



Planning for an Ageing Population: Strategic Considerations



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


Planning for an Ageing Population: Strategic Considerations

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National Council on Ageing and Older People

Report No. 87





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22 Clanwilliam Square
Grand Canal Quay
Dublin 2

Report No. 87
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ISBN 1 900378 38 8
Price: €13

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Foreword



As Chairperson of the National Council on Ageing and Older People, it gives me great pleasure to present this publication which comprises proceedings from the conference, *Planning for an Ageing Population: Strategic Considerations*, a discussion paper, 'The Older Population: Information Issues and Deficits' and the Council Comments and Recommendations arising from them.

The conference took place on 15 June 2004 in the Burlington Hotel, Dublin. Attended by 130 delegates from the statutory, voluntary and private sectors, the conference was organised with the aim of promoting a positive understanding of population ageing in Ireland with a view to influencing the creation of a policy, planning and implementation environment that will support and contribute to health and social gain for older people in the short and medium terms.

The conference also provided an opportunity for delegates to familiarise themselves with the key findings of the Council report *Population Ageing in Ireland: Projections 2002-2021*, as well as to consider issues relating to planning for the ageing of the population, and to review data sources, needs and deficits in the light of planning requirements. It was also hoped that the conference would contribute to the further development of evidence-based planning to meet the needs of older people.

I would like to express my appreciation to Dr Garrett Fitzgerald for his keynote address, to the speakers for presenting insightful and thought-provoking papers, and to the Chairs of each of the four sessions. I would also like to thank conference delegates for their contribution. Finally, the Council would also like to thank its Director, Mr Bob Carroll, and the staff of the Council Secretariat for their work in planning and organising the conference.

A handwritten signature in black ink that reads "Eibhlin Byrne".

CIlr Éibhlin Byrne
Chairperson



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Council Comments and Recommendations

Council Comments and Recommendations

Introduction

This report presents both the proceedings of the Council's conference, *Planning for an Ageing Population: Strategic Considerations*, and the Council's discussion paper, 'The Older Population: Information Issues and Deficits', which was introduced at that conference.

The Council is committed to the promotion of a positive and practical understanding of population ageing in Ireland. Such an understanding is key, the Council believes, to the development of a policy, planning and implementation environment responsive to the challenge of population ageing. There are specific requirements in meeting the challenge of population ageing. These include: population projections; information systems which can provide us with timely and adequate data about the older population; the practice of strategic planning; and the further analysis of concepts – such as independence, dependence and interdependence – which are pivotal in the management of population ageing. The Council's conference and discussion paper were planned in tandem to enable consideration of the *status quo* with regard to these requirements.

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The Conference and Discussion Paper

The conference comprised four sessions. The focus of the first of these sessions was population ageing. Population projections 2002-2021, which had been prepared for the Council, were presented and the issue of population ageing was discussed. The second session considered the themes of independence and dependence in old age.

The third session examined the evidence base for planning to meet the needs of the older population. Key findings from the Council's discussion paper – based on a survey and analysis of national datasets – were presented and responses invited from a panel of contributors. The discussion paper was presented as a draft document with a commitment to revision in light of comments from conference participants.

The fourth session, 'A Society for All Ages', explored the theme of interdependence and, with the aid of the conference *rapporteur*, drew conclusions with a view to setting an agenda in respect of planning for an ageing population.

The percentage of males aged 65 and over is projected to increase from 9.7 per cent in 2002 to between 13.9 per cent and 14.1 per cent in 2021. The percentage of females aged 65 years and over is projected to increase from 12.5 per cent in 2002 to between 15.8 and 16.4 per cent in 2021. An accelerating increase in the old age dependency ratio is predicted after 2011. Nonetheless, Ireland's old age dependency ratio remains low relative to other developed countries and will continue to do so. The projected Irish old age dependency ratio in 2021 will be similar to the current ratio in European countries such as the UK, Spain and France.

As highlighted at the conference, Ireland is fortunate in having time to prepare for the impact of population ageing. **The Council recommends the adoption of preparation for population ageing as a policy priority at Ministerial level. The Council also proposes that consideration should be given to the establishment of an inter-Departmental committee to devise an integrated strategic plan for population ageing in Ireland.**

Independence and Dependence in Old Age

Conference contributors challenged the practice of equating old age with dependency, the measurement of participation in terms only of paid work and the failure to recognise the contribution to society of older people. The need for policy and service planning responsive to three different types of dependency was highlighted: necessary dependency, flowing from individual life situations; unnecessary dependency created by society, for example through the failure to design buildings and housing to accommodate people with different levels of physical capacity; and complex dependency which is a combination of the first two.

The challenge, in the Council's view, is to create a society which, in its physical, economic, social and cultural structures and processes, maximises independence and minimises dependence for people of all ages, including the older population.

Policy-makers and planners are, as was pointed out, ill-served by a predominantly narrow conception of ageing, which focuses on medical needs and problems, and views ageing mainly as a chronological event without regard to the psychological and social process. If policy-makers and planners are to meet the needs of older people who experience elements of both independence and dependence in their lives, a range of actions is necessary.

The Council agrees with the view expressed at the conference that we need to arrive at a better understanding of how people experience their own ageing, including their shifting understandings of independence and dependence over time. The value of undertaking a longitudinal cohort study of the older Irish population was also mooted at the conference. The Council recommends that such a study be undertaken and is willing to assist in planning such an initiative.

The Council recommends that the Department of the Environment, Heritage and Local Government (DoEHLG) adopt an active policy of promoting, designing and planning lifetime adaptable housing.

The accessibility of existing housing stock is a concern, given the desire of older people to complete their lives in their own homes and the proportion of the old who experience disability. **Adequate budgets and streamlined procedures are required to enable people with disabilities, including older people with disabilities, to benefit from the Disabled Persons Housing Grant and to make necessary adaptations to their own homes.** The Council strongly recommends coordinated action by the DoEHLG, the Department of Health and Children (DoHC), the Health Services Executive (HSE) and local authorities in relation to the Disabled Persons Housing Grant.

The Evidence Base for Planning

The World Health Organisation (WHO) has characterised active ageing as the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age. The determinants of active ageing fall into seven broad categories. These are: the cross-cutting determinants of culture and gender; personal, behavioural, and economic determinants; and determinants related to the social environment, the physical environment and to health and social services. If programmes and policies are to be designed to support effectively and to enable the active ageing of the population, policy-makers need access to information about those determinants as they relate to older people and within a national framework. Existing information systems are not, as the Council's own survey and analysis of national datasets has shown, able to provide this kind of data. Typically, datasets operate on a standalone basis and it is not possible to link and integrate data from a range of datasets either to create a more holistic profile of the older population or to identify more vulnerable sub-groups of that population.

In terms of a national framework of information about the older population, there are significant issues and deficits. Notably, these relate to social determinants, including the quality of life and social contribution of older people; to determinants related to the physical environment, including housing and transport; and to the health and social services where datasets are stronger in the provision of institutional than community-based data, though the majority of older people live in community settings. There are particular concerns about the lack of person-centred data; of population-based morbidity data; of a national psychiatric out-patient database; and of data on the prevalence and incidence of different forms of impairment and disability in the population.

Contributors to this session also highlighted the fact that a burden of health inequality is carried by people on low incomes, that there are gaps in life expectancy between the richest and poorest and that there is a need for the design of information systems to capture and analyse this data for Ireland.

The Council welcomes the publication by the DoHC of the *National Health Information Strategy* (NHIS) and looks forward to collaborating with the Health Information and Quality Authority (HIQA). Specific actions identified in the Strategy will begin to address some of the information issues and deficits of concern to the Council. The Council welcomes the steps taken towards the development of a Population Health Observatory and looks forward to the introduction of electronic patient records and a unique system of patient identification within an information governance framework. The Council recommends the implementation of these actions within as tight a time framework as is feasible.

Currently, the National Physical and Sensory Disability Database (NPSDD) does not include people with disabilities aged 65 years and over.¹ The Council welcomes the Health Research Board's indication at the conference that the rationale for this exclusion could be reconsidered. The Council recommends the broadening of criteria for the register to enable the inclusion of older people with disabilities as soon as possible.

¹ With the exception of people already on the Database who reach the age of 65 and who are not removed from it.

The Council welcomes the planned conduct of a post-censal National Disability Survey by the Central Statistics Office (CSO) in 2006. The findings of Census 2002 showed that 31.1 per cent of the 65+ population reported a disability. Given these findings, the Council wishes to highlight the importance of an overall approach to the research – including design, sampling and analytic strands – that adequately captures and analyses the interface between disability and ageing.

In the Council's view, our knowledge and understanding is inadequate of how income and resource inequality influence the quality of life, health and social well-being of older people and their access to health and social services. This is a deficit that must be addressed. The Council believes that a study of the experience of poverty among the older population is necessary. Such a study, incorporating an examination of income and resource issues from the perspective of older people, would yield policy relevant findings about the best ways of tackling poverty and inequality among older people.

A Society for All Ages

In a modern society whose norms and institutions are in flux, as one conference speaker indicated, an acceptance of the concept of interdependence between the generations cannot be taken for granted. It is an understanding that needs to be established, managed and explained. The value of timely data about different aspects of contemporary Irish society as a tool in promoting such an understanding was highlighted, as was the potential of the work of the Steering Group on Social and Equality Statistics (SGSES) and the Quarterly National Household Survey (QNHS) in generating such data.

The conference conclusions drew attention to the prevailing representation of older people as a burden on rather than a resource to society. Many examples of older people's contributions had been cited in the course of the conference: childcare, transfer of resources to younger family members, active voting patterns and participation in voluntary and sporting organisations. The protection of intergenerational solidarity – in terms of values, policies and practice – was also pinpointed as a goal for Irish society. The importance of the direct involvement of older people in policy-making and service-planning processes was also emphasised.

The Council recognises the centrality of intergenerational solidarity in creating and sustaining a society for all ages. In terms of policy development, service planning and fiscal management, the Council recommends governmental decisions that will nurture voluntary intergenerational solidarity.

Arising from the work of the SGSES and the ensuing Statistical Potential of Administrative Records (SPAR) initiative under the direction of the CSO, the scope of existing administrative records to provide useful data about the population has been explored (CSO, 2003). It has been pointed out that, if the potential of existing administrative records is to be fully realised, the introduction of a system of unique identification such as the Personal Public Service Number (PPSN) and the use of geo-coding are necessary. The Council would support both developments within an information governance framework. **Meanwhile, the Council welcomes the publication by the CSO of a series of social trends reports based on their work to date. The Council understands that the 2005 report will include sections on the older population and recommends that the content provide a holistic view of older people's lives; that is, content that reflects, within the parameters of available data, older people's participation in and contribution to families, communities and society.**

The QNHS allows for the occasional collection of data on social topics. There are significant deficits in our knowledge about the experience of interdependence between the generations, and of diverse forms of participation in and contribution to the community and society across the age bands. The Council recommends the exploration of these issues through a QNHS social module.

The Council supports the view that older people themselves should be centrally involved in policy-making, decision-making and service-planning provision. In the Council's view, the inclusion of older people's organisations in the Social Partnership process at national level is a welcome step in the right direction. The Council draws attention to the guidelines set out in the *HeSSOP* study (Garavan *et al.*, 2001) which could form a protocol for service providers to adhere to in developing ways of consulting with older people. The guidelines state that: consumers should develop initiatives themselves; the process should be accessible in terms of setting and format and should also have access to decision-making; participants should be supported through measures such as the facilitation of skills-building; qualitative methods should be used in consultations; all stakeholders should be involved; and the process should be accountable, ongoing and responsive (to participants). **The Council recommends that health service leaders actively promote the inclusion and participation of older people as a stakeholder group in decision-making and service planning processes.**

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Planning for an Ageing Population: Strategic Considerations

Conference Proceedings

Overview

Dr Eamon O'Shea, NUI Galway

The structure of these proceedings follows the format of the conference *Planning for an Ageing Population: Strategic Considerations* organised by the National Council on Ageing and Older People (NCAOP). The conference presentations took place across four sessions and dealt with a range of issues critical to the implementation of successful planning for an ageing population:

- population ageing
- independence and dependence in old age
- the evidence base for planning for an ageing population
- a society for all ages.

Population Ageing

In the Opening Session **Peter Connell** and **Dennis Pringle** presented a summary version of their population projections for 2002-2021. The absolute number of males aged 65 years and over will increase by 70-79 per cent between 2002 and 2021; the equivalent increase for females is 52-59 per cent. There will be a substantial increase in the absolute number of males and females aged 75 years and over. The eastern part of the country contains the highest absolute numbers of older people, while western counties contain the highest projected percentages of older people. By 2021 there will be 211,000 older people living alone, representing just over 30 per cent of all those aged 65 years and over.

In his response to the paper by Connell and Pringle, **Garret Fitzgerald** noted that there is time to plan and prepare for an ageing population in the future in this country. He highlighted the change in the balance of dependency in the future from young to old but pointed out that taking the combined number of older people and younger people, it is likely that the overall dependency ratio relative to the working population will only increase from currently 67 per 100 people of working age to 75 per 100 in 2041. Dr Fitzgerald pointed to the poor life expectancy figures for men and women aged 65 in Ireland, allowing for recent improvements, and acknowledged the importance of policy measures to address the poor comparative performance in this area. He also made the case for the gradual reinstatement of the public pension at the age of seventy, which would provide flexibility for older people as well as reducing the country's mid-century public pensions bill by about one quarter.

Independence and Dependence in Old Age

In the Second Session **Anne Goode** and **Eithne Fitzgerald** presented a paper on understanding dependency and the challenge for planners in developing appropriate responses for dependent populations. They argued that there is a need to distinguish three main types of dependency if we are to plan policy and services effectively. The three types of dependency are: necessary dependency (flowing

from individual life situations); unnecessary dependency (created by society); and complex dependency (a combination of the first two). Within this framework, Goode and Fitzgerald argued for a social model of dependency which takes account of the social and environmental factors that influence the participation of older people in economic, social, political and cultural life. They placed particular importance on creating a supportive environment for independence in all aspects of life including lifetime adaptable housing, transport, work and social care.

Hannah McGee's presentation emphasised the importance of maximising independence for all in old age. Individuals are living longer and living better for longer. She made the point that ageing is simultaneously a uniquely personal and global challenge. Older people make significant contributions at all levels of society and are a significant resource to other members of society. That contribution is not always acknowledged either in official datasets or at the level of policy. Independence in old age is about being able to make decisions and have the same level of autonomy as people at younger ages. It is about choice and consultation in decision-making. McGee argued that planning for ageing should be based on partnership and respect for the preferences of older people. The challenge for planners is to create a society in which they would be willing to grow old themselves.

The Evidence Base for Planning

The Third Session dealt with the evidence base for planning and was based on a presentation by **Patricia Conboy** on information issues and deficits for older people in Ireland. The discussion paper has its origins in a recent survey and analysis of selected national datasets undertaken on behalf of the NCAOP. In general, national datasets are poor in terms of recording, collating and publishing data about the older population; neither do existing datasets adequately capture the impact of public policy on older people or the contribution that older people make to Irish society. These datasets lack an ageing perspective, which means that they are of limited value when it comes to planning for an ageing population. The paper argued for more person-centred data on older people combined with a mechanism for linking and cross-referencing across multiple datasets. The information systems designed to collect data on older people should both reflect and record the heterogeneity of the older population.

There were a number of responses to the discussion paper presented by Patricia Conboy. **Ruth Barrington** highlighted the need to optimise opportunities for older people in old age. She emphasised the influence of socio-economic status on health and healthy ageing. Poor people are much less likely to live to enjoy an active old age than people who are well-off. Current information flows on ageing are inadequate. Existing datasets need to bring out the ageing dimension more and there needs to be linkage across datasets. A longitudinal cohort study of older people is necessary to enhance our understanding of the ageing process and the various influences on healthy ageing.

John Cooney took up the point on information deficiencies and argued for greater investment in information by the new HSE. We currently spend too little on generating information on older people. He too argued for linked datasets. He also highlighted the need for greater coordination by Government Departments in the planning and delivery of services for older people. Cooney also recognised the importance of prioritisation and made the point that as not everything can be done we need to know what is important and what is not. Evaluation is also necessary to judge the efficiency and effectiveness of various interventions and investments.

Richard Layte also spoke on information issues, highlighting the potential of official statistics as repositories of valuable information. Data protection laws may need to be changed to allow the potential of administrative datasets to be explored fully and a new licensing system may need to be developed for that purpose. Administrative records, however, can never be a substitute for a good research information strategy with access to linked datasets covering all aspects of ageing. Layte examined the potential of diary-generated time-use data on caring for older people. He also pointed to the need for more information on the things that older people value, including data on the requirements for a decent standard of living for older people in Ireland.

Paul Morrin argued that the needs of older people should be reflected in the development of any new statistical framework. Information on older people is necessary for good policy-making in a range of Government Departments. The Office for Social Inclusion (OSI), for example, is very interested in identifying the groups among older people most at risk from poverty and deprivation. The Department of Social, Community and Family Affairs also has an interest in the development of statistics in the pensions policy area, particularly in order to find out if the funds being built up by workers at the moment are sufficient to provide them with a decent standard of living in retirement. More information is also required on resource sharing within households and the impact this has on standards of living for household members. Finally, more information on disability and dependency within households is necessary for developing an effective long-term care infrastructure.

Aidan Punch reminded us that since 1981 the number of persons aged 65 and over has increased by 18 per cent while the number of persons aged under 15 has decreased by 20 per cent. The population is therefore ageing. He projects that the population aged 65 and over could increase from its present level of 436,000 to about 1 million in the next thirty years. The population aged eighty years and over is projected to increase three-fold in the same period, to over 300,000. A number of new questions on disability and carers which have a direct bearing for older persons were included in the 2002 census form and a further set of relevant questions have recently been piloted for inclusion in the 2006 census. These include questions relating to unpaid work looking after the home or family, voluntary activities, household income and family interrelationships.

A Society for All Ages

In the Final Session, **Dermot McCarthy** spoke of the importance and relevance of various interdependencies in society, including the relationship between young and old. He pointed out that changes in the global economic environment make it difficult sometimes to make sense of dependencies and interdependencies. Rapid technological change makes it more important than ever to nurture and develop intergenerational solidarity through genuine social partnership and the development of appropriate institutional and procedural structures and processes. He highlighted the importance of identifying and mobilising all relevant stakeholders in the pursuit of successful policies and strategies for healthy and participative ageing at both national and local levels. Information is also critical to our understanding of ageing, hence the need for more and better data to inform public debate and our understanding of social change.

To achieve a society for all ages **Eamon O'Shea** outlined the main recommendations for future strategic planning for older people. He identified seven main issues as critical to successful planning for older people in the future:

- recognition of the positive contribution older people make to society
- recognition of the importance of comprehensive and timely information for planning
- nurturing of existing intergenerational relationships and responsibilities
- separating dependency from situations of dependency in the lives of older people
- implementing a home-based model of care for dependent older people
- integrating medical and social models of care for dependent older people
- reducing health inequalities at all age groups so that more people reach old age.

Opening Session

Population Ageing

Chair: *Cllr Éibhlin Byrne, Chairperson, NCAOP*

Population Ageing in Ireland: Projections 2002-2021

Peter Connell, Information Systems Services Dept, Trinity College, Dublin, and Dr Dennis Pringle, Dept of Geography and National Institute of Regional and Spatial Analysis, NUI Maynooth

Introduction

This paper looks at population projections for the years 2002-2021 based upon an extrapolation of recent demographic trends subject to various assumptions regarding the major components. Changes in the total population are a function of three factors: births, deaths and net migration, that is, the difference between the total number of people moving into the area and the number moving out. To predict future population changes, it is necessary to make assumptions about future trends for each of these factors:

- birth rates, by age and marital status
- migration rates, by age and sex
- death rates/survivorship, by age and sex.

The accuracy of the predictions will obviously depend on the accuracy of the assumptions made.

Each of the key demographic variables is influenced by the composition of the population, especially age and sex. Assumptions must therefore be made for each age and sex category. These assumptions are used to estimate the number of births, deaths and movements for each age and sex category over the first inter-censal period, that is, for 2002-2006. The procedure is repeated to project the population for each of the predicted census years, namely for 2011, 2016 and 2021.

The key demographic variables also vary over space; for example, some areas have higher mortality rates than others, some areas experience net migration into the area whereas others experience net migration out of the area. Unlike other projections that tend to operate at the national level, we have attempted to take account of these geographical variations by analysing the data at a county or county borough level. In addition to total population by age and sex, by county, we estimated future trends in various other demographic variables including fertility rates, marriage rates, dependency ratios and percentages living alone.

This paper examines the assumptions that underlie the population projections made in this study and summarises the main features of the projections of the total population by age, sex and county. The paper then discusses the projected trends in marital status and people living alone, focusing upon older people, and also examines the projected trends in dependency ratios.

Three sets of assumptions were made:

Assumptions about Birth Rates

In Ireland, the Total Period Fertility Rate (TPFR), which is the most widely recognised measure of fertility, fell from 4.07 in 1964 to 1.85 in 1995, but subsequently increased to almost 2.0. This study assumes that the fertility rate will remain higher than the European average, but will decline to 1.80 by 2021. This assumption about the TPFR was used to generate age-specific birth rates for each inter-censal period until 2021. Geographical variations were ignored when calculating these birth rates.

Assumptions about Death Rates

Age-specific death rates were analysed for the period since 1981. Little change was observed for people aged under 45. It was assumed that the death rates for those under 45 would remain the same until 2021. Deaths rates are still declining for those aged 45-54. It is assumed that there will be further improvements for five years, but at a slower rate, followed by static rates until 2021. For each of the age groups from 55 years and over, it is assumed that improvements will continue until 2021 at the same rate as a weighted average over the period since 1981. Under these assumptions, life expectancy at birth will increase from 73.0 in 1996 to 78.3 in 2021 for males, and from 78.5 to 81.5 for females.

Death rates tend to fluctuate from year to year for individual counties. Over the longer term, however, some counties are observed to have higher death rates than others, with all cause standardised mortality rates (SMRs) generally within the range 80 to 120. It was assumed that the geographical variations in mortality for each age group observed in the period since 1981 will remain until 2021.

Assumptions about Migration

Net migration at national level can be defined as the number of immigrants minus the number of emigrants. To make projections at county level, it is necessary to make assumptions about the number of emigrants leaving each county and the number of immigrants moving into each county. It is also necessary to make assumptions about internal migration (i.e. movements between counties).

The census provides information on inter-county moves in the previous 12 months. It also provides information on movements into each county from abroad in the previous 12 months. The census does not provide information on the moves to abroad from each county – this has to be estimated as a residual from estimates of net migration. The census information was used to generate assumptions about the patterns of internal and external moves for each age group. Movement patterns are based on information from the censuses in 1996 and 2002.

Predicting the number of moves is much more problematic than predicting births or deaths. Ireland has experienced net out-migration for most of its history, but the period since 1996 has seen large-scale migration into the country. It is impossible to know whether the period until 2021 will experience a continuation of recent trends, or whether migration will revert to traditional patterns. To take account of this uncertainty, four different projections were made based on four different sets of assumptions about external net migration (Table 1). The A1 assumption follows the M1 assumption adopted by the CSO for projections based on the 1996 census. The other three assumptions assume increasing rates of net migration.

Table 1: Assumptions regarding annual net external migration numbers

	2002-2006	2006-2011	2011-2016	2016-2021
A1	15,000	10,000	5,000	5,000
A2	20,000	15,000	15,000	10,000
A3	25,000	17,500	17,500	10,000
A4	25,000	25,000	25,000	25,000

There were several complicating factors encountered when making the projections, for example:

- the six-year gap between the censuses of 1996 and 2002 complicated the tracking of cohorts
- the most recent Life Tables (1995-1997) are quite old and do not provide county-specific estimates. It was, therefore, necessary to estimate death and survival rates using data from the annual reports on vital statistics. This, in turn, necessitated the reassignment of deaths within age groups to cohorts.

Population Projections

The total population projected for 2021 ranges from a low of 4.57 million (A1) to a high of 4.91 million (A4). The other estimates were 4.70 million (A2) and 4.75 million (A3).

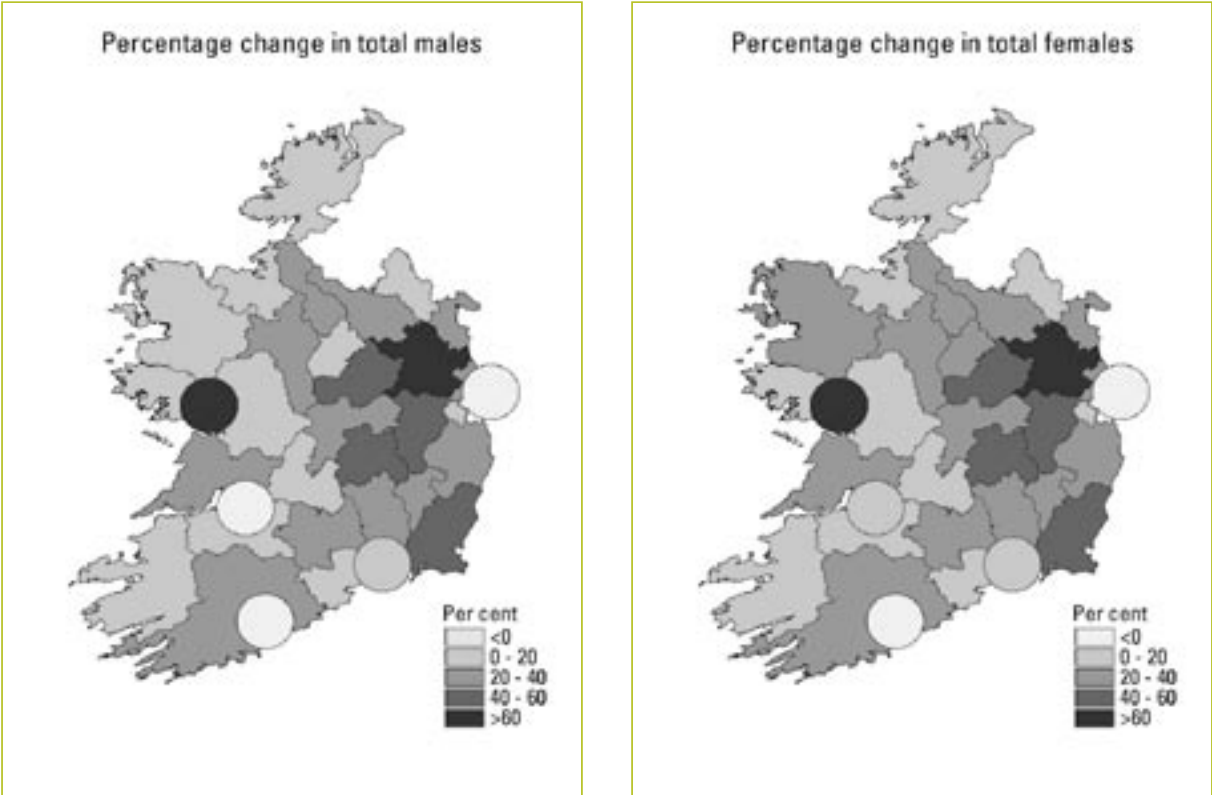
The population projected for 2021 by the CSO in 2001 ranges from 4.04 million (M2F3) to 4.56 million (M1F1). The population projected for 2020 by Blackwell and Associates in 2001 for the National Spatial Strategy ranges from 4.39 million (Current Trends 2) to 5.02 million (Economic Growth 1). Our ‘best’ estimate (A1) lies about halfway between the extremes of the other projections.

Geographical Distribution

Our projections suggest that the largest population increases will be in the East, but that the county boroughs will not experience much growth, with the exception of Galway.

These projections are strongly influenced by the migration patterns in the period 1996-2002. They suggest that the existing county borough areas are approaching ‘saturation’. It is likely that Galway County Borough will become saturated before 2021. Population increases can be expected in the counties adjoining the county boroughs due to the continued growth of commuter populations (Figure 1).

Figure 1: Projected changes in total population, 2002-2021



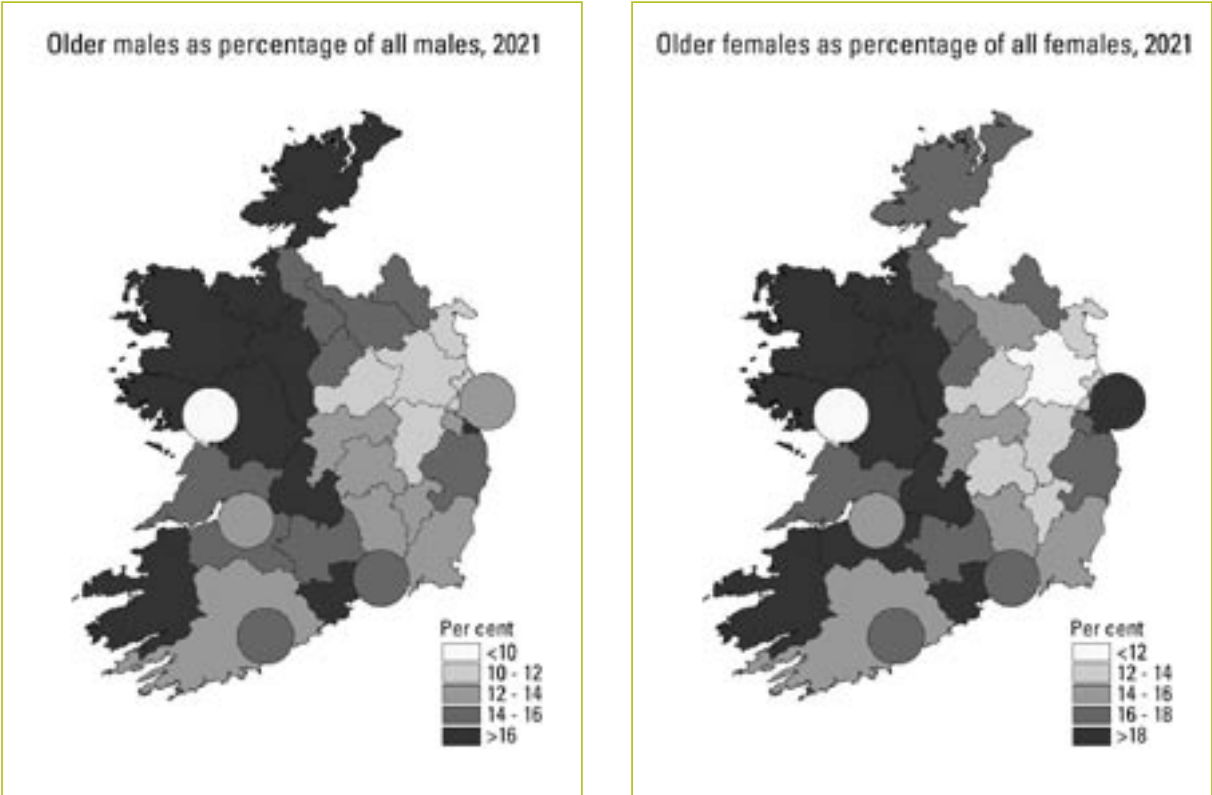
Projections on Percentages of Older People

The percentage of males aged 65 and over is projected to increase from 9.7 per cent in 2002 to between 13.9 (A4) and 14.1 per cent (A1) in 2021. The percentage of females aged 65 and over is projected to increase from 12.5 per cent in 2002 to between 15.8 (A4) and 16.4 per cent (A1) in 2021. The number of males aged 65 and over is projected to increase by between 70.2 and 79.1 per cent. The number of females is projected to increase by between 52.2 and 57.6 per cent. There will also be a substantial increase in the absolute numbers of people aged 75 years and over.

