Older People in Ireland:

A Profile of Health Status, Lifestyle and Socio-Economic Factors from SLÁN

National Council on Ageing and Older People
An Chomhairle Náisiúnta um Aosú agus Daoine Aosta

Older People in Ireland: A Profile of Health Status, Lifestyle and Socio-Economic Factors from SLÁN

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National Council on Ageing and Older People

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Foreword

As Chairperson of the National Council on Ageing and Older People, I am delighted to introduce this report *Older People in Ireland: A Profile of Health Status, Lifestyle and Socio-economic Factors from SLÁN*. It presents an analysis of the data provided by the older people who took part in the National Health and Lifestyle Surveys of 1998 and 2002. The surveys were commissioned by the Health Promotion Unit at the request of the Minister for Health and Children as a direct response to an information deficit relating to national lifestyle data categorised by gender, age and social class.

It is hoped that in this report policy-makers will find dependable up-to-date baseline information on a range of health and lifestyle issues affecting older people. It is also envisaged that this information will be of great use in strategic planning for the population health of our older citizens.

A comprehensive analysis of factors relating to the physical and mental health of older people is presented. Disability and quality of life are also subjected to detailed analysis and, through this process, the extent and nature of inequalities affecting older people is exposed. The critical issues of accidents and social capital are also investigated in some detail. I am confident that this analysis will assist those involved in setting regional priorities in public health, health promotion and health services, as well as those involved in planning living environments for an ageing population.

On behalf of the Council, I would like to thank those older people who took the time to complete the SLÁN questionnaire, which has given us this opportunity to better understand factors affecting the health and welfare of older Irish people. I would like to thank sincerely the authors Dr Frances Shiely and Prof. Cecily Kelleher of the Department of Public Health and Epidemiology in University College Dublin.

I would also like to thank the members of the Council's Healthy Ageing Consultative Committee who advised on the progress of the research and oversaw the preparation of the report, as well as the members of the Policy Standing Committee who contributed to the development of the research.

Finally, I would like to thank the Council's Director, Mr Bob Carroll, its Healthy Ageing Programme Advisor, Dr Helen McAvoy, and Healthy Ageing Project Officers, Ms Dervilla Keegan and Ms Jane England. Particular thanks are also extended to Ms Sinead Quill, Research Officer, Ms Gabrielle Jacob, Resources and Publications Officer and the Council's administrative staff for their ongoing support.

Cllr Éibhlin Byrne
Chairperson

Author's Acknowledgements

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The authors wish to thank Sinéad Quill, Research Officer, Dervilla Keegan and Jane England, Project Officers with the Healthy Ageing Programme for their helpful comments. They also wish to thank the members of the Healthy Ageing Consultative Committee for their assistance.

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

(Fahey and Murray, 1994)

Introduction

The National Council on Ageing and Older People (NCAOP) is pleased to present this report, which details the findings from a secondary analysis of the National Health and Lifestyle Surveys (SLÁN).

The Council commissioned this analysis in response to the policy recommendations made in the report *Healthy Ageing in Ireland: Policy, Practice and Evaluation* (O'Shea, 2003). O'Shea's report highlighted certain deficiencies in relation to information on the health and well-being of older people. In particular, it advised that national prevalence figures for issues such as sensory impairment, dental health and lifestyle (smoking, alcohol, diet and physical activity) would assist in goal-setting and the monitoring of progress toward implementation of *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998).

This report provides empirical data on the well-being of older people with a focus on health, equity, environment and lifestyle factors. The Council is of the opinion that this report provides an up-to-date appraisal of many of the issues first addressed in Fahey and Murray's 1994 study on health and autonomy among those aged 65 and over. The Council also considers these findings to be most useful if used in conjunction with the findings of the HeSSOP report (Garavan *et al.,* 2001), which surveyed older people's health service needs and usage over a similar period.

Council research has previously documented the health inequalities affecting older Irish people (Layte *et al.,* 1999), while O'Shea's recent review of existing projects and services that promote healthy ageing concluded that few initiatives focus on lower-income groups (O'Shea, 2003). The Council considers that the development of health promotion policy and practice aimed at reducing health inequalities in later life should be evidence-based. In this regard, the analysis of relationships between socio-economic factors and the health, disability and quality of life of older people is particularly welcome. It is the Council's hope that the empirical data analysis presented in this report would be utilised by policy-makers in the development of strategy and programmes relating to the health and welfare of older people at national, regional and local levels. Furthermore, it is hoped that the information will inform health promotion approaches across the life-course as part of the implementation of the next National Health Promotion Strategy.

The Physical and Mental Health of Older People

1. The Council recognises that targets are a powerful tool for concentrating attention where it is needed. Council considers that this study provides a rich source of data from which targets for healthy ageing can be derived at national, regional and service-based levels. The Council encourages policy-makers and service planners to utilise the data to decide priorities and develop targets in the development of health promotion strategy and service plans for older persons. Such a process would positively impact on the population health of Ireland's people and the health of older people in particular. It is ultimately hoped that the data produced in the report will stimulate action for the implementation of the action plans set out in the Health Promotion Strategy for Older People.

   The Council recommends that the Health Services Executive Population Health Working Group give careful consideration to the issues raised in this report and, in the light of recent projections for population ageing (Connell and Pringle, 2004), to the development of approaches to population health within the reformed health structures.

   The Council further recommends that health boards (or the proposed regional health offices) consider the issues raised in the light of the particular needs and demography of the older population at regional level.

A process of regional target setting is recommended within the established planning round of the health board, whereby this national data could be supplemented with local data sources for maximum effect. This process should focus attention on the implementation of the action plans set out in the Health Promotion Strategy for Older People.

2. The analysis in this report demonstrates that the self-rated health of the older population improved between 1998 and 2002, a finding also observed in the general SLÁN sample. However, the association between markers of socio-economic deprivation (lower educational level, lower income and medical card status) and lower ratings of health persisted despite a period of economic growth. **The Council supports the key health target of the National Anti-Poverty Strategy to reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10 per cent for circulatory diseases, cancers, injuries and poisoning by 2007, and proposes that this target be monitored specifically in relation to the older population.**

3. **The Council further recommends that explicit consideration be afforded to lower income older people in the service plans produced by the health boards in relation to public health, health promotion and services for older persons.** It also recommends that equity be a key consideration in the evaluation of all service developments for older people in line with the recommendations made in *Healthy Ageing in Ireland, Policy, Practice and Evaluation* (O'Shea, 2003).

4. The Council recognises that lifestyle significantly impacts on the health of older people. This study builds on Fahey and Murray's 1994 findings that 'the healthier the lifestyle, the lower the morbidity score'. **As smoking, use of salt and physical inactivity were found to be independently associated with lower ratings of health in the analysis conducted for the report, the Council recommends that these factors in particular should be targeted in relation to promoting the health of older people.**

5. This study reinforces the finding that lower ratings of health are independently associated with symptoms of poor mental health (Fahey and Murray, 1994). Robust and independent associations between depression and self-rated health even when controlling for physical illness and functional disability have been previously demonstrated (Mulsant, 1997; Leibson, 1999). The Council has previously recommended that future health promotion programmes should

take account of the strong links that exist between psychological well-being and physical health status (Keogh and Roche, 1996). **The Council therefore recommends that older people in ill-health be afforded particular attention in the design, implementation and evaluation of mental health promotion and the development of mental health services for older people.**

6. The Council notes a striking increase in the proportion of older people taking prescribed pills and medication between 1998 and 2002. Significant increases in the prescription of medications used in the primary and secondary prevention of cardiovascular disease were noted, in line with the findings of the interim report of the National Cardiovascular Strategy (DoHC, 2003). The Council welcomes the positive effect of the Strategy in relation to rising numbers of older people having their cholesterol checked and the increased use of pharmaceutical treatments for risk factors for cardiovascular disease.

   However, the Council considers that the increased number of medications being prescribed to older people may pose dangers in relation to the increased risk of drug interactions, side effects and poisoning. **The Council recommends that priority be given to the promotion of safety in prescribing policy, dispensing and patient education, and that guidelines be developed in relation to prescribing practices for older people in the community in conjunction with prescribers and pharmacists.**

7. The Council notes that over half of the older respondents in this study reported experiencing extreme or moderate pain and that pain was most commonly reported by women and by the socio-economically disadvantaged. Such high estimates of pain are supported by the findings of previous Council research (Garavan *et al.,* 2001). **Council considers that research on pain and older people, in particular the association observed between pain and disability, should be a priority in clinical research with older people. The Council recommends that healthcare providers working with older people be facilitated to develop pain assessment and management skills, and that older people be supported to access specialist pain services.**

8. One of the goals of the Health Promotion Strategy for Older People is to reduce the incidence of diabetes and the morbidity associated with the complications of diabetes in older people. The Council is aware, however, that the incidence of diabetes in the Irish population is predicted to increase in the short-term and considers that much of this increase will occur among older people. The analysis for this report indicates a point prevalence of diagnosed

diabetes of between 5 per cent and 6.4 per cent for people aged 55 and over. As most diabetes in the population is undiagnosed at any one time, Council would caution against such a figure being used for planning purposes, at least prior to the initiation of an appropriate national diabetes screening programme. **In view of the evidence that the early detection, management and treatment of diabetes can reduce morbidity and costs, Council recommends the appointment of additional resources and service development to internationally recognised ratios as detailed in the report of the Diabetes Service Development Group (Diabetes Service Development Group, 2002).**

9. With regard to dental health, the stated goal of the Health Promotion Strategy for Older People is to reduce the morbidity associated with dental and oral disorders in older people. The Strategy emphasises that dentures should not be considered an inevitable consequence of ageing. Improvements in the numbers of older people retaining all or some of their natural teeth have been occurring over the past 40 years; from 28 per cent in 1979 to 52 per cent in 1990 (O'Mullane and Whelton, 1992). The figures produced in this study indicate that the trend for tooth retention continues with 67 per cent of those aged 55 and over dentate in 2002. These improvements mirror the findings of the Adult Dental Health Survey (Office for National Statistics UK, 1999). **The Council proposes that a target be set to reduce to 15 per cent by 2010 the proportion of people aged 55 and over who have lost all their natural teeth. The Council considers that this would be achieved by implementation of the action plans outlined in the Health Promotion Strategy for Older People in conjunction with oral health promotion across the life-course.**

   The Council further recommends that oral health promotion programmes should pay particular attention to older women in relation to their increased risk of reporting full dentures and the well-documented association between poor nutrition and poor dentition.

   While high levels of satisfaction with dental services were found in the HeSSOP report (Garavan *et al.,* 2001), only 8 per cent of people aged 65 and over reported using dental services in the previous year, which is very low by international standards. **In view of the changing trends in tooth retention, the Council recommends that issues of access to, and planning for, appropriate dental services for older people be examined.**

10. The report demonstrates associations between mental health and overall health and quality of life. The Council considers the independent association between home ownership and poor mental health of interest, particularly in relation to the declining rates of home ownership detected over the study period. **The Council recommends that research be undertaken required to further examine the trend towards decreasing home ownership and to examine the effects of this phenomenon on physical and mental health, including a special focus on the situation of older people living in rented accommodation.**

    The Council considers that while levels of reported mental illness dropped between 1998 and 2002, the proportion of people aged 55 and over reporting being moderately or extremely anxious or depressed remains unacceptably high at 25 per cent. The findings reinforce the high levels of psychiatric disorder previously recorded in community-dwelling older Irish people (Lawlor, 1994). The study also indicates that levels of diagnosis and service use are relatively low, with 7 per cent of all older people reporting a diagnosis of depression and 3 per cent attending mental health services. **The Council reiterates the recommendation made in *Mental Disorders in Older Irish People* (Keogh and Roche, 1996) that a national strategy for the future development of mental health services for older people be developed by the Department of Health and Children, in consultation with all concerned parties in this area. The Council also considers that health promotion practitioners have a particular role to play in relation to mental health education and awareness for older people at community level.**

The Health Behaviours of Older People

11. The target set in relation to smoking in the Health Promotion Strategy for Older People is to reduce the prevalence of smoking in people aged 55 and over by at least 16 per cent, to no more than 20 per cent by 2005 (from a baseline of 24 per cent in 1994). **The Council is pleased to see this target has already been bettered and envisages that the workplace smoking ban will further support reductions in smoking in current and future generations of older people.**

12. With regard to nutrition, the goal set in the Health Promotion Strategy for Older People is to ensure that older people have an affordable diet which provides adequate nutrition and optimises their health status. **The Council recommends that the Food Safety Authority's recommendations for a national food and nutrition policy for older people (Food Safety Authority of Ireland, 2000) be implemented in full.**

    The Council further expresses particular concern in relation to the trend towards rising obesity observed among older people and welcomes the establishment of the Obesity Task Force. **The Council recommends that the findings of this study be considered in the development of national policy and practice to reduce obesity across the life-course, and among older people in particular.** The analysis suggests that obese older men would represent a target group for nutritional advice and preventive strategies at both clinical and societal levels.

13. With regard to physical activity, the goal set in the Health Promotion Strategy for Older People is to promote physically active lifestyles among older people. The Council considers the findings of this report relating to physical activity as complex, representing an interplay of the socio-demographic variables of age, gender and socio-economic status. It also considers physical activity levels among older people to be unacceptably low and notes a rapid decline in physical activity with age. **It recognises that the high levels of inactivity among men in the 55-64 age group may be associated with sedentary work practices and recommends that physical activity programmes for older men in the workplace be developed by health promotion officers with a remit for physical activity and/or workplace health promotion/occupational health specialists.**

    The Council recommends, in view of the sharp social gradient observed in relation to physical activity, that resources should be directed towards promoting exercise and improving access to opportunities for activity among lower income older people. As physical activity and non-smoking delay the deterioration of mobility as well as delaying morbidity and mortality (Ferucci, 1999), these issues should be addressed as a priority area in all policies and programmes aiming to keep older people healthy and independent.

14. With regard to alcohol consumption, the goal set in the Health Promotion Strategy for Older People is to promote moderation in alcohol consumption

and reduce the risks to physical, mental and family health associated with alcohol misuse. The analysis in this report indicates that alcohol consumption among older people is rising with a trend towards diminishing numbers of abstainers. **The Council considers the rates of binge drinking among older men and women who drink to be of great concern and recommends that older people should be afforded priority in relation to the ongoing monitoring and implementation of the National Alcohol Policy (DoHC, 2002).** The high-risk groups identified in this analysis could be considered in such a process.

15. The goal set in the Health Promotion Strategy for Older People in relation to sexual activity is to ensure that older people understand and are comfortable with their sexuality, and that they can expect to have their sexual needs and dysfunctions considered on the same basis as those relating to their general health. The Council considers this first national data on sexual activity to be an important first step towards the development of an understanding of the sexual needs of older Irish people. **The Council recommends that qualitative research be undertaken to explore the issue with a view to the development of appropriate environments, attitudes and services supportive of older people's sexual needs.**

Disability and Older People

16. The Council notes that disability increases with age (disability in this case being measured subjectively as being limited in daily activity or work by a long-term illness, health problem or disability). This finding is in line with all previous Council research (Fahey and Murray, 1994; Layte *et al.,* 1999; Garavan *et al.,* 2001) and the Census 2002 report on disability and carers (CSO, 2004). **Council research has demonstrated that 31 per cent of people cited illness and disability as the main reason for early retirement (Fahey and Russell, 2001) and it recommends that this group should be addressed in relation to workplace health promotion and flexible retirement options.**

Markers of socio-economic deprivation are associated with disability, in keeping with the correlation between the deprivation index and functional capacity score first recorded by Fahey and Murray in 1994. **The Council recommends that particular attention be paid to preserving the income of older disabled persons and ensuring that they receive their entitlements.**

17. With regard to sensory impairment, the stated goal of the Health Promotion Strategy for Older People is to reduce the prevalence and degree of hearing loss and visual impairment in older people. The Council welcomes the Census 2002 data on the prevalence of sensory impairment, which found that 41,415 people aged 65 and over (9.5 per cent) reported severe vision or hearing impairment including blindness or deafness (CSO, 2004).

    The Council notes the large numbers of older people experiencing hearing impairment and the steep age gradient observed. The prevalence of hearing impairment recorded in this sample is equivalent to other surveys of community-dwelling older people (Abutan, 1993; Stumer, 1996) and is likely to increase with an ageing population irrespective of any improvements in general health. While almost half of those aged 55 and over reported difficulties following conversation when there is background noise, only 7 per cent wear hearing aids. This is despite the fact that the adverse effects of hearing impairment on quality of life are at least partially reversible with hearing aids (Mulrow, 1990). **The Council recommends that evidence-based national guidelines on the screening and assessment of age-related hearing loss be developed. It further recommends that the Department of Health and Children examine resource implications for audiology services and hearing specialists as a matter of priority, in line with the recently published population projections (O'Connell and Pringle, 2004).**

    The Council is aware that the listening needs of the older population cannot be dealt with by hearing aids alone and therefore recommends that health promotion programmes be developed to assist older people in managing their hearing loss. It also recommends that the development of environments supportive of hearing impaired older people be developed in relation to assistive listening devices and systems.

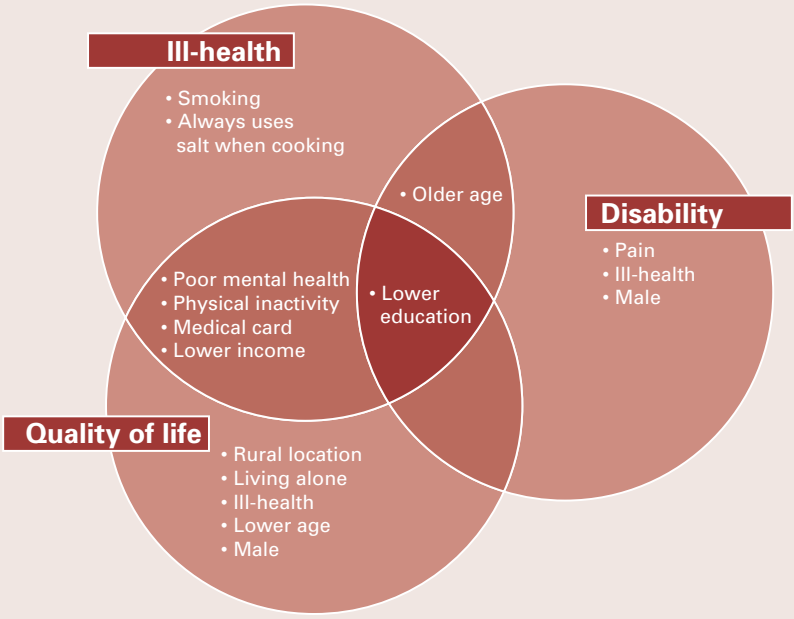
    The Council also welcomes this first survey data on visual impairment among older people and considers that it would be of most use if combined with objective data on the extent and nature of the visual impairment in older people, for which further research would be required. **As statistics on registration of the blind and partially-sighted underestimate the true extent of visual impairment in Ireland (Canavan, 1997) and most eye disease is not known to health services (Natin, 1999), further research is urgently required in order to set targets and to form an appropriate basis for prevention strategy and service development.**

The Council considers that visual impairment is highly preventable and notes that 25 per cent of blindness in Ireland is potentially avoidable (Evans, 2004; Munier, 1998). Screening for visual problems is specifically included in the single assessment process to be offered to older people in the UK (Department of Health UK, 2002). **The Council recommends that national guidelines relating to the assessment and referral mechanisms for older people's vision be developed in Ireland.**

The Quality of Life of Older People

18. The Council is pleased to see the increase in ratings of quality of life observed between the 1998 and 2002 surveys, and proposes that this pattern be monitored through future surveys. The associations between markers of socio-economic deprivation and lower ratings of quality of life suggest that interventions aimed at reducing socio-economic disadvantage may benefit older people's quality of life in addition to their health. Figure 1 demonstrates the overlapping concepts of health, disability and quality of life, and provides a framework for those planning policy and programmes that promote the well-being of older people.

Figure 1: Factors associated with health, disability and quality of life of the population aged 55 and over in the SLÁN surveys



19. One of the goals of the Health Promotion Strategy for Older People is to provide a supportive physical environment to enable older people to remain independent and living in their own homes for as long as they choose. The analysis indicates that older people living alone, particularly those in a rural setting, experience a worse quality of life than others. The absence of an association between living alone and ill-health or psychological distress was noted in relation to previous surveys of older people (Fahey and Murray, 1994). This would suggest that the association between living alone and poor quality of life is unlikely to be mediated solely through mental or physical health factors, but other factors such as environment and social contact may play a substantial role. **The Council recommends that older people living alone should be afforded special attention in relation to promoting health and well-being.**

    The Council also notes that older people consider poor public transport to be the priority issue in relation to the physical environment. **The Council recommends that the Department of Transport undertake a needs assessment with older people in relation to public transport to inform future policy in the area.** A study of the transport situation of older people in eight European countries indicated that older Irish people are critical of public transport connections between rural towns and villages (O'Cinneide and O'Leary, 2004). **The Council recommends that ensuring adequate public transport for older people form a core part of the strategies developed by the City and County Development Boards, as should ease of access to food shops.**

20. With regard to the social environment, the stated goal of the Health Promotion Strategy for Older People is to help maintain the well-being and autonomy of older people by increasing their involvement in social activities. The Council notes that a significant proportion of older people are actively involved in clubs and community-based activities, in particular religious and voluntary associations, and considers that this provides evidence of the significant contribution that older people make to society. The Council has previously advised that the capacity-building of older people's groups through organisational development, the provision of training and intersectoral working between active retirement groups and health promotion departments, would be of benefit in promoting the health of older people (O'Shea, 2003). It

recommends that the inclusion of older people and older people's issues in local decision-making processes may be assisted by encouraging older people to become involved in community action groups where they are poorly represented in comparison to the national average.

The Council further recommends that improving the proportion of older people who are members of sports clubs represents a key strategy in improving physical activity and promoting their health and well-being.

The multivariate analysis undertaken for this report demonstrated an independent association between accommodation and social and interpersonal trust, in that those older people living in rented accommodation reported lower levels of social capital measures. This is in keeping with the finding that community efficacy and active involvement is higher among owner-occupiers in Ireland (Balanda and Wilde, 2003). The lower levels of social capital in rental communities is of concern, particularly as the proportion of older people who are owner-occupiers decreased between 1998 and 2002. **The Council recommends that further examination of the social world and living circumstances of older people in rented accommodation be undertaken.**

Accidents and Older People

21. The Council supports the development of a National Injury Prevention Strategy as proposed in the National Health Strategy (DoHC, 2001) and recommends that the prevention of accidents among older people form a core component of such a Strategy. As more than one in ten SLÁN respondents aged 55 and over reported an injury serious enough to interfere with daily activity over the previous two years, the Council considers that injury prevention programmes are key to the prevention of disability and the preservation of independent living. **Based on the report findings, the Council recommends that the following categories of injury should be given precedence in the development of a National Injury Prevention Strategy for community-dwelling older people: home safety; falls and fracture prevention; and the safety of the older pedestrian. The Council also recommends that the following groups of older people be afforded priority: older women; older people living alone; mobility-impaired older persons; and older people in urban areas.**

22. The Council expresses particular concern that 10.3 per cent of those reporting a significant injury described that injury as 'non-accidental'. This represents

approximately 1 per cent of those aged 55 and over surveyed, which if extrapolated in absolute terms would number approximately 7,875 people. Previous estimates indicate that between 12,000 and 20,000 older people living in the community may be suffering from abuse, neglect or maltreatment (O'Loughlin and Duggan, 1998). The Council considers that this data may be detecting the 'physical abuse' component of elder abuse among community-dwelling older people. **The Council recommends the full implementation of the recommendations of *Protecting Our Future*, the report of the Working Group on Elder Abuse (Working Group on Elder Abuse, 2002).**

23. The analysis demonstrates that older people, in general, tend to adopt safe behaviours in relation to seatbelt use but not in relation to the use of bicycle helmets. **The Council considers that the safety of older people be afforded special attention in the development of future National Road Safety Strategies. The Council also recommends that the National Roads Authority and National Safety Council develop design standards for signs, signals, markings, lighting and other characteristics of the roadway environment to improve visual stimuli and protect the safety of older drivers and pedestrians.**

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Executive Summary

Executive Summary

Background

This report is concerned with the health and well-being of older people in Ireland. It is hoped that it will contribute to the Council's work in promoting the health and autonomy of older people. The report examines key health, lifestyle, socio-demographic and social status variables according to age, sex, education level, social class and medical card status. Area level results are presented where appropriate. The determinants of self-rated health, quality of life, disability and mental health are also presented. The sources of data for this report are the 1998 and 2002 SLÁN National Health and Lifestyle Surveys. While not primarily a report of prevalence, trends over time are reported where applicable. This report focuses on the sample aged 55 years and over, which represented 25.8 per cent of respondents for SLÁN 1998 (n = 1634) and 29.3 per cent for SLÁN 2002 (n = 1754).

Objectives

- To provide a profile of the physical and mental well-being of older people in Ireland and to establish the factors likely to influence these aspects of older people's lives.
- To identify vulnerable sub-groups of older people as far as these dimensions of well-being are concerned.
- To contribute to the formulation of health promotion policies for older people.

Educational Status

The largest percentage of older people are in the ED1 category (none/primary/ some secondary education), though this percentage decreased from 78.96 per cent in 1998 to 69.29 per cent in 2002. On both occasions of measurement, this group represented the overwhelming majority of older people. There was a slight increase in the percentage of those with secondary and tertiary education though this may have been due to sample variation.

Social Class

The percentage of respondents grouped in the SC1-2 category (professional, managerial and technical) increased between the two surveys (42.8 per cent in 2002 compared to 32.2 per cent in 1998). There was a decrease in the numbers in the SC5-6 category (semi-skilled and unskilled). Social class and educational status are not independent of each other in either survey, indicating that social class and education are related.

Health Boards

The proportions represented in each health board area are similar in both surveys with the exception of the North Eastern Health Board.

Accommodation Type

The results for accommodation types are similar for SLÁN 1998 and SLÁN 2002. More than 50 per cent of respondents live in detached homes, while less than five per cent live in multi-storey apartments. All of this latter group are medical card holders. 77.19 per cent owned their homes outright in 1998, while 68.15 per cent did so in 2002. This represents a decrease of almost 10 per cent. The distribution of home ownership is significantly different in rural and urban settings. Older people in rural settings are more likely to own their homes outright. Home ownership is not independent of health board area. The largest group renting from a council is in the Northern Area Health Board area. Those in the Southern Health Board area are more likely to own their own homes.

Medical Card Status

In 2002, 63 per cent of respondents reported having a medical card compared with 53.5 per cent in 1998. This increase is found in the 70+ years group and reflects the extension in July 2001 of medical card entitlement to all those aged 70 and over. This resulted in a larger percentage with medical cards in the SC1-2 category in 2002 compared with 1998.

Income

64.5 per cent of older people reported earning less than €320 per week. The lowest income group (earning less than €65 per week) is found almost exclusively in the rural setting. Similarly, the €65 to €130 per week group has three times more rural dwellers than urban dwellers. When adjusted for household size, 76.6 per cent of respondents earn less than €320 per week. The low income groups are in the rural setting and the trend shifts as the incomes move from average to higher.

General Health

Self-rated Health

There is an increase in excellent and very good ratings for health and a decrease in good, fair and poor ratings in SLÁN 2002, which is statistically significant. Self-rated health demonstrates an age effect, with younger age groups dominating the excellent and very good categories. The reverse is observed for the poor self-rated health category in which the 80-84 years group dominates. However, those aged 85 and over reverse the trend. Combining excellent and very good self-rated health categories, a decrease is observed across the age categories but an increase is noted for those in the 85+ years group. In SLÁN 2002 those rating their health as excellent are over-represented in SC1-2 and under-represented in SC3-4 and SC5-6. Respondents in ED1 are under-represented in the excellent and very good health categories and over-represented in the fair and poor health categories. Medical card holders are under-represented in the excellent, very good and good health categories and over-represented in the fair and poor health categories.

Quality of Life

The results regarding quality of life were similar for both SLÁN 2002 and SLÁN 1998. Quality of life was rated as very good or good by 78.1 per cent in 2002 while 73.3 per cent rated it so in 1998. Age group was a significant factor in both surveys. The 65-69 years group dominate the very poor rating category and the younger age groups dominate the good category. Significantly more women than men rated their health as very good in SLÁN 2002. Those classed in ED3 are more likely to rated their quality of life as very good while those in ED1 are more likely to rate theirs as poor. Those who do not hold a medical card are more likely to rate their health as very good.

Sexual Activity

For both SLÁN 2002 and SLÁN 1998, 64.5 per cent of respondents reported that they were not sexually active; 3.9 per cent always use contraception; 4.8 per cent sometimes use contraception and 26.8 per cent never use contraception. 7 per cent more women than men reported being sexually active. Social class does not influence an individual's sexual practices. Those with tertiary education are more likely to be sexually active than those without and are also more likely to always use contraception. An age effect is evident in SLÁN 2002: sexual activity decreases with age, but an increase is observed in the 85+ years group. Similarly, the numbers of those who never use contraception decreases with age, but increases again for those aged 85 and over.

General Health Check-up

SLÁN 2002 found that 79.8 per cent of respondents underwent a general health check-up in the previous three years; this figure stood at 81.9 per cent in 1998. Neither gender or social class was found to relate for either survey. SLÁN 2002 also found that those in ED1 are more likely and those in ED3 are less likely to have attended their GP for a check-up in the previous three year period. Of those with a medical card 82.6 per cent had had a check-up in the previous three years, compared with 75.2 per cent of those without. The majority of respondents attended their GP's surgery for their check-up (74.9 per cent in SLÁN 2002; 77.5 per cent in SLÁN 1998). Over half of the respondents in both surveys attend their GP's surgery or health centre on a regular basis (once every three months). There has been an increase in reported high cholesterol (11.9 per cent to 16.4 per cent) and diabetes (5.4 per cent to 6.4 per cent). Levels of anxiety (10.0 per cent to 8.8 per cent) and depression (7.9 per cent to 7.3 per cent) have decreased. Reports of circulatory diseases have remained at the same level.

Vision and Hearing (SLÁN 1998)

The report found that 85.8 per cent of respondents wear glasses or contact lenses all or some of the time. This represents 55.5 per cent women and 44.5 per cent men. The majority of respondents (47.9 per cent) reported taking an eye test during the previous five years with 5.3 per cent never having had one.

With regard to hearing, 43.4 per cent of respondents (50.2 per cent women; 49.8 per cent men) find it very difficult to follow a conversation if there is background noise. The percentage of those with hearing difficulties increases with age. One-fifth of the group have either great or moderate difficulty following a TV programme at a volume others find acceptable and without any aid to hearing. A statistically significant gender effect is evident in this instance, with more men than women experiencing great, moderate and little difficulty. Respondents who wear a hearing aid all or some of the time total 6.8 per cent (44.9 per cent men; 55.1 per cent women).

Dental Health

There is a significant decrease over time in the numbers of older people with full dentures and an increase in the numbers with no missing teeth. A significantly higher proportion of women have full dentures for both SLÁN 1998 and SLÁN 2002. There are more men with no missing teeth and also with some missing teeth.

Limitations of Work Due to Health Difficulties

25.6 per cent of respondents reported being limited in their work or daily activity due to long-term illness or disability in 2002, compared with 28.6 per cent in 1998. A gender effect was evident in 2002, with more men than women affected. Of those whose self-rated health was excellent, 99.2 per cent said they were not affected by long-term illness or disability. Of those whose self-rated health was poor, 97.2 per cent said they were affected by ill-health. Standardised residuals show that the SC1-2 category is under-represented and the SC5-6 category is over-represented, while the ED1 category is under-represented and the ED3 category is over-represented. Of those affected by long-term illness or disability, 77.2 per cent hold a medical card.

Pain/Discomfort

While the percentages of those experiencing pain/discomfort has not changed over time, more than 50 per cent of respondents aged 55 and over experience extreme or moderate pain. Gender is a statistically significant factor in SLÁN 1998, with more women than men experiencing extreme pain/discomfort (5.1 per cent women; 2.1 per cent men) and moderate pain/discomfort (50.1 per cent women; 44.8 per cent men). Although there are still more women in SLÁN 2002's moderate and extreme pain/discomfort categories, it was not statistically significant. Those with extreme and moderate pain are more likely to hold a medical card.

Mobility

The majority of respondents experience no difficulty walking about. Just two respondents in 1998 and nine in 2002 were confined to bed. Those experiencing some mobility problems increase with age and peak in the 75-79 years group. There is a decrease again in the 80-84 and 85+ years groups. This is the case for both surveys.

Mental Health

There is a decrease in the percentage of respondents who reported being moderately anxious or depressed. This supports the decreasing percentage of respondents who are attending mental health services for regular checks (2.1 per cent in SLÁN 1998 and 1.7 per cent in SLÁN 2002). Gender, social class, educational status or age group were not statistically significant factors.

Social Indicators

Membership of Organisations

Older respondents exceed the national average when it comes to membership of religious and voluntary organisations, and social clubs. Those who are members of sports clubs are more likely than others to rate their health as excellent or very good.

Physical Environment

Respondents identified the biggest problem in their neighbourhoods as being poor public transport (25 per cent). Rubbish was rated next, on a par with a lack of food shops. Poor public transport ratings did not vary according to social class or educational status; however, an age effect was evident. The 55-59 and 60-64 years groups were over-represented while all other age groups were under-represented.

House Break-ins

Concerns about house break-ins vary according to health board area and rural/urban location. An east coast effect is noted, with over 30 per cent of people in the South Western Area Health Board area sample identifying house break-ins as a big problem and a further 20 per cent rating it as a bit of a problem. Both the East Coast Area Health Board and the Northern Area Health Board areas are more affected than the other areas. Those living in an urban area are twice as likely to rate house breaks-ins as either a big problem or a bit of a problem.

Areas Where Children Can Play Safely

Of the 60.9 per cent of respondents reporting they live in a neighbourhood where children can play safely, 47 per cent were in the SC1-2 category, compared with 17 per cent in the SC5-6 category.

Trust in People Generally

Those people living in a rural setting are more likely to strongly agree that, generally speaking, most people can be trusted. Those in the Southern Health Board area are more likely to strongly agree with the statement while those in the Mid-Western Health Board area are more likely to strongly disagree. Those in the SC5-6 and ED1 categories and who hold a medical card are also more likely to strongly agree.

