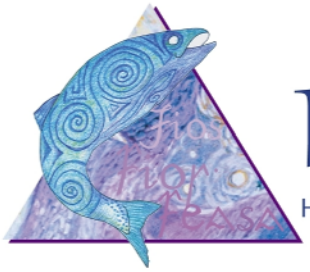

Health Inequalities and Ageing in the Community

Report of the Findings and Conclusions of the Social Study

SUMMARY

Health Systems Research Centre
Dept. of Sociology, University of Limerick

In collaboration with
Department of Medicine for the Elderly, Mid-Western Regional Hospital Limerick

December 2008

This research was supported through funding provided to the Health Systems Research Centre, Department of Sociology, UL by the Department of Health and Children and Health Services Executive. Financial support to contribute to the costs of the fieldwork was provided by the PAUL Partnership and West Limerick Resources. Financial support for support of the clinical research was provided by HSE West.

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FOREWORD

This study was initiated in mid 2006 and the community survey conducted mainly during 2007. That period represented the latter stage of the "Celtic Tiger" phenomenon. The recent rapid disintegration of the reliability of a predominantly market driven philosophy positions this report's findings as a local baseline and a national reference point to monitor any emergent changes in health and social status arising from new socioeconomic models during the years ahead.

This report is the product of community and university collaboration. Its origins are based on a local perception of the immediate social needs of older persons in one of four parishes that are described as the "Thomond Cluster" in the north Limerick City area. That created a dialogue with the "Priests and People" of those parishes regarding the wider and varied needs of those communities. The scope of the study is universal and inclusive!

The aim of the study has both practical and policy implications affecting health inequalities amongst older persons in urban communities. The objectives are to assess the socioeconomic and health status and characteristics associated with difference in health status in older age. They explore the relative importance of factors in communities that may affect people's health as they age and in particular the consequences of structural dimensions of neighbourhoods. While people are living longer the evidence indicates widening inequalities in advanced societies.

The study collaborators present the empirical and theoretical evidence of a unique Irish social study that includes subjective health profiles and perspectives on social capital and public service utilisation. The process of disseminating the findings commenced recently with a gathering of the vast majority of participants in Thomond Park. This is being followed in the New Year with an invited group of representatives from interested agencies and academics. There are additional forthcoming reports that will result from further analysis and in particular from data linkage with a twin clinical study of the same population.

The Heath Systems Research Centre and Thomond Cluster representatives gratefully acknowledge the contribution of parish councils, local voluntary associations and individuals who facilitated the scoping of the study population. The overall high response rate is due to that level of engagement. The funding for additional surveyors was kindly provided by Paul Partnership and West Limerick Resource Centre and is very much appreciated.

Dr Eileen Humphreys, Senior Research Fellow, HSyRC who undertook the main work and write up with survey assistance from Eilish Dolan and Gerardine Flynn merits our deepest gratitude for bringing a concept and design to reality. The next steps fall to be addressed by the local communities and associated agencies.

Prof. Stiofan de Burca,
Director,
Health Systems Research Centre,
Dept of Sociology,
University of Limerick. December 2008

1. Introduction

This research links the themes of (i) ageing populations with a specific focus on those living in urban communities, and (ii) inequalities in health in the population, linked to individual social class. These present major challenges to public policy and public health.

2. Background

Demographic projections anticipate an increase in the population aged 65 years and over and a trend towards an ageing population in Ireland. By 2030, 25 percent of the population will be aged 60 years or over, from 11 per cent at present. By 2050, the old age dependency ratio[1] is expected to be at 45 percent compared with 18 per cent in 2004/5. This is well below the expected EU ratio of 53 per cent by 2050. A further trend expected in Ireland is a large increase in "oldest old" (i.e. people aged 80 years and over). While Ireland has a younger population structure and will not age as fast as many other countries in the EU, similar to the situation in the EU in general, a large increase in public expenditure on social protection (pensions), health care and long-term care is expected, especially between 2030 and 2050, linked to the ageing population.

3. Policy Context

A key element of the strategy at EU level to address the challenge presented by the ageing population is to prolong working lives by providing incentives for later retirement. Proposed initiatives relate to pension reforms, keeping older people employable and health promotion / health care. Policies in Ireland addressed to older people, in practice, have focused more narrowly on health and social care stressing from the 1988 policy document (*The Years Ahead*) the principle of maintaining independence of older people, and encouraging and supporting community care services. More recently, emphasis has been on fair access, and patient-centredness in health services (*Quality and Fairness* 2002) and the need for coordinated public services provision. However, the evidence suggests that there have been weaknesses in the extent to which community and integrated care service have been put into place in Ireland.

In relation to health inequalities, this refers to differences in the health of individuals in the population linked to their position in the social class hierarchy. People lower down the social class hierarchy have higher incidence of health problems than those higher up. There is considerable evidence that poorer people have shorter lives and worse health while they are alive than those who are more affluent. Poorer people also tend to have less access to services

[1] % 65 years and over / 15-64 years

than those who are well-off. While people are living longer, there is evidence of widening inequalities in health in advanced European countries – i.e. that the situation is not improving but getting worse - and the persistence of health inequalities into old age.

4. Key Literature and Existing Research

Approaches to ageing over the lifecourse divide between an optimistic and a pessimistic perspective. The optimistic perspective focuses on healthy and active ageing such that illness is compressed into a short phase at the end of life. The pessimistic perspective adopts the view that there is no evidence that illness is becoming less common in old age and that early disadvantage creates a deterministic pattern and cumulative disadvantage into old age.

There is much emphasis in research on the determinants of health – i.e. the factors which influence an individual's state of health and life expectancy. These comprise: (1) fixed factors such as age, gender, genetic make-up; (2) behaviour and lifestyle choices such as smoking and drinking behaviour, diet, physical exercise; and (3) social, economic and cultural factors including occupation, income, education, housing etc. The relationships between social determinants and health outcomes are not completely understood in terms of how social factors affect health – i.e. what causes what? Main theories proposed to explain social causes of health / ill-health are as follows:

- The psychosocial perspective (Wilkinson 1996, 2005). Increased inequality in society and worsening relative poverty affect the cohesion in society and trust leading to stress, depression and insecurity. This, in turn, affects the immune system resulting in ill-health. It is also argued that social hierarchies mean that people lower down the hierarchy have less control over various aspects of their lives – for instance, choices about work, where to live etc. – and stresses linked to this affects health (Marmot 2004).
- Material conditions of living where certain groups of people have less favourable conditions than others (income, housing, education) resulting in poorer health for those less well-off. Worse conditions for certain groups are associated with an unequal distribution of resources in advanced societies. These are regarded as the structural causes of inequality (Lynch, Davey-Smith *et al* 2000) and they are deeply rooted in the way in which society is stratified.

Levels of social capital in society affect health outcomes. Health of the population is better where the social capital is high (Putnam 2000). Social capital refers to shared values of trust

and reciprocity (looking out for each other) and involvement in social networks including associations which bring people together as communities to deal with common problems.

Recent studies have explored the link between health and neighbourhood of residence (Hou and Myles 2005; Wen, Browning *et al* 2003). Concentrations of affluence or poverty at neighbourhood level affect health outcomes for residents over and above their own individual characteristics (Wilson 1987; Hou and Myles 2005). Poorer people benefit from sharing neighbourhoods with more affluent individuals linked to: (i) better functioning institutions and better services in more affluent areas and (ii) learning from each other (Wilson 1987). Research in this area is at an early stage, however, and not all agree that this is the case.

Access to health services can contribute to reducing inequalities in health (Mackenbach 2006), particularly when primary care services are considered (Starfield 2007; Starfield, Shi *et al* 2005). While there is higher demand for GP services in deprived areas in Ireland linked to higher illness rates, there are difficulties in providing quality care and barriers to access to services including long waiting lists for community services and hospital services and lack of community-based services. Quality of professional care provided by GPs, however, is highly rated.

In Ireland, existing research shows a relationship between health status and social class with those in higher social class groupings rating their health better than those in intermediate and lower social class groupings (Shiely and Kelleher 2004). Older people experiencing either basic or secondary deprivation are at increased risk of chronic illness (Garavan, Winder *et al* 2001). Women are at a greater disadvantage compared with men (Garavan, Winder *et al* 2001; Shiely and Kelleher 2004). Older people are relatively heavy users of certain types of health services (GPs, hospital outpatients, inpatients etc.) linked to worsening health status as people get older. People of lower socio-economic status are also relatively heavier users and this is linked to poorer health status (O'Reilly, Thompson *et al* 2006; Layte, Nolan *et al* 2007).

