100	100

Table C.28: Having a Meal with Meat, Chicken or Fish Every Second Day by Family Type, 1987

Having a Meal With Meat or Fish Every Second Day	Type of Household					
	Family with Children Under 16 and No Elderly	Head of Household Aged 65 to 74	Head of Household Aged 75 or Over	Household Headed by an Under 65 with Elderly	Household Without Children Under 16 or Elderly	All Types
	Per Cent					
Has	88	88	87	92	85	87
Does Not Have	12	12	13	8	15	13
Total	100	100	100	100	100	100

Table C.29: Having a Meal with Meat, Chicken or Fish Every Second Day by Composition of Households Containing Elderly, 1987

Having a Meal With Meat or Fish Every Second Day	Composition of Households Containing Elderly People					
	Elderly Person Alone	Two or More Elderly People	One or More Elderly. 1 Adult. No Children	One or More Elderly. 2 or More Adults. No Children	One or More Elderly. 1 or More Adults. With Children	All Types
	Per Cent					
Has	85	91	88	91	91	88
Does Not Have	15	9	12	9	9	12
Total	100	100	100	100	100	100

Table C.30: Having a Warm, Waterproof Overcoat by Family Type, 1987

Having a Warm, Waterproof Overcoat	Type of Household					
	Family with Children Under 16 and No Elderly	Head of Household Aged 65 to 74	Head of Household Aged 75 or Over	Household Headed by an Under 65 with Elderly	Household Without Children Under 16 or Elderly	All Types
	Per Cent					
Has	85	91	82	89	87	87
Does Not Have	15	9	18	11	13	13
Total	100	100	100	100	100	100

Table C.31: Having a Warm, Waterproof Overcoat by Composition of Households Containing Elderly, 1987

Having a Warm, Waterproof Overcoat	Composition of Households Containing Elderly People					
	Elderly Person Alone	Two or More Elderly People	One or More Elderly. 1 Adult. No Children	One or More Elderly. 2 or More Adults. No Children	One or More Elderly. 1 or More Adults. With Children	All Types
	Per Cent					
Has	88	86	90	90	87	88
Does Not Have	12	14	10	10	13	12
Total	100	100	100	100	100	100

Table C.32: Having Two Pairs of Strong Shoes by Family Type, 1987

Having Two Pairs of Strong Shoes	Type of Household					
	Family with Children Under 16 and No Elderly	Head of Household Aged 65 to 74	Head of Household Aged 75 or Over	Household Headed by an Under 65 with Elderly	Household Without Children Under 16 or Elderly	All Types
	Per Cent					
Has	82	85	83	84	**85**	84
Does Not Have	18	15	17	16	**15**	16
Total	100	100	100	100	100	100

Table C.33: Having Two Pairs of Strong Shoes by Composition of Households Containing Elderly, 1987

Having Two Pairs of Strong Shoes	Composition of Households Containing Elderly People					
	Elderly Person Alone	Two or More Elderly People	One or More Elderly. 1 Adult. No Children	One or More Elderly. 2 or More Adults. No Children	One or More Elderly. 1 or More Adults. With Children	All Types
	Per Cent					
Has	86	83	85	84	78	84
Does Not Have	14	17	15	16	22	16
Total	100	100	100	100	100	100

Table C.34: Having New, Not Secondhand, Clothes by Family Type, 1987

Having New, Not Second Hand Clothes	Type of Household					All Types
	Family with Children Under 16 and No Elderly	Head of Household Aged 65 to 74	Head of Household Aged 75 or Over	Household Headed by an Under 65 with Elderly	Household Without Children Under 16 or Elderly	
	Per cent					
Has	89	91	92	91	91	90
Does Not Have	11	9	8	9	9	10
Total	100	100	100	100	100	100

Table C.35: Having New, Not Secondhand, Clothes by Composition of Households Containing Elderly. 1987

Having New, Not Second Hand Clothes	Composition of Households Containing Elderly People					All Types
	Elderly Person Alone	Two or More Elderly People	One or More Elderly, 1 Adult, No Children	1 or More Elderly, 2 or More Adults, No Children	One or More Elderly, 1 or More Adults, With Children	
	Per cent					
Has	90	94	92	93	87	91
Does Not Have	10	6	8	7	13	9
Total	100	100	100	100	100	100

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