The determinants of general trust were established in SLÁN 2002. Housing tenure and education level emerged as statistically significant factors. Those who own their homes with a mortgage and those who rent privately are less likely to trust in people generally than those who own their homes outright. Those who rent from a council are more likely to trust people generally than those who own their homes outright. A lower level of education indicates less likelihood of trust in people generally. Those with complete secondary and some tertiary education are more likely to trust people generally than those with complete tertiary education.

People in This Area Can Be Trusted

Those living in a rural setting are more likely to strongly agree that people in their area can be trusted. People in the Southern Health Board area represent the largest proportion that strongly agree with the statement but also the largest proportion that strongly disagree. The South Western Area Health Board sample represents the next largest percentage of those who strongly agree and nobody in this area strongly disagrees with the statement. As before, respondents from the SC5-6 and ED1 categories are more likely to strongly agree.

The significant determinants of trust in people in a person's own area are housing tenure and gender. Those who rent privately are less likely to trust the people in their area than those who own their homes outright. While owning a house with a mortgage or renting from a council are not statistically significant, the trend is the same – they are less likely than those who own their homes outright to trust people in their area. Men are less likely than women to trust people in their area.

Social Support

More than 50 per cent of respondents reported receiving a lot of support from a spouse or partner. Approximately 45 per cent reported receiving a lot of support from children and 30 per cent reported receiving a lot of support from friends.

Lifestyles

Physical Activity/Exercise

There is an increase in the numbers of older people involved in regular moderate and regular strenuous exercise. However, from 1998 to 2002 there was a decrease in the numbers involved in mild exercise. A statistically significant age effect is also evident. In SLÁN 2002, levels of strenuous and moderate exercise decrease with age but increase again for the 85+ years group. Levels of mild exercise are similar for 55-79 year olds but a decrease is observed for those aged 80 and over. More women than men walk on most days of the week. 5.2 per cent of respondents attend a gym/leisure centre. Attendance decreases with age but an increase is again noted for the 85+ years group. Those attending a gym/leisure centre are more likely to be in the SC1-2 category (68.3 per cent) than the SC5-6 category (6.3 per cent).

Those employed in very physically active and fairly physically active jobs decrease with age (except for the 85+ years group). Light housework is done most days of the week by 69.5 per cent of respondents, but women are significantly more likely to do this than men. Men are more likely to seldom or never do light housework. Similar trends are observed for heavy housework. More than 60 per cent of respondents use a car when shopping.

Tobacco

The numbers regularly smoking are under the national 20 per cent target, with 39 per cent of respondents reporting having smoked in the past. Just 0.9 per cent of respondents smoke cigars (SLÁN 2002 and SLÁN 1998). The percentage of pipe smokers decreased from 1998 to 2002 (from 2.4 per cent to 1.3 per cent). Those wishing to continue smoking decreased from 1998 to 2002 but at more than 30 per cent it is still quite high. Of these, 42.9 per cent of men wish to continue smoking compared with 30 per cent of women. Smokers acknowledge the need for more willpower and to know their own health is being damaged in order to help them stop smoking.

Alcohol

For SLÁN 2002, 47.3 per cent of respondents reported having consumed a drink; an increase of 5 per cent since 1998. The percentage of those never having a drink 'beyond sips and tastes' decreased from 28.6 per cent to 23.6 per cent in 2002. While the percentage of those taking one or two drinks increased from 1998 to 2002, the percentage taking three or four decreased. There is an increase in those drinking on three or more days per week. There is also an increase across age groups in those drinking seven days per week, except for those aged 85 and over. There is an increase in the percentages of those driving a car after two or more drinks (11.3 per cent to 13.1 per cent), with those in the 55-59 and 60-64 years groups more likely to do so. 26.9 per cent of male respondents compared with 15 per cent of female respondents reported exceeding the recommended units of alcohol per week. Binge drinking habits were similar for men and women, with 40.7 per cent of men and 43.6 per cent of women reporting binge drinking. While there is no age group effect for men, standardised residuals revealed an over-representation of female binge drinkers in the 70-74, 75-79 and 80-84 years groups. For both men and women, the largest group of binge drinkers are in the SC-3-4 category.

Food Habits

Among the respondents, 54 per cent feel they could eat more healthily. Gender, social class or educational status did not influence this. Food supplements had been taken by 45 per cent of respondents in the previous year, with significantly more women than men doing so. Those taking food supplements are more likely to be in the ED3 and SC1-2 categories. The numbers of those taking supplements decrease with age but increase again for those aged 80 and over.

There was a dramatic decline in the consumption of cereals, bread and potatoes from 1998 to 2002. However, fruit and vegetable consumption increased, as did consumption of dairy products. The majority of older people (49.3 per cent) use full-fat milk. Low-fat milk is used by 34 per cent. While the consumption of meat, fish and alternatives stays the same, there has been an increase in the consumption of top shelf foods. For SLÁN 2002, there was no significant gender difference in the percentages of men and women consuming cereals, bread, potatoes, dairy or top shelf products. With regard to fruit and vegetables, more women (72.5 per cent) than men (67 per cent) exceed the recommended amount. Finally, concerning fried food, more men (11.6 per cent) than women (3.7 per cent) consume fried food four or more times per week. In SLÁN 2002, respondents in the ED1 category are significantly more likely to consume fried food. Age appears to have little impact on food habits in either survey. In both 1998 and 2002, a change in weight was identified as an important indicator of health improvements.

When regard to body mass index (BMI), the proportion of underweight and normal adults remains unchanged since 1998; however, there is an increase in the proportion of obese adults (15.2 per cent to 17.6 per cent). Just over a third of those aged 55 and over have an acceptable BMI. Men are more likely to be obese and overweight. Women are more likely to be normal or underweight. In SLÁN 2002, those who are underweight increase with age.

Safety

Accidents and Injuries

In SLÁN 2002, 11.6 per cent of respondents (58.2 per cent men and 41.8 per cent women) reported incurring an injury over the previous two years serious enough to

interfere with daily activity. Social class and educational status were not statistically significant in 2002, but interesting trends did emerge. Within the 'yes' category, 49.6 per cent were in the SC1-2 category, compared with 18.1 per cent in the SC5-6 category. With regard to educational status, 64 per cent of those reporting a serious injury were in the ED1 category, compared with 18.3 per cent in the ED3 category. Accidental or non-accidental injury was relevant to only 190 respondents: 89.7 per cent reported accidental injury with 10.3 per cent reporting non-accidental injury. Gender was not a significant factor. The majority of injuries occurred at home in the house. Most other injuries occurred while walking on the road or pavement. Injuries incurred in the workplace represented 12.2 per cent. Injuries caused by 'a fall' represented 66 per cent. Of the injuries, 70 per cent were treated in hospital accident and emergency departments or by the GP service.

95 per cent of respondents always or nearly always wear seatbelts when sitting in the front of a car. Just over 50 per cent always use seatbelts in the back of a car. On two wheels, 72 per cent rarely or never use a helmet when cycling or on a motorbike.

Determinants of Self-rated Health, Quality of Life, Disability and Mental Illness

Self-rated Health

The determinants of self-rated health were established for the combined SLÁN 1998 and 2002 data. Those who are not anxious or depressed, are very satisfied with their health, do heavy housework on most days, have some tertiary education, do not smoke, are younger, do moderate exercise on a number of days per week and do not hold a medical card are more likely to rate their health as excellent, very good or good. The SLÁN 2002 data was also considered separately, and included information on income, social support and number of days not physically or mentally unwell, which were areas not included in the 1998 questionnaire. As well as those mentioned above, respondents with higher incomes, who rarely use salt when cooking and who regularly attend sports clubs are more likely to rate their health as excellent, very good or good.

Quality of Life

The determinants of quality of life were established for the combined SLÁN 1998 and 2002 data. Those who are in the older age groups, are not anxious or depressed, have favourable self-rated health, do heavy housework on most days, do not hold a medical card and do not live alone are more likely to rate their quality of life as very good or good. The SLÁN 2002 data was also considered separately, and included information on income, social support and number of days not physically or mentally unwell, which were not areas included in the 1998 questionnaire. Fewer recorded days feeling mentally unwell, favourable self-rated health, living in an urban setting, older age and regular visits to community sports clubs are significantly associated with very good or good quality of life.

Disability

The determinants of disability were established, with disability measured as self-reported limitation of work or daily activity by long-term illness or disability. Women, those who rate their health favourably, are reasonably mobile, have no problems engaging in usual activities, have no or only moderate pain and those aged 80 and over are less likely to be affected in their work or daily activity by long-term illness or disability.

Mental Illness

The determinants of mental illness were established for the combined SLÁN 2002 and SLÁN 1998 datasets. The number of days experiencing poor mental health was used as the core measure of mental illness. Those who have a good quality of life, own their homes outright, have favourable self-rated health and exercise regularly are less likely to report mental health difficulties.

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Introduction

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1.1 Background to the Study

The NCAOP is required to advise on 'measures to promote the health and autonomy of older people'. Consistent with this objective, the Council developed a Healthy Ageing Programme that was initiated with the launch of *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998). The aims of this strategy and the associated Healthy Ageing Programme are to improve life expectancy at age 65 and beyond, to improve the health status of people aged 65 and beyond and to improve the lives and autonomy of older people who are already affected by illness and impairment.

The strategy sets out goals, targets and action plans for improving the health status of the older population across four domains:

- specific illnesses, suicide and accidents
- lifestyle
- physical environment
- social environment.

Specific, measurable and time-bound targets are set in relation to reducing deaths from cardiovascular disease, cancer and accidents, and to reducing the prevalence of smoking. For example, one of the strategy's stated targets is to reduce the prevalence of smoking in people aged 55 and over by at least 16 per cent to no more that 20 per cent by the year 2005 (from a baseline of 24 per cent in 1994).

This report delivers on recommendations made in a position paper on measures to promote health and autonomy for older people (Kelleher, 1993). This paper

foreshadowed the development of the Health Promotion Strategy for Older People and stated that basic epidemiological research was required and would be crucial to long-term planning. The surveillance of the social and physical environment of older people, their attitudes to their own health and ongoing epidemiological surveys of key age-related conditions were proposed as priority areas for future research.

A comprehensive review of policy and practice in health promotion for older people in Ireland was undertaken in 2003 and is presented in the report *Healthy Ageing in Ireland: Policy, Practice and Evaluation* (O'Shea, 2003). This report recognised that meaningful monitoring of the Health Promotion Strategy for Older People was hindered by information deficits in relation to a variety of factors that affect the health of older people. Indeed, a comprehensive multivariate analysis of data on the health and well-being of a representative sample of Ireland's population aged 65 and over 65 was last conducted a decade ago (Fahey and Murray, 1994). This analysis provided information on life expectancy, incomes, lifestyles, and the physical and social environments of older people, and filled a crucial information deficit at the time. However, given that the data is ten years old and that the intervening years have been a time of unprecedented economic growth and social change, it was recognised that further prevalence figures derived from other national datasets were required. Such data could then be used to set a baseline from which targets for a range of factors that affect the health of older people could be set, and progress in the achievement of these targets be monitored.

1.2 Data Requirements: Setting Targets, Monitoring Progress and Predicting Ill-health

1.2.1 Setting Targets

The first European targets in relation to healthy ageing were set under Target Six of the World Health Organisation's *Health for All Targets* (WHO, 1993), which stated that 'by the year 2000, life expectancy at birth in the region should be at least 75 years and there should be a sustained and continued and continuing improvement in the health of all people aged 65 years and over'. *Health for All Targets* went beyond gross measures, such as life expectancy, to include targets for the reduction of mortality from specific diseases, such as cancer and heart disease.

However, these targets referred *only* to the population aged 65 years and under, an unfortunate trend that was subsequently replicated in many European countries. This situation prompted the Council to commission a separate health promotion strategy for older people, in which targets relating to improving the population health of older persons aged 65 and over could be set.

How have we fared in relation to Target Six? While improvements in the life expectancy at age 65 have been achieved in the past decade, O'Shea (2003) highlighted that Ireland still has the lowest life expectancy at age 65 of any EU country. Furthermore, healthy life expectancy at age 60 for the year 2000 is worse than the EU average, at 13.9 years for men and 16.1 years for women (WHO, 2001).[1]

The Healthy Ageing Programme is conscious of the need to set targets relating to factors known to adversely affect the health of older people as well as health outcomes, such as national figures for the prevalence of certain disorders. The establishment of baseline data on the physical, psychological and emotional status of older people is a prerequisite for the setting of such targets, and the lack of complete, accurate, representative and up-to-date data on certain key aspects of older people's health and the wider determinants of their health, has been recognised.

1.2.2 Monitoring Progress

Monitoring the success of programmes and policies for improving the health status of older people can only be undertaken if it is possible to monitor movement towards (or away from) the achievement of stated targets. Let us take vision as an example of one such factor affecting the health and well-being of older people. Vision is a defining aspect of quality of life and a major public health issue. In Ireland 25 per cent of blindness is potentially avoidable, the treatable causes in older people being glaucoma and cataract (Munier, 1998). The goal stated in the Health Promotion Strategy for Older People is 'to reduce the prevalence and degree of hearing loss and visual impairment in older people'. But what is the prevalence of visual impairment among Irish people aged 65 and over and how much of an improvement can we reasonably achieve in a five or ten year period? The authors of the strategy were not in a position to set targets as there is no data on levels of visual and hearing impairment in a large representative community-based sample of older people.

1 These figures do not include the ten member states that acceded to the EU on 1 May 2004.

Let us compare the Irish situation with the American Healthy People 2000 Strategy (US Department of Health and Human Services, 1990). The targets set in the USA are to 'reduce significant visual impairment among people aged 65 and older to a prevalence of no more than 70 per 1000'. A baseline average of 87.1 per 1000 was recorded for the period 1986-1988. This target uses the proxy measure of self-reported blindness and self-reported visual impairment (i.e., the inability to read ordinary newsprint even with corrective lenses). There is clearly a need to record baseline data from secondary analysis of existing surveys such as SLÁN. Simple measures can be used to set targets in the first instance.

As an aside, it should be stated that the 'gold standard' in relation to the estimation of incidence and prevalence rates for impairments or health conditions is the development of an epidemiological register which records all cases of a disease or other health condition with a defined population. The National Cancer Registry is an example of good practice in this regard.

Another aspect of monitoring progress in relation to health promotion and older people is the examination of trends through longitudinal and/or cohort studies. These can be especially useful in predicting changes in the prevalence of certain disorders and in better understanding the outcomes of factors affecting the health and well-being of the older population.

1.2.3 Predicting Health and Illness

Successful health promotion policy and programmes support the building blocks of well-being and target the determinants of ill-health. The multivariate analysis conducted on health, disability and quality of life in this report facilitates the identification of key factors associated with well-being in later life. The complex relationship between well-being and a range of factors, including socio-demographic factors, lifestyle, living circumstances and social networks, are also examined. This provides a signpost to the future in terms of what really matters in health promotion for older people.

At present, the health of the Irish population is monitored largely by examining rates of death and illness. Mortality data is most commonly used and so success is measured in terms of reducing the number of deaths over time. Hospital-based data, notably the Hospital Inpatient Enquiry System (HIPE), is also used to record the numbers of people presenting to hospital with particular diseases or injury, the outcome of their hospital stay in terms of length of stay and destination on discharge.

There are clearly limitations to using data of this nature to monitor population health, particularly so in monitoring the health of older people. Firstly, the data measures illness and death, instead of health, which are not necessarily two sides of the one coin. Without becoming too caught up in the ongoing debate on 'what is health', it is fair to say that health is 'not merely the absence of disease' (Winslow, 1954). Secondly, hospital-based data is biased, representing only a small fraction of the population, and can be skewed by operational issues, such as the availability of beds, admission policies and coding systems. Furthermore, the HIPE system does not record key determinants of health, such as socio-economic group, and is thus limited in terms of providing predictors of ill-health outside a biomedical perspective.

Two additional types of data are required in order to monitor health and provide better information for the development of policy and practice in health promotion. Firstly, morbidity data analyses (measuring the prevalence and incidence of illness) in community-based samples of the population are important. Such analyses provide a more realistic view of the real burden of disease to the population and the health and social care services in their entirety, rather than solely hospital services. The 1993 research on national care of the elderly, conducted by the Irish College of General Practitioners (Dobbs, 1999; Natin, 2000; Prosser, 1997) and the HeSSOP study (Garavan *et al.,* 2001), have provided vital insights in this regard. Secondly, longitudinal studies of community-based samples that monitor both health and the major determinants of health, such as lifestyle, income and environment, over time are vital. The Census provides important information on population health but, as the remit of the Census questionnaire is understandably broad, it cannot focus exclusively on the intricacies of health and ageing issues.

The SLÁN datasets are used for this report as they were specifically designed to focus on these issues on the advice of the Department of Health and Children. The Council's research programme is committed to influencing health and social policy by communicating the views of older people and, in this regard, has invested considerably in qualitative research eliciting the 'lived experience' of older people (Haslett, 2003). While the SLÁN study is essentially a quantitative study, the research tools used in the questionnaire elicit the views of older people regarding their health and quality of life. Therefore, the data is rooted in the personal views of older people themselves, rather than in measures of health or disease recorded by the health service.

1.3 Objectives and Study Design

1.3.1 Objectives

- To provide a profile of the physical and mental well-being of older people in Ireland and to establish the factors likely to influence these aspects of their lives.
- To identify vulnerable subgroups of older people as far as these dimensions of well-being are concerned.
- To contribute to the formulation of health promotion policies for older people.

1.3.2 Study Design

1.3.2.1 Data Source

The dataset used in the analysis is derived from two baseline surveys of health and health-related behaviour among adults, carried out across the Republic of Ireland in 1998 and 2002. The National Health and Lifestyle Survey (SLÁN) aims to produce reliable data of a representative cross-section of the Irish population in order to inform the Department of Health and Children's policy and programme planning. It maintains a survey protocol that enables lifestyle factors to be re-measured so that trends can be identified and changes monitored to assist national and regional setting of priorities in health promotion activities.

1.3.2.2 Sample

The sample was generated randomly from the Irish electoral register and was powerful enough to detect differences according to socio-economic status in key variables. The sample of adults aged 55 years and over was extracted for the purposes of secondary data analysis for this report.

1.3.2.3 Data Analysis

The Department of Public Health Medicine and Epidemiology at University College Dublin conducted the secondary analysis. The analysis first focused on the generation of prevalence figures for key issues relevant to healthy ageing across five-year age bands (i.e., 55-59, 60-64 etc.). Secondly, trends over the four-year

time period were examined. Finally, a series of multivariate logistic analyses were conducted, related to specific outcome measures (namely quality of life, self-rated health, disability, mental health, accidents and social capital). For further details on methodology, see Chapter Two.

1.4 Key Outcomes Examined in the Multivariate Analysis

1.4.1 Self-rated Health

Health status has become increasingly popular as a means of assessing healthcare effectiveness, but how diseases and symptoms are associated with health status is not yet completely understood (Cooper and Kohlmann, 2001). A widely used measure of health status is self-rated health, which is an overall assessment by the individual of his or her health status (Manor *et al.,* 2000). Respondents are asked to rate their health on a five-point Likert scale from excellent to poor. Self-rated health is a particularly relevant measure to use in relation to examinations of population health. As measured in this study, it enhances our understanding of what older people consider constitutes good health.

Self-rated health is associated with fitness, morbidity and visits to the doctor. It is also related to clinical health status, socio-demographic characteristics, access to medical care and nursing home placement (Reyes-Gibby *et al.,* 2002; Bath, 1999; Dening, 1998). Empirical studies observe a higher risk of disability in persons with health self-rated as poor (Wilcox, 1996). Furthermore, measures of self-rated health have the ability to predict mortality (Manor *et al.,* 2000; Idler, 1997; Tsuji, 1994). The *Manitoba Longitudinal Study on Ageing* (Mossey, 1982) and the *MacArthur Field Study on Successful Ageing* (Schoenfeld, 1994) confirmed the predictive value of self-rated health and mortality in older people, even in apparently healthy older people. However, longitudinal studies examining the predictors of self-rated health among older people are relatively scarce (Leinonen *et al.,* 2001). A longitudinal study conducted in Finland found that from the baseline to a five-year follow-up, one fifth of the subjects reported a deterioration in self-rated health and a further fifth reported an improvement. Declines in self-rated health levels were particularly associated with decreases in cognitive capacity and physical activity (Leinonen *et al.,* 2001).

Previous reports on the well-being of older Irish people found that the majority of them rated their health as good or very good (Layte and Fahey, 1999; Fahey and Murray, 1994). No significant age gradient in ratings of health was recorded, even though functional impairment rose steeply with age. This suggests that older people take their age into account when rating their health, a finding consistent with data from several European countries (Kivinen, 1998). Borawski (1996) found that 'older' older people base their health ratings more on psychological outlook and health promoting behaviours, whereas 'younger' older people base their ratings more on illness and disability. In this regard, higher ratings of health among 'older' older groups have been described (Ebly, 1996). However, similar ratings of self-rated health are recorded in the 65-69, 70-79 and 80+ age groups in Ireland to date (Layte and Fahey, 1999; Fahey and Murray, 1994).

Layte and Fahey (1999) have also examined the complex association between material living standards and the health of older Irish people, and found that deprivation was a significant risk factor for ill-health and chronic illness. The multivariate analysis presented in Chapter Six of this report examines these issues in a representative sample of older Irish people. This analysis provides, therefore, key insights into what older people consider to be 'good health' and what factors exert an influence on health.

1.4.2 Disability and Older People

Health and disability are strongly related in old age. Older people tend to view their health as an asset, allowing them to function and remain independent in daily life, rather than simply the absence of illness or diagnoses. Table 1.1 shows that in Ireland there are more than 180,000 older people (aged 55 and over) with a disability. Older women, particularly those aged 70 and over, represent a significant proportion of older disabled people. Layte and Fahey (1999) found that around 45 per cent of older people (aged 65 and over) have a chronic illness that hampers them in their daily activities. The analysis presented in this report allows a wider consideration of factors associated with disability among older people, including lifestyle, socio-economic and environmental factors.

Data collection in relation to disability has improved considerably over the last decade, and this report contributes to our knowledge base on disability among older Irish people. Health boards now have a remit to record data relating to persons under the age of 65 with learning disability, impaired mobility and sensory disability (vision and/or hearing) in their regions. Census 2002 included a more comprehensive set of questions relating to disability. Volume 10 of the Census

figures (CSO, 2004) focused on disability and carers, and disability and older people. It is hoped that the findings of this report will complement and augment the Census findings.

Table 1.1: Disability by age group for men and women (CSO, 2004)

Age group	Total (n)	Men (n)	Women (n)	Percentage of relevant group		
				Total	Men	Women
55-59 years	25,067	13,475	11,592	12.7%	13.5%	11.9%
60-64 years	24,715	13,720	10,995	16.0%	17.7%	14.3%
65-69 years	23,517	11,948	11,569	17.6%	18.3%	17.0%
70-74 years	26,141	11,554	14,587	23.3%	22.3%	24.1%
75-79 years	30,288	11,547	18,741	33.7%	30.9%	35.7%
80-84 years	27,847	9,337	18,510	47.3%	41.9%	50.6%
85+ years	27,903	7,387	20,516	66.9%	59.2%	70.2%

1.4.3 Mental Health

Mental health is another critical aspect of healthy ageing. Council research conducted on the incidence, prevalence and treatment of mental illness among older people acknowledged that there is a lack of information on mental disorders among older Irish people (Keogh and Roche, 1996). This report also recognised that this dearth of incidence data could not be remedied by a single study.

Mental disorders in older people, and depression in particular, tend to be under-diagnosed and under-treated (Kirby *et al.,* 1999 and 1997; Kelleher, 1998; Keogh and Roche, 1996). This casts doubt on the relevance of only using the data recorded by the psychiatric services to understand and plan for the mental health needs of older people. Strong associations exist between psychological well-being and physical health status in later life, particularly in relation to life-limiting illnesses (Fahey and Murray, 1994).

O'Shea (2003) noted that the importance of mental health promotion was rated very highly by a range of sectors involved in projects and services that promote healthy ageing. The role of the voluntary sector in providing social contact and support networks to older people has already been included in Council recommendations regarding mental health promotion (Keogh and Roche, 1996).

The secondary analysis presented in this report re-examines the relationship between mental health and general health and quality of life, thus facilitating the establishment of priority areas for mental health promotion with older people.

1.4.4 Quality of Life

Quality of life is a term that is commonly used in relation to older people. The World Health Organisation (WHO) defines quality of life as an individual's perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards and concerns. It is a broad-ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment (WHO, 1997). In the context of health promotion, older people's own perceptions of their quality of life, rather than those of health and social care providers, are of greatest importance. Studies examining older people's quality of life are, therefore, of fundamental importance in the development of policy to promote healthy ageing.

Considering this information, neither the Living in Ireland Survey, the Quarterly National Household Survey, nor the Census, directly asks respondents to rate their quality of life. In 1994 the physical, psychological and emotional well-being of older people was assessed using the twelve-item general health questionnaire, and an *ad hoc* eight-item battery was designed to measure morale, but no separate analysis of older people's perceptions of their quality of life was conducted (Fahey and Murray, 1994).

The majority of studies relating to quality of life in later years have tended to focus on health-related quality of life in care settings. This makes the multivariate analysis conducted for this report of special importance as it represents the first comprehensive analysis of older people's quality of life, as they themselves perceive it to be. Through this analysis the relative importance of the factors impacting on quality of life are revealed and the concept of promoting quality of life can become a reality with the creation of set priorities for prevention.

1.4.5 Social Capital

The concept of social capital is one that is gaining much attention and has particular relevance to older people's health and quality of life. Social capital relates to networks, relationships and feelings of belonging, trust and civic responsibility. It draws on processes that are crucial to community development and the functioning of a democratic and cohesive society (NESF, 2003).

This study presents analysis on aspects of social capital, as reported by Ireland's older and oldest citizens. In this regard, they are considered to be both significant contributors to, and beneficiaries of, social capital. Older people's contribution to social capital would include, for example, their significant role as family carers or voluntary workers and their membership in organisations supportive of health and social gain amongst their peers (e.g. active retirement associations).

High levels of social capital have positive consequences for both the individual and the community, particularly in relation to equality, quality of local governance and economic growth. In terms of community, higher levels of social capital are associated with reductions in crime levels, suicide and antisocial behaviour. At an individual level it is associated with personal growth indicators and general psychological well-being (Gaffney, 2003). The issue of social capital was explored in the HeSSOP study (Garavan *et al.,* 2001), which noted that social and community involvement were associated with higher levels of morale among older Irish people. The majority of older people surveyed also reported feeling that they still contributed to community and society as much as they would like to.

A decline in social capital in any community is a cause for concern because it threatens the informal networks and frameworks that quietly hold society together. Both Ireland's ageing demography and the recent economic boom will have important implications for policy development relating to social capital in Irish society. Shared relations and resources are at the forefront in the concept of social capital, but increased time pressures and family constraints can challenge both the caring role and society's views about a perceived 'dependency burden'. This is why analysis on the subject is given prominence in this report, and it has now been recommended that social capital measures be included in the Quarterly National Household Survey.

How is social capital measured? Robert Putnam, who coined the term, has chronicled its decline in the USA over the past generation by measuring indices of participation in church-related groups and labour unions (Putnam, 1995). Social capital can be measured by various means, most notably as responses to questions about interpersonal and social trust, levels of involvement in voluntary activity, membership of clubs and levels of social contact (Balanda and Wilde, 2003).

Health promotion policy and practice will need to be increasingly cognisant of social capital among ageing communities and seek ways to actively promote and encourage policies that continue to nurture social and human capital (NESF, 2003). The picture of social capital among older people presented in this report is a first step in the development of such approaches.

1.4.6 Accidents and Older People

Accidental injury is a major public health issue. Injuries caused by falling result in significant costs to health and social care services, a loss of independence and are a significant factor in the onset of disability, dependency and nursing home care. The Health Promotion Strategy for Older People includes a stated goal to reduce the number of accidents and associated mortality and morbidity among older people. The targets, commensurate with the Laffoy report on accidental injury in Ireland (Laffoy, 1995) are:

- to reduce the death rate from accidents and their adverse effects in people aged 65 and over by at least 17 per cent, to no more than 67.6 per 100,000 in the year 2005 (from a baseline of 81.5 per 100,000 in 1995)

- to reduce hospital admissions due to falls in people aged 65 and over by at least 17 per cent, to no more than 1,171 per 100,000 in the year 2005 (from a baseline of 1,411 per 100,000 in 1993).

Secondary analysis of health service activity (the HIPE database) has shown that older people admitted to hospital following a fall have a high risk of death and a prolonged hospital stay; only two thirds of these patients return home from hospital. As only 10 per cent of injuries require in-patient treatment, the HIPE database only examines the tip of the injury iceberg. Therefore, further information on accidents among older Irish people is required to ensure that the development of health promotion policy on falls prevention is evidence-based. Data is required on falls in long-stay units and from community-based samples of older Irish people. The secondary analysis presented in this report provides some insight into the latter of these requirements and allows a deeper understanding of the factors associated with accidents among older people. In addition, information relating to road safety, such as the use of seatbelts, bicycle helmets and drink driving, are examined for the first time in a large community-based sample of older Irish people.

The lack of an overriding Irish health strategy to reduce the incidence of injury among older people, and falls in particular, is a major deficit and one that was recognised in the National Health Strategy (DoHC, 2001). The development of a National Injury Prevention Strategy has been proposed and it is hoped that the information arising from this analysis will make a significant contribution to its development.

Chapter Two
Methodology

Chapter Two
Methodology

2.1 Methodology of the National Health and Lifestyle Surveys

2.1.1 Procedures

The National Health and Lifestyle Survey, known as SLÁN, was first undertaken in 1998 and repeated again in the summer of 2002. The detailed methodology employed has been reported previously in all the main reports and peer publications. In both rounds, a representative cross-section of the Irish adult population was surveyed, using a sample powerful enough to detect summary differences at national level. It focused on socio-economic status and key lifestyle variables that would be of interest to the Commissioners and the DoHC, such as smoking, exercise and diet. Allowances were made for non-response and the likelihood of ineligibility to participate. The sample was generated randomly from the Irish electoral register and was supplied by Precision Marketing Information (PMI) Ltd, a subsidiary of An Post.

The sampling procedure followed on both occasions was the same. A national postal sample was generated randomly and distributed proportionately. It was based on health board population size and urban rural breakdowns so that each county of the Republic of Ireland was represented. Final selection was made at district electoral division level.

The self-completion questionnaires were posted from the National University of Ireland (NUI) Galway, with Freepost return envelopes enclosed. A helpline to deal with general queries about questionnaire completion was set up in NUI Galway and respondents were entered into a prize draw, unless they stated otherwise. Following a reminder letter and further reminder questionnaire, all remaining non-respondents were contacted by telephone, where possible, or by trained fieldworkers calling to the person's home to collect the questionnaire. Excluding those not eligible (that is, deceased or confirmed at the follow-up stage to be

unavailable at that address), the total valid sample of questionnaires was 11,212 in 2002 and 12,722 in 1998. The response rates were 53 per cent and 62 per cent respectively. Data entry was carried out by RES Ltd.

2.2 Methodology of the Secondary Analysis

2.2.1 General Procedures

Our objective in undertaking this analysis was not primarily to establish prevalence data for health and lifestyle variables in older people, since this was the purpose of the SLÁN reports, but rather to analyse in greater depth the patterns that emerged from both surveys according to age. It was also planned, if feasible, to combine the datasets to explore in richer detail the determinants and inter-relationships of these patterns. Data for those aged 55 years and over was extracted from the national sample for the purposes of this investigation. This yielded a sample size n=1754 for SLÁN 2002 and n=1634 for SLÁN 1998. This represents 29.3 per cent and 25.8 per cent respectively of the total samples. For the purposes of the analysis, respondents were categorised in five-year age bands: 55-59, 60-64 and so on up to those aged 85 and over. Where possible, analysis by social class, educational status, age, gender and medical card status was performed on each variable and comparisons were also made between the 2002 and 1998 measurements. The social class categories were determined according to the CSO (i.e., the reported social class was determined by the job title of either the respondent or the respondent's spouse). The valid response for each question has been used (i.e., those who did not answer the question(s) under consideration are excluded in all figures and tables). In some questions, respondents were asked to choose all applicable options. These responses are not mutually exclusive and the presented results, therefore, may not add up to 100 per cent.

2.2.2 Standardisation Procedures

An *a priori* assumption in relation to the SLÁN surveys is that they would provide, as far as possible, a nationally representative portrait of the adult population. Precision is dependent on sample size, and sub-analyses will clearly have less power to detect prevalence accurately or to discriminate between groups and so should be interpreted with appropriate caution, as indicated throughout the report. For SLÁN 2002, data at both time points was standardised to the Census 1996

results and the subsequent regional reports were adjusted to Census 2002 when those results became available. This procedure simply means that the survey sample is adjusted to reflect a standard population age distribution, principally so that valid between-time comparisons can be made and not confounded by different age distributions between the samples. However, the selection of a standard population is arbitrary and there have, in fact, been real changes in the age distribution of the Irish population between the census points 1996 and 2002. We did consider, therefore, whether or not to age-adjust the datasets for the present analysis to either the 2002 or 1998 population for comparison purposes. As we present in the results, the age distribution of the two SLÁN samples is, in fact, very similar and slightly over-represents the oldest members of the population; this actually benefits the secondary analysis in allowing assessment across a wide age spectrum. Furthermore, remarkably little change was observed in most of the variables under examination between the two time points, justifying a combination of the datasets for in-depth analysis. We have presented, therefore, unadjusted age stratified figures throughout the report in order to show the real rates in the surveys and performed, as is appropriate, statistical comparisons on these unadjusted figures. However, for information purposes Appendix 2 also includes key variables for both rounds standardised to Census 2002 results, showing very little difference compared to the unadjusted rates.

2.2.3 Statistical Methodology

Chi squared statistics were used to formally test for relationships between categorical variables at $\alpha = 5$ per cent. Chi squared tests are reported with the degrees of freedom, total number of subjects in the test, Chi squared value and the p-value. To investigate the source of any difference in the Chi squared tests, standardised residuals were reported. Residuals are calculated by subtracting the value predicted by the regression equation for each case from the observed value of the dependent variable (Altman, 1991). Standardised residuals (also called Pearson residuals) are the residual divided by an estimate of its standard error (SE). Standardised residuals have a mean of 0 and a standard deviation of 1 (Altman, 1991).