5. Aim and Objectives of the Research

The aim of this research is to inform the policy debate on health inequalities as this affects older people in the population living in urban communities (city neighbourhoods), and to use this evidence to suggest what could be done to improve the situation. The objectives are:

- To examine the association between socio-economic status and health status with reference to an older population living in urban communities of high, medium and

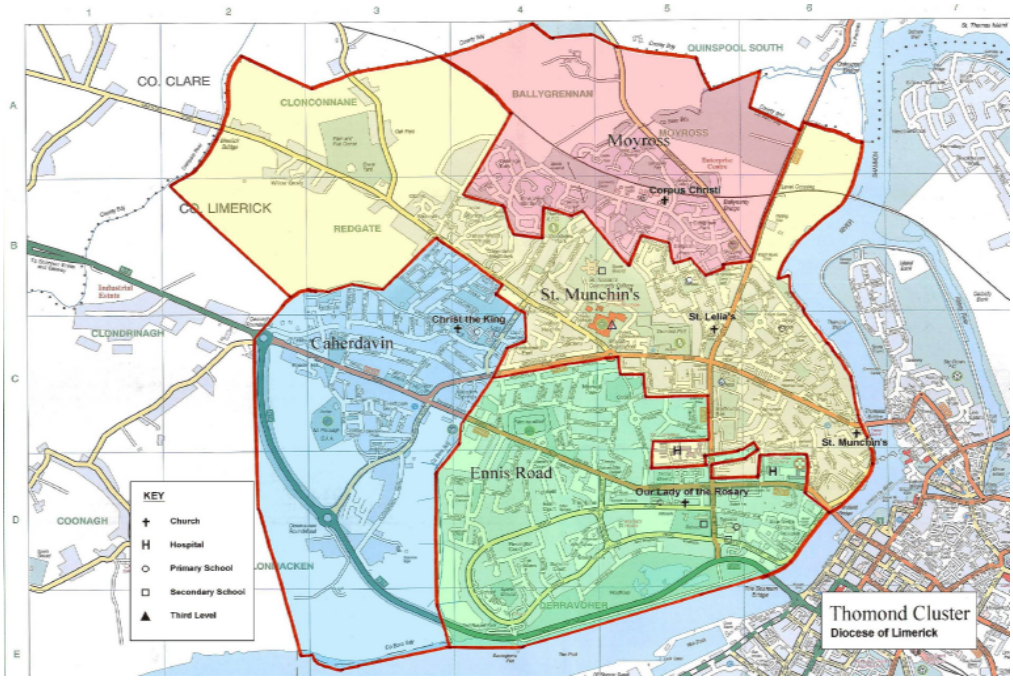
low socio-economic status (with the parishes in Thomond Parish Cluster used as a basis for this);

- To identify the main demographic (gender, age) and socio-economic characteristics (social class, education) of people associated with differences in health status in older age; and
- To explore the relative importance of other factors in communities that may affect people's health as they age. These include in particular: whether neighbourhoods are structured as affluent, poor or socially mixed, conditions of the environment of neighbourhood including local services, aspects of the social capital of the community including trust in people in general and in institutions, sense of community, supportive networks of family and friends, the extent of health services utlilisation, and the quality of professional care and health services delivery.

6. Thomond Parish Cluster: The Four Parishes

This research was undertaken in four parishes on the northside of Limerick City and suburbs which, recently, have come together to form Thomond Parish Cluster. The four parishes in the Cluster are: St. Munchin's (the original parish from with the others were formed), Our Lady of the Rosary, Christ the King and Corpus Christi. The origins of the study from the local community perspective arise from the need identified in one of the parishes (Our Lady of the Rosary) for a day centre for older people to meet. A focal point for the Cluster is the ageing population in the parishes and the need to develop facilities and services in the communities to meet the needs of the people as they age in their communities.

Figure 1: Thomond Parish Cluster



Limerick City has a profile of social disadvantage. It is the second most disadvantaged local authority area in the state. Limerick City has a stronger pattern of inequality based on social segregation of people into relatively more affluent and relatively poor small areas / neighbourhoods compared with the national average. Thomond Parish Cluster, on the northside of the city, has a slightly higher social class profile than the city as a whole. The four parishes within the Cluster, however, are very different in their social composition and demographic structure:

1. Our Lady of the Rosary, mainly on the Ennis Road / North Circular Road, the most affluent parish in the city and now with an ageing population;
2. Christ the King, covering a large part of Caherdavin, a parish of middle / high socio-economic status in the suburbs constructed in the 1970's with a relatively small older population. Older people generally are in the younger age grouping (65-75 years) and are more active elderly;
3. St. Munchin's, a mixed and "sprawling" parish centred on traditional working class communities of Thomondgate, Killeely and into Ballynanty with a low socio-economic profile, also including more prosperous areas such as Mayorstone and Clancy Strand and into parts of Caherdavin. This parish has a large elderly population;
4. Corpus Christi centred on the Moyross Estate, a local authority housing estate constructed from the 1970's with a low socio-economic profile, and a very small group of older people generally resident in the older and (more settled) parts of Moyross. Its elderly population includes two communities of sisters, many of whom are now elderly.

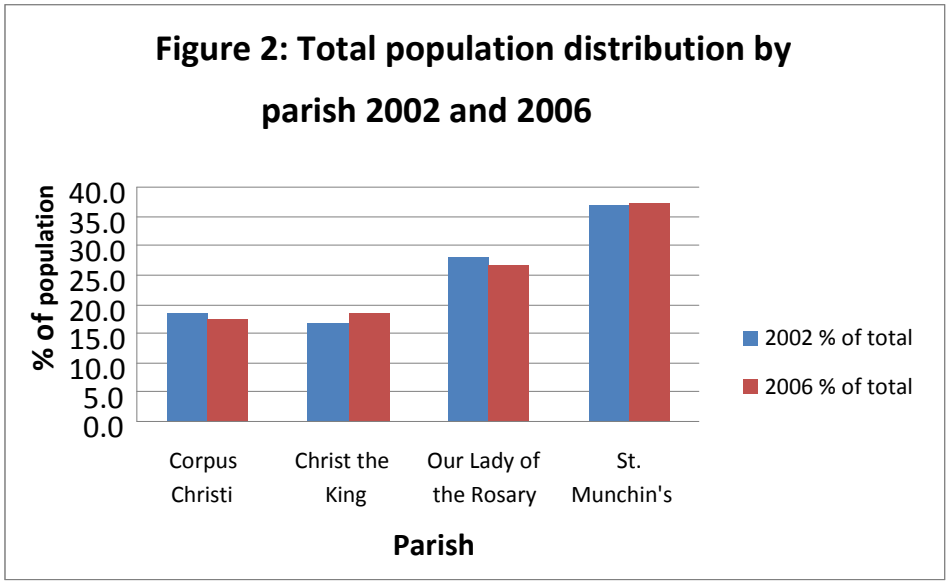
The distribution of population across the four parishes for the years 2002 and 2006 is presented in **Table 1** and illustrated in **Figure 2**.

Table 1: Distribution of population: Thomond Parish Cluster and by Parish, 2002 and 2006

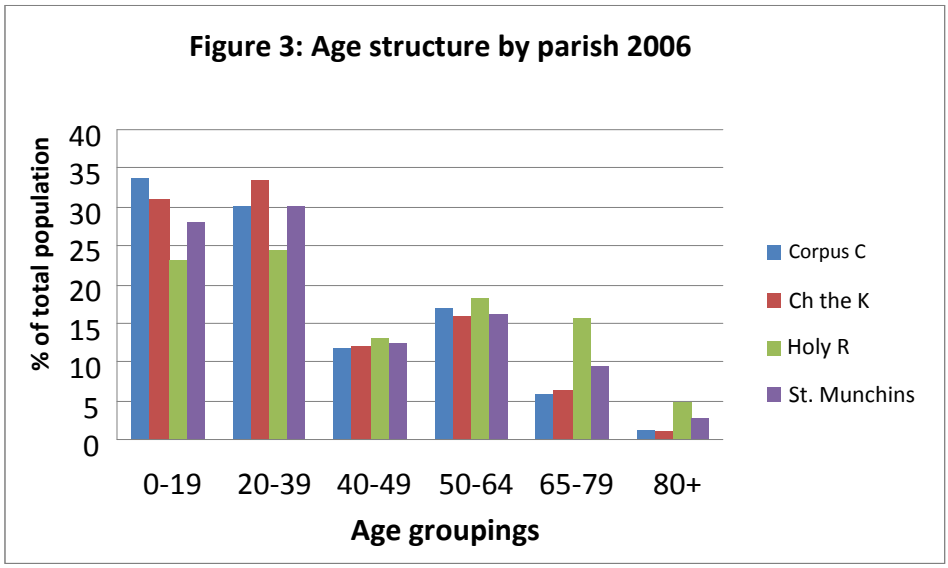
Parish	2002		2006	
	No.	% of total	No.	% of total
Corpus Christi	4020	18.3	3674	17.5
Christ the King	3702	16.9	3865	18.4
Holy Rosary	6136	28.0	5617	26.7
St. Munchin's	8081	36.8	7863	37.4
Thomond Cluster	21939	100.0	21019	100.0

St. Munchin's is the largest parish in terms of population size (as well as land area) having more than twice the population of each of the smaller parishes of Christ the King and Corpus Christi. Together, the older parishes of St. Munchin's and Our Lady of the Rosary account for

approximately two-thirds of the population of Thomond Parish Cluster. The population of the cluster has declined slightly between 2002 and 2006 (CSO 2006). Population has declined in all parishes with the exception of Christ the King with the greatest decline in Corpus Christi.



The age structure by parish is presented in **Figure 3**. Our Lady of the Rosary Parish and, to a lesser extent, St. Munchin's Parish, has an older population profile compared with Corpus Christi and Christ the King parishes. Corpus Christi parish has the highest proportion in the age grouping 0-19 years (34%) while Our Lady of the Rosary has the lowest (23%); Christ the King parish has the highest proportion in the age group 20-39 years (34%) and Our Lady of the Rosary the lowest (24%); Our Lady of the Rosary parish has the highest proportion in all of the older age groupings, 50-64 years, 65-79 years and 80 years and over.



Comparing the Four Parishes, Our Lady of the Rosary Parish has a high social class profile and Corpus Christi a low social class profile relative to the city. In terms of the other parishes in the intermediate positions between the highest and lowest, Christ the King leans towards a higher social class profile and St. Munchin's towards a lower social class profile – **Table 3**.

Table 3: Social Class Base: High / lower professional v. Semi- & Unskilled 2006				
Area	**Total pop**	**Pop excluding SC 7 (unclassified)**	**% SC 1 (Professional) and 2 (Managerial & Technical)**	**% SC 5 (Semi-skilled) and SC 6 (Unskilled)**
Corpus Christi	3674	2714	22.2	33.3
Christ the King	3865	2830	36.5	18.3
St. Munchin's	7863	5963	27.6	28.1
Our Lady of the Rosary	5617	4763	56.5	9.6
Thomond Cluster	21019	16270	36.7	21.9
Limerick City	52539	39792	28.9	28.5
Ireland	4239848	3492408	32.9	18.6

Indicators of high and low levels of educational attainment at the level of parish show a similar pattern to that of social class – i.e. a profile of high levels of educational attainment amongst residents of Our Lady of the Rosary Parish (only 7 per cent has primary or no formal education while 42 per cent has a third level qualification), and low levels in Corpus Christi (30 per cent having primary or no formal education as the highest level of education and 15 per cent with third level education) at the extremes. In relation to the parishes in the intermediate positions, Christ the King has an education profile above the city and Cluster average and in some respects better than the national average while St. Munchin's has a lower education profile.