The increase in the absolute number of people aged 65 and over will have numerous ramifications for the health services, for example. On the plus side, the percentage of people aged 65 and over is likely to remain under the west European average. Also, a large proportion of those aged 65 and over in 2021 will be aged under 75 years. The impact of the ageing population will probably be much greater by 2031 when the ‘baby boomers’ will be aged approximately eighty.

The highest percentages of people aged over 65 will be in the West (Figure 2). The county boroughs will generally tend to have lower percentages (except Dublin for females). Many of the areas with low percentages of older people have large populations, so the map may give a misleading impression of the need for services. Absolute numbers of older people are also important and, in that respect, Dublin City Borough and County will be home to an estimated 24 per cent of males and 26 per cent of females aged 65 and over in Ireland.

Figure 2: Percentage of the projected population aged 65 or over, 2021

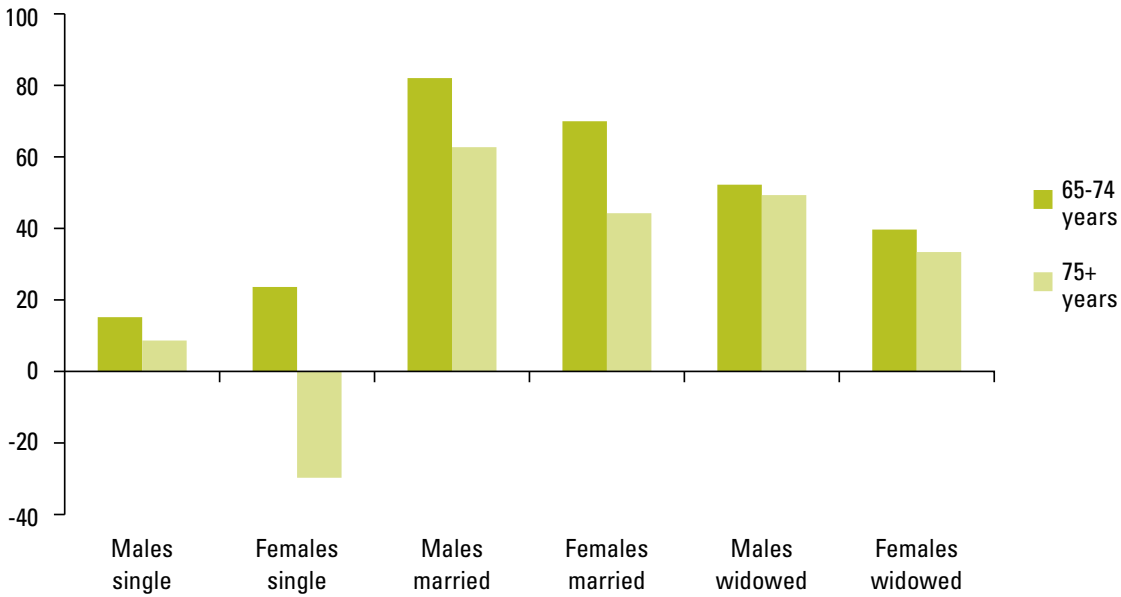


Projected Trends in Marital Status

The marriage rate has stabilised at 5.0 per thousand from 4.3 per thousand in 1995, with a later age of marriage. Eighty three per cent of females aged 30 to 34 were married in 1986 compared to 60 per cent in 2002. The assumption was made that there will be a slow decline in the marriage rate, with 53 per cent of females aged 30 to 34 predicted to be married in 2021. There has been a gradual decline in total fertility rate, but it is predicted that the fertility rate will remain above that of most western European countries. There is clear evidence of rising rates of marital separation, with 10 per cent of females aged 40 to 54 recorded as separated or divorced in 2002. The assumption was made that this trend, evident in 1996-2002, will continue to 2011 and will then increase more slowly.

The future marital status of the older population is easier to project, based on the current population aged 45 and over. Disaggregated by marital status, the composition of the larger older population will show a number of significant changes with a shift towards married and separated and a shift away from single and widowed. It is predicted that there will be a slight increase in the number of single males and a fall in the number of single females aged 75 and over. It is also predicted that there will be an increase of over 80 per cent in married males aged 65 to 74 and of over 70 per cent in married females aged 65 to 74. These broad changes are shown in Figure 3.

Figure 3: Percentage change in males and females by marital status, 2002-2021



Based on assumption A1, it is predicted that the population aged 65 and over will increase by 262,000 by 2021. As a proportion of all aged 65 and over, it is predicted that:

- those who are single will represent a smaller proportion of the older population in 2021 than at present, with the percentage of single people falling from 18 per cent to 11 per cent
- both married men and women will represent a larger proportion of the older population in 2021, rising from 49 per cent to 60 per cent, although the increase is countered slightly by the growing number who are separated
- the number of widowed people will fall from 33 per cent to 28 per cent
- the relatively high separation rates of those in their late forties and early fifties evident in 2002 will have fed through to much higher rates of separation in older age groups than is currently the case, rising from 9,000 to 60,000, or 8 per cent of the older population.

Projected Changes in the Geographic Distribution of Single Older People

The overall number of single older people is predicted to rise marginally, from 77,000 to 80,000. It is expected that most of the increase will take place in the Dublin hinterland, rising from 6,500 to 11,500. The number of older people in the West and North West will remain almost constant, rising only from 18,000 to 18,500, but there will be a sharp decline in the proportion of single older men in this region, dropping from 28 per cent to 21 per cent.

Projected Changes in Older People Living Alone

There is a growing propensity for older people to live alone. Up to 2006, the growing propensity of the single and widowed to live alone is cancelled out by the growing proportion of older people who are married. However, the overall number of older people living alone is predicted to almost double between 2002 and 2021, with the proportion of older people living alone increasing from 25 per cent to 30 per cent.

In general, those counties that currently have relatively low numbers of older people living alone will experience the most significant growth in older people living alone, while those counties that already have relatively high numbers of older people living alone will experience the lowest increases. Although the eastern region will still have a relatively low proportion of older people living alone, Dublin, Meath and Kildare will between them gain an additional 24,000 households with an older person living alone. The counties of the North West will continue to have the highest proportion of older males living alone, while the cities of Dublin, Cork and Limerick will have the highest proportion of older females living alone.

Projected Changes in Dependency Ratios

It is predicted that there will be an accelerating increase in the 'old age' dependency ratio after 2011. The young dependency ratio is likely to stabilise after a sustained fall up to 2002. The overall dependency ratio is projected to rise after 2006. Ireland's old age dependency ratio remains very low relative to other developed countries. Internationally, the old age dependency ratio is projected to increase significantly by 2020, according to the UN. The projected Irish ratio in 2021 will be similar to the ratio in some European countries, for example, the UK, Spain and France.

Population Ageing

Dr Garret Fitzgerald, former Taoiseach, Chancellor, National University of Ireland

This is the right time to discuss the issue of ageing in Ireland because, unlike most other countries, we on this island are starting to address the ageing of our population well before the impact of this phenomenon starts to hit us. We in Ireland are fortunate in having much more time to prepare for the stage at which the older population will constitute a much higher proportion of the total, and we are already setting aside more than €1 billion a year to cover some of the additional pension costs that this will entail in the future.

This is still a young state. No less than 21 per cent of our population is under 15 years of age, and only 11 per cent is aged 65 or over. In other words, we have almost twice as many children as over-65s. By contrast, in the rest of the enlarged EU the numbers of older people are already equal to the number of children: both groups constitute 15.5 per cent of the population. The very different Irish and EU young/old ratios have important implications for the balance between workers and older people in our population – at least in the medium term.

I have examined with interest the new population projections to 2021 which have been prepared by Peter Connell and Dennis Pringle, using the census data for 2002 as a base. Before receiving it I had my own rough estimates, looking forward, however, to the year 2041 when our ageing problem will be approaching its peak. Using the same cautious migration projections as they used in their shorter-term projections, but employing a much less sophisticated estimate of future fertility – viz. assuming that total completed fertility falls to, and then stabilises at 1.75 by 2011 – I estimate that the number of people in our state aged 65 and over is likely to grow by the year 2041 to about two and one third times its present level, with the number aged 75 and over rising two and a half times over this period.

This much larger older population would be supported by a working population that, on my assumption, would be about one eighth higher than today. However, this may prove to be too low a figure, as it is probable that net immigration after 2011 will be at a higher level than the 5,000 a year that your study and mine have assumed. On this, probably somewhat pessimistic, assumption, every hundred workers would in 2041 be supporting about fifty people aged 65 and over, as against less than twenty today.

That is, I think, the worst scenario. On the other hand, if one takes account of the other dependent element in our population – the young – and if we include not just children under 15 but also the 15-19 age group, most of whom are today students rather than workers (as, of course, are an increasing proportion of the 20-24 age group), the proportion of young people to be supported in 2041 could be almost 20 per cent lower than today. As a result, the combined number of older people and children to be supported by the working population would increase between now and 2041 only from 67 per 100 of working age to 75 per 100.

This seems to me to be an important point that is often missed by people discussing the ageing issue. I do not know how significant this factor might be in terms of cost, and I am not aware of any research having been done on the relative cost to the community of supporting and educating children and students, as against paying pensions to and caring for older people. I would suggest that this is a matter that might usefully be studied, in respect of both parts of our island, with a view to getting a better fix on the scale of the net increase in the cost of catering for dependents that we will face at the two ends of the age scale.

Next, any assessment of how we need to approach the issue of ageing must start with a recognition of the extent to which the expectation of life has been rising during the past three quarters of a century. In the seventy years between 1926, the year when I was born, and 1996, the expectation of life at birth rose

in the Republic by 16 years in the case of men and by 21 years in the case of women. The equivalent Northern Ireland figures are two years greater for both sexes. What these figures particularly reflect is the drastic reduction in infant mortality – in this state down by 93 per cent from 7 per cent in 1926 to 0.5 per cent today – as well as in TB, which seventy years ago was almost doubling the death rate for young people in their twenties.

More relevant figures, however, are those for the expectation of life for people aged 65, the standard retirement age for men. In the Republic these figures have not changed by anything like as much as the expectation of life at birth: by the late 1990s they had risen by less than two years in the case of men, and by four years in the case of women, to a level that remained below that of any of the other pre-accession EU states. (By contrast, in Northern Ireland the expectation of life at age 65 has increased since 1926 by three years in the case of men and five years in the case of women.)²

Despite the somewhat disappointing scale of the improvements in the male expectation of life at age 65 in the Republic, which reflects a lifestyle problem that has yet to be adequately tackled, there is already a case for reviewing the pension age of 65 – a retirement age that seems to have originated in the British civil service 150 years ago. A first step would be to remove the element of compulsion about retirement at that age (which I understand has already been done in the Republic in respect of most new entrants to the public service), leaving it open to people to remain at work thereafter should they wish to do so, which I believe would be the case with many of them. Of course, this must be dependent on their continuing good health but that is equally true of people in the years before retirement age when a proportion already drop out because of bad health.

Such a change would recognise the reality that in practice people leave the workforce at many different ages from 45 years onwards. In the case of men in the Republic, the labour force participation rate starts to decline in the late forties from its 93 per cent peak, dropping by 5 per cent in the 45-54 years group, and by a further 25 per cent in the 55-64 years group. The result is that by age 65 less than two thirds of men and only one third of women are still at work. This pattern suggests to me that a phasing down of hours worked in the later years of employment deserves consideration. At the same time, in the Republic 13 per cent of men, mainly self-employed, remain in the labour force after the age of 65. The truth is that retirement at 65 is already far from being the norm and compulsory retirement at that age makes no sense at all.

In the Republic of Ireland, the social welfare retirement pension age is not in fact 65; it is 66. Let me explain why this is so. Until 1973 the public pension age was seventy, the age at which such pensions were payable from the time they were introduced by the Lloyd George Government in 1909. But during the 1973 election campaign rumours of an impending Fianna Fáil social welfare programme led me to devise at very short notice a Fine Gael social welfare policy, which was publicly announced and released to the press by the party's leader in a pre-emptive strike, just 1 hour and 40 minutes after I had been prompted by this rumour to start drafting it – which must surely be a world record for speed of party policy-making! In government two weeks later, at the request of the Labour Party Leader and Minister for Social Welfare, I converted this document into a Memorandum for Government, which was subsequently fully implemented.

Now, one of the elements of my policy was an annual reduction of one year in the age at which people would qualify for public pensions, moving down in each year's Budget, towards age 65. The truth is that no one, myself included, foresaw the evolution of our demography over the eighty year period to the mid-21st century – so this seemed a very good idea at the time. I have to say that 31 years later it seems to me that there is now a strong case for a gradual reinstatement of the public pension age of seventy which, if decided upon now, would reduce the Republic's mid-century public pension bill by about one quarter.

2 Figures published since this lecture was delivered show a further improvement, especially for men.

At this point let me say a few words about the history of our welfare services. The Lloyd George reforms of 95 years ago, involving the introduction of old age pensions and unemployment payments, took place a dozen years before the separation of the two parts of Ireland. In conjunction with the slightly earlier Conservative Government's reforms at the start of the twentieth century (which sought to 'kill Home Rule by kindness' through such measures as the provision of development grants for western areas), these radical Liberal reforms had the effect of reversing the nineteenth-century subsidisation of Britain by much poorer Ireland – a process that had taken place through substantial transfers of Irish tax revenue to Britain, not compensated by British expenditure here. (In the nineteenth century there were very few financial transfers from central to local level to finance housing, health, education or social welfare; taxation was spent in central services such as government and defence.)

This Lloyd George social revolution made Ireland for the first time dependent on financial transfers from across the Irish Sea. Independence for the 26 counties thus had a short-term negative financial effect, requiring reductions in civil service pay and, for a couple of years in the late 1920s, an actual reduction in the monetary value of the recently increased old age pension which, however, was more than compensated for by a fall in the cost of living.

The long-term effect of independence was, however, positive, saving the Republic from the debilitating effects of large-scale subsidisation by Britain. It also gave the Irish State an incentive as well as the freedom (of which, however, it did not take advantage until the end of the 1950s), to adopt fiscal, educational and promotional policies that eventually generated rapid economic growth. As a result, the historic gap between Irish and British per capita output and living standards has been eliminated. It should, however, be added that up to the late 1950s the rate of economic growth of the Irish State was even slower than that of Britain which was otherwise the slowest growing country in Europe from the 1890s until about 1980. Moreover, in the postwar period social provisions in Ireland lagged behind those in the UK, from which Northern Ireland as a part of the UK benefited.

By the early 1970s the Republic's social provisions fell so far short of the British provisions available in Northern Ireland that I then calculated that it would require a doubling of our social expenditure to match the contemporary level of social provisions in Northern Ireland.³ However, the process of narrowing this gap in social provisions had already begun in the 1960s, and in terms of social payments the gap has since gradually closed. The Republic, however, has yet to catch up with the UK, and therefore Northern Ireland, in the quality of some of its other social provisions although it has run ahead of Northern Ireland in respect of certain matters such as free transport for the old.

Why does the Republic still lag behind in certain social respects, given that its output per head is now slightly higher than that of Britain and much higher than in the North? (Due to the huge scale of transfers from Britain to Northern Ireland, living standards are still slightly higher there than here.) In part, the fact that in some respects social provisions in the Republic have yet to match up to those in Northern Ireland reflects a time-lag factor with respect to physical infrastructure. It takes a long time for the infrastructure of a poorer society to catch up with a rapid increase in its income and despite the fact that the Republic has for some time been allocating annually to investment (a 50 per cent higher proportion of its output than the UK), it will probably take another 15 years for the Republic to achieve a physical infrastructure matching that of Northern Ireland where in the later decades of the twentieth century public investment was on a very generous scale.

I have, however, to say that some of the remaining inadequacies in the Republic's social provisions seem to me to derive rather from a combination of two factors. Firstly, the Republic has had something of a stop-go economy because of fiscal mismanagement, which created a major hiccup in the late 1970s and a smaller one at the end of the 1990s, each of which were followed by damaging cuts in social spending.

3 Appendix 2 of my book *Towards a New Ireland*, 1972.

Secondly, a marked swing to the Right in public policy since the 1980s placed too much emphasis on reducing personal taxation at the expense of filling continuing gaps in the public and social services. It is significant that social services expenditure in the Republic today involves only 18 per cent of GNP, as against 27.5 per cent for the 15-member pre-accession EU as a whole.

Nevertheless, although more progress was made in improving social welfare provisions, including pensions, in the 1970s, when governments were more committed to social progress, recent years have also seen some further progress, especially in respect of pensions.

Table 2: Average manufacturing wage and non-contributory old age pension, 2003

	Wage	Pension	Ratio
1973	€340	€46	13.6%
1982	€354	€81	22.3%
2004	€533	€154	29%

Between 1973 and 1982, although the purchasing power of the average wage barely increased, the old age pension was raised by 80 per cent. Since 1982 the real wage has risen by 50 per cent and the pension by 90 per cent. Between 1961 and 1973, therefore, the pension increased from 12.6 per cent to 22.3 per cent of the average wage, and in the last two decades it has been raised further to 29 per cent of the average wage.

Let me mention, in conclusion, some of the issues in respect of which I believe further action is required; action that would, I believe, be stimulated by studying the experience of other countries in respect of these matters. Such comparisons could usefully be undertaken in conjunction with Northern Ireland, which, on this question of ageing, as on many others, has so much in common with us. These issues include:

- quality of residential care for older people who can no longer look after themselves
- services for older people in rural areas
- action to combat ageism
- pre-retirement allowances, PRSAs and Approved Retirement Funds
- equity release plans
- educational courses for older people
- housing for older people and home improvements grants
- dissemination of the WHO Heidelberg guidelines for promoting physical activities among older people
- nursing home inspection arrangements
- carer support programmes
- provision of transport, electricity, telephone and television for older people
- provision of specialist services for older people
- voluntary services for older people.

Second Session

Independence and Dependence in Old Age

Chair: Jimmy Duggan, Principal, Services for Older People and Palliative Care, Dept of Health and Children

Understanding Dependency: Challenges for Planners

Dr Anne Goode and Dr Eithne Fitzgerald, Senior Research Officers, National Disability Authority

Introduction

The term 'dependency' is widely used without always being clearly understood. The authors of this paper argue that there is a need to distinguish between three main types of dependency if we are to plan policy and services effectively. These are:

- necessary dependency (flowing from individual life situations)
- unnecessary dependency (created by society)
- complex dependency (a combination of the first two).

Each of these (necessary, unnecessary and complex dependency) can be expressed in various dimensions or aspects of people's lives, whether physical or economic, social, emotional, sensory or intellectual.

Necessary dependency is part of being human. It comprises our need for support and assistance from others because of frailty, illness, impairment or poverty. It is something we all experience at the beginning of our lives and most will experience at the end, whether that end comes in old age or earlier. In addition, very many people experience necessary dependency at other stages in the life cycle, whether because of disability or life crisis, temporary illness, accident or economic misfortune.

By contrast, socially created dependency may be associated with similar life events but is not a necessary consequence of them. Rather, it is a product of the interaction between the individual's life situation and the structures and systems within which that individual lives. We will see that if society were to change in, for example, its attitudes, the physical environment it builds or the services it provides, then some of the dependency that many older people experience would be reduced, if not eliminated.

It must also be stressed that some socially-created dependency is a myth, a product of misapprehension about the reality of people's lives. In relation to older people, perhaps the biggest of these myths is that absence from the world of paid work means dependency.

Finally, and perhaps most importantly for policy and service provision, we need to identify areas of complex dependency where there is a mixture of necessary dependency, which must be acknowledged and catered for, along with socially-created dependency, which can be reduced or eliminated.

A Social Model of Dependency

Following on from this analysis of the types of dependency, we propose that a social model of dependency needs to be developed similar to the social model of disability which is already widely accepted.

Traditionally, statisticians use terms like 'the active age groups' and 'dependency ratios' which label older people *per se* as dependent members of society. The predominant stereotype of older people tends to be one of dependency rather than seeing them as active and contributing citizens. In a similar way, people with disabilities are often seen as passive recipients of services, unable to work save in the most sheltered of employments, rather than as active citizens with a contribution to make.

In contrast, the social model of disability places a person's impairment in the context of the social and environmental factors which create disabling barriers to their participation in society. This differs from the more medical and individual concepts of disability, which equate a person's impairment with their disability, without placing it in any broader context.

In terms of old age, a social model would focus on whether society, in recognition of increasing frailty in old age, has created structures and supports which facilitate and maximise independence. Furthermore, a social model of dependency would challenge those myths which categorise people as 'dependents' while refusing to recognise their contribution to present-day society, whether in the present (through unwaged work, volunteerism, active citizenship) or in deferred benefit from the past (savings, insurance contributions, investment in the education of the younger generation).

To take a practical example, is physical dependency in old age primarily a result of failures of social supports and accommodation of diverse physical capacities, rather than primarily due to declining physical capacity? Since lowered physical capacity as we age is an almost universal part of the human condition, then accommodating that reduced capacity should be built in naturally to the way as a society we structure environments, products and services.

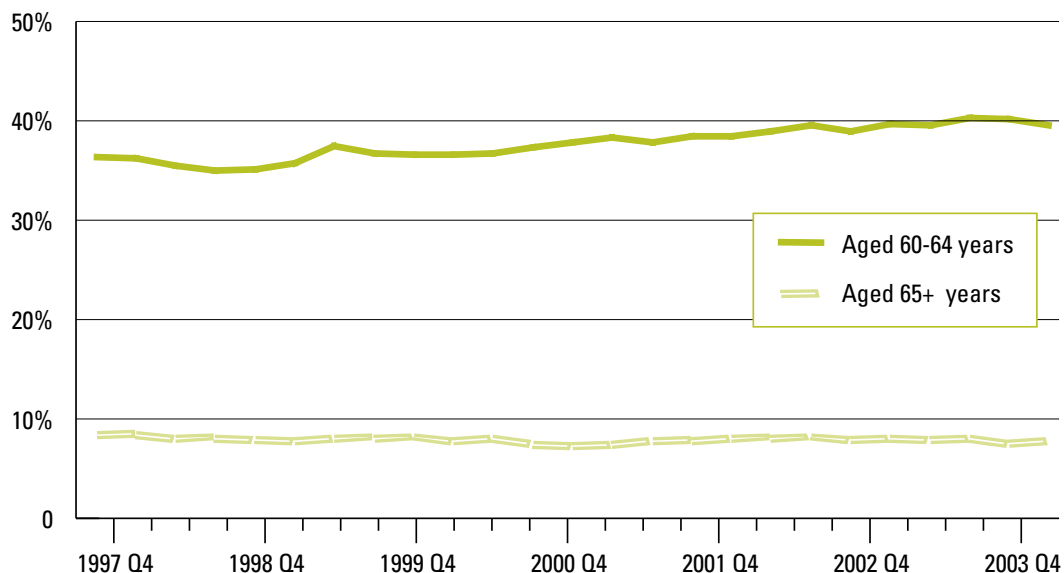
Take the concept of universal design, which in architectural terms means designing homes and environments that are usable by most people regardless of their level of ability or disability. This requires an understanding and consideration of the broad range of human abilities throughout the lifespan. The dishing of footpaths at road junctions not only facilitates wheelchair users, but also parents with buggies and older people who find steps difficult. Provision of a downstairs bathroom in a house can help prolong independent living for people who find stairs difficult to manage as they get older. We will return to this issue in more detail later in this paper.

First, we wish to look at the reality behind the myth that older people are less active in society and that participation can be measured in terms of paid work only.

Paid and Unpaid Work

Although we have a later age of retirement than in most OECD countries, along with other western societies Ireland has seen a trend towards earlier retirement. About 40 per cent of those aged 60-64 and about 8 per cent of those aged 65 and over are in the labour market.

Figure 4: Labour force participation aged 60+ years



While a majority of those aged over sixty are not in paid employment, many in the older generation play an important economic and social role in other ways. Routine daily childcare is provided by unpaid relatives, frequently the grandparents, to 54,000 families where the parents are at work, and care by relatives is the mainstay of after-school care. Another critical economic support from older to younger generations is the increasingly common practice of cash transfers to help younger people get started on the housing ladder. Furthermore, the education and training which underpins younger people's participation in paid work was paid for by the previous generation through taxes and other contributions to society as well as through private support and nurturing within families.

Finally, while the stereotype is that older people are the cared-for group, the 2002 Census enumerated over 16,000 people aged over 65 as primary carers.⁴

Community Activity

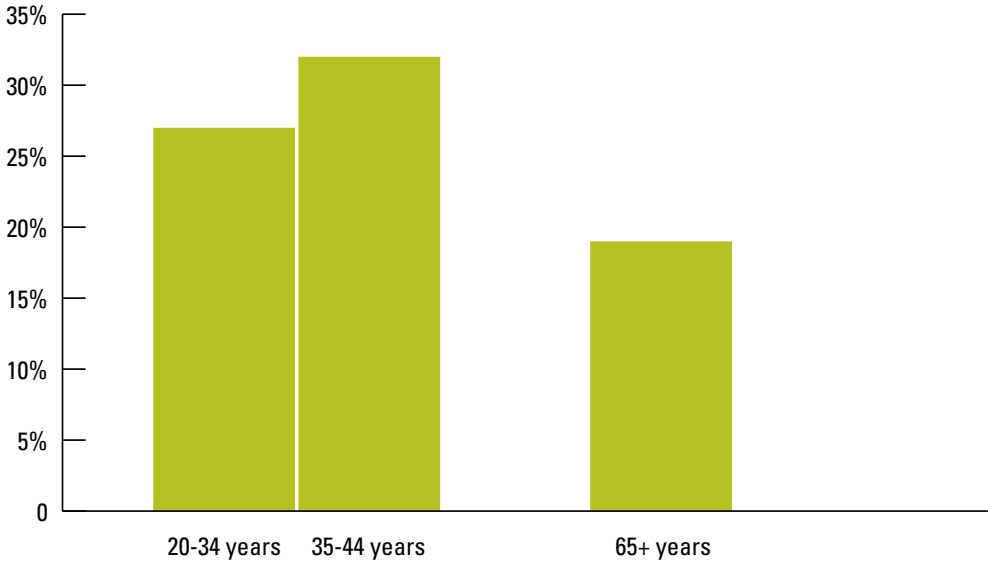
People who have retired form a key resource to all community organisations. Active participation in organised groups is somewhat lower among the older age groups than among those in their forties. (Parental involvement with their children's team games may account for much of the higher level of formal participation in the forties age group.) 19 per cent of over 65s become actively involved in groups, such as voluntary or community organisations, sports clubs, political or religious organisations, compared to 32 per cent of those aged 35-44.⁵

Organised community activity is only one way in which older people contribute to the fabric of a community. Very often, theirs is the only significant daytime presence in housing estates. The informal web of connections woven over generations by today's older people is an essential ingredient in sustaining community and a sense of place.

4 3.8 per cent of this age group.

5 QNHS module on voter participation and abstention, 2002.

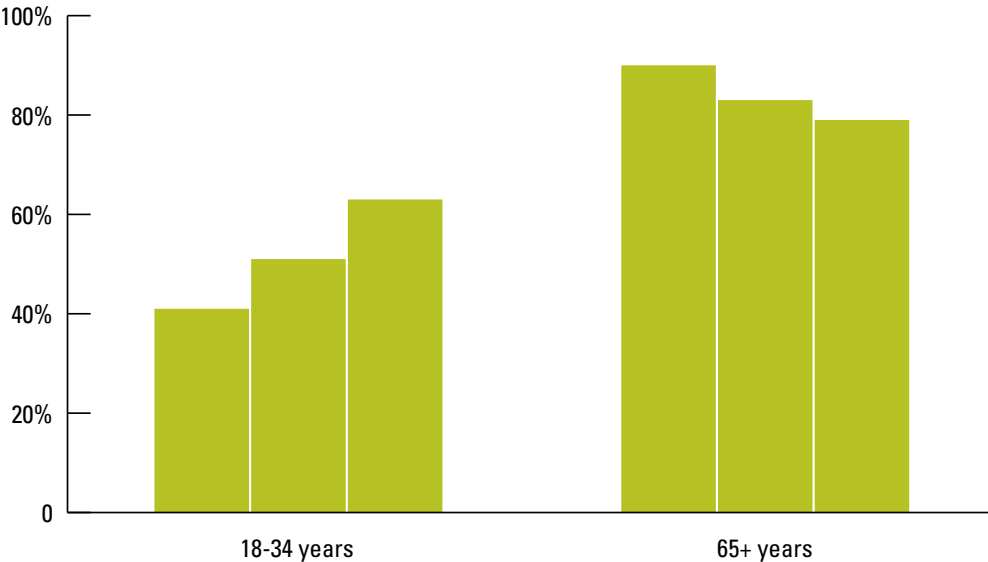
Figure 5: Percentage of older people active/very active in organisations, 2002



Political Involvement

In terms of one of the central measures of civic participation and active citizenship, older people are more likely to vote than younger age groups. Figures on voting by age group show that the proportion aged over 65 who vote ranges from 80 to 90 per cent, compared to just over 40 per cent turnout among voters aged under twenty, and about 66 per cent for those aged 25 to 34.