To investigate the strength of the agreement in ranked data rho (ρ) was calculated. Spearman's rank correlation coefficient ρ is exactly the same as the Pearson correlation coefficient r calculated on the ranks of the observations. Rho can take on values between -1 and +1. If the value of rho is near 1 or -1, it is concluded that there is a monotone relationship between x and y. Conversely, if rho is near 0, it is concluded that there is not evidence of a monotone relationship (Altman, 1991).

Prior to logistic regression analysis, Categorical Principal Components Analysis (CatPCA) was carried out. The goal of principal components analysis is to reduce an original set of variables into a smaller set of uncorrelated components that represent most of the information found in the original variables. PCA finds a linear combination of variables that accounts for as much variation in the original variables as possible. It then finds another component that accounts for as much of the remaining variation as possible and is uncorrelated with the previous component, continuing in this way until there are as many components as original variables. By reducing the dimensionality, interpretation of a few components rather than a large number of variables is possible. CatPCA was thus conducted on the general health, individual lifestyle, demographic and social support variables. Three dimensions (factors) were extracted in each case, with the exception of the demographic factors. In this instance, more than three factors were included in the logistic regression.

Binary logistic regressions were carried out to examine the determinants of self-rated health, quality of life, disability and trust. All variables were dichotomised and removal set at 0.10. Ordinal regression was carried out to examine the predictors of mental health. Backward stepwise method was chosen. The full model is thus fitted, including all the variables, and unimportant variables are removed one at a time until all those remaining in the model contribute significantly. At each step, the variable with the smallest contribution to the model (or the largest *p*-value) is removed. The last category is referenced. Estimates, standard error, Wald test, degrees of freedom, *p*-value and odds ratios are reported in each instance. Odds of less than 1 indicate less likely to support the dependent variable and odds greater than 1 indicate more likely to.

Chapter Three

Socio-Demographic Profile

Chapter Three

Socio-Demographic Profile

3.1 General Distributions

The total number of respondents in the SLÁN surveys are n=5998 (SLÁN 2002) and n=6358 (SLÁN 1998). Respondents aged 55 years and over represent 29.3 per cent and 25.8 per cent respectively of the total sample and are therefore well represented for the purposes of secondary analysis. The population distribution for both Census 1996 and Census 2002 are presented for comparative purposes in Table 3.1, which also illustrates that there have been real changes in the population since 1996, with a rise in the relative proportion of those aged 55-59 years. The distribution of the SLÁN sample populations is similar across all age groups except for those aged 95 or over, where there are no respondents older than 95 years in the SLÁN 1998 survey. For balance of numbers, the 85-89, 90-94 and 95+ years categories were grouped to form the 85+ years group. This yielded a percentage of 8.9 per cent in 2002 and 5.1 per cent in 1998. The advantage of the SLÁN surveys for the current analysis is the relatively larger numbers of 'older' older people, particularly in SLÁN 2002.

Table 3.1: Population distribution of SLÁN 2002, SLÁN 1998, Census 2002 and Census 1996

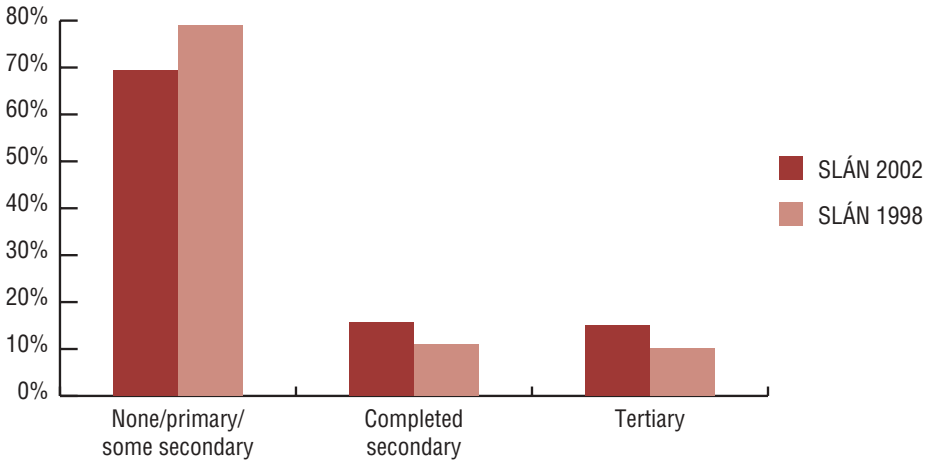
Age group	SLÁN 2002		Census 2002	SLÁN 1998		Census 1996
	Frequency	Percentage	Percentage	Frequency	Percentage	Percentage
55-59 years	341	19.4%	25.1%	312	19.1%	21.8%
60-64 years	290	16.5%	19.6%	318	19.5%	19.5%
65-69 years	275	15.7%	16.9%	290	17.7%	18.0%
70-74 years	276	15.7%	14.2%	265	16.2%	15.9%
75-79 years	261	14.9%	11.4%	234	14.3%	11.9%
80-84 years	155	8.8%	7.5%	132	8.1%	7.9%
85-89 years	73	4.2%	85+ years 5.2%*	64	3.9%	85+ years 4.9%*
90-94 years	19	1.1%		19	1.2%	
95+ years	64	3.6%		0	0	
Total	1,754	100%	100%	1,634	100%	100%

* Breakdown for those aged 85 and over not available in Census 2002

3.2 Educational Status

Frequencies were conducted on both the SLÁN 1998 and SLÁN 2002 data. The results for educational status are visually presented in Figure 3.1 where ED1 is no schooling/primary school education/some secondary education, ED2 is complete secondary education and ED3 is tertiary education. The majority of older people are in the ED1 category (78.96 per cent in 1998 and 69.29 per cent in 2002), which is indicative of the period prior to the *Free Education Act* (1967). The percentage decrease in the size of the ED1 category is reflected in the increased percentage of those who completed secondary education and also those with tertiary education. This may be attributable to the sampling process.

Figure 3.1. Educational status (SLÁN 2002 and SLÁN 1998)



Some gender differences are found in both SLÁN 1998 (χ^2 (2, n = 1543) = 28.436, p = 0.000) and SLÁN 2002 (χ^2 (2, n = 1596) = 31.994, p = 0.000). In both surveys, the proportions in the ED1 category are strikingly similar; however, there are significantly more women in the ED2 category in both surveys. While in 1998 more men had tertiary education than women, this trend is reversed in 2002.

Table 3.2 represents the distribution of SLÁN 2002 and SLÁN 1998 participants by age, gender and educational status. Across the time span, there is an expected decrease in the percentage of respondents with no schooling/primary school education/some secondary education (ED1) and an increase in the percentage of respondents with tertiary education (ED3). Generally speaking, as age increases, there is a decrease in the percentages with tertiary education for both men and women. Those aged 85 and over reverse this trend, suggesting a higher survival rate among educated older people.

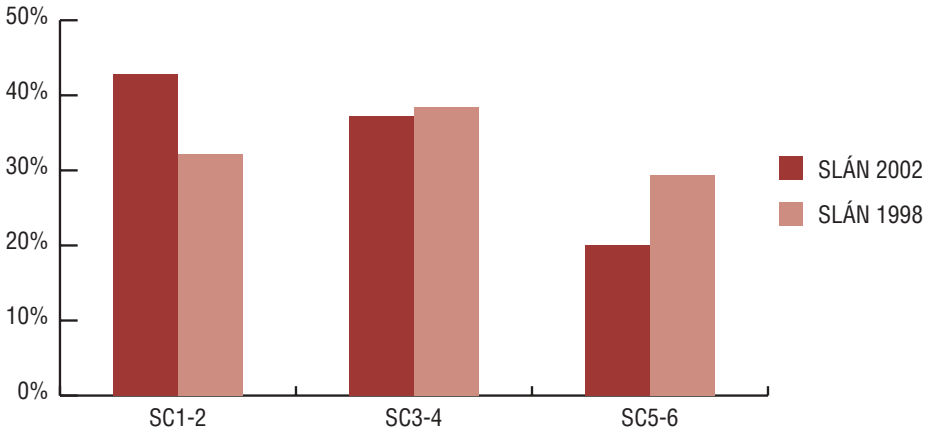
Table 3.2: Percentage of those aged 55 and over by age group, gender and educational status (SLÁN 2002 and SLÁN 1998)

	ED1		ED2		ED3		Total N	
Men	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998
55-59 years	61.9%	75.3%	13.6%	8.2%	24.5%	16.4%	147	146
60-64 years	74.0%	79.9%	8.4%	7.6%	17.6%	12.5%	131	144
65-69 years	77.1%	76.5%	8.5%	11.05%	14.4%	12.5%	118	136
70-74 years	81.3%	88.0%	7.1%	1.7%	11.6%	10.3%	112	117
75-79 years	78.9%	87.5%	11.0%	6.7%	10.1%	5.8%	109	104
80-84 years	76.1%	87.8%	14.1%	4.1%	9.9%	8.2%	71	49
85+ years	81.4%	81.8%	7.0%	3.0%	11.6%	15.2%	43	33
Women								
55-59 years	49.4%	72.9%	23.5%	15.9%	27.1%	11.9%	170	151
60-64 years	56.2%	73.5%	28.5%	14.6%	15.3%	11.9%	137	151
65-69 years	60.0%	71.2%	25.6%	18.7%	14.4%	10.1%	125	139
70-74 years	71.4%	79.5%	17.7%	15.2%	10.9%	5.3%	147	132
75-79 years	82.8%	85.5%	9.0%	11.1%	8.2%	3.4%	134	117
80-84 years	71.2%	79.5%	17.8%	10.3%	11.0%	10.3%	73	78
85+ years	70.9%	84.85%	17.7%	13.0%	11.4%	2.2%	79	46

3.3 Social Class

Figure 3.2 represents the distribution of respondents according to social class for both SLÁN 2002 and SLÁN 1998. SC1-2 represents professional, managerial and technical workers, SC3-4 represents non-manual and skilled manual, while SC5-6 represents semi-skilled and unskilled. There are relatively more respondents in SC1-2 and relatively fewer in SC5-6. This is most likely to reflect coding variations between both surveys, as more women were classified accurately in SLÁN 2002.

Figure 3.2: Social class status (SLÁN 2002 and SLÁN 1998)



There were statistically significant differences in the proportions of men and women in each of the social classes for both SLÁN 1998 (χ^2 (2, n = 680) = 7.091, p = 0.029) and SLÁN 2002 (χ^2 (2, n = 1097) = 21.544, p = 0.000). These are displayed in Table 3.3. Both surveys show significantly more women than men in SC1-2, and more men than women in SC5-6. SC3-4 remains the same.

Table 3.3: Social class by gender distribution (SLÁN 2002 and SLÁN 1998)

	SLÁN 2002		SLÁN 1998	
Education	Men	Women	Men	Women
SC1-2	36.8%	48.5%	28.6%	36.3%
SC3-4	38.4%	36.2%	38.1%	38.8%
SC5-6	24.8%	15.3%	33.3%	25.0%
Total	100%	100%	100%	100%

3.4 Social Class and Educational Status

Social class and educational status were cross-tabulated in SLÁN 2002. There is a significant relationship between the variables (χ^2 (4, n = 1003) = 211.78, p = 0.000). One would expect the results to be diagonally dominant: a large proportion of those with tertiary education should also be in the SC1-2 category (Table 3.4). Although this is the case for tertiary education, the pattern is not as pronounced for the other two groups. Other factors, such as occupation, marital status and the secular trends in free education may also affect this table. Similar trends were observed in SLÁN 1998.

Table 3.4: Social class and educational status groupings (SLÁN 2002)

	ED1 (N)	ED2 (N)	ED3 (N)	Total (N)
SC1-2 (N)	150	106	157	413
SC3-4 (N)	292	58	32	382
SC5-6 (N)	176	21	11	208
Total	618	185	200	1,003

3.5 Health Board Areas

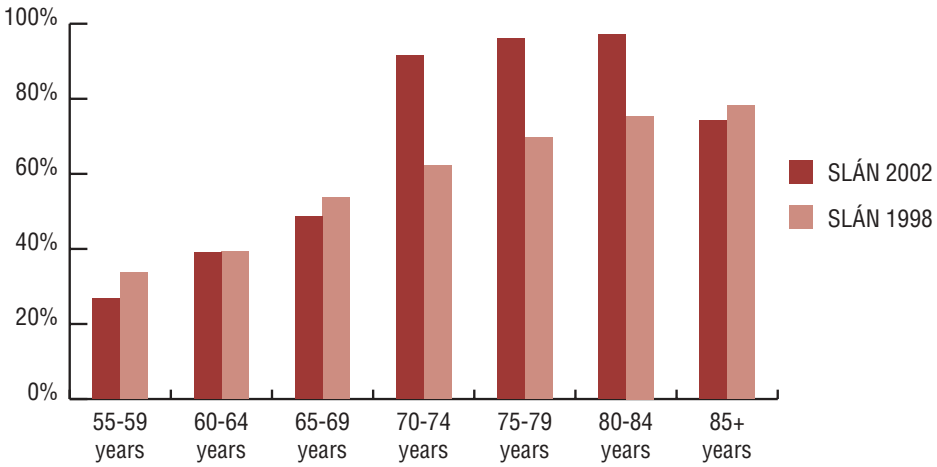
The percentage of respondents in each of the health board areas was considered for both datasets (aged 55 years and over). Each health board area shows similar representation in 1998 and 2002, except the North Eastern Health Board (NEHB), which requested an augmented sample in 1998.

3.6 Medical Card Status

Respondents were asked if they had a medical card. According to SLÁN 1998 (n = 1515), 53.5 per cent held a medical card rising to 63 per cent in SLÁN 2002 (n = 1640). This increase reflects the Government decision in 2001 to extend eligibility for a non-means-tested medical card to all adults aged 70 and over. Figure 3.3 displays the percentage of respondents in each age group holding a medical card. In general, an increase across all age groups is observed. While there were gender differences in 1998 (χ^2 (1, n = 1514) = 11.68, p = 0.001), with more women than men in possession of a medical card (57.6 per cent compared to 48.8 per cent), a gender difference was not observed in 2002.

In terms of rural and urban differences, 43.3 per cent of those who have a medical card are urban-based compared to 56.7 per cent in a rural location (SLÁN 2002). This difference is less marked than in 1998 when all medical cards were means-tested (40.1 per cent in an urban location compared to 59.9 per cent in a rural location).

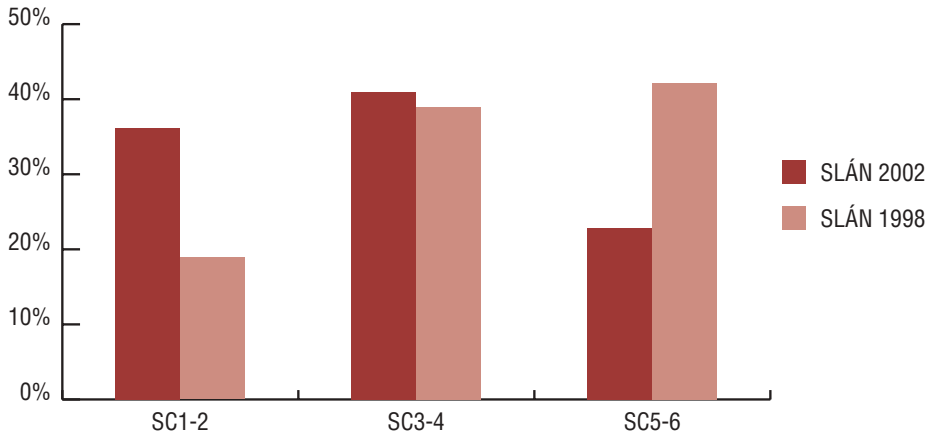
Figure 3.3: Medical card status (SLÁN 2002 and SLÁN 1998)



Analysis was conducted to investigate whether educational status influenced possession of a medical card. This was statistically significant for both SLÁN 2002 (χ^2 (2, n = 1502) = 132.64, p = 0.000) and SLÁN 1998 (χ^2 (2, n = 1436) = 110.58, p = 0.000). The majority of medical card holders are in the ED1 category. There is an increase across time in the percentages of medical card holders in the ED2 and ED3 categories. This reflects the previously mentioned entitlement of those aged 70 and over to non-means-tested medical cards.

A similar analysis was conducted for social class (Figure 3.4). The percentage of medical card holders and non-medical card holders is not the same in each social class. This is the case for both SLÁN 2002 (χ^2 (2, n = 1075) = 22.17, p = 0.000) and SLÁN 1998 (χ^2 (2, n = 667) = 52.86, p = 0.000). The large percentage increase in SC1-2 in 2002 compared with 1998 is reflective of both the increased uptake of non-means tested medical cards and the national SLÁN sample.

Figure 3.4: Social class of medical card holders (SLÁN 2002 and SLÁN 1998)

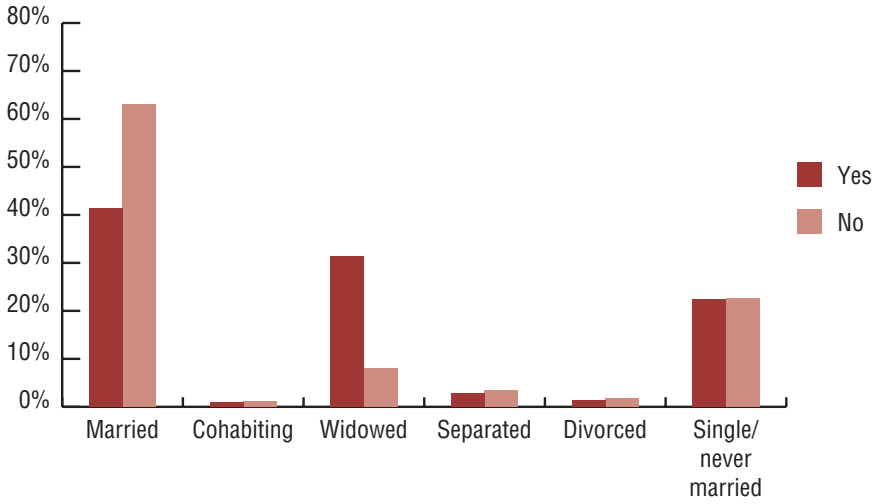


3.7 Marital Status

Marital status was considered for both SLÁN 2002 (n = 1722) and SLÁN 1998 (n = 1634). Both findings are similar. Almost 50 per cent of respondents are married, 25 per cent are widowed with a further 20 per cent single/never married. Those respondents who are cohabiting, divorced or separated represent a very small proportion of the cohort. No gender differences are evident.

Marital status was found to influence whether or not a person holds a medical card (χ^2 (5, n = 1616) = 127.75, p = 0.000). Figure 3.5 represents the findings. Medical card holders are more likely to be married, widowed or single/never married. Those who do not hold a medical card are more likely to be married or single/never married.

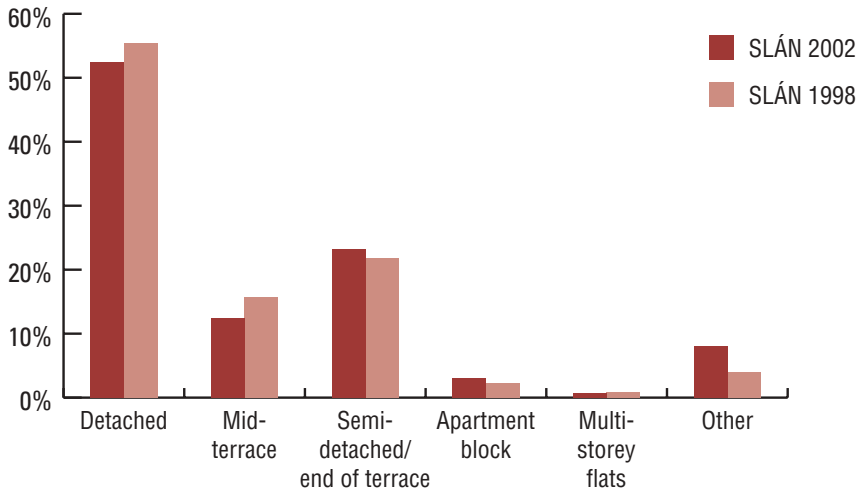
Figure 3.5: Medical card status and marital status (SLÁN 2002)



3.8 Accommodation Type

Respondents' living accommodation was examined for both SLÁN 2002 and SLÁN 1998. Findings are quite similar for both surveys, with over 50 per cent living in detached houses in both instances. The percentages living in apartments and multi-storey flats are quite small. However, there is a decrease in those living in detached houses across time and an increase in the numbers residing in semi-detached and apartment block accommodation. This may reflect of older people moving into smaller or more manageable accommodation.

Figure 3.6: Accommodation type (SLÁN 2002 and SLÁN 1998)

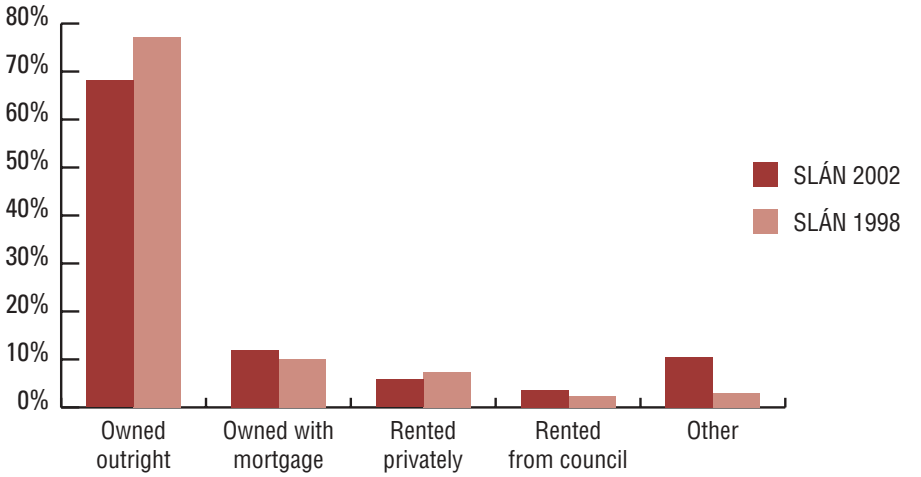


Analysis was conducted to investigate whether possession of a medical card influences the type of accommodation in which a person lives and the Chi squared test was statistically significant (χ^2 (5, n = 1606) = 18.19, p = 0.003). 100 per cent of respondents living in multi-storey flats and approximately 70 per cent of those living in mid-terraced accommodation are medical card holders. This falls to 60 per cent for all other accommodation types.

3.9 Housing Tenure

Respondents were asked about home ownership (Figure 3.7). There are very high rates of home ownership but there was a 10 per cent decrease between the 1998 and 2002 samples. There is an increase in the numbers who own their home with a mortgage and an increase in the percentages renting from the local council.

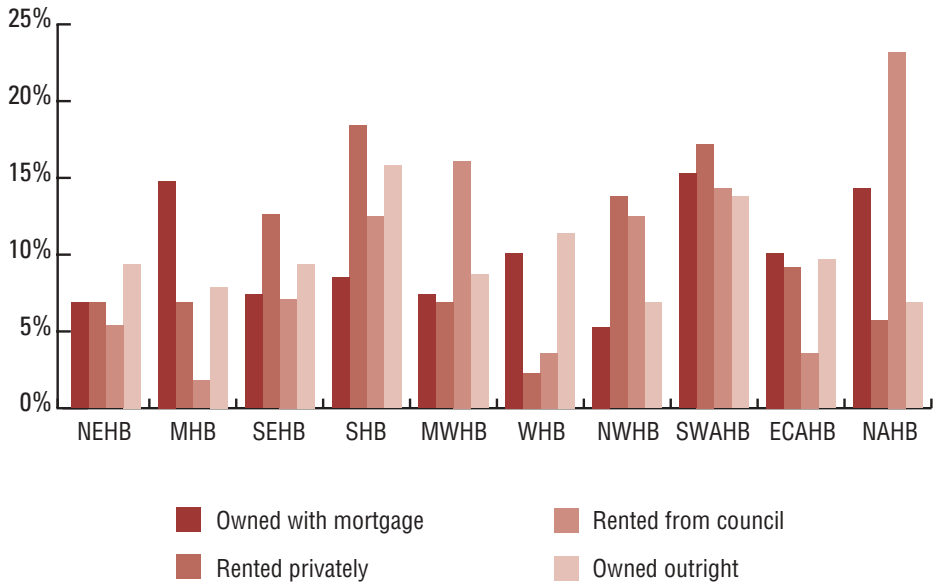
Figure 3.7: Home ownership (SLÁN 2002 and SLÁN 1998)



There is a significant difference in home ownership between rural and urban locations. This is the case for both SLÁN 2002 (χ^2 (4, n = 1576) = 23.63, p = 0.000) and SLÁN 1998 (χ^2 (4, n = 1449) = 42.89, p = 0.000). Results from SLÁN 2002 indicate that those in a rural location are more likely to own their homes outright. They are also less likely to rent either privately or from the local council.

Home ownership also varies by health board region (χ^2 (36, n = 1576) = 99.22, p = 0.000). The differences may be seen in Figure 3.8. The largest percentage of those renting from a local council is found in the NAHB and the MWHB areas. The largest groups to rent privately are found in the SHB and SWAHB areas respectively. Both of these health board areas also contain the largest proportion of those who own their homes outright.

Figure 3.8: Home ownership by health board area (SLÁN 2002)



3.10 Income Levels

3.10.1 Household Net Income Per Week

Information on income levels (household net income per week) is only available in SLÁN 2002. Table 3.5 presents the household net income per week, both unadjusted and adjusted, for the number in the household. Focusing on the unadjusted figures, the largest percentage (20.9 per cent) records between €130 and €190 per week while 64.5 per cent record less than or equal to €320 per week.

One of the issues concerning the analysis of income is the lack of consideration given to the size of the older person's household. Differences in household size must be taken into account, as an income adequate for one household size may be totally inadequate for another. Household size is accounted for by using equivalence scales that convert each household to a common basis, that is to the equivalent of a single adult or a married couple. Scale C, referred to by Fahey and Murray (1994), is utilised in this study. By converting bands of income, the households are set in a band equal to the band's middle value. It takes a value of 1 for a single person household, or for the first adult in larger households, with the following values for additional members: 0.66 for adults and 0.33 for children. This is close to the scale implicit in rates of unemployment assistance in Ireland, when

child benefit payments are also taken into account. Table 3.5 also presents the household net income per week (for the total sample and men and women separately) when size of household is taken into consideration (adjusted). This reveals a different picture; the majority of respondents still record between €130 and €190 per week while 69.1 per cent of older adults live on less than €260 per week. The variation between men and women separately is negligible (adjusted).

Table 3.5 Weekly household net income (SLÁN 2002)

	Unadjusted	Adjusted		
Weekly household net income	Total sample	Total sample	Men	Women
Less than €65	1.3%	2.3%	2.4%	2.1%
€65 to under €130	14.1%	22.9%	23.5%	22.5%
€130 to under €190	20.9%	25.4%	23.7%	26.9%
€190 to under €260	15.9%	18.5%	18.7%	18.4%
€260 to under €320	12.3%	7.5%	7.5%	7.5%
€320 to under €380	5.9%	5.3%	5.0%	5.35%
€380 to under €450	7.6%	6.1%	5.5%	6.7%
€450 to under €500	4.5%	3.5%	4.2%	2.9%
€500 to under €640	5.8%	3.4%	3.0%	3.8%
€640 to under €760	2.6%	1.9%	2.2%	1.6%
€760 to under €950	3.7%	1.6%	2.4%	0.9%
€950 to under €1,150	2.0%	1.1%	1.1%	1.1%
€1,150 to under €1,270	1.2%	0.1%	0.2%	0.0%
€1,270 to under €1,900	1.4%	0.6%	0.8%	0.4%
€1,900 or more	0.9%	0.0%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%

Fahey and Murray considered household income (unadjusted) in 1994 and found that 82.4 per cent of those aged 65 and over lived on less than €254 per week. This fell to 69.4 per cent in 1999 (Layte *et al.,* 1999) and to 59.6 per cent in 2002 (SLÁN 2002). This does not take inflation or cost of living adjustments into account.

Household net income (adjusted for household size) was also examined in terms of age group. Income bands were expanded in some instances, due to small numbers. Table 3.6 presents the findings. Lower incomes have a similar

distribution across each of the age groups, while larger incomes are more likely to be recorded by those under 64 years.

Table 3.6: Weekly household net income (adjusted) by age group

Weekly household net income	55-59 years	60-64 years	65-69 years	70-74 years	75-79 years	80+ years	Total
Less than €65	25.0%	25.0%	15.6%	3.1%	12.5%	18.8%	100%
€65 to under €130	18.1%	19.3%	14.6%	15.6%	17.1%	15.3%	100%
€130 to under €190	11.5%	12.3%	16.8%	19.6%	20.2%	19.6%	100%
€190 to under €260	22.7%	13.5%	19.6%	18.1%	11.9%	14.2%	100%
€260 to under €450	23.4%	20.8%	18.5%	15.5%	10.9%	10.9%	100%
€450 to under €760	38.2%	22.8%	11.4%	10.6%	7.3%	9.8%	100%
€760 or more	39.1%	23.95%	6.5%	8.7%	15.2%	6.5%	100%

Income levels were further divided into quintiles. In the case of older people in Ireland, 40 per cent of households are living on less than €96.51 per week (Table 3.7). The percentage in each quintile is significantly different for those aged less than and more than 65 years (χ^2 (4, n = 1335) = 83.37, p = 0.000). There are significantly fewer people aged 65 and over in the top 40 per cent, while significantly more people under 65 years record less than €68.96 per week.

Table 3.7: Adjusted income levels (quintiles)

Quintiles	Frequency (all age groups)	Percentage aged less than 65 years	Percentage aged more than 65 years	Percentage for all age groups
Less than €68.96	257	22.3%	17.4%	19.3%
€68.97 to €96.51	289	10.5%	28.5%	21.6%
€96.52 to €125.00	275	17.4%	22.6%	20.6%
€125.01 to €204.74	241	22.1%	15.6%	18.1%
€204.75 to €114.58	273	27.7%	16.0%	20.4%
Total	1,335	100.0%	100.0%	100.0%

3.10.2 Rural and Urban Settings

Further analysis was conducted on rural and urban settings, using the unadjusted and adjusted figures. It shows significant differences in income levels in rural and urban locations for both the unadjusted (χ^2 (14, n = 1426) = 116.49, p = 0.000) and adjusted figures (χ^2 (13, n = 1332) = 137.229, p = 0.000). Table 3.8 reveals that the lowest income group is found almost exclusively in a rural setting: three times more people in a rural setting appear in the €65 to €130 per week income group. As incomes increase, people are more likely to live in an urban setting and it is home to most of those with the highest income levels. Living in a rural or urban setting did not influence these income levels in 1994 (Fahey and Murray, 1994).

Table 3.8: Weekly household net income by rural and urban settings (SLÁN 2002)

	Unadjusted		Adjusted	
Weekly household net income	Rural (N)	Urban (N)	Rural (N)	Urban (N)
Less than €65	19	1	30	1
€65 to under €130	153	50	219	87
€130 to under €190	188	107	194	142
€190 to under €260	120	107	124	124
€260 to under €320	90	86	48	52
€320 to under €380	39	44	21	48
€380 to under €450	45	65	19	63
€450 to under €500	19	44	18	30
€500 to under €640	32	49	18	25
€640 to under €760	18	20	7	18
€760 to under €950	19	32	9	13
€950 to under €1,150	13	15	3	10
€1,150 to under €1,270	6	12	0	1
€1,270 to under €1,900	3	16	2	6
€1,900 or more	5	9	0	0
Total	769	657	712	620

Chapter Four

The Health Behaviours of Older Irish People

Chapter Four

The Health Behaviours of Older Irish People

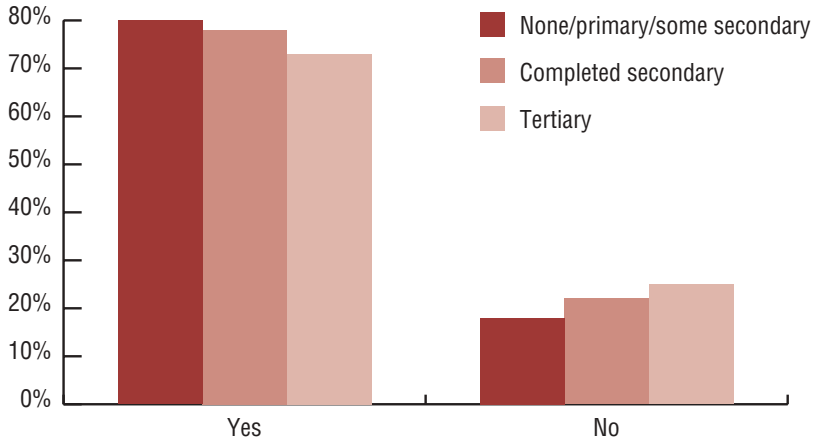
4.1 Health Check-ups

4.1.1 General Health Check-ups

Figures for respondents who had a general health check-up in the previous three years stand at 79.8 per cent for SLÁN 2002 (n = 1700) and 81.9 per cent for SLÁN 1998 (n = 1421). The pattern of response is similar for men and women, and does not vary across social class.

While SLÁN 1998 indicated that educational status did not influence the likelihood of someone having had a general health check-up in the previous three years, a statistically significant pattern emerged in SLÁN 2002 (χ^2 (2, n = 1553) = 10.44; p = 0.005). Figure 4.1 shows the percentage of respondents who did or did not report having a general health check-up for SLÁN 2002. Those with tertiary education represent the smallest percentage of those having a general check-up while those respondents with none/primary/some secondary education represent the largest group. The majority of respondents went to their own doctor's surgery for their check-up (74.9 per cent for SLÁN 2002 and 77.5 per cent for SLÁN 1998).

Figure 4.1: General health check-up and educational status (SLÁN 2002)



The frequency of undergoing a general health check-up is influenced by medical card status (SLÁN 2002) (χ^2 (1, n = 1594) = 12.56; p = 0.000). Of those respondents for SLÁN 2002 who have a medical card (n = 1005), 82.6 per cent had been for a check-up within the previous three years compared to 75.2 per cent of those who do not have a card.

4.1.2 Regular Health Check-ups

Table 4.1 represents the venues attended for regular health check-ups (once every three months). Over half of the respondents attend their GP's surgery or health centre. Hospitals are the next most common venue.