Scores on the Relative Deprivation Index for the year 2006 at Electoral District (ED) level[2] confirms that the Cluster contains the extremes: one of the EDs in Our Lady of the Rosary Parish is ranked in the top one percent of the most affluent areas in the state, and two EDs in that parish are ranked in the top two percent; Ballynanty ED, mainly covering Corpus Christi parish, and one ED in St. Munchin's Parish (Killeely A) are ranked in the bottom one percent of most disadvantaged local areas in the state; the Cluster also contains areas (EDs) in intermediate positions. The ED corresponding closest to Christ the King Parish, for instance, is classified as above average.

[2] The index being a composite measure of relative affluence / deprivation based on analysis of census variables (Haase and Pratschke 2008)

7. Research Methodology

The primary research involved: (i) a social survey and (ii) clinical screening based on a snap-shot of older people in the parish at a single point in time (2007). The social survey is addressed to older people (aged 65 years and over) resident in the Four Parishes. Clinical screening was offered to all respondents surveyed. While the study is based in northside Limerick, as explained above, the Four Parishes represent different types of area and, as such, the research findings could have wider applicability beyond the study population.

The social study involved face-to-face interviews with older people in their own homes. The clinical screening was undertaken at St. Camillus's hospital over two visits. The survey is based on independent samples in two parishes where the older population is relatively large (Our Lady of the Rosary and St. Munchin's) and a census in two parishes (Christ the King and Corpus Christi) where the older population is relatively small. The sample size varies from approximately half of the older population in Christ the King and Corpus Christi (51% and 47% respectively) to 15 percent in St. Munchin's with the largest older population, and 19 per cent in Our Lady of the Rosary. Samples were randomly-selected in Our Lady of the Rosary and St. Munchin's. An overall response rate of 65 per cent was obtained and 542 valid questionnaires. Response rates were highest in relatively more affluent areas. See **Table 4**. The opportunity to participate in health screening proved to be a strong incentive for participation, particularly for those individuals in higher socio-economic groupings.

Table 4: Parish Surveys – Response Rates

Parish	Sample house-holds approached (No.)	65+ individuals	Not contactable	Not eligible (eg. not 65)	Refused	Respond-ents / Useable interviews (No.)	Response rate (%)
Christ the King	210	334	87	32	69	146	68
Holy Rosary	284	417	99	10	90	218	71
St. Munchin's	391	544	198	76	119	151	56
Corpus Christi	67	79	18	21	13	27	68
Total	**952**	**1374**	**402**	**139**	**291**	**542**	**65**

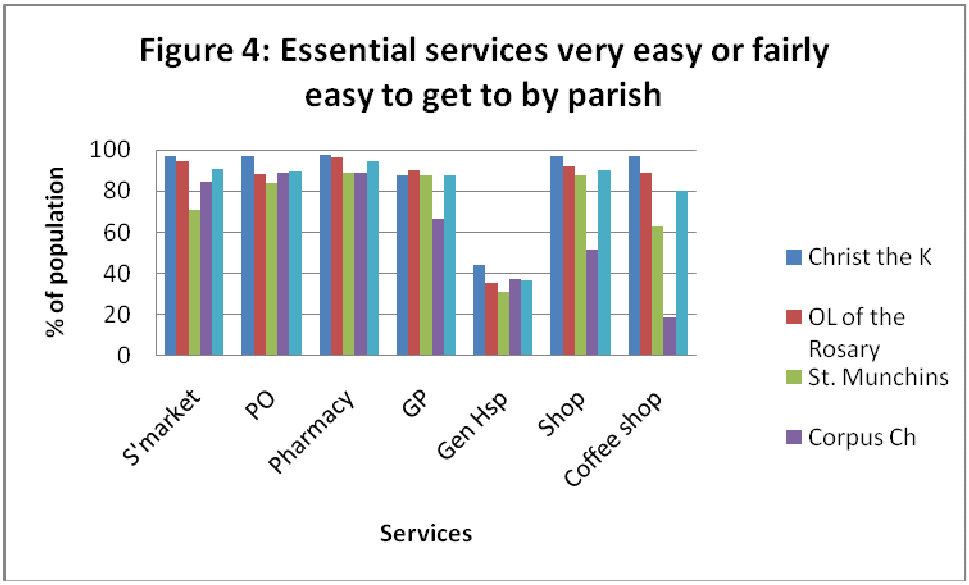
Further elements of the work involved analysis of secondary data from (i) the Small Area Population Statistics (SAPs), 2002 and 2006 Census of Ireland and (ii) the measures of relative affluence / deprivation at spatial level derived from analysis of census variables (Haase and Pratschke 2008) to profile the parishes in terms of overall socio-economic and demographic characteristics.

Local meetings of the Cluster and consultations with individuals working in / with the Parishes and other stakeholders informed the research design. Members of the Cluster assisted with practical aspects of study implementation.

8. Main Findings

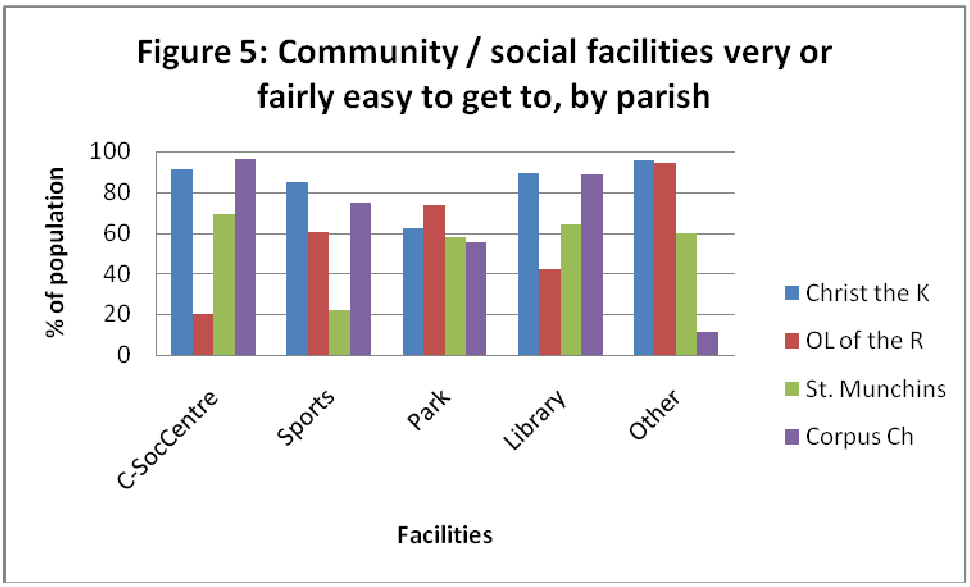
Residents subjective view of neighbourhood is that it relates to very localised areas, typically centred on well-defined neighbourhoods with physical boundaries (Caherdavin, Moyross) or a clear identity such as traditional communities of place (Thomondgate, Killeely). A significant proportion, however, viewed the neighbourhood at a smaller scale such as a street or small estate. Sense of belonging to community is strong in all of the parishes. It is strongest in Christ the King parish (93% feel a sense of belonging to community), followed by Our Lady of the Rosary Parish (91%). It is weakest in the most disadvantaged parish of Corpus Christi (70% feel a sense of belonging to community) while St. Munchin's is in an intermediate position (83%).

With the exception of a general hospital, essential services and facilities including shops, post office, a pharmacy and GP surgery are very or fairly accessible in the parishes – see **Figure 4**.

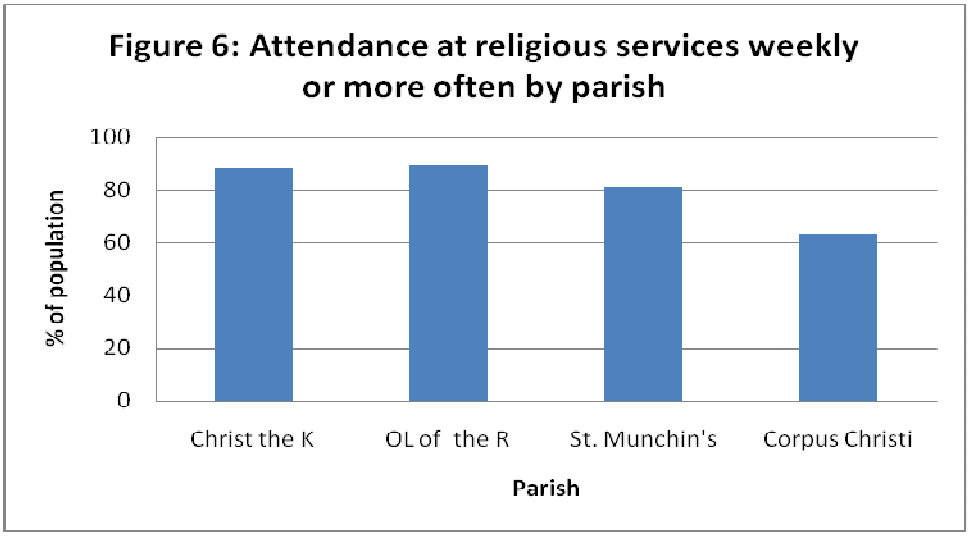


Christ the King followed by Our Lady of the Rosary parish – the areas with the higher social class profile – have the best profile overall on accessibility of essential services and the most disadvantaged parish, Corpus Christi, has the worst profile. For instance, a coffee shop, GP surgery and shops generally are least accessible in Corpus Christi parish.