Figure 6: Percentage of people who voted, 2002



The voting turnout of those aged eighty and over is exactly double that of 18 and 19 year olds.

Having challenged the notion that old age is synonymous with a dependent role, the paper now proceeds to examine some of the supports and accommodations the wider society needs to make if independence in old age is to be fostered.

Living at Home

For most people, one of the key tests of an independent old age is to be able to continue to live at home. The vast majority of older people do live at home, however, a significant minority, which rises with age, are in nursing homes or hospitals.

A third of those aged over 75 who live at home live alone, and are clearly more vulnerable to loss of independence than those who live with others. How can independent living be better supported?

Table 3: Housing circumstances of older people

	Living in communal establishments*	Living alone in private households
65+ years	9.1%	28.4%
70+ years	11.1%	21.4%
75+ years	14.3%	33.9%

Source: Census 2002.

*Communal establishments includes those people recorded as staying in a hotel or guesthouse on census night as well as those in nursing homes, hospitals, religious congregations or hostels.

Lifetime Adaptable Housing

One in five people aged over 65 experiences substantial limits to basic physical activities, rising to one in three aged over eighty.

The concept of lifetime adaptable housing means providing homes which can continue to meet people's needs as they grow older and as mobility becomes more restricted. Basic features would be a downstairs bathroom, a minimum of steps and a room at the entrance level which could be used as a bedroom. Fully accessible housing would mean an absence of steps, a gentle gradient to the entrance door, wide doorways and circulation areas, and a bathroom with enough space to manoeuvre a wheelchair.

There is currently no data collected on the accessibility of the present housing stock, but the pointers suggest there is a significant accessibility problem. In urban areas, two-storey semi-detached or terraced housing is the norm, and downstairs WCs were only standard in more expensive or recently-built homes of this kind. Given that 80 per cent of people over 65 live in pre-1981 housing,⁶ most are likely to have missed out on this improvement.

Traditional local authority flat complexes never provided lift access for upper floors although that has become standard in modern apartments. Bungalows, which form the majority of newer built rural housing, provide fewer accessibility problems than the traditional urban housing stock.

6 Watson, D. and Williams, J., 2003. *Irish National Survey of Housing Quality 2001-2002*. Dublin: ESRI.

Housing grants for people with disabilities have averaged about 4,000 a year over the last five years, or 0.3 per cent of the housing stock every year.

Up to 2001, no requirements on accessibility applied to newly-built housing. Since then, Part M of the Building Regulations requires that new homes⁷ be visitable by people with disabilities, effectively requiring a level entrance threshold, and a downstairs WC. However, duplexes and walk-up apartments are still permitted provided the stairs meet certain minimum standards. It may also be permissible to have steps from the street to the entrance.

The National Disability Authority (NDA) has recently commissioned research to look at the effectiveness of these building standards and at best practice in regulation for accessibility. However, even if future new homes are fully accessible, there remains the issue of ensuring that existing homes fully meet the needs of the frail older people and those with mobility difficulties. While people may be eligible for State grants to adapt homes, in practice limited council budgets can restrict or delay such grants. Delays in getting an occupational therapy appointment can slow down getting work done, as can restrictive requirements by local authorities that no work should start until all the paperwork is complete.

There is still a considerable distance to go before we have achieved the goal of lifetime adaptable housing.

Transport and Mobility

Transport to and from the shops, to other community and social facilities, and to visit friends and relatives is another essential part of independence. While Free Travel is a wonderful scheme, it is not effectively accessible to people who are not served by public transport (for example, in rural areas), to people who are too frail to get to the bus stop or train station, or who cannot get on and off buses or trains.

All new buses being purchased by Dublin Bus are to be fully accessible, and a programme is underway of route by route implementation of an accessible fleet.

Currently the Free Travel Pass can only be used on regular public transport services such as CIE buses and trains. The Mobility Allowance, a cash payment which can be spent on taxi fares or other alternative transport, is limited to those aged under 66 who fulfil the qualifying criteria (unable to walk and use public transport).

Footpaths as Obstacle Courses

We have had election campaigns about potholes, but Ireland's footpaths and pavements constitute a considerable obstacle course for people with impaired mobility. It is interesting to note that in the US, often seen as behind 'old Europe' when it comes to social provision, has successfully ensured that every footpath in half a continent is dished at junctions. If we chose as a society to make it a priority, in the same way that motorway plans are being fast-tracked, it would be perfectly feasible to plan that accessible footpaths would be achieved over the next two years if the budget were allocated and the work programmed to that end.

Likewise, if bonds were issued for all road openings and forfeited if the resultant surface was not properly restored, local authorities could readily ensure that the army of road openings for water, telecommunications and gas connections did not give rise to fresh obstacle courses for those whose mobility has become impaired through illness or old age.

7 That is, new homes built after 1 January 2001 unless planning permission was secured before 31 Dec 2000 and the work has been substantially completed by 31 December 2003. Effectively the provision on 'visitable' housing is only fully in force for new building since January 2004.

The *Study to Examine the Future Financing of Long-Term Care in Ireland* (Mercer Report) was published by the Department of Social and Family Affairs (DSFA) exactly one year ago. A formal process of consultation on its provisions with specialist interests has begun, and wider public consultation is due to begin shortly.

The Mercer Report documents how people are *entitled* to subventions towards care in a nursing home but are merely *eligible* for community support services such as nursing, home help, respite care, or occupational therapy, where actual receipt of a service may be limited by health board budgets.

This study recommends payment of a subvention for home care or assisted living facilities as an alternative to the subvention for residential care. The proposed subvention could consist of services, vouchers to enable the recipient to purchase services, or cash (which would give the recipient complete flexibility either to purchase care or to use the benefit for some other purpose). It suggests that a scheme of assistance with long-stay care costs could be financed through social insurance.

If, as a society, we want to promote and underpin independence in old age, putting in place a workable, accessible system of home support is central. We look forward to an in-depth discussion on the detail of these proposals with a view to coming up with a workable and achievable system of support which is put into action.

Conclusions

Independence and autonomy are something most people take for granted when we reach adulthood, but the language and practice of dependence re-emerge as people enter old age. Fostering and supporting independence in old age means creating a society that removes obstacles and offers practical supports which ensure that declining physical strength does not become synonymous with a loss of independence, autonomy or dignity. Old age is a natural part of living, and support for old age should be embedded in everyday structures of our community and society, not just in provisions which segregate older people from the rest of the community.

If this vision is to become a reality, those planning our national policies and services face a number of challenges. These can be summarised as:

- making universal design and access the norm across Ireland
- adapting all mainstream services so that they address the needs of all citizens. This may include changing perceptions and attitudes of those providing services
- creating the knowledge base required for evidence-based change
- challenging myths and prejudices regarding older people
- consulting with older people and their organisations as a coherent part of the planning process
- where new initiatives are piloted and shown to be effective, these then need to be rolled out nationally.

These changes must be informed by the principles which underlie the approach of the NDA to removing the obstacles that prevent people with disabilities playing a full part in our society. Those principles apply with equal force to securing independence in old age.

Maximising Independence for All in Old Age: Challenges for the Planners

Prof. Hannah McGee, Health Services Research Centre, Royal College of Surgeons in Ireland

Introduction

Independence is about not being under obligation or not being subject to others. The challenge is to ensure how we can make everyone independent, even when there is a level of dependency. This presentation asks what the challenges for older people are and addresses two specific issues:

- old age presents a complex problem for planners, involving as it does elements of independence and dependence
- the meaning of 'independence for all' needs to be explored and defined.

Ageing is a Complex Problem for Planners

One of the difficulties is that ageing contains both positive and negative elements. On the positive side, individuals are living longer and living better for longer through a compression of morbidity. There is strong evidence of increasing good health into old age, albeit for well-off older people. Older people can also be a successful lobby group for changes that can benefit society as a whole. They are a potential resource that can make a significant contribution to their own families and to society generally. Older people continue, therefore, to make a significant but largely unrecorded contribution to economic, social and civic society. Sometimes, however, this potential is overlooked because of excessive concern about the costs associated with an ageing population. On the negative side, policy-makers worry about both the pension implications of increased longevity and the health and social care costs associated with ageing. The problem is that the latter concern sometimes dominates official thinking on planning for ageing.

One of the difficulties in the current thinking about ageing is that the medical model predominates. This leads to a narrow conception of the ageing process and focuses on medical needs and problems to the exclusion of environmental and psychological influences. Ageing is seen as a chronological event, not as a psychological and social process. A generic understanding of ageing is absent. We need, therefore, to distinguish biological and genetic aspects of ageing from prejudice and discrimination exhibited through economic structures and social processes. We also need to get a better sense across the population of how people experience their own ageing. Ongoing work commissioned as part of the Healthy Ageing Research Programme (HARP), a five year research programme on ageing in community and patient population contexts funded by the Health Research Board (HRB), should shed some light on this issue.

Meeting the needs of older people requires action on a number of fronts: psychological; social; physical; and environmental. Independence is centrally linked to who makes the decisions about issues affecting older people. In a Eurobarometer Survey of 1992⁸, a question was asked about who should decide about services for older people. In Ireland, over 40 per cent of respondents said that decisions should be made by relatives and close friends. Only 22 per cent of respondents in Ireland said it should be older people themselves, compared to 34 per cent for the rest of Europe. Both of these percentages are relatively low but the Irish figure suggests an even more paternalistic attitude to the capabilities of older people than does the European average.

Another dimension of independence is the need to feel that an older person can acknowledge their needs and feel comfortable accessing or using the required services should they need them. In the *Health and Social Services for Older People (HeSSOP)* report (Garavan *et al.*, 2001), stigma was reported as a barrier to availing of services. Thirty per cent of older people said that they would find using the meals-on-wheels service 'highly embarrassing' and would only use the service 'with difficulty'. Twenty per cent of people would not use a home help service even if they needed it because of a sense of shame or stigma. The more obvious or the more social the need, the more likely people were to refuse the service due to embarrassment or shame. It is clear from this data that we need to create an environment where services are available by right and are also perceived to be so by older people.

The *HeSSOP* study also shows that older people have very strong preferences about their own long-term care, yet over three quarters have never discussed these with others (Garavan *et al.*, 2001). There is little evidence in the data of forward planning by people. There is a clear need to encourage discussion of long-term care needs much more widely and earlier in life. That said, independence is also linked to the availability of the services that the older person needs, and where and when the individual needs those services. There is strong evidence of an imbalance between need and availability of services. One of the difficulties in this regard is the paucity of some community care services, which continues to undermine the independence of older people living at home. The *HeSSOP* study again shows the difficulties that older people encounter in accessing the services needed (Garavan *et al.*, 2001). One of the reasons for the weakness of supply is that not enough attention has been given to the training and funding of the range of health professionals to meet the level of need that exists in this country.

Independence is also associated with the choice of where people live. When older people were asked in the *HeSSOP* study for their wishes were they to need long-term care in the future, there was a clear preference to be cared for in their own homes with minimal health service involvement (Garavan *et al.*, 2001). Eighty seven per cent of those questioned wanted to remain in their own homes. Over 50 per cent wanted to be cared for by a family member or friend, with 25 per cent having no preference and 25 per cent preferring professional help. Planning for the future needs to acknowledge the wishes of older people about where they want to live and to provide appropriate services to enable them to do so.

The task for planners is to ensure that the voices of older people are heard when it comes to decision-making about services, about where older people live and where they die. People want to stay at home but much of the funding goes to support care in residential settings. We need more information about how older people feel about current decision-making structures, including their own involvement in the process. We also need greater advocacy for older people in the policy process, to ensure that policy designed to support home-based living is implemented.

8 Commission of the European Communities, 1993. *Age and Attitudes: Main Results from a Eurobarometer Survey*. Brussels: Commission of the European Communities.

There are a number of challenges for planners, which need to be addressed to improve the quality of life and well-being of older people. We need to:

- develop our understanding of ageing
- enable older people to feel valued
- encourage discussion of important life decisions as the norm
- ensure service planning for projected need in most appropriate setting
- consider preferences and creative solutions to challenges such as housing
- achieve most of this through commitment to consultation and evidence.

In summary, the challenge for planners and for each of us is to create a society in which we are willing to grow old and a society that allows us to grow old with dignity.

Third Session

Meeting the Needs of the Older Population: The Evidence Base for Planning

Chair: Dr Davida de la Harpe, Dept of Public Health, ERHA and Chairperson, NCAOP Policy Standing Committee

The Older Population: Information Issues and Deficits

Patricia Conboy, Policy Officer, NCAOP

Introduction

In planning to meet the needs of an ageing population, information about that population is a key requirement. This is a subject that the members of the NCAOP's Policy Standing Committee and staff working with the Committee have been considering in recent months.

The thinking that we have done to date is encapsulated in a discussion paper entitled 'The Older Population: Information Issues and Deficits'. Copies of the discussion paper will be available to you following the conference today. The findings set out in the discussion paper are based on a survey and analysis of national datasets. In this presentation, I hope to introduce you to some of the findings in that paper.

Survey and Analysis of National Datasets

A short preamble is necessary to establish the wider context for the NCAOP's work on national datasets. In this preamble, I am commenting on four points: our reasons for examining national datasets; our application of the WHO's Active Ageing Policy Framework to our work; the importance of evidence-based policy-making; and the overall approach we have taken to the survey and analysis of datasets.

Why Examine National Datasets ?

In terms of meeting the challenge of population ageing, there are specific requirements. These include population projections, information systems which can provide us with adequate and timely data about the older population and the practice of strategic planning.

National datasets, such as the census, are repositories of information about the Irish population. They represent an important part of the evidence base for planners and policy-makers. Within the Policy Standing Committee, we thought it important to establish both what those datasets tell us about the older population and what they fail to tell us about that population. We also thought it important to identify, for the purposes of wider and ongoing discussion, information issues arising in the course of our work.

Determinants of Active Ageing

Participants in this conference are already familiar, I know, with the WHO's Active Ageing Policy Framework. I refer to it here because the WHO's positive vision of ageing has provided the NCAOP with a touchstone in considering the orientation and content of the national datasets referred to in this survey. Active ageing is 'the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age' (WHO, 2002).

The WHO identifies a range of determinants and the interplay between those determinants as predictors of how well both individuals and populations age. There are two cross-cutting determinants: culture and gender. There are also determinants related to personal factors, the social environment, the physical environment and to health and social service systems. Finally, there are behavioural and economic determinants.

Evidence-Based Policy-Making

In the Irish setting, there is an increasing emphasis on evidence-based policy-making. I am simply going to refer, without elaboration in this presentation, to the fact that the National Statistics Board (NSB) and the CSO have been involved in a series of initiatives to promote the development of data frameworks at national level. There is also the NHIS promised by the DoHC, and the HRB's strategy for health research.

The point is that the NCAOP's work on national data frameworks is happening at an opportune time. Our hope is that thinking from the perspective of the older population may both contribute to, and benefit from, other data development initiatives in the national setting.

Approach to the Work

There are some comments that I need to make at the outset :

- the work has been carried out within a fairly limited timeframe of just over six months
- it has been done within specific parameters. The focus has been on national datasets rather than local or regional studies or the research literature about the older population
- the discussion paper that you will receive today is a working document, incorporating an interim summary and interim conclusions. The intention is that the contents of the paper will be reviewed in light of your comments. We hope to receive your feedback today and in the weeks following the conference.

The Datasets Explored

The datasets explored in this survey were:

- Census 2002 from the CSO
- *Health Statistics 2002* published by the DoHC

- the Hospital In-Patient Enquiry Scheme (HIPE), managed by the HIPE Unit of the Economic and Social Research Institute (ESRI) on behalf of the DoHC
- the *Irish National Survey of Housing Quality 2001-2002* (NSHQ), conducted by the ESRI on behalf of the DoEHLG
- the Living in Ireland Surveys (LIIS), which were part of an EU-wide survey to collect information on income distribution between 1994 and 2001, and were managed by the ESRI. These surveys have now been replaced by the Survey on Income and Living Conditions (SILC), under the management of the CSO
- the *Long-Stay Activity Statistics* published by the DoHC
- the National Cancer Registry which collects comprehensive cancer information for the whole population of Ireland
- the National Intellectual Disability Database (NIDD), maintained by the HRB which provides information on specialised health services either currently used or needed by people with intellectual disability
- the NPSDD, maintained by the HRB, which provides information on specialist services currently used or needed by people with physical or sensory disabilities
- the National Psychiatric In-Patient Reporting System (NPIRS), which provides national and regional information on in-patient psychiatric services and the users of those services
- the QNHS, conducted by the CSO. The principal purpose of the QNHS is the production of labour market estimates, but it also carries additional modules on social topics
- The National Health and Lifestyle Surveys, SLÁN (Survey of Lifestyle, Attitudes and Nutrition), conducted by the Centre for Health Promotion Studies at NUI Galway on behalf of the Health Promotion Unit of the DoHC. These surveys are intended to identify lifestyle trends and changes in health behaviours in the Irish adult population.

Thematic Headings

I am presenting findings on information issues and topics under six thematic headings. These are derived from a draft framework devised by the SGSES which, last year, published a report, *Developing Irish Social and Equality Statistics to Meet Policy Needs*.

1: Population

Concept of Old Age Dependency

When we talk about population, we inevitably talk in terms of the dependency of the older population. How useful is this? In commenting here, I am drawing on the work of Arber and Ginn in the UK. They question usage of terms and concepts such as 'the dependent population' and 'old age dependency'. Such thinking, they suggest, conveys an implicit message that devalues the lives and contributions of a particular group in society, and also no longer accurately reflects the realities of our society. The 16-64 years range, for example, no longer reflects the age patterns of paid employment. Younger people

spend longer in education and fewer enter the labour force in their mid teens. Retirement patterns are changing for the older population. In addition, activity that benefits the economy is not confined to paid employment. A significant percentage of older people, for example, are providing unpaid, informal care to spouses or other family members.

Publication of Age-Specific Data

There are two aspects to the issue of the publication of age-specific data. One aspect is the presentation of results without any data on age of respondents (although such data may be potentially available by special request); the publication of the census results on housing is an example of this. The other aspect is the presentation of data about the older population using the single age band of 65 years and over. This approach fails to take account of the heterogeneous nature of the older population and the reality that the needs of older people change with advancing years.

2: Households, Families, Social Relations and Integration

The Social Contribution of Older People

The kind of data that is gathered for the main datasets reflects mainstream concerns with labour market participation, and with education and training oriented towards labour market participation. These are forms of participation in, and contribution to, our society that are valued, measured and recognised.

Measures and indicators designed to assess other forms of contribution to societal well-being are much less well developed. Day-to-day experience in families, communities and public life may indicate to us that older people, the majority of whom are not labour force participants, make a valuable contribution to societal well-being in their myriad roles as individuals, family members and citizens.

However, the means of systematically naming and measuring the types of social contribution made by older people and other groups who are not primarily labour force participants have yet to be applied in our national datasets.

The Care of Older People

Census 2002 provides us with data about the percentage of the population providing regular, unpaid personal help for a family member or friend. Of the total population, 4.8 per cent are providing this kind of help and more than a tenth of those carers are themselves older people. The national datasets, however, do not provide data from the point of view of the care recipient, nor do they show:

- how many of those to whom care is provided are in the 65+ years group
- what the relationships are between care giver and care recipient
- the nature and range of tasks undertaken by those providing informal care to others, for example, personal care, household tasks, help with shopping or correspondence
- how the family and social networks of older people function at times of crisis or transition in the lives of older people, for example, discharge from hospital with a new level of disability or dependency.

In terms of, for instance, the strategic planning of long-term care services for the older population, information of this kind is essential.

Participation of Older People in Society

Beyond figures in one QNHS module on voter participation and some SLÁN data on social engagement, data on the participation of older people in society is not systematically gathered.

3: Health and Access to Healthcare

Under this heading, I would first like to make some comments about population-based morbidity and disability data. Then I will refer to aspects of three datasets in particular.

Population-Based Morbidity and Disability Data

Existing sources of population-based morbidity data are the National Cancer Registry, the National Disease Surveillance Centre (NDSC) which tracks notifiable diseases and, potentially, the Coronary Heart Attack Ireland Register (CHAIR), currently being piloted in the Southern Health Board. There is an unmet need for the inclusion of population-based morbidity data in our national datasets.

Census 2002 has provided some data on disability in the total population. This shows that 8.3 per cent of the total population reported a long lasting health problem or disability. The proportions of people reporting problems increases with age. Of those aged 65 years and over, 31.1 per cent reported a long lasting health problem or disability.

There is much that the national datasets do not tell us about disability in the older population. Not least, the datasets surveyed do not yield systematic and population-based data on the causes of the increasing occurrence of impairment in older age. No data, for example, is centrally recorded on the development of disabilities associated with injuries including falls, or the extent to which chronic diseases (e.g. problems associated with stroke, osteoporosis and diabetes), are the cause of recorded disability in older age.

This has implications for the development of preventative and health promotion strategies targeted at the older population.

Exclusion of Older People from the NPSDD

Currently, inclusion on the NPSDD is limited to those who are less than 66 years of age (with the exception of people who reach the age of 66 while on the Database and who are not removed from it). This is the case despite the fact that a significant percentage of the older population is afflicted by late onset disability.

National Psychiatric Out-Patient Database

At present, there is no national psychiatric out-patient database (though the HRB is working on the development of a software system which will eventually be used to gather psychiatric out-patient data).

In contrast, details of in-patients of the psychiatric services are recorded in the NPIRS. This system includes details of in-patients' demographic, clinical and socio-economic status.

One of the implications of the lack of an out-patient database is that the activities of community-oriented services such as those of Old Age Psychiatry are not fully reflected in the national datasets. Old Age Psychiatry did not feature as a dedicated heading in any of the datasets surveyed and relevant figures quoted in this section of the discussion paper are from data compiled by the Irish College of Psychiatrists rather than a national dataset.

Figures for Length of Stay in Long-Stay Care

The *Long-Stay Activity Statistics* provided by the DoHC showed that 76.9 per cent of older people who were in long-stay care in 2002 had been resident for less than three months. When the figure is unpacked, however, it proves to be unreliable: it includes older people who are availing of respite care and collates admissions, discharges and re-admissions in one global figure.

People, Services and Information Systems in the Health Domain

Remaining within the health domain, I would like to make more general points about our health-related datasets under three headings: people, services and the development of information systems.

People

The main health-related datasets operate within specific parameters, tracking activities and events within discrete areas of the health services. For example, both HIPE and the *Long-Stay Activity Statistics* track activities in their respective spheres.

The overall system we have is one in which datasets operate as 'islands of information' (a phrase I have borrowed from a CSO report), tracking activities and events rather than individuals. The same individuals may be making recurrent visits to hospitals; or, invisibly, negotiating 'a revolving door' in terms of both health and social services; or experiencing multiple difficulties in a community setting.

Our datasets, since they are not person-centred, cannot enable us to identify those individuals or construct a more accurate profile of the older population as a whole or of vulnerable sub-groups within the total population of older people.

The Services

In terms of the health services, and here I'm thinking particularly of the health statistics provided by the DoHC, the focus is on inputs, for example, the numbers of Public Health Nurses (PHNs) in different health board areas; and on throughputs, for example, the rates of bed occupancy and numbers of clinical attendances in different hospitals and clinics.

Data on the outcomes of their interactions with services is much harder to find. Similarly, data on the composition of client groups is limited. There is an overall lack of contextual data enabling the analysis of the adequacy of health services provision for a population. This applies, for example, to the geographic distribution of health services and, therefore, the access of older people in different parts of the country to services that they might need. It also applies to levels of provision within specific sectors and specialities such as homecare and geriatric services.

The Development of Information Systems

There is, as indicated at the start of the presentation, recognition of the need for further development of our national information systems, in health as in other domains. The issues to be tackled if this kind of development is to take place have been identified:

- if datasets are to provide person-centred data, the use of a unique personal identifier is necessary. The SGSES has recommended the use of the PPSN as such an identifier. However, legislative change would be necessary to enable this

- the difficulty in cross-referring and linking between datasets needs to be tackled, not within the health sector alone, but between datasets in different sectors such as housing and education
- there is a need to build up a profile of the older population using an agreed, consistent and comparable range of variables, including those denoting socio-economic status, across different datasets. In their absence, analysis of the links between poverty, inequality and ill-health, for example, will be circumscribed.

4: Income, Wealth and Poverty

Under this broad heading, I am going to comment on four points: income and living standards; indicators of socio-economic status; family support systems; and health and social care expenditure on the older population.

Income and Living Standards

The authors of reports based on the findings of the LIIS have suggested that, in the case of the older population, there is a particularly weak link between cash income and people's living standards. This is attributed to the range of 'free schemes' operated by the DSFA, the accumulation of resources over a lifetime and family support systems. Data from the DoEHLG shows that a significant proportion of older people have difficulty in meeting needs outside the basic range, for example, in replacing worn furniture or taking holidays.

The surveys cited deal with samples of the whole population rather than the older population in particular. Furthermore, they present older respondents with questions and options in closed response formats. I suggest that we need more open-ended research that will explore the material needs of older people from the perspective of older people themselves.

Indicators of Socio-Economic Status

With regard to indicators of socio-economic status, I would like to pose a question to others who are more expert in this area: are the usual indicators of socio-economic status adequate in the case of older people? The traditional indicators of socio-economic status are income, occupation and education. Each of these indicators seems to have its own shortcomings when applied to the older population.

Does further work need to be done to develop composite measures that take better account of other dimensions already identified as important for the older population? Such dimensions include condition of housing, access to public health and social services of decent quality, ability to cope with financial emergencies and unplanned spending needs. This is a question that I would welcome feedback on.

Family Support Systems

Family support systems have been referred to above in terms of how families may support older members. In practice, these intergenerational transfers work both ways. For example, we know, in a general sense, that members of the older generation are helping young adult members of their families to purchase their first homes.

Remarks have already been made about perceptions of dependency in old age and the general lack of data about the contribution and participation of older people. In that context, it would be beneficial to have more systematic data about how such intergenerational transfers from old to young work in practice.

Health and Social Care Expenditure on the Older Population

The DSFA provides figures on total expenditure on Old Age Pensions and other benefits. The result is that it is possible to see what proportion of that Department's budget is allocated to the older population.

The same is not true of the expenditure of the DoHC on services for older people. The result is that it is not possible to examine the level of funding allocated to the older population; or to compare levels of funding allocated to services for older people with levels allocated to services for other sectors of the population.

5: Education, Training, Labour Market and Working Conditions

The fifth thematic heading in the discussion paper is that of education, training, labour market and working conditions. In this presentation, I am referring to just two points: older people's educational opportunities and preferences; and labour market issues.

Educational Opportunities and Preferences

The datasets do not provide us with information about older people's needs and preferences in terms of lifelong learning opportunities. Similarly the datasets do not inform us about barriers to access and participation of older people in existing education provision.

Labour Market Issues

Commentary about population ageing is frequently conflated with discussion about the 'ageing crisis'. The consequences of population ageing are not inevitably dire; they may become dire in the absence of proper planning to meet a future challenge.

One of the spheres in which this kind of planning can bear fruit is that of employment, retirement and pension planning. The NCAOP's own research shows that a significant proportion of older people have employment and retirement preferences which, if facilitated, could dovetail with public planning and policy needs. For example, a significant proportion of older retired workers have reported that they would have liked a more gradual retirement than was possible. To name just one area, more information is needed about factors influencing the retention of older workers whose preference is to remain within the labour force.

6: Transportation, Housing, Safety and Security

Comments here fall under three headings: access to transport and travel patterns; housing needs of older people; and vulnerability to crime.

Access to Transport and Travel Patterns

Data on older people's access to transport and on their travel patterns is patchy. Twenty five per cent of SLÁN respondents reported difficulties with public transport, though the nature of the difficulties was not specified. The DoEHLG survey showed that significant percentages of older households cannot afford a car or van.

Census 2002 did not seek to establish the travel patterns of older people. The focus in the census was on the travel patterns of those attending school, college or going to work.

Housing Needs of Older People

In terms of older people's housing needs, there is a significant gap in information about their needs for: housing adaptations/extensions in the event of disability and ill-health; and intermediate accommodation options between their own homes and residential care (i.e. nursing homes and other forms of long-stay care).

Vulnerability to Crime

Our data about older people's vulnerability to crime is limited. QNHS findings from 1998 showed that a small percentage of older people were repeat victims of crime. This suggests a vulnerable sub-group. Currently, as indicated earlier, there is no systematic way of identifying vulnerable sub-groups or of building a profile of them through the national datasets.

Finally, elder abuse takes many forms and is a stark example of crime against older people that often remains unnamed, invisible and, therefore, unrecorded.

Interim Conclusions

Representations of Ageing and Older People

Datasets are not neutral repositories of information about the older population. The selection and usage of concepts and indicators to describe older people reflect underlying assumptions about ageing. One of the most striking features of the datasets relates to the use of the concept of dependency to consider the implications of an ageing population, juxtaposed with the limited data available on the older population's participation in and contribution to society, communities and families.

Person-Centred Data and the Profiling of the Older Population

The population of older people does not form a homogeneous group. The reality is that increasing numbers of older people are remaining active and independent into older age. At the same time, there are also smaller sub-groups of older people who are more vulnerable and in need of special support whether due to reasons of ill-health, low income, social isolation or vulnerability to crime, or a combination of these and other factors. In the NCAOP's view, what is required is the capacity to plan simultaneously to meet the needs of the total population of older people and of vulnerable sub-groups of that population.

The corollary of this is the need to be able, through national datasets, to profile the older population as a whole, within different age bands, in terms of a range of health, social and economic indices; and to identify vulnerable sub-groups. The availability of person-centred data about older people would help to meet these needs.

In advocating the need for the availability of person-centred data about older people, the NCAOP is mindful and fully supportive of requirements to honour the confidentiality of individual patients and to operate within the parameters of both Freedom of Information and data protection legislation.

