

The New Agenda on Ageing

To Make Ireland the Best Country to Grow Old In



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Published by; Ageing Well Network,
16-17 College Green, Dublin. ©2012
Email; info@ageingwellnetwork.ie

Cover photo; Shutterstock.com

Graphic Design and Production; Anita O Sullivan
Email; anitaosullivan86@gmail.com

This report is available online at www.ageingwellnetwork.ie

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Sinead Shannon, Research Manager, Ageing Well Network

Contributors

Health:

John Church (Chair); RoseAnne Kenny; Mo Flynn; Cillian Twomey; Hannah McGee; Maurice O'Connell; Patricia Hallahan; Rodd Bond; Brian MacCraith; Eugene Murray; Des O'Neill

Income;

Brendan Whelan (Chair); Alice O'Flynn; Paul Sweeney; Robin Webster; Brendan Kennedy; Donal de Buitleir; Brian Duncan

Engagement;

Maureen Kavanagh (Chair); Miriam McKenna; Cillian Twomey; Louise Richardson; Maurice O'Connell; Robin Webster; Gerard Quinn; Gerard O'Neill; Mary Nally

Home;

Mo Flynn, (Chair), Louise Richardson, Maurice O'Connell, Suzanne Cahill, Enda Egan, Rodd Bond, Siobhan Barron, John McCarthy, Tadhg Daly

Age Friendly Communities;

Conn Murray (Chair); Andy Cullen; Miriam McKenna; Louise Richardson; John McCarthy; Maureen Kavanagh; Enda Egan; Rodd Bond; Siobhan Barron; Louis Harkin; Gerard O'Neill; Mary Doyle; Des O'Neill; Mary Nally; Louis Harkin; Maurice O'Connell;

Strategy Development and Implementation;

Anne Connolly; RoseAnne Kenny; Mo Flynn; Eoin Gahan; Paul Sweeney; Suzanne Cahill; Maureen Kavanagh; Robin Webster; Brendan Kennedy; Patricia Hallahan; Enda Egan; Noel Usher



Message from the Executive Director

The projected increase in longevity is a cause of celebration. It represents significant improvements in standards of living, lifestyles and the health and care systems. It must be seen as a very positive development, both for all of us at a personal level as well as for the societies in which we live.

However, the agenda on ageing has generally been very negatively depicted. At the individual level it has traditionally been painted as a homogeneous portrait of decline, loss, frailty and dependency. At a societal level it is described as a major problem, with the focus on the challenges for the health, care and pensions systems and on the potential for the projected increases in numbers to bankrupt the economy.

The government has committed to introducing a National Positive Ageing Strategy, but why do we need a Strategy for Older People - what exactly is the nature of the problem we are trying to solve? There are three compelling reasons:

- Firstly, the quality of life of too many of our older people is poor. This report highlights the many ways in which this is the case, provides evidence of the extent and nature of those problems and explores ways in which they can be addressed.
- Secondly, the scale of the projected increase in the number of older people will require long-term planning to ensure that we have the systems, structures and supports that address the challenges of health, care and income security, while 'exploiting' fully the demographic dividend'.
- Thirdly, people reaching the normal age of retirement are, in general, healthy and active. They have a life-time's wisdom and experience and seek a life of purpose, balanced with leisure, social connections and contribution to the lives of their communities. We need to create a new way of thinking about our later years. We need to create new opportunities and a new language to underpin a whole new approach.

This report seeks to provide the evidence for what those changes are - from research, consultations with older people and the views of 'experts' in the field. It seeks to use those findings to set out the Key Issues for a National Positive Ageing Strategy.

Clearly not all the issues can be addressed in a single strategy but what is clear from a review of the Key Issues is that we need a stronger 'life-course' approach. So much that determines the quality of life is determined in our earlier years - our health, our income security, our disposition to be happy and engaged, our rootedness and sense of belonging. The big challenge for all of us is that we arrive into later life, healthy and active.

It will be important that the Strategy is backed by strong political and policy commitment to create a strong infrastructure. Implementing a New Agenda on Ageing will require a 'whole of government' approach with departments and agencies across health, environment, transport, education, social protection collaborating at both national and local levels with those organisations across public, private and voluntary sectors who have a key role to play in implementing a new approach.

Anne Connolly,
AWN Executive Director.

Foreword

When the Ageing Well Network was established in 2007 one of the original objectives was the development of a series of Position Papers which would inform the policies and plans of all key agencies in the sector and contribute to the proposed National Positive Ageing Strategy. This objective initially led to the creation of a framework for identifying and communicating the key issues of concern regarding older people's lives. The model that was developed from this framework the achievement of six targeted outcomes - achieving an Ireland which is a great country to grow old in and in which older people can...

- Enjoy an adequate income, free from the fear of poverty
- Live in a place that feels like home
- Participate as valued members of their own communities
- Have access to a good health service responsive to their needs
- Live in age friendly communities
- Benefit from policies and plans informed by their needs and reliable research

To develop this report, members of the Network formed six working groups to contribute their experience and expertise. The meetings of these working groups gave members the opportunity to test and debate ideas, access the latest research and policy developments from Ireland and abroad, influence and be influenced by the cutting-edge thinking of the many different disciplines represented, and together determine best practice in relation to all aspects of ageing and older people. Each working group met three times throughout 2009 and 2010, to contribute to the final report.