In terms of accessibility of community / social facilities such as a community centre, sports / leisure centres, Christ the King parish followed by Corpus Christi has the best profile, while the lower and mixed social class parish, St. Munchin's, has the worst – for instance, only 20 percent of the older people consider that sports facilities are very or fairly accessible to them in St. Munchin's. The most affluent parish, Our Lady of the Rosary, also has relatively poor accessibility to community / social facilities - in particular, a community / social centre. Other facilities – like hotels or other places to meet are not accessible to the older population in Corpus Christi and are most accessible in Christ the King and Our Lady of the Rosary – **Figure 5**.

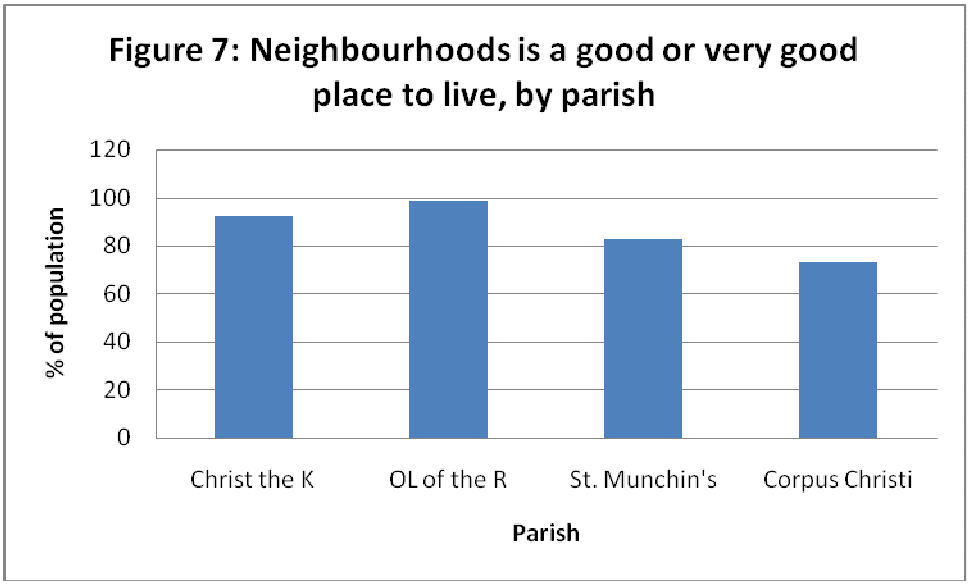


It is perhaps not surprising that regular church attendance is very high overall with approximately 90 percent of the older population in Christ the King and Our Lady of the Rosary attending religious services once a week or more often. Regular church attendance amongst older people is lowest in Corpus Christi parish – **Figure 6**.

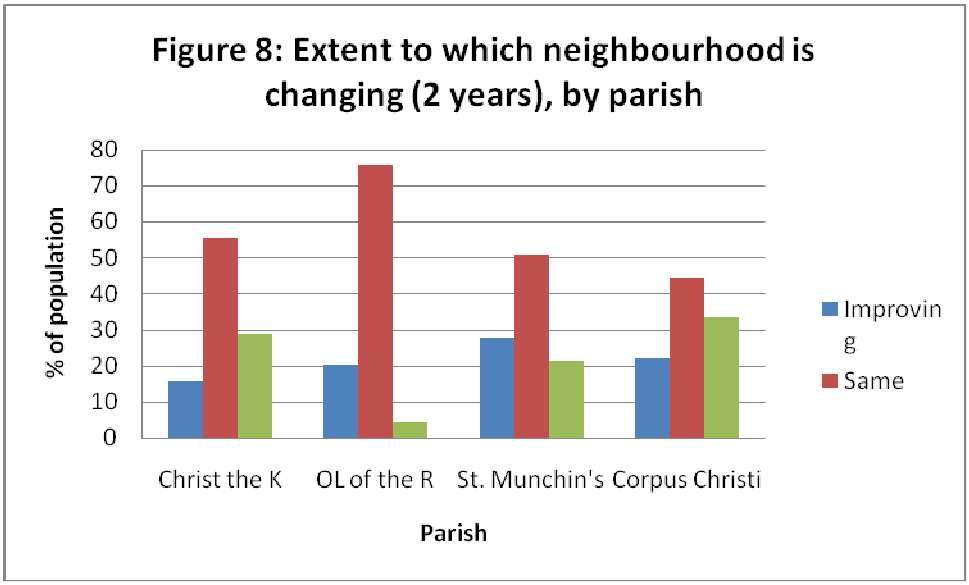


Religiosity is high in terms of regularity of individual prayer (i.e. praying at least daily). This is highest in St. Munchin's parish where approximately 89 per cent pray at least daily, followed by Corpus Christi (85%). Approximately 84 percent and 78 per cent of older people in Our Lady of the Rosary and Christ the King respectively pray at least daily.

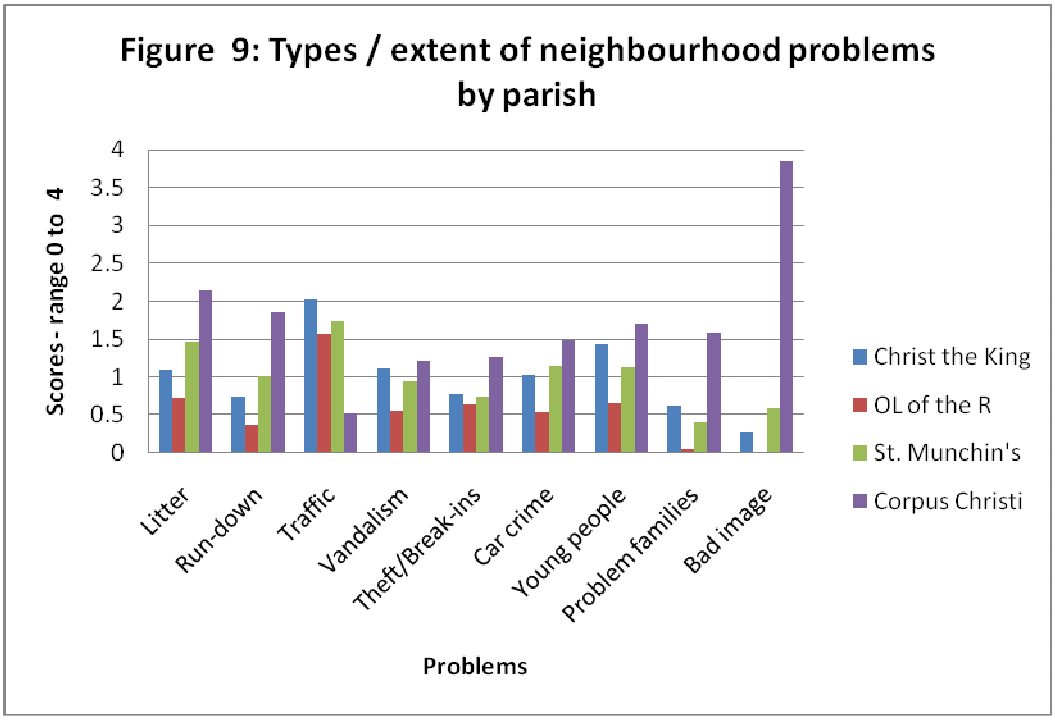
The vast majority of older residents considers their neighbourhood a very good or fairly good place to live. Satisfaction with neighbourhood is lowest in Corpus Christi (but just over 70% considers it a good or very good place to live) followed by St. Munchin's (just over 80%) – the two parishes with a lower socio-economic profile. Almost all of the older population of Our Lady of the Rosary considers it a very good or good place to live – **Figure 7**.



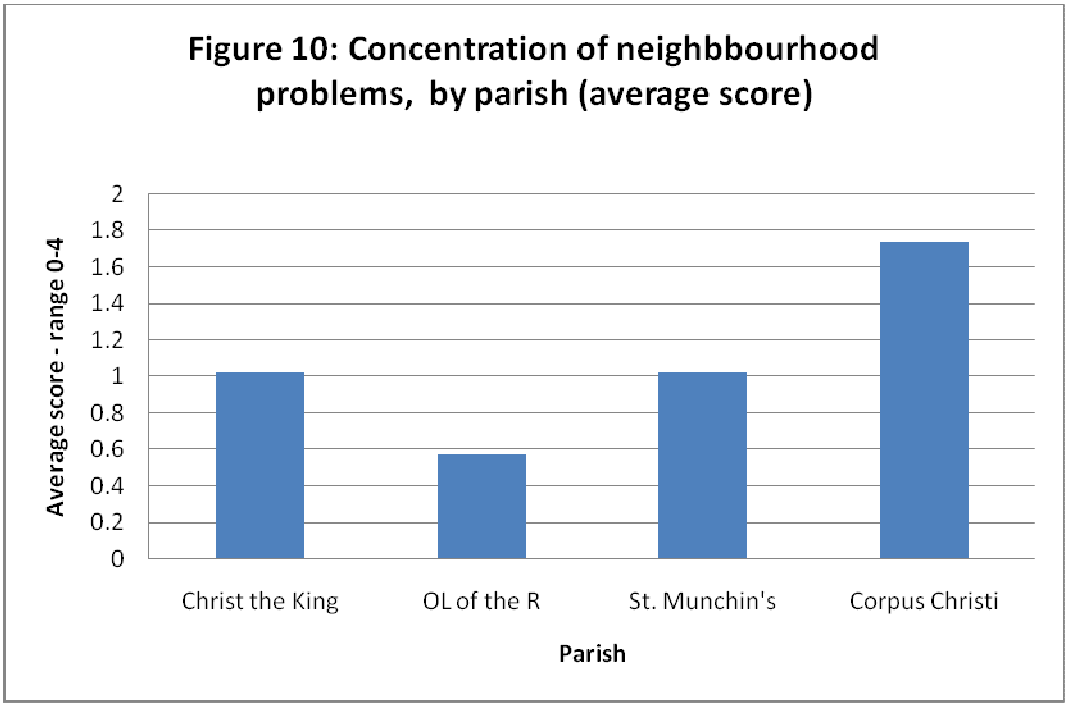
The majority considers that the neighbourhood is stable (staying much the same) and opinion is mixed as to whether it is getting better or worse over the last two years. Approximately 30 percent Corpus Christi Parish and Christ the King considers that the neighbourhood is getting worse over the past two years while less than 3 per cent consider it is getting worse in Our Lady of the Rosary – **Figure 8**.