Data to Support Preventative Healthcare and Health Promotion Strategies

Valuable data on the health status of the older population is included in existing datasets. There are significant gaps in the data, however, with respect to population-based morbidity data and data on the prevalence and incidence of different forms of impairment and disability in the older population. Increased levels of impairment, disability and ill-health affect the lives of all of us as we age. Much of this debilitation is preventable. We need a continuing emphasis on preventative healthcare and health promotion to reduce the impact of preventable illness and disability. Population-based information in national datasets is an essential tool to facilitate this process.

Proactive Development of Inclusive and Holistic National Datasets

In terms of the development of holistic datasets fully inclusive of the older population, the NCAOP advocates a proactive approach on the part of the responsible individuals and agencies. The NCAOP also signals its own willingness to contribute actively to that process with others.

There is a need for all relevant national datasets to record, collate and publish data about the older population. Criteria for inclusion in a national dataset which exclude a sector of the population on the basis of age are discriminatory.

Where the older population are included in datasets, published reports need both to provide age-disaggregated data and to move beyond the presentation of all data relating to the older population under a single band of 65 years and over. The older population, as already stated, is heterogeneous and this is reflected in differing needs and concerns as older people move through successive age bands.

Datasets must be holistic, that is, incorporating the perspectives of older people and depicting them in the round, not solely as frail dependents but as interdependent citizens with a part to play in all areas of family, community, social and national life.

Final Words

In conclusion, I would like to draw on a phrase coined by the SGSES. In the course of their work on national datasets, this group spoke of the importance of 'mapping the interface between data and policy-maker'. This is a phrase that I like. It captures something of the meaning of the task that the NCAOP's Policy Standing Committee embarked on some months ago. It also reflects something of the sense of adventure and path-finding that goes with the work that I have sought to introduce to you this afternoon.

By its very nature, the process of exploring the interface between data and policy-maker must be a shared process. At the outset, I referred to the fact that the paper on which this presentation is based is a working paper with an interim summary and conclusions. I hope, along with members of the NCAOP's Policy Standing Committee, that you, the conference participants, will offer comments and feedback on the work to date, both today and in the coming weeks.

Panel Discussion

Speaker: Dr Ruth Barrington, CEO, Health Research Board

Thank you to the NCAOP for the invitation to participate in this very important conference today. Congratulations to Patricia Conboy on what I think is an excellent and very stimulating paper, and one that I think will certainly hold up a mirror to a number of us with responsibilities in the system for health information. It challenges us to do better in our contribution to planning for an ageing society. The paper is not so much a criticism as a call to all of us to think in new and fresh ways about what is a relatively new social phenomenon, an ageing Ireland.

The concept of active ageing that the WHO has promoted and which is reflected throughout this report, is one of optimising opportunities, participation and security for older people in order to enhance their quality of life. This is a very fruitful concept and one that, if we keep it in mind as we think of information and research needs, will help answer some of the questions that we have. The WHO has defined the determinants of ageing, of active ageing, as culture and gender, health and social service systems, behaviour, personal factors, physical environment, social environment and economic conditions. These are logged in a very helpful way in the paper.

The interesting thing for me about these determinants of active ageing is that they are not only the determinants of active ageing, they are the determinants of whether you live a healthy life at all ages. Recent research on the determinants of health has highlighted the extraordinary impact of socio-economic conditions on our health at every age. There is a very important paper, published recently by the Institute of Public Health in Ireland on behalf of the Public Health Alliance (a new alliance formed to promote health), that highlights the fact that the death rates of poor people in Ireland are three times higher than those for the most privileged in society. Perhaps, therefore, the greatest health inequality may be that poor people are much less likely to live to enjoy an active old age than people who are better off. Thus, a significant number of people in our society may not actually get to benefit from the revolution in life expectancy that the average Irish person has come to expect over the last hundred years or so. The poor who do live to old age tend to have much worse health because of an accumulation of lifetime disability and ill-health, and they tend to face old age with higher levels of disability. They are also likely to have lower life expectancy at age 65 than those who are better off.

Given the evidence from other countries about the burden of health inequality carried by people on low incomes, it seems fundamental to me to try to capture this information for Ireland and to design information systems that will monitor the impact of determinants of health and active ageing on a regular basis. More immediately, what do we need to do? We can certainly do more with the datasets that we already have to bring out the ageing dimension. I am representing an organisation that is responsible for three of the datasets that Patricia used as a foundation for her paper. I can see a number of small but significant steps that we can take to make an analysis by age easier, including, for instance, a breakdown of the over 55 years category in the NIDD. We can certainly reconsider the rationale for excluding those who develop a disability when they are older than 65 from the NIDD. We can also build bridges across various databases to bring out more clearly information relevant to older people both between health datasets, a particular challenge to us in the health system, and also between datasets and other important sources of information such as the census. The use of a single identification system is an important element in this process and has been on the agenda for some time but no Government decision has yet been taken to develop it further.

There is, however, a ready-made identifier now for the older population, at least in relation to health data, and that is the medical card number. Every person over the age of seventy is now entitled to a medical card and anecdotally it appears that there has been an overwhelming response to the offer of the extension of eligibility. We could probably begin linking health data relevant to older people with medical card number with some new thinking. An added benefit would be, of course, to emphasise more strongly the human aspect of the databases, which Patricia has brought out. Currently, there is an over-emphasis on services delivery; the people aspect could be brought out more in addition to their value to service planning and monitoring.

The extent of the deficiencies in information and data raises its own questions as to what are the most important needs in this area. We need to prioritise the information needs relevant to older people and an ageing society. I think that an important point is made by this paper in even raising this question. I would refer back to the NCAOP the challenge: can the NCAOP through its extensive contacts with people who are old and people who are involved in designing, planning and delivering services for older people prioritise information needs? Can a consensus emerge as to what are the key information needs that have to be met and how to provide some kind of a prioritisation of these? I think it would be very helpful to do that on behalf of the system.

It also struck me from reading the paper that we should think of applying some tried and tested methodologies in order to understand the process of ageing and the experience of growing old, and from where I sit nothing beats a longitudinal cohort study for this purpose. The longitudinal cohort study was a research tool developed to improve the health of children in the last century, which was, as some people have said, the century of childhood. This century is going to be the century of ageing. A longitudinal cohort study is ideally suited to understand better the experience of ageing, to provide information to promote active ageing, to capture personal experiences and intergenerational contacts. After many years of discussion, many of us will be aware that a longitudinal study of children is about to get underway. It seems to me that there is a clear case for a complementary study of a cohort of older people. Perhaps two cohorts beginning simultaneously, one of sixty-year-old people and one of seventy-year-olds, and perhaps every ten years the cohorts could be refreshed with new recruits, thereby establishing a continuum of information for comparison.

One other thing that the NCAOP might help us with is to give us a vision of what a society in which people age actively might look like. With ageing we can afford to take a long view. Is it possible to develop indicators and targets based on best practices in other countries such as Scandinavia or Japan? What life expectancy do we want to achieve for people given the width of the gap in life expectancy between the poorest and the richest in our society? What reduction in difference should we be aiming for? What are we doing well, what do we need to protect and where do we need to put greater emphasis? A model of a society that promotes active and healthy ageing would provide a framework for agreeing priority datasets and for building bridges between datasets. The NCAOP is the only body with an explicit mandate to prepare for an ageing society and it should take the lead role in developing this model on behalf of us all. This is one issue that we have to get right because our future depends on it.

Speaker: John Cooney, NCAOP Policy Standing Committee and retired Health Board CEO

I would like to congratulate Patricia on her wide-ranging and thought-provoking paper. I think you could find material in it for about ten PhDs if any of you wish to apply yourselves in that direction. As a retired administrator in the health services I would like to look at the paper from that perspective. I spent most of my career trying to manage a service with virtually no information at all and in a context where there was very little long-term national planning. Long-term national planning was frowned on because it meant long-term financial planning and there hadn't been much interest in long-term financial planning since Dr Whitaker's time. When I was about to retire, there was a budget of about €600 million in the South

Eastern Health Board (SEHB) and we spent about €3 million on information processing of various kinds; that was about half of a percent of overall spending. I was aware from management literature that in large commercial industries, many of which would be less complex than the health service, a typical figure for budgeting for IT and related matters would be about 7 per cent of the budget. If that percentage were applied to Ireland's health service as a whole it would be close to €750 million per year for information systems alone.

Given my experience to date it is most unlikely that such resources will be made available for information generation when services are under pressure. This shows how difficult it will be to generate enough information upon which we can base our policies and decisions. Bearing in mind that we are also one of the lowest spending countries now in the EU in terms of social expenditure, this makes the information deficit even more acute. There are many social needs to be met and many competing demands for scarce public resources. In addition, the new health service organisation will have a huge need for data and information for its own management process. It will be important, therefore, to identify priorities in the gathering of information so that we will get as much value as possible from such resources as are likely to come our way.

The new HSE can play a huge part in this by promoting the use of a unique personal number so that linkage can take place among different elements of the health and social care system and Government agencies. For example, if you look at present hospital statistics you will know that older people account for a large percentage of bed usages. We know these numbers are going to double in the next 10-15 years. That presents the potential for exponential growth in demand and the HSE is going to have to plan for this change. Change is going to manifest itself across the whole spectrum of care and we will need to have additional capacity to cope with these increasing needs and demands. All of this, of course, will further intensify pressure on funding for information projects.

In deciding where to invest on information and in what priority, policy-makers will have to bear in mind the four main axes of management which are mentioned in Patricia Conboy's paper. They will have to maintain an equilibrium between supply and demand for various kinds of care and between hospital and support care in the community, and all of this will have to be done in the context of population change and rapidly changing technology. Policy-makers will have to keep an eye on the quality issue, which is notoriously difficult because of its complexity, including the speed of the service's response, the waiting lists, and so on.

Policy-makers will have to have regard for the poor, as Ruth Barrington has said. I happen to be involved in an exercise involving the supplementary welfare allowance system. The people who operate this are also working for the health system. There is a huge interface between the people who are receiving income as a last resort from financial support systems and those who have medical cards. There is a huge connection between poverty and health which is just beginning to be understood, and the State will have to examine and monitor various causal relationships in this area. Of course lifestyle factors also matter and trying to manage obesity, smoking, alcoholism and so on is also part of a necessary response to current health inequalities. All of these complexities illustrate how difficult it will be to choose between desirable information projects.

In trying to cope with this vast need for data, the State, through its various bodies, needs to bring about a better coordination of the Departments involved in dealing with the health of various populations, including older people. The various agencies need to work much more closely together to improve the quality of life of older people because all aspects of their lives are present simultaneously and they need to be addressed in a coordinated and holistic way.

What then can the management system do? Firstly, it can act as a management system and integrate and coordinate the various agencies. It needs to decide what are the really important things and what are the attainable things. Of course, governments don't like to measure things they don't want to do. A lot, therefore, will depend on social policy and on political philosophy, as well as on the economic situation.

There will be opportunities for improving efficiency in the current information collection arrangements so that you can get a better result at a relatively low cost. There will be some things that cost too much. So there will be, I believe, a need for the development of sampling to generate information on matters that cannot be examined in their totality. We need to keep an eye on research being done in other countries, in the EU and in English-speaking countries which are improving the health and well-being of older people. We need above all to progress the unique personal number so that we can make connections across the various datasets. That's a critical and practical issue which I know is being worked on. I will conclude at this point as we could spend the whole afternoon discussing various aspects of information regarding ageing which are required for the future.

Speaker: Dr Richard Layte, Senior Research Officer, ESRI

I will try to keep this presentation short as time is moving on and, like the other speakers, congratulate Patricia on a fine report. It is a tough job, lots of information to sort out and then trying to make sense of the information.

As Patricia and a number of other speakers pointed out this morning, there are major information deficits regarding the situation of older people in Ireland. That is the problem that has to be tackled in a number of different ways. One way that it could be tackled, which Patricia pointed out, is by the better use of official statistics. There is a large amount of data gathered on a daily basis about the population of Ireland, including older people, and this information is a resource that sits in computer systems across the nation waiting to be used.

To give you some idea of the benefit of this data you only have to look at the research that has been done in many Scandinavian countries, notably in Sweden and Denmark, where they have a linked system. Every child that is born in Sweden is allocated a number and that number is used in all official data holdings; these data holdings can be brought together and information can then be used for research purposes. You can imagine the amazing research possibilities that arise as a result of this potential for linked data. I would like to be able to say we should or could do this in Ireland. Unfortunately, there is a particularly acute problem that makes it very difficult, the primary one being that we don't have any kind of a linking number.

It was mentioned earlier that we could use the PPSN and that is one option. We also have medical card numbers which could be used as a way of linking records. A major problem, however, with databases is a legal one; we have data protection laws in Ireland which make it very difficult to share data between State organisations. I came across this myself when I was doing research for one Department of the State and we needed to use information that was being held by another Department. When we tried to access this data, which was shared on a daily basis by staff within the Department as part of their administrative duties, we found that their use of the data actually contravened data protection laws. They were, therefore, breaking the law on a daily basis and our research project duly collapsed as we could not access the necessary data.

I would imagine that if we tried in Ireland to introduce a system to link databases it would run into similar legal problems. The only solution might be to go back to data protection laws and to look at who should be able to link databases and on what basis they can do it. It may be that we need some kind of licensing system of accredited research or institutions or something along these lines because there are major resources out there waiting to be used. It is a matter of trying to link them in an appropriate fashion and of being legally allowed to do it.

The other problem that I would put forward as being a major obstacle to linking databases is the fact that these databases are administrative, that is, databases that are created for a particular end, and not for researchers. The underlying conceptual structure of them, their rationale and the measures that they use are not usually very explicitly thought out. I have found in doing research with State agencies that you are often handed a large database but when you try to use it you are continually on the phone to the people who set it up in order to interpret the information. The data could mean this, but in this instance it could mean something else, and there are a thousand different reasons why it doesn't actually mean what it says it means and that is a big problem. I don't think administrative databases are ever going to be a replacement for a programme of research or a good research strategy that knows the kinds of questions it wants answered and goes about researching them in a scientifically valid way. A programme like this will give people the data they need to do appropriate research.

In these final couple of minutes may I respond to something else which Patricia has said. First, the issue which I've read of with interest in her report, relating to a real problem with the analysis of 'soft' data measuring caring responsibilities and social participation of older people in Ireland. It is very difficult to get information on these kinds of patterns of association that you get amongst older people in Ireland and how they are shaped. There are some Living in Ireland Surveys which ask questions such as: How often have you seen neighbours? How often have you seen family? But these are very blunt instruments and not particularly detailed. It is very difficult to make anything of them. What I would say is that there is a crying need in Ireland for the development of what is called time-use data where you ask people to keep a diary of what they have been doing for segments during each day, or for a full day, or for a whole week. This gives a rich data source on people's time usage and great insight into caring, as you can imagine. At the moment, our data on caring is very difficult to use because of difficulties with the estimates. We could actually get very good measures of caring if we were to institute these kinds of diary-based data sources, so I would put that forward as one way of achieving progress in this field.

Can I also respond to another of Patricia's questions, which is about the relationship between income and standard of living of older people in Ireland. It is true, as Patricia said, that if you look at older people's level of income, it is a much rougher and poorer guide to their actual standard of living than it would be for younger age groups. There are a number of reasons for this. The primary reason is that income does not summarise past living standards. People come to their retirement with a lifetime build-up of resources, some more than others, but you are basically looking at somebody who has over time built up resources and then has a stable income during retirement; this makes income a poor guide to actual living standards. There are also the factors which Patricia pointed out about family support networks. These also contribute to older Irish people's living standards as do Government transfers of non-cash benefits. Free electricity, phone use, bus passes and so on all contribute to the living standards of older people in Ireland.

Patricia also raised the question about whether we could do research to find out more about what it is that older people value, and I think this is a really good idea. Research does need to be done into what it is that older people see as necessary; this was the basis of much of the research that was done across the population of Ireland in the LIIS throughout the 1990s. In these surveys we asked people: What do you see as necessary for an adequate standard of living in Ireland? What should be the minimum standard of living? The measures we came up with formed the basis of the deprivation indices which you see as consistent poverty in poverty statistics. These measures are for the population at large but they do not necessarily reflect what older Irish people see as necessary, and of course, the needs of older Irish people might be very different from those of younger generations. Research is needed to look at what is the requirement for a decent standard of living for an older person in Ireland and I think that is an important question.

The paper gives a very valuable summary of the main gaps in our national statistics in relation to older people. As national surveys have not always been developed with the specific needs of older people in mind, this work is a very important quality control of our existing statistical system. It also comes at a very important time in the development of social statistics. Together, statisticians and policy-makers are trying to develop data together so that policy will be based increasingly on independent evidence. The difficulties with administrative records, mentioned earlier by Richard, are being examined in this project. A lot of background to this development process is described in the paper, and a clear message comes out that the needs and perspectives of older people should be reflected in the new statistical framework.

The paper groups the main issues facing older people under six main headings and this fits very well with the approach that the NSB and the CSO are taking with national statistics. I've been asked to give the DSFA's perspective on gaps in our statistical infrastructure and, as the Department's work is organised by different policy areas, I hope to group these points into these main policy areas. Sorry for adding another layer to a topic that's already complex.

The OSI has an important interest in developing social statistics. The OSI is responsible for the National Anti-Poverty Strategy (NAPS) which aims to promote the needs of the poor and socially excluded, so it clearly has an interest in identifying the groups within the older population that are most at risk. The Government data initiatives described in the paper are particularly welcomed by the OSI as it needs to monitor developments in very small population groups, like, for example, the homeless and Travellers. The paper explains how national surveys, especially sample surveys, have great difficulty in separating these very small groups from the rest of the population. The problems are even greater where the groups don't live in private households. Developing social statistics based on the huge volumes of data already collected by Government Departments should help to meet this very important need, and the potential for identifying specific groups within the older population is there too. Older homeless people and Travellers are specifically mentioned in the NCAOP paper; it should also be possible to get more information on the needs of older people in specific local areas from these large comprehensive datasets. One of the key findings of the paper is that person-centred data will fill many of the gaps in our statistical knowledge and this is also something that will help our understanding of the causes of poverty in the future.

The OSI also has a specific interest in the consistent poverty and relative income poverty statistics that are examined in the Income, Poverty and Wealth section of the paper. Another important finding of the paper is that there is a weaker link between income and living standards for older people than for the rest of the population, which Richard covered in some detail earlier. Housing affordability is a key issue for a significant proportion of the population, though less so for the older population who tend to be owner occupiers without mortgages; older people in rented accommodation, however, have different concerns. The ESRI has recently carried out work on excluding housing costs from income data, and found that, by and large, the same number of people remained at risk of poverty after accounting for these costs; however, the composition of the group changed and many older people moved above the poverty line. So maybe a fuller examination of all the benefits and costs of housing tenure in the income statistics in future will enable us to get a clearer picture of the most vulnerable older people.

The pensions policy sector also has an interest in statistical developments. Supplementary pensions coverage is mentioned in the paper, though it may be of less direct concern to the current generation of pensioners; however, as it's an important current policy area, I might mention our needs in this area. The Government has a medium-term commitment to raise pensions coverage so that 70 per cent of the workforce is covered. This is based on independent evidence from the QNHS, which is a good example of an evidence-based policy. We're very happy with the coverage data and grateful to the CSO for developing it. Our main requirement now is to develop better statistics to show if the pension funds that are being built up by workers will provide adequate retirement incomes. We'll be keen to develop these statistics, possibly through the new national statistical framework that the paper describes in great detail.

The needs of single person households come up again and again in the paper, and single person households where the resident is aged 65 and over have become a key risk group in the income poverty statistics. More work needs to be done on how resources are shared within older people's households. If there are certain overheads that are the same for all households regardless of composition, these overheads should be identified and the best policy response to meet these needs can also be identified. If the most appropriate policy response is through the free schemes or extension of medical cards rather than through cash payments, then policy-makers should not be penalised by the income poverty data for choosing this option. At the moment, the contribution of the free schemes to the welfare of older people is not recognised in these income statistics.

Finally, the DSFA also has a policy interest in carers and has recently published a study into the financing of long-term care. The paper mentions that the disability prevalence statistics used to cost long-term care proposals in the study had to be based on UK data, and this is a key data gap in developing long-term care policy. Prof. McGee also mentioned earlier that we have no data available on the compression of morbidity in the population. We need data on the length of time people are incapacitated to measure whether medical advances are prolonging healthy life expectancy in line with increased life expectancy.

Congratulations again to Patricia and all at the NCAOP for making this first contribution, hopefully the first of many, at such a timely stage in the development of social statistics.

Speaker: Aidan Punch, Senior Statistician, CSO

On behalf of the CSO I would like to thank the NCAOP for the opportunity to respond to Patricia Conboy's paper on 'The Older Population: Information Issues and Deficits'.

The CSO is the lead agency involved in data provision in Ireland. It seems only right, therefore, that the statistics provided by the CSO should come under close scrutiny in Patricia's paper. The main data sources to which the author refers are the five yearly Censuses of Population and the QNHS. During the course of my brief presentation I shall address some of the points which the author makes about these sources, but first I will make a number of general points.

Population ageing refers to the increase in the relative number of old people in the population due to fertility decline and increased life expectancy. Comparing 2002 with 1981, the number of people aged 65 and over increased by 18 per cent while the number of people aged under 15 decreased by 20 per cent. The population is therefore ageing. However, Ireland still has a long way to go to catch up with countries like Italy and Greece where the number of people aged 65 years and over is nearing one in five of the population.

The situation in Ireland is, however, changing. I have just come from a meeting of our population projections group this morning. First run data using the most up-to-date information on age structure from the 2002 Census, coupled with assumptions based on improvements in life expectancy, show that the population aged 65 and over could increase from its present level of 436,000 to about 1 million in the next thirty years. The population aged eighty years and over is projected to increase threefold in the same period, from about 100,000 to over 300,000, using the same assumptions.

Before turning to specific references to CSO data sources in the paper, I would like to make a number of general points about the census. The census has a major advantage as a data source in terms of its comprehensive coverage and its small area dimension. It is limited, however, in terms of the types of questions which may be asked; because the census form is completed by individuals of every educational attainment level in households throughout the country, the questions that are asked have, of necessity, to be easily understood.

In advance of the 2002 Census and again in recent times, the CSO engaged in a wide-scale public consultation process relating to the questions which should be included on the census form, while bearing in mind of course that the final decision on the matter rests with Government. As a result of the 1999 consultation a number of new questions which have a direct bearing on older persons were included in the 2002 census form. These are referred to by the author and include those related to disability and carers. Based on the most recent round of consultations, a number of new questions have recently been piloted in 32 enumeration areas throughout the country. These include questions relating to unpaid work looking after the home or family, voluntary activities, and household income and family interrelationships. The results of the pilot will be discussed by the consultative group set up for this purpose and based on the findings the CSO should be in a position to obtain Government agreement to the content of the 2006 questionnaire later this year.

Because of the age variable on the census dataset it is possible to cross-classify all census variables by detailed age group. All of the published census data appears on the CSO's website in the form of easily downloadable files. Quite a number of these contain detailed age breakdowns, not just at national level but also at local level. Some of the age breakdowns are by single year of age up to 99 years and over, while others show the population eighty years and over. All the published information appeared within two years of census day which compares with best practice internationally and adds greatly to the usefulness of the information.

Turning finally to some of the specific points in the paper, the issue of non-publication of age data in the housing report is referred to. The housing report deals mainly with the characteristics of the housing stock, such as the year the house was built, the owner occupancy status of the housing unit and sewage facilities. It is, of course, possible to give the demographic characteristics of those enumerated or usually resident in the housing unit. However, as there is no indication on the census form of who actually owns the housing unit, the demographic analysis is done for households and families.

The author is correct when she states that travel patterns only arise in the context of travel to work, school or college. However, this is understandable given that the focus is on peak time traffic movements. The question on carers refers to those who are doing the caring. It is not possible to infer from the responses to the question who is the recipient of the care. The lack of individual data on visual and aural impairment has also been criticised. The layout of the question, however, which followed the US model, was agreed with the various organisations in the disability arena. In this regard, we are currently examining the possibility of a dedicated disability study to be carried out following the fieldwork phase of the 2006 Census.

I would like to conclude my response to Patricia Conboy's paper by complimenting her on the comprehensiveness of her study.

Fourth Session

A Society for All Ages

Chair: Dr Garret Fitzgerald

Interdependence in a Society for All Ages

Dermot McCarthy, Secretary General, Dept of the Taoiseach, Secretary General to the Government

I'm delighted to have been invited to participate in this conference. I'm only sorry that other matters of less strategic importance prevented me from being here to hear the earlier papers, but I did have the opportunity to read the material circulated in advance and I think the conference represents a very significant contribution to policy development in this central area.

I suppose when you think of famous teams which have made their mark in history, their relationships are such that it is impossible to think of one without the other; Laurel and Hardy at one end of the spectrum or any great creative combination in the arts on the other. Even political parties can have their interdependencies, if not romantically, at least memorably, from time to time. I think it is the question of what is the relationship between the things which go together, by choice or by necessity, that underpins this concept of interdependence. Whether it be the relationship between taxation and spending which our friends from the Department of Finance are fond of reminding us about, between production and consumption in an economic sense, capital and labour, traded and sheltered sectors of the economy, urban and rural, national and international, or young and old. We tend, perhaps instinctively, to see these as oppositional; we see the tensions between them and only on reflection see the necessity of one for the other.

Interdependence, in many ways, is thrust upon us rather than chosen, be it at a personal or a social level. I suppose, in nature and history, the best and most successful forms of symbiosis are so natural and taken for granted that they are instinctive; yet in contemporary society we know that the scope for the pre-conceptual and non-reflexive has diminished. We live in a society which is profoundly self-conscious; given the week that is in it, in commemorating Bloomsday we are remembering, on one level, the birth of the self-consciousness of modern man, at least in the creative sphere, and that is liberating in so many ways. But it creates fundamental issues and challenges in the development and management of progress in society because it makes every aspect of society potentially problematic, even the very concept of progress itself. Whether things are better or worse is no longer something that people can judge instinctively, but it has to be thought about, measured and debated, and that reflects the fact that we live in a more atomistic society, a more individualistic age. My reality is constructed, to at least some degree, by myself, yours by yourself, and the shared space in every regard is potentially shrinking. How we see the world, therefore, at different ages, locations and occupational settings can be very different to that of our fellow citizens. So the resources for policy, the instinctive resources for policy coordination and the maximisation of the benefit of interdependence can, as I say, be problematic.

This is compounded by the fact that our sources of information about the world are more diverse and more contested. The explosion of media outlets, both printed and broadcast, which are now available, make for differentiated audiences and therefore differentiated populations in terms of both understanding and attitudes. Extending beyond that, changes in the global economic environment make it difficult sometimes to make sense of dependencies and interdependencies. Changes in technology, occupational

structures and the occupational and economic profiles of countries and continents have made for rapid change which is hard to digest and feel comfortable in. With greater wealth has come greater insecurity about identity and occupational stability. It is an insecurity which is reflected in various aspects of our lives, a generalised, perhaps unspoken unease about various aspects of modern life. This is capped by the lack of respect for inherited authority which characterises the modern or post-modern age. Not only do we not have, as our previous society had, an instinctive set of norms regarding the relationship between different parts of the population, different age groups and so on, but we don't necessarily have institutions that are respected and effective in charting that relationship in a way that would have been the case in the past. Interdependence is, therefore, harder to recognize and manage and potentially harder to explain to those who don't immediately grasp it. This is compounded by the difficulty of understanding where we are in any aspect of economic and social development.

A number of presentations at the conference today have addressed the question of data, lack of data, interpretation of data and analysis of data which would help, in particular, in influencing attitudes towards policy, older people, and society where ageing is a reality and an indicator of economic and social success. We know that there are difficulties in generating timely and efficient data on various aspects of contemporary Irish society. We know, and I'm sure you've heard, about some of the attempts that are being made to address this, not least in the analysis of potential sources in the papers which have been prepared for this conference.

At a policy level we have been seeking to respond to information problems through the work of the SGSES in particular, and the development of new resources such as the QNHS as a means of finding out a little more comprehensively about aspects of contemporary life which are of relevance to policy and of social interest. One of the developments, which I'm sure has been referred to and has huge potential for the future, is the growth of the role of administrative records of public Departments and agencies in helping to expand our understanding of the life and life chances of different groups of the population and the experience, in particular, of people who are consumers and producers of public services. I think there is the potential to learn a little more, to help fill in the gaps in our understanding, and perhaps to address some of the difficulties of establishing patterns of meaning and coherence and coherent policy responses in contemporary society.

In Ireland, as a small open economy which is deeply integrated into global trends, we face particular difficulties in understanding where exactly we are on the economic curve. Is the economy expanding or contracting? What are the prospects for employment at a sectoral level? What are the implications of flows of investment and so on? One area where we can have much greater confidence and, indeed, certainty is in the area of demographic analysis, especially as it affects older people. Demography is a lynchpin of our approach to this broad issue but set nonetheless against a background of much uncertainty about the nature of the society in which we live. If that weren't bad enough, we have to recognise that the policy-making process, whether it be in relation to intergenerational solidarity or in the development of services which support active and successful ageing in our society, has become much more complex. We see this, for example, in the debate about where competence for handling problems of interest to contemporary society best lies, and in the tension between finding ways of organising ourselves which are efficient and the legitimacy of decision-making. Sometimes efficient processes can lose legitimacy; sometimes the search for legitimacy can involve such complexity that we lose significantly in terms of taking decisions and moving on.

Similarly, issues arise about the appropriate level at which such decisions should be taken. Can we devolve responsibility more than we currently do and have solutions which are tailored to widely differing local circumstances, or does both efficiency and territorial justice require that we have national norms and standards so that citizens have roughly the same entitlements and experiences wherever they happen

to live? Or are some issues of such complexity, requiring resources beyond the national level, that competence should move to, for example, Europe? The current debate about the proposed Constitution for Europe encapsulates precisely that sort of dilemma about where our decisions are best taken for the benefit of citizens and their aspirations for economic and social well-being, as well as for freedom, justice and security. It seems to me that in responding to these difficulties we have seen a number of innovations which reflect the problems of the kind which I've mentioned but also seek to capture positive aspects of interdependence, recognizing that in the words of the old proverb, *'ar scáth a chéile a mhaireann na daoine'*, (where exactly are the people gathered in whose shadow we wish to live?).