Table 4.1: Venues attended for regular check-ups (SLÁN 2002 and (SLÁN 1998)

	SLÁN 2002 (n=1,745)		SLÁN 1998 (n= 634)	
	Yes	No	Yes	No
GP's surgery/health centre	55.4%	44.6%	56.2%	43.8%
Place of work	0.6%	99.4%	0.4%	99.6%
Mental health services	1.7%	98.3%	2.1%	97.9%
Hospital	12.1%	87.9%	11.4%	88.6%
Private medical company	0.8%	99.2%	0.9%	99.1%
Other	1.7%	98.3%	3.8%	96.2%

Table 4.2 represents the total number of respondents who visit the locations listed for regular health check-ups and includes the percentages of those who hold a medical card. Of those attending a GP's surgery, health centre or hospital, 75 per cent have medical cards compared with the much smaller percentages of those attending a private medical company or place of work.

Table 4.2: Proportion of medical card holders attending for regular checks (SLÁN 2002)

	Total number	Medical card
GP's surgery/health centre	684	75.1%
Place of work	5	55.6%
Mental health services	20	71.4%
Hospital	150	75.0%
Private medical company	5	38.5%
Other	13	44.8%

4.2 Sexual Activity

Respondents were asked if they were sexually active and if they had used contraception in the previous twelve months. Approximately 65 per cent said they are not sexually active, and 7 per cent and 9 per cent (SLÁN 1998 and SLÁN 2002 respectively) always or sometimes use contraception. Marital status was found to influence sexual practices but, due to small numbers, statistical significance was not tested. For SLÁN 2002, 50.7 per cent of married couples are sexually active and 19.9 per cent always or sometimes use contraception. Among those widowed, 15 per cent are sexually active and 13 per cent always or sometimes use contraception. Among those listed as single/never married, 16.5 per cent are sexually active and 46.1 per cent always or sometimes use contraception. Of those who are separated, 47.8 per cent are sexually active, with 36.3 per cent using contraception. Similar trends were observed for SLÁN 1998.

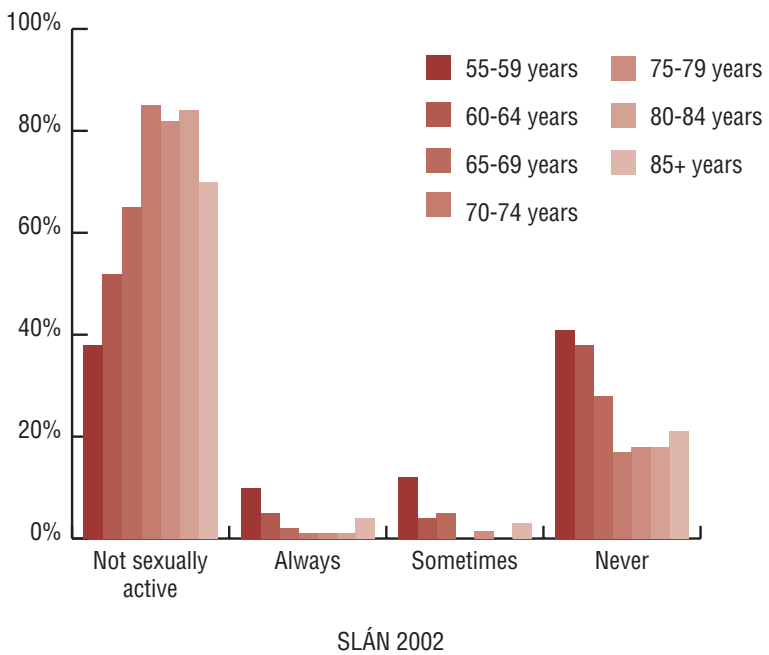
The sexual behaviour of men and women differs significantly in both 2002 (χ^2 (3, n = 1387) = 20.57; p = 0.000) and 1998 (χ^2 (3, n = 1262) = 30.62; p = 0.000). There are 7 per cent more sexually active women than men. While 6 per cent of men always use contraception, it is used by only 2 per cent of women. More men than

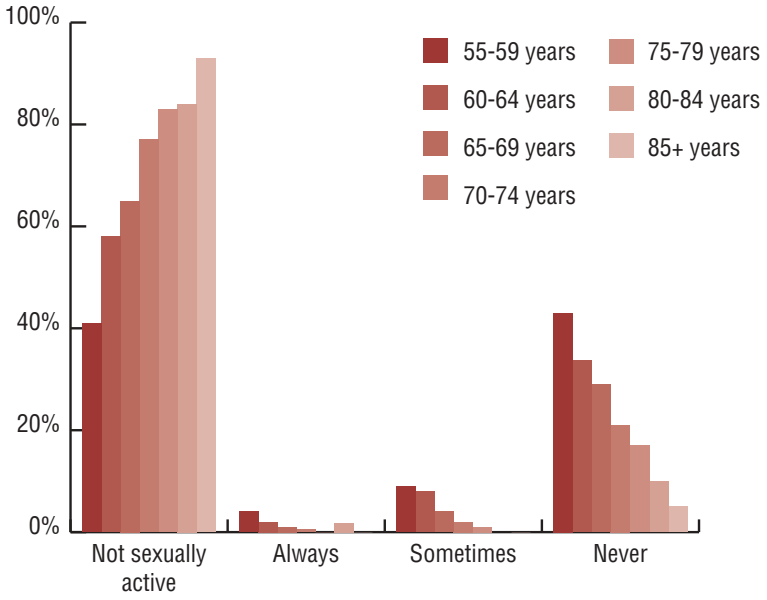
women report that they sometimes use contraception, as would be expected in a post-menopausal group.

Social class does not influence sexual practice but educational status was found to influence sexual activity in both SLÁN 2002 (χ^2 (6, n = 1272) = 32.03; p = 0.000) and SLÁN 1998 (χ^2 (6, n = 1199) = 21.09; p = 0.002). Both surveys show that those in category ED1 are less likely to be sexually active. Although just 9 per cent of respondents use contraception, those older people with tertiary education are more likely to always use it.

Age was found to influence sexual activity significantly in both SLÁN 2002 (χ^2 (18, n = 1395) = 226.62; p = 0.000) and SLÁN 1998 (χ^2 (18, n = 1264) = 169.97; p = 0.000). In both surveys, those in the younger age groups are more likely to be sexually active. However, in contrast with SLÁN 1998, the SLÁN 2002 survey shows that those aged 85 and over differ from this pattern. Approximately 60 per cent of the 55-59 years group are sexually active, with 40 per cent never using contraception. Those in the younger age groups are also more likely to always use contraception. For SLÁN 2002, the 70-74 years group contains the largest number of sexually inactive respondents who are also most likely to rate their quality of life as poor.

Figure 4.2: Sexual activity by age group (SLÁN 2002 and SLÁN 1998)





SLÁN 1998

4.3 Physical Activity

In both surveys, respondents were asked about their exercise levels; specifically, in a seven-day period, how many times on average they engage in strenuous, moderate and mild exercise. Strenuous exercise was defined as resulting in a rapid heart beat, moderate exercise was defined as not exhausting and mild exercise was defined as being of minimal effort. Examples of exercise types were also given. Regular strenuous and regular moderate exercise is defined as three or more times per week for twenty minutes or more at a time. Regular mild exercise is defined as four or more times per week.

Table 4.3 shows the percentages of men and women aged 55 years and over who regularly take exercise. Between the surveys, there is an increase in the numbers of older people taking regular moderate and regular strenuous exercise. However, there is a decrease in those taking mild exercise. Given that physical activity and exercise is recognised as one of the primary risk factors for coronary heart disease, this is of considerable importance.

Table 4.3: Percentage of men and women regularly taking exercise (SLÁN 2002 and SLÁN 1998)

	Men		Women	
	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998
Mild exercise	24.3%	29.7%	25.3%	28.4%
Moderate exercise	19.6%	18.9%	19.2%	16.4%
Strenuous exercise	2.8%	2.6%	1.4%	0.7%

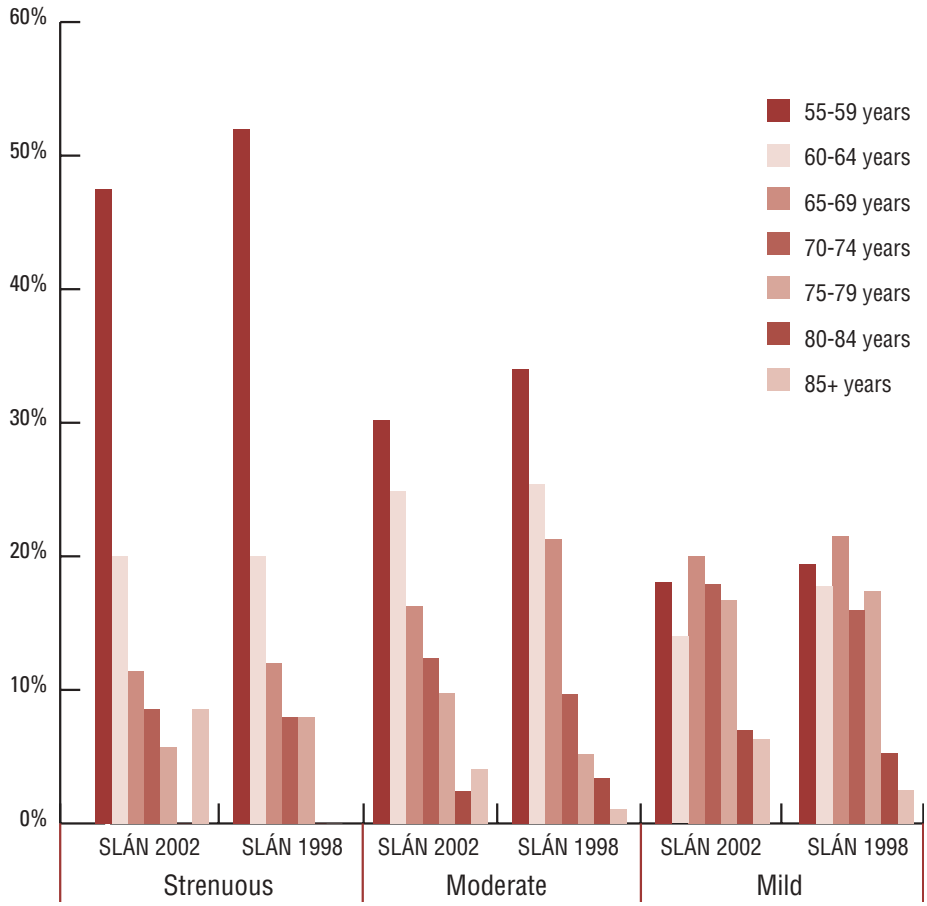
4.3.1 Physical Activity by Age

If we consider each of the age groups separately, the results are interesting. In both surveys, Chi squared tests revealed that age influences participation in strenuous, moderate and mild exercise, with a very sharp fall off in strenuous activity between 55 and 60 years. Those who report little or no activity also differ by age. These findings are shown in Table 4.4 and Figure 4.3. Participation in all forms of exercise generally decreases with age. However, in SLÁN 2002, respondents aged 85 and over reverse this trend.

Table 4.4: Percentage of respondents taking exercise by age group (SLÁN 2002 and SLÁN 1998)

	Strenuous		Moderate		Mild		No exercise	
	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998
55-59 years	47.5%	52.0%	30.2%	34.0%	18.1%	19.4%	14.1%	10.7%
60-64 years	20.0%	20.0%	24.9%	25.4%	14.0%	17.8%	14.0%	17.3%
65-69 years	11.4%	12.0%	16.3%	21.3%	20.0%	21.5%	12.9%	14.1%
70-74 years	8.6%	8.0%	12.4%	9.7%	17.9%	16.0%	16.4%	19.8%
75-79 years	5.7%	8.0%	9.8%	5.2%	16.7%	17.4%	16.6%	18.3%
80-84 years	0.0%	0.0%	2.4%	3.4%	7.0%	5.3%	13.7%	11.1%
85+ years	8.6%	0.0%	4.1%	1.1%	6.3%	2.5%	12.4%	8.7%

Figure 4.3: Age groups taking strenuous, moderate and mild exercise (SLÁN 2002 and SLÁN 1998)



4.3.2 Physical Activity by Gender, Age and Educational Status

Further analysis of physical activity by gender was undertaken, with educational status and age as factors. Table 4.5 presents the findings for mild physical activity for both SLÁN 2002 and SLÁN 1998. Regular mild physical activity has decreased across time in all age groups and at each education level, with the exception of men in category ED3 where an increase is noted.

Table 4.5: Percentage of respondents taking mild exercise by gender, age and educational status (SLÁN 2002 and SLÁN 1998)

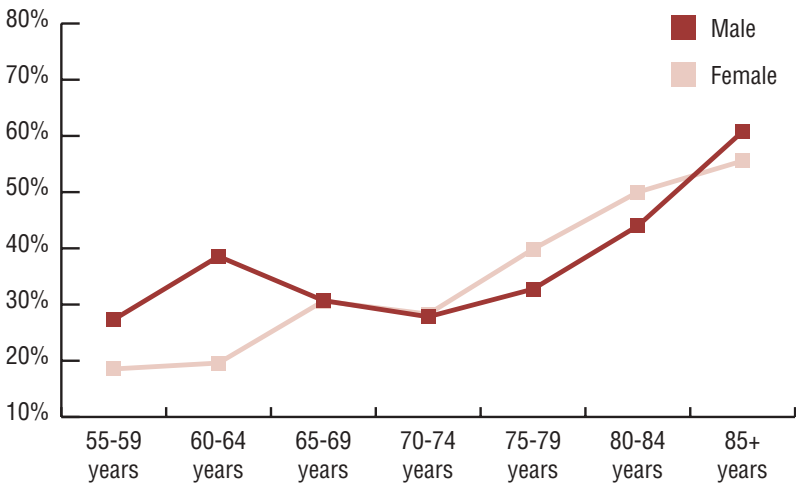
	Men						Women					
	ED1		ED2		ED3		ED1		ED2		ED3	
	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002
55-59 years	26.0%	19.8%	25.0%	30.0%	20.8%	33.3%	29.6%	20.7%	33.3%	20.0%	38.9%	32.6%
60-64 years	21.8%	19.8%	60.0%	9.1%	31.3%	22.7%	20.6%	15.8%	42.1%	33.3%	38.9%	23.8%
65-69 years	34.4%	23.1%	33.3%	60.0%	29.3%	35.3%	31.1%	26.7%	52.0%	28.1%	38.5%	38.9%
70-74 years	24.1%	19.8%	100%	37.5%	36.4%	53.8%	31.0%	31.4%	31.6%	34.6%	42.9%	18.8%
75-79 years	40.5%	23.8%	66.7%	50.0%	60.0%	36.4%	26.3%	24.8%	36.4%	58.3%	50.0%	27.3%
80-84 years	13.9%	20.4%	0.0%	30.0%	33.3%	57.1%	20.4%	3.8%	28.6%	30.8%	57.1%	50.0%
85+ years	27.3%	11.8%	0.0%	0.0%	25.0%	80.0%	11.4%	17.9%	0.0%	21.4%	0.0%	33.3%

4.3.3 Walking For 30 Minutes or More (SLÁN 2002 Only)

Respondents reported how many days of the week they walk for 30 minutes or more. Significantly more men than women do not walk at all (χ^2 (7, n = 1725) = 23.79; p = 0.001). More women walk on one to six days per week but more men walk seven days per week.

The results were also considered by age group. This emerged as statistically significant for both men (p = 0.033) and women (p = 0.000) separately. The gender variation was specifically considered for those who do not walk on any day of the week. It is evident in all age groups (Figure 4.4). Males are more likely to be inactive in the younger age groups (55-59 and 60-64 years). However, as years increase, fewer women than men walk for 30 minutes on any day of the week (70-74, 75-79 and 80-84 years). This trend is reversed for those aged 85 and over where inactive men outnumber inactive women.

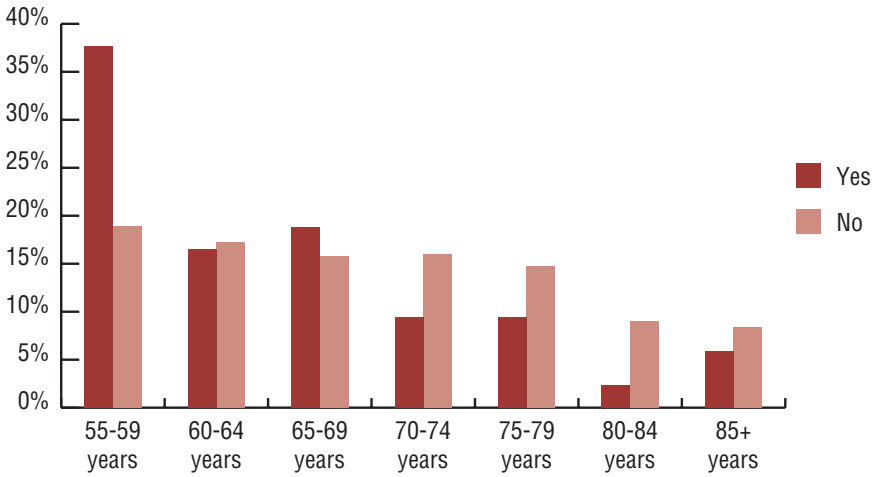
Figure 4.4: Respondents not walking on any day of the week (SLÁN 2002)



4.3.4 Gym/Leisure Centre Attendance

Figures reveal that 5.2 per cent of respondents aged 55 and over attend a gym or leisure centre. The difference across the age categories can be seen in Figure 4.5 (χ^2 (6, n = 1641) = 23.34; p = 0.001). Younger groups represent the largest proportion of those who attend a gym. We see again that those aged 85 and over reverse the trend for declining gym attendance with age.

Figure 4.5: Age groups attending a gym/leisure centre (SLÁN 2002)



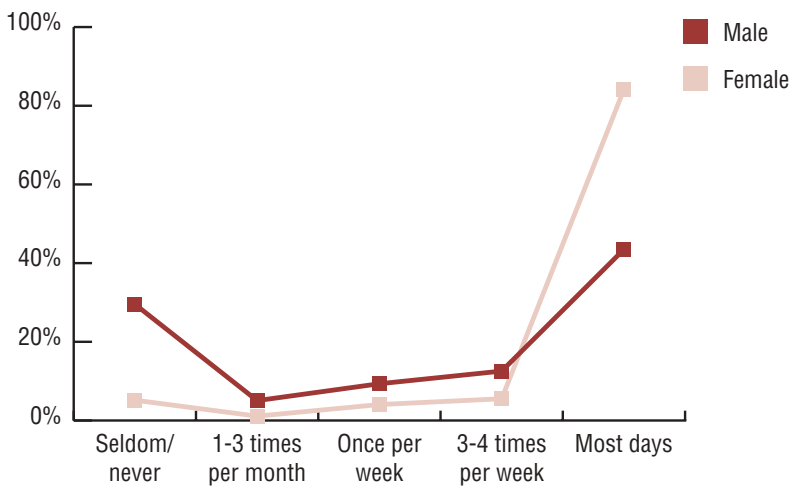
Gym or leisure centre attendance was also influenced by social class. Almost 68.3 per cent of those attending a gym/leisure centre are in the SC1-2 category, compared to 6.3 per cent in the SC5-6 category (χ^2 (2, n = 1061) = 18.26; p = 0.000). Of the proportion attending a gym or leisure centre, 40 per cent are men and 60 per cent are women.

Of the 5.2 per cent that attend a gym or leisure centre, almost 50 per cent attend once per week with almost 40 per cent attending three or four times per week.

4.3.5 Household Activities

Results to illustrate light housework are similar for both surveys, therefore, only the 2002 results are presented here. Light housework is undertaken on most days of the week by 69.5 per cent of respondents, three to four times per week by 10.2 per cent, once per week by 7 per cent, one to three times per month by 1.3 per cent and 11.9 per cent seldom or never take part. Chi squared analysis revealed differing patterns for men and women (χ^2 (4, n = 1619) = 193.94; p = 0.000). Significantly more women do light housework on most days of the week. Men are more likely to seldom or never do housework. Similar trends were also observed for heavy housework.

Figure 4.6: Gender representation for respondents undertaking light housework (SLÁN 2002)

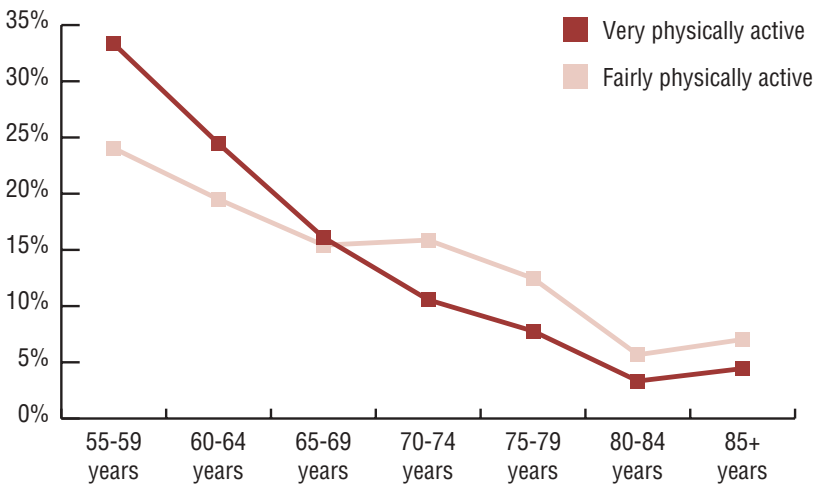


4.3.6 Level of Physical Activity in the Workplace

From 1998 to 2002 there was a slight increase in respondents in very physically active and fairly physically active jobs.

A Chi squared test was conducted on the SLÁN 2002 results to investigate if the level of activity differed by age, which revealed this association as statistically significant (χ^2 (18, n = 887) = 50.47; p = 0.000). Figure 4.7 displays the very physically active and fairly physically active categories only. There is a decrease in activity levels as age increases, except for those aged 85 and over.

Figure 4.7: Physical activity in the workplace by age group (SLÁN 2002)



4.4 Food Habits and Nutrition

4.4.1 The Food Pyramid

Table 4.6 displays the percentages of those consuming above or below the recommended servings per day from the food pyramid. There is a dramatic decline in the consumption of cereals, bread and potatoes, while meat and fish consumption remains relatively unchanged. Approximately one third of the sample does not consume the recommended daily servings of dairy products, fruit and vegetables, or meat, fish and alternatives. There has been an increase in the consumption of top shelf foods with 82.4 per cent exceeding the recommended quantity.

Table 4.6: Food consumption (SLÁN 2002 and SLÁN 1998)

	Recommended servings per day	SLÁN 2002 (n = 1,754)	SLÁN 1998 (n = 1,634)
Cereals, bread, potatoes	≥6	33.0%	42.4%
	<6	67.0%	57.6%
Fruit and vegetables	≥4	70.1%	57.2%
	<4	29.9%	42.8%
Dairy consumption	>3	37.1%	18.7%
	3	31.2%	22.8%
	<3	31.6%	58.5%
Meat, fish and alternatives	>2	30.7%	30.7%
	2	38.6%	39.8%
	<2	30.7%	29.5%
Top shelf	≥3	82.4%	80.0%
	<3	17.6%	20.0%
Fried food (2002 only)	≥4 times per week	7.3%	
	1-3 times per week	29.45%	
	< once per week	63.3%	

Age has little effect on the food consumption results in either survey but gender analysis revealed some differences. In SLÁN 2002 there are no significant gender differences in the percentages of men and women consuming cereals, bread and potatoes, dairy products or top shelf products. However, significant differences were observed for fruit and vegetables (χ^2 (1, n = 1693) = 5.928; p = 0.015), meat, fish and alternatives (χ^2 (2, n = 1660) = 17.795; p = 0.000) and fried food (χ^2 (2, n = 1611) = 52.439; p = 0.000). Men are more likely than women to consume more than two portions of meat, fish and alternatives in both surveys. Women are more likely to exceed the recommended quantity of fruit and vegetables. Finally, more men (11.6 per cent) than women (3.7 per cent) consume fried food four or more times per week.

SLÁN 1998 found that educational status did influence fruit and vegetable consumption; the largest percentage of respondents to consume four or more servings per day is in the ED3 category. This trend was not observed in SLÁN 2002, however, where educational status impacts only on the consumption of fried foods (χ^2 (4, n = 1481) = 21.055; p = 0.000). Those respondents in the ED1 category are most likely to consume fried foods four or more times per week.

4.4.2 Body Mass Index

Body mass index (BMI) is a measure of the relationship between height and weight. It is calculated by dividing mass in kilograms by height in metres squared. In Ireland the cut-off points are as follows:

- <19.45 = underweight
- 19.55 to 24.54 = normal
- 24.55 to 29.54 = overweight
- >29.55 = obese.

Table 4.7 shows the proportion of older Irish people in each of the above BMI categories for both surveys. While the proportion of underweight and normal adults remains unchanged, there is an increase in the proportion of obese adults. Just over one third of those aged 55 and over have an acceptable BMI.

Table 4.7: BMI of respondents aged 55 and over (SLÁN 2002 and SLÁN 1998)

	SLÁN 2002		SLÁN 1998	
	Frequency	Percentage	Frequency	Percentage
Underweight	88	5.7%	82	5.6%
Normal	567	36.6%	563	38.3%
Overweight	621	40.1%	600	40.8%
Obese	273	17.6%	224	15.2%
Total	1,549	100%	1,469	100%

These results have changed remarkably since Fahey and Murray's study (1994) on people aged 65 and over. For comparative purposes, Table 4.8 presents the SLÁN 2002 data for those aged 65 and over and the Fahey and Murray study. There has been a decrease in the percentages of normal and underweight people, and an increase in the percentages of the overweight and obese. Most notably, there is a 9 per cent increase in older adults classified as obese.

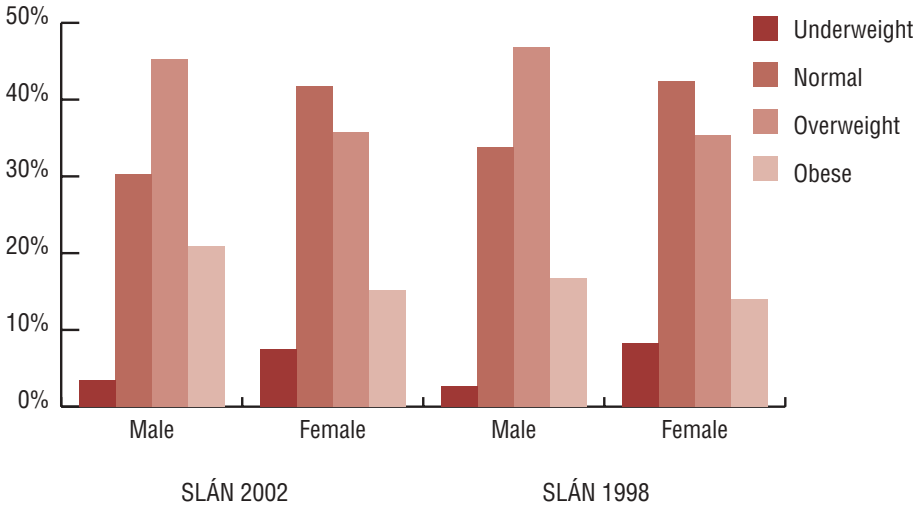
Table 4.8: Comparison of respondents' BMI: SLÁN 2002 and Fahey and Murray 1994

	SLÁN 2002	Fahey and Murray 1994
Underweight	6.8%	10.5%
Normal	40.8%	48.1%
Overweight	37.3%	35.3%
Obese	15.1%	6.1%
Total	100%	100%

This data is consistent with a one per cent per annum increase in obesity which, if borne out as a long-term trend, could have major implications for obesity-related diseases. This may be compounded for future generations by lifetime exposure to weight problems and obesity.

In both SLÁN 2002 (χ^2 (3, n = 1539) = 40.28; p = 0.000) and SLÁN 1998 (χ^2 (3, n = 1467) = 40.46; p = 0.000) these results mask some gender differences (Figure 4.8). Although the difference in gender between the two occasions of measurement is negligible, there is a marked difference in men and women's BMI within each survey. Men are more likely to be obese and overweight than women. Women are more likely than men to be normal or underweight.

Figure 4.8: Respondents' BMI by gender (SLÁN 2002)



For SLÁN 1998, social class was not an influence on BMI but significant differences were revealed for educational status. Trends from this analysis suggest that those in category ED1 are more likely to be obese and adults in category ED3 are more likely to be overweight. These trends were not observed in SLÁN 2002.

Medical card status was found to significantly influence BMI (χ^2 (3, n = 1458) = 15.76; p = 0.001). Those who are underweight or are of normal weight are more likely to hold a medical card. Those who are overweight or obese are more likely not to hold one. This is the case for both surveys. Age group is also a statistically significant factor in both SLÁN 2002 (χ^2 (18, n = 1549) = 76.44; p = 0.000) and SLÁN 1998 (χ^2 (18, n = 1469) = 86.05; p = 0.000) in which the numbers of overweight and obese people decrease with age. Those with normal weight increase until the 70-74 years group. Thereafter, a decline is observed as respondents get older. The proportion of those underweight decreases with age.

4.4.3 Nutritional Habits

SLÁN 2002 observed that 54 per cent of respondents consider that they could eat more healthily (Table 4.9). This does not differ between men and women but there is an age effect (χ^2 (6, n = 1591) = 81.12; p = 0.000). The 55-59 and 60-64 years groups have a higher percentage of respondents answering affirmatively (68 per cent and 65.9 per cent respectively). The trend is reversed for the other age groups but differences between the affirmative and negative responses are smaller. Chi squared analysis revealed that neither educational status nor social class is an influence.

Table 4.9: Responses to question 'could you eat more healthily' (SLÁN 2002)

Age group	Yes	No
55-59 years	68.0%	32.0%
60-64 years	65.9%	34.1%
65-69 years	52.9%	47.1%
70-74 years	47.3%	52.7%
75-79 years	44.8%	55.2%
80-84 years	33.6%	66.4%
85+ years	43.5%	56.5%
Total	54.0%	46.0%

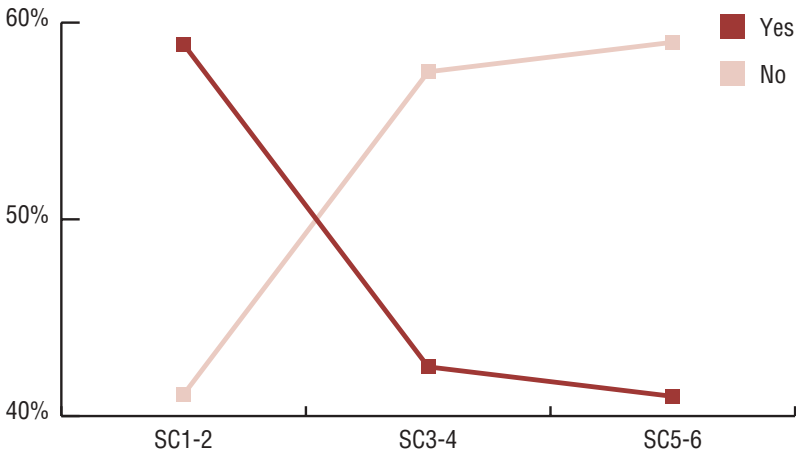
4.4.4 Vitamins, Minerals and Food Supplements

Respondents were asked if they had taken any vitamins, minerals or food supplements in the previous year. The results show that 45 per cent of older adults take such products. Gender analysis revealed that 20 per cent more women than men record consumption (χ^2 (1, n = 1626) = 56.43; p = 0.000).

Educational status was also found to influence consumption of vitamins, minerals or food supplements (χ^2 (2, n = 1494) = 52.99; p = 0.000). 60 per cent of those with tertiary education take vitamins, minerals or food supplements compared with 38 per cent in the none/primary/some secondary education category.

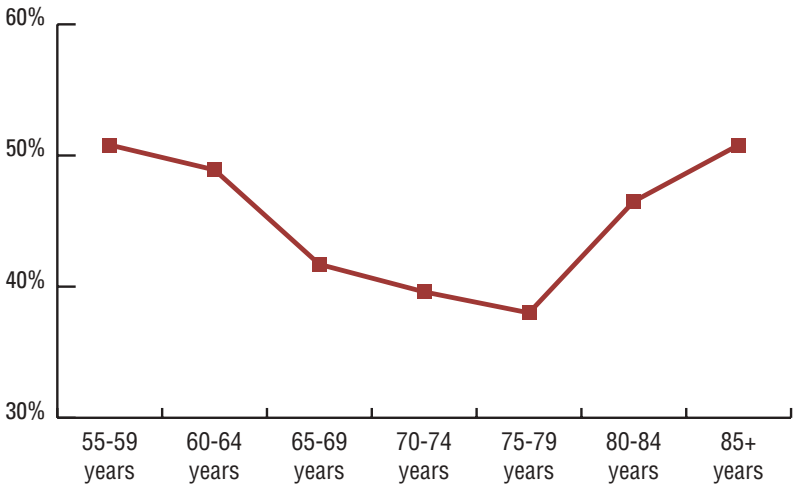
A social class effect was also evident, as can be seen in Figure 4.9. Those in the SC1-2 category are more likely to take vitamins, minerals or food supplements than those in either the SC3-4 or SC5-6 categories.

Figure 4.9: Proportion of respondents taking vitamins, minerals and food supplements by social class (SLÁN 2002)



A significant age effect is also evident (χ^2 (6, n = 1638) = 16.95; p = 0.009). The percentages taking vitamins, minerals or food supplements decline with age but, as has been observed previously, a U-shaped pattern is evident, with an increase again for those aged 80 years and over.

Figure 4.10: Proportion of respondents taking vitamins, minerals and food supplements by age group (SLÁN 2002)



4.4.5 Milk Type

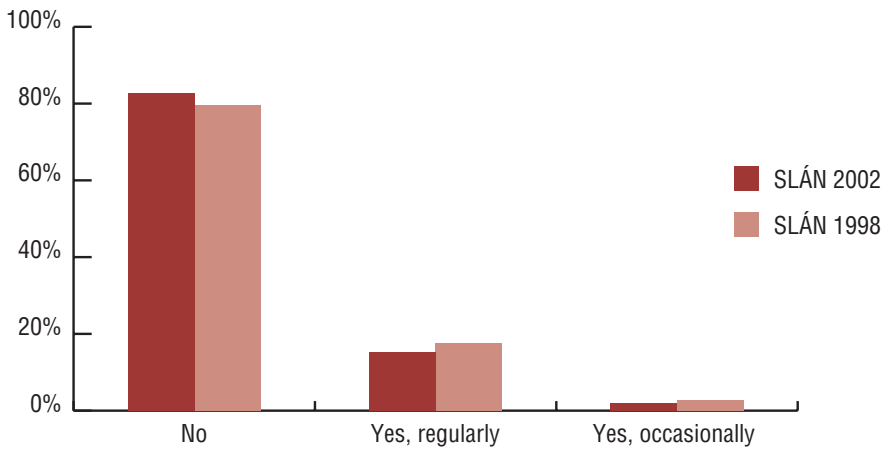
Respondents were asked what type of milk they use most often. Almost 50 per cent use full-fat milk, with low-fat milk identified as the next most popular choice. A relatively high proportion of older people still opt for full-fat milk.

