NATIONAL COUNCIL FOR THE AGED

CARING FOR THE ELDERLY

PART I: A STUDY OF CARERS AT HOME AND IN THE COMMUNITY

NATIONAL COUNCIL FOR THE AGED

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on ways of meeting the needs of the most vulnerable elderly,

on ways of encouraging positive attitudes to life after 65 years and the process of ageing,

on ways of encouraging greater participation by elderly people in the life of the community,

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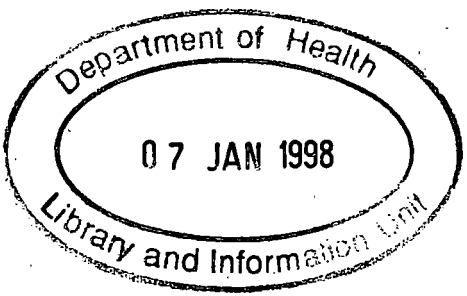

CARING FOR THE ELDERLY

PART I: A STUDY OF CARERS AT HOME AND IN THE COMMUNITY

By

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and Brendan Whelan

NATIONAL COUNCIL FOR THE AGED, 1988
REPORT NO. 18

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Foreword

This study, *Caring for the Elderly, Part I: A Study of Carers at Home* and in the Community is Part One of a research programme on family carers of elderly persons in the Republic of Ireland which was initiated by the National Council for the Aged in 1985. While the rôle of the family in providing care for elderly persons has been frequently referred to by academics and policy-makers, this is the first time that an attempt has been made to quantify the nature and extent of family care of elderly persons within an Irish context. This is a baseline study, descriptive in nature, which provides a profile of carers in the community and a database for further exploration of the caring process. Part Two of the study, *The Caring Process: A Study of Carers in the Home,* which provides an in-depth picture of all aspects of caring for elderly persons within households will be published by the Council later in 1988. The Council will make detailed comments and recommendations on the caring issue in the report of Part Two of the Study.

The Council is particularly pleased to publish this report and to focus attention on an essential and critical aspect of the care of elderly persons in the community. The Council considers that one of the basic questions to be addressed in this respect is how families and relatives can be effectively supported by the statutory services is the care of elderly persons in the home. This study identifies the nature and extent of this caring. It estimates that some 66,000 elderly persons in the community are particularly dependent on help and require some level of care. Some 36 per cent of these are described as requiring a 'lot of care'. The study also shows that the major part of the caring rôle falls on women who not only act as carers in some 80 per cent of instances but, also, care for the more dependent elderly. The study indicates that some 25 per cent of carers of elderly persons are aged 65 years and over. The study also shows that approximately 11 per cent of households have at least one household member who gives care to an elderly person in another household. One particulary interesting finding of the study is that professional and managerial households are less likely than farm households

to care for an elderly person within their own home. It is the hope of the council that the findings of the study as presented in this report will provide the context for an adequate consideration of the many and complex issues surrounding family care of elderly persons.

The Council would like to thank and to congratulate the authors, Professor Brendan Whelan of The Economic and Social Research Institute and Professor Joyce O'Connor and Ms. Emer Smyth of the Social Research Centre, N.I.H.E., Limerick. The Council also wishes to thank the field research teams of The Economic and Social Research Institute and An Foras Talúntais and the Survey Unit of the Economic and Social Research Institute and the Social Research Centre, N.I.H.E. for their respective contributions in collecting, processing, and analysing the data. The Council is particularly indebted to the respondents in various parts of the country without whose co-operation and goodwill the study could not have been carried out.

The Council also wishes to acknowledge the contribution of the members of the Consultative Committee established to advise on the preparation of the report, Dr. Michael Hyland (Chairman), Dr. Ruth Barrington, Mrs. Iris Charles, Mr. Jim Cousins, Mr. Fred Donohue, Ms. Aideen O'Connor, Mr. Joseph Rowe and Mr. Seamus Shields. Finally, the Council would like to thank its staff, Mr. Bob Carroll (Secretary) and Mr. Michael Browne (Research Officer) for their considerable contributions in the production and publication of the report.

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Preface

In recent years there has been renewed emphasis on the importance of informal care and support for the elderly. The demographic structure of the Republic of Ireland indicates that, in the future, large numbers of elderly people, particularly those aged 75 years and over, will be living in the community. Demographic trends indicate that a larger percentage of these elderly people will be women.[1] Research suggests that because of the relationship between old age on the one hand, and dependence and disability on the other, the number of people requiring care and support will also increase. This projected increase in the number of people requiring care must be placed, in the first instance, within the context of the current debate about community care and prevention and secondly, within the context of wider social issues and policy considerations which they raise. In particular, the extension of community care as a policy and as a practice needs to be examined.

There is a considerable body of research about the population of elderly people and about dependent elderly people in particular, in the Republic of Ireland. Research and knowledge about the number and characteristics of those who are caring for these people and who maintain them in the community is, however, limited. This is the first study to provide this kind of information.

Recent studies conducted in the Republic of Ireland have looked at institutional care[2] and boarding-out schemes[3]and have also explored the support systems from the point of view of the elderly themselves.[4] Consensus about the importance of carers has highlighted the need to understand the distribution, correlates and consequences of caring. Noonan[5] carried out a study on carers for the Council for the Status of Women and highlighted the situation for a selected group of carers. However, there has been no national representative survey of carers carried out in the Republic of Ireland. The number of persons in receipt of the Prescribed Relative Allowance has been decreasing. In March 1983, 2,600 people were in receipt of the Prescribed Relative Allowance,

the majority of them being women. The corresponding figures for the same period in 1986 show that 2,067 people qualified for this allowance, a decrease of 533 in that period.[6] However, these figures represent only a small proportion of people who are involved in the care and support of the elderly.

It is believed that, because of the dearth of information on those people who care for the elderly in their homes, it is necessary to research and establish the current position in relation to carers. This is the central concern of the current research programme set down by the National Council for the Aged. The research programme, initiated in 1985, is being undertaken in two phases. This research programme has the following aims and objectives:

—To provide basic data on family carers and on elderly persons being cared for at home — who they are; their number; socio-economic status; relationship to persons cared for, and how and why they became carers.

—To identify the impact that the responsibility of caring has had on the life situation of the individual providing the care, both while the person they are caring for is alive and after that person dies.

—To identify needs of carers not currencly being catered for.

—To make specific recommendations about statutory services needed to support the carer.

—To provide guidelines for carers' support groups which may be established in the future.

—To identify ways in which the broader community of friends and neighbours can be used to support the family/individual in the caring role.

—To identify factors which enable families/individuals to provide care for dependent elderly persons with a view to more effective use of the family caring network.

—To provide information on the basis of which a more effective programme of community care for elderly persons — both from a human and a cost-effective perspective — can be developed by Health Boards.

This study represents Phase 1 of the National Council for the Aged

Research Programme on family carers of elderly persons. It is a simple baseline study. It is descriptive in nature, providing a profile of the carers in the community and a database from which to explore Phase 2 of the study. The aim of Phase 2 is to provide an in-depth picture of all aspects of carers' lives, and it focuses on the caring process.

Structure of the Report

The report consists of five chapters. An Introduction provides background to the study by describing previous research in the area and indicates the study's main focus and direction. Chapter One describes the methodology of the study. The socio-economic characteristics of the elderly who are in receipt of care are given in Chapter Two. Chapters Three and Four examine carers within the home and in the community and describe the type of care provided by them. The final chapter, Chapter Five, presents the main findings and outlines the research design for Phase 2 of the study which will focus on all aspects of carers' lives. One appendix accompanies the main text. This appendix contains a copy of the questionnaire used in the study. The terms "old" and "elderly" are used interchangeably throughout the report. These terms refer to persons aged 65 years or over.

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INTRODUCTION

Background and Context

Community Care

Recent research in the United Kingdom has mapped the phases through which the concept of community care has developed in that country. These various stages and developments provide a useful way of looking at what has happed in the Republic of Ireland. Henwood[1] and McIntosh[2] argue that, in the United Kingdom, three phases in the postwar evolution of community care philosophy and practice can be distinguished. The first phase covers the earlier post-war period where care in the community came to mean care in small-scale local residential accommodation. In the second phase, covering the 1960s and early 1970s, 'community care' was used to refer to any care outside of institutional settings. Since the mid-'70s there has been an increasing concern with the nature of commuity care and a shift in emphasis towards the role of private, voluntary and informal agencies in the support of, rather than in the provision of, care.