The mechanisms which we have developed at European level, for example, are interesting in this regard. We've obviously had some functions which have been identified as properly European to be settled as matters of European law. We have others which have been arbitrated upon when differences arise between Member States or between different European policy objectives. We have also sought to develop, and we're still struggling to develop, ways of learning from experience in the interest of pursuing shared objectives using what is called the open method of coordination. This means that instead of seeking to harmonise and legislate for behaviour at an EU-wide level, Europe agrees certain objectives and sees how the different Member States, and indeed the different regions, seek to achieve these objectives and in some systematic way share learning and identify good practice which could be copied. In a sense that is one form of interdependence, the interdependence of experience of different reactions to shared problems.

The second aspect of interdependence at a European level is about defining our common objectives under the Lisbon Strategy. This strategy, as you know, was about seeking to make Europe the most successful knowledge-based economy by 2010. But it wasn't just about that; it wasn't just about providing for growth and employment based on adding value and building a larger economy, it was also about achieving social inclusion on the basis of a strategy for cohesion which would complement the economic growth being sought. That inclusion should be made possible by growth and, if one looks at the debate in Continental Europe more than on our own shores, the arguments about the sustainability of pensions at European level are very much about the importance of restoring growth to the European economy. So there is no tension there; there is, indeed, a symbiotic requirement that growth and wealth be created to sustain the social standards which European society has nurtured and seeks to maintain. It is not, of course, just about social inclusion but also environmental sustainability. One cannot have social sustainability without economic growth and high performance, and that in turn cannot be sustained unless we pay attention to the needs of the environment. At the level of policy development, therefore, interdependence has been acknowledged and recognised even if it is difficult in practice to give all components equal attention.

A third example of seeking to capture this form of interdependence between policy objectives and policy instruments is, I think, in our own national experience of social partnership where, in the evolution of that process over the last 17 years or so, there has been a recognition that you can't have successful economic performance without recognising and managing the trade-offs that are necessarily involved. It makes no sense, for instance, to seek to maximise wage income growth on the one hand if it is going to be undermined by inflation and increases in the tax burden on the other. There is very little attraction in maximising income growth for some parts of the population or labour force if it is at the expense of unemployment and exclusion from the labour market for others. Indeed, as a political project it is not viable to have a partnership process if it delivers for those who are active in the labour market and doesn't for those who are outside of the labour market and who are the beneficiaries of social transfer arrangements. So in a sense, by a process of logical extension, the scope of social partnerships has grown as we have sought to capture and include the necessary interdependence to be both efficient and legitimate in pursuing the goals which Government, the social partners and wider society would seek to achieve.

That was a rather long detour via issues of interdependence at the broad policy level. I will now return to the question of concern to this conference: the requirements for successful ageing and providing for an older population in a way which is respectful both of the need for support and the need to achieve inclusion, participation and recognition of the positive contribution of older people. What sort of lessons might we learn and what conclusions might we draw about managing the interdependence between those who are older in society and the rest of the population, and between the old and young of the population who require economic and social support from the rest of society. It seems to me that there are a number of conclusions that we can draw which might be helpful.

The first is the importance of identifying and mobilising the relevant stakeholders. Successful policies and strategies for healthy and participative ageing are of concern to us all because we either are, or aspire to be, among that happy band at some time. How to do this seems, if we look at other policy domains, to require a fairly strategic approach to encouraging analysis and engagement with the issue. We need to be proactive in informing, shaping debate and providing opportunities for deliberation and reflection about the issues which are identified. In the process of deliberation we can and will benefit from the papers presented today. We have to identify both linkages which are positive and trade-offs which are potentially difficult and have to be managed as best we can. It is not always easy to do that. There are, for example, difficulties in factoring in long-term considerations into a political cycle which tends to be short-term. However, there are, I suggest, some grounds for optimism in that regard, whether it be looking at the decision to establish a national pension fund or the approach to providing a better basis for physical planning and the development of guidelines which reflect long-term demographic reality. There is the potential to have the longer-term integrated into current policy-making; that is important because, as we know, in issues which are marked by demographic change, the sooner appropriate policy developments are initiated the more effective they can become over time. If we are to identify such linkages and be successful in managing the trade-offs, we cannot just leave it to a process of disengaged debate. We have to seek to create and adapt institutions and processes which actually make that possible.

It strikes me that there are a number of potential players in terms of this intergenerational question and they are not solely those who have a particular mandate or interest in the issues. This conference, and the ongoing work of the organisers, is evidence of an institution which has that particular focus and expertise. We have many active NGOs in the community and voluntary sector which are equally expert in contributing to the debate and shaping policy but we need to engage others. We need to engage not just the political process at national level but seek to influence how these issues are integrated into thinking at local level, be it in strategic policy committees of local authorities or by those which are shaping investment in our regional assemblies. There is, therefore, a need to look at both the institutional and procedural resources that might be drawn on for that purpose and, if we are to have an effective outcome, we need to keep a close eye on the evaluation of performance and impact. However, evaluation, performance and impact are not just about scientific research and systematic measurement because there is a risk that such a narrow approach devalues the experience of people, including older people, families and, indeed, the wider society.

There have been some attempts to create new ways of linking the perspectives of consumers and those of service deliverers in, for example, the work of the National Economic and Social Forum (NESF). Teams have been brought together to look from different perspectives at how policies are operating in different areas, sometimes to the great surprise of the participants, and with effects which are very different from what was intended when programmes were introduced. If, therefore, we are to have the identification and the positive exploitation of interdependence in the interest of a positive strategy for ageing, it is going to require an active process. It is going to require the development and adaptation of institutions, good information to inform debate and the mobilisation of stakeholders whose interests will never fully coincide but who can, I think, be persuaded to work together on the basis of outcomes which are of benefit to all

to some degree. The role of public policy is inevitably placed at the centre of much public debate but, of course, the question goes beyond public policy into societal attitudes, behaviours and lifestyles. Indeed, we have to be reasonably modest about the extent to which public policy can both influence and make up for difficulties which arise from the wider social reality. If we can have successful engagement about the policy domain, there is every prospect that will also influence behaviour, attitudes and lifestyle issues.

So, I think today's conference and the materials which have been generated to prepare for it, represent a significant contribution to the process which I have outlined. The focus on the participation of older people and their representatives in the policy process is particularly encouraging. I think there is much about which to be hopeful; the deliberations today are timely as they coincide with an effort to improve our information about older people and our understanding of social change, and our ongoing efforts to shape institutions and policy processes which can effectively respond to current and future challenges in this area.

I am grateful to have had the opportunity to contribute to this conference and I congratulate the organisers and various contributors.

Conclusions

Dr Eamon O'Shea, Conference Rapporteur, Dept of Economics, NUI Galway

This conference reflects the beginning of a dialogue among stakeholders on planning for an ageing population in this country. What follows is an attempt to bring together the various strands of the discussion during the day. These conclusions are influenced by the papers presented during the conference and by contributions from the floor about the way forward for planning for an ageing population in Ireland.

Philosophical issues are important in contemplating future planning issues for older people. Hannah McGee made the observation about the unhelpful use of age as a 'determinant of everything' but an 'explanation of nothing'. This insight points to the need to establish a strong framework of values for public policy on ageing to overcome superficial and sometimes prejudiced treatment of older people's issues. Older people have multiple identities, each impacting differently on their relationships to others in society. If older people and their contribution to society are highly valued, then public policy is likely to be much more positive than if older people are seen as a burden on society. One of the strong messages coming from today's proceedings is the positive contribution older people make to society through work, saving, education and voluntary effort in many different sectors.

Older people are a resource not a burden and planning for the future should acknowledge that resource in a much more formal way than at present. Many contributions pointed to the need to recognise the importance of social production and the contribution older people make to that production. Social production incorporates the regeneration of communities, the nurturing of grandchildren, volunteerism and the transfer of knowledge. It is very important when we are planning for the future not to lose sight of all of these varied contributions that older people continue to make to modern societies. It makes no sense to divide our individual and collective contributions to society on the basis of age, and just because a person is no longer in the paid labour force does not mean that their contribution to society can be ignored.

One of the important points raised during the discussion on demography is the fact that we are fortunate to have some time to prepare for the stage at which older people will constitute a much higher proportion of the total population in Ireland. We have an opportunity now to get things right for the future, particularly in relation to the development of innovative structures, processes and policies for older people. As Garrett Fitzgerald pointed out, we can address the ageing of our population well before the impact of this phenomenon starts to hit us. But planning for the future requires good data on the needs of older people and this was a central theme of the conference. Many of the papers reflect the importance of good data, appropriate data management and timely information flows for good decision-making about older people in the future. Equally, however, information must be acted upon if it is to be really useful.

In particular, we need much more information on the health and well-being of older people in Ireland if we are to improve length of life and quality of life for older people in the coming years. Policy should aim to build on recent gains in life expectancy at age 65 for older people in Ireland, especially since we still lag behind the majority of EU countries in respect of life expectancy at age 65. We need, however, more information on the determinants of healthy ageing if we are to optimise life chances and life expectancy for older people. The value of longitudinal cohort studies for the study of ageing issues was outlined by Ruth Barrington during the conference. A longitudinal cohort study for older people, including people at 60+ and 70+ years, would provide important information on the opportunities and hazards of ageing, as well as providing an insight into support structures for older people within households. This should be the information cornerstone of future health policy for older people in this country. In addition, the introduction

of a unique system of patient identification would also help to address some of the information deficiencies in the system. So also would the extension of the NPSDD to include people with disabilities aged 65 years and over.

Dependency is a key concept in the planning of services for older people. There is, of course, a cultural context in the way we use the word 'dependency' and that cultural context cannot be ignored. Our understanding of the world we live in, of ourselves, of the narrative of our own life and the lives of our families matters for independence and dependence. The difference between dependency and situations of dependency was highlighted during the conference in a number of the papers. Contributors were anxious to separate genuine dependency from situations of dependency. Dependency may be caused or exacerbated by the absence of social integration, solidarity relationships, accessible home environments and adequate economic resources in the lives of older people. The problems of accessibility for older people in rural areas were highlighted as an example of a situation of dependency. The need to enhance the capabilities of older people, to allow them to reach their human potential whatever their age, was signalled as an important policy goal. There was a call for more information and further exploration of situations of dependency as a means to understanding the factors that impact negatively on the lives of older people and prevent them from reaching their various capabilities. Anne Goode and Eithne Fitzgerald proposed that a social model of dependency be developed similar to the social model of disability which is already widely accepted. A new social model of dependency would place a person's dependency in the context of the social and environmental factors which create disabling barriers to their participation in society.

One of the strong themes to emerge from the conference was the need for greater investment in community-based living. There was a strong consensus that planning for the future must be about the implementation of stated policy for older people: to keep people in their own homes for as long as is possible and practicable. Good housing is critical if older people are to remain in their own homes, even with significant levels of dependency. Anne Goode and Eithne Fitzgerald highlighted the importance of lifetime adaptable housing as a means of providing homes which can continue to meet people's needs as they grow older and as mobility becomes more restricted. The importance of an active public policy to promote, design and plan lifetime adaptable housing was a feature of the discussions on this issue. In addition, many people felt that not enough has been done to improve the accessibility of the existing housing stock for older people. It was felt that some of the concerns about this issue could be met by increasing budgets and developing better procedures to allow more older people with disabilities to benefit from the Disabled Persons Housing Grant, thereby allowing them to make adaptations to their own homes.

The absence of support structures for families was a recurrent theme during the conference. Without families the community care system for older dependent people would have collapsed a long time ago. Many carers are themselves old and the stress and strain of caring has been well documented. On the margin between community care and residential care, family care has the same significance as nursing care within public and private institutions. There was unanimity on the need for greater investment in community care services to support vulnerable older people and their carers. More resources are required for the employment of social care personnel that contribute to improving the capacity and potential of dependent older people to remain in their own homes. There was also a view that if care was to be effective, then caring personnel need to be adequately trained to take account of the specific needs of older people, including knowledge of the ageing process itself.

An increased emphasis on community care does not mean that the residential care sector can be ignored. The development of intensive rehabilitation services for older people in public residential care is an important prerequisite for the new community-based model of care for older people. Rehabilitation provides the critical interface between community care and residential care for many dependent older people. An expansion of dedicated beds and services for people with dementia is also required in line

with the recommendations of *An Action Plan for Dementia* published by the NCAOP. The continued development of geriatric medicine is critical for best practice in the delivery of care for dependent older people, particularly an investment in facilities and staff necessary to provide high-quality, multi-disciplinary geriatric medical care in hospitals and the community. Specialised geriatric training for staff working with older people in all types of residential settings, including acute care facilities, was again highlighted as an important component of good quality care for older people.

Many contributors spoke of the need for the development of a genuinely integrated model of care for older people in Ireland. Many opposed the unnecessary division of the care of older people into either a social or medical model. Such a distinction may be unhelpful, leading to unnecessary division. There was general agreement that we need a model of integrated provision where the medical and social services work together for the benefit of older people. Integrated provision would include a strong role for the primary care sector and for general practitioners in particular. Some people saw the general practitioner as being the key person in facilitating the integration of care for older people. Where integration works, as for example in some district care units, the benefits to older people are likely to be significant.

Planning for the future must take into account the relationships across generations, both within families and in society generally. There were many examples of intergenerational solidarity presented during the conference. There were references to the involvement of grandparents in childcare and of significant financial transfers from old to young, particularly to support the purchase of houses. Public policy must seek to develop and renew commitments and responsibilities between young and old because they can be easily lost. The increasing focus on the economy has encouraged a form of economic determinism which is focused on the promotion of the self and accumulation for the self. It is easy in this environment to forget about other objectives, other responsibilities and other relationships in society. That is why nurturing intergenerational solidarity through the direct involvement of older people and their representatives in policy formulation and implementation is crucial for planning for the future. Dermot McCarthy spoke about the importance of identifying and mobilising all the relevant stakeholders for this purpose. For that reason, older people must be consulted about policies and programmes that affect them, and they must be directly represented in the social partnership process.

Equity issues were also raised during the day by various contributors who pointed out that many people don't reach old age. In one sense, the people who reach the age of 65 are a privileged group compared to the high number of people in the less well-off socio-economic categories that don't get there, who die prematurely and never have an opportunity to experience old age. A major part of planning should be to ensure that more people reach old age. Some questions were also raised as to whether there is currently an implicit rationing of health care resources by age. There were calls for more information on whether older people are accorded the same rights as younger people in terms of access to, and utilisation of, health care resources. What is needed is some recognition of this issue, not the implicit *ad hoc* rationing on the basis of age that exists at present, but an explicit decision-making calculus that allows us to make judgements on the equity implications of current resource allocations. People were also concerned about the insidious effects of age discrimination in other areas of life such as the labour market, pensions, education and insurance. While legislation was seen as critical in combating discrimination, lifelong learning and education were also seen as important components in empowering older people, thus making discrimination less likely.

Planning for an ageing population forces us to consider more carefully the relationship between economic growth and social progress than perhaps we do at present. We need continued economic growth to pay for pensions and to fund services for older people. However, if we continue to emphasise economic growth over social issues, we run the risk of losing sight of important ties that bind rich to poor and young to old. We need to think more about the ties that bind between individuals and families, between

families and communities, between communities and the state, between young and old. We have not yet exhausted the level of goodwill that exists between the generations in Ireland. We talk about commitments in a historical way, about the fact that we once had a country where age was respected and treasured. By and large that country still exists; solidarity between the generations remains strong even if it disappears from view now and again. That solidarity still needs to be encouraged and nourished through good planning and enlightened public policy. Public policy should respect the individuality and complexity of ageing but it should also protect the social and intergenerational dimensions of the ageing process.

Speakers' Biographies

Dr Ruth Barrington

Formerly a senior civil servant at the Department of Health, with a particular interest in older people, Dr Ruth Barrington had a key role in the preparation of *The Years Ahead: A Policy for the Elderly*. She is the CEO of the Health Research Board, whose functions are to promote, assist, commission or conduct medical, health, epidemiological and health services research; and to liaise and cooperate with other research bodies in Ireland and internationally.

Patricia Conboy

Patricia Conboy is policy officer with the NCAOP. Prior to this, she worked as an independent researcher undertaking research and evaluation studies for a range of local and national organisations in the areas of education, training, employment, community development, equality and health.

Peter Connell

Peter Connell is a training analyst in Information System Services in Trinity College Dublin. He prepared the population projections used as the basis for the NCAOP report, *Health and Social Care Implications of Population Ageing in Ireland 1991-2011* (Fahey, 1995). He is also a co-author of the study *Ageing in Ireland: Population Projections 2002-2021*, published by the NCAOP in 2004.

John Cooney

John Cooney was CEO of the South Eastern Health Board until his retirement. He was also a member of the NCAOP from 1998 until 2002, and is currently a member of its Policy Standing Committee.

Dr Garret Fitzgerald

A former Taoiseach and leader of Fine Gael, Dr Garret Fitzgerald is regarded by many as a highly-skilled economist and one of the greatest ever Taoisigh. His approach to governance included significant liberalisation of Irish society, including several attempts to broaden the availability of contraception and to legalise divorce.

Fitzgerald also opened negotiations with the British Government, which led to the signing of the Anglo-Irish Agreement, a precursor to the later Good Friday Agreement.

Currently, he is a columnist for *The Irish Times*, as well as being Chancellor of the National University of Ireland. He has retired from politics, however he came out of retirement in 2001 to campaign for the ratification of the Nice Treaty.

Dr Anne Goode

Dr Anne Goode is a senior Researcher at the NDA and is co-author of the paper 'Understanding Dependency: Challenges for Planners' along with Dr Eithne Fitzgerald, also a senior researcher at the NDA.

Dr Richard Layte

Dr Richard Layte is an economic sociologist at the ESRI. His main area of interest is the interaction between individuals, households and the labour market, and the impact that this has on poverty, deprivation and health. Richard was co-author of the report, *Income, Deprivation and Well-Being Among Older Irish People*, published by the NCAOP in 1999.

Dermot McCarthy

Following service in the Department of Industry and Commerce, Dermot McCarthy joined the Department of Health in 1977. He was appointed Director of the National Economic and Social Council in 1990.

He became Assistant Secretary in the Department of the Taoiseach in 1993, with responsibility for the Economic and Social Policy Division.

In January 2000, he became Secretary General to the Government, with additional responsibility for Economic and Social Policy and the Strategic Management Initiative, and was appointed Secretary General of the Department of the Taoiseach in July 2001. He is also the Chairperson of the National Economic and Social Council.

Prof. Hannah McGee

Prof. Hannah McGee is a health psychologist in the Department of Psychology, Royal College of Surgeons in Ireland (RCSI). She is the founding director of the Health Services Research Centre at RCSI. The Centre was established as the first such multidisciplinary centre in Ireland in 1997. Its focus is on promoting quality in Irish healthcare through research. The Centre conducted two important studies for the NCAOP: *Older People's Experiences of Health and Social Services In Ireland (HeSSOP, 2001)* and *Care and Case Management for Older People in Ireland (2001)*. Currently Prof. McGee is the principal investigator in an extensive study of ageing, health and healthcare, which, *inter alia*, will conduct follow-up interviews with the 2000 HeSSOP sample.

Paul Morrin

Paul Morrin works as a statistician for the Department of Social and Family Affairs, a position he has held for the past two years. His work primarily focuses on the development of statistics on pensions and social inclusion. Before taking up his current position, he worked in the CSO for nine years.

Dr Eamon O'Shea

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Eamon is also the author or co-author of a number of studies published by the NCAOP including *An Action Plan for Dementia* (1999), *The Cost of Care for People with Dementia and Related Cognitive Impairments* (2000) and *Healthy Ageing in Ireland, Policy, Practice and Evaluation* (2003).

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The Older Population: Information Issues and Deficits

A Discussion Paper

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Patricia Conboy, Policy Officer, NCAOP

1. Overview

1.1 Introduction

This discussion paper has its origins in a recent survey and analysis of selected national datasets undertaken on behalf of the NCAOP. The purpose of the survey was to establish what information was available in those datasets about the older population in Ireland and where the deficits in information might lie. The stimulus for this work was provided by the NCAOP's awareness of the requirement to plan now to meet the future needs of an ageing population. The NCAOP's view is that adequate and accurate data is a vital tool for planners and policy-makers.

Through the aforementioned survey of datasets, combined with contributions derived from NCAOP staff, notably the Director, Research Officer and Healthy Ageing Programme Adviser, and from members of the Policy Standing Committee, the NCAOP has drawn together thinking about deficits in our information about the older population and about issues that need to be considered in light of these deficits.⁹ With the presentation of this paper, the NCAOP hopes to facilitate the exchange of ideas, views and information among all those with an interest in addressing such information issues and shaping public policy so that it contributes to health and social gain for older people in our society.

1.2 Datasets Explored

The datasets explored in the preparation of this discussion paper are listed here and briefly described in Appendix Two. These datasets were selected because they are key sources of data at national level about the Irish population.

The main datasets explored were taken from: Census 2002, *Health Statistics 2002* (DoHC, 2003a), HIPE, the LIIS, *Long-Stay Activity Statistics 2002* (DoHC, 2003b), the National Cancer Registry, the NIDD, the NSHQ, the NPSDD, the National Parasuicide Registry, the NPIRS, the QNHS, the SLÁN surveys and SILC.

1.3 Approach to Exploration of Datasets

The approach adopted to exploring the datasets was based on:

- clarifying the purpose of the dataset, and the focus and range of the data about older people collated within the dataset

⁹ Members of the Policy Standing Committee and staff are named in Appendix One.

- examining published data based on the datasets. In the case of Census 2002, for example, raw tables based on census findings are published in a series of volumes. In the case of the LIIS, findings related to specific themes are discussed in published research reports
- consulting original questionnaires and interview schedules to ascertain the approach to recording the age of participants and the scope for secondary analysis of existing data from the perspective of the older population. (The HIPE Unit, for example, will respond to requests for specific information based on HIPE data.)

1.4 Preparation of the Paper

The first opportunity for wider sharing and consideration of the findings of the survey of datasets was that provided by the NCAOP's conference, *Planning for an Ageing Population: Strategic Considerations*, which took place on 15 June 2004. A discussion paper was distributed to conference participants as a working document, with an invitation to comment on and respond to its contents. Participants were told that, in light of their contributions, the contents of the discussion paper would be developed and the interim summary and conclusions revisited and finalised. This is what has happened.

1.5 Parameters of the Paper

The focus of this discussion paper is on the contents of selected national datasets. The overall exercise was undertaken within a limited timeframe and was not intended to include a comprehensive survey of the research literature about older people. A limited number of research reports were consulted in the course of the work; they were included on the basis that they might indicate lines to be followed in further developing data frameworks to reflect fully the status of older people in Irish society.

1.6 A Perspective on Ageing

The WHO espouses a vision of ageing as a positive experience and has adopted the term 'active ageing' to express the process for achieving this vision. Active ageing 'is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age' (WHO, 2002). The vision of ageing as a positive experience is one shared by the NCAOP and provides a touchstone in considering the focus and orientation of the particular datasets surveyed in the preparation of this discussion paper.

1.7 The Determinants of Active Ageing

The WHO's perspective is that active ageing depends on a variety of influences or 'determinants' that surround individuals, families and nations, and that these determinants need to be considered in the design of effective policies and programmes to support the process of active ageing. These determinants and the interplay between them are seen as good predictors of how well individuals and populations age. They fall into seven broad categories:

- cross-cutting determinants of culture and gender
- determinants related to health and social service systems
- behavioural determinants
- determinants related to personal factors
- determinants related to the physical environment

- determinants related to the social environment
- economic determinants.

Cultural values and traditions shape the way a society views older people and the ageing process. Gender is a 'lens' through which to view policy options and choices, and their likely effects on both men and women. Health systems promoting active ageing adopt 'a life-course perspective'¹⁰, focusing on health promotion, disease prevention and equitable access to quality primary healthcare and long-term care. Health systems organised around acute, episodic experiences of disease do not reflect this ideal. Behavioural determinants refer to the adoption of healthy lifestyles and the active promotion of one's own care through, for example, physical activity and healthy eating. Determinants related to personal factors include genetic and psychological factors. Determinants related to the physical environment include public transport, safe housing and safe environments, for example, without multiple physical barriers which restrict mobility and independence. With regard to the social environment, determinants include social support, opportunities for education and lifelong learning, peace and protection from violence and abuse. Finally, economic determinants include income, work and social protection which can include old age pensions, occupational pension schemes, voluntary savings incentives, compulsory savings funds and insurance programmes for disability, sickness, long-term care and unemployment.

1.8 Evidence-Based Policy-Making in the Irish Setting

In the Irish setting, there is an increasing emphasis on evidence-based planning and policy-making, resulting in a series of initiatives undertaken by the NSB and the CSO and oriented towards the strategic development of data frameworks at national level.

The NSB, in *Implementation of Strategy for Statistics, 1998-2002: Progress Report, 2001*, formally recognised the need for a long-term strategy in order to develop the social statistics required to support policy formulation and to monitor progress on achieving social and equality outcomes. Subsequently, the SGSES was established to determine the scope of expected or likely requirements for social and equality statistics and the extent to which these were being met, or could be met, by existing statistical surveys and administrative records.

In the course of its work, the SGSES devised a draft framework of twelve domains within which social and equality data for Ireland might be conceptualised and developed. It then sought 'to map the interface between data and policy-maker' by asking Government Departments to articulate their data needs in a structured and comprehensive manner (SGSES, 2003). Arising from this exercise, the SGSES concluded that 'there is an inadequate national framework to underpin the development of social policy in Ireland and the perspective of those data users and data producers within the system tends to be departmental or divisional'. The recommendations set out in the final report of the SGSES, (referred to from this point on as the SGSES report), were designed to address these shortcomings.

1.9 Strategies for Health Research and Health Information

There are a growing number of initiatives focused on the development of strategies and datasets to enable evidence-based planning and policy development. The strategy outlined in *Making Knowledge Work for Health: A Strategy for Health Research* was adopted as policy in 2001 and greatly enhanced the funding made available to the HRB to support health research (DoHC, 2001b). The NHIS was published by the DoHC in July 2004 with the aim of recommending 'the necessary actions to rectify present deficiencies in health information systems and to put in place the frameworks to ensure the optimal development and utilisation of health information'.

10 'A life-course perspective on ageing recognises that older people are not one homogeneous group and that individual diversity tends to increase with age. Interventions that create supportive environments and foster healthy life choices are important at all stages of life' (WHO, 2002).

1.10 Quality of Life Indicators

The Combat Poverty Agency, in its role as the statutory advisory body on poverty in Ireland, has commissioned research on social indicators as a tool for monitoring poverty performance under a revised NAPS. This work also highlights issues of availability of data in several key areas, among them housing and, in the case of older people, the need for indicator development, particularly under the heading of 'quality of life' (Palmer and Rahman, 2002).

1.11 Promoting Statistical Development

As anticipated in the SGSES report, the *Strategy for Statistics 2003-2008* of the NSB advocated a lead role for the CSO in developing a collaborative and 'whole system' approach throughout the public service to strategic statistical development that would: enable understanding and tracking of structural change in economy and society; facilitate international comparisons with a changing Ireland; permit objective evaluation and monitoring of economic and social progress in Ireland; and better inform policy-making, especially in relation to cross-cutting issues (NSB, 2003). These are all goals which the NCAOP upholds from the perspective of the cross-cutting issue which is its *raison d'être*: the ageing of the population.

In follow-up work, the CSO has examined the potential statistical value of the major social data holdings in six Government Departments. The findings have been presented in a report known as the SPAR report (CSO, 2003c). The lack of central documentation of data holdings held in Departments and their agencies has, it was found, contributed to an inadequate awareness among staff of the content and full range of data holdings being managed by their Department. Another deficiency, it was found, is the absence of common standards in the design, content and processing of administrative questionnaires, preventing Departments from compiling an overall, integrated profile of their clients.

1.12 Government Departments to Develop Data Strategies

These findings were of concern in light of the requirement (arising from a Government memorandum accompanying the publication of the SGSES report) for each Government Department to prepare a data/statistics strategy. The NSB has recently published best practice guidelines to assist Departments in the preparation and implementation of their data strategies. Departmental data/statistics strategies should, according to these guidelines:

- determine how, and to what extent, the Department's data needs can be met within the Department
- establish what information is required that is not internally available
- identify the data needs in respect of complex and cross-cutting issues with which the Department is concerned
- identify how the skills of its staff can be enhanced in using data as a tool for policy evaluation and development.

The NCAOP hopes that the content of the current discussion paper will both contribute to, and benefit from, the wider consideration of the interface between data and policy-maker stimulated by some of the developments described above.

1.13 A Framework for Examining Information Deficits

The twelve-domain framework devised by the SGSES has been adapted to present the findings in this paper about deficits in our information about the older population. The original twelve domains were: health and access to health care; labour market and working conditions; income, wealth and poverty; education and training; households and families; housing; safety and security; social relationships and integration; environment; transportation; lifestyles and consumer expenditure; and population. It was pointed out in the SGSES report that 'the domains represent a generic set of areas of interest that are independent of institutional structures (e.g. Government Departments/agencies) at any given time' (SGSES, 2003).

The section headings in the current paper are:

- population
- households, families, social relationships and integration
- health and access to healthcare
- income, wealth and poverty
- education, training, labour market and working conditions
- transportation, housing, safety and security.

1.14 Organisation of the Paper

Each section of the paper is divided into three parts. The first part incorporates a brief outline of salient data already available about older people under the heading in question. The second part comments on information issues arising in relation to the themes under consideration. The third identifies information deficits.

The most extensive section in the paper, reflecting the data available in the datasets explored, relates to health and access to healthcare.

2. The Population of Older People

2.1 Salient Points of Information

2.1.1 Overall Population

The population enumerated on census night was 3,917,203, compared with 3,626,087 in April 1996, representing an increase of 291,116 people or 8 per cent over the six-year period. The 2002 population is the highest recorded since the census of 1871. Of this total population, 436,001, that is 11 per cent, were aged 65 years and over.