A gender effect is not statistically significant, with full-fat milk being used by 53 per cent of men compared to 46.3 per cent of women. Low-fat milk is used by 33.1 per cent of men compared to 35 per cent of women. Skimmed milk is used by 2.6 per cent of men compared to 6.8 per cent of women.

4.5 Tobacco

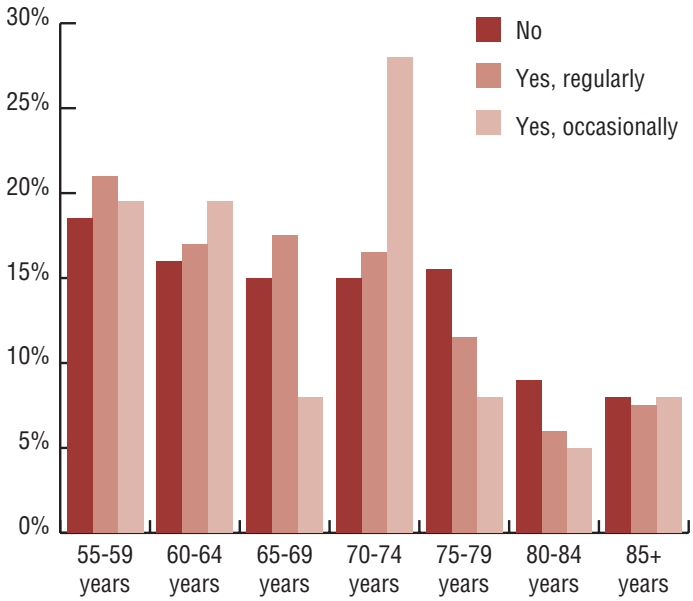
Respondents were asked about their smoking habits. Figure 4.11 displays the findings. The vast majority of respondents surveyed do not smoke. There is a decrease in the percentage who smoke regularly and occasionally. In fact, the numbers smoking regularly are well below the 20 per cent target set out in the Health Promotion Strategy for Older People in both surveys. No gender differences occur. A comparison of smoking trends with the Fahey and Murray study (1994) shows that the percentage of current smokers aged 65 years and over decreased from 23.9 per cent in 1994 to 16.7 per cent in 2002. The levels have also decreased since the HeSSOP study (Garavan *et al.,* 2001), in which 19 per cent were regular smokers.

Figure 4.11: Smoking status (SLÁN 2002 and SLÁN 1998)

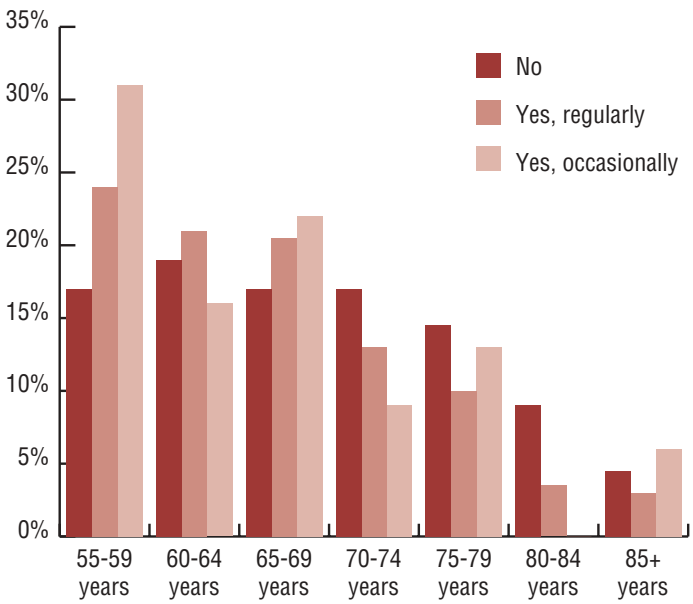


Further analysis was conducted to investigate whether age influences a person's smoking habit. In SLÁN 1998 an age effect was observed (χ^2 (12, n = 1552) = 29.95; p = 0.003). Most notably, the percentage of regular smokers decreases with age. There was no evidence of an age influence on smoking habits in SLÁN 2002.

Figure 4.12: Smoking status by age group (SLÁN 2002 and SLÁN 1998)



SLÁN 2002



SLÁN 1998

4.5.1 Past Smoking Habits

Respondents were asked in both surveys if they had smoked cigarettes in the past. The results are almost identical and show that 39 per cent had been regular smokers in the past (Table 4.10).

Table 4.10: Frequency and percentage of past smokers (SLÁN 2002 and SLÁN 1998)

	SLÁN 2002		SLÁN 1998	
	Frequency	Percentage	Frequency	Percentage
Never	709	44.8%	649	44.6%
Current smoker	116	7.3%	105	7.2%
Occasionally	141	8.9%	131	9.0%
Regularly	618	39.0%	571	39.2%
Total	1,584	100.0%	1,456	100.0%

4.5.2 Cigar and Pipe Smoking

In both surveys, almost identical small percentages of respondents regularly smoke cigars (Table 4.11). The pattern of occasional cigar smoking and those who used to smoke cigars did not change between the two surveys.

Table 4.11: Percentage of cigar smokers (SLÁN 2002 and SLÁN 1998)

	SLÁN 2002	SLÁN 1998
Never	86.2%	87.0%
Used to	11.0%	10.3%
Occasionally	1.9%	1.7%
Regularly	0.9%	0.9%

The percentages of those smoking pipes are similar to those represented above. A 1 per cent decrease over time is noted among those who currently smoke a pipe regularly.

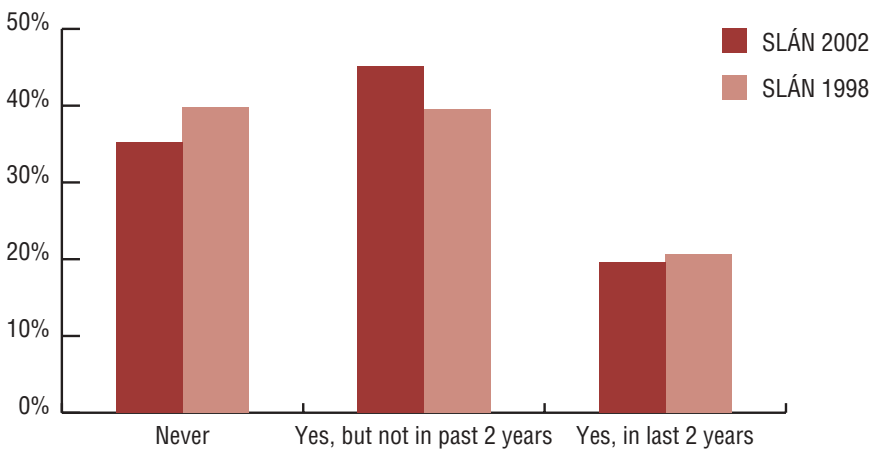
Table 4.12: Percentage of pipe smokers (SLÁN 2002 and SLÁN 1998)

	SLÁN 2002	SLÁN 1998
Never	87.3%	85.8%
Used to	11.1%	11.2%
Occasionally	0.3%	0.6%
Regularly	1.3%	2.4%

4.5.3 Stopping Smoking

Respondents were asked if they had tried to stop smoking. It would appear from Figure 4.13 that a slightly greater effort to stop smoking is evident in the 1998 survey.

Figure 4.13: Respondents who have tried to stop smoking (SLÁN 2002 and SLÁN 1998)

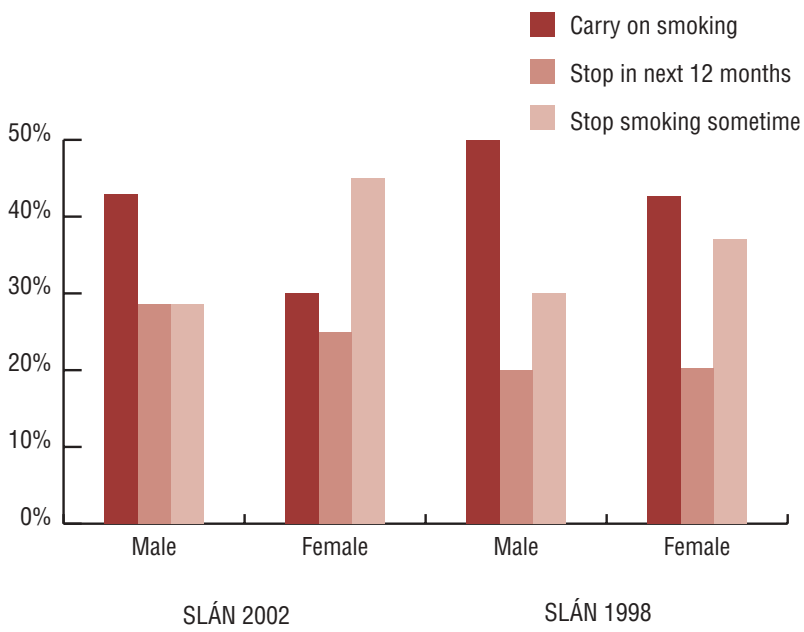


In both surveys, quite a large percentage of current smokers wish to carry on smoking, although this decreased in the 2002 survey. There is an increase in those who wish to stop smoking at some time and those considering giving up in the following twelve months.

Gender patterns among respondents were not statistically significant but some interesting trends emerged. In 2002, 42.9 per cent of men compared with 30 per cent of women expressed a wish to carry on smoking. The same trend was observed in 1998 although the difference between both years is not as great. Also in 2002, slightly more men than women expressed a wish to stop smoking in the

following twelve months. Finally, in both surveys, women are more likely to want to stop smoking at some time (Figure 4.14).

Figure 4.14: Smoking status by gender (SLÁN 2002 and SLÁN 1998)



Respondents were also asked what they would need to help them stop smoking and were invited to select as many applicable items as they wished from the list shown in Table 4.13. In both surveys, respondents most frequently selected the indicators of willpower and knowledge that their health was being damaged.

Table 4.13: Aids to giving up smoking (SLÁN 2002 and SLÁN 1998)

	SLÁN 2002	SLÁN 1998
Willpower	21.6%	60.0%
Knowing that my health is being damaged	9.7%	28.6%
Less stress	2.2%	17.0%
Confidence	2.2%	15.7%
Give up something I enjoy	4.5%	13.2%
Doctor's advice	4.5%	11.6%
Cigarette prices	4.55%	10.7%
Other	0.0%	10.4%
Family/friends	3.0%	8.2%
Stop smoking scheme	0.7%	4.4%
Smoking policies at work	0.8%	1.3%
Nicotine replacement therapy	9.7%	Not asked in 1998

4.6 Alcohol

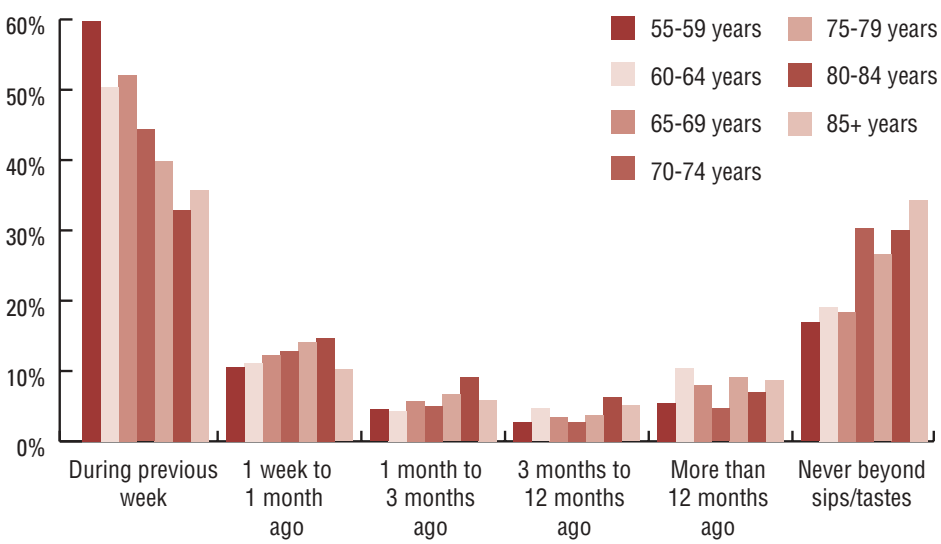
Respondents were asked how long it had been since their last alcoholic drink (Table 4.14). There is an increase in the percentage of those who had consumed a drink in the previous week and a slight increase in those who stated that their last alcoholic drink had been between one week and one month previously. The number of those who never drink 'beyond sips and tastes' (i.e. abstainers) has decreased across time. SLÁN 2002 records that 76.4 per cent of respondents are 'drinkers' while SLÁN 1998 records a figure of 71.4 per cent.

Table 4.14: Time elapsed since last alcoholic drink (SLÁN 2002 and SLÁN 1998)

	SLÁN 2002	SLÁN 1998
During previous week	47.3%	42.2%
1 week to 1 month ago	12.1%	11.3%
1 month to 12 months ago	5.6%	6.0%
3 months to 12 months ago	3.8%	5.4%
More than 12 months ago	7.5%	6.6%
Never 'beyond sips and tastes'	23.6%	28.6%
Total	100.0%	100.0%

Drinking habits were found to differ by age group in both SLÁN 2002 (χ^2 (30, n = 1648) = 75.60; p = 0.000) and SLÁN 1998 (χ^2 (30, n = 1520) = 44.37; p = 0.044). As can be seen in Figure 4.15, those who had consumed an alcoholic drink in the previous week decreased with age. Those aged 85 and over again reverse the trend with a noted increase. Also of interest is the abstainers group: the 55-59 years group represents the smallest group in this category and this increases with age.

Figure 4.15: Proportion of respondents who consume alcohol by age group (SLÁN 2002)



4.6.1 Number of Drinks Consumed

Respondents were asked how many drinks they had consumed on the days that they drank alcohol. The majority drink between one and four with the remaining percentage exceeding this (Table 4.15).

Table 4.15: Number of drinks consumed (SLÁN 2002 and SLÁN 1998)

	SLÁN 2002	SLÁN 1998
1 drink	26.8%	16.2%
2 drinks	27.7%	22.7%
3 drinks	13.1%	18.1%
4 drinks	13.9%	18.4%

4.6.2 Drinking Habits in the Previous Year

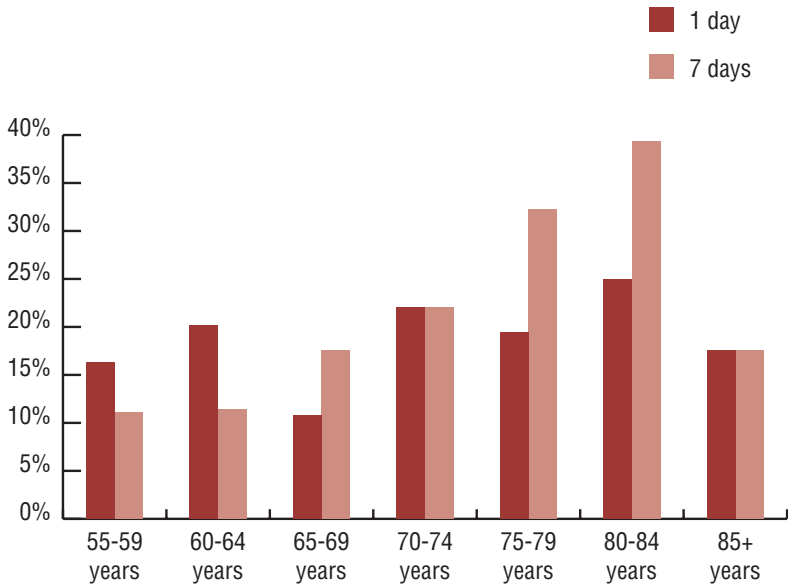
Respondents were also asked about their drinking habits in the previous year, specifically if they drank alcohol in a typical week. 54 per cent drink alcohol in a typical week, with no change over time.

4.6.3 Drinking Habits in a Typical Week

Respondents were asked about the number of days they drink alcohol in a typical week. This question was applicable to 569 people in SLÁN 2002 and 556 people in SLÁN 1998. Results show an increase in the percentages of people drinking on three or more days per week.

Figure 4.16 shows the percentages of respondents consuming alcohol on one day and seven days per week by age group (SLÁN 2002). There is an increase across the age groups in those drinking seven days per week, except in those aged 85 and over where a decrease is again observed. Further analysis on the percentage of respondents drinking more than five days per week was conducted. Results showed that 30.2 per cent of older people (n = 569) drink alcohol five or more days per week.

Figure 4.16: Proportion of respondents consuming alcohol on one day and on seven days per week (SLÁN 2002)



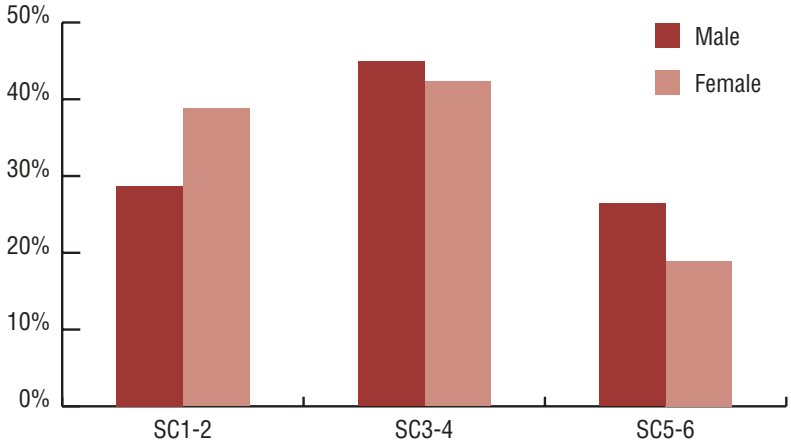
4.6.4 Excessive Alcohol Consumption

The available data was computed for men and women separately, and outcome variables for 'over the limit' and 'under the limit' alcohol consumption were obtained (n = 331 men and n = 253 women). Considering the units of alcohol consumed in one week, results revealed that 26.9 per cent of men, compared with just 15 per cent of women, consumed more than recommended limits.

Binge drinking habits (as defined by more than six units per sitting for men and more than four units per sitting for women) are similar for men and women, with 40.7 per cent of men (n = 788) and 43.6 per cent of women (n = 951) reporting these amounts. Age does not influence men's binge drinking habits but was found to significantly influence women's habits (χ^2 (6, n = 951) = 28.21; p = 0.000). Standardised residuals revealed that there is an over-representation of binge drinkers in the 70-84 years categories.

Figure 4.17 illustrates that social class influences the binge drinking habits of both men (χ^2 (2, n = 536) = 10.69; p = 0.005) and women (χ^2 (2, n = 561) = 11.49; p = 0.003). Those in category SC3-4 are more likely to binge drink. Women in category SC1-2 are more likely to binge drink than men, whereas the opposite trend is noted for category SC5-6.

Figure 4.17: Gender differences in binge drinking by social class (SLÁN 2002)



Educational status also significantly influences the binge drinking patterns of men (χ^2 (2, n = 731) = 7.78; p = 0.020) and women (χ^2 (2, n = 865) = 40.67; p = 0.000). The majority of binge drinkers are in the ED1 category i.e., those with none/primary/some secondary education. Men with tertiary education are more likely to drink than women in the same category. The opposite is true of those with secondary education only.

Chapter Five

Safety and Older People

Chapter Five
Safety and Older People

5.1 Accidents and Injuries

Respondents were asked if, in the previous two years, they had incurred any injuries serious enough to interfere with their daily activities. Of the valid 2002 sample (n = 1640), 11.6 per cent had reported incurring an injury serious enough to interfere with daily activity (58.2 per cent men and 41.8 per cent women). This was a decrease from the 1998 survey, when 12.7 per cent (n = 1516) had reported a serious injury (41.1 per cent men and 58.9 per cent women). The gender effect was not statistically significant in 2002 but it was in 1998 (χ^2 (1, n = 1516) = 4.01; p = 0.045). Analysis for an age group effect did not reveal a statistically significant result for either survey. Neither educational status nor social class significantly influence the prevalence of self-reported accidents and injuries.

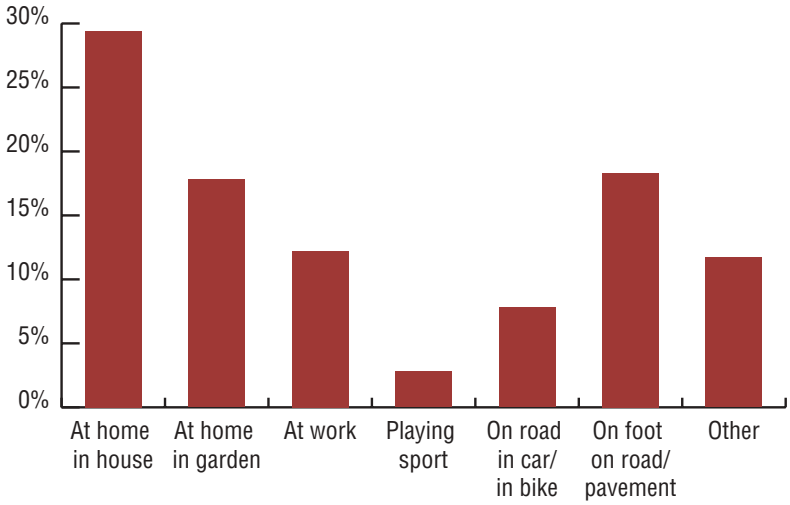
5.1.1 Accidental and Non-accidental Injury

Of the valid responses for SLÁN 2002 (n = 185), 89.7 per cent of respondents reported accidental injury with 10.3 per cent reporting non-accidental injury. Gender did not influence this result. Analysis to look for an effect due to educational status was not conducted as the sample size was insufficient. However, the percentages show that more accidental injuries are incurred in categories ED1 (93.6 per cent) and ED2 (90.3 per cent) than in the ED3 category (74.2 per cent).

5.1.2 Where Injuries Occur

The majority of injuries occur in respondents' homes (Figure 5.1). This is followed by injuries received while walking on the road or pavement, and then by injuries at home in the garden. Injuries incurred in the workplace amount to 12.2 per cent. The 'other' category is dominated by injuries on farms (n = 4). Other places mentioned include 'a beach' (n = 3) or 'someone else's home' (n = 2).

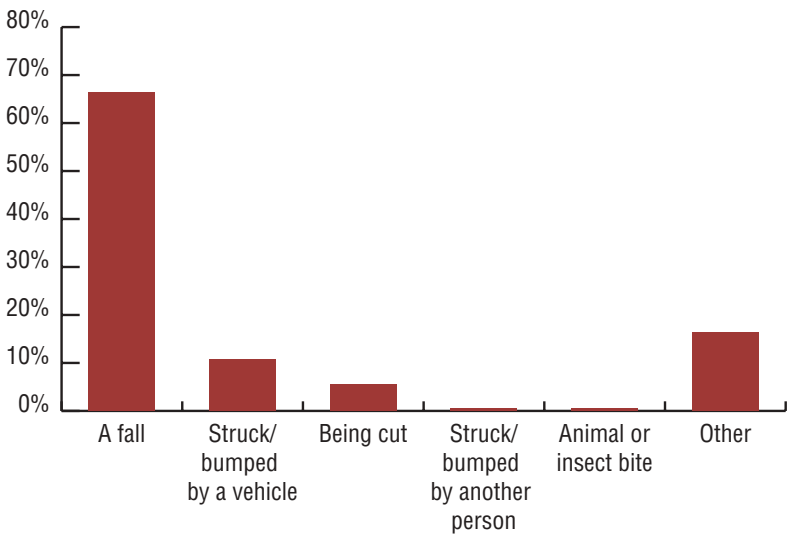
Figure 5.1: Locations where injuries occur (SLÁN 2002)



5.1.3 Causes of Injury

Of the injuries reported by respondents, 66 per cent were caused by a fall. In the 'other' category, lifting heavy objects was mentioned most frequently (n = 5).

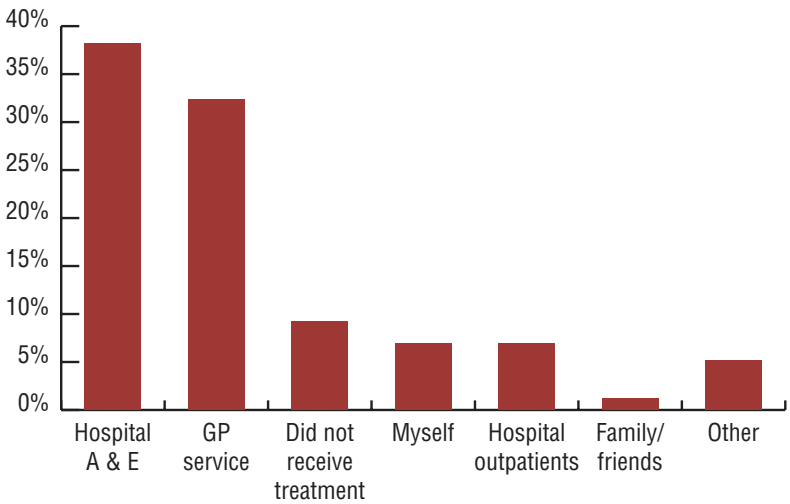
Figure 5.2: Causes of injury (SLÁN 2002)



5.1.4 Treatment of Injury

70 per cent of reported injuries had been treated in either a hospital accident and emergency department or by the GP service (Figure 5.3). In the 'other' category, physiotherapists and chiropractors were listed most often (n = 3 each).

Figure 5.3: Treatment of injury (SLÁN 2002)



5.2 Road Safety

5.2.1 Seatbelt Usage

Respondents were asked how often they use seatbelts as a car driver or front seat passenger and 95 per cent of respondents always, or nearly always, wear seatbelts.

Respondents were also asked about using seatbelts in the back of a car. Just over 50 per cent of respondents always use seatbelts in the back of a car, with the remainder divided uniformly between nearly always, sometimes, seldom and never (approximately 10 per cent in each category).

5.2.2 Helmet Usage

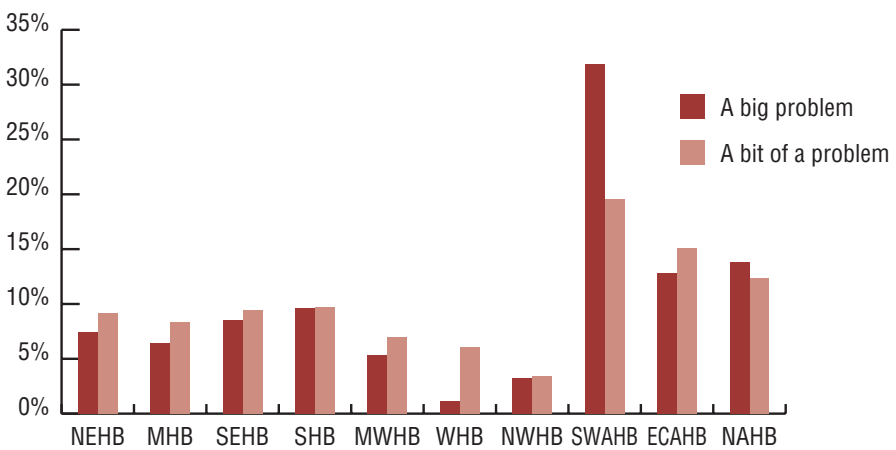
Respondents were asked how often they wear a helmet when riding a bicycle. This question was not applicable to everybody. Of the valid 2002 sample (n = 211), 72 per cent rarely or never wear a helmet, with just 20 per cent of respondents always wearing one. Gender differences were not evident.

Respondents were also asked how often they wear a helmet when riding a motorbike. IN SLÁN 2002, this question was only applicable to 45 respondents aged 55 and over. Of those people, 68.9 per cent always and 31.1 per cent rarely or never wear a helmet.

5.3 House Break-ins

Respondents were asked to consider house break-ins in their neighbourhood. Of the 2002 valid sample (n = 1426), 6.9 per cent said break-ins pose a 'big problem', 32.8 per cent said they pose 'a bit of a problem' and 60.2 per cent said they are 'not a problem'. These results vary significantly according to health board area (χ^2 (18, n = 1350) = 155.93; p = 0.000) as displayed in Figure 5.4. An eastern area effect becomes evident, with the biggest problems reported in the SWAHB, ECAHB and NAHB areas.

Figure 5.4: Respondent ratings of house break-ins (SLÁN 2002)



Those respondents who considered house break-ins to be a problem are more likely to live in an urban location (χ^2 (2, n = 1350) = 74.57; p = 0.000). Of those rating neighbourhood house break-ins as 'a big problem', 66 per cent live in an urban area while 34 per cent live in a rural area (Table 5.1). Similar percentages are observed for those rating house break-ins as 'a bit of a problem'. This trend is reversed for those who do not rate house break-ins as a problem: 62.4 per cent live in a rural location compared with 37.6 per cent in an urban location.

Table 5.1: Respondent ratings for house break-ins by urban/rural setting

Setting	A big problem	A bit of a problem	Not a problem
Rural	34.0%	39.6%	62.4%
Urban	66.0%	60.4%	37.6%
Total	100%	100%	100%

5.4 Drink Driving

Respondents were asked if, during the previous 12 months, they had driven a car after taking two or more alcoholic drinks. SLÁN 1998 recorded this percentage at 11.3 per cent, which increased to 13.1 per cent in SLÁN 2002. An age effect was observed in SLÁN 2002 (χ^2 (6, n = 1197) = 39.12; p = 0.000). Standardised residuals revealed an over-representation of 55-59 and 60-64 year olds in the 'yes' category, illustrating that those aged 55-64 years are more likely to drive a car after consuming two or more drinks than their older counterparts.

5.5 Medication

There is an increase in the percentage of older adults taking prescribed pills or medication from SLÁN 1998 to SLÁN 2002 (60.6 per cent to 67.2 per cent). Table 5.2 shows the number of older adults taking prescribed medication for particular illnesses. Respondents may be taking multiple medications simultaneously. There is an increase in the numbers taking prescribed medication for all the illnesses listed, except stroke and anxiety. The numbers reporting high cholesterol levels have also increased since 1998. While 8.7 per cent of the 1998 survey had difficulty reading the instructions, this decreased to 7.9 per cent in 2002.

Table 5.2: Frequency of medication prescribed for illness (SLÁN 2002 and SLÁN 1998)

	SLÁN 2002	SLÁN 1998
Angina	180	164
Heart attack	107	91
High blood pressure	467	420
Stroke	51	55
Diabetes	107	82
High cholesterol	253	144
Anxiety	130	135
Depression	113	112

5.6 Multivariate Analysis

5.6.1 Accidents

In order to determine factors associated with accidents, the data from SLÁN 1998 and SLÁN 2002 was combined for the purposes of the multivariate analysis. This was possible given the minor changes over time. A binary logistic regression was conducted with 'in the last two years, have you had an injury serious enough to affect your work or daily activity' as the dependent variable, and backward stepwise method was chosen. Selected factors likely to be influential were f (age, gender, medical card status, marital status, location, accommodation type, mobility, living alone and duration since last alcoholic drink). The full model is thus fitted, including all the variables, and unimportant variables are removed one at a time until all those remaining contribute significantly to the model. At each step, the variable with the smallest contribution to the model (or the largest p-value) is removed. Removal was set at 0.10. Table 5.3 shows the remaining factors. The last category is referenced.

Those who are less likely to have reported sustaining an injury are male, mobile, living in a rural area and have a medical card. Those who are significantly more likely to sustain an injury live alone. Those consuming an alcoholic drink in the previous week are more likely to sustain an injury than those who never drink 'beyond sips and tastes', though at a level of 5 per cent this is not significant. Those consuming a drink in the previous 3 to 12 months are more likely to sustain an injury than those who never drink 'beyond sips and tastes'.

Table 5.3: Logistic regression and determinants of accidents (SLÁN 2002 and SLÁN 1998)

Covariates		Estimates	S.E.	Wald	df	*p*	OR
Mobility				43.088	2	0.000	
	No problems walking about	-1.512	0.864	3.062	1	0.080	0.220
	Some problems walking about	-0.638	0.866	0.543	1	0.461	0.528
	Confined to bed						
Living alone	Not living alone	-0.402	0.135	8.8999	1	0.003	0.669
	Living alone						
Location	Rural	-0.229	0.132	3.004	1	0.083	0.795
	Urban						
Gender	Male	-0.272	0.136	4.012	1	0.045	0.762
	Female						
Medical card status	Yes	-0.256	0.138	3.436	1	0.064	0.774
	No						
Last alcoholic drink				10.449	5	0.063	
	During previous week	0.076	0.164	0.215	1	0.643	1.079
	1 week to 1 month ago	-0.298	0.246	1.461	1	0.227	0.742
	1 month to 3 months ago	-0.956	0.412	5.385	1	0.020	0.384
	3 months to 12 months ago	0.320	0.289	1.229	1	0.268	1.377
	More than 12 months ago	-0.126	0.283	0.198	1	0.656	0.882
	Never beyond sips and tastes						
Model Chi square 75.853 df = 11 p = 0.000							
Model n 2299 Nagelkerke R square = 0.062							

Chapter Six

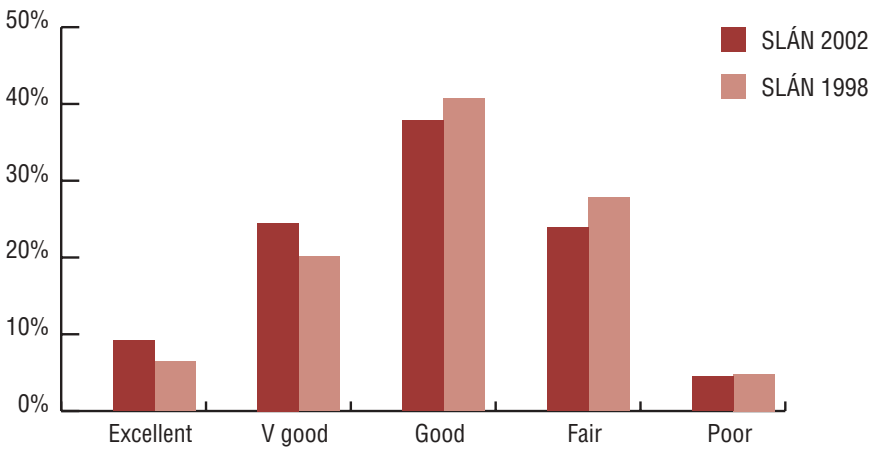
Older People's Health

Chapter Six
Older People's Health

6.1 Self-rated Health

Self-rated health is an overall assessment by the individual of his/her health status. Respondents are asked to rate their health on a five point Likert scale from excellent to poor. Figure 6.1 shows that the pattern of self-rated health has changed significantly over time (χ^2 (4, n = 3271) = 21.3, p = 0.000). In 1998, 6.5 per cent of respondents aged 55 and over reported their health was excellent but in 2002 this rises to 9.2 per cent. The proportion rating their health as poor remains unchanged. There is also an increase in those rating their health as excellent and very good in 2002, compared to 1998. The numbers rating their health as good, fair or poor has decreased. Living in a rural or urban location does not significantly influence self-rated health in either year.