The justification for community care has been twofold. Firstly, community care for the elderly was aimed at attacking the dependency associated with institutions[3] and it was argued that it was in the best interests of dependent people to be cared for within the community.[4] Secondly, community care was related to the imperative of cost effectiveness, especially in relation to the growing cost of residential care, retrenchment in the growth of public expenditure on social service provision and an increase in the number of very elderly people requiring care.[5]

The 1981 British Government White Paper, *Growing Older*[6] provides an illustration of the third phase of community care as experienced in the British context:

> "The primary sources of support and care for elderly people are informal and voluntary . . . it is the role of public authorities to sustain and, where necessary, develop — but never to displace — such support and care. Care in the community must increasingly mean care by the community".[7]

Thus, the primary role of the public services is seen as an enabling one. The rhetoric of natural obligations is combined with economic concerns: it is argued that public authorities do not command the resources to provide adequate support and care for the elderly and, even if they did, official help should not meet all individual needs since "the personal ties of kinship, friendship and neighbourhood . . . are irreplacable".[8]

The Family

There is substantial evidence that the family is the main provider of care for the elderly. As Becker notes:

> "Although families in Western countries have changed drastically during the past twenty years, obituaries for the family are decidedly premature".[9]

Research evidence from the United Kingdom and the United States concerning family caring can be summarised as follows:

—the bulk of family care is provided by female relatives[10] and often provided until the "burden" is perceived to be too great.[11]

—spouses and adult children are the main carers within the family.[12]

—carers are usually middle-aged or elderly.[13]

—once a principal carer is established, support from other relatives tends to decrease.[14]

—the most common caring activity is emotional support/ companionship;[15] however, family contributions to personal care, domestic tasks and at times of crisis are substantial.[16]

—very little research has been done on the amount of time spent on caring tasks; however, Sivley and Fiegener[17] report an average of 72 hours per month while Nissel and Bonnerjea[18] report 167

minutes for housewives and 111 minutes for working wives per (week) day.

Costs of Caring

Caring for an elderly relative carries direct and indirect costs for the carer. Not least of these costs is the financial cost of caring. All except 4 of the families in Nissel and Bonnerjea's[19] study had made some (often fairly substantial) adaptation to the house to facilitate care for the dependent relative. Other indirect costs include wages forgone, estimated at Stg £4,500.00 per head per annum for those who had left employment and at Stg £1,900.00 for those who could only work part-time.

Caring has also been found to have effects on family life. Some of the stress-producing factors associated with the caring situation include the undefined role and lack of social guidelines for carers, the strain on carers' health, changes in the family routine, role shifts and role overload resulting from competing demands.[20] Such disruption was apparent in the Nissel and Bonnerjea's[21] sample: half of the wives reported that their relationships with their husbands had deteriorated since the start of caring and, in many cases, the families were near to breakdown. However, this level of stress may not be typical as the relatives involved were highly dependent.

Women and Caring

There is a substantial body of evidence which indicates that women are the principal carers and there is an increasing awareness that 'community care' means care by women, usually female relatives.

There has been little attempt to assess the prevalence of informal caring:

> "Research has, until recently, rarely focused specifically on carers themselves, their characteristics, the tasks they perform, the costs they bear and the benefits they derive from caring".[22]

However, initial indications demonstrate the widespread nature of the provision of informal care and support. Parker[23] estimates that in the United Kingdom there are about 1.3 million principal carers to adults and children with disabilities severe enough to warrant support in daily

living tasks. In a survey of households in the North Tyneside Metropolitan Borough, Briggs[24] found that between 14 per cent and 16 per cent of adults were engaged in caring for a dependent relative who was sick, disabled or frail.

Walker[25] and Means and Smith[26] maintain that state policy towards the elderly has always been based on assumptions about the caring rôle of female relatives. They suggest that in the 1980s the community care strategy is increasingly based on the exploitation of women as unpaid domestic labor. For Walker, women and the elderly share a dependent status, a dependency which the state creates and legitimises, and which is founded on financial dependence.

This view is supported by a wide range of empirical evidence from Britain, the US and elsewhere. Studies by Soldo and Myllyluoma[27] Haavio-Mannila,[28] Sivley and Fiegener,[29] Hauber,[30] Briggs,[31] Charlesworth[32] and Gilhoolly[33] show that women act as the principal carers in the majority of caring situations.

There is also variation between male and female carers in the amount and intensity of the care provided. Briggs found that women assumed more of the intensive all-day caring than men. Nissel and Bonnerjea found that shared care was uncommon: husbands rarely gave direct help to wives with the care of a dependent relative living with them[34] and outside help was rare and/or infrequent.[35]

Women carers were likely to give up paid employment, or otherwise adjust their working lives in order to care for dependent relatives.[36] In Nissel and Bonnerjea's study 9 wives had given up employment and 4 others had to have time off to care for their relatives.[37] In addition, Sivley and Fiegener found that caring may discourage the resumption of paid employment. This division of labour according to gender is carried over into paid caring. Ninety-five per cent of the paid carers working in innovatory community care schemes are women[38] and volunteers participating in neighbourhood care schemes are predominantly female.[39] In a study of Finnish social services, Haavio-Mannila[40] found that although care of the elderly has increasingly been taken over by the state, it is still mainly women who perform caring functions, often as paid instead of unpaid work.

Clinicians working with carers often assume that men and women will respond to the carer role differently. This assumption is based upon cultural stereotypes. For example, the finding that women form more intimate relationships with others in their social environment and have stronger social support systems than men[41] suggests that male carers

would be more socially isolated. Gilligan's[42] studies on women and moral development also suggest that women put a stronger emphasis than do men on their personal relationships. If women have a stronger 'ethic of caring' than men, as Gilligan hypothesizes, and also have stronger social supports, as suggested by Lowenthal *et al.*,[43] then male carers would be expected to feel a greater burden and have more difficulty adjusting to their newly acquired role. Women have been the traditional carers in their families. Lowenthal *et al.*[44] however, suggested that middle-aged women undergo a role shift away from full-time caring and begin to pursue new interests. Thus, they may resent a return to a full-time carer role. Men, on the other hand, might enjoy taking on the role of carer because it is new and is a means to express their nurturing feelings.

In summary, community care, and especially the increasing emphasis on informal care, has important implications for the role of women in terms of both the unpaid and the paid caring they perform.

Age and Carers

Little is known about the effects of age on the carers' psychological adjustment. Younger carers might feel more distressed and burdened than older carers because a chronic illness is an unexpected 'one-off' event in the middle years. They might also have more demands on their time from family and work responsibilities than older carers. On the other hand, older persons may feel more burdened because they are more likely to suffer health difficulties that would interfere with their ability to provide care to a dependent elderly person. They might also feel robbed of retirement plans they had looked forward to for many years. Children who are carers for parents feel more strain in their role than do spouse carers. Whether this is due to the relationship difference or is an age effect is unclear.[45]

Friends

In general, friends do not compete with neighbours and family as carers. However, they do provide certain services and are an important resource for those without kin. For clients of innovatory community care schemes, friends and neighbours provide very little personal care but a larger amount of domestic help. Tinker found that more visits were made to those living alone and to the more dependent than to other elderly

persons.[46] A relatively low proportion of those in Wenger's study were cared for by friends.[47] Friends and neighbours provided very little personal care but gave more help with routine household chores than home helps. Friends and neighbours act as an important source of support for the widowed and those living alone in times of crisis.

Jerrome[48] emphasises the importance of friendship for elderly middle-class women; friends may help each other to get over a crisis such as bereavement, and can provide practical help and support in adjusting to retirement and in times of illness. Spakes[49] found that friends were relatively more important than families as a source of support. He also found that the number of close friends an elderly person had and their satisfaction with their social contacts were found to be related to life satisfaction. However, the members of the chosen sample (those living in planned 'new' and retirement communities) had greater geographical mobility and higher resources than the population as a whole; as a result, contact with relatives was reduced — 76 per cent had no relatives living close by.

Neighbours

Abrams' study[50] reveals the complementarity of neighbouring, friendship and kinship ties. He also found that certain tasks — especially those involving speed of reaction, those related to the sharing of a common territorial location and those involving a constant local presence ('keeping an eye on') — emerge as the special province of neighbours. Studies both in Ireland[51] and England[52] confirm that neighbours are more involved in helping with routine household chores than with personal care tasks and reveal the importance of neighbours as a potential substitute for family, especially for those living alone. Daly and O'Connor's study[53] supports these findings and highlights the fragile nature of a support network which comprises people of the same ages and with similar health concerns.

Voluntary Association/Community Involvement

According to Spakes, factors relating to community involvement include age, income, education, marital status and community type. There is a slight but significant association between community involvement and life satisfaction. Lowry[54] also found a positive relationship between activity level and life satisfaction. Bull and Aucoin[55] found a positive

relationship between participation in voluntary associations and life satisfaction; however, this may have been due to the fact that high participators had better subjective health and/or higher socio-economic status than non-participators.

About half of those in Wenger's sample belonged to at least one voluntary organisation, membership declining with age.[56] Almost all of the women in Jerrome's study belonged to voluntary associations; this may reflect the class-related nature of participation as all of those studied were middle-class.[57]

The amount of care provided by voluntary organisations to elderly people seems to be very low in comparison with other care sources. Three per cent of Wenger's sample were visited by voluntary organisations,[58] usually local or youth groups, while only one of the carers in Briggs' study received such support.[59]

The Relationship between Formal and Informal Care

> "Conventional health and welfare services typically see the dependent person, rather than his or her carer, as their client. Any support which accrues to a carer is usually a secondary, and often unintentional, result".[60]

Indeed, state services may operate on the assumption that if elderly people are being cared for by their family (or other informal carers) they do not need statutory services.

Domiciliary services are often allocated by criteria which discriminate against informal carers. Wenger found that home help, meals on wheels and visits from social workers were more frequently allocated to those living alone. Similar findings are reported by Parker,[61] Means and Smith,[62] Charlesworth[63] and by the Equal Opportunities Commission.[64]

There is no evidence that family care declines where statutory services are provided. Tinker[65] emphasised the importance of family care even where statutory provision was relatively high. Likewise Sivley and Fiegener[66] reported similarities in the type, frequency and duration of informal assistance given to recipients and non-recipients of an in-home chore service programme.