The types and extent of neighbourhood problems are illustrated in **Figure 9**. These are scored from 0 (not at all a problem) to 4 (a very big problem) and aggregated to parish level. The greatest variation between parishes is in relation to poor external image. All residents of the disadvantaged parish, Corpus Christi, consider the negative image of the area as a very big / big problem. The more affluent parishes of Christ the King and Our Lady of the Rosary and St. Munchin's highlight traffic (heavy traffic, noise, danger) as the most serious problem. "*Young people hanging around*" is identified as more of a problem in Corpus Christi and Christ the King compared with the other two parishes. Litter, run-down buildings and problem families are amongst the more serious problems identified in Corpus Christi.

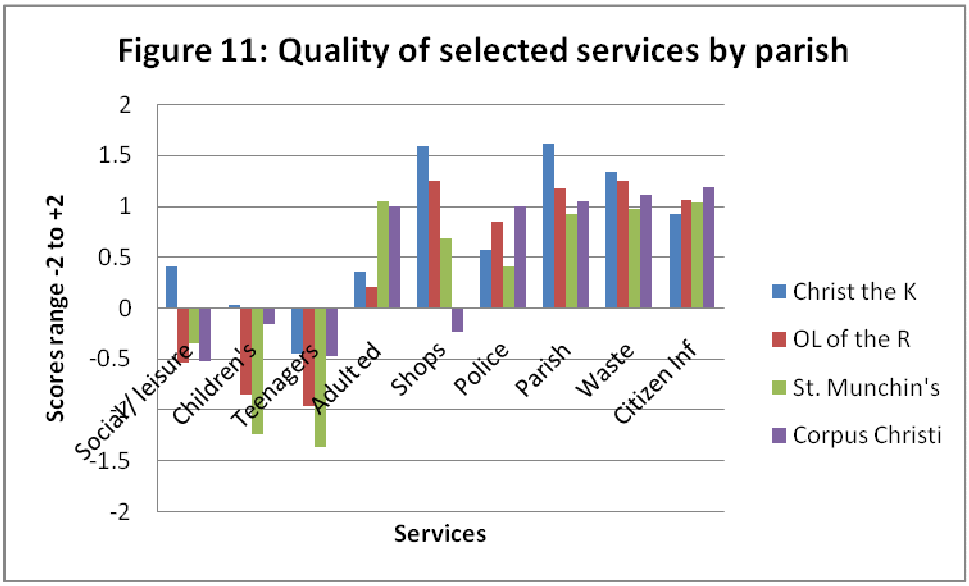


Corpus Christi has the strongest concentration of neighbourhood problems while the affluent parish, Our Lady of the Rosary, has the weakest concentration of problems – **Figure 10**.

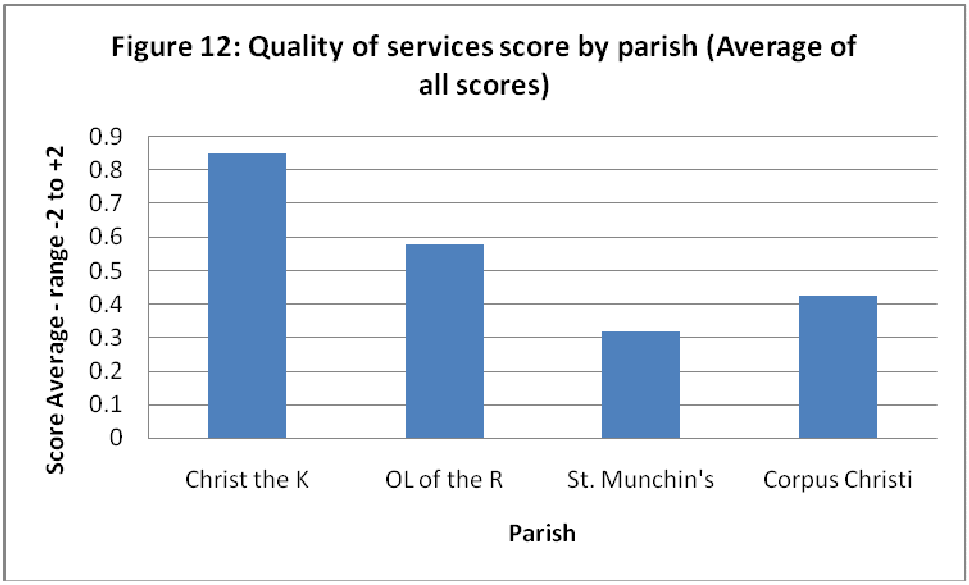


In terms of quality of local services, these are scored from -2 (very poor) to +2 (very good) and again aggregated in the reporting to parish level. The highest quality / satisfaction ratings are for parish / religious services. The lowest satisfaction ratings are for services for teenagers

- more people in all parishes considers facilities for teenagers poor compared with the proportion that rates them good or very good. Children's services and social and leisure services for older people are also rated poorly. With the exception of Christ the King parish, more people in other three parishes rate them as poor / very poor compared with the proportion that rates them as good / very good – **Figure 11**.



Christ the King followed by Our Lady of the Rosary parishes have the best overall scores for quality of local services and St. Munchin's the lowest score – **Figure 12**.



The overall picture, therefore, is that the more affluent parishes have the most accessible services, the lower concentration of neighbourhood problems and best quality ratings for local services.

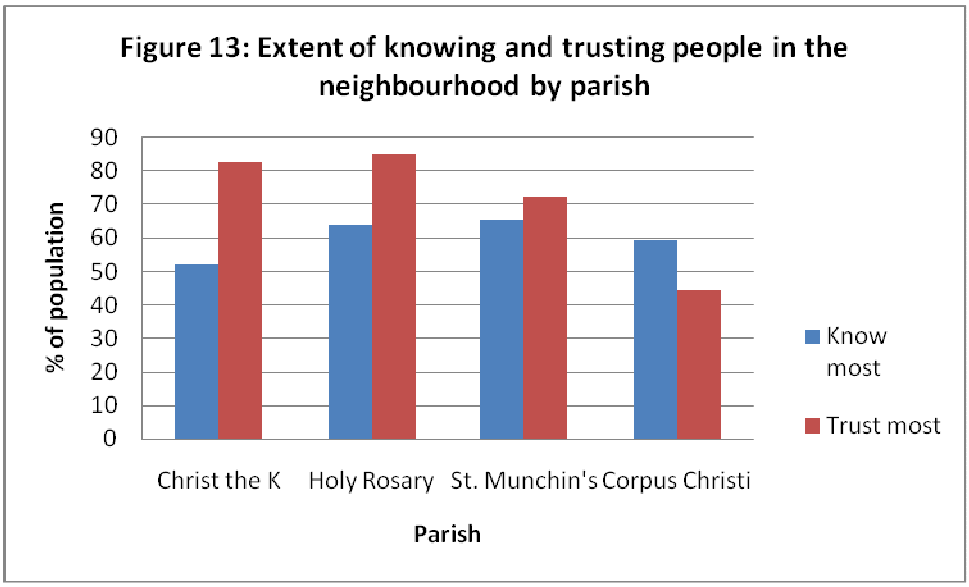
Focusing on social capital, generalised social trust (trusting people in the neighbourhood) is high, highest in the more affluent parishes of Our Lady of the Rosary and Christ the King and lowest in the most disadvantaged parish, Corpus Christi. The findings indicate that trust is high with 79 per cent across all parishes indicating that they trust most or many of the people in the neighbourhood and only 6 per cent indicating that they trust only a couple or nobody – **Table 5**.

Table 5: Generalised trust of people in the neighbourhood, by parish

Would you say you trust	**All**		**Christ the King**		**OL of the Rosary**		**St. Munchin's**		**Corpus Christi**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Most or many of the people in the neighbourhood	425	78.8	120	82.8	185	84.9	108	72.5	12	44.4
Some of the people	79	14.7	21	14.5	24	11.0	26	17.4	8	29.6
Just a couple of people	31	5.8	3	2.1	9	4.1	13	8.7	6	22.2
Nobody in the neighbourhood generally	4	0.7	1	0.7	0	0	2	1.3	1	3.7
Total	539	100	145	100	218	100	149	100	27	100

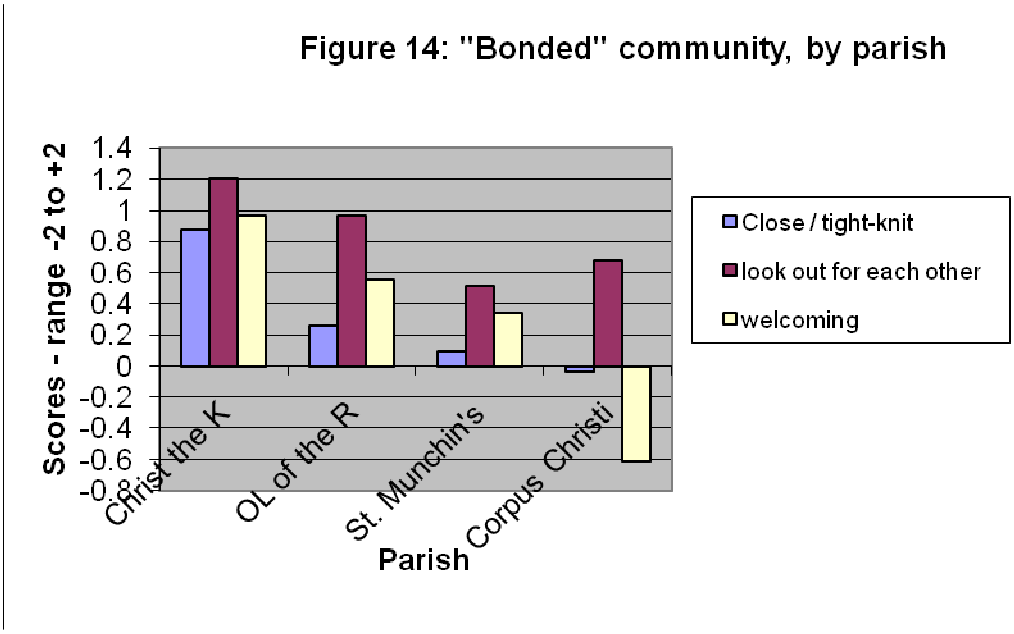
Tests: Pearson's Chi-sq. = 0.000; Association: Cramer's V =0.153, p<0.001

It is only in Corpus Christi parish that residents report knowing people to a greater extent than they trust them – **Figure 13**.