Figure 6.1: Reported self-rated health (SLÁN 2002 and SLÁN 1998)



6.1.1 Self-rated Health and Age

Self-rated health was further assessed by age category (Figure 6.2). There is an association between self-rated health and age in both SLÁN 2002 (χ^2 (24, n = 1556) = 74.71, p = 0.000) and SLÁN 1998 χ^2 (24, n = 1715) = 78.26, p = 0.000). In general, self-rated very good health decreases with age but an increase is again noted in those aged 85 and over. In both surveys, the 80-84 years group are most likely to rate their health as poor.

Figure 6.2: Reported self-rated health by age group (SLÁN 2002 and SLÁN 1998)

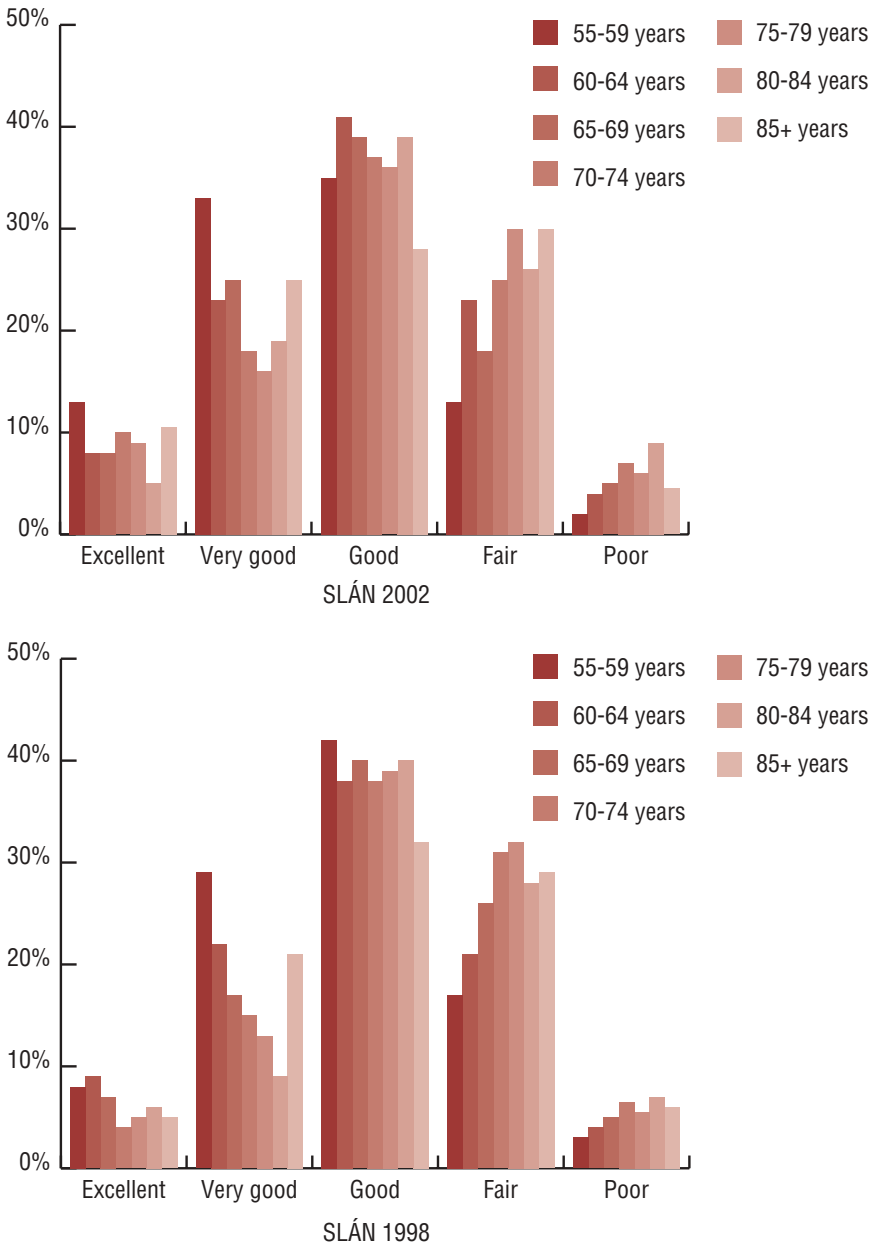


Figure 6.3 presents self-rated health in SLÁN 2002 for the following age groups: 75-79, 80-84 and 85+ years. Respondents aged 85 and over rate their health more highly (excellent and very good) than the younger age groups and record the lowest percentage of respondents reporting their health as poor.

Figure 6.3: Reported self-rated health for older age groups (SLÁN 2002)

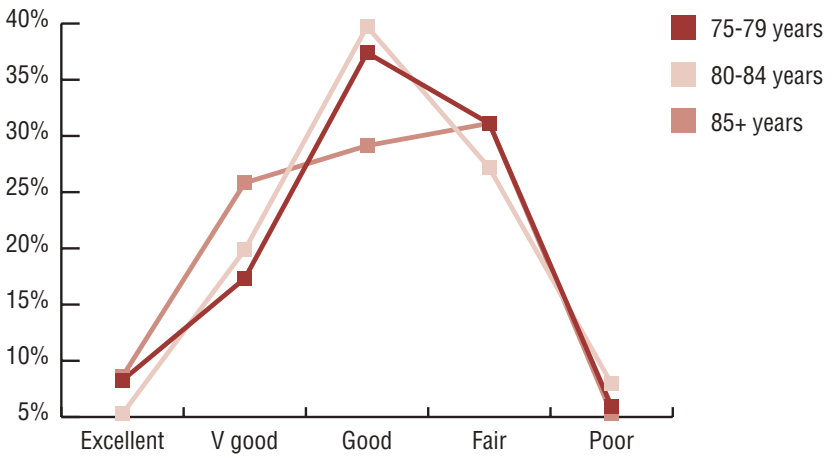
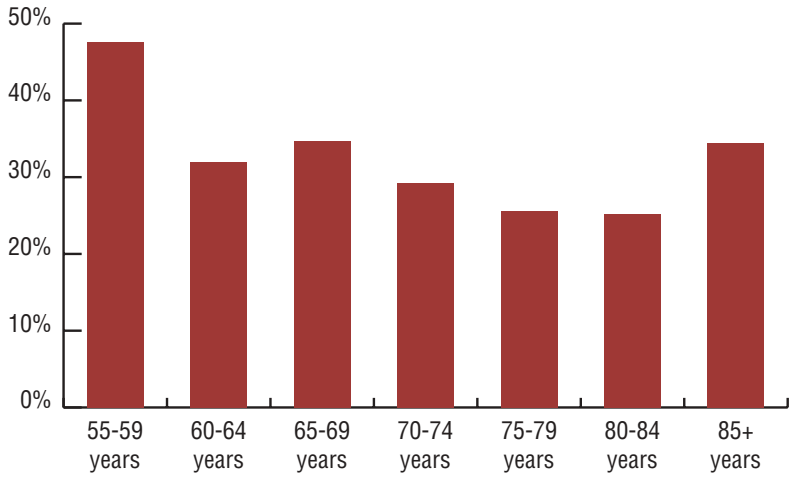


Figure 6.4 presents the combined results of those whose self-rated health is excellent and very good. There is a general lowering of self-rated health levels across each age category but the U-shaped effect is again observed in the group aged 85 and over. This is consistent with previous literature which identified that the majority of older people tend to assess their health as being similar to, or even better than, in earlier years, despite an increase in chronic diseases and a decline in functional performance (Leinonen *et al.,* 2001). In fact, looking at the sum of the excellent and very good categories, the 85+ years group rate their health similarly to the group 20 years their junior, with a decrease noted in between.

Figure 6.4: Combined results for self-rated health reported as excellent and very good (SLÁN 2002)



A two-way ANOVA was performed to investigate the relationship between self-related health and age for each of the surveys. Both an age effect and survey effect are noted. Though older adults self-rated health differs by age group, the difference between the age groups is equal in both SLÁN 2002 and SLÁN 1998. Age categories were also ranked in order from poorest to best self-rated health as follows: 80-84; 75-79; 70-74; 85+; 65-69; 60-64; 55-59.

6.1.2 Self-rated Health and Social Class

Social class was found to significantly influence self-rated health in both SLÁN 2002 (χ^2 (8, n = 1087) = 37.99, p = 0.000) and SLÁN 1998 (χ^2 (8, n = 655) = 28.96, p = 0.000). SLÁN 2002 has those classed in category SC1-2 as more likely to rate their health as excellent or very good. A distinction between social classes is not evident in the excellent rating in SLÁN 1998, but those in SC1-2 are more likely to rate their health as very good or good. SLÁN 2002 has those in the SC5-6 category as most likely to rate their health as poor or fair.

Figure 6.5: Self-rated health and social class (SLÁN 2002 and SLÁN 1998)

Standardised residuals are presented in Table 6.1. In SLÁN 2002, those rating their health as excellent are over-represented in the SC1-2 category and under-represented in both SC3-4 and SC5-6 categories. This trend is reversed for the SC5-6 category. The results for SLÁN 1998 are similar.

Table 6.1: Standardised residuals for social class and self-rated health

	SC1-2		SC3-4		SC5-6	
	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998
Excellent	2.4	0	-1.1	0.3	-2.0	-0.3
Very good	2.2	1.2	-1.0	-0.3	-1.9	-1.0
Good	-1.5	1.5	1.4	-1.6	0.3	0.3
Fair	-1.4	-3.5	-0.2	2.3	2.3	1.1
Poor	-1.6	1.2	0.4	-0.4	1.8	-0.9

6.1.3 Self-rated Health and Educational Status

Educational status was found to significantly influence self-rated health in both SLÁN 2002 (χ^2 (8, n = 1564) = 101.35, p = 0.000) and SLÁN 1998 (χ^2 (8, n = 1470) = 56.75, p = 0.000). The trends are similar to those found in the social class data. In both surveys, older adults in the ED1 category are less likely to rate their health as excellent, very good or good and most likely to rate their health as fair or poor.

The standardised residuals (Table 6.2) for both SLÁN 2002 and SLÁN 1998 also reveal a similar pattern to those observed in Section 6.1.2. Older adults with either no formal education, a primary education or some secondary education are under-represented in the excellent and very good health categories and over-represented in the fair and poor health categories.

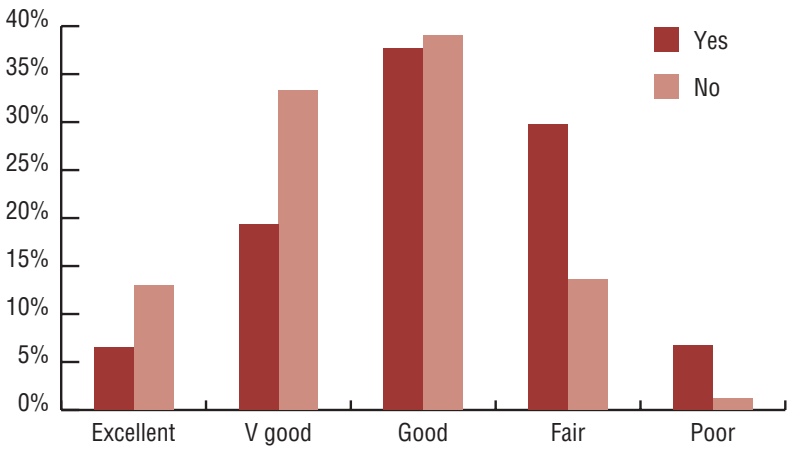
Table 6.2: Standardised residuals for educational status and self-rated health

	ED1		ED2		ED3	
	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998
Excellent	-2.5	-2.0	2.9	1.1	2.4	4.4
Very good	-2.7	-1.4	1.6	2.4	4.2	1.4
Good	0.0	-0.2	0.7	0.2	-0.8	0.2
Fair	3.0	1.9	-3.1	-2.2	-3.4	-3.1
Poor	2.6	1.0	-2.8	-1.4	-2.7	-1.3

6.1.4 Self-rated Health and Medical Card Status

Medical card status was found to have a significant influence on self-rated health for SLÁN 2002 (χ^2 (4, n = 1606) = 113.24, p = 0.000) and is illustrated in Figure 6.6. Those in possession of a medical card are less likely to rate their health as excellent, very good and good and more likely to rate it as fair or poor.

Figure 6.6: Self-rated health and medical card status (SLÁN 2002)



6.2 Mental Health

Table 6.3 displays the percentage of respondents who self-reported as being depressed or not depressed. Although approximately 25 per cent reported moderate or extreme depression (SLÁN 2002), though only 7.3 per cent had had this diagnosis confirmed by a doctor (Section 6.5). A similar trend is observed in both SLÁN 1998 and the HeSSOP study (Garavan *et al.,* 2001), in which 6 per cent reported being clinically anxious or depressed.

There is a decrease over time in the percentage of respondents reporting moderate and extreme depression, as well as diagnosed depression. This positive finding is supported by figures showing that 2.1 per cent and 1.7 per cent (SLÁN 1998 and SLÁN 2002 respectively) are attending mental health services for regular checks. Gender, social class, educational status and age group are not statistically significant factors contributing to anxiety or depression.

Table 6.3: Reported anxiety/depression levels (SLÁN 2002 and SLÁN 1998)

	SLÁN 2002		SLÁN 1998	
	Frequency	Percentage	Frequency	Percentage
Not anxious or depressed	1,121	74.98%	960	67.46%
Moderately anxious or depressed	353	23.61%	425	29.87%
Extremely anxious or depressed	21	1.40%	38	2.67%
Total	1,495	100%	1,423	100%

6.3 Dental Health

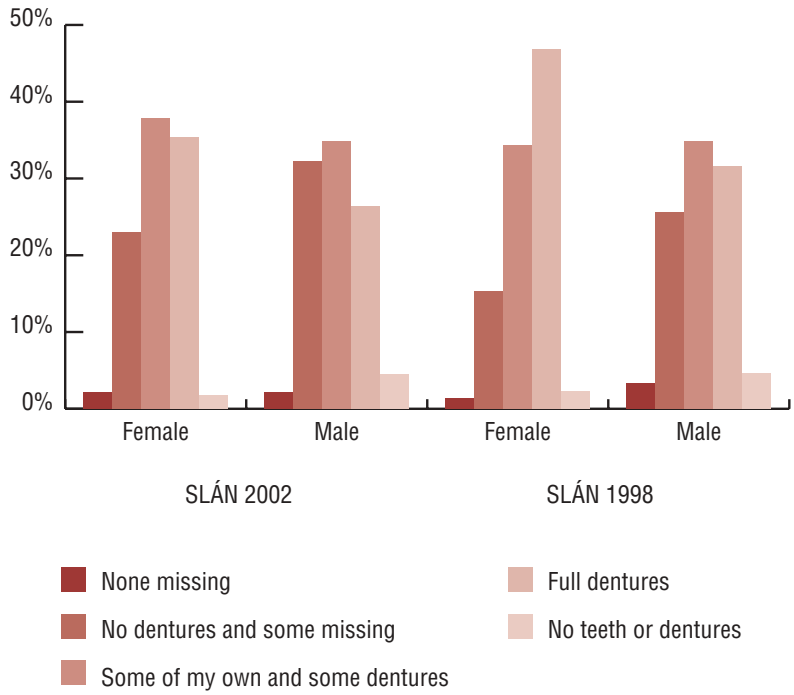
Table 6.4 presents the data on respondents' dental health status. There are small but significant differences in the numbers of respondents with full dentures and no teeth missing. While in SLÁN 1998 the majority of respondents reported having full dentures, this figure decreases in SLÁN 2002, in which the majority reported having some dentures and some of their own teeth.

Table 6.4: Respondents' dental health status (SLÁN 2002 and SLÁN 1998)

	SLÁN 2002		SLÁN 1998	
	Frequency	Percentage	Frequency	Percentage
No teeth missing	39	2.3%	36	2.3%
Some teeth/no dentures	466	27.3%	320	20.1%
Some teeth/some dentures	619	36.3%	550	34.6%
Full dentures	533	31.2%	631	39.7%
No teeth or dentures	50	3.0%	54	3.4%
Total	1,707	100%	1,591	100%

In both surveys, these results mask some gender differences (Figure 6.7) with women significantly more likely to have full dentures in both SLÁN 2002 (χ^2 (4, n = 1693) = 35.07; p = 0.000) and SLÁN 1998 (χ^2 (4, n = 1589) = 57.82; p = 0.000). Men are significantly more likely to have no teeth missing or some teeth missing and no dentures.

Figure 6.7: Dental health status (SLÁN 2002 and SLÁN 1998)



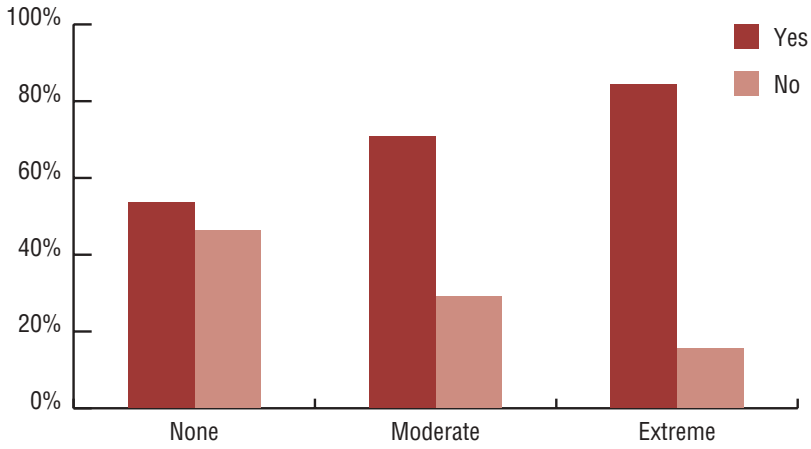
6.4 Pain or Discomfort

The percentages of those experiencing pain or discomfort have not changed over time, with more than 50 per cent of older adults experiencing extreme or moderate pain. Gender is seen as a statistically significant factor in SLÁN 1998 (χ^2 (2, n = 1470) = 16.46; p = 0.000), with 5.1 per cent of women and 2.1 per cent of men experiencing extreme pain or discomfort, and 50.1 per cent of women and 44.8 per cent of men experiencing pain or discomfort. Though more women than men are found in the moderate (48.7 per cent women; 47.1 per cent men) and extreme (4.6 per cent women; 3.8 per cent men) categories in SLÁN 2002, this is not statistically significant.

For SLÁN 2002, pain or discomfort was also found to be associated with medical

card status. Those people suffering extreme and moderate pain are more likely to hold a medical card (Figure 6.8).

Figure 6.8: Pain/discomfort by medical card status (SLÁN 2002)



Social class was not found to influence pain or discomfort but educational status did emerge as statistically significant (χ^2 (4, n = 1433) = 16.55; p = 0.002). Those in the ED1 category are more likely to experience extreme or moderate pain or discomfort (Table 6.5).

Table 6.5: Pain/discomfort by educational status (SLÁN 2002)

	ED1	ED2	ED3
Extreme pain/discomfort	5.4%	1.8%	1.8%
Moderate pain/discomfort	50.5%	46.3%	43.9%
No pain/discomfort	44.1%	51.8%	54.3%
Total	100%	100%	100%

6.5 Prevalence of Illness

Respondents were asked if, according to a doctor, they had any of the illnesses listed in Table 6.6. High blood pressure and high cholesterol are the most common illnesses reported, followed by angina. There was no decrease over time. Reported high cholesterol levels have increased most significantly, but this is most likely due

to improved detection as outlined in the National Cardiovascular Strategy. Diabetes levels have also increased fractionally.

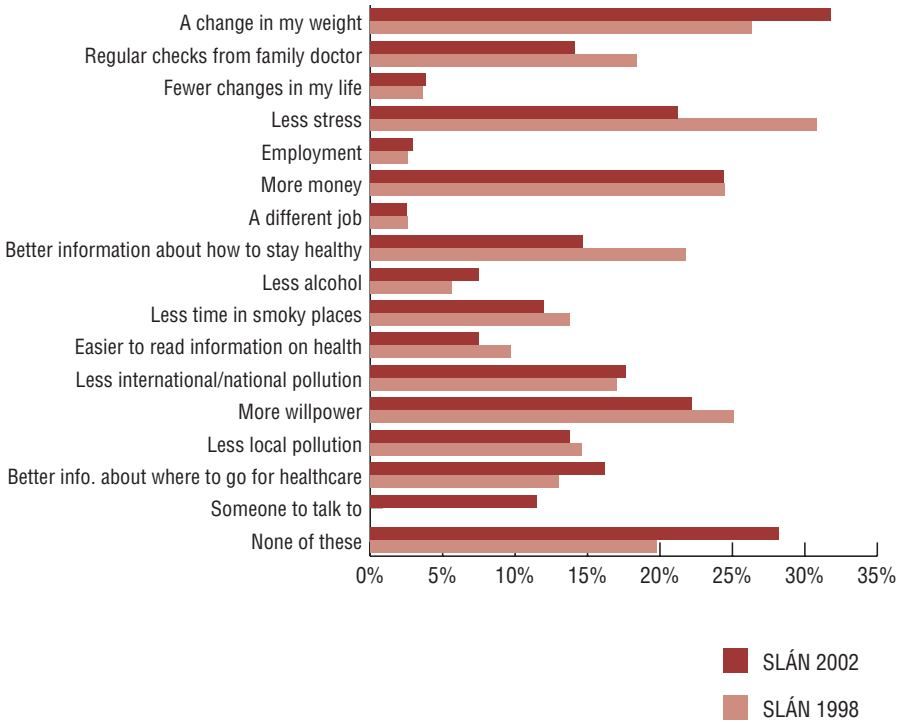
Table 6.6: Illnesses diagnosed by GP (SLÁN 2002 and SLÁN 1998)

	SLÁN 2002 (n = 1,745)	SLÁN 1998 (n = 1,634)
Angina	10.7%	10.8%
Heart attack	6.4%	5.9%
High blood pressure	28.8%	28.3%
Stroke	3.0%	3.4%
Diabetes	6.4%	5.4%
High cholesterol	16.4%	11.9%
Anxiety	8.8%	10.0%
Depression	7.3%	7.9%
Other	8.9%	1.4%

6.6 Obstacles to Health Improvement

Respondents were asked what they would need to improve their own health. A new category of 'someone to talk to' was added to the questionnaire for SLÁN 2002, therefore, results for SLÁN 1998 are not directly applicable. Figure 6.9 presents the findings from both surveys. While 'a change in my weight' was second to 'less stress' in 1998, it supersedes this category in 2002. A larger percentage of respondents in 2002 reported that none of the categories were relevant to them. Consistently important factors appear to be more money and willpower. These findings are in keeping with the general adult population.

Figure 6.9: Responses to 'I think my own health would be better if I had...' (SLÁN 2002 and SLÁN 1998)



6.7 Multivariate Analysis

6.7.1 Self-rated Health (SLÁN 2002 and SLÁN 1998)

In order to predict the determinants of self-rated health, the data from SLÁN 1998 and SLÁN 2002 was combined for the purposes of the multivariate analysis. In order to determine the covariates for the logistic regression, CatPCA was first conducted on groups of candidate variables including general health, lifestyle, demographics and social support. Three factors were extracted in each category (Appendix 1) and listed in the order of their extraction. More than three extracted demographic factors were included.

In the final model a binary logistic regression was conducted, with self-rated health as the dependent variable. This excludes social support factors, household net income, days of mental ill-health and use of salt while cooking; variables that are not available in SLÁN 1998. Self-rated health was dichotomised (excellent/very good/good versus fair/poor) and backward stepwise method was chosen. At each

step the variable with the smallest contribution to the model (or the largest *p*-value) was removed. Removal was set at 0.10. Table 6.7 shows the remaining factors (i.e. the predictors of self-rated health). The last category is referenced.

Respondents who rated themselves as not anxious or depressed or moderately anxious or depressed are significantly more likely to rate their health as excellent, very good or good than those who are extremely depressed. Those who are not very satisfied with their health, who seldom or never do heavy housework and who hold a medical card are less likely to rate their health favourably. As age increases, older adults are less likely to rate their health favourably. Those with primary, some secondary or complete secondary education are less likely to rate their health as excellent, very good or good than those with complete tertiary education. Those with some tertiary education are more likely to rate their health favourably than those with complete tertiary education. Those who do not smoke are more likely to rate their health favourably. As the number of days a person takes moderate exercise increases, respondents are more likely to rate their health favourably. Those who have a medical card are less likely to rate their health favourably.

Table 6.7: Logistic regression and determinants of self-rated health (SLÁN 2002 and SLÁN 1998)

Covariates		Estimates	S.E.	Wald	df	*p*	OR
Anxiety/ depression				5.390	2	0.068	
	Not anxious	0.806	0.768	1.100	1	0.294	2.238
	Moderately	0.336	0.767	0.192	1	0.661	1.400
	Extremely						
Health satisfaction				138.341	4	0.000	
	Very dissatisfied	-4.783	0.853	31.412	1	0.000	0.008
	Dissatisfied	-5.116	0.771	44.019	1	0.000	0.006
	Neither satisfied nor dissatisfied	-3.722	0.742	25.182	1	0.000	0.024
	Satisfied	-2.038	0.730	7.782	1	0.005	0.130
	Very satisfied						
Heavy household work				9.540	4	0.049	
	Seldom/never	-0.833	0.293	8.103	1	0.004	0.435
	1 to 3 times per month	-0.118	0.407	0.084	1	0.772	0.889

Covariates		Estimates	S.E.	Wald	df	*p*	OR
	Once per week	-0.353	0.283	1.551	1	0.213	0.703
	3 to 4 times per week	-0.245	0.377	0.422	1	0.516	0.783
	Most days						
Education				25.279	4	0.000	
	Primary only	-1.237	0.390	10.051	1	0.002	0.290
	Some secondary	-0.485	0.409	1.406	1	0.236	0.616
	Complete secondary	-0.267	0.445	0.362	1	0.547	0.765
	Some tertiary	0.394	0.583	0.458	1	0.498	1.484
	Complete tertiary						
Smoking				5.305	2	0.070	
	No	0.438	0.248	3.129	1	0.077	1.549
	Yes, occasionally	-0.529	0.629	0.706	1	0.401	0.589
	Yes, regularly						
Age		-0.024	0.012	3.713	1	0.054	0.977
No. of days' moderate exercise		0.107	0.051	4.440	1	0.035	1.113
Medical card status	Yes	-0.725	0.222	10.615	1	0.001	0.485
	No						
Model Chi square 412.260 df = 19 p = 0.000							
Model n 995 Nagelkerke R square = 0.506							

6.7.2 Self-rated Health (SLÁN 2002)

A binary logistic regression was also carried out on the SLÁN 2002 data only. Self-rated health as the dependent variable was dichotomised as before. Factors included were the same as those in Section 6.7.1 with the addition of social support, household net income, salt used in cooking and anxiety or depression variables. Backward stepwise method was chosen. At each step the variable with the smallest contribution to the model (or the largest p-value) was removed. Removal was set at 0.10. Table 6.8 shows the remaining factors.

The final model was similar to that above with the exclusion of medical card status and the inclusion of household net income, how often salt is used when cooking and 'regularly join in sports clubs' variables. People who class themselves as not anxious or depressed, or moderately so, are more likely than those who are extremely depressed to rate their health as excellent, very good or good. Those who are very satisfied with their health and in the tertiary education category are more likely to rate their health favourably. The less often someone does heavy household work, the more likely it is that their health is rated as fair or poor. As age increases, older adults are less likely to rate their health favourably. The categories within household net income are not statistically significant, but the general trend is for a lower income to indicate a lower health satisfaction. Those who always, usually or sometimes use salt when cooking are also less likely to rate their health favourably. Finally, those who do not regularly attend sports clubs are less likely to rate their health as excellent, very good or good.

Table 6.8: Logistic regression and determinants of self-rated health (SLÁN 2002 only)

Covariates		Estimates	S.E.	Wald	df	*p*	OR
Anxiety/ depression				9.893	2	0.007	
	Not anxious/ depressed	4.845	1.541	9.886	1	0.002	127.145
	Moderately	4.808	1.580	9.264	1	0.002	122.503
	Extremely						
Health satisfaction				78.079	4	0.000	
	Very dissatisfied	-10.345	16.966	0.372	1	0.542	0.000
	Dissatisfied	-12.305	16.960	0.526	1	0.468	0.000
	Neither satisfied nor dissatisfied	-9.728	16.954	0.329	1	0.566	0.000
	Satisfied	-7.590	16.952	0.200	1	0.654	0.001
	Very satisfied						
Heavy household work				8.600	4	0.072	
	Seldom/never	-1.107	0.440	6.326	1	0.012	0.330
	1 to 3 times per month	-0.202	0.663	0.092	1	0.761	0.817
	Once per week	-0.284	0.455	0.390	1	0.532	0.753

Covariates		Estimates	S.E.	Wald	df	*p*	OR
	3 to 4 times per week	-0.950	0.563	2.583	1	0.091	0.387
	Most days						
Age		-0.053	0.019	7.830	1	0.005	0.948
Education				10.145	4	0.038	
	Primary only	-1.464	0.690	4.500	1	0.034	0.231
	Some secondary	-1.564	0.711	4.832	1	0.028	0.209
	Complete secondary	-0.927	0.717	1.673	1	0.196	0.396
	Some tertiary	-0.450	0.953	0.224	1	0.636	1.569
	Complete tertiary						
Household net income per week				12.285	5	0.031	
	<€130	-0.766	0.563	1.847	1	0.174	0.465
	€130 to €190	-0.769	0.514	2.238	1	0.135	0.463
	€190 to €260	-0.003	0.505	0.000	1	0.995	0.997
	€260 to €320	0.451	0.534	0.714	1	0.398	1.570
	€320 to €450	1.031	0.579	3.170	1	0.075	2.804
	>€450						
Use of salt when cooking				10.300	4	0.036	
	Always	-1.232	0.498	6.114	1	0.013	0.292
	Usually	-0.417	0.519	0.646	1	0.422	0.659
	Sometimes	-1.036	0.499	4.312	1	0.038	0.355
	Rarely	0.131	0.625	0.044	1	0.834	1.140
	Never						
Regularly join in sports clubs	No	-0.891	0.407	4.791	1	0.029	0.410
Model Chi square 272.398 df = 25 p = 0.000							
Model n 545 Nagelkerke R square = 0.608							

6.7.3 Mental Health

An ordinal regression was conducted with mental health as the dependent variable. The dependent variable had five categories: 0 days of poor mental health; 1 to 9 days of poor mental health; 10 to 19 days of poor mental health; 20 to 25

days of poor mental health; and 30 days of poor mental health. The selected covariates were f (self-rated health, activity or work affected by long-term illness or disability, high cholesterol, smoker or non-smoker, tranquillisers or sedatives with prescription, home ownership, eating more healthily, abstention from alcohol, medical card status, age, gender, social class groups, quality of life, educational status, health state, number of days per week that a respondent walks for more than 30 minutes).

The statistically significant factors in the final model are displayed in Table 6.9. The positive coefficients for quality of life indicate that as scores move from very good to very poor, the probability of mental health difficulties increases. Those owning their houses with a mortgage are more likely to have mental health difficulties than those owning their houses outright. This is also the case with those renting accommodation from a local council, but this did not attain statistical significance. Although all the coefficients for self-rated health are negative, the lower scores for the excellent category indicate that when health is rated as excellent, it decreases the probability of an increased number of days of mental illness. The negative coefficient for health state indicates that as the level of health on the scale decreases, a person is more likely to experience an increased number of days spent in poor mental health. The positive coefficient for the number of days per week a person walks for more than 30 minutes indicates that as this increases, the number of days spent in poor mental health is more likely to decrease.

Table 6.9: Ordinal regression and mental health (SLÁN 2002 and SLÁN 1998)

Covariates		Estimates	S.E.	Wald	df	*p*
Health state	0 = worst health 100 = best health	-0.01966	0.009	4.690	1	0.030
No. of days per week walk >30 mins		0.113	0.052	4.735	1	0.030
Self-rated health	Excellent	-2.581	0.934	7.645	1	0.006
	Very good	-2.256	0.777	8.433	1	0.004
	Good	-2.317	0.688	11.327	1	0.001
	Fair	-2.064	0.609	11.483	1	0.001
	Poor	0[a]				
Home ownership	Owned with mortgage	0.780	0.329	5.622	1	0.018
	Rented privately	0.307	0.491	0.392	1	0.531
	Rented from council	0.938	0.694	1.826	1	0.177
	Owned outright	0[a]				
Quality of life	Very good	2.658	1.275	4.348	1	0.037
	Good	2.575	1.221	4.445	1	0.035
	Neither poor nor good	3.452	1.207	8.182	1	0.004
	Poor	4.284	1.268	11.418	1	0.001
	Very poor	0[a]				
Model Chi square 124.591 df = 32 p = 0.000						
Model n 616 Nagelkerke R square = 0.264						

a. This parameter is set to zero because it is redundant.