Overall, available services are likely to have little effect for informal carers because:

—few dependent people with informal carers appear to receive services

—services received are usually crisis-orientated rather than a part of long-term support

—the criteria used for allocation are often irrational or discriminatory.[67]

Innovatory Community Care Schemes

In recent years a number of schemes have been introduced which are intended to promote the care of the elderly within the community. These can be divided broadly into (i) schemes concerned with the direct provision of care for elderly people in their own homes, (ii) schemes concerned with the promotion and fostering of informal care for the elderly and (iii) the provision of support groups for informal carers. This emphasis on community-based professional care now seems to enjoy popular support. In one care preference study carried out in Scotland, however, findings indicate that the public are not inclined to allocate the major responsibility for the care of dependent groups to the family, preferring instead a continued policy of partnership between informal care systems and the welfare state.[68]

Provision of Care for Elderly People in their Own Homes

The first group of schemes concerned with the direct provision of care for elderly people in their own homes includes alarm systems provided by a growing number of housing and social services departments as well as care attendant and intensive domiciliary care schemes.[69] Some of these care schemes have formalised existing informal care arrangements — for example, neighbours have been involved in the implementation of some alarm systems schemes and some care systems (for example, in one scheme provided by Cambridgeshire Social Services, neighbours have been paid to provide specific services). Intensive domiciliary care schemes are targeted towards helping elderly people at a higher level of dependency to remain in their home environment for as long as possible. Some of these schemes (for example, Hammersmith and Fulham; East Sussex) have been used to relieve families and/or neighbours caring on an informal basis as well as providing care for those living alone or those with little community support.

Overall, Tinker's[70] assessment of these innovatory schemes is that they supplement rather than replace existing informal help. Relatives remained the major source of help for most personal and domestic tasks. Even for those tasks (such as bathing, washing and cutting toenails) where statutory help was major, there was substantial help from families. In addition, these schemes reflected the overall orientation of statutory services which is to channel provision towards those who live alone or have no relatives.

Promotion of Care by the Community

The second type of innovatory community care scheme is more directly concerned with the promotion of care by the community. The aim of the Kent Community Care Project[71] was to generate help in the community through the recruitment of 'care helpers' to fill gaps in the services directly available to the frail elderly. Similarly, Elderly Persons Support Units (EPSU)[72] initiated by Sheffield Family and Community Services Department have aimed at encouraging community participation and maximising neighbourhood support. They have operated on the assumption that the provision of intensive and wide-ranging services by the EPSUs might encourage people to become involved by assuring them that only a limited commitment would be required.

Neighbourhood care schemes (including Good Neighbour schemes) have attempted to forge a middle ground between purely informal care and statutory care.[73] These schemes have used volunteers (sometimes paid) and have maintained a limited commitment on the part of the carer. Each 'good neighbour' provides help to a limited number of people and care tasks performed by helpers include visiting, shopping, collecting prescriptions, odd jobs, transport and referrals to other organisations. Clients of neighbourhood care schemes appear to be those living in significant isolation from informal care networks; compared with non-client residents, they have less contact with relatives and neighbours. These schemes, therefore, seem to have little impact on pre-existing informal care arrangements.

Provision of Support Groups

The third type of innovatory community care scheme focuses on the need for emotional support for the carers. Recent developments in the

provision of support groups (by statutory, voluntary and private agencies) have attempted to meet this need. Most groups of this kind combine emotional support with the provision of information relating to the caring role. Hartford and Parsons[74] describe the formation of one such group by the Andrus Gerontology Center in the United States. This group was intended to develop support, feeling of belonging, mutual aid and strength which the participant could carry outside the group. It was also intended to provide practical help and information about the ageing process, illness and senility. Overall, group members reported some change in their behaviour, attitudes and understanding of ageing at the completion of the sessions. A voluntary caring programme focusing on the provision of information about ageing, illness and community resources was evaluated by Hauber.[75] Hauber reported that, after the programme, carers reported greater efficiency with caring activities but this did not extend to new caring activities nor to linkages with formal service agencies. Carers showed little inclination to participate in mutual help groups. However, this group reported very low stress levels and did not feel burdened by the caring role. By contrast participants in the Andrus Gerontology Centre group were referrals from counsellors' caseloads so the need for emotional support probably differed between the two groups.

This review indicates the variety of research that has been carried out on the care of the elderly in the community. It also provides a useful context for understanding the results of the present study described in the following chapters.

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CHAPTER ONE

Methodology

Introduction

This chapter presents the methodology of the study. It sets out details of sample selection, weighting procedures and methodological aspects relating to the definition of carers.

Sample Selection

Since the population of carers is a very scattered one and one for which no comprehensive listing exists, it is difficult to obtain a genuinely representative sample. The strategy adopted in the present study was to carry out a 'sift' based on the AFT/ESRI Consumer Survey (An Foras Taluntais/Economic and Social Research Institute Consumer Survey). This is a quarterly* survey of a large sample of the general population which is interviewed on a variety of questions relating to consumer behaviour, buying patterns, etc. The sample for the present study was obtained by including in the 1985 rounds of the Consumer Survey some questions which served to identify those households which contained carers. The sample of carers so obtained is representative of carers in general in the community.

The basic sample used is derived from the Electoral Register using the ESRI's RANSAM system.[1] Each round of the Consumer Survey involves generating the names of 1,680 persons each of whom is visited by an interviewer. After allowance for non-response, this results in approximately 1,250 completed interviews. The sampling system is designed so that each elector in the country is given an equal chance of selection.

In the rounds of the Consumer Survey carried out in April, July and

*Since July 1986, the Survey has been conducted on a monthly basis.

October 1985, the basic questionnaire was augmented with questions on carers, as shown in Appendix 1, and administered to all the respondents in the survey. As can be seen from this Appendix, these questions related to the presence of old people in the household, their characteristics, the extent and nature of care required, and the characteristics of the carers. It also enquired whether anyone in the household *gave* care to someone outside the household and about the characteristics of the carer and the cared-for person. In October 1985 the sample for the study of the carers was supplemented by interviewers calling on both the original name and address specified in the Consumer Survey sample and on an adjacent household selected from the Electoral Register.

The fieldwork thus yielded the following numbers of households:

April 1985	1,275
July 1985	1,257
October 1985	2,394
Total	4,926

Of these households, 1,437 contained at least one old person aged 65 years and over and 325 contained at least one old person who was reported to need some care. Six hundred and four households contained individuals who said they gave care to an old person outside the household. It is on those 325 households which contained 'within household' carers and the 604 households that contained an 'outside household' carer that the analysis in the rest of this report is based.

Weighting Procedures

In the sampling procedure used in the Consumer Survey, each elector has an equal probability of selection. This means that households have a probability of selection proportional to the number of electors in the household. Thus, households with smaller than average numbers of electors are under-represented in the sample while larger households are over-represented. To make inferences about the total population it is, therefore, necessary to re-weight the data from the survey. The following weights, which are derived from the 1981 Census of Population, were used.

Household Size	*Weight*
1	300.3
2	196.3
3	157.1
4	123.1
5	122.8
6 and over	102.1

It was decided that the most meaningful way in which to present the tables was in the form of aggregate estimates for the total population. It should not be forgotten, of course, that these figures, being based on samples, are subject to a margin of sampling error. They do however represent the best estimate of what the numbers would be in the population had a complete examination been possible. To give the reader an idea of the likely margin of sampling error, it is estimated that, for the 'within household' carers, the confidence interval around an observed percentage of 50 per cent in the survey is in the region of 6 per cent. This means that if a particular percentage (say, for example, the percentage who help with transportation) is estimated from the sample at 50 per cent, there is a 95 per cent probability that the true value in the population is between 44 and 56 per cent.

'Multiple Aspects'

'Multiple Aspects' is the term used in the study to indicate that caring relationships between two people in different households can crop up in the sample in two ways:

—because the selected household contains a person who is cared for or

—because the selected household contains a carer.

The study therefore covers three types of relationship:

(i) within-household carer, i.e. care of an old person by other members of his/her household;

(ii) old persons who report that they are cared for by someone outside the household;

(iii) persons who report that they care for an old person in a household other than their own.

In drawing inferences about the total number of carers or cared-for persons, it is crucial to recognise that categories (ii) and (iii) are two ways of sampling the same thing. In particular, it is invalid to add the estimated total number of old persons in category (ii) to the estimated total of carers in category (iii). In fact the two estimates should be equal. They only differ because of differences in definition between what the cared-for person defined as 'receiving care' and what the carers regarded as 'giving care'.

The Interview Schedule

The inteview schedule was structured and pre-coded with a fixed sequence of topics to be followed by the interviewers. The following are the main areas covered in the interview schedule:

—Household composition

—Socio-economic characteristics

—Level of care needed in the household

—Type of care given in household

—Type of care given in the community

Processing and Analysis of Interview Data

All the interviews were checked thoroughly before being prepared for computer analysis. The data were prepared for computer analysis by the ESRI Survey Unit and the analysis undertaken by both the SRC Survey Unit and the ESRI using the SPSS computer package.