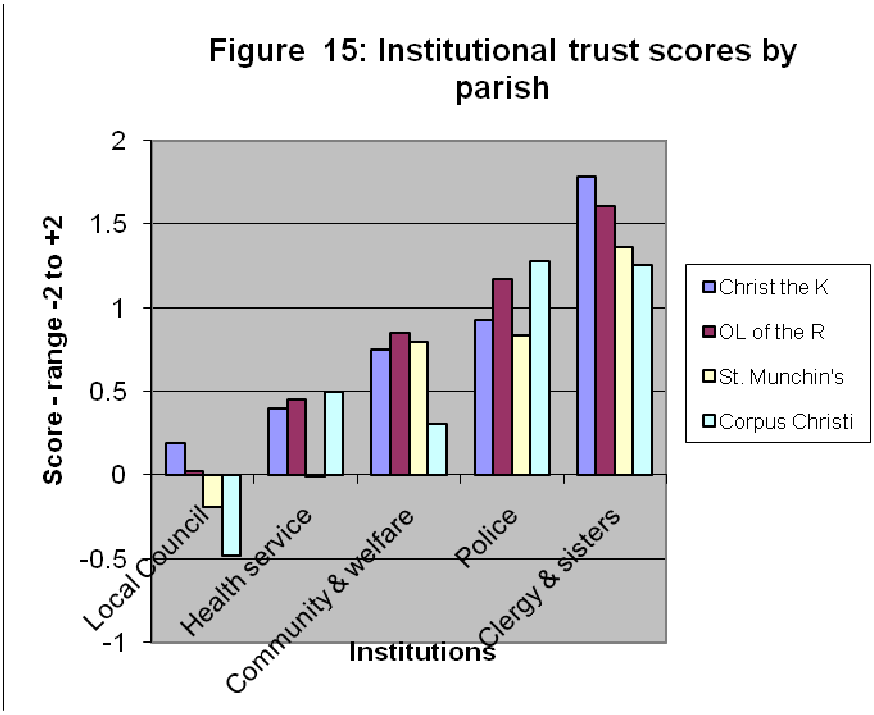


In relation to the notion of bonded communities, attitudinal statements are scored from -2 (strongly disagreeing with the statement) to +2 (strongly agreeing). The findings indicate that a sense of social reciprocity (the notion that people "*look out for each other*") is high across all parishes. This follows the same pattern of being highest in the affluent parishes and lower in the more disadvantaged parishes of Corpus Christi and St. Munchin's. In relation to community cohesion (i.e. the extent to which people agree that they live in "*close / tight knit*

communities") and inclusion ("*welcoming to newcomers*"), the more affluent parishes again are more cohesive and more inclusive than the disadvantaged parishes. Corpus Christi is least inclusive on this indictor. In residents' experience, newcomers onto the estate have often been problem families whose presence led to a deterioration of the quality of life on the estate – **Figure 14**.

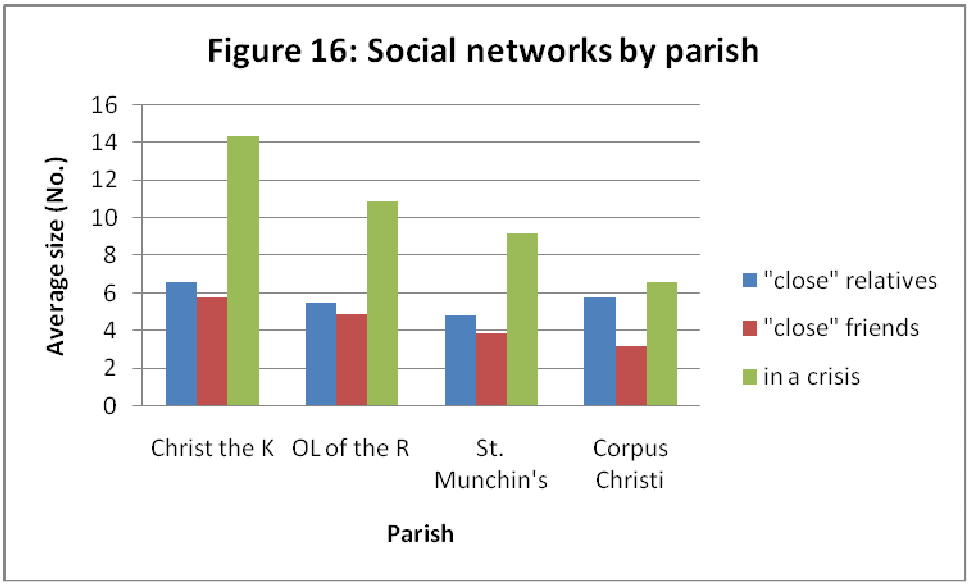


In terms of institutional trust, the extent of trusting the various institutions is again scored from -2 (not at all) to (+2 completely or in most things). Trust is highest in the local clergy and sisters followed by the police and lowest in the local authority. The lowest levels of trust in the local authority are reported by residents of the most disadvantaged parish, Corpus Christi. In both Corpus Christi and St. Munchin's parishes, more people express a distrust than trust in the local authority. Trust in the health services, generally, is not at a high level – **Figure 15**.



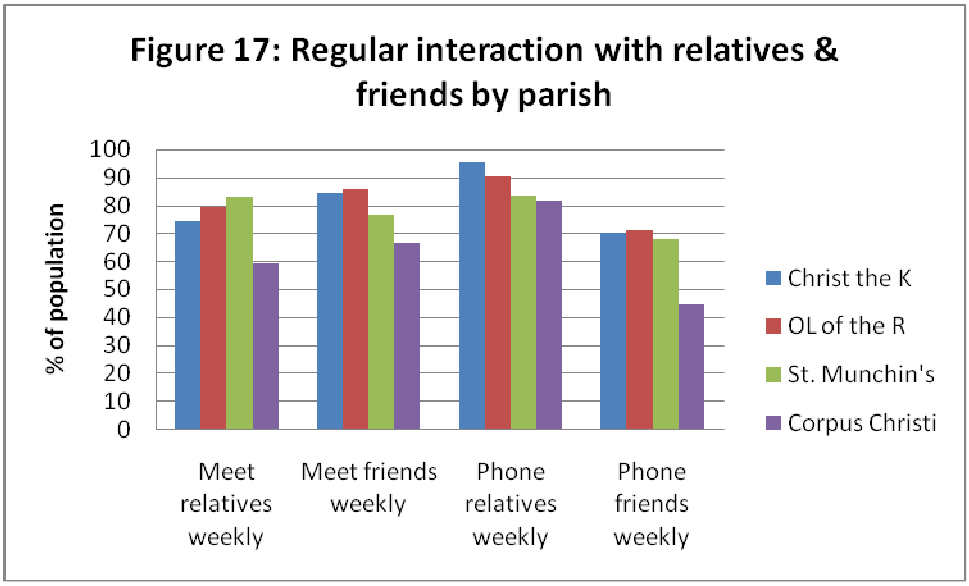
On an overall score of institutional trust, the affluent parishes of Christ the King and Our Lady of the Rosary have the highest scores and the more disadvantaged, St. Munchin's followed by Corpus Christi, the lowest scores.

Focusing on social capital at individual level in terms of strong ties of family and friends and people to turn to for support in a crisis, residents of Christ the King have the largest average size of networks of relatives (family), friends and people to turn to in crisis. Networks of friends and people to turn to in times of crisis are smaller on average in Corpus Christi parish- **Figure 16**.



A very small proportion of the population surveyed have no relatives (2%, 11 people) with whom they have a close relationship, a larger proportion has no friends (8%, 42 people) and a very small number (0.6%, 3 people) has nobody to turn to in times of crisis. The incidence of having no close friends is higher in the more disadvantaged parishes of Corpus Christi (19%) and St. Munchin's (13%). It is only in these more disadvantaged parishes that older people report having no one to turn to for support in times of serious personal crisis (1% in St. Munchins and 3% in Corpus Christi).

Generally, older people are in touch with relatives and friends on a regular basis by visiting and telephone contact. A smaller proportion of older people in Corpus Christi parish meets and 'phones relatives and friends weekly compared with other parishes – **Figure 17**.