Core demographic data about the population of older people is available. Tables on the numbers of older people in the 65 years and over category are published in CSO reports, as are tables on the numbers of those in the 65-69 years category, 70-74 years category, 75-79 years category, 80-84 years category and

the 85 years and over category. Data on ratios of males to females is available, as is data on marital status and the geographic location of older people throughout the country. The ratios of males to 100 females in the older population in 2002 were: 65-74 years, 91.0; 75-84, 67.0; and 85 years and over, 42.7.

2.1.2 Traveller Population

Close to 24,000 Irish Travellers, representing 0.6 per cent of the total population were enumerated in the 2002 Census. The age profiles for the general and Traveller populations differ markedly. While the younger population aged 0-14 years accounted for 21.1 per cent of the general population, the corresponding proportion was 42.2 per cent for Travellers. Older Travellers, those aged 65 years and over, accounted for just 3.3 per cent of the total Traveller population compared with 11.1 per cent for the general population.

2.1.3 Age Dependency Ratios

Age dependency ratios provide summary measures of the age structure of the population at a particular point in time. The young and old dependency ratios are derived by expressing the young population (aged 0-14 years) and the old population (aged 65 years and over) as percentages of the population of working age (15-64 years). The total dependency ratio is the sum of the young and the old ratios. This total has fallen from 73.4 in 1961 to 47.6 in 2002. Youth dependency has fallen from 54.0 to 31.2 over the same period. Old age dependency has fallen from 19.4 in 1961 to 16.4 in 2002 (Connell and Pringle, 2004f).

2.1.4 Life Expectancy

According to the CSO Life Table, life expectancy at birth in 2002 was 75.1 years for males and 80.3 years for females. Life expectancy at age 65 is 15.4 years for males and 18.7 years for females (CSO, 2004f).

Life expectancy has increased consistently for both men and women since the first life table was compiled in 1926. In that year, males had a life expectancy of 57.4 years, while it was slightly higher for females at 57.9 years. The improvement is a direct result of decreasing mortality, particularly infant mortality rates over the period. Much of the improvement occurred between 1946 and 1961, with more modest increases since then. Over the last decade, life expectancy has increased by 2.8 years for males and 2.4 years for females.

In 1926, males had a life expectancy of 57.4 years, while it was 0.5 years higher for females, at 57.9 years. This gap widened over the following sixty years to stand at 5.7 years in 1986. Since then it has narrowed to 5.2 years in 2002.

The gap in life expectancy between the sexes is also present internationally and this gap has been increasing. In 1960, the EU-15 average showed a gap of 5.5 years and this had increased to 6.4 years in 1996. The CSO figures indicate a reversal in this trend in the EU-15, with a narrowing of the gap in life expectancy between the sexes to 5.8 years in 2002. Spain had the largest gap at 7.4 years in 2002, while Sweden had the smallest at 4.4 years. In the case of the EU-25, the gap between the sexes was 6.3 years in 2002.

2.1.5 Irish Life Expectancy Compared

Irish male life expectancy at birth, of 75.1 years, is below the EU-15 average of 75.8 years and above the EU-25 average of 74.1 years. Male life expectancy at age 65, of 15.4 years, is below that of the EU-15 average of 16.3 years and the EU-25 average of 16.0 years.

Irish female life expectancy at birth, of 80.3 years, is below that of the EU-15 average of 81.6 years and also that of the EU-25 average of 81.1 years. Female life expectancy at age 65, of 18.7 years, is below that of the EU-15 average of 19.9 and the EU-25 average of 19.6 years.

2.2 Issues

2.2.1 The Concept of 'Old Age Dependency'

The concepts of the 'dependent' population and of old age dependency have been questioned on the basis that they convey implicit messages serving to devalue the lives and contributions of particular groups within society, and do not accurately reflect the realities of our society (Arber and Ginn, 2004).

In considering this issue, the same authors have made a series of points in support of a view that trends based on population age structure are misleading:

- the 16-64 years age range no longer reflects the age patterns of paid employment¹¹
- young people spend longer in education with few entering the labour market at age 16
- most workers leave the labour market well before State pension age. A larger percentage of women are in paid employment than in the past, offsetting the shorter duration of employment among men
- activity that benefits the economy is not confined to paid employment. The example of older people providing unpaid, informal care to spouses and other family members is cited as an example of this kind of benefit.

2.2.2 Publication of Age-Specific Data

The datasets surveyed for this paper gather data on the ages of participating respondents/clients. However, age-specific or age-disaggregated data is not always published in resulting reports, thus limiting their ability to meet the needs of those who require age-specific information about the older population. The issues are:

- presentation of results without any data on age of respondents (acknowledging that such data is potentially available by special request)
- presentation of data about the older population using the single age band of 65 years and over (again acknowledging that further data may potentially be available by special request). This approach fails to take account of the heterogeneity of the older population; the reality that the needs of older people change with advancing age; and the fact that policy-makers cannot take adequate account of those changing needs if age-band profiles of the older population are not readily available.

2.3 Information Deficits

2.3.1 Lower Life Expectancy of Irish Men and Women

Though pointers are available, for example, in terms of high Irish death rates from cardiovascular disease and strokes, it is acknowledged that not enough is known about the lower life expectancy of the Irish population, compared with the populations of other developed countries (O'Shea, 2003).

11 The age range, 16-64 years, is quoted from Arber and Ginn's study.

2.3.2 Projecting Healthy Life Expectancy

Shortcomings in the data about prevalence of disability in the Irish population also create problems in accurately projecting healthy life expectancy for the older Irish population.¹² For example, the Mercer study of the future financing of long-term care in Ireland is based on the central projection that healthy life expectancy will increase in line with total life expectancy and an estimated reduction in disability prevalence in the future. Prevalence figures are drawn from a UK study of disability prevalence in that population which includes four alternative projections based on static, optimistic and pessimistic premises, all drawn from UK data (Mercer Consulting, 2002).

3. Households, Families, Social Relations and Integration

3.1 Salient Points of Information

3.1.1 Households and Family Units

There were 1,287,958 private households in total in 2002, containing 3,791,316 usual residents. Of these, 1,279,617 were in private households in permanent housing units, while the remaining 8,341 were in temporary units. The average size of private households fell from 3.14 in 1996 to 2.94 in 2002, thus continuing the long-term decline.

Between 1996 and 2002, the number of private households increased by 164,700 or 14.7 per cent. Households comprising childless couples represented the fastest growing category, up 38.7 per cent in six years, while the number of households consisting solely of couples with children increased by 11.1 per cent in the same period. Households consisting of lone parents with children increased by 25,800 (24.5 per cent) between 1996 and 2002, while the rate of growth of one person households just exceeded the overall average increase for this period. Multi-family households continued to decline in number during the recent intercensal period. See Table 1 in Appendix Three for a breakdown of private households by composition in 1996 and 2002.

A volume of census findings on household composition and family units also provides tables with data on the age structure of households. This includes, for example, the numbers of older lone mothers and older lone fathers living with children of any age, the numbers of older children (65+ years) living with their parents and the numbers of older parents living with their children (Census 2002).

3.1.2 Older People Living Alone

Older people living alone represent an important component of one-person households. Over one in four people aged 65 years and over lived alone in 2002, and people aged 65 years and over comprised 41 per cent of all people living alone in 2002. (See Table 2 in Appendix Three for a breakdown of the figures.) More detailed data on sex, age group and marital status of older people living alone is also available from the census reports.

12 Available data for the actual and projected numbers of chronically disabled Americans during the period 1982-1999 shows that the projections inaccurately predicted a steep rise in the numbers of chronically disabled (WHO, 2002).

3.1.3 Informal, Unpaid Care

Almost 149,000 persons aged 15 years and over (4.8 per cent of the total population in that age range) indicated that they provide regular unpaid personal help for a friend or family member with a long-term illness, health problem or disability in April 2002. Women accounted for over 91,000 (or 61 per cent) of the total and over half of them were in their forties or fifties. Proportionately more females than males were carers in all age groups up to and including the 60-64 years group. The highest proportions were amongst the middle aged, with over one in ten women aged 40-59 years being reported as a carer. The proportions of male and female carers change for the older age groups, with males predominating in the 80-84 years group and 85+ years group (CSO, 2004d).

Just over 40,000 people, representing more than one in four carers, provide regular unpaid help for 43 or more hours each week (i.e. on average more than six hours per day throughout the week). Two thirds of these heavily committed carers are women. There are 16,571 carers aged 65 years and over, that is 11 per cent of the total number of carers enumerated. A half of all older carers spend more than 43 hours each week providing help to others.

The census results also provide useful data on the occupational status of carers which should enable further analysis of the effects of labour force participation on women's involvement in the provision of care.

3.1.4 Social Support and Engagement

Secondary analysis of the 2002 SLÁN surveys, conducted on behalf of the NCAOP and based on the responses of 1,754 participants aged 55 years and over, provides data on perceived levels of 'support' received from spouses, children and friends; and 'social engagement' measured by participation in a range of clubs, societies and other activities.

The majority of participants reported high levels of support from spouses, children and friends. Higher percentages reported support from spouses and friends rather than from their children.¹³

In terms of social engagement, the largest proportion (31 per cent) of participants were involved in religious/voluntary groups and the smallest proportion (8.2 per cent) were involved in political parties.

The *HeSSOP* study has also reported on respondents' social supports and quality of life (Garavan *et al.*, 2001); the findings of a follow-up study with the original participants, a randomly selected sample of 937 older people in two health board areas, one rural and one urban, are to be published in 2005.

3.1.5 Voter Participation

Patterns of voter participation and abstention in the May 2002 General Election were examined in a QNHS special module. The results showed significant differences between the patterns of younger and older voters. Of those aged 20-24 years, 53 per cent voted, with voter participation increasing with age to reach a peak of almost 90 per cent for those aged 65-74 years. Of those aged 65+ years who did not vote, the largest proportion (37.9 per cent) attributed this to illness or disability. Other reasons given included: no interest (11 per cent); disillusioned (9.6 per cent); and lack of transport (8.3 per cent).

13 87 per cent of respondents received 'a lot of support' from spouses; 66.8 per cent 'a lot of support from children'; and 76.9 per cent 'a lot of support' from friends (Shiely and Kelleher, 2004).

3.2 Issues

3.2.1 *The Social Contribution of Older People*

The kind of data that is gathered for the main datasets reflects mainstream concerns with labour market participation, and education and training oriented towards labour market participation. These are forms of participation in, and contribution to, our society that are valued, measured and recognised.

Measures and indicators designed to assess other forms of contribution to societal well-being are much less well developed. Day-to-day experience in families, communities and public life may indicate to us that older people, the majority of whom are not labour force participants, make a valuable contribution to societal well-being in their myriad roles as individuals, family members and citizens. However, the means of systematically naming and measuring the types of social contribution made by older people (and other groups that are not primarily labour force participants) have yet to be developed.

3.2.2 *Marital Status and the Availability of Carers*

In considering the future care needs of an ageing population, marital status has been used as a proxy for the availability of family carers. The expectation is that the older single and older ever-married will enjoy differing levels of support in old age. However, marital patterns and family forms are changing and data held in national datasets will need to track these changes. Data about, for example, family and other relationships between care givers and care recipients, the functioning of the family and social networks of older people, particularly at points of crisis and transition in the life of the older person, and the family status of older people in long-stay care is necessary to enable effective planning on an evolving basis in response to older people in need of care.

3.2.3 *Experience of Discrimination*

Under the Employment Equality Act 1998 and the Equal Status Act 2000, discrimination in employment, vocational training, advertising, collective agreements, the provision of goods and services and other opportunities to which the public generally have access, is outlawed on nine grounds: gender, marital status, family status, age, disability, race, sexual orientation, religious belief and membership of the Traveller community.

Ideally, the main datasets should support the need for information about all sectors of the population, including the older population, in relation to any or all of the grounds on which discrimination is illegal. At the moment, they do not do so nor do they enable the kind of linkage across datasets which would facilitate the identification of sectors of the population experiencing multiple discrimination. The mortality data, for example, does not record ethnic status which is an issue given the age profile of the Traveller population. The National Cancer Registry's report highlights the need for the development of clinical guidelines and treatment protocols targeting older cancer patients (National Cancer Registry Board, 2001). Census 2002 incorporated data on the travel patterns of school-goers and workers. Comparable data about the travel patterns of the older population has not been gathered in that dataset. Relevant data about older people is dispersed throughout a series of datasets, and the collation of that data represents a considerable challenge.

3.3 Information Deficits

3.3.1 The Care of Older People

Due to the inclusion of new questions about carers in Census 2002, useful data on the proportion of the population providing informal and unpaid care to others is now available. It is worth noting that this data is available from the perspective of care givers rather than care recipients.

What the census data does not provide is answers regarding the following:

- how many of those to whom care is provided are in the 65+ years group
- the specific needs, concerns and preferences of older carers of whom, according to the census findings, there are substantial numbers (15,682 i.e. 11 per cent).
- the existing supports accessed by carers of older people, older people who are carers and the sources of such supports
- what the relationships are, whether they are relatives, neighbours, friends or volunteers, between care providers and care recipients.
- the nature and range of tasks undertaken by those providing informal care to others including personal care, help with shopping and correspondence
- how the families and social networks of older people function at times of crisis/transition in the lives of older people such as discharge from hospital with a new level of disability or dependency. This is of critical importance since it is at these points that the autonomy of older people and their capacity to remain living in their own homes are most severely challenged. The *HeSSOP* study, for example, found that half of the older people interviewed wanted family and friends to be their principal care givers. Approximately one fifth had a preference for care from professionals and more than a quarter were happy to receive care either from family or professionals (Garavan *et al.*, 2001). The perspectives of families and friends on this caring role in changing circumstances are the other side of the coin.

3.3.2 Older People in Long-Stay Care

Data on the family status of older people in long-stay care is not recorded in the main national dataset on this theme, the *Long-Stay Activity Statistics 2002* (DoHC, 2003b).

In 2002, 12.8 per cent of older people enumerated in the *Long-Stay Activity Statistics* were reported to be in long-stay care 'for social reasons'. No data is available on what those social reasons are.

3.3.3 Participation in Society

Beyond figures on voting patterns in elections, available from one QNHS module, and the SLÁN data on social engagement referred to above, data on the participation of older people in society is not systematically gathered.

3.3.4 Intergenerational Relationships

The existing datasets do not enable the examination of relationships between generations. What kind of interaction do children and younger people have with older people in families and communities? How are older people involved in the lives of families and communities? Similarly, the datasets do not enable examination of interdependence within families, for example, care of grandchildren by grandparents or transfers of resources to younger family members to enable the purchase of a first home or other assets.

4.1 Salient Points of Information

4.1.1 Mortality and Morbidity

The causes of mortality in the older population are known since mortality data for the population is compiled by the CSO and published quarterly and annually.

The physical health status of the 'young old' and the 'old old' differs, but profiles of the health status of successive age groups within the 65+ years sector of the population are not available from the datasets surveyed.

4.1.2 Disability in the Total Population

Almost 324,000 people, representing 8.3 per cent of the total population, reported a long-lasting health problem or disability in Census 2002. The occurrence of disability was higher among females than males (8.7 per cent compared with 7.8 per cent) and was age related. For people aged 15 years and over, the proportion who indicated that they had a long-lasting health problem or disability increased for every five-year age group from 15-19 years up to 80-84 years for both males and females.

The proportion of people aged 65 years and over who reported a disability is 31.1 per cent. The proportion of disabled people who are over 65 is 41.9 per cent. The proportion of the total population who are older and disabled is 3.4 per cent. The proportion of the older population who are disabled and living alone is 8.2 per cent.

4.1.3 Population-Based Morbidity Data¹⁴

Existing sources of population-based morbidity data are the National Cancer Registry and the NDSC which tracks notifiable infectious diseases in Ireland. The CHAIR has been running on a pilot basis in the Southern Health Board on behalf of the DoHC since 2002. At the time of writing, decisions have yet to be made about the adoption of CHAIR or Cardiology Audit Registration Datasets (CARDS) as the relevant dataset for Ireland. The SLÁN surveys also include some data on older people's experiences of illness, disability, levels of visual and hearing impairment, and dental health.

4.1.3.1 Morbidity Data: Cancer

The National Cancer Registry used the completion of five years of data from 1994 to 1998 as an occasion to produce a summary report for that period (National Cancer Registry Board, 2001). In terms of the incidence of cancer in the population, the Registry's own analysis showed that older people were much more likely to develop cancer, with the risk doubling in every successive decade of life. Most patients (60 per cent) were aged over 65 at the time of diagnosis and the majority of deaths (72 per cent) also occurred in those aged over 65.

14 The DoHC and Departments of Public Health make use of the Public Health Information System (PHIS) in the preparation of regional and national public health reports. This system has been in existence for eight years and is described by the Information Management Unit of the DoHC as 'a common minimum dataset to bring together data disaggregated by age, gender, area of residence and mortality/morbidity across a range of information sources (including Census, Vital Statistics, HIPE, National Cancer Registry, NPIRS) and over time'. It is disseminated on CD-ROM and work on the PHIS to include further data sources, such as NDSC and SLÁN, is ongoing.

4.1.4 Intellectual Disability

There were 2,457 adults aged 55 years and over registered with the NIDD in 2002. Though date of birth is recorded for the database, results are published for the age band '55 years and over' without further disaggregation of the older age group.

The age profile of the population with intellectual disabilities is changing; there are increasing proportions of people aged 35 years and over, from 29 per cent in 1974 to 45 per cent in 2002, based on those with moderate, severe and profound intellectual disabilities.

4.1.5 Residential Circumstances of Older People With Intellectual Disabilities

Of the 2,457 adults aged 55 years and over registered with the NIDD, the majority are living in residential centres (794) or community group homes (508). A significant proportion (432) are living in home settings and more than half of these adults are living at home with siblings. 130 are living in independent or semi-independent settings. Of the remainder in residential settings, 238 are in psychiatric hospitals and 28 are in nursing homes (Mulvany and Barron, 2003).

4.1.6 National Psychiatric In-Patient Database

The NPIRS is a national database which provides detailed information on all admissions to and discharges from in-patient psychiatric services in Ireland.

4.1.6.1 Admission to Psychiatric Hospitals

Of 2,039 people aged 65-74 years who were admitted to psychiatric hospitals in 2000, 505 were first admissions. Of 1,189 aged 75 years and over, 426 were first admissions (Daly and Walsh, 2001).

4.1.6.2 Diagnoses for Older In-Patients of Psychiatric Services

Diagnoses for the 65-74 years group in 2000 included: depressive disorders, 909; schizophrenia, 367; alcoholic disorders, 235; and organic psychoses, 174. For the 75 years and over group, diagnoses were as follows: depressive disorders, 517; schizophrenia, 111; alcoholic disorders, 57; and organic psychoses, 353 (Daly and Walsh, 2001).

4.1.6.3 Admissions of Older Patients With 'Mental Handicap'

Of 1,965 patients aged 65-74 years admitted to psychiatric units in 2002, the diagnosis for 16 patients was 'mental handicap'. Of 1,157 patients aged 75 years and over, the diagnosis for six patients was 'mental handicap' (Daly and Walsh, 2003).

4.1.7 Old Age Psychiatry Services

The Psychiatry of Old Age is a psychiatric speciality which, broadly, deals with two groups of people: older people developing functional psychiatric disorders for the first time over the age of 65 years; and dementia sufferers with behavioural or psychological problems for which psychiatric intervention is required. (In the 65 years and over population, 5 per cent of people are likely to suffer from dementia and this increases to 20 per cent of those aged over eighty years.)

There are 18 public old age psychiatry services in Ireland, two private services and two new public services starting in 2004. The thrust of such services is to adopt a community-oriented approach, offering domiciliary assessment and treatment where practical (Section for the Psychiatry of Old Age, 2003).

4.1.8 Parasuicide and Suicide

In the Republic of Ireland in 2002, the numbers of hospital treated episodes of parasuicide for older men and women respectively were as follows: 30 for men, 43 for women in the 65-69 years group; 11 for men and 23 for women in the 70-74 years group; 13 each for men and women in the 75-79 years group; 2 for men and 3 for women in the 80-84 years group; and 2 each for men and women in the 85+ years group.¹⁵ The total number of male parasuicide episodes treated in hospital that year was 3,513 and, for female episodes, the number was 4,788 (National Suicide Research Foundation, 2003).

The annual rate of suicide in the Republic of Ireland was as follows: 18 per 100,000 men and 6 per 100,000 women aged 65-69 years; 16 per 100,000 men and 4 per 100,000 women aged 70-74 years; 15 per 100,000 men and 5 per 100,000 women aged 75-79 years; 12 per 100,000 men and 4 per 100,000 women aged 80-84 years; and 14 per 100,000 men and 2 per 100,000 women aged 85+ years (National Suicide Research Foundation, 2003).

4.2 Issues

4.2.1 Issues Raised by Datasets

4.2.1.1 NPSDD

The NPSDD does not systematically register older people experiencing disability. Currently inclusion on the database is limited to those who are less than 66 years of age. The rationale for this decision is as follows:

Information is only being collected until the age of 66 as this is the group funded by Physical and Sensory Disability Services. There would automatically be a percentage of people over the age of 65 who would have a physical or sensory disability arising from their age as opposed to a disease, disorder or trauma. This group is more appropriately funded by Services for Older People. Including this group on the database and in requests for funding would result in the funding allocated for physical and sensory disability (in persons under 66 years) being unnecessarily reduced.

(Gallagher, 2001)

Arising from discussion of this point, the decision has been made that individuals who are already registered with the database and who then reach the age of 66 will not be removed from it. However, those who acquire disability in older age are not currently added to the database though the proportion of the population experiencing disability increases with advancing age. For example, Census 2002 results show 23.3 per cent of the population aged 70-74 years reporting a disability and 33.7 per cent of those aged 75-79 years doing so.

¹⁵ The National Parasuicide Registry's definition of parasuicide is 'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences' (National Suicide Research Foundation, 2003).

4.2.1.2 HIPE Data

HIPE records generate some data on morbidity in the population, but their primary purpose is to facilitate analysis of hospital activity rather than incidence or prevalence of disease. HIPE data is frequently cited in terms of, for example, the number of bed days used by different age groups within the population and the number of bed days used in the treatment of different types of disease. Issues in relation to HIPE data include the following:

- they track hospital activity rather than individual patients
- occupational status of patients is not recorded
- discharge status of patient is recorded in terms of their public/private status rather than their health status
- waiting times, between GP referral and meeting with consultant(s), and between meeting with consultant(s) and admission to hospital, are not recorded. (The SPAR report has suggested that the HIPE system might gather this data [CSO, 2003c])

The Information Management Unit of the DoHC points out that 'the purpose of HIPE is to track hospital activity and not to track patient activity. Ideally, it could do both but the lack of a UPI number hinders this' (DoHC, 2003a).

Commenting on HIPE data, one geriatrician consulted in the course of this survey indicated that he and many of his colleagues would be keen to take a fresh look at the coding of HIPE data with a view to enabling the dataset to provide a more complete picture of the patterns of illness of older people in acute hospitals. Features of these patterns are: non-specific presentation of illness; length of time needed to arrive at a diagnosis; presence of co-morbidities; and development of other symptoms such as confusion or reduced mobility emerging during the course of the hospital stay, possibly in response to medication.

Finally, a comment on the Diagnosis Related Group (DRG) case-mix classification scheme which has been adopted as the national standard for Ireland by the DoHC since 1993 and which draws on data from the HIPE system: The DRG system may be summarised 'as the identification in the acute care setting of a set of case types, each representing a class of patients with similar processes of care and a predictable package of services (or product) from an institution' (Wiley, 1995). The system is used to measure hospital workload and to determine the allocation of Departmental funds to hospitals on the basis of that measurement. An analysis of the implications of this system for older patients within acute hospitals is necessary, but is beyond the scope of the present study.

4.2.1.3 Patients, Hospital Activity and Contextual Information

In terms of a national information framework, there is a lack of contextual information to support analysis and interpretation of trends in hospital activity identified through HIPE data. HIPE data, however, records the destination of patients on discharge from hospital and this is useful data in itself.¹⁶

¹⁶ The discharge codes used are as follows: self-discharge; home; nursing home, convalescent home or long-stay accommodation; transfer to hospital in HIPE listing or any acute hospital not specified in HIPE listing (emergency); transfer to hospital in HIPE listing or transfer to any acute hospital not specified in HIPE listing (non-emergency); transfer to psychiatric hospital/unit; died with post mortem; died no post mortem; transfer to non-acute hospital not in HIPE listing (emergency); transfer to non-acute hospital not in HIPE hospital listing (non-emergency); rehabilitation facility (not in HIPE hospital listing); hospice (not in HIPE hospital listing); prison; absconded; other (e.g. foster care) (HIPE, 2004).

Information issues remain in relation to the gathering of contextual data of a kind which is outside the remit of HIPE. Such information might include: data on the outcomes of treatment; treatment plans; follow-up needs and support requirements. Data on the time lag between patient readiness for discharge and doctors' inability to discharge due to lack of availability of suitable step-down facilities or home situation for patients would also be extremely useful, particularly in light of periodic discussion of older patients as 'bed-blockers'.

4.2.1.4 Long-Stay Activity Statistics

The data available from the DoHC's *Long-Stay Activity Statistics* are limited by the fact that they do not enable:

- tracking of individual residents, including triggers for admission to and discharge from long-stay care
- contextual information about residents such as family status and socio-economic status.

The DoHC points out that 'long-stay units are the unit of analysis in this survey and not the individual patients within the units' (DoHC, 2003b).

4.2.1.5 DoHC Health Statistics 2002

The usefulness of the data on health services in the DoHC's report, *Health Statistics 2002*, could be enhanced if the following were provided (with reference here to specialised services for older people):

- population incidence and prevalence rates for specific health conditions¹⁷
- recommended norms for specialised services/personnel, that is, one consultant geriatrician per 70,000 population
- availability of specialised services in health board/geographic areas in light of those recognised norms
- gaps in services in light of those norms, referring to both gaps in existing services, that is, gaps in multi-disciplinary services, and areas (both geographic and health care speciality) where services do not yet exist, that is, where dedicated rehabilitation services are available/not available for older people.

4.2.1.6 Morbidity Data: Cancer

With regard to National Cancer Registry data, a number of limitations have been identified by the Registry and these are also pertinent to the purpose of this paper:

- there is no obligation, either legal or administrative, on individuals or institutions to supply the Registry with data
- the Registry does not register a case based on death certification alone, but only after the diagnosis has been confirmed from another source. Their experience is that the accuracy of death certificates as a source of notification of cancer is questionable
- cancer cases are also notified to the Registry by GPs, but the number of cases is small. This is the only source of information on non-fatal cancers treated solely by GPs

17 The DoHC says that the limited population-based morbidity data available in Ireland, as in most other countries, means that it is generally not possible to publish prevalence and incidence rates as suggested here. In preparing its 2005 report, the DoHC says that it would be happy to include additional data of interest to the NCAOP and others in this area.

- the Registry has no facilities for data linkage with other national datasets such as the census or occupational registers. The occupational data collected by the Registry is limited and their view is that the absence of mechanisms to link data on occupations with cancer registration, as can be done, for instance, in Denmark, is unfortunate as it limits scope for identifying new occupational risk factors (National Cancer Registry Board, 2001).

4.2.1.7 Parasuicide and Suicide

Though the levels of parasuicide and suicide in the older population are relatively low, this is recognised as an area that requires further research and analysis.

4.2.2 Aspects of Datasets

4.2.2.1 Activity Rather Than Person-Centred Data

There is a need for person-centred data about the older population. Features of some of the main datasets which limit their potential to meet this need are the following:

- several of the key datasets are activity-centred, rather than person-centred
- it is not possible to track individuals across the datasets
- many of the administrative data systems which are repositories of relevant data on older people operate on a standalone basis
- older people feature in health-related datasets when they come in contact with institutions and formal systems, for example, on admission to hospital or on diagnosis of a specific illness.

The SGSES has recommended the expanded use of a common identifier, like the PPSN, which would enable, for example, identification of repeat occurrences such as stays in hospital, and integration of findings from a range of datasets. The SPAR report has also recommended the use of a unique personal identification number, taking the view that this would enable the production of a sound statistical health profile of the population from birth to death: ‘... an integrated framework of health data would enable longitudinal analyses of the population from the point of view of their health status and their interactions with health services over time and under changing conditions (e.g. if residence or occupation changed)’ (CSO, 2003c).

The NHIS has stated that ‘the only safe and practical method of being able to draw together the separate parts of an individual’s health record is through the use of unique identification. In the absence of this, it is not feasible to plan, manage, deliver or evaluate services on a person-centred basis since this can only be achieved by associating records belonging to the same client/patient’ (DoHC, 2004). It has recommended the introduction of a system for unique identification within the health sector using the PPSN. It is recognised that, if this proposal is to be successfully implemented, a comprehensive legislative basis is required which will both enable appropriate access and maintain patient privacy, confidentiality and security of information. The HIQA will be given a central role in implementing the NHIS and ‘a specialist function for information governance will be established within the Authority’.

4.2.2.2 Data about Input and Throughput rather than Outcomes

The main emphasis of the data available on older people's contact with health services is on the input and throughput dimensions of those services: the provision and take-up of allowances and supports; the distribution of services; the numbers of staff employed; numbers of patients attending clinics; usage of bed days. Virtually no systematic data is gathered on the outcomes of access to and participation in those services for older people.

4.2.2.3 Occupational Status and Health Status

The links between occupational status and health status are well established. In their study of Irish mortality data, Balanda and Wilde found that, for all major causes of death – circulatory diseases, cancers, respiratory diseases, injuries and poisonings – mortality rates were significantly higher in lower occupational classes than in higher occupational classes (Balanda and Wilde, 2001).

Reporting on Irish psychiatric services, Daly and Walsh note a failure to provide complete data on occupational status of patients to the NPIRS in the preceding year (2001); and based on the available data, the fact that 'socio-economic disadvantage, whether antecedent to, or consequent on, psychiatric disorder, has a positive relationship with morbidity' (Daly and Walsh, 2003). They highlighted the following:

- rates for the unskilled occupational group were the highest for all and first admissions, and six times those of the lowest group, own account workers
- fifty per cent of admissions to health board hospitals and general hospital psychiatric units had manual occupations compared to 22 per cent to private hospitals
- nine per cent of admissions to private hospitals had a diagnosis of schizophrenia, the condition most closely associated with socio-economic disadvantage, compared with 23 per cent to health board hospitals and 20 per cent to general hospital psychiatric units.