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CHAPTER TWO

The Demography of Care

Introduction

Average life expectancy at birth in Western Europe and in North America is now over 70 years. At 65 years men living in the Republic of Ireland can expect to live a further 12 years while women can expect to live a further 15 years. This figure is expected to rise by the year 2000. Though ageing is a universal phenomenon, the ageing of the population in Western Europe and North America is not just the result of people living longer; it is also due to lower birth rates, so that the proportions of older to younger people in the population are rising. In the next 15 years, the fastest growth rates will be in the group aged 75 and over. An overall national increase in the elderly population is expected during the period 1981-2006, but the projected increases will not be distributed evenly through the country. Some areas will experience actual decreases in both absolute and relative terms while other areas will experience substantial increases. These increases will apply particularly to the greater Dublin area where the elderly population will more than double from 24,000 to 51,000.

Presently in the Republic of Ireland just under 11 per cent of the entire population are aged 65 years and over. Of these, over half (55 per cent) are women. Examination of the distribution of elderly people within different age categories reveals that 4 per cent of the entire population are aged 75 years and over. As would be expected, these elderly people are more likely to be female (60 per cent) than male. Within the European context, the proportion of people aged 65 years and over relative to other sections of the population is lower in Ireland than in other EEC countries. For example, in the United Kingdom those aged 65 years and over represent 15 per cent of the total population.

The elderly are not a homogeneous group and variations exist in this group as within any other age cohort. The elderly are now more heavily

represented in counties like Donegal, Leitrim, Sligo, Mayo and Roscommon, although this pattern is changing. In keeping with other societies, the average life expectancy of people in Ireland at present is 69.5 years for males and 75 years for females. This figure is lower than in most other EEC countries with the exception of Belgium and Luxembourg. Studies clearly show that most elderly people live independent lives within the community. Contrary to popular belief, only a small proportion of the elderly population, about 5 per cent, live in hospitals or other institutions. A higher percentage (14 per cent) live alone, with the proportion of females/males living alone being 2:1. This will increase by the year 2006.

The likelihood of living in an institution increases with age and gender. People aged 75 years and over comprise almost two-thirds of the elderly population in hospitals and institutions. These elderly people are predominantly female due to women's greater life expectancy.

However, it is important to put these figures in perspective as 95 per cent of elderly persons live in the community in a range of housing circumstances.[1] It is with this group of elderly that this study is concerned.

This chapter provides information on the characteristics of the elderly in general in the Republic of Ireland and within this group those elderly persons aged 65 years and over who are in receipt of care.

As outlined in Chapter One, the figures given in the Report are estimates, and all are subject to a margin of sampling error. They do, however, represent the best estimate of what the numbers would be in the population and had it been possible to carry out a complete examination of all households in the Republic.

Perceived Levels of Dependency by Age and Gender

Question 5(b) of the questionnaire was used to establish the level of care required by each person aged 65 years or more living in the households surveyed. About 81 per cent of the elderly in these households were stated to be fully independent and did not require regular care. Twelve per cent required some or occasional care with 7 per cent requiring a lot of care (Table 2.1). This gives a nationally adjusted figure of 66,300 elderly persons who are at least partially dependent and in need of care.

TABLE 2.1

Level of Dependency of Elderly Persons* (based on data from households which contained an elderly person)

Level of Care Needed	Estimated Number	
	(000)	%
A Lot of Care Needed	24.0	7.0
Some Care Needed	25.0	7.3
Occasional Care Needed	17.3	5.1
No Care Necessary	275.2	80.6
Total	341.5	100.0

*Note that in this and all subsequent tables, figures may not add exactly due to rounding.

Details regarding the ages of the elderly persons in receipt of care were also collected. As one might expect, the dependent elderly tend to be older than the fully independent. Three-quarters of the independent elderly are aged 74 or younger while only 29 per cent of this age group

TABLE 2.2

Level of Care Required by Elderly Persons, Classified by their Age (based on data from households which contained an elderly person)

	Level of Care Required				
Age Group	A Lot of Care	Some Care	Occasional Care	No Care	Estimated Total Number
	%	%	%	%	(000)
65-69	11.0	13.2	8.4	41.0	120.1
70-74	17.9	20.1	27.3	34.7	109.4
75-79	24.2	17.3	24.5	14.8	55.2
80-84	21.8	31.7	25.4	7.2	37.3
85-89	14.8	12.6	10.9	2.1	14.5
90 and over	10.3	5.1	3.5	0.2	4.9
Total	100.0	100.0	100.0	100.0	
Estimated Total No. (000)	23.9	25.0	17.3	275.2	341.5

require a lot of care (Table 2.2). Over half (55 per cent) of the elderly who require a lot of care are female, while 45 per cent are male (Table 2.3).

TABLE 2.3

Level of Care Required by Elderly Persons Classified by their Sex (based on data from households which contained an elderly person)

Sex of Elderly Person	Level of Care Required				
	A Lot of Care	Some Care	Occasional Care	No Care	Estimated Total Number
	%	%	%	%	(000)
Male	44.5	42.4	48.7	47.7	160.9
Female	55.5	57.6	51.3	52.3	180.6
Both Sexes	100.0	100.0	100.0	100.0	
Estimated Total No. (000)	23.9	25.0	17.3	275.2	341.5

Variations in Caring by Social Class and Region

Table 2.4, which is based on information supplied by the households in which the old people lived, shows the estimated number and percentage of those who receive care from another household member, and those who receive it from a non-household member, classified by the occupation of the head of the household in which the old person lives. Households headed by farmers have the highest percentages of old people receiving care — some 18 per cent of old people in such households receive care from another household member and 6 per cent are cared for by someone outside their household. The lowest percentage receiving care is in the professional and managerial group where only 12 per cent receive care from a household member and only 1 per cent report that they receive care from outside the household.

Table 2.5 presents the number of people receiving care in households classified into two groups: Urban (i.e., towns of 10,000 or more inhabitants) and Rural (i.e., the rest of the country). As might be expected from the distribution by occupation, care levels appear to be higher in rural than in urban areas.

TABLE 2.4

Number and Percentage of Old People Receiving Care from a Household Member, Receiving Care from a Non-Household Member and not Receiving Care, Classified by Occupation of the Head of the Household. (based on information supplied by those households containing an elderly person)

Occupation of Head of Household		Cared for by H/hld member	Cared for by non-H/hld member	Not receiving care	Total
Self Employed	No. (000)	3.6	1.1	20.9	25.6
	%	14.1	4.3	81.6	100.0
Farmer	No. (000)	18.7	6.3	78.0	103.0
	%	18.2	6.1	75.8	100.0
Professional and Managerial	No. (000)	3.8	0.4	27.1	31.3
	%	12.1	1.3	86.6	100.0
Other non-manual	No. (000)	5.0	0.9	33.7	39.6
	%	12.6	2.3	85.1	100.0
Skilled manual	No. (000)	7.5	2.1	38.9	48.5
	%	15.5	4.3	80.2	100.0
Other manual	No. (000)	10.9	4.8	73.2	88.9
	%	12.3	5.4	82.3	100.0
Unknown	No. (000)	1.3	0.0	3.3	4.6
	%	28.2	0.0	71.7	100.0
All Occupations	No. (000)	50.8	15.5	275.2	341.5
	%	14.9	4.5	80.6	100.0

TABLE 2.5

Estimated Number of Old People Receiving Care from a Household Member, Receiving Care from a Non-Household Member and not Receiving Care, Classified by Type of Region (based on information supplied by households which contained an elderly person).

		Type of Region		
		Urban (towns of 10,000+)	Rural	Total
Receiving care from a H/h member	No. (000)	16.8	34.0	50.8
	%	11.4	17.4	14.9
Receiving care from a non-H/h member	No. (000)	2.2	13.3	15.5
	%	1.5	6.8	4.5
Not receiving care	No. (000)	128.2	147.0	275.2
	%	87.3	75.7	80.6
Total	No. (000)	147.2	194.3	341.5
	%	100.0	100.0	100.0

Summary

This chapter provides a demographic profile of elderly persons in the population aged 65 years and over. It shows that this age group live in households which are more likely to be located in rural areas or small towns. The age and sex distributions are as expected with two-thirds aged between 65 and 74 years and over half being female. The vast majority of the elderly in the households do not require care. A nationally adjusted figure of 66,300 elderly are partially dependent on help and require some level of care. Some 36 per cent of these are described as needing a lot of care. The dependent elderly tend to be older, are more likely to be women, live in rural areas and tend to be in households headed by farmers. The study highlights the fact that professional and managerial households are less likely than farm households to care for an elderly person within their own home.

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CHAPTER THREE

Carers within the Home

Introduction

While knowledge about the actual numbers and proportions of elderly people in the population and information on their characteristics is important for service provision, it is equally important to know who their carers are. Much research has addressed problems relevant to the provision of formal services such as hospital and residential care which affect only a relatively small proportion of dependent people. While knowledge about the population of dependent people is patchy, knowledge of those who are caring for these people and maintaining them in the community is even more sparse and less reliable. These carers have been referred to as the 'forgotten army'.[1]

A variety of levels of care have been documented from the very restricted to the quite broad. The term 'carer' is used in this study to describe those who care for, or look after, an elderly person to any extent either in their own home or in the old person's home. This usage of the term covers a wide range of circumstances because the caring itself takes place in a wide range of circumstances, depending on the nature and severity of the need of the elderly person. It is important to emphasise that from the elderly's point of view the difference between staying in the community and going into an institution can mean more than having routine daily tasks undertaken for them. For carers it may mean a 24 hour commitment. In this study, our operational definition of carer encompassed those persons who were reported, in answer to Q.5(b) of the questionnaire, to give an elderly person either a lot of care, some care or occasional care.