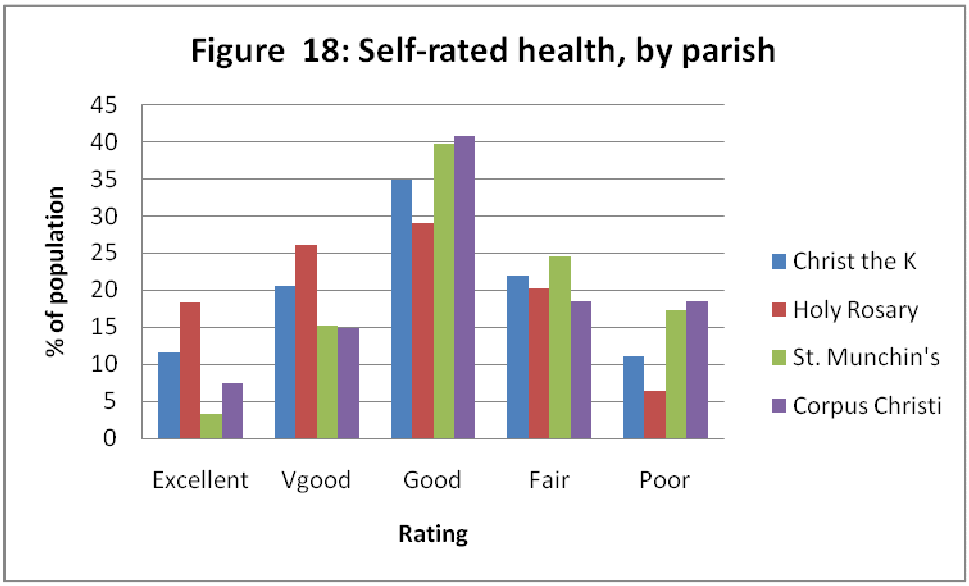


Age of respondent also affects the regularly of meeting relatives with older people meeting relatively less frequently. In terms of broader social networks of acquaintances, as illustrated above, the majority of older people know their neighbours.

Involvement in voluntary associations including church-based activities, and social clubs where older people meeting regularly is high (56% across all parishes). Participation in voluntary associations is highest in Our Lady of the Rosary parish (67%) followed by Christ the King (60%) and lowest in Corpus Christi parish (33%) with St. Munchin's at 40 per cent. The largest proportion across all parishes is involved in sport and leisure (including card playing) and then church-based associations. There are also differences in the types of associations in which older people are involved by parish. For instance, in Corpus Christi parish, the largest proportion is involved in a social group / club (such as a lunch club); in St.

Munchin's, the largest proportion is involved in church-based associations, in Our Lady of the Rosary, sports / leisure and in Christ the King, a similar proportion is involved in sports / leisure and church-based associations.

In terms of health status, based on the single question asking respondents to rated their health, the older population of the most affluent parish, Our Lady of the Rosary has the best profile, Christ the King, the second best, St. Munchin's, with a lower socio-economic profile, has the worse health profile and Corpus Christi, the second worst – **Figure 18**.



More refined measures of health status were developed from an analysis of the SF-36 module (36 questions on health) included in the survey. This provides an analysis of various dimensions of health producing eight scales: Physical Functioning, Role Physical, Bodily Pain, General Health, Social Functioning, Role Emotional and Mental Health and two summary components developed from these eight scales: Physical Health Component and Mental Health Component. Scores range from 0 (worst possible health) to 100 (best possible health).

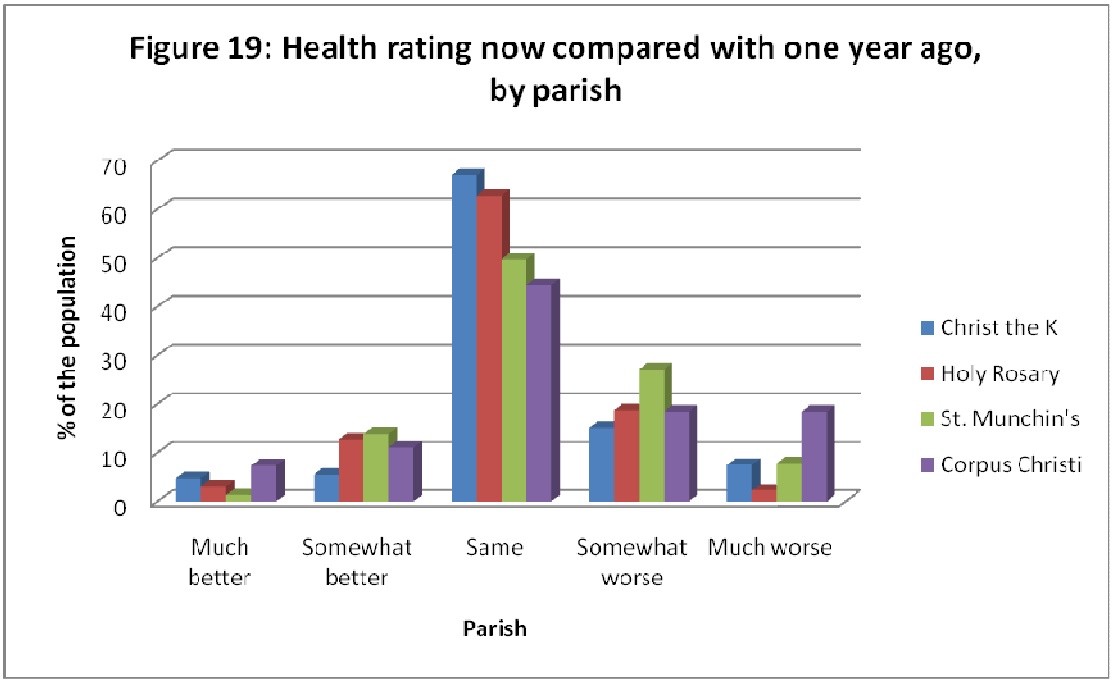
Scores on all eight scales and on the Physical Health and Mental Health Summary Component are higher for males than for females. Variation by gender, however, is not statistically significant for the General Health Scale and the Mental Health Summary Component. Scores for both males and females are highest on scales which measure aspects of mental health, and generally show good mental health in this older population. Scores are lower on the scales measuring aspects of physical health such as Vitality, General Health, Bodily Pain and Role Physical. Scores on all scales are lower for those in older age groupings (75 years and over compared with the population 65 to 74 years). The results

indicate, as expected, that physical health declines with age but this is not the case for overall mental health.

Health status by social class grouping (high, middle and low socio-economic class) broadly follows the social gradient. Those in the highest social classes score highest, those in the middle social classes the next highest and those in the lowest social classes tend to have the lowest scores across the various scales (with some exceptions). Variation by social class is not statistically significant, however, for the Bodily Pain scale and the Physical Health Summary Component. Variation by social class is greater on scales designed to measure aspects of mental health where scores are lower here for those in the lowest social classes. Variation by parish also follows the social pattern with highest scores, indicating best health, in the most affluent parish (Our Lady of the Rosary), the next highest in the parish of mid-to high socio-economic status (Christ the King), lower scores in the socially mixed area leaning towards lower socio-economic status (St. Munchin's) and lowest scores in the most disadvantaged parish (Corpus Christi).

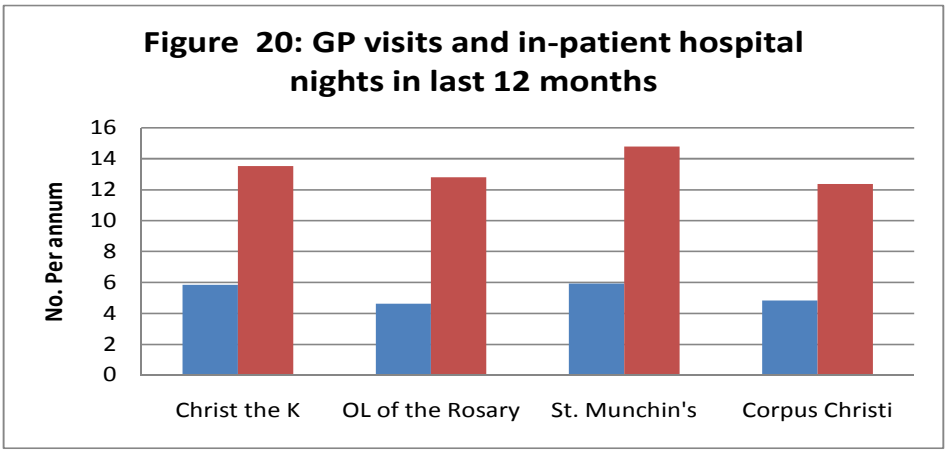
The relationship between physical health and social class based on place of residence (in this cases parishes) disappears as people enter the oldest age groups. The oldest population remaining in those disadvantaged areas at this stage of their lifecourse, as such, represent the most resilient group of survivors and some are not typical of the mainstream population of the estates.

In terms of change in health profile over a period of one year, the same pattern of a better health profile in the more affluent parishes and worst the in disadvantaged parishes is in evidence – **Figure 19**.



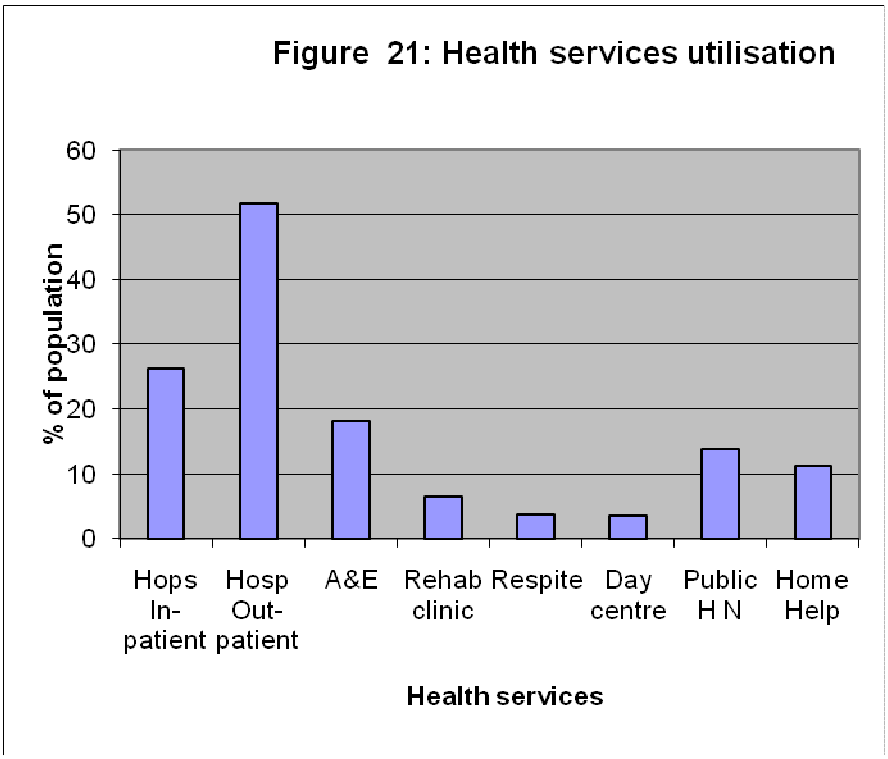
The relationship between physical and mental health status and selected social capital indicators were explored. This showed that people with strong social trust, a sense of looking out for each other (reciprocity) and higher levels of trust in institutions have a better health profile (higher scores). Similarly, those with larger social networks and more frequently in social contact with relatives and friends, and engaged in voluntary associations have a better health profile.