Age-specific data, correlated with occupational status of admissions, was not published in their report.

Some of the issues relating to data on occupational status have already been identified. These include: lack of occupational data of any kind; lack of complete data in some datasets on older people who are retired or female; and inability to link occupational with other relevant data on older people.

4.2.3 Other Themes from Datasets

4.2.3.1 Implications of Geographic Location

Geographic location, and specifically health board location, affects patient experience of the health services, both in terms of their physical and mental health. There are considerable variations between health boards, for example, in admission rates to psychiatric hospitals (Daly and Walsh, 2003). The authors state that 'it is unlikely that these differences reflect differential morbidity between health board areas but rather contrasting styles of practice delivery'. They also highlight differentials in the provision of community facilities between health boards.

There is scope for further analysis of existing datasets to assess fully the implications of geographic location for older people's health and social gain; and to enable planning to reduce geographically-based inequalities in access to health and social care provision based on models of best practice.

In considering the future development of Ireland's statistical systems, the NSB has also recommended the introduction of a Postal Code System (PCS), alongside the introduction of a PPSN to fully realise the potential of the statistical system (NSB, 2003). The NSB points out that, outside the census, it is difficult at present to gather or compare data at any geographical level lower than a county. A postcode system would, it is argued, increase ability to use statistics to understand what is happening at the level of localities and to link statistics from different datasets, for example, on health and educational status in particular communities (NSB, 2003).

Though there are different views on how it should be done, there is agreement that a spatial dimension in data collection would enhance national datasets. This can be achieved by geocoding, that is assigning all records a 'locational identifier'. Like personal identifiers, these locational identifiers could be used to link records from different sources within a geographic area.

4.2.3.2 Public and Private Provision

Variations in trends of admission to, and discharge from, public and private psychiatric hospitals are also noted in Daly and Walsh's report on the activities of the Irish psychiatric services. Twenty two per cent of discharges from health board hospitals and general hospital psychiatric units occurred within one week of admission compared to 9 per cent from private hospitals. Over 70 per cent of discharges from health board hospitals and general hospital psychiatric units occurred within four weeks of admission compared to 42 per cent from private hospitals. Private hospitals had an average length of stay, for each discharge, of 40.8 days, compared to 22.0 days in general hospital psychiatric units and 25.8 days in health board hospitals. Re-admissions accounted for 59 per cent of admissions to private hospitals compared to 72 per cent of admissions to health board hospitals and to general hospital psychiatric units (Daly and Walsh, 2003).

The choices available to older people and the implications for them in terms of access to public or private care within the health services warrant further analysis.

4.2.4 Ageism in the Health Services

The *HeSSOP* study of community-residing older people found that 20 per cent of respondents did not feel their views were sufficiently taken into account by health professionals (Garavan *et al.*, 2001). The NCAOP has since commissioned research on ageism in the health services and the findings are to be published in 2005. The study is examining perceptions of ageism from the perspectives of older people who are users of the services and of healthcare professionals who are providing the services.

4.3 Information Deficits

4.3.1 Person-Centred Data

The fact that the main datasets do not yield sufficient person-centred data about the older population leads to other deficiencies in the evidence base for planning. These deficiencies have implications for:

- the identification of the clusters of health and social care issues which older people experience, and the development of holistic assessment approaches to underpin the care of older people (a need identified in previous publications and by the Mercer report on the financing of the long-term care of older people [Mercer Consulting, 2002])
- the identification and evaluation of outcomes of services and responses to the health and social care needs of older people

- the care of older people with more intractable health and social care issues, some of whom experience ‘a revolving door’ in terms of services and who become, and may remain, unresolved ‘problem cases’. (The recent elder abuse pilot projects initiated by the Working Group on Elder Abuse [WGEA] under the auspices of the NCAOP drew attention to several such cases.)

4.3.2 Lack of Psychiatric Out-Patient Database

There is currently no national psychiatric out-patient database. Though data on the numbers of psychiatric out-patient clinics, day hospitals and day centres, and the numbers of attendances at those facilities are published in the reports on the psychiatric services (from HRB and DoHC), no patient data is provided at national level. This contrasts with the data on in-patients of the psychiatric services which includes details of their demographic, clinical and socio-economic status.¹⁸

One of the implications of this deficit is that the activities of community-oriented services such as those of Old Age Psychiatry are not fully reflected in the national datasets. Old Age Psychiatry did not feature as a dedicated heading in any of the datasets surveyed and relevant figures quoted earlier in this section of the report are from data compiled by the Irish College of Psychiatrists rather than a national dataset.

4.3.3 Mortality Data

Shortcomings in mortality data have previously been identified in a study conducted by the Institute of Public Health in Ireland (Balanda and Wilde, 2001). These concern:

- the failure to code secondary causes of death to ICD-9 on death records, though secondary causes can be recorded on death certificates
- the poor quality of occupational data on health records, particularly amongst people outside the working years and amongst females, which limits ability to explore the relationship between socio-economic circumstances and mortality.

4.3.4 Impairment and Disability in Old Age¹⁹

4.3.4.1 Impairment in Old Age

The datasets surveyed do not yield systematic and population-based data on the causes of the increasing occurrence of impairment in older age. This has implications in terms of the development of preventative and health promotion strategies targeted at the older population.

4.3.4.2 Injuries as a Cause of Impairment

Injuries are thought to be the main cause of severe acquired disability in those aged 65 years and over (O’Shea, 2003). No data is centrally recorded on the development of disabilities associated with injuries, including falls, or associated consequences of injury in old age such as depression, loss of confidence, increased isolation and loss of independence (Ibid).

18 A Two County Psychiatric Case Register, managed by the HRB, was in operation from 1973 to early 2004. This register aimed to gather information regarding users and the use of developing community psychiatric care services which could complement information already being collected from in-patient psychiatric services. The register has now been discontinued. The HRB, however, is working on the development of a software system, COMCAR, which will eventually be used to gather psychiatric out-patient data. The expectation is that the COMCAR system will be piloted before the end of 2004. The HRB has also recently published a report about psychiatric day care which incorporates psychiatric out-patient data from two health board settings (Hickey *et al.*, 2003).

19 The NDA bases its work on a social model of disability, which places a person’s impairment in the context of the social and environmental factors which create disabling barriers to their participation in society. This contrasts, the NDA says, with more medical and individual concepts of disability, which equate a person’s impairment with their disability without placing it in any broader context. For example, employing the social model of disability would mean that a wheelchair user cannot get into a building because of the planning and design of the building or the attitudes of the owner, rather than because they are unable to climb steps. This use of language, speaking of older people in terms of impairment, and disability in terms of social and environmental factors, is applied here.

4.3.4.3 Chronic Disease as a Cause of Impairment

The extent to which chronic disease, for example problems associated with stroke, osteoporosis and diabetes, is the cause of recorded disability in older age is not documented in the datasets.

4.3.4.4 Visual and Aural Impairment

Data on reported levels of sensory impairment are available from Census 2002.²⁰ The value of the data, however, is limited by the fact that data on visual and aural impairment has been synthesised in terms of original question posed and the presentation of results. It is not possible to identify proportions of the older population who experience visual impairment alone, aural impairment alone or both together. Furthermore, given the nature of the data available, it is not possible to locate older people within a continuum of impairment.

4.3.4.5 Social and Environmental Barriers

Data on the social and environmental barriers to the participation in society of older people with impairments is not systematically gathered in national datasets. The absence of such data has implications in terms of the identification of needs and the planning of responses to meet those needs and to reduce the impact of impairment acquired in older age.

4.3.4.6 Access to Services and Supports for Older People With Impairments

It is not possible, on the basis of the datasets surveyed, to profile older people with impairments in terms of their access to services and supports, and the factors (geography, income status, educational attainment, family and friendship networks) influencing levels of access to those supports.

4.3.5 Intellectual Disability

People registered with the NIDD are categorised in terms of the severity of their intellectual disability (mild to profound). The specific types of intellectual disability are not identified, nor are mental and physical co-morbidities associated with all or specific intellectual disabilities. (The DoHC points out that the NIDD was set up specifically to enable service planning and the assessment of service need, and not as a population register for people with an intellectual disability. Thus, diagnosis was specifically excluded from consideration in the dataset.)

4.3.6 Population-Based Morbidity Data

There is an unmet need for the inclusion of population-based morbidity data in national datasets.²¹ This applies to both the physical and mental health of the older population.

20 The SLÁN findings, with reference to participants in the 1998 survey, showed that 85.8 per cent of respondents wore glasses or contact lenses some or all of the time, and that 43.4 per cent of older adults found it very difficult to follow a conversation if there was background noise from a TV, radio or children playing (Shiely and Kelleher, 2004).

21 For example, a study of heart disease in Ireland over fifty years conducted on behalf of the Irish Heart Foundation encapsulated the issues from that perspective (Codd, 2001). In Ireland, the most significant cause of death in the older age groups is disease of the circulatory system, of which Ischaemic Heart Disease (IHD) accounts for the largest number of deaths. Though this is the case, analysis of mortality data had established a decline in mortality from IHD between 1985 and 1999, attributed to preventative measures and early intervention. The corollary of reduced mortality from cardiac disease is increased prevalence of the disease in the population. HIPE data shows that patients with circulatory diseases require more bed days than patients in any other diagnostic category. Increased prevalence, coupled with a change in the demographic structure of the population, has implications for the health services in planning to meet the needs of an older population, more of whom will have cardiac disease. Data on morbidity associated with heart disease in the Irish population and the older Irish population was limited to that which could be extracted from HIPE. Once established on a national basis, the CHAIR will be a source of data on morbidity associated with heart disease in the Irish population.

4.3.6.1 Morbidity Data: Cancer

With regard to the treatment of older cancer patients, the National Cancer Registry points out that older people were much less likely to have cancer-specific treatment and, when treated, were less likely to receive surgery or combination therapy. Age differences persisted even after adjusting for stage of cancer, gender of person and health board of residence. The Registry took the view that 'a better understanding of mechanisms underlying clinical decision-making with regard to cancer treatment is required. Information on stage (of cancer), co-morbidity and reasons behind treatment decisions should be recorded more systematically. Clinical guidelines and treatment protocols targeting older cancer patients should be developed and updated regularly' (National Cancer Registry, 2001).

4.3.7 The Provision of Health Services and Supports

4.3.7.1 Community-Residing Older People

The datasets surveyed tell us little about the health status and well-being of the population of older people residing in the community whose primary healthcare contacts are with their GPs and/or local PHNs. There are two aspects to this gap in information. The first concerns older people whose health and social issues remain invisible, undiagnosed or, if diagnosed, unresolved, perhaps coming to light at a point of crisis when preventative and/or health promotion measures are much less likely to be effective. The second concerns the contribution that data about older people who are residing satisfactorily in their own communities could make to perceptions and understandings of old age: understandings which currently are influenced heavily by an emphasis on the level of resources, bed days and service provision absorbed by an ageing population.

The NCAOP recommended, in 1996, 'the development of information systems to routinely collate the activities of all health and social care services in a particular district, whether at the community care, acute hospital, psychiatric hospital or long-stay unit level. These systems would be patient-focused and integrated to allow the tracking of individual patients through various care sectors' (Keogh and Roche, 1996).

4.3.7.2 Homecare Supports and Services

The DoHC's *Health Statistics* include data on the provision of home help services to older people and the numbers of PHNs in different health board settings. Beyond this, there is no centrally collated data on the provision of homecare supports and services to older people around the country, whether on a voluntary basis or otherwise.

4.3.7.3 Geriatric Services Within the Health System

Similarly, DoHC-published data on geriatricians and geriatric services within the health service is limited to numbers of geriatric beds, rates of bed occupancy in acute hospitals and numbers of attendances at geriatric out-patient clinics. Contextual data that would enable analysis in terms of matches with recommended service and resource requirements and/or gaps in services is not included.

4.3.8 Acute Hospitals

4.3.8.1 Waiting Times for Admission to Hospital

The main source of data on waiting times for public in-patient and day-case hospital procedures, the waiting lists published by the DoHC, cannot provide systematic data on the numbers of older people waiting for treatment; there are two categorisations, child and adult, therefore the available data cannot be disaggregated by age.

4.3.8.2 Unpacking 'Bed Days'

The fact that older people have longer hospital stays and use more bed days is frequently cited in discussions about the ageing of the population and the implications for health service resources. HIPE data is frequently referred to in this regard. This data, however, cannot show why it is the case that older people occupy more bed days than younger people. Data on the extent to which systemic deficiencies, for example in the provision of home care and step-down facilities, contribute to longer hospital stays for older people has not been systematically collated and analysed at national level (although at least one study is in progress at regional level).

4.3.8.3 Accident and Emergency Services

Systematic and nationally-based data on older people's contacts with hospital Accident and Emergency services are not available (although at least one regional study is in progress).

4.3.9 Length of Stay of Older People in Long-Stay Care

It is reported that more than three quarters (76.9 per cent) of older people who were in long-stay care in 2002 had been resident for less than three months and that a much smaller proportion (12.1 per cent) had been resident for a year or more (DoHC, 2003b). However, figures returned to the DoHC include older people who are availing of respite care, admissions, discharges and re-admissions. There is no accurate figure for length of stay of older people in long-stay care.

4.3.10 Other Aspects of Long-Stay Care

No data is available about residents' perceptions and experiences of long-stay care. Similarly no data is centrally collated on the range and quality of facilities and services provided within different categories of long-stay units.

5. Income, Wealth and Poverty

5.1 Salient Points of Information

5.1.1 Relative Income Thresholds

According to the results of the 2001 LIIS, more than one in three households where the reference person is aged 65 years or over fall below 60 per cent of median income, the relative income threshold used to denote those 'at risk of poverty'.²² There is also a gender disparity within the older population with an increasing proportion of older women at risk of poverty.

22 This percentage has increased consistently across five Living in Ireland Surveys, from 6.5 per cent in 1994 to 25.3 per cent in 1998 to 36.6 per cent in 2001. Those aged 65 years and over also face a higher risk than other adults of falling below 60 per cent of median income. The percentage of individuals in this category has increased from 5.9 per cent in the 1994 LIIS to 32.9 per cent in 1998 to 44.1 per cent in the 2001 survey. In terms of gender disparity, in 1994, 6.4 per cent of men and 5.5 per cent of women fell below 60 per cent of median income. In 2001, 36.1 per cent of men and 50.2 per cent of women fell below 60 per cent of median income (Whelan *et al.*, 2003).

5.1.2 Deprivation and 'Consistent' Poverty Measures

Deprivation, as opposed to income poverty, was measured through the use of a basic lifestyle deprivation index, and the findings show a fall in basic deprivation over the 1994-2001 period across all household types and for all categories of individuals, including those aged 65 years and over. 18.5 per cent of the 65+ years group experienced deprivation in 1994, compared with 6.1 per cent in 2001.²³

The composition of people experiencing consistent poverty by labour market status in 2001 shows that 33.7 per cent were engaged in home duties; 12.1 per cent were retired; and 17.8 per cent were ill or disabled.

5.1.3 Categories at High Risk of Poverty

The sub-groups of the older population whose incomes are particularly low compared to others are those on non-contributory widow's pension, those on non-contributory old age pension and those on the contributory widow's pension (Layte *et al.*, 1999).

5.1.4 Household Type and Household Finances

Data from the DoEHLG survey on housing quality also throws light on the material status of older people (Watson and Williams, 2003). Figures are presented on the proportions of different types of households experiencing financial strain. Of households composed of 'one person 65 or over', 13 per cent experienced housing costs as a very heavy burden, 6 per cent had arrears on housing or utility bills, and 5 per cent reported 'great difficulty in making ends meet'. In terms of 'other all adult 65+' households, 10 per cent experienced housing costs as a heavy burden, 6 per cent had arrears on housing or utility bills, and 4 per cent reported 'great difficulty in making ends meet'.

5.1.5 Cannot Afford Goods and Services

Higher percentages of older households, according to the same survey, report that they cannot afford certain goods and services. The goods and services in question, and percentages of 'one person 65 or over households' who could not afford them, were: replacing worn furniture (42 per cent); adequate heating (14 per cent); one week's holiday per year (51 per cent); meal with meat every second day, if desired (8 per cent); new clothes (15 per cent); presents once a year (22 per cent); socialising once a month (46 per cent); and ownership of car or van (58 per cent). The overall percentages are lower, but still significant, for 'other all adult 65+ households' ranging from 36 per cent who cannot afford an annual week's holiday to 4 per cent who cannot afford a meal with meat every second day.²⁴

23 Basic deprivation measures are combined with relative income poverty lines to construct a 'consistent' poverty measure, distinguishing households that have both relatively low income and are experiencing basic deprivation. Using the 60 per cent median income line, the percentage of people falling below the income line and experiencing basic deprivation has fallen from 8.3 per cent in 1994 to 4.1 per cent in 2001. Using the 70 per cent median income line, the percentage has fallen from 14.5 per cent in 1994 to 4.9 per cent in 2001. The 70 per cent median income line is used to present the remainder of the findings for the population based on a combination of income lines and a basic deprivation index. The percentage of persons aged 65 years and over affected by consistent poverty, using this income/deprivation combination, fell from 8.4 per cent in 1997 to 3.9 per cent in 2001. The gender breakdown shows figures of 6.1 per cent for men in 1997 and 10.2 per cent for women; in 2001, the figure for men was 3.1 per cent and for women, 4.4 per cent (Whelan *et al.*, 2003).

24 The survey also incorporated data on the percentage of households experiencing an 'enforced lack' of household appliances. Percentages of 6 to 14 per cent of 'one person 65 or over' households could not afford one or other of the following: a freezer; microwave; dishwasher; washing machine; clothes dryer; video recorder and home computer. The percentages of 'other all adult 65+' households experiencing such a lack ranged from 3 to 11 per cent. (An 'enforced lack' means the household does not possess an item, would like to have it but cannot afford it.)

5.1.6 Fuel Poverty

Fuel poverty, defined as 'the inability on the part of a household to afford adequate home heating' is an issue for a proportion of lone pensioner households in Ireland. The highest levels of fuel poverty in northern Europe for this category of household are found in Ireland: 11.8 per cent of lone male pensioner households and 7.8 per cent of lone female pensioner households experience fuel poverty (Healy, 2003). This study also highlights the public health implications of fuel poverty in terms of premature mortality among the very young and also among older people.

5.1.7 Social Expenditure on the Older Population

Irish social expenditure has been examined in a comparative international context (Timonen, 2003). This study has shown that, while Irish social expenditure has grown briskly throughout the 1990s in real terms, its share of GDP/GNP has fallen. Ireland's social welfare pensions expenditure is comparatively low due to the country's demographic profile and low level of pensions. Nevertheless, old age pensions, at 25.4 per cent of total expenditure, represented the largest area of spending by the DSFA in 2000. Of this expenditure, 69 per cent was on contributory old age pensions and 31 per cent on non-contributory pensions.

5.2 Issues

5.2.1 Income and Living Standards

In reviewing the findings of the LIIS, researchers have taken the view that there is a particularly weak link between income and basic deprivation for the older population and that cash income gives an imperfect understanding of older people's living standards (Whelan *et al.*, 2003; Layte *et al.*, 1999). This is attributed to the range of 'free schemes', the accumulation of significant resources, and family support systems.

5.2.2 Poverty and Population

The same researchers make the point that low incomes are not unimportant as an indicator of social disadvantage and it is not that trends towards increasing numbers below income poverty thresholds are not a cause for concern for anti-poverty policy; it is 'rather that poverty measures, whether income or deprivation, designed to operate across the *entire population may have significant limitations in grasping the complexities of the situation of any particular sub-group* (my italics)... For the elderly, policies focused on quality rather than cost of housing and health and social services may be particularly important' (Whelan *et al.*, 2003).

5.2.3 Quality of Health and Social Services

As the data in the other sections of this paper indicates, large proportions of the older population experience disability and ill-health, and will, therefore, have recourse to health and social services. Where such services are unavailable, of poor quality or excessively costly, older people who need them will experience deprivation. Furthermore, there are links between poor health and material disadvantage, and these are compounded in the case of older people who do not have the ability to purchase private health insurance and who are, therefore, more vulnerable to any inadequacies in the public health system (Layte *et al.*, 1999).

5.2.4 Indicators of Socio-Economic Status and the Older Population

There are some issues in applying traditional indicators of education, occupation and, as indicated above, income to the older population.²⁵ Access to good quality health and social services, housing tenure, adequacy and quality of housing, access to transport and the capacity to deal financially with unforeseen events and crises of various kinds are each, potentially, indicators of the material status and well-being of the older person.

It is evident from the DoEHLG data (which covers expenditure outside the 'basic' range) that any unplanned or additional expenditure, such as a need for nursing support in the home due to ill-health or a need for housing adaptation, will represent a problem for a proportion of older people (Watson and Williams, 2003).

All of this suggests that further work is needed to develop a composite measure or series of measures to reflect and inform planners better about the socio-economic status of older people.

5.2.5 How Healthcare Costs are Measured

How are the healthcare costs of sectors of the population measured?

Studies of healthcare costs in Great Britain have shown that the highest *per capita* healthcare costs are incurred in the months before death, regardless of the age of the patient (Arber and Ginn, 2004). The high costs of caring for an ageing population are frequently commented upon negatively. However, the point made by Arber and Ginn about the high costs of caring for any sick person in the last year of their life, regardless of age, underscores the need to be mindful of the measures used, the assumptions underpinning them and the ongoing challenge to develop measures, in health economics as in other areas, that fully reflect the breadth of issues involved in costing the healthcare of the entire population.

As the review of the Nursing Home Subvention Scheme made clear, the system of planning and funding the long-term care of older people is in need of reform and this is now in progress (O'Shea, 2002). There are cost measurement issues to be addressed here also, for example, the identification and breakdown of the different elements of long-stay care of older people and the costing of those elements. What are the care elements? What are the 'hotel' elements? How are each of these elements to be measured and costed? What are the comparative costs of community and residential care of older people?

5.3 Information Deficits

5.3.1 Sub-Groups of the Older Population

As the ESRI has made clear with regard to the LIIS, the sampling approach did not enable the inclusion of particular sub-groups of the population, such as Travellers and homeless people. Comparative income data is not available in the case of older people in long-stay care, older Travellers and older homeless people.

5.3.2 Family Support Systems

Since family support systems are regarded as one of the factors weakening the link between income and deprivation in the case of older people, data about the (intergenerational) functioning of family support systems in income and other material terms would be useful.

25 Some of these issues have also been discussed in the context of socio-economic inequalities in mortality among older people (Huisman *et al.*, 2004).

5.3.3 Accumulated Resources

The point that the majority of older people own their own homes and are, in this sense, asset rich is frequently made. There has been some discussion about the use of the family home as a resource in financing the long-term care of older people. In the exploration of policy options in this area, there is a need for more data about the perspectives of older people and their families on this use of the family home.

5.3.4 Material Requirements from the Perspective of the Older Population

Existing data is oriented towards examination of older people's material status from the perspective of other age groups. Data developed from the perspective of older people, based on their own assessment of income, resource issues and requirements, would be of value.

5.3.5 Health and Social Care Expenditure on the Older Population

The DSFA provides figures on total expenditure on old age pensions and other benefits. It is possible, therefore, to see what proportion of that Department's budget is allocated to the older population. The same is not true of the expenditure of the DoHC on provision for older people; it is not possible to examine the level of funding allocated to the older population in comparison with levels of funding for other sectors of the population.

5.3.6 Composition of Client Groups for Various Health and Social Services

Given the importance for older people of access to good quality health and social services, regardless of their material status, the systematic recording of data to enable analysis of composition of client groups for diverse health and social services (including home help, meals-on-wheels and other services for which input type data is currently available) would be useful.

6. Education, Training, Labour Market and Working Conditions

This section of the report is organised under two headings: Education and Training; and Labour Market and Working Conditions.

6.1 Education and Training: Salient Points of Information

6.1.1 Educational Attainment

Older people have lower levels of educational attainment, as measured by participation in formal education, than their younger counterparts. For example, Census 2002 results show that, for 48 per cent of 65-69 year olds, the highest level of education completed was primary level with just 8 per cent having completed third level to degree level or higher. For 30-34 year olds, just 5.2 per cent had completed primary level only and 25 per cent had completed third level to degree level.

6.1.2 Participation of Older People in Formal Education

According to Census 2002, 22 people aged 85 years or over (of a total number of 41,726) were participating in school, college or university. A total number of 212 in the 65+ years group were classified as students.

6.1.3 Older People and Lifelong Learning

According to the QNHS, almost a third of respondents over the age of sixty had received 'informal education' in the 12 months prior to the survey (CSO, 2003i). Participation in non-formal and formal education was far less pronounced, with only 4.5 per cent involved in non-formal education and less than 1 per cent involved in formal education.²⁶ The most common sources of informal education for older people were professional books and magazines, followed by educational broadcasting and visits to libraries and other centres. The smallest proportion made use of online internet-based sources.

6.2 Education and Training: Information Deficits

6.2.1 Older People's Preferences

Older people's preferences in terms of lifelong learning opportunities, both informal and non-formal, are not known. Similarly, there is no data on barriers to access and participation in existing provision (though there are indicators under other headings discussed earlier: illness, disability, transport, and lack of confidence).

6.2.2 Educational Opportunities in Both Day and Residential Care Facilities

Some day and residential care facilities do provide opportunities for older people under a therapeutic heading; art therapy is one example. Data on this kind of intervention and older people's needs and preferences in their regard is not systematically gathered.

6.3 Labour Market and Working Conditions: Salient Points of Information

6.3.1 Economic Status of the Older Population

According to Census 2002, 6.3 per cent of those aged 65 years and over are labour force participants. It is only among the self-employed, and especially among farmers, that there is a notable tendency to work beyond age 65 (Russell and Fahey, 2004). The total number of those aged 65 years and over in the Irish population is 436,001. In terms of economic status, this older population breaks down as follows: 27,595 are at work; 212 are students; 101,751 are looking after home/family; 273,180 are retired; 27,240 are unable to work due to permanent sickness or disability; and 6,021 fall into the 'other' category.

6.3.2 Socio-Economic Group and Social Class

The census classification of older people by socio-economic group shows that the largest number, 54,817, are, or were, farmers. The next largest groupings are of non-manual workers who comprise 46,791 of the total number, and employers and managers who comprise 36,671 of the total.

Classified according to social class, 72,691 of older people belong to the 'managerial and technical' social class, 55,080 are classified as 'skilled manual', 49,924 as 'non-manual' and 17,393 as 'professional workers'.

6.3.3 Ageing and Labour Market Participation

Across the EU, there is wide variation in the employment rate of people aged 55-64. The European average (based on EU-15 in 2000) is an employment rate of 38.8 per cent for people in this age group, with rates of 48.8 per cent among males and 29.1 per cent among females. The employment rate for all Irish people in that year was 46.8 per cent: 64.7 per cent for men, and 28.8 per cent for women. In 2001, Ireland had the oldest average exit age at 63.1 for all people compared with a European average of 59.9. The figure for Irish men was 63.2, compared with a European average of 60.5, and 62.2 for Irish women, compared with a European average of 59.1 (CSO, 2003f).

²⁶ Informal education is defined for the purposes of the survey as 'non-taught learning including self-learning with the purpose of improving skills/knowledge'; and non-formal education as 'organised learning activities outside the regular education system'.

6.3.4 Older People's Preferences for Employment and Retirement

The NCAOP's own research on older people's preferences for employment and retirement, based on a sample of 55-69 year olds, found that substantial minorities wished to change their current employment status (Fahey and Russell, 2001). Of those at work, 37 per cent wished to retire as soon as possible, while 26 per cent of the non-employed (the retired, those in home duties and others) wished to take up some paid work. The group who were most dissatisfied with their current situation were those who were unemployed or permanently sick or disabled. In the *HeSSOP* study, 10 per cent of respondents indicated that they were interested in returning to work (Garavan *et al.*, 2001).

6.3.5 Preference for Gradual Retirement

In terms of the relationship between what older people would prefer and what the present retirement system offers, the most significant pattern identified in the above research related to the preference of older people for gradual retirement. Approximately seven out of ten of those currently at work in the 55-69 years group would prefer to retire more gradually than is normal in the present system. Among those who were already retired, a somewhat smaller proportion – less than half – say that in retrospect they would have preferred to have retired more gradually than they actually did. The study also found a significant minority of retired people (between one fifth and a quarter) for whom lack of flexibility in either the pension system or employer practices hampered them from retiring at the age or pace they would have preferred.

6.3.6 Pension Coverage

The pension coverage rate for all people in employment aged between 20 and 69 years is 50.7 per cent, according to findings from the QNHS for the first quarter of 2002. This coverage rate comprises 35.2 per cent with an occupational pension only, 12.6 per cent with a personal pension only and 2.9 per cent with both types of pension cover. For the purposes of the QNHS, entitlement to a contributory or non-contributory pension did not, on its own, count as having pension cover. Slightly less than half, 49.2 per cent, of people in employment aged 55-69 years have pension coverage.

6.4 Labour Market and Working Conditions: Information Issues

6.4.1 Ageing of the Population Perceived as a Threat

The ageing of the population is presented in some discussions as a threat: 'The idea that population ageing may be a threat to our pensions (and especially to the first-pillar or state pension financed by the working population through the pay-as-you-go or intergenerational transfer method) preoccupies many people. If the working population in proportion to the retired population declines, then, so the argument goes, our system of financing pensions is in danger.' (Geneva Association, 2002). The information issue here relates to assumptions and perceptions which underpin consideration of the economic dimensions of population ageing.

The consequences of population ageing are not inevitably dire. They may become dire in the absence of proper planning to meet a future challenge. One of the spheres in which this kind of planning can bear fruit is that of employment, retirement and pension planning. The establishment of the Irish National Pensions Reserve Fund in 2001 has been a step in the right direction. The objective of the Fund is to meet as much as possible of the cost of social welfare and public service pensions from 2025 onwards.

It has been proposed that, if sufficient priority were given to labour market issues, the 'ageing crisis' would not evolve as speculated currently, and governments would also be in a position to maintain pensions at current levels (Geneva Association, 2002). The further dimension of this discussion is that there is a significant proportion of older people whose employment and retirement preferences, if facilitated, could dovetail with public planning and policy requirements in this sphere.