As indicated in Chapter Two an estimated total of some 66,300 persons over 65 resident at home require some degree of care. About 77 per cent of these (some 50,800 persons) are looked after by members of their household while the remainder (totalling an estimated 15,500

persons) report that they are cared for by persons from outside the household. (Table 3.1) This chapter (which is based entirely on data supplied by households containing elderly persons) examines the situation of those who receive care from other members of their household, while Chapter Four looks at the extent of care received from persons outside the household.

Who Are the 'Within Household' Carers

The vast majority of elderly people (92.1 per cent) are cared for by a relative, most commonly a daughter (30 per cent), followed by spouse (24 per cent), son (16 per cent) and daughter-in-law (14 per cent). Some 14 per cent are cared for by other relatives; only 3 per cent of those in the study are cared for by a non-relative (Table 3.2).

TABLE 3.1

Whether the Carer is a Member of the Elderly Person's Household

Category of Carer	Estimated Total Number of Recipients of Care	
	%	No. (000)
Member of household	76.6	50.8
Not a member of household	23.4	15.5
Total	100.0	66.3

TABLE 3.2

Relationship of Carer to Elderly Person

Relationship	Elderly Persons	
		Estimated Total
	%	(000)
Spouse	24.0	12.2
Son	15.9	8.1
Daughter	29.7	15.1
Daughter-in-law	14.2	7.2
Other relative	13.6	6.9
Non-relative	2.5	1.3
Total	100.0	50.8

In common with findings from other countries, almost 80 per cent of elderly people have female carers (Table 3.3).

TABLE 3.3
Sex of Carers

Sex of Carer	Elderly Persons	
		Estimated Total
	%	(000)
Male	21.8	11.1
Female	78.2	39.7
Total	100.0	50.8

They are usually cared for by carers aged between 20 and 54 (52 per cent); however, over one-fifth of elderly persons are looked after by carers who are themselves elderly (Table 3.4).

TABLE 3.4
Age of Carers

Age Group of Carers in Years	Elderly Persons	
		Estimated Total
	%	(000)
<20	9.0	4.6
20-39	22.8	11.6
40-45	29.5	15.0
55-64	14.0	7.1
65 or over	24.8	12.6
Total	100.0	50.8

The majority of the dependent elderly, both male (85.2 per cent) and female (72.4 per cent), have female carers. However, female elderly people are slightly more likely to have male carers than male elderly people: over a quarter of females have male carers compared with 15 per cent of males (Table 3.5).

TABLE 3.5
Sex of Carer by Sex of Care Recipient

Sex of Carer	Sex of Recipient	
	Male	Female
	%	%
Male	14.8	27.6
Female	85.2	72.4
Estimated Total (000)	22.8	28.0

If one looks at the age of the elderly person receiving care along with the sex distribution of the carers, the gender dimension of caring is brought into focus. In this study it was found that those cared for by a female carer are slightly older than those cared for by a male carer: almost half of those looked after by a woman are aged 80 or over compared to 33 per cent of those looked after by a man (Table 3.6).

TABLE 3.6

Age of Care Recipient by Sex of Carer

Age Group of Care Recipient	Care Recipient With: Male Carer	Female Carer
	%	%
65-69	10.5	11.4
70-74	31.5	19.3
75-79	25.6	21.8
80+	32.5	47.5
Estimated Total (000)	11.1	39.7

Those looked after by female carers are also more dependent: 47 per cent of those looked after by a woman require a lot of care compared to 38 per cent of those looked after by a man (Table 3.7).

TABLE 3.7

Level of Dependency of Care Recipient by Sex of Carer

Level of Dependency of Care Recipient	Care Recipient With: Male Carer	Female Carer
	%	%
A Lot of Care Needed	38.0	46.6
Some Care Needed	40.7	32.9
Occasional Care Needed	28.5	20.5
Estimated Total (000)	11.1	39.7

Type of Help Given

Help is most commonly given with domestic tasks such as shopping (80 per cent), laundry and ironing (76 per cent), making the fire (75 per cent) and bringing in fuel (72 per cent) (Table 3.8). Almost two-thirds of the dependent elderly are helped in getting to places beyond walking distance while over a quarter have assistance with mobility within the

house. Approximately one-third receive help with personal care such as bathing, dressing and brushing hair or shaving (Table 3.8).

TABLE 3.8

Type of Help given to Care Recipient

Type of Help	Estimated Number Receiving this type of help	
		Estimated Total
	%	(000)
All over wash/bath	33.6	16.8
Dressing	35.5	17.8
Brushing hair/shaving	30.3	15.2
Getting to/using WC	24.4	12.2
Feeding self	17.7	8.9
Taking medication	45.5	22.8
Getting up and down stairs	30.4	15.2
Getting about the house	31.9	16.0
Shopping	80.3	40.2
Transport	69.0	34.5
Coping with day-to-day living	67.2	33.7
Handling money/bills	56.6	28.4
Preparing meals	72.8	36.5
Using telephone	41.0	20.5
Doing laundry	75.8	38.0
Doing ironing	75.8	38.0
Making fire	74.6	37.3
Bringing fuel	71.8	36.0

Over half of the elderly persons in the study require assistance with 9 or fewer tasks; 19 per cent of the elderly require assistance with almost all of the tasks listed (Table 3.9).

TABLE 3.9

Number of Tasks with which Carer Helps Care Recipient

Number of Tasks	Care Recipients Estimated
	%
1-3	11.0
4-6	20.5
7-9	25.1
10-12	14.9
13-15	9.9
16-18	18.6
Estimated Total (000)	50.8

The Extent of Care Given by Carers within the Household

It is clear from Table 3.8 above that the extent of the care given varies enormously from just doing some chores for the old people (like their laundry or ironing, or shopping) to what must amount to practically full-time care — washing, feeding, dressing the old people, helping with mobility around the house and visits to the toilet and so on. It is of interest to ask what are the characteristics of these high intensity caring relationships. Are the elderly people in question among the very old? Are they men or women? And what of the high intensity carers? Are they young or old, male or female? What types of household do they live in?

Table 3.10 clearly documents the effect of advancing years on the amount of care required. Some 23 per cent of old people in the 65-69 age group are helped with 3 or fewer tasks, compared with only 3 per cent in the oldest age group. At the other end of the scale, under 10 per cent of the old people aged 65-69 receive the highest intensity of care (i.e., have 16-18 tasks performed for them) while 21 per cent of the oldest age group receive this high level of care.

TABLE 3.10

Extent of Care Received, Classified by the Age of the Old Person

Extent of Care	Age Group of Old Person				
	65-69	70-74	75-79	80+	All Ages
			%		
1-3 Tasks	23.4	18.3	13.6	2.9	10.9
4-6 Tasks	12.3	30.9	19.2	18.0	20.3
7-9 Tasks	31.3	20.1	20.3	28.0	24.9
10-12 Tasks	15.3	8.8	14.0	18.9	15.2
13-15 Tasks	8.0	5.4	11.8	11.3	9.8
16-18 Tasks	9.7	16.5	21.2	20.8	18.7
Total	100.0	100.0	100.0	100.0	100.0

The findings show that there is little variation between elderly people of different sexes in terms of the extent of care received. Just under one-third of both male and female old people could be classified as receiving a high degree of care (i.e., being helped with at least 13 of the 18 tasks listed).

It was previously indicated that about one-fifth of all within household carers are male and four-fifths female. However, female carers tend to

be involved in more intense care-giving relationships (Table 3.11). Thus, over 30 per cent of female carers help with at least 13 of the 18 tasks mentioned, compared to 18 per cent of male carers. In contrast, over 20 per cent of male carers give the lowest intensity of care (1-3 tasks) compared with 8 per cent of female carers.

Examination of the levels of intensity of care given by carers of different ages indicates that the highest intensities of care were concentrated in the middle-age group. Carers aged between 40 and 64 gave more intense levels of care than younger or older carers.

TABLE 3.11

Extent of Care Received, Classified by the Sex of the Carer

Extent of Care	Sex of the Carer		
	Male	Female	Both Sexes
		%	
1-3 Tasks	20.8	8.4	11.0
4-6 Tasks	23.9	19.6	20.5
7-9 Tasks	24.4	25.3	25.1
10-12 Tasks	12.7	15.4	14.9
13-15 Tasks	3.5	11.6	9.9
16-18 Tasks	14.8	19.7	18.6
Total	100.0	100.0	100.0

Table 3.12 shows the extent of care received, classified by the occupation of the head of household. The higher status households had slightly more low intensity carers (6 tasks or fewer) than other households. Apart from this, there is little variation in the levels of intensity exhibited by the different social class groups.

TABLE 3.12

Extent of Care Received, Classified by the Occupation of the Head of the Household

Extent of Care	Occupation of Head of Household				
	Self-Employed/ Farmer	Prof/ Managerial/ Non-manual	Skilled Manual	Unskilled Manual	All Occupations
			%		
1-6 Tasks	27.7	38.7	29.6	34.7	31.5
7-12 Tasks	43.8	35.7	39.4	35.0	39.7
13-18 Tasks	28.5	25.6	31.0	30.3	28.8
Total	100.0	100.0	100.0	100.0	100.0

Summary

This chapter focuses on carers within the home. The results support the findings outlined in the research review above which show that families are the main carers of dependent elderly persons and that the major part of the caring role falls on women whether wives, mothers, spouses or other relatives. It is worth noting, however, that over 15 per cent of sons give some level of care. Women carers also look after the more dependent elderly. The majority of carers are between 20-54 years of age with a large group aged between 40-54 years. However, one-quarter of the carers are 65 years or more. This study also shows the range of help given with ordinary day-to-day activities. Over 18 per cent of carers provide help with all aspects of living, thus enabling the elderly person to live within a family setting in the community. More women than men tend to be carers and to be involved in more intensive care-giving relationships. Differences also emerge with respect to different social class groupings. The higher status households are more likely than other households to be involved in low intensity care-giving situations than other households. The next chapter explores caring in the community.