Chapter Seven

Disability and Older People

Chapter Seven

Disability and Older People

7.1 Limitations in Daily Activities

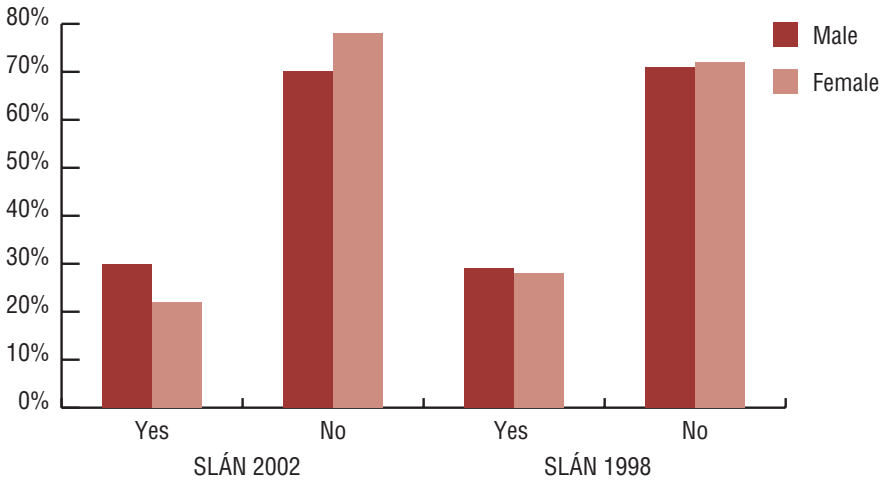
Respondents were asked if their work or daily activity is limited by a long-term illness, health problem or disability. 25.6 per cent of respondents for SLÁN 2002 reported that they are affected, which is a decrease from the 28.6 per cent reported in SLÁN 1998. Age was a significant influence in 1998 (χ^2 (6, n = 1439) = 21.33, p = 0.002) but not in 2002. Standardised residuals (Table 7.1) indicate that the younger categories (55-59 and 60-64 years) have an under-representation of respondents. However, as respondents get older, the reverse is true. Those aged 85 and over do not conform to the general trend.

Table 7.1: Standardised residuals for age groups by limitations in work or activity by ill-health

Age group	Affected	Not affected
55-59 years	-2.5	1.6
60-64 years	-1.4	0.9
65-69 years	0.4	-0.2
70-74 years	1.5	-0.9
75-79 years	1.8	-1.1
80-84 years	1.2	-0.8
85+ years	-0.1	0.1

By analysing men and women separately, it was observed for SLÁN 2002 that more men than women are affected by ill-health in their daily activity or work. A gender effect was not evident in 1998, that is, the distribution of men and women is similar for both categories.

Figure 7.1: Limitations in work or activity by gender (SLÁN 2002 and SLÁN 1998)



7.1.1 Relationship Between Limitations in Daily Activity and Self-rated Health

A significant correlation was found between self-rated health and limitations in daily activity by long-term illness or disability for SLÁN 2002 (χ^2 (4, n = 1612) = 574.44; p = 0.000), as shown in Table 7.2.

Of those rating their health as excellent, 99.3 per cent said their daily activity is not affected by ill-health. Similarly, 94 per cent of those rating their health as very good are also unaffected. Of those rating their health as poor, 97.2 per cent said they are affected by ill-health. The data was further explored by splitting the file by age group. Percentages similar to those reported in Table 7.2 were observed for each age category and all Chi squared tests were statistically significant (p = 0.000).

Table 7.2: Self-rated health and limitations of work or activity by ill-health (SLÁN 2002)

Self-rated health	Affected	Not affected
Excellent	0.7%	99.3%
Very good	6.0%	94.0%
Good	15.7%	84.3%
Fair	58.9%	41.1%
Poor	97.2%	2.8%
Total	25.7%	74.3%

7.1.2 Relationship Between Limitations in Daily Activity, Social Class, Educational Status and Medical Card Status

For SLÁN 2002, it was noted that social class is associated with a person's work or daily activity being affected by long-term illness, health problems or disability (χ^2 (2, n = 1045) = 10.02; p = 0.007), as shown in Table 7.3. In category SC1-2 there is an under-representation of respondents whose work or activity is limited by ill-health but there is an over-representation in category SC5-6. This situation is reversed for those whose work or activity is not limited by ill-health.

Table 7.3: Social class and limitations of work or activity by ill-health (standardised residuals in italics)

Social class	Affected	Not affected
SC1-2	21.0%	79.0%
	-1.5	*0.9*
SC3-4	24.5%	75.5%
	0.0	*0.0*
SC5-6	32.4%	67.6%
	2.3	*-1.3*
Total	24.6%	75.4%

Table 7.4 shows those affected and not affected by ill-health in terms of educational status. Educational status significantly influences a person's work or daily activity being affected by long-term illness, health problems or disability (χ^2 (2, n = 1495) = 10.58; p = 0.005). 22 per cent of those in the ED3 category are affected by ill-health, but the standardised residual shows that this is an under-representation. Conversely, the standardised residual for the ED1 category shows that there is an over-representation of respondents whose work or daily activity is affected by ill-health. These trends are similar to those observed for social class.

Table 7.4: Educational status and limitations of work or activity by ill-health (standardised residuals in italics)

Educational status	Affected	Not affected
ED1	28.2%	71.8%
	1.5	*-0.9*
ED2	18.9%	81.1%
	-2.1	*1.2*
ED3	22.0%	78.0%
	-1.1	*0.7*
Total	24.6%	75.4%

Possession of a medical card is influenced by long-term illness or disability (χ^2 (1, n = 1526) = 47.23; p = 0.000). Of the respondents whose work or activity is limited by long-term illness or disability, 77.2 per cent hold a medical card. 57.7 per cent of those whose work is not limited by long-term illness or disability hold a medical card.

7.2 Mobility

Across both surveys, the majority of older adults (70 per cent) experience no difficulties walking about, a figure that has not changed over time. Just two respondents in 1998 and nine in 2002 were confined to bed. There is an association with age. Those experiencing some mobility problems increase with age and peak in the 75-79 years group. There is a decrease again in the 80-84 years and 85+ years groups. This is the case for both surveys.

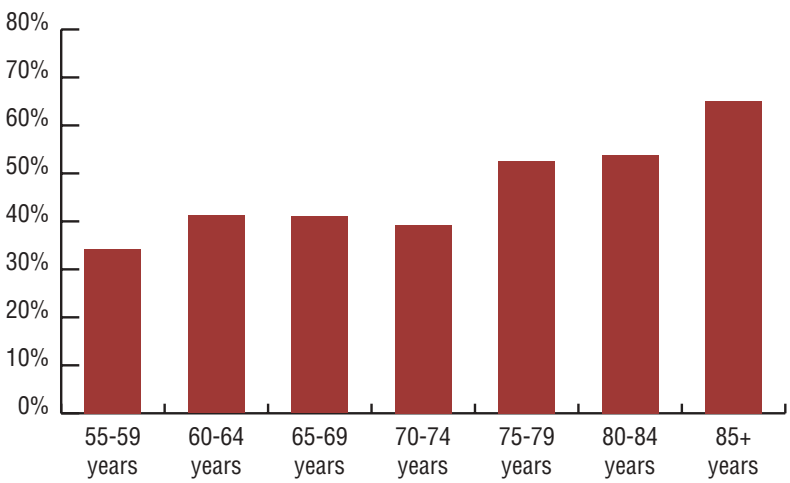
7.3 Visual Impairment (SLÁN 1998 Only)

Glasses or contact lenses are worn by 85.8 per cent (n = 1576) of respondents for all or some of the time, with some gender differences detected. More women (55.5 per cent) than men (44.5 per cent) wear glasses or contact lenses. While 5.3 per cent of respondents had never had an eyesight test, 47.9 per cent had undergone such a test between one and five years prior to the survey, and 35 per cent had undergone a test less than a year prior to the survey.

7.4 Hearing Impairment (SLÁN 1998 Only)

Almost half of the respondents (43.4 per cent) find it very difficult to follow a conversation if there is background noise, for example, a television, radio or children playing. There were no gender differences in this finding. However, hearing difficulties were found to increase significantly with age (χ^2 (12, n = 1634) = 67.73; p = 0.000), as shown in Figure 7.2. A general increase is noted over time, with notable hearing difficulties for those aged 75 years and over.

Figure 7.2: Proportion of respondents with hearing difficulties (SLÁN 1998)



Respondents were also asked if they could follow a television programme at a volume acceptable to others and without a hearing aid (Table 7.5). Over half the group recorded some level of difficulty with this task and one fifth recorded either great or moderate difficulty.

Table 7.5: Prevalence of difficulty in hearing without a hearing aid (SLÁN 1998)

	Percentage
Great difficulty	6.0%
Moderate difficulty	15.6%
Little difficulty	22.3%
No difficulty	56.2%

A gender effect is evident in this instance with more men than women experiencing great, moderate and little difficulty (χ^2 (3, n = 1569) = 13.83; p = 0.003). Consequently, more women experience no difficulty in following television programmes at a volume acceptable to others and without any hearing aid. A total of 6.8 per cent (44.9 per cent men; 55.1 per cent women) wear a hearing aid all or some of the time.

7.5 Multivariate Analysis

7.5.1 Disability

Binary logistic regression analysis was carried out taking disability (i.e., work or daily activity affected by long-term illness or disability) as the dependent variable. The selected covariates were f (mobility, self-care, usual activities, pain/discomfort, anxiety/depression, health state, quality of life, number of days when physical health not good, number of days when mental health not good, gender, education level, marital status, age, medical card status, social class, serious injury). Backward stepwise method was chosen and removal was set at 0.10.

The final model is displayed in Table 7.6. While each of the covariates is statistically significant at the 10 per cent significance level, not all categories within the covariates display significant *p* values. Those who rate their health as excellent, very good or good are less likely to be limited by long-term illness or disability than those who rate their health as poor. Those with moderate or no pain and with a high health score are significantly less likely to be limited in their daily work or activity. All age groups are significantly more likely than those aged 80 and over to be limited in their daily work or activity. Men are significantly more likely than women to be limited in their daily work or activity.

Table 7.6: Logistic regression and determinants of disability (SLÁN 2002 and SLÁN 1998)

Covariates		Estimates	S.E.	Wald	df	*p*	OR
Self-rated health				20.039	4	0.000	
	Excellent	-10.420	16.740	0.387	1	0.534	0.000
	Very good	-9.147	16.703	0.300	1	0.584	0.000
	Good	-8.878	16.700	0.283	1	0.595	0.000
	Fair	-7.576	16.700	0.206	1	0.650	0.001
	Poor						
Mobility				13.401	2	0.001	
	No problem walking	-7.969	30.905	0.066	1	0.797	0.000
	Some problems	-6.775	30.904	0.048	1	0.826	0.001
	Confined to bed						
Usual activities				38.695	2	0.000	
	No problem	-9.665	18.733	0.266	1	0.606	0.000
	Some problems	-7.628	18.733	0.166	1	0.684	0.000
	Unable to perform						
Pain/discomfort				5.830	2	0.054	
	No pain/discomfort	-3.695	1.578	5.484	1	0.019	0.025
	Moderate pain/ discomfort	-3.431	1.580	4.718	1	0.030	0.032
	Extreme pain/discomfort						
Health state	0 = worst health 100 = best health	-0.030	0.011	7.261	1	0.007	0.970
Age group				12.289	5	0.031	
	55-59 years	1.228	0.533	5.307	1	0.021	3.415
	60-64 years	1.607	0.535	9.019	1	0.003	4.986
	65-69 years	0.949	0.570	2.771	1	0.096	2.582
	70-74 years	0.334	0.557	0.360	1	0.548	1.397
	75-79 years	0.980	0.578	2.875	1	0.090	2.664
	80+ years						
Gender	Male	0.554	0.281	3.879	1	0.049	1.740
	Female						
Model Chi square 416.103 df = 17 p = 0.000							
Model n 719 Nagelkerke R square = 0.662							

Chapter Eight

Quality of Life and Older People

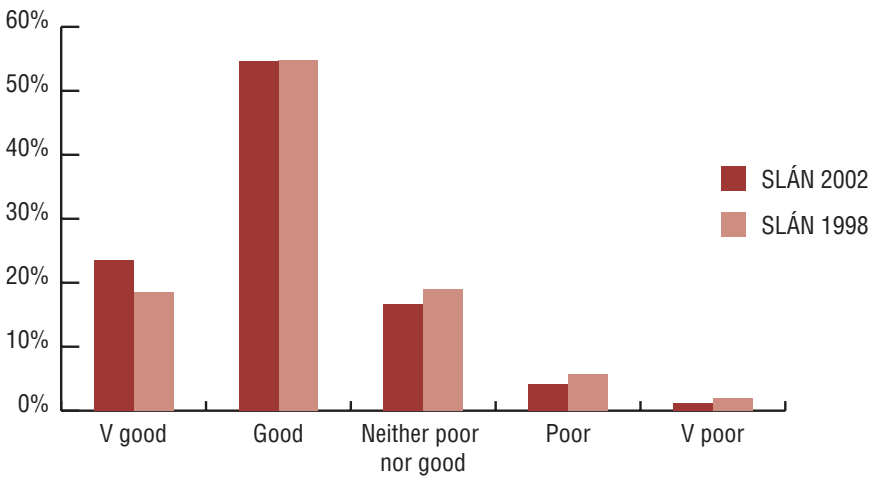
Chapter Eight

Quality of Life and Older People

8.1 Quality of Life

Quality of life has increased between the two surveys, with a significant increase of more than 7 per cent in those rating their quality of life as very good (Figure 8.1). Overall, 78.1 per cent rate of respondents reported their quality of life as very good or good in 2002 compared to 73.3 per cent in 1998.

Figure 8.1: Distribution of quality of life ratings (SLÁN 2002 and SLÁN 1998)



A significant age effect was seen in both SLÁN 2002 (χ^2 (42, n = 1711) = 54.65; p = 0.000) and SLÁN 1998 (χ^2 (24, n = 1540) = 48.59; p = 0.002), as shown in Table 8.1. Only small proportions rate their quality of life as poor or very poor in both surveys. SLÁN 2002 shows that very good quality of life is similar for all groups aged 60 and over. The 55-59 years group is also more likely to rate quality of life as very good. In both surveys, those aged 85 and over do not follow this age-related trend.

Table 8.1: Percentage of respondents to quality of life by age category (SLÁN 2002 and SLÁN 1998)

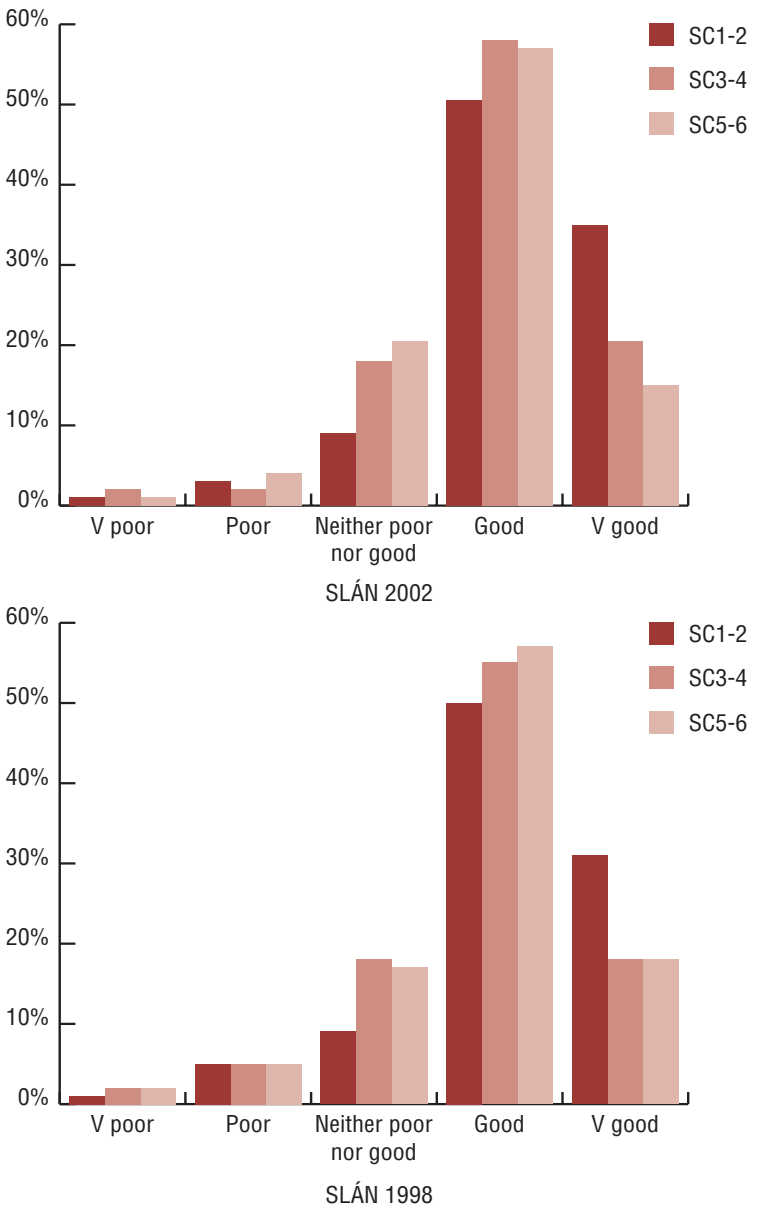
Age group	Quality of life (SLÁN 2002)					
	Very poor	Poor	Neither poor nor good	Good	Very good	Total
55-59 years	0.0%	2.7%	14.7%	53.0%	29.6%	100%
60-64 years	2.1%	3.2%	20.1%	53.0%	21.6%	100%
65-69 years	2.6%	2.9%	12.5%	55.1%	26.8%	100%
70-74 years	0.4%	5.5%	12.5%	59.2%	22.4%	100%
75-79 years	0.4%	3.5%	21.3%	54.7%	20.1%	100%
80-84 years	1.45%	8.2%	15.6%	57.1%	17.7%	100%
85+ years	1.3%	6.0%	22.8%	49.0%	20.8%	100%
Age group	Quality of life (SLÁN 1998)					
	Very poor	Poor	Neither poor nor good	Good	Very good	Total
55-59 years	0.7%	4.7%	12.8%	61.3%	20.5%	100%
60-64 years	1.3%	4.4%	19.1%	49.7%	25.5%	100%
65-69 years	3.0%	6.6%	19.2%	51.3%	19.9%	100%
70-74 years	2.8%	4.4%	20.1%	57.8%	14.9%	100%
75-79 years	0.9%	6.6%	22.6%	56.6%	13.3%	100%
80-84 years	4.1%	7.3%	24.4%	52.8%	11.4%	100%
85+ years	2.6%	10.5%	19.7%	50.0%	17.1%	100%

8.2 Quality of Life and Gender

In relation to quality of life no gender differences were evident in SLÁN 1998. In 2002, women were more likely to rate their quality of life as very good while men were more likely to rate theirs as either good or neither poor nor good (χ^2 (4, n = 1698) = 21.26; p = 0.000).

The social class of respondents is also an influence on quality of life in both SLÁN 2002 (χ^2 (8, n = 1082) = 54.60; p = 0.000) and SLÁN 1998 (χ^2 (8, n = 647) = 18.85; p = 0.016). People in category SC1-2 are more likely to rate their quality of life as very good and less likely to rate it as very poor than those in categories SC3-4 or SC5-6. The trends vary with other quality of life categories. In 2002 older adults in SC3-4 were more likely to report their quality of life as good.

Figure 8.2: Quality of life by social class (SLÁN 2002 and SLÁN 1998)



Educational status is also an influence on quality of life in both SLÁN 2002 (χ^2 (8, n = 1561) = 74.47; p = 0.000) and SLÁN 1998 (χ^2 (8, n = 1459) = 83.36; p = 0.000). Those in the ED3 category are more likely to rate their quality of life as very good while those classed as ED1 are more likely to dominate each of the other quality of life categories.

8.4 Quality of Life and Self-rated Health

While quality of life could be expected to relate to self-rated health, they are two different concepts. Table 8.2 demonstrates that there is relatively little overlap. Overall, 388 older adults (23 per cent) rated their health and quality of life comparably.

Table 8.2: Quality of life and self-rated health cross-tabulation (SLÁN 2002)

Quality of life	Self-rated health					
	Excellent	Very good	Good	Fair	Poor	Total
Very good	92	204	83	15	0	394
Good	61	191	468	183	9	912
Neither poor nor good	1	13	72	167	27	280
Poor	0	3	11	23	32	69
Very poor	1	4	3	1	10	19
Total	155	415	637	389	78	1,674

There is an association between the measures of self-rated health and quality of life, but how well they agree is not evident. Spearman's rank correlation (Spearman's ρ or rho) was calculated as 0.60 (n = 1674), p = 0.001. An explained variance of 36 per cent indicates that the agreement between both measures is only fair to moderate. The results for SLÁN 1998 are similar to those reported above.

8.5 Quality of Life and Medical Card Status

Possession of a medical card is also an influence on quality of life (χ^2 (4, n = 1604) = 90.53; p = 0.000). Those with a medical card are more likely to rate their quality of life as neither poor nor good or poor; those not holding a card are more likely to rate it as very good.

8.6 Multivariate Analysis

8.6.1 Quality of Life (SLÁN 2002 and SLÁN 1998)

Two separate binary logistic regressions were conducted as not all variables were available in SLÁN 1998. Quality of life was the dependent variable for both, that is, the merged data (SLÁN 2002 and SLÁN 1998, excluding social support, household net income, number of days spent mentally unwell and salt use while cooking) and the SLÁN 2002 data (all variables included). CatPCA was used to determine the covariates. Quality of life was dichotomised (very good or good versus neither poor nor good, poor or very poor) and backward stepwise method was chosen. The full model is thus fitted, including all the variables, and insignificant variables are removed one at a time until all those remaining in the model contribute significantly.

Table 8.3 displays the determinants of quality of life on the merged data for both surveys. As age increases, people are more likely to rate their quality of life as very good or good. Those who are not anxious or depressed, or moderately anxious or depressed, are more likely to rate quality of life favourably than those who are extremely depressed. Those who rate their health favourably, do not live alone and do not have a medical card, are more likely to rate quality of life as very good or good. Those who do not do heavy housework on most days of the week are less likely to rate quality of life favourably.

Table 8.3: Logistic regression and determinants of quality of life (SLÁN 2002 and SLÁN 1998)

Covariates		Estimates	S.E.	Wald	df	*p*	OR
Age		0.031	0.013	6.148	1	0.013	1.032
Anxiety/ depression				39.427	2	0.000	
	Not anxious/ depressed	1.361	0.688	3.920	1	0.048	3.902
	Moderately	0.120	0.691	0.030	1	0.862	1.127
	Extremely						
Self-rated health				93.417	4	0.000	
	Excellent	4.472	0.825	29.421	1	0.000	87.567
	Very good	4.288	0.692	38.448	1	0.000	72.844
	Good	3.785	0.658	33.128	1	0.000	44.048
	Fair	2.275	0.651	12.218	1	0.000	9.732
	Poor						
Heavy household work				15.271	4	0.004	
	Seldom/never	-0.975	0.302	10.442	1	0.001	0.377
	1 to 3 times per month	-0.515	0.412	1.563	1	0.211	0.598
	Once per week	-0.221	0.300	0.543	1	0.461	0.802
	3 to 4 times per week	-0.867	0.359	5.827	1	0.016	0.420
	Most days						
Medical card status	Yes	-0.679	0.223	9.295	1	0.002	0.507
	No						
Living alone	No	0.538	0.213	6.345	1	0.012	1.712
	Yes						
Model Chi square 292.073 df = 13 p = 0.000							
Model n 1006 Nagelkerke R square = 0.401							

8.6.2 Quality of Life (SLÁN 2002)

Table 8.4 presents the determinants of quality of life for the 2002 data only. In addition to the covariates mentioned above, household net income, social support factors, number of days mentally unwell and salt use when cooking were included. Five significant factors remain in the final model. As the number of days of poor mental health increase, older adults are less likely to rate their quality of life as very good or good. Those who rate their health as excellent, very good, good and fair are more likely to rate their quality of life as very good or good than those who rate their health as poor. The odds increase as health rating increases. Those in a rural location and who do not join in sports clubs are less likely to rate their quality of life favourably. As age increases, quality of life is more likely to increase.

Table 8.4: Logistic regression and determinants of quality of life (SLÁN 2002)

Covariates		Estimates	S.E.	Wald	df	*p*	OR
Days of mental health not good		-0.137	0.031	19.880	1	0.000	0.872
Self-rated health				51.401	4	0.000	
	Excellent	11.120	14.858	0.560	1	0.454	67474.903
	Very good	5.073	1.201	17.827	1	0.000	159.588
	Good	4.238	1.143	13.740	1	0.000	69.286
	Fair	2.290	1.131	4.104	1	0.043	9.877
	Poor						
Rural/urban setting	Rural	-0.680	0.334	4.135	1	0.042	0.507
	Urban						
Age		0.034	0.019	3.100	1	0.078	1.034
Regularly join in sports clubs	No	-0.759	0.438	3.002	1	0.083	0.468
	Yes						
Model Chi square 147.875 df = 8 p = 0.000							
Model n 463 Nagelkerke R square = 0.461							

Chapter Nine

Environments Supportive of Healthy Ageing

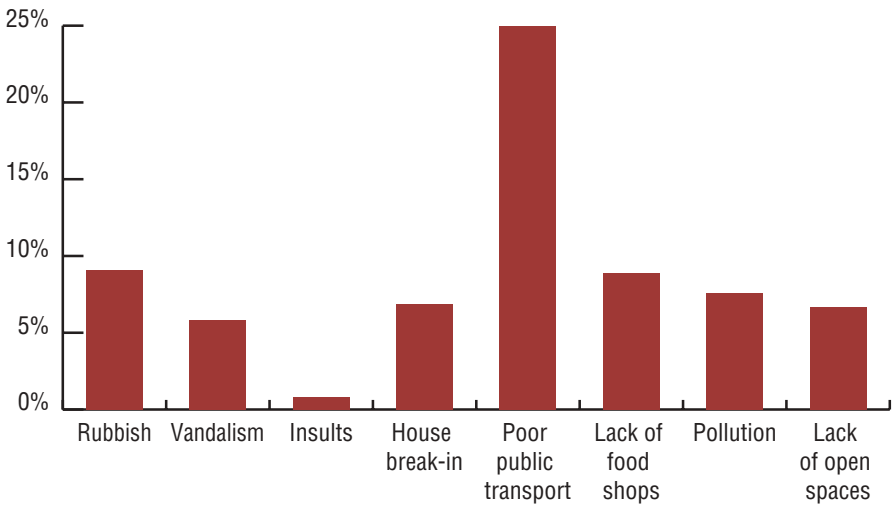
Chapter Nine

Environments Supportive of Healthy Ageing

9.1 Physical Environment

Respondents were asked questions of particular significance to older people about their neighbourhoods. Responses were made on a three point Likert scale, from 'a big problem' to 'not a problem'. Figure 9.1 presents the percentages of respondents who rate each issue listed as being 'a big problem'.

Figure 9.1: Percentage of respondents rating issues in neighbourhood as 'a big problem' (SLÁN 2002)



Poor public transport was felt by 25 per cent of respondents to be the outstanding problem in their neighbourhoods. Rubbish or litter was considered the next biggest problem (9.1 per cent), followed by a lack of accessible food shops or supermarkets (8.9 per cent). In terms of issues that were considered a 'bit of a problem', house break-ins (32.8 per cent) and rubbish (32 per cent) were the two list items most frequently selected, followed by poor public transport (23.6 per cent). Neither social class nor educational status influenced these findings, but an age effect was evident (χ^2 (12, n = 1413) = 23.17; p = 0.026). The 55-59 and 60-64 years groups were more likely than the others to rate poor public transport as 'a big problem' (22.7 per cent and 19.5 per cent respectively).

9.1.1 Mode of Transport When Shopping

Very little changed between the 1998 and 2002 surveys with regard to the type of transport used when shopping. Cars are used by the majority of respondents (70 per cent), with a small increase noted between the two occasions of measurement. There is also a decrease in the numbers walking to the shops. Only a small minority use bicycles or public transport.

9.1.2 Food Shops or Supermarkets That Are Accessible

Finding easily accessible food shops or supermarkets was a big problem for 8.9 per cent of respondents, with 15.4 per cent saying it was a bit of a problem. Age was not a significant factor.

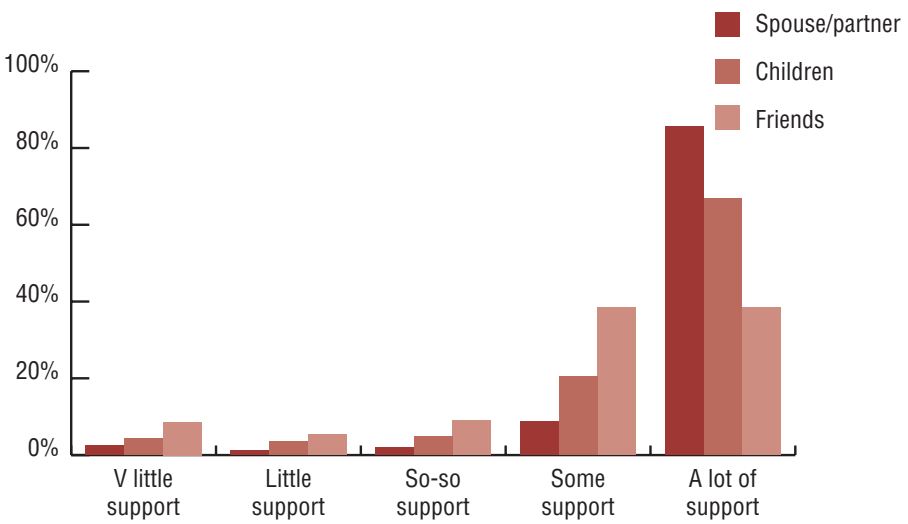
9.1.3 Areas Where Children Can Play Safely

When asked about children's play, 60.9 per cent of respondents reported that there are safe areas in their neighbourhoods, 20.2 per cent reported that there are not and 19 per cent said they didn't know. There was no gender difference, but there were variations due to social class (χ^2 (4, n = 1045) = 12.69; p = 0.013). Of those responding affirmatively, 47 per cent are classed as SC1-2 compared with just 17 per cent classed as SC5-6. Of those responding negatively, 38 per cent are in the SC1-2 category compared with 25.5 per cent in the SC5-6 category. Standardised residuals for the Chi squared test revealed an over-representation of positive responses and an under-representation of negative responses in the SC1-2 category. The opposite is true for those classed as SC5-6.

9.2.1 Social Support

Respondents were asked to rate the support they receive from their spouse or partner, children and friends (Figure 9.2). The largest response was in the 'a lot of support' category. Within this category, the greatest support comes from the spouse or partner. Only 2.5 per cent of older adults receive 'very little support' from their spouse or partner, with 85.7 per cent saying they receive 'a lot of support'. Children offer 'a lot of support' for 66.8 per cent, but 'very little', 'little' or 'so-so' support for 12.8 per cent. Friends gave either 'a lot' or 'some' support for 76.9 per cent of older people.

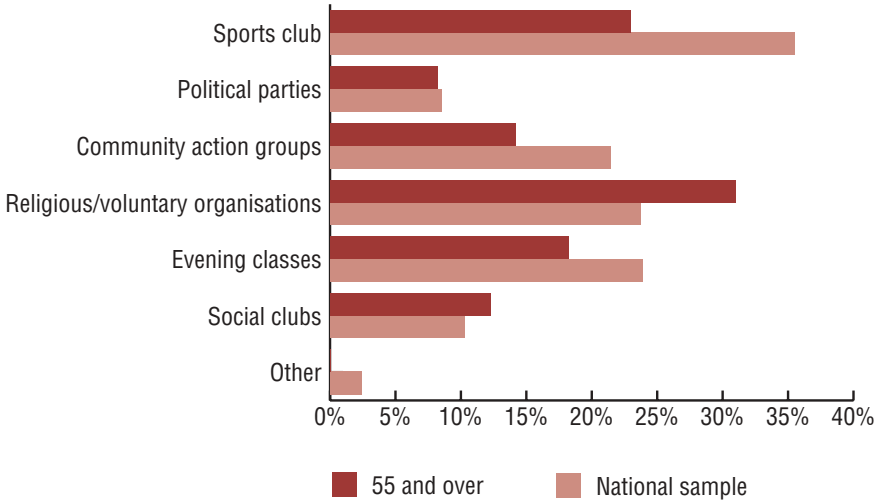
Figure 9.2: Social support (SLÁN 2002)



9.2.2 Social Engagement

Respondents were asked questions about social engagement. They were also asked if they attend sports clubs and community programmes in their local area. The proportion of participants involved in each activity or organisation is presented in Figure 9.3 and compared to the entire SLÁN 2002 sample. The highest participation rate for older adults is in religious or voluntary groups – a higher rate than in the national sample. Sports clubs are also popular but participation is not as high as in the entire sample.

Figure 9.3: Participation in activities and organisations (SLÁN 2002)

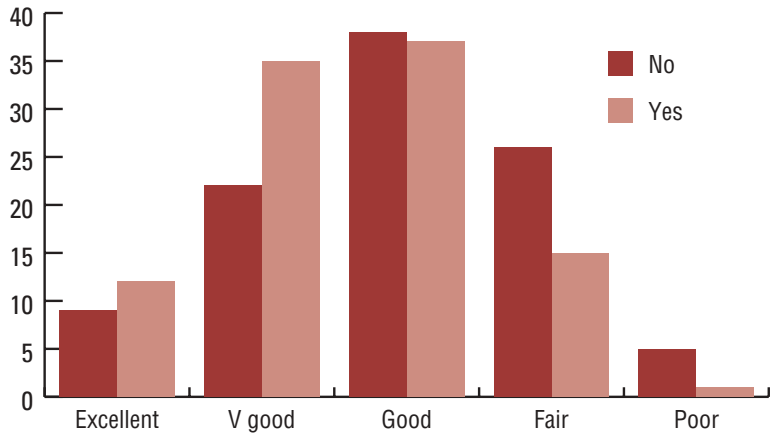


23 per cent of respondents said they regularly join in the activities of a sports club (e.g. GAA, parish or golf) and, of these, 84.9 per cent do so in their local area. 8.2 per cent of respondents are involved in a political party (83.9 per cent in the local area), while 14.2 per cent are actively involved in community action groups, such as Neighbourhood Watch (94.2 per cent in the local area). 31 per cent participate in the activities of church or religious groups and charitable or voluntary organisations (91.3 per cent in the local area), while evening classes, arts or music groups involve 18.2 per cent of respondents (77.6 per cent in the local area). Social clubs, such as the rotary club, involve 12.3 per cent of respondents (86.6 per cent of these clubs in the local area). Apart from bridge (n = 31), all other listed activities had less than four people in each category.