In terms of health services utilisation, the average annual number of GP visits is highest in the disadvantaged parish, St. Munchin's, followed by Christ the King parish, and lowest in the most disadvantaged parish, Corpus Christi. The average number of hospital in-patient nights in the previous 12 month period for those who were hospital inpatients (142 people surveyed) was 14 nights, slightly higher in St. Munchin's and lowest in Corpus Christi – **Figure 20**. There is no statistically significant difference between the parishes on the average number of hospital in-patient nights.



Age is an influencing factor with the annual number of GP visits increasing as age increases. Focusing on the relationship between annual number of GP visits and self-rated health, those with better health visit the GP less often on average than those in worse health.

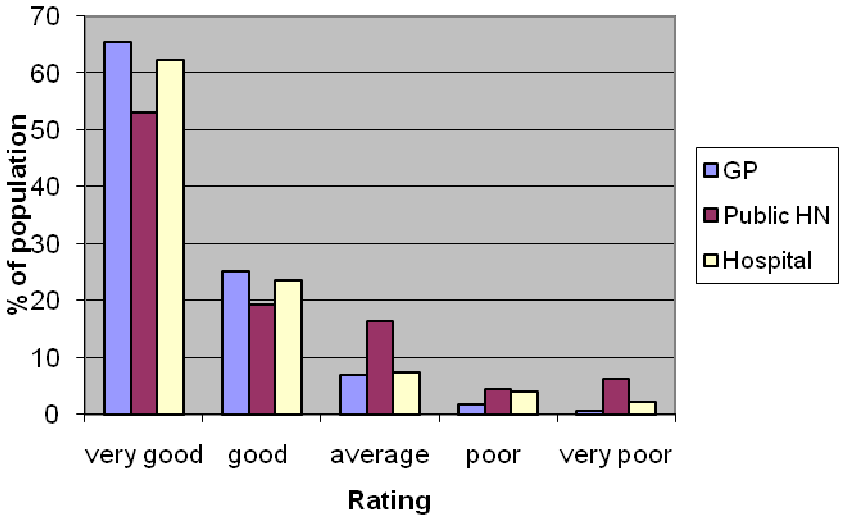
In terms of other services, hospital out-patients clinics has the highest level of utilisation by older people (52%) followed by hospital in-patient services (26%) and accident and emergency (18%). Community-based services have relatively low levels of utilisation. Services like home help and public health nursing have a greater up-take in the disadvantaged parishes – **Figure 21**.



The findings show greater utilisation of several health services with increasing age. Poorer self-rated health is also associated with greater utilisation of health services.

Quality of professional care is rated highly with GPs getting the highest quality rating (90% rating them as very good / good) compared with other health care professionals – **Figure 22**.

Figure 22: Quality of professional care, various settings



Quality of health services delivery is rated highest for GPs (73% rating delivery as good / very good) and lowest for hospitals (44% rating delivery as good / very good). Quality of service delivery in all cases is lower than quality ratings for professional care. Quality ratings are higher by those with better self-rated health.

Using more complex statistical techniques to develop models which explain differences in physical and mental health for this older population, a combination of socio-economic and demographic characteristics of people, conditions of neighbourhood, social capital and health services utilisation and quality of provision prove to be statistically significant. The analysis provided a better model of physical health compared with mental health in that it explained more of the variation in the former (43%) compared with the latter (25%).

In relation to demographic and socio-economic characteristics of people, the results confirmed that men have better physical health than women. Eventhough data from existing sources indicate that women have a longer life expectancy on average than men, men have better physical health ("men die quicker but women are sicker"). As expected, the research

confirmed that physical health declines with increasing age. People with higher levels of education (as an indicator of social class) tend to have better physical health.

Focusing on conditions of neighbourhood, the accessibility of essential neighbourhood services such as shops, pharmacy, post office, and GP surgery is positively associated with better physical health. In relation to social capital, a sense that people look out for each other (reciprocity), higher levels of institutional trust and frequency of interaction with friends are positively associated with better physical health. In relation to health services, high levels of health services utilisation are associated with poorer health indicating that people in poor health use them to a greater extent.

Age and gender do not explain differences in mental health status. Low social class is associated with poorer mental health. Living in a relative more affluent area is associated with better mental health and living in a disadvantaged area associated with poorer mental health. Greater social trust in people in general is associated with better mental health. High levels of health services utilisation is associated with poorer mental health, while quality of care by health professionals and quality of services delivery is associated with better mental health.

9. Conclusions

As well as characteristics of individuals, neighbourhood conditions and aspects of social capital affect health outcomes. The relationships are complex in terms of how neighbourhood or place of residence affects health. The findings of this research provides some support for the view that poorer people living in more affluent compared with poor neighbourhoods have better outcomes in terms of health. This is linked to positive effects arising from living in more affluent areas. Wilson (1997) linked this to: (i) richer institutional resources and better services in more affluent areas and (ii) social learning effects from attitudes and behavioural characteristics of more affluent individuals. The more complex statistical analysis identified these effects as factors explaining variations in health status over and above individual characteristics of the population. In particular, accessible essential services at neighbourhood level were found in this research to be positively associated with physical health (and more accessible services were a characteristic of the more affluent neighbourhoods). Factors of social capital including social trust in the community (associated with mental health), institutional trust or the sense that local institutions can be trusted “to do what is right” in terms of service to the community (associated with physical health) and the sense that people in communities “look out for each other” / generalised reciprocity (associated with physical health) could be regarded as social learning effects. These attitudes were more prevalent in

the relatively more affluent communities. They are attitudes associated with civic communities (Putnam, Leonardi *et al* 1993, Putnam 2000) and are more in evidence in low mobility and relatively more affluent communities of place (Humphreys 2005, 2007; Humphreys and Dineen 2006).

The association between living in a relatively more disadvantaged area and poorer mental health could provide some support for the psychosocial explanation of health outcomes (Wilkinson 1996) and its effects on health status, but this would require more investigation of the links.

While the findings indicate that those in poorer health (and oldest old, low socio-economic status and living in disadvantaged areas) are heavier users of the health services, the research does not give insights to preventive aspects of health services provision – for instance the role of primary care in reducing health inequalities (Shi, Starfield *et al* 2002; Starfield, Shi *et al* 2005) or in keeping older people in good health in their homes and communities for as long as possible. The population reports high levels of satisfaction with the quality of professional care. However, rates of take-up (and provision) of community-based health services are low. For this group of elderly people, it is argued that heavier utilisation by those in lower socio-economic groups is linked to redressing the socio-economic differentials in health status accumulated over the lifecourse (Veugelers and Yip 2003). As such, it could be argued that health services provision moderates effects of socio-economic status on health status.

A further issue which emerges from the study is that cohort or generational effects – i.e. common experience of living in a certain time period - results in greater homogeneity within an elderly grouping than in the general population. This is reflected, for instance, in strong religiosity across the social class divide and in aspects of social capital such as strong family ties where expected variations linked to health status were not in evidence.

The results of the research provided a poor explanation of variations in mental health (despite testing a very wide range of indicators). A related finding, however, is that mental health status (scores) are quite high into the oldest age groups. Poorer mental health, however, is associated with low social class and living in relatively more disadvantaged areas. A possible explanation, as such, is that those with poorest mental health are at greater risk or have less chance of surviving into old age because of the linkage between poor mental health and morbidities, leading to various causes of premature death.

10. What Lessons for Public Policy?

The research confirms that health inequalities linked to social class is a major challenge for public policy and public health. Because the aspects over and above individual characteristics affecting health also tend to favour those in higher social classes (better neighbourhoods, higher levels of social capital), there is an accumulated disadvantage to those in the lowest social classes. If health inequalities are linked to social hierarchies, they are likely to persist while societies are stratified along class lines with differential access to material and other resources (particularly education). Many in the lowest social classes do not survive into old age and there is evidence that they have poorer physical and mental health in old age. It seems only fair that health services should intervene to provide good quality care to reduce illnesses and alleviate the consequences of living in poor health for this population rather than highlight that those in the lowest social classes are heavier uses of such services.

Other possibilities suggested by the findings of this research are the importance of interventions to improve conditions of neighbourhood – in particular, to avoid situations of planning neighbourhoods which are socially segregated, specifically towards concentrations of people of lower socio-economic status and lacking a base of services. Residential neighbourhoods with concentrations of people with low socio-economic status will not have the capacity (e.g. purchasing power) to sustain a base of essential services of high quality. They also tend to be less attractive as a site for such services including public, amenity as well as commercial services. Such deficiencies coupled with negative perceptions will tend to reinforce each other to have a downward spiralling effect on relatively disadvantaged neighbourhoods.

Lack of safe and accessible meeting places – in this case for older people – will tend to affect capacity to engage in social networks and maintain contact with friends and this can negatively impact on health. More opportunities for contact across the social divide might highlight aspects of commonality of experience and common interests. Public policy, through planning decisions and provision (direct or via voluntary associations), can positively impact on this.

While some argue that public policy / public health interventions might seek to promote social capital – e.g. more engagement in voluntary associations – it is more difficult to be effective in promoting values of trust in people, sense of community and institutional trust which are central to social capital. Trust needs to be earned, reciprocated and valued through

positive experiences of social engagement, working together as communities, and quality of service provision by public agencies.

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