REFERENCES

1. Henwood, M. and Wicks, M. *The Forgotten Army; Family Care and Elderly People.* London: Family Policy Studies Centre, 1984.

CHAPTER FOUR

Caring within the Community

Introduction

The preceding chapter described those who care for elderly members of their own household and noted the similarities and differences between male and female carers. The focus of this chapter is on the extent of care given to elderly persons in the community by people who are not living with them.

Information was obtained on this topic in two ways: (a) from the elderly people who were receiving care and (b) from the care-givers, i.e. from those who reported that they gave care to an old person outside their household. In strict logic, if both the givers and the recipients understood the term 'caring' in an identical way, then the two approaches should give similar estimates of the number of carers looking after someone from outside their household and the number of elderly persons being looked after by them. In actual fact it was found that the two approaches gave quite divergent results and it is very important to be clear why this happened. The survey results indicate that, if every private household in the country were interviewed, about 16,000 elderly people would be found who would state that their principal carer lived outside the household. The results further suggest that, if a complete enumeration of households was conducted, 128,000 old persons would be reported as 'being cared for' by a non-household member. There are at least two reasons why these figures differ so substantially.

(a) The carer's perception differs from the recipient's perception as to what 'care' means. It is clear, for instance, that many carers regard 'keeping the elderly person company' as giving care. In many cases, the elderly person would probably not regard this as care. Furthermore, the relatively low visitation frequency of many outside carers (30 per cent weekly or less)

suggests that this 'care' is much less intensive and more intermittent than the care given by household members.

(b) The number of carers must be less than the number of care recipients, since many old people are cared for and visited by more than one person. Thus, the total of 128,000 persons being visited by outside carers must be divided by the (unknown) average number of carers per old person to obtain a valid estimate of the number of old people cared for.

In this chapter it is necessary, therefore, to examine the situation of carers from outside the old person's household in two ways: (a) based on the data supplied by the old person and (b) based on the information supplied by those who state that they give care to someone outside their household. In each case, particular attention will be paid to the situation of the old people who live alone. The chapter concludes with an attempt to assess the overall magnitude and nature of inter-household caring.

Caring in the Community as Described by the Elderly Person

Table 4.1 summarises the characteristics of the old people who report that they are cared for by someone outside the household.

TABLE 4.1
Characteristics of Old Persons who Report that they are Cared for by Someone Outside the Household

Characteristic			Estimated Total
		%	(000)
(a) Sex	Male	47.6	7.4
	Female	52.3	8.2
	Both Sexes	100.0	15.5
(b) Age Group	65-69	11.3	1.8
	70-74	19.2	3.0
	75-79	20.4	3.2
	80+	49.0	7.6
	All Ages	100.0	15.5
(c) Household Type	Single Person	54.2	8.4
	More than 1 Person	45.8	7.1
	All Types	100.0	15.5

It is clear that the percentage of males and females who are recipients of outside care are roughly similar to those in the elderly population as

a whole. However, the differences with regard to age and household type are striking. Almost half of those old people who stated that they were in receipt of outside care were aged 80 or over, and just over half of them lived alone. Thus, it is predominantly those old people who are in the situations of greatest need who see themselves as receiving high levels of care from outside the household.

Table 4.2 shows the characteristics of the carers as reported by the old people. Eighty per cent are female compared to 20 per cent who are male; a situation which is almost identical to that which prevailed among the within-household carers described in Chapter Three. However, the age distribution of the outside carers differs substantially from that of the within-household carers. A lot more of the outside carers are in the youngest (under 20) age group and far fewer are in the oldest age group.

TABLE 4.2

Characteristics of Carers from Outside the Household as Reported by the Old People

Characteristic			Estimated
		%	(000)
(a) Sex	Male	19.7	3.1
	Female	80.3	12.5
	Total	100.0	15.5
(b) Age Group	<20	12.6	2.0
	20-39	7.9	1.2
	40-54	46.2	7.2
	55-64	24.8	3.8
	65 or over	8.5	1.3
	Total	100.0	15.5
(c) Relationship to old person	Son	6.1	0.9
	Daughter	18.4	2.9
	Other relative	44.6	6.9
	Non-relative	30.8	4.8
	Total	100.0	15.5

Thus, care from outside the household is much more frequently given by persons of a different generation from the elderly person. Similarly, fewer of the outside carers are sons or daughters and considerably more of them are non-relatives than was the case with the within-household carers.

Table 4.3 shows the type of tasks with which carers helped the elderly persons. Contrasting this table with Table 3.8 in Chapter Three reveals that those receiving care from outside are substantially less dependent than those receiving care from other household members. Outside carers are much less likely to help with the more intimate and basic tasks such as washing and feeding. The help given is much more concentrated on such things as transport, laundry and ironing, fire-making and so on.

TABLE 4.3

Extent of Care Given by Outside Carers as Reported by the Old People

Type of Task	Per cent receiving this type of care	Estimated total receiving this type of care
		(000)
Having all over wash/bath/shower	11.0	1.7
Dress (incl. buttons and zips)	9.3	1.4
Brushing or combing hair/shaving	9.3	1.4
Getting to and using the WC	6.3	1.0
Feeding self	6.4	1.0
Taking his/her medication	7.2	1.1
Getting up and down stairs	10.7	1.7
Getting about the house	9.1	1.4
Shopping for groceries	68.0	10.5
Going places beyond walking distance	38.3	5.9
Coping with day-to-day living	38.0	5.9
Handling money/bills	25.5	4.0
Preparing his/her own meals	32.1	5.0
Using phone (finding nos./dialling)	15.3	2.4
Doing own laundry	48.5	7.5
Doing own ironing	43.9	6.8
Making fire	42.3	6.6
Bringing in fuel	45.0	7.0
Estimated Total Receiving Outside Care		15.5

Table 4.4 examines the situation of those who live alone as regards the tasks with which they get help. Again, the intimate tasks like washing and feeding do not figure at all prominently and help is mostly concentrated on transport, fire-making and dealing with money/bills.

TABLE 4.4

Extent of Care Given by Outside Carers to Old People who Live Alone, as Reported by the Old People

Type of Task	Per cent receiving this type of care	Estimated total receiving this type of care
		(000)
Having all over wash/bath/shower	3.5	0.3
Dress (incl. buttons and zips)	7.1	0.6
Brushing or combing hair/shaving	7.1	0.6
Getting to and using the WC	7.1	0.6
Feeding self	3.5	0.3
Taking his/her medication	3.5	0.3
Getting up and down stairs	3.5	0.3
Getting about the house	3.5	0.3
Shopping for groceries	7.1	0.6
Going places beyond walking distance	67.9	5.7
Coping with day-to-day living	46.4	3.9
Handling money/bills	25.0	2.1
Preparing his/her own meals	28.6	2.4
Using phone (finding nos./dialling)	35.7	3.0
Doing own laundry	10.7	0.9
Doing own ironing	32.1	2.7
Making fire	35.7	3.0
Bringing in fuel	46.4	3.9
Estimated Total Living Alone		8.4

Caring in the Community as Described by the Carers

Examination of the situation regarding inter-household care-giving, as described by the carers, reveals that in 11 per cent of the households interviewed, at least one household member reported giving care to an elderly person in another household (Table 4.5).

TABLE 4.5

Whether any Household Member Helps any Elderly Person Outside the Household

Category	Estimated Households
	%
Engages in Outside Care-giving	11.3
Does not Engage in Outside Care-giving	88.7
Total Number of Households (000)	866.1

Of those who give informal care of this type, three-quarters give help to one elderly person and one-fifth to two elderly people (Table 4.6). Approximately 5 per cent look after more than two elderly people (Table 4.6).

TABLE 4.6

Number of Elderly Persons Helped by non-Household Members

Number of Persons Helped	Estimated Total Persons Cared for by Non-household Member	Estimated Total Care-giving Households
	(000)	%
One	74.1	75.5
Two	39.4	20.1
Three	8.2	2.8
Four	6.5	1.7
Estimated Total (000)	128.2	98.2

Thus a total of about 98,000 households are estimated to engage in outside caring, while some 128,000 elderly persons are reported to be cared for by them. It must be carefully borne in mind, as was pointed out at the beginning of this chapter, that this does not represent 128,000 different old persons since some old people are visited by more than one carer. The figure for the number of different old persons receiving outside care is considerably less than this but cannot be accurately assessed from the present data. Furthermore, readers are reminded that the carers' definition of 'care' tends to be much more inclusive than the recipients' definition.

Characteristics of Outside Carers

Female carers look after the majority of elderly persons (71 per cent) who receive care (Table 4.7) and carers aged between 20 and 54 years of age look after over 72 per cent of care recipients (Table 4.8). Furthermore, it is interesting to note that carers who are themselves elderly look after approximately 7 per cent of those elderly who receive care (Table 4.8).