9.2.3 Self-rated Health and Membership of a Sports Club

Self-rated health was found to be associated with membership of a sports club (χ^2 (4, n = 1465) = 45.28; p = 0.000), as shown in Figure 9.4. Those who are members of a sports club rated their health higher (in the excellent and very good categories) than non-members. The reverse trend is observed in the fair and poor categories.

Figure 9.4: Membership of a sports club and self-rated health (SLÁN 2002)



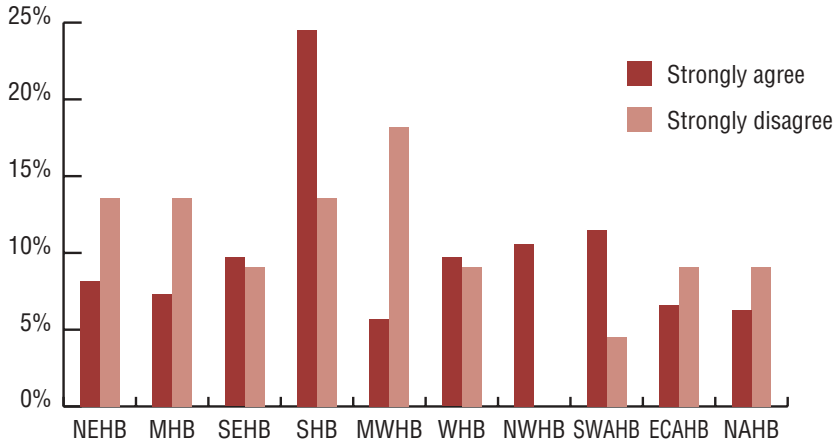
9.3 Social Capital

9.3.1 Most People Can Be Trusted

When it comes to matters of trust, 21.4 per cent of respondents strongly agreed that generally speaking, most people can be trusted: 55.9 per cent agreed and 1.4 per cent strongly disagreed. These responses were significantly related to whether the respondent lives in a rural or urban location (χ^2 (4, n = 1523) = 11.85; p = 0.018), with the greatest difference in the strongly agree category (18 per cent urban dwellers and 24 per cent rural dwellers).

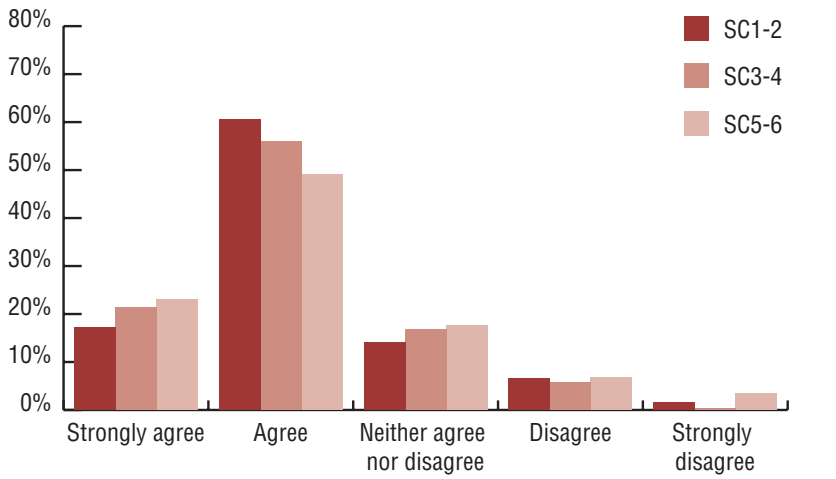
People's opinions on trust also vary by health board area. Figure 9.5 represents the strongly agree and strongly disagree categories only. Respondents from the SHB area have the highest percentage of those who strongly agree. Thereafter, the differences are slight. The MWHB area has the smallest percentage of those who strongly agree and the largest percentage of those who strongly disagree.

Figure 9.5: Most people can be trusted by health board area (SLÁN 2002)



Social class was also found to influence how people trust others generally (χ^2 (8, n = 1039) = 17.57; p = 0.025), as shown in Figure 9.6. Those in the SC5-6 category represent the largest percentage of those who strongly agree, followed by SC3-4 and SC1-2. The largest group is in the agree category, which is dominated by SC1-2.

Figure 9.6: Most people can be trusted by social class (SLÁN 2002)



Educational status was also found to significantly influence people's trust in others generally (χ^2 (8, n = 1480) = 16.05; p = 0.042). Those in the ED1 category are most likely to strongly agree while those in the ED2 category are most likely to agree.

Marital status was not found to be a significant factor in people's trust of others generally, but medical card status was found to be a factor (χ^2 (4, n = 1521) = 24.01; p = 0.000). Those with a medical card are more likely to strongly agree that most people can be trusted, while the opposite is true for those in the agree category.

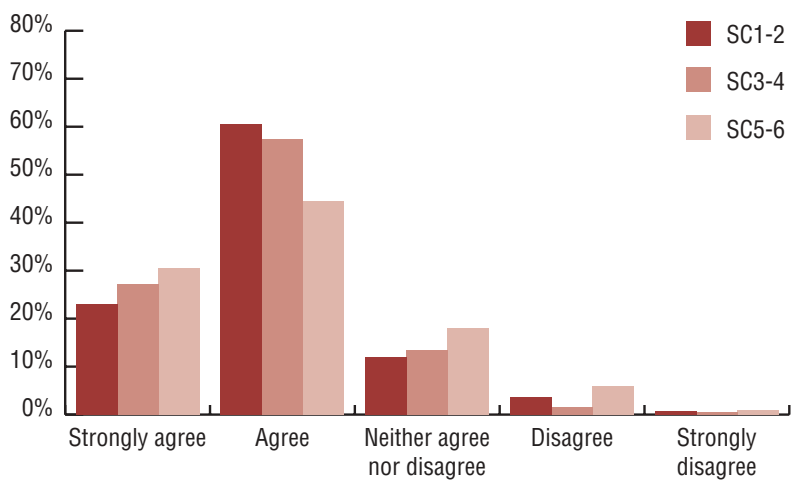
9.3.2 People in This Area Can Be Trusted

When asked if people in their area can be trusted, 28 per cent of respondents strongly agreed, 54.2 per cent agreed, 13.5 per cent neither agreed nor disagreed, 3.2 per cent disagreed and 0.8 per cent strongly disagreed. Living in a rural or urban location was found to influence people's opinions significantly (χ^2 (4, n = 1505) = 18.12; p = 0.001). Those in a rural location are more likely to strongly agree.

Variation in response was also noted according to health board area. The SHB area has the largest percentage of those who strongly agree. This was also the case for trust in people generally. In this instance, the SHB area also has the largest group of those who strongly disagree. This may be due to the rural and urban differences.

Social class was also found to significantly influence respondent's opinions regarding trust of people in their area (χ^2 (8, n = 1043) = 22.19; p = 0.005). As before (Figure 9.7), those in category SC5-6 are most likely and those in category SC1-2 least likely to strongly agree that people in their area can be trusted. The reverse is true for those who agree.

Figure 9.7: People in this area can be trusted by social class (SLÁN 2002)



A similar pattern emerged for educational status. Respondents with the least level of education are significantly more likely to strongly agree (χ^2 (8, n = 1459) = 16.18; p = 0.040). Those in the ED3 category are more likely to agree that people in their area can be trusted and they represent the largest group in the agree category.

Marital status was not found to significantly influence respondent's opinions regarding trust of people in their area whereas medical card status is a factor. Those with a medical card are more likely to strongly agree that people in their area can be trusted.

9.4 Multivariate Analysis

9.4.1 Trust in People Generally

A binary logistic regression was carried out on the SLÁN 2002 data with the dependent variable being trust in people generally. The covariates were gender, age, education, marital status, social class, housing tenure, medical card status and household net income. Backward stepwise method was chosen. Removal was set at 0.10. The last category is referenced in each case. The final model is displayed in Table 9.1. The predictors of trust in people generally are housing tenure and level of education. While not all categories are significant, a pattern does emerge. Those owning their houses with a mortgage and those who rent privately are less likely to trust in people generally than those owning their houses outright. Those who rent from the local council are more likely to trust in people generally than those owning their houses outright. Although the overall education level is statistically significant, none of the categories within it are significant. The general trend in the odds rations is that a lower level of education indicates less likelihood of trusting people generally. Those with complete secondary and some tertiary education are more likely to trust in people generally than those with complete tertiary education.

Table 9.1: Logistic regression and determinants of trust in people generally (SLÁN 2002)

Covariates		Estimates	S.E.	Wald	df	*p*	OR
Housing tenure				17.306	3	0.001	
	Owned with mortgage	-0.669	0.380	3.102	1	0.078	0.512
	Rented privately	-1.752	0.438	16.030	1	0.000	0.173
	Rented from council	0.206	1.054	0.038	1	0.845	1.228
	Owned outright						
Education				12.083	5	0.034	
	No schooling	-2.128	1.630	1.703	1	0.192	0.119
	Primary only	-0.354	0.527	0.451	1	0.502	0.702
	Some secondary	-0.905	0.528	2.943	1	0.086	0.405
	Complete secondary	0.971	0.752	1.668	1	0.197	2.641
	Some tertiary	0.026	0.761	0.001	1	0.973	1.026
	Complete tertiary						
Model Chi square 30.099 df = 8 p = 0.000							
Model n 622 Nagelkerke R square = 0.108							

9.4.2 Trust in People Locally

A binary logistic regression was carried using the same procedure mentioned above, with the dependent variable being trust in people locally. The covariates selected were gender, age, education, marital status, social class, housing tenure, medical card status and household net income. Removal was set at 0.10 and the last category is referenced. The final model is displayed in Table 9.2. The significant predictors of trust in people in a respondent's area are housing tenure and gender. Those who rent privately are less likely to trust people in their area than those owning their houses outright. While owning a house with a mortgage or renting from the local council is not statistically significant, the trend is the same. Gender is statistically significant at the 10 per cent significance level. Men are less likely than women to trust people in their area.

Table 9.2: Logistic regression and determinants of trust in people locally (SLÁN 2002)

Covariates		Estimates	S.E.	Wald	df	*p*	OR
Housing tenure				20.776	3	0.000	
	Owned with mortgage	-0.293	0.657	0.199	1	0.656	0.746
	Rented privately	-2.230	0.496	20.200	1	0.000	0.108
	Rented from council	-0.698	1.075	0.421	1	0.516	0.498
	Owned outright						
Gender	Male	-0.803	0.467	2.952	1	0.086	0.448
	Female						
Model Chi square 21.131 df = 4 p = 0.000							
Model n 649 Nagelkerke R square = 0.118							

Chapter Ten
Conclusions

Chapter Ten

Conclusions

In recent years social attitudes towards older people have changed, though some may argue not enough. A recent study by O'Shea (2003) on the future priorities for healthy ageing projects and services found that, in terms of priority needs, promotion of improved attitudes towards old age within society was ranked second only to social interaction and integration. Retirement is no longer seen as a preparation for decline. This shift in attitude is exemplified by the Council's own name change, from the National Council for the Elderly to the National Council on Ageing and Older People. Older people should no longer be seen as a burden on society but a resource of experience and wisdom. This report provides a detailed contemporary profile of the physical, social and mental well-being of older people in Ireland. A discussion of the key findings is carried out in the following sections.

10.1 Variation Between SLÁN 1998 and SLÁN 2002

There does not appear to be a huge variation between both occasions of measurement but some results are marked. The majority of older adults have none/primary/some secondary education only, which is indicative of the period prior to the *Free Education Act* (1967). The education level of this sample, therefore, may not be as important a predictor of disadvantage for the general contemporary population of younger adults. These are the last generations of Irish people reflecting this phenomenon.

There has been an expected increase in the numbers of medical card holders aged 55 and over. This effect is seen for the first time since the 2001 extension of eligibility for a non-means-tested medical card to all citizens aged 70 and over. However, this general trend masks some age differences. There is a decline in the numbers with medical cards in the 55-59, 60-64 and 65-69 years groups and a marked increase in the 70+ years groups.

Self-rated health is used as a proxy for health status (Manor *et al.,* 2002). In fact, in the current study, 99.3 per cent of those rating their health as excellent reported

being unaffected by ill-health. Between 1998 and 2002 overall self-rated health increased due to the greater numbers rating their health as excellent and very good. There was also a decrease in those rating their health as fair or poor. The figures on self-rated health reported in this study for those aged 55 and over (9.2 per cent excellent and 24.5 per cent very good) are similar to the findings in Census 2002 for those aged over 65 years, in which 8 per cent regarded their health as excellent and 21.7 per cent regarded it as very good. Fahey and Murray (1994) also reported health ratings for those over the age of 65. They found that 67 per cent of this population rated their health as either very good or good. In SLÁN 2002, excellent, very good and good ratings constitute 71.6 per cent of those aged 55 and over. Given that self-rated health and quality of life are highly correlated, quality of life also significantly improved between 1998 and 2002. These particular older adults are more likely to be found in the SC1-2 or ED3 categories. These are similar findings to those for self-rated health.

Since 1998, there has been a one per cent rise in reported levels of diabetes. There is also an increase in people diagnosed with high cholesterol levels (from 11.9 per cent to 16.4 per cent), a rise that may be attributable to improved screening services and public awareness. Rates for diseases, such as stroke and angina, remain largely unchanged. There has been a 1.8 per cent increase in the numbers driving a car after drinking two or more alcoholic drinks. The 55-64 years group is most likely to drink and drive.

The proportion of homeowners has decreased over time (by 10 per cent) though there are significantly more homeowners in rural areas. This decrease coincides with a decline in the numbers living in detached homes and an increase in those living in semi-detached and terraced houses or apartment blocks. There is also a rise in those renting from a local council. To some degree this may reflect differences in the sample. However, a deeper consideration of the causes and implications of this phenomenon is warranted. Do these changes reflect natural downsizing? Are people selling their homes to release capital or to pay for care? And what are the implications for the increased numbers in the rental sector with regards to housing conditions, security of tenure and the health of older people?

There is a decrease in reported injury over time and this is not influenced by gender. There is an increase in the percentage of those taking prescribed pills or medication (from 60.6 per cent to 67.2 per cent). Reported levels of moderate and extreme levels of depression have decreased, as have levels of diagnosed depression. This supports the findings that only 1.7 per cent of respondents attend mental health services for regular check-ups.

10.2.1 Rural and Urban Settings

While levels of home ownership in Ireland are very high, this study has found that for those aged 55 and over, outright home ownership is on the decline (down 10 per cent over four years). However, significantly more rural dwellers (up 10 per cent) own their homes outright. They are also less likely to rent, either privately or from the local council. Inequalities also exist with regard to house break-ins. Twice as many respondents from urban areas considered house break-ins to be a problem.

Income levels in rural and urban areas are also significantly different. This is the case for both unadjusted figures and those adjusted for the number in the household. Lower incomes are almost exclusively found in rural areas: while 30 rural older people live on less than €65 per week (adjusted for household size), only one urban dweller falls into this category. Similarly, 219 rural dwellers live on €65 to €130 per week, compared with 87 urban dwellers living on the same amount. At the higher end of the income scale the numbers recording a weekly income of over €1,000 are quite small, but a greater proportion of them are urban dwellers. While three rural dwellers live on €950 to €1,150 per week, ten urban dwellers are in the same category. A composite measure of total means is required, one that includes income but also other material and social support, in order to assess the relative advantage or disadvantage of being a rural- or urban-based older person.

An examination of quality of life also reveals disparities. Although there has been an overall increase in quality of life ratings, multivariate analysis reveals that rural dwellers are less likely than urban dwellers to rate their quality of life as very good or good. However, they are more likely to strongly agree that people in their area can be trusted and that, generally speaking, most people can be trusted.

Medical card status also differed for rural and urban dwellers. Figures for medical card holders reveal that 56.7 per cent are rural dwellers compared with 43.3 per cent who are urban-based (SLÁN 2002). This difference is less marked than in 1998 when all medical cards were means-tested (40.1 per cent urban dwellers compared with 59.9 per cent rural dwellers). Multivariate analysis reveals that, among other factors, those in a rural area are less likely to sustain an injury due to an accident.

10.2.2 Medical Card Status

There has been an increase in the proportion of older adults with medical cards. No gender differences exist because all adults aged 70 and over are now entitled to a medical card. The majority of card holders are found in category ED1 but there is an increase across time in the numbers found in categories ED2 and ED3. A similar finding is observed in relation to social class.

Those with medical cards are more likely to rate their health as fair or poor while those without are more likely to rate it as excellent, very good or good. It is possible, therefore, that uptake has been influenced by a need for acute health care. The HeSSOP study (Garavan *et al.,* 2001) found that cost and stigma were significant barriers to older people accessing services, in addition to a lack of knowledge regarding entitlements.

Of those who underwent a general health check-up in the previous three years, 82.6 per cent had a medical card. Of those who did not have a card, 75.2 per cent had had a check-up. 75 per cent of those visiting a doctor's surgery have a medical card. Those with a medical card are more likely to rate their quality of life as poor or neither poor nor good, while those without are more likely to rate their quality of life as very good. Those who are also members of sports clubs are more likely to rate their health as excellent or very good.

Having corrected for age, those who are overweight, obese or experience extreme or moderate pain are more likely to hold a medical card. Those whose work or daily activity is limited by long term illness or disability are also more likely than those who are unaffected to hold a medical card. Medical card holders are also more likely to strongly agree that people in their area can be trusted and also that, generally speaking, most people can be trusted.

10.2.3 Disability

The risk of sustaining a disabling injury increases substantially in later life. There is evidence that about one third of those over the age of 65 living in the community and one half of those living in institutions suffer a fall every year. In Ireland, 11.6 per cent of older people incur an injury serious enough to interfere with their daily activities and 89.7 per cent report an accidental injury. Most injuries occur in the home, followed by injuries incurred while walking on roads or pavements. 66 per cent of injuries are caused by a fall. Most injuries in Ireland (70 per cent) are treated by either a hospital accident and emergency department or the GP service.

The large number of accidents occurring in the home is consistent with the international picture regarding falls and older people. While this phenomenon is well documented internationally, Irish research into this area is yet to be developed.

Multivariate analysis reveals the determinants of accidents to be poor mobility, living alone, living in an urban setting, possession of a medical card and regular alcohol consumption. Women are also more likely than men to have an accident.

More than 50 per cent of older adults experience extreme or moderate pain. While it did not emerge in the multivariate models as a significant determinant of quality of life or self-rated health, it is nonetheless a relatively high rate and, therefore, an important unmet need.

Women are more likely than men to experience pain. Those who experience pain are also more likely to hold a medical card. 25.6 per cent of older adults are limited in their work or daily activity by long-term illness or disability. This is much higher than the 8.3 per cent reported for the entire population in Census 2002. Those in the 55-64 years group are less likely to be affected; those in categories SC5-6 or ED1 are more likely to be affected. Multivariate analysis reveals the determinants of disability as poor self-rated health, poor mobility, difficulties undertaking usual activities, extreme pain and poor state of health. In the current study, men are more likely than women to be affected in their work or daily activity by long-term illness or disability. This trend is reversed for the population as a whole (Census 2002). Those aged 80 and over are less likely to be affected.

The high prevalence of hearing impairment and the marked age gradient has important implications for the provision of appropriate services and environments.

10.3 Socio-demographics

This survey reflects secular trends in relation to contemporary older Irish people, exemplified by the high level of respondents who left school before completing secondary education. The predominance of either single, widowed or married people and shifts in housing tenure are also significant factors. Population projections predict increasing numbers of separated and divorced people in the short-term and relatively more people aged 70 and over (O'Connell and Pringle, 2004). It is therefore important to interpret trends for current older people and anticipate the needs of a future generation.

10.3.1 U-shaped Factors

The oldest respondents considered in the survey may represent natural rates of survival, but they may also reflect healthier lifestyles or socio-economic circumstances that have led this unique group to live longer than more disadvantaged people of the same age cohort. It is important to note that these respondents tend to live independently rather than in institutional care, a factor that may also contribute to a healthier profile.

As age increases there is a notable decrease in the percentages of those in receipt of tertiary education. However, there is an increase noted for men and women aged 85 and over.

The number of those who are not sexually active increases with age but decreases again for those over the age of 85 (SLÁN 2002). The percentage of those who never use contraception decreases with age but increases again for the 85+ years group.

Participation in strenuous and moderate exercise decreases with age but increases again for the 85+ years group (SLÁN 2002 only). The numbers taking part in a gym or leisure centre activity decrease with age but increase again for this group. Respondents with very physically active and fairly physically active jobs decrease significantly with age but again increase for the 85+ years group. The numbers of those with some mobility problems increase with age but also decrease for the 80-84 and 85+ years groups.

Those reporting consumption of an alcoholic drink in the previous week decrease significantly with age but increase again for the group aged 85 and over. The numbers of those who think they could eat more healthily decrease with age but also increase for this group. Lastly. the percentages taking food supplements decrease with age and increase again for the 80-84 and 85+ years groups.

10.3.2 Determinants of Self-rated Health

A number of variables emerge as important determinants of self-rated health with mental health being one of the significant factors. Respondents who are not anxious or depressed or moderately anxious or depressed are significantly more likely to rate their health as excellent, very good or good than those who are extremely depressed. Those who are not very satisfied with their health, who seldom or never do heavy housework and who hold a medical card are less likely

to rate their health favourably. As age increases, older adults are less likely to rate their health favourably. Those with primary, some secondary or complete secondary education are less likely to rate their health as excellent, very good or good than those with complete tertiary education. Those with some tertiary education are more likely to rate their health favourably than those with complete tertiary education. Non-smokers are more likely to rate their health favourably. As the number of days featuring moderate exercise increases, older adults are more likely to rate their health favourably.

10.3.3 Mental and Physical Health

Mental health has emerged as a significantly important factor in relation to self-rated health and quality of life. Moderate or extreme depression is self-reported by 25 per cent of respondents but only 7.3 per cent of these have been diagnosed by a doctor. The determinants of poor mental health in those aged 55 and over are low self-rated health, low health rating, not owning their own house, not walking for more than 30 minutes per day on a regular basis and poor quality of life. The determinants of a good quality of life in those aged 55 and over are an absence of depression, favourable self-rated health, not living alone, not holding a medical card and doing heavy housework on most days. It seems that not much has changed since the Council's report *Mental Disorders Among Older Irish People* (Keogh, 1996). In both reports, anxiety and depression among older people tend to go undetected and self-reported depression is very high. The need for mental health promotion for older people has been stressed by a significant number of those working in the area of healthy ageing (O'Shea, 2003). Why are older people apparently more likely to receive better medication for cardiac health and not for mental health? Why are so few older people attending mental health services?

10.3.4 Social Variation

When it comes to social support, 85.7 per cent of respondents report receiving a lot of support from their spouse or partner and 66.8 per cent receive a lot of support from their children. With regard to participation in the community, the highest rate of participation for older adults is in religious or voluntary organisations. Comparatively speaking, this is greater than the national sample. The participation rate for sports clubs is also high at 23 per cent, with the majority of clubs being local. Given the public transport problems identified by older people, establishing clubs in local areas is essential for participation by those aged 55 and over. This overall pattern is indicative of the positive contribution made by older people to society and their value as a resource in terms of social capital.

Generally speaking, most people can be trusted, is a statement with which 77.3 per cent strongly agree or agree. It has been noted that this relates to residence in rural or urban areas. Differences also exist between health board areas. Those residing in the SHB area are most likely to strongly agree with the statement while those in the MWHB area are least likely to strongly agree. Social class and educational status were also found to influence people's opinions about trust: those in SC5-6 and ED1 categories are most likely to strongly agree with the statement. Respondents were also asked about trusting people locally and similar results were identified.

Multivariate analysis identified housing tenure and education level as determinants of trust in people generally. Those owning their houses with a mortgage or who rent privately are less likely than those who rent from a local council to trust people generally. Those with none/primary/some secondary schooling are less likely than those with complete tertiary education to trust people generally. Those with complete secondary and some tertiary education are more likely than those with complete tertiary to trust people generally.

Multivariate analysis also identified housing tenure and gender as determinants of trust in people in a respondent's own area. It emerged that those owning their houses with a mortgage or who rent privately or from a local council are less likely to trust people locally than those owning their houses outright. Women are more likely than men to trust people locally.

10.4 Relationships With Previous Findings

Examination of lifestyle reveals the percentage of older people who are obese or overweight has increased since the Fahey and Murray's 1994 study. The number of smokers aged 65 years and over has decreased from over 30 per cent in 1987 and 23.9 per cent in 1994 to 16.7 per cent in 2002.

Fahey and Murray considered household income (unadjusted) in 1994 (in Irish pounds). Conversion to Euros shows that in 1994, 82.4 per cent of older people aged 65 and over lived on less than €254 per week. This fell to 69.4 per cent in 1999 (Layte *et al.,* 1999) and to 59.6 per cent in 2002. Location did not influence these income levels in 1994, but the 2002 study discovered that those living in rural areas are more likely to be in the low income categories.

Outright home ownership stood at 68.3 per cent in 1977 and rose to 81.8 per cent in 1993 (Fahey and Murray, 1994). Layte et al. (1999) reported this figure at 80.6 per cent and, in 2002, 71.9 per cent of older people owned their homes outright.

10.5 Implications For the Future

The implications for the future, based on this data, are threefold. Firstly, if the present patterns of adverse lifestyle adopted by some people persist into older age, particularly by those in the least socially advantaged groups, ill-health will become a significant burden, especially that related to inactivity, obesity, diabetes and the complications of chronic disease. Secondly, the snapshot of today's older people reflects many of the positive characteristics of current Irish society in relation to social capital and support indicators, which may well be eroded by increasing urbanisation. Policy measures to check such trends are justified, particularly at an environmental and macro social level. Thirdly, in keeping with integrated health promotion strategies generally, it is important to take into account not just health status and lifestyle, but also the socio-economic determinants of such patterns in achieving effective long-term benefits. This report integrates such information and is particularly timely, coming a decade after the NCAOP pointed to such an approach in its first initiatives on health promotion for older people.

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Appendices

Appendix 1

CatPCA and Resulting Factors for Multivariate Analysis of Self-rated Health

	Factors for CatPCA	Factors for final model (SRH and QOL)
General health		
	Self-rated health	SRH (excluding SRH from model, health satisfaction is extracted first)
	Scaled state of health	No. of days in poor mental health
	Quality of life	Anxiety/depression
	Health satisfaction	
	No. of days in poor mental health	
	No. of days in poor physical health	
	Activity or work affected by long-term ill-health	
	Mobility	
	Anxiety/depression	
	Pain/discomfort	
Lifestyle		
Smoking	Do you smoke cigarettes now	Do you smoke cigarettes now
	Smoke cigarettes in past	Ever smoked a pipe
	Ever smoked cigars	Ever tried to stop smoking
	Ever smoked a pipe	
	Ever tried to stop smoking	
	How many cigarettes do you smoke	

	Factors for CatPCA	Factors for final model (SRH and QOL)
Exercise	No. per week strenuous exercise	Heavy household
	No. per week moderate exercise	Moderate exercise
	No. per week mild exercise	Little or no activity (attend gym/leisure)
	How many days do you walk >30 mins	
	Attendance at gym/leisure centre	
	Light housework	
	Heavy housework	
	Transport while shopping	
Alcohol	How long since last alcoholic drink	Property vandalised
	How many days in a week do you drink	How long since last alcoholic drink
	Have you driven a car after two or more drinks	Arguments with family or friends
	As a result of someone else's drinking have you: Had property vandalised Had arguments with family and friends Got into a fight Had family/marital difficulties Been a passenger with a driver who was drunk Been verbally abused Been hit or assaulted None of these	
Diet	Do you think what you eat could be healthier	How often do you add salt
	Do you read food labels	How often do you eat fried food
	Have you taken any vitamins, minerals or food supplements	How often do you eat vegetable oil
	Have you taken folic acid	
	How often do you eat fried food	

	Factors for CatPCA	Factors for final model (SRH and QOL)
	How often do you eat butter or hard margarine as a spread or for cooking	
	How often do you eat a low-fat spread	
	How often do you eat vegetable oil	
	How often do you eat lard or dripping in fried, roasted or baked foods	
	What type of milk do you use most often	
	How much milk do you drink each day	
	How often do you add salt to food while cooking	
	How often do you add salt to food while at the table	
Demographics	Age	Medical card status
	Sex	Home ownership
	Education	Education
	Accommodation type	
	Social class	Sex
	Marital status	Social class
	Medical card status	Age
	Income	Marital status
	Urban/rural setting	Income
	Home ownership	Location
Social support	Support from spouse	Most people can be trusted
	Support from children	Rubbish or litter lying around
	Regularly join in sports club	Regularly join in sports club
	Regularly join in religious clubs	
	Rubbish or litter lying around	
	Poor public transport	

	Factors for CatPCA	Factors for final model (SRH and QOL)
	Any areas where children can play	
	Generally speaking most people can be trusted	
	People around here are willing neighbours	
	People in this neighbourhood do not share the same values	
	People in this area can be trusted	
	This is a close-knit neighbourhood	
	In this neighbourhood people feel safe from personal attacks	

Appendix 2

SLÁN 2002 and SLÁN 1998 Standardised to Census 2002

		Males	Males	Females	Females
		SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002
Education	None/primary/some secondary (ED1)	80.1%	73.2%	76.5%	63.1%
	Completed secondary (ED2)	7.1%	10.2%	14.7%	21.2%
	Tertiary (ED3)	12.4%	16.6%	8.8%	15.7%
Social class	SC1-2	28.3%	36.6%	36.3%	48.1%
	SC3-4	38.7%	38.5%	36.8%	36.5%
	SC5-6	33.0%	24.9%	26.9%	15.4%
Medical card	Yes	46.3%	55.3%	56.7%	60.1%
Location	Rural	57.1%	58.5%	54.4%	50.5%
	Urban	42.9%	41.5%	45.6%	49.5%
General health check-up in last 3 years	Yes	80.0%	81.1%	82.4%	77.4%
Sexual activity	Not sexually active	57.8%	57.6%	70.0%	66.1%
	Always use contraception	3.6%	6.4%	1.0%	2.3%
	Sometimes use contraception	8.0%	7.1%	2.8%	3.5%
	Never use contraception	30.6%	28.9%	26.4%	28.0%

		Males	Males	Females	Females
		SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002
Regular exercise	Mild (4+ times)	28.8%	24.3%	28.3%	25.1%
	Moderate (3+ times)	20.1%	21.4%	17.7%	20.8%
	Strenuous (3+ times)	3.0%	3.3%	1.0%	1.5%
BMI	Underweight (<20kg m^{-2})	2.4%	3.2%	8.4%	7.2%
	Normal (20-25kg m^{-2})	32.5%	27.9%	42.6%	41.6%
	Overweight (25-30kg m^{-2})	47.7%	46.5%	35.1%	36%
	Obese (>30kg m^{-2})	17.4%	22.4%	13.8%	15.2%
Smoking	No	76.8%	80.8%	81.2%	83.9%
	Yes, regularly	20.0%	17.3%	16.1%	13.9%
	Yes, occasionally	3.2%	1.9%	2.7%	2.2%
Alcohol consumption	During last week	55.0%	57.1%	31.8%	41.1%
	1 week to 1 month ago	10.5%	11.0%	11.8%	12.8%
	1 month to 12 months ago	4.8%	4.6%	6.9%	6.2%
	3 months to 12 months ago	2.8%	2.6%	7.6%	4.7%
	More than 12 months ago	7.4%	8.5%	5.9%	6.8%
	Never beyond sips and tastes	19.6%	16.2%	36.0%	28.4%
Injury serious enough to interfere with daily activity	Yes	11.3%	10.9%	14.3%	12.2%
	No	88.7%	89.1%	85.7%	87.8%

		Males	Males	Females	Females
		SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002
Self-rated health	Excellent	8.0%	8.3%	5.7%	10.4%
	Very good	22.0%	22.9%	20.3%	27.2%
	Good	37.8%	39.1%	43.7%	37.4%
	Fair	27.4%	24.7%	26.0%	21.6%
	Poor	4.8%	5.1%	4.4%	3.4%
Prevalence of illness	Angina	11.8%	14.6%	8.8%	6.5%
	Heart attack	8.1%	8.6%	3.6%	4.2%
	High BP	25.1%	27.4%	30.5%	29.7%
	Stroke	3.6%	4.1%	2.8%	1.7%
	Diabetes	6.1%	8.0%	4.3%	5.1%
	High cholesterol	11.1%	16.2%	13.5%	18.4%
	Anxiety	7.3%	8.9%	13.0%	9.5%
	Depression	6.0%	7.9%	9.8%	7.4%
Disability	Limitations in work or daily activity by long-term illness or disability	28.2%	30.1%	27.6%	21.3%
Quality of life	Very good	17.5%	18.9%	20.1%	28.2%
	Good	54.3%	57.5%	55.9%	52.0%
	Neither poor nor good	20.2%	18.5%	16.9%	14.7%
	Poor	6.2%	3.8%	5.2%	4.1%
	Very poor	1.9%	1.3%	1.9%	1.0%

Terms of Reference

Terms of Reference

The National Council on Ageing and Older People was established on 19th March 1997 in succession to the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990).

The functions of the Council are as follows:

1. To advise the Minister for Health on all aspects of ageing and the welfare of older people, either at its own initiative or at the request of the Minister and in particular on:

    a) measures to promote the health of older people;

    b) measures to promote the social inclusion of older people;

    c) the implementation of the recommendations contained in policy reports commissioned by the Minister for Health;

    d) methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for older people;

    e) methods of encouraging greater partnership between statutory and voluntary bodies in providing services for older people;

    f) meeting the needs of the most vulnerable older people;

    g) means of encouraging positive attitudes to life after 65 years and the process of ageing;

    h) means of encouraging greater participation by older people;

    i) whatever action, based on research, is required to plan and develop services for older people.

2. To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:

    a) undertaking research on the lifestyle and the needs of older people in Ireland;

    b) identifying and promoting models of good practice in the care of older people and service delivery to them;

    c) providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health, well-being and autonomy of older people;

    d) liaising with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for older people.

3. To promote the health, welfare and autonomy of older people.

4. To promote a better understanding of ageing and older people in Ireland.

5. To liaise with international bodies which have functions similar to the functions of the Council.

The Council may also advise other Ministers, at their request, on aspects of ageing and the welfare of older people which are within the functions of the Council.

Membership

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Ms Kit Carolan
Mr Paul Cunningham
Mr John Grant
Ms Patricia Lane
Ms Martina Queally
Mr Bernard Thompson
Mr Noel Byrne
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