Some good thinking has already been done in this area. Six components of 'age management' in the workplace are cited in the Geneva Association study. These are: training and occupational 'recycling' and promotion; flexible work schedules; ergonomics and 'function identification'; promoting occupational health and capacity; age diversity; and age discrimination (Geneva Association, 2002). A further information issue in the Irish setting relates to the active dissemination of such thinking and consideration of opportunities and obstacles in terms of its application here.

6.5 Labour Market and Working Conditions: Information Deficits

6.5.1 Unable to Work Due to Illness or Disability

The NCAOP's own research has shown that the most common cause of early retirement is illness and disability ((Fahey and Russell, 2001). A high proportion of older workers who are unable to work due to illness or disability are dissatisfied with their life circumstances (Russell and Fahey, 2004). The possibilities for retaining employees within the workplace in circumstances that take account of their changed health status have also been noted (NESF, 2003). What is not known is: how many employers are prepared to make such arrangements for older employees; what the barriers are for employers who might wish to make such arrangements; and what the barriers to continued employment are from the perspective of employees.

6.5.2 Assistance from Employers

The findings of a QNHS in 2002 showed that assistance was provided by employers to 8,900 (or 8.2 per cent) of the 108,600 people in employment who reported a longstanding health problem or disability. Just over 3,000 worked in sheltered or supported employment. Almost 22,000 people with a disability or longstanding health problem not in employment stated that they would require assistance in order to work (CSO, 2002a). However, data on the nature of the assistance already provided in open employment settings or on the nature of assistance required (by both employed and unemployed with a longstanding health problem or disability) is not available.

6.5.3 Skills of Older Employees

Data is not systematically gathered on the employment-related skills and attributes associated with older employees; nor on skills of older employees or types of older employees whom employers might wish to retain within the labour force.

Findings in this section of the report are presented under three headings: Transportation, Housing, Safety and Security.

7.1 Transportation: Salient Points of Information

7.1.1 Household Access to a Vehicle

There is some data to show that access to a vehicle is a problem for a proportion of older people (Watson and Williams, 2003). More than half (58 per cent) of 'one person 65 years or over' households reported that they could not afford a van or car. For 'other all adult 65 years and over' households, the proportion who could not afford a van or car was 24 per cent.

7.1.2 Public Transport

Twenty five per cent of SLÁN respondents reported difficulties with public transport, though the nature of the difficulties was not specified. (The *HeSSOP* study also provides data on older people's experiences of public transport and use of other modes of transport [Garavan *et al.*, 2001].)

7.2 Transportation: Information Deficits

7.2.1 Access to Private Transport

Census 2002 included a question about household access to a car or van. Though findings, disaggregated by age and household composition, have not been published, they are potentially available. However, what this data will not show is what kind of access to, and usage of, the household vehicle is available to all the older members of the household.

7.2.2 Travel Patterns

Data on the travel patterns of school-goers and labour force participants is available from Census 2002. However, questions about the travel patterns of older people were not posed. The main datasets do not yield any significant data on the transport needs and patterns of older people. (The SLÁN data shows that cars are predominantly used by older people in shopping, but not what the shopping/transport arrangements are, for example, who drives, who owns the car, and whether family or neighbours are involved in the exercise. In terms of public transport, 25 per cent of respondents indicated that they had problems with public transport, but the nature of the problems was not specified.)

7.3 Housing: Salient Points of Information

7.3.1 Older People Living Alone

As stated earlier in the paper, 113,826 people aged 65 years and over, that is 8.2 per cent of the older population, are living in private households on their own. Of this number, 112,677 have their households in permanent housing units and the remaining 1,149 are living in temporary housing units.²⁷ This includes older people living in mobile homes, caravans and sleeping rough.

²⁷ The CSO definition of a permanent private household is a private household occupying a permanent dwelling such as a dwelling-house, flat or bedsitter. A temporary private household is a private household occupying a caravan, mobile home or other temporary dwelling and includes Travellers and homeless people living rough on census night (CSO, 2003b).

7.3.2 Older People in Communal Establishments

Of 436,001 people aged 65 years and over in 2002, a total of 20,959 were in long-stay care according to the DoHC's survey of long-stay units (DoHC, 2003b). According to Census 2002 data on people living in communal establishments, 12,662 people aged 65 years and over live in nursing homes and have a disability. A further 9,016 older people with a disability were enumerated in hospitals (though hospitals were not further categorised to specify long-stay and other types of hospital). A figure for the total number of older people living in communal establishments has not been published.

7.3.3 Home Ownership

Older householders, particularly those over age 65 living alone or in all adult households, are highly likely to own their homes outright. The national survey conducted by the ESRI on behalf of the DoEHLG reported percentages of 81-87 per cent of those aged 65 years and over owning their own homes outright (Watson and Williams, 2003).

7.3.4 Services, Utilities, State of Repair

The same survey provides some data on access to services and utilities, and state of repair of accommodation occupied by older people. In older households (combining findings on households of 'one person 65 or over' and 'other all adult 65 years and over households'):

- 8 per cent have no hot water
- 40 per cent have no central heating
- 9 per cent report major problems with heating
- 12 per cent report major problems with leaks/dampness
- 11 per cent report problems with sanitary facilities.

With regard to the presence of a telephone, either landline or mobile, 91 per cent of 'one person 65 or over' households have a telephone and 97 per cent of 'other all adult 65 years and over' households have a telephone.

7.3.5 Satisfaction With Accommodation

High proportions (minimum 83 per cent) of older respondents expressed satisfaction with the general condition of their accommodation; the area/neighbourhood in which they were living; privacy of the accommodation; and overall running costs.

7.4 Housing: Information Issues

7.4.1 Analysis and Publication of Age-Specific Data

Both Census 2002, which included household questions on housing, and the ESRI findings referred to above are potentially useful sources of further data on the housing situation of older people. In both cases, secondary analysis and publication of more detailed age-specific data are required to realise the full potential of the available data for planning purposes.

7.5 Housing: Information Deficits

7.5.1 Needs of Older People in Temporary Housing Units

There is a requirement for further data to identify the needs, and to plan responses to those needs, of older people living in temporary housing units.²⁸

7.5.2 Older People in Communal Establishments

The existing datasets do not provide data on the adequacy and quality of accommodation available to older people living long-term in communal establishments.

7.5.3 Older People and Social Housing

Data on older people in social housing schemes is limited. The DoEHLG and ESRI study findings show that 9 per cent of 'one person 65 or over households' are local authority renters and 4 per cent are categorised under 'other tenures'. This, for the purposes of the study, refers to those occupying dwellings rent-free and those 'renting dwellings from voluntary agencies such as Respond'. Of 'other all adult 65 years and over households', 4 per cent are local authority renters and 2 per cent are categorised under 'other tenures'.

Data on the support needs and preferences of older people living in social housing schemes, or on the needs and preferences of older people who would like to change their accommodation situation and move into social housing schemes, is not available from the datasets surveyed.

7.5.4 Needs of Older People for Housing Adaptations²⁹

The datasets referred to do not provide any data on older people's needs in terms of:

- housing adaptations
- adaptations required in association with specific disabilities
- income restrictions on making changes to their accommodation in light of changing health status.

7.6 Safety and Security: Salient Points of Information

7.6.1 Older People as Victims of Crime

In 1998, the QNHS incorporated a module on crime and victimisation (CSO, 2003k). Survey findings were that 6.7 per cent of older people had been victims of one of five named crimes (household burglary, theft of bicycles, theft of or from vehicles and vandalism). This percentage was lower than for younger age groups. Respondents in the 25-44 age group formed the largest proportion (15.0 per cent) of the population who had been victims of crime.

7.6.2 Repeat Victims of Crime

Though the overall percentage of older people reporting an experience of crime in the QNHS was small, the most striking finding was that some respondents had repeated experience as victims of crime. 2.9 per cent of the older population had been burgled, but 14.2 per cent of this percentage had been burgled more than once. 2.8 per cent of older people had experienced vandalism of their property; of this percentage, 15.2% had experienced such vandalism twice and 15.7% had experienced it more than twice.

28 Some data is available about temporary housing units occupied by Travellers (CSO, 2004b).

29 The conference paper of Dr A. Goode and Dr E. Fitzgerald highlighted the fact that no data is collected on the accessibility of the current housing stock.

7.6.3 Safety in the Home and Neighbourhood

Asked, in the QNHS survey, how safe they felt walking in their neighbourhood after dark, 3.9 per cent of males and 17.1 per cent of females felt very unsafe. Asked how safe they felt in their own homes at night, 0.8 per cent of males and 3.1 per cent of females felt very unsafe.

7.7 Safety and Security: Information Deficits

7.7.1 Vulnerable Sub-Group

The QNHS findings cited above indicate a vulnerable sub-group of older people who have been victims of crime more than once. It would be useful to be able to identify this sub-group, to identify and explore the factors, whether personal, familial or environmental, that make them vulnerable, in order to formulate potential responses to reduce their vulnerability.

7.7.2 Older People's Experience of Crime and Victimization

In terms of the datasets surveyed, the QNHS module findings published in 1998 are the sole source of data on older people's experience of crime and victimisation (CSO, 2003k). Crime statistics published by An Garda Síochána, with the exception of figures on the numbers and ages of victims of homicide, are not age-disaggregated (An Garda Síochána, 2003). There is a need for current and ongoing data to monitor crime trends *vis-à-vis* older people and to identify environmental and other factors that may contribute to higher crime rates against older people in some settings rather than others.

7.7.3 Invisible Crime Against Older People

A proportion of older people are victims of crime that may remain invisible to the public eye and go unrecorded in the public domain. The experience of the elder abuse pilot projects, implemented by the WGEA under the auspices of the NCAOP, brought to light examples of financial and physical abuse of older people.

8. Summary and Conclusions

8.1 Summary

8.1.1 The Report

Through a survey and analysis of selected datasets, the NCAOP has drawn together some thinking about deficits in our information about the older population and issues that need to be considered in light of those deficits; as well as in light of the overall requirement to plan and devise policy to meet the needs of an ageing population. As described in the introduction to the paper, the findings have been presented within a framework adapted from the work of the SGSES, itself established by the NSB to 'map the interface between data and policy-maker'.

Findings in each of the six sections which make up the body of the report are presented under three headings: Salient Points of Information; Issues; and Information Deficits.

8.1.2 Population of Older People

With regard to the population of older people, the issues raised relate to the concept of old age dependency and the publication of age-specific data. Information deficits relate to data about the health status of older people and issues arising in explaining and projecting healthy life expectancy figures.

8.1.3 Households, Families, Social Relations and Integration

One of the key issues raised in this section of the report relates to the lack of measures to adequately reflect the social contribution of older people and the nature of their participation in society. Information deficits, in national datasets, concern the numbers of older people to whom care is provided, the functioning of family and social networks at points of crisis/transition in the lives of older people, the family status of those in long-stay care, and intergenerational and interdependent relationships in families and communities.

8.1.4 Health and Access to Healthcare

In the section on health and access to healthcare, issues are raised under three broad headings. The first identifies issues in relation to specific datasets. The criteria for inclusion on the NPSDD which exclude older people are discussed. The need for more contextual data to support analysis and interpretation of trends identified through HIPE is identified. Gaps in information about older people in long-stay care, including the lack of an accurate figure for duration of stay of older people in permanent long-stay care, are highlighted. The second broad heading relates to aspects of datasets, notably their activity-centred rather than person-centred focus; the focus on input and throughput rather than outcomes of access to and participation in those services; and deficiencies in data on occupational status. The third broad heading identifies other themes emerging in consideration of the datasets: the implications of geographic location and access to public or private health provision.

The fact that the main datasets do not yield sufficient person-centred data is identified as an information deficit. So too is the lack of a psychiatric out-patient database. Shortcomings in the mortality data, including the failure to record secondary causes of death on death records, are noted. A range of deficits in respect of information in national datasets about impairment and disability in the older population are noted. These include the need for population-based data on the causes of increasing occurrence of impairment in older age, essential for the development of preventative and health promotion strategies. Specific deficits in respect of the provision of health services in both community and acute care sectors are discussed. The lack of accurate figures for length of stay of older people in long-stay care is noted.

8.1.5 Income, Wealth and Poverty

In terms of assessing living standards, issues relate to: the weak link between income and living standards in the case of older people (attributed to the range of 'free schemes', the accumulation of significant resources and family support systems); the shortcomings of population studies in grasping the situation of any sub-group, including the older population; the deprivation of older people relying on public health and social services if these prove to be inadequate; and the adequacy, or otherwise, of traditional measures of socio-economic status – education, occupation and income – when applied to older people. The need for data about the income and resource issues and requirements of older people, as perceived by older people themselves, is identified. A question is also posed about approaches to the measurement of healthcare costs.

There are information deficits *vis-à-vis* the material status of sub-groups of the older population such as Travellers and homeless people. The potential value of data at national level about the (intergenerational) functioning of family support systems is highlighted, as is the need for data about the perspectives of older people and their families on the use of the family home as a resource in the financing of long-term care of older people. Finally, figures for expenditure on services for older people are not available from the DoHC.

8.1.6 Education, Training, Labour Market and Working Conditions

The education and training needs and preferences of older people have received little attention in the datasets surveyed. Data on older people's preferences for employment and retirement have been discussed in the light of concerns about the economic costs of population ageing. There are information deficits in relation to: barriers to the retention of older and disabled or ill older workers within the labour force; the employment-related skills and attributes associated with older workers; and the types of skills and employees whom employers might wish to retain within the labour force.

8.1.7 Transportation, Housing, Safety and Security

There are information deficits in the national datasets with regard to older people's access to private and public transport and travel patterns. There are also information deficits with regard to older people's housing needs, specifically those of older people in temporary housing units, those who might require social housing and those for whom housing adaptations are necessary due to physical impairment.

The limited data on older people who are victims of crime indicates a vulnerable sub-group. They, and the factors that contribute to their vulnerability, remain unknown. Many abuses against older people remain unknown and invisible to the public eye.

8.2 Conclusions

8.2.1 Active Ageing

The WHO has characterised active ageing as the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age. The influences or determinants of active ageing, identified by the WHO, fall into seven broad categories. There are the cross-cutting determinants of culture and gender; personal, behavioural, social and economic determinants; and determinants related to the physical environment and the health and social services. If programmes and policies are to be designed to support effectively and to enable the active ageing of the population, policy-makers need to be able to access information within a national framework about those determinants in relation to older people.

The NCAOP recognises that individual datasets operate within specific parameters and to particular ends. However, the NCAOP's survey and analysis of national datasets has enabled it to form an overview. In terms of a national framework of information about the older population, the NCAOP's conclusion is that there are significant issues and deficits. Notably, these relate to social determinants, including the quality of life and social contribution of older people; determinants related to the physical environment, including housing and transport; and to the health and social services where the datasets are stronger in the provision of institutional rather than community-based data, though the majority of older people live in community settings. There are particular concerns about the lack of population-based morbidity data, lack of a national psychiatric out-patient database and lack of data on the prevalence and incidence of different forms of impairment and disability in the population.

8.2.2 Perceptions of Old Age

Datasets are not neutral repositories of information about the older population. The selection and usage of concepts and indicators to describe older people reflect underlying assumptions about ageing.

One of the most striking contrasts in the datasets relates to the expanded use of the concept of dependency to consider the implications of an ageing population, sometimes in terms of cost to the population as a whole. This is juxtaposed with the limited nature of the data available on the participation in, and socio-economic contribution to, society, communities and families made by the older population.

Chronological age is not, as the WHO has pointed out, a precise marker for the changes that accompany ageing. There are wide variations in the health status, participation and levels of independence among older people of the same age. Given this, the assumption that all those aged 65 years and over are dependent is ageist, as is the failure to gather data that more completely reflects the role of older people and their contribution to their families, communities and wider society.

8.2.3 The Population of Older People

The population of older people does not form a homogeneous group. The reality is that increasing numbers of older people are remaining active and independent into very old age. At the same time, there are also smaller sub-groups of older people who are more vulnerable and in need of special support, whether due to reasons of ill-health, low income, social isolation or vulnerability to crime, or a combination of these factors, all of which can be inferred from existing data. What is necessary is the capacity to plan simultaneously to meet the needs of the total population of older people and of vulnerable sub-groups of that population. The corollary of this is the need to be able to profile the older population as a whole, within different age bands, in terms of a range of health, social and economic indices and to identify vulnerable sub-groups. Typically, datasets operate on a stand-alone basis and it is not possible to link and integrate data from a range of datasets either to create a more holistic profile of the older population or to identify more vulnerable sub-groups of that population.

In terms of planning to meet the needs of a diverse older population, person-centred data is a requirement. At the moment, the emphasis in several of the main datasets is on tracking activities and events, rather than individuals. The same individuals may be making recurrent visits to hospitals, moving through a series of health and social services or, invisibly, experiencing multiple difficulties in a community setting. In the absence of a unique personal identifier and a mechanism for linking and cross-referring to multiple datasets, opportunities for identifying and connecting with vulnerable sub-groups are lost, as are opportunities for adequately profiling the population of older people across a range of interconnected indices.

In advocating the need for the availability of person-centred data about older people, the NCAOP is mindful and fully supportive of requirements to honour the confidentiality of individual patients and to operate within the parameters of both Freedom of Information and data protection legislation. In that context, the NCAOP welcomes the publication of the NHIS and looks forward to the implementation of its recommendations in respect of a Unique Patient Identifier (UPI) within an information governance framework.

8.2.4 Systematic Recording, Collation and Publication of Data about the Older Population

There is a need for all relevant national datasets to record, collate and publish data about the older population. Criteria for inclusion in a dataset which exclude a sector of the population on the basis of age are effectively discriminatory. Where the older population are included in datasets, published reports need both to provide age-disaggregated data and to move beyond presenting all data relating to the older population under a single age band of 65 years and over. The older population, as already stated, is heterogeneous and this is reflected in differing needs and concerns as they move through successive age bands.

8.2.5 Health Status of the Older Population

Valuable data on the health status of the older population is included in existing datasets. However, there are significant gaps in the data, with respect to population-based morbidity data and data on the prevalence and incidence of different forms of impairment and disability in the older population. The tracking of the relationship between socio-economic inequality and health and social well-being is also a fundamental, and currently unmet, requirement in terms of strategic planning to meet the needs of the older population.

Given the extent to which increased levels of impairment and ill-health affect the lives of older people, there is a clear need for a continued and strengthened emphasis on preventative healthcare and health promotion strategies to reduce the onset of preventable ill-health in later life. Population-based information in national datasets is an essential tool to facilitate this process.

In light of these concerns, the NCAOP welcomes recognition in the NHIS that ‘... the population health surveillance function is under-developed and information on morbidity, health inequalities, health status and health determinants of the population and sub-groups is limited and fragmentary’ (DoHC, 2004).

The NCAOP looks forward to the implementation of recommendations to remedy these deficiencies, among them the development of the electronic healthcare record and of a population health observatory.

8.2.6 The Health Services and the Older Population

There are limitations to the information about the health services in the main datasets, viewed from the perspective of the older population. The DoHC does not provide a figure for the proportion of its expenditure allocated to services for older people. Consequently, it is not possible to examine the level of funding allocated to the older population in comparison with levels of funding for other sectors of the population.

In terms of the provision of health services, there is an emphasis in datasets on activity, input and throughput of patients, including older patients, without corresponding data on composition of patient groups, patient profiles and outcomes of care. The NCAOP is aware that these comments are formulated at a time of reform and modernisation in the health services. The reforms which are ongoing at the time of writing have been preceded by a series of studies identifying similar information issues in relation to the health services as a whole (Brennan, 2003). The NCAOP looks forward to collaborating with colleagues in existing and new organisations on actions to develop an improved national information framework to support the health system.

Data on the provision of specialised services for older people, that is, geriatric medicine and dedicated rehabilitation services in which there are regional variations and inequalities, is incomplete. There is no national psychiatric out-patient database and the speciality of Old Age Psychiatry is not identified as a dedicated service in the datasets surveyed. In the case of older people in long-stay care, published figures on the duration of their residency in permanent care are unreliable.

8.2.6.1 The Development of Evidence-Based Planning and Policy-Making in the Irish Setting

As outlined in the first section of this paper, there is a growing emphasis on the development of national data frameworks to support evolving trends towards evidence-based planning and policy-making in the Irish setting. The NCAOP welcomes these developments. The findings of this survey and analysis of main datasets highlight the necessity for further development of national data frameworks to better and more completely reflect the status of the older population in Irish society. In light of these findings, the NCAOP advocates a proactive approach on the part of the range of individuals and agencies involved in enhancing existing data frameworks to the inclusion of data in respect of the older population. The NCAOP also signals its own willingness to contribute actively with others to this process.

The NCAOP is also acutely aware of the complexity of some of the information needs it has identified. It recognises the continuing importance of carefully designed qualitative research programmes to explore core issues in depth and to provide signposts for the ongoing development of national datasets.

8.2.7 The Perspectives of Older People

The main datasets were not established to seek the perspectives of older people on the issues explored in those datasets. The observation that the voices and perspectives of older people are largely absent from those sources is made, not as a point of criticism, but to state a further point. This point is that the perspectives of older people are a necessary component of the information needed about the older population. The inclusion of their perspectives, coupled with the further development of data frameworks as discussed earlier, will help to ensure an evidence base for planning that is truly responsive to the needs of the older population.

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Appendices

Appendix One: Members of NCAOP Policy Standing Committee

Dr Davida de la Harpe, Chairperson

Mr John Cooney

Dr Anne Goode

Mr John Grant

Mr Joe Larragy

Ms Mary McDermott

Ms Sylvia Meehan

Dr Virpi Timonen

Mr Bob Carroll, Director

Ms Patricia Conboy, Policy Officer

Appendix Two: Datasets Explored

Census 2002

The Census of Population includes every individual resident in the State on census night. It is the only Irish dataset that enumerates the entire population. Census data, generally available on a five-yearly basis, provides information on characteristics such as age, education, occupation, employment status and household structure. The results of Census 2002 have been made available in three reports and twelve volumes, all of which are published in report form and also accessible *via* the internet.

Health Statistics 2002

The report, *Health Statistics 2002*, is prepared by the Information Management Unit of the DoHC and is a 'compendium of health statistics' which brings together data from a wide variety of sources on demography, health status and the delivery of health services. It incorporates the following sections: population; life expectancy and vital statistics; health status and lifestyle; community health and welfare services; children in care and child abuse cases; psychiatric services; services for people with intellectual disabilities; acute hospital services; district/community hospitals and extended care; health service employment statistics; and expenditure statistics. The report is available from the DoHC's website.

Hospital In-Patient Enquiry (HIPE)

HIPE is a computer-based health information system designed to collect clinical and administrative data on deaths and discharges from the sixty acute public hospitals currently participating in the system. Since 1990, management of the system has been contracted by the DoHC to the ESRI where it is the responsibility of the HIPE and National Perinatal Reporting System (NPRS) Unit. HIPE records facilitate analysis of hospital activity rather than incidence or prevalence of disease. Data is collected under the headings of: demographic data, including date of birth; clinical data including principal diagnosis and principal procedure; administrative data including dates of admission and discharge, destination of discharge, public/private status and admitting consultant. Occupational data is not collected.

HIPE data for the period 1990-1999 is available in a published report (HIPE, 2002). A report including 2000 and 2001 data is currently under preparation. Staff in the HIPE unit will also respond to requests for information based on HIPE data.

Irish National Survey of Housing Quality (NSHQ)

The DoEHLG commissioned the ESRI to carry out the NSHQ in 2001-2002. The survey obtained information from a representative sample of over 40,000 householders on characteristics and problems of the dwelling and on the household members.

Long-Stay Activity Statistics 2002

The report, *Long-Stay Activity Statistics 2002*, presents data collected through a survey of long-stay units in 2002 (DoHC, 2003b). The report was prepared by the Health Information Unit of the DoHC and is available from the Department's website. Findings are based on responses to a questionnaire distributed by health boards to registered long-stay units/nursing homes in their respective areas. Of 569 questionnaires distributed in 2002, 497 were returned, giving a response rate of 87.3 per cent.

The Living in Ireland Surveys (LIIS)

The LIIS were designed primarily to collect information on income distribution. The LIIS formed part of the EU's Community Household Panel Survey (ECHP), with the same households surveyed in successive years across participating Member States between 1994 and 2001. The objective of the LIIS sample design was to obtain a representative sample of private households in Ireland. However, there was a loss of participants over time. Of the original 4,000 sample households in 1994, 67 per cent remained by 1998. In Ireland, the LIIS have been managed and administered by the ESRI which has also published a number of reports on national poverty trends based on survey results (Nolan *et al.*, 2002; Whelan *et al.*, 2003). It is possible for organisations to commission the ESRI to undertake research based on the LIIS. Otherwise, researchers and research organisations are encouraged by the ESRI to examine LIIS data through the ECHP which is said to be almost identical in content. ECHP data is available at a fee from the Irish Social Science Data Archive.

The National Cancer Registry

The National Cancer Registry was established in 1991 and has been collecting comprehensive cancer information for the whole population of the Republic of Ireland since 1994. Data on the incidence of cancer in the older Irish population is available as is, to a much more limited extent, data on treatment and survival.

The National Intellectual Disability Database (NIDD)

Established in 1995, the NIDD includes three basic elements of information about people with intellectual disabilities: demographic details (including date of birth); current service provision; and future service requirements. To date, five annual reports have been published by the NIDD Committee which comprises representatives of the DoHC, the health boards, the Federation of Voluntary Bodies providing Services to People with Intellectual Disability and the Disability Databases Division of the HRB. The HRB is responsible for the management of the database.

National Physical and Sensory Disability Database (NPSDD)

The NPSDD collects information on people who: have an ongoing disabling condition that is physical or sensory; are receiving or need a specialist service that is related to their disabling condition; have consented to inclusion in the database; *and* are less than 66 years of age. A report based on the work of the NPSDD Development Committee was published in 2001 which reports the findings of their pilot work in four community care areas in the North Eastern Health Board (NEHB), South Eastern Health Board (SEHB), South Western Area Health Board (SWAHB) and the Western Health Board (WHB).

National Parasuicide Registry Ireland

The National Parasuicide Registry is a national system of population monitoring for the occurrence of parasuicide. It has been established, at the request of the DoHC, by the National Suicide Research Foundation (NSRF). The primary aims of the NSRF are to define the true extent of the problem of suicidal behaviour in Ireland, to identify and measure the factors which induce and protect against suicidal behaviour, and to develop strategies for the prevention of suicidal behaviour. The Registry has published two annual reports to date.

National Psychiatric In-Patient Reporting System (NPIRS)

The NPIRS is a national psychiatric database which provides detailed information on all admissions to and discharges from in-patient psychiatric services in Ireland. It includes details of demographic, clinical and socio-economic status. Annual reports based on database holdings are published by the Mental Health Research Division of the HRB. These annual reports also include data on community psychiatric facilities in each health board setting, though not on the patients who are attending those facilities. In addition, the NPIRS database has been used to carry out in-patient censuses every ten years since the 1960s. The DoHC also conducts an annual end-of-year census of psychiatric hospitals and units.

The Quarterly National Household Survey (QNHS)

This national survey is conducted on a quarterly basis by the CSO. Initiated in September 1997, the QNHS replaced the annual Labour Force Survey. It is a continuous survey and collects information from 3,000 households each week, giving a total sample of 39,000 households in each quarter. Households are asked to participate for five quarters, after which they are replaced by a new selection of households. The principal purpose of the QNHS is the production of quarterly labour force estimates. The QNHS also allows for the occasional collection of information on social topics. For example, modules have been carried on home computing, health, disability and crime and victimisation. QNHS reports are accessible via the internet.

Survey of Lifestyle, Attitudes and Nutrition (SLÁN Surveys)

In 1998, the Health Promotion Unit of the DoHC commissioned the SLÁN study to capture lifestyle data on the Irish adult population for the first time. The second SLÁN survey in 2002 allowed for the identification of lifestyle trends and changes in health behaviours in the Irish adult population. Both studies were conducted by the Centre for Health Promotion Studies at the National University of Ireland, Galway. The SLÁN studies aim to produce data about a representative cross-section of the Irish population in order to inform the DoHC's policy and programme planning.

The SLÁN data referred to in this paper is drawn from a secondary analysis of SLÁN 1998 and 2002 data undertaken on behalf of the NCAOP and concerned with respondents aged 55 years and over.

Survey on Income and Living Conditions (SILC)

The LIIS has now been replaced by SILC, for which the CSO is responsible. A SILC survey was conducted in 2003 and the publication of results is expected towards the end of 2004.

Appendix Three

Table 1: Private households by composition, 1996 and 2002

Composition of household	Number of households		Change	Percentage
	1996	2002	1996-2002	change
One person	241,800	277,600	35,700	14.8%
Couple*	152,500	211,400	58,900	38.7%
Couple with children	440,400	489,500	49,100	11.1%
Couple with children and other persons	16,900	17,200	300	1.8%
Lone parent with children	105,400	131,200	25,800	24.5%
Lone parent with children and other persons	20,100	19,400	-700	-3.3%
Two or more family units	6,100	5,700	-400	-6.5%
Non-family households	80,700	91,700	11,000	13.6%
Total	1,123,200	1,288,000	164,700	14.7%

Source: Census 1996 and Census 2002

* Couples include both married and cohabiting couples.

Table 2: Older population living alone in private households, 2002

Persons living alone in private households	65 years and over	70 years and over	75 years and over
Total	113,800	88,400	59,800
Percentage of all one person households	41.0%	31.9%	21.5%
Percentage of all persons in the age group	25.8%	28.9%	31.0%

Source: Census 2002



Terms of Reference

Terms of Reference

The National Council on Ageing and Older People was established on 19 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

Chairperson: Cllr Éibhlin Byrne

Mr Bernard Thompson

Mr Eddie Wade

Mr Michael Dineen

Fr Peter Finnerty

Mr Eamon Kane

Mr Michael Murphy

Mr Pat O'Toole

Ms Pauline Clancy-Seymour

Mr Noel Byrne

Dr Davida de la Harpe

Dr Ruth Loane

Mr Paddy O'Brien

Ms Bernard Thompson

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