TABLE 4.7

Sex of Outside Carer

Sex	Estimated Total Carers
	%
Male	28.7
Female	71.3
Total %	100
Estimated Total (000)	105.6

TABLE 4.8

Age of Outside Carer

Age Group	Estimated Total Carers
	%
<20	4.5
20-39	35.0
40-54	37.4
55-64	15.8
65 or over	7.3
Total %	100
Estimated Total (000)	105.6

The elderly who receive outside care are helped mainly by relatives, usually a daughter. However, it is worth emphasising that 40 per cent receive help from non-relatives (Table 4.9) showing the extent of informal care in the community.

TABLE 4.9

Relationship of Outside Carer to Care Recipient

Relationship	Estimated Total Recipients
	%
Son	10.0
Daughter	23.2
Son-in-law	0.2
Daughter-in-law	6.5
Other relative	19.6
Non-relative	40.5
Total %	100
Estimated Total (000)	128.2

Table 4.10 shows the occupational distribution of households which care for at least one elderly person outside the household. The professional/managerial group appears to engage in such caring to a considerably greater extent than the other groups. Farmers and the self-employed seem to engage in outside caring to a lesser extent. This provides an interesting contrast with the data provided in Chapter Two above on within-household caring. There it was found that the professional/managerial group did considerably *less* within household caring than other groups while farmers did substantially more. This contrast may reflect a greater tendency for the higher social classes to utilise institutional care. Alternatively, or additionally, it may reflect a greater concentration of multi-family households in the farming sector.

TABLE 4.10
Estimated Number and Percentage of Households which give Care to at least one Old Person outside the Household, Classified by Occupation of the Head of the Caring Household (based on information supplied by the caring household)

Occupation of Head of Caring Household	Giving Care to Non-h/hld Member	Not Giving Outside Care	Total
	%	%	
Self Employed	8.9	91.1	100.0
Farmer	9.5	90.5	100.0
Professional/Managerial	17.4	82.6	100.0
Other Non-manual	11.9	88.1	100.0
Skilled Manual	11.9	88.1	100.0
Unskilled Manual	10.1	89.9	100.0
All Occupations %	11.3	88.7	100.0
Estimated total	98.2	767.9	866.1

Outside carers are more likely to be located in rural areas. Over half of the households engaged in outside care-giving are rural compared to 45 per cent of households in the sample which are urban (Table 4.11).

TABLE 4.11
Area of Residence of Outside Carers

Area	Estimated Total Care-giving Households
	%
Rural/Small towns	54.9
Urban	45.1
Total %	100
Estimated Total (000)	98.2

As might be expected, elderly people who live alone are more likely to receive informal support. Three-fifths of the elderly (59 per cent) cared for by outside carers live alone (Table 4.12).

TABLE 4.12

Whether Elderly Persons Helped by Outside Carers Live Alone

Category	Estimated Total Care Recipients
	%
Lives Alone	59.4
Does Not Live Alone	40.6
Total %	100
Estimated Total (000)	128.2

Frequency of Visits by Outside Carers

Over one-third of the carers report that they visit daily and a further one-third visit two or three times a week (Table 4.13). This means that almost 70 per cent of those who receive care are visited by the carer at least 2-3 times a week.

TABLE 4.13

Frequency of Visits by Outside Carers

Frequency	Estimated Total Care Recipients
	%
Daily	37.3
2-3 times a week	32.7
About once a week	21.1
Less often	8.9
Total %	100
Estimated Total (000)	128.2

Nature of the Care Given

The main tasks with which the outside carer helps are social or domestic. Approximately 86 per cent of the elderly people are 'kept company' by their carers (Table 4.14).

Around a quarter are helped with cooking, laundry/ironing, making the fire or household decoration. Approximately half of the elderly are

helped with transport provision, shopping or collecting their pension (Table 4.14).

TABLE 4.14

Main Tasks with which the Outside Carer Helps

Tasks	Estimated Total Number Care Recipients
	%
Shopping/Collecting Pension	56.6
Cooking	23.7
Laundry/Ironing	28.2
Making Fire	24.1
Household Decoration/Repairs	29.4
Company	85.5
Transport	48.9
Other	9.4
Total %	100
Estimated Total (000)	128.2

Summary

This chapter examines the extent of 'community carers' in the sense of inter-household transfers of care. Somewhere between 16,000 and 100,000 persons are in receipt of such 'care', the number varying according to the definition of 'care'.

The study shows that an estimated 16,000 elderly state that their principal carer lives outside their household. However, the results also show that, if a complete enumeration of all households was conducted, 128,000 old persons would be reported as 'being cared for' by a non-household member.* It is clear that in many instances there is a substantial difference between the definitions of care adopted by the recipient, i.e. the elderly person, and that of the carer. The elderly who see themselves as receiving high levels of care from outside their homes are in situations of greater need, almost half of them living alone. Most of those providing outside care to this group are younger than those who provide care in the home and fewer are relatives. The elderly themselves who are receiving care from outside carers are substantially less depen-

*This figure does not represent 128,000 different old persons who receive care, since some of these elderly persons are visited by more than one carer. The figure for the number of old people receiving outside care is considerably less than this but cannot be accurately assessed from the present data.

dent than those receiving care from other household members in their own homes. The kind of help given is concentrated on laundry, ironing and transport. It is worth noting here that the carers are predominantly female with almost one-fifth being male compared to four-fifths female.

Examination of care-giving in the community as described by carers themselves indicates that 11 per cent of households interviewed give care to an elderly person who is not living in their home. This represents a considerable number of people who are involved in informal support within the community. Here again women, whether relatives or not, are reported to be the principal outside carers. Several studies have shown the importance of social contact to the elderly themselves. The tasks undertaken by carers emphasise again the importance of social contact and of help with routine daily activities. The vast majority (86 per cent) provide company and over half (57 per cent) undertake shopping and collection of pensions. Approximately one-quarter of carers perform household tasks like cooking, ironing and making a fire, indicating their essential role in integrating and supporting elderly persons in the community.

CHAPTER FIVE

Conclusions

Introduction

In recent years in Ireland, as in many other countries, there has been renewed emphasis on the importance of informal care and support of the elderly. The need to focus attention on the care of the elderly has become urgent because the demographic structure of the country indicates that Ireland is fast becoming an ageing society. In the future, an increasing number of elderly people, particularly those aged 75 years and over, will be living in the community. Because illness, disability and dependence are frequent concomitants of old age, an increasing proportion of the population is going to require different levels of care and a higher level of service provision. Traditionally, the main burden of providing care for the elderly has fallen on families. In the United States, for example, 80 per cent of long-term care services for the elderly are provided by family members.[1] Similarly, in England and Ireland, the majority of the elderly are cared for at home rather than in institutions.[2, 3, 4] While there are no comprehensive figures available for Ireland, the fact that only 5 per cent of the population aged 65 and over live in institutional care indicates that the vast majority of elderly people live in the community. The fact that families have typically been at the forefront in providing care has led to the development of an explicit community care policy. The stated objective of community care is to maintain the highest possible quality of life for the elderly by providing care in their own homes as far as possible. While this aim is laudable, much concern is being expressed about the fact that governments are using the notion of community care to shirk their responsibilities and are simply exploiting the commitment of families to look after their elderly without providing the kind of supportive services that a genuine policy of community care implies.[5, 6, 7] A recent NESC report highlights

the gaps in community care in general and for elderly persons in particular in Ireland.[8]

Despite the emphasis on family care of the elderly, little research has been carried out in Ireland which would provide some understanding of what it is to be a carer; research which would explore their life on a day-to-day basis as well as indicating the distribution, experience, costs and consequences of care-giving. However, this present study sets the scene for further research to be carried out into the caring process by providing preliminary baseline data on carers in Ireland.

The study highlights, firstly, that in Ireland there are somewhere in the region of 66,300 elderly people who are at least partially dependent on help and require some level of care. Furthermore, of the 66,300 elderly people requiring care, it is estimated that 50,000 of these are cared for from within the home — by family carers. In addition, those elderly requiring care from within the household are more dependent than those being cared for by non-household members. The results of this study confirm the findings of research in other countries which found that the dependent elderly tend to be older, are more likely to be women and to live in rural areas and tend to be in households headed by farmers. As regards the provision of care, there are differences according to socio-economic class. Professional and managerial households are less likely than farm households to care for an elderly person within their own home. Higher status households tend to be involved in lower intensity care-giving situations than other households. This is an interesting point. The care-giving process is indeed very complex. Besides looking in detail at who are the carers and care recipients we need to answer a number of questions: what is the nature and level of the carer commitment? Do carers experience competing familial and work demands? What, if any, are the characteristics of primary versus secondary carers? Who uses voluntary and formal services — what access do carers have to information support and services in general?

Who Are the Carers?

With regard to who are the carers, this study confirms what has already been highlighted by other studies — community care in practice generally means care by a female relative regardless of social class or rural/urban background.[9, 10, 11] In the present study it was found that 78 per cent of the carers are female. A number of influences are no doubt involved here. For example, there is the cultural stereotype of the woman as

'carer' and the fact that women have a longer life expectancy than men which means that women more often care for husbands than vice versa. There is also the fact that women still earn less than men which means that they are often perceived as being more available to care. Research suggests that the experience of caring is very different for men and women. For example, female carers are more likely than males to share the same household with the elderly people: a finding which is supported by the results of this study, which show that about 80 per cent of elderly people have female carers living in the same household. The fact of living in the same household as the elderly person means that the carer is likely to be providing more care for longer periods since he or she is more readily available at all hours of the day and night.[12] Research also shows that women assume more of the intensive all-day caring than men[13] and again, women are more likely to give up paid employment or otherwise adjust their working lives in order to care for dependent relatives.[14, 15] However, even where men and women are coping with the same level of dependency in the elderly person, both informal support and care services are more likely to be received by male than by female carers.[16] There is also the fact that the only allowance specifically available to carers — Prescribed Relative Allowance — is not available to married or cohabiting women whereas it is available to all males regardless of marital status. It seems too, that not only are women usually the carers but often they have cared for more than one person in their lifetime and may also have young children living at home.[17]

Those advocating a policy of community care must not only examine the implications of the fact that carers are predominantly women but must also take account of the evidence which indicates that care by the community often means care of the elderly by the elderly. This study, for example, established that one-quarter of the carers are 65 or older. It has also been found in England that 42 per cent of carers are themselves over 60 years of age and just 8 per cent are below the age of 40.[18]

How do People Become Carers?

The study raises questions as to how people become carers. What are the choices and decisions to be made when deciding to take on the caring role? Why does one person in a family become a carer as opposed to another member? Previous research suggests that a number of factors come to play in the decision to become a carer.[19] Distance is one

factor and may be responsible in the present study for the rural/urban differences highlighted. The 'availability' of the person to become a carer is another important factor. The elderly person would most probably turn to his/her spouse for care and in the absence of a spouse, she/he would turn to a child or in the absence of a child, to a brother or sister and so on. Household composition is also important. For instance, if the dependent elderly person has only one child, then the choice of who becomes carer is very much restricted. The level of dependency and state of health of the elderly person would also be influencing factors. Other factors which also seem important include the other responsibilities which 'potential' carers may have which would render then unable to care. In some cases a family member will refuse to care, in other cases a family member will volunteer, for whatever reason, to care. A second research report* will investigate these and other issues which have been raised by this preliminary report.

What Are the Costs of Caring?

As yet, little is known in Ireland about what day-to-day caring for an elderly person entails and the costs and consequences to a carer of taking on the caring role. However laudable the notion of community care may be, it is vital that it should take into account the quality of life experienced by carers. The second phase of this study on the caring process will examine some of the following issues raised by this baseline study. The costs to the carer's physical, mental and social well-being need to be investigated fully in order that the impact of caring on the carer's life may be fully understood so that the most appropriate services may be provided and strain be alleviated.

A much used measure of the impact of caring on a carer's life is the amount of 'burden' experienced. Burden is deemed to result from both subjective and objective factors. The most important subjective factors include the carer's personal reaction to caring and her/his relationship with the elderly person. Objective factors include the level of dependency, disability and state of mind of the elderly person. A further objective factor is the carer's social support network. With regard to the elderly people we do know from the present study that those cared for in the home are in the main more dependent than those living in the community.

**Caring for the Elderly Part II, The Caring Process: A Study of Carers in the Home* will be published later by the National Council for the Aged.

What Support is Available to Carers?

Relatives, friends and neighbours have the potential to play a supportive role to the family. However, it is too simplistic to talk of neighbouring as if it is a homogeneous resource. All carers will not receive the same levels of support or perceive the role and function of their relatives, friends and neighbours in the same way.

It is important to raise the issue of the potential support available and the range of support the carers' networks can provide. Research must look at who carers turn to and for what kind of help. One important question to look at is why overstretched family carers decide not to seek help from other sources. In the context of caring, the nature of relationships as well as the subtle and complex interactions that underlie these relationships need to be explored.

Research has shown that there is a strong link between a person's degree of geographical isolation and the extent of support from relatives and also from friends and neighbours. In many ways, it is a fragile system of support. These findings, however, are important for the type of knowledge-base necessary to build a more complete picture of informal care. In particular, this information is essential for looking at social care and its inter-relatedness and the connections between informal, voluntary and formal care in different contexts and the implications of this for service delivery strategies for state agencies.

Implications for Policies of Community Care

The challenge for the professional carers is to link effectively with these sources of care in the community and to look at how different sources of care can be more effectively interwoven into an integrated community care support service for elderly people and their carers. Connections between the family, other informal, voluntary and formal care need to be explored to maximise the potential in the community but also to support and develop the potential of the carers as care-givers and as people.

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APPENDIX

EEC Consumer Survey — Supplement (1985)

CARING FOR THE ELDERLY

We have also been asked to gather some information about how old people are cared for and the problems encountered in looking after them. It is hoped to use this information to plan better facilities for old people and to provide more help for those who care for them.

5.(a) Is there any person aged 65 or over living in this household?

Yes ..... 1 No ..... 2 Go to Q. 7

(b) If yes, please state for each elderly person	Person 1	Person 2	Person 3	Person 4
(i) Sex (M = 1; F = 2)	_____	_____	_____	_____
(ii) Age	_____ yrs	_____ yrs	_____ yrs	_____ yrs
(iii) Their relationship to the Head of Household	_____	_____	_____	_____
(iv) Is he/she fully independent or does he/she need regular care in order to live at home? How much care does he/she need?				
A lot of care	1	1	1	1
Some care	2	2	2	2
Occasional care	3	3	3	3
No care needed — fully independent	4	4	4	4

(v) Is any of the above members of the household an incapacitated pensioner in receipt of a Prescribed Relatives Allowance from the Department of Social Welfare?

Yes ..... 1 No 2

Person No [ ]

6. For each of the elderly people who receive some care (i.e. are coded 1-3 in b (iv)), could you indicate (a) the sex, age and relationship to the old person of the person who normally gives the care (e.g. son, daughter, daughter-in-law etc.) and whether the care-giver lives in *this* (the old person's) household; (b) the tasks with which the old person usually needs help? (Circle all that apply to each person.)

	Old persons resident in this household			
	Person 1	Person 2	Person 3	Person 4
(a) Sex (M = 1; F = 2)				
Care-giver's age				
Care-giver's relationship to the old person cared for				
Is the care-giver a member of this household? (Yes = 1; No = 2)				
(b) Type of Help Given (Circle all that apply)				
1 Having an all over wash/bath/shower	01	01	01	01
2 Dress (incl. buttons and zips)	02	02	02	02
3 Brushing or combing hair (women), shaving (men)	03	03	03	03
4 Getting to and using the W.C.	04	04	04	04
5 Feeding self	05	05	05	05
6 Taking his/her medication	06	06	06	06
7 Getting up and down stairs	07	07	07	07
8 Getting about the house	08	08	08	08
9 Shopping for groceries and other items	09	09	09	09
10 Getting to places beyond walking distance	10	10	10	10
11 Coping with day-to-day living	11	11	11	11
12 Handling his/her own money, managing and paying bills	12	12	12	12
13 Preparing his/her own meals	13	13	13	13
14 Using the phone (including looking up nos./dialling)	14	14	14	14
15 Doing own laundry	15	15	15	15
16 Doing own ironing	16	16	16	16
17 Making fire	17	17	17	17
18 Bringing in fuel	18	18	18	18

7. (a) Does any member of this household give any type of care to a person aged 65 or over who lives *outside* this household?

Yes ..... 1 No 2

(b) How many such old people are helped by members of this household?

(c) For each of these old people, please state

	Old persons outside this household who are cared for by members of this household			
	No. 1	No. 2	No. 3	No.4
(i) The care-giver's sex (M = 1; F = 2)	_____	_____	_____	_____
(ii) The care-giver's age	_____ yrs	_____ yrs	_____ yrs	_____ yrs
(iii) Does the old person live alone (Yes = 1; No = 2)	_____	_____	_____	_____
(iv) Relationship of care-giver to old person	_____	_____	_____	_____
(v) Does the care-giver see the old person				
Daily	1	1	1	1
Two or three times per week	2	2	2	2
About once a week	3	3	3	3
Less often	4	4	4	4
(vi) What are the main tasks with which the care-giver helps? (Circle all that apply.)				
Shopping/collecting pension	1	1	1	1
Cooking	2	2	2	2
Laundry/ironing	3	3	3	3
Making fire/cutting/gathering firewood	4	4	4	4
Household decoration/repairs	5	5	5	5
Keeping the old person company	6	6	6	6
Providing transport	7	7	7	7
Other (specify) _____	8	8	8	8

8. If the household contains an old person who receives care and/or someone who gives care to an old person, would they be willing to participate in a survey on this topic early next year?

Yes ..... 1 No 2

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NATIONAL COUNCIL FOR THE AGED REPORTS:

1. Day Hospital Care, April 1982
2. Retirement: A General Review, December 1982
3. First Annual Report, December 1982
4. Community Services for the Elderly, September 1983
5. Retirement Age: Fixed of Flexible (Seminar Proceedings), October 1983
6. The World of the Elderly: The Rural Experience, May 1984
7. Incomes of the Elderly in Ireland: And an Analysis of the State's Contribution, May 1984
8. Report on its Three Year Term of Office, June 1984
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18. Caring for the Elderly, Part I: A Study of Carers at Home and in the Community

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The front cover shows the 'Tao' symbol for long life. The symbol is signed by the eighty five year old artist Yen Chih.

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