The significance of this report lies in the fact that it combines evidence of best practice from international and national literature with the knowledge and experience of the Network members. It brings together the high-level critical issues and strategic challenges identified in each area. Based on the latest research and knowledge, the report sets out the options for addressing them, and the likely implications of pursuing different strategies. It does not advocate for particular positions, but is intended to support government and other high-level decision-making by providing evidence on the nature and extent of those issues, clarifying and exploring the range of options available, and the likely outcomes of each. The report is offered as a resource to all those who wish to know more about the issues facing our population as it ages.

We would like to acknowledge the vision of our funders the Atlantic Philanthropies and the commitment of our members who gave generously of their time and experience to develop the ideas and themes contained in this report.

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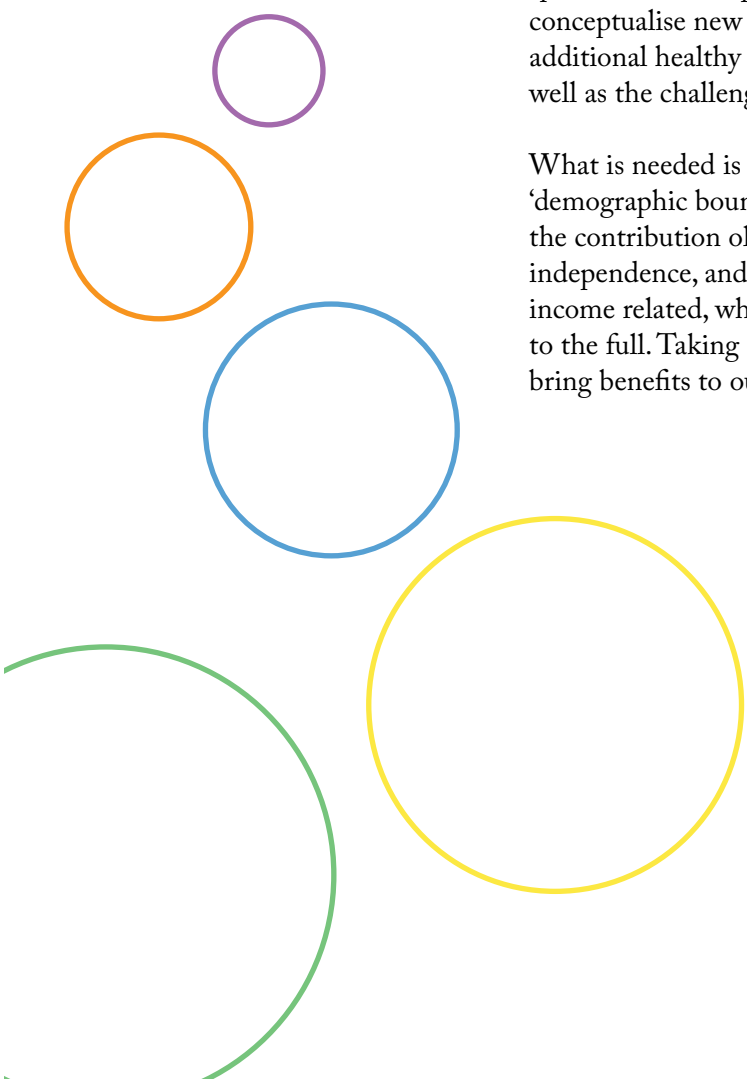
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Executive Summary

Throughout the developed world, people are living longer, healthier lives and as a result the proportion of older people has been increasing steadily over the past century. In 2011, Ireland had the highest proportion of young people (21.3%) in the EU, and the lowest proportion of old people (11.7%). However over the next thirty years this is about to change and the numbers of people aged over 65 years will be between 1.3 and 1.4 million in 2041, compared with 460,000 in 2006 and the number of “oldest old” – persons aged 80 years and over is projected to quadruple from a level of 110,000 in 2006 to about 440,000 in 2041.

These significant changes in the structure of our population will have major implications for policy development, forward planning and integrated service delivery by Government, state agencies and others involved in provision of services and supports for older people. While Ireland has a short breathing space in which to plan the best possible future for everyone, we need to conceptualise new social roles for older people which take account of their additional healthy and active years and which focus on the opportunities as well as the challenges of an ageing population.

What is needed is new thinking, backed by evidence, that focuses on the ‘demographic bounty’ by promoting quality of life and well-being, valuing the contribution older people make in their communities, promoting their independence, and removing the barriers, whether legal, attitudinal or income related, which limit or inhibit the capacity of older people to live life to the full. Taking this approach will not only benefit older people but will bring benefits to our communities for people of all ages.



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As people live longer it is becoming more important to ensure that the extra years of life are healthy, happy and fulfilled. Research has found strong links between being happy and various other positive outcomes. Happy people were reported to be psychologically and physically healthier than those who are less happy. The key to promoting a positive experience for all of us as we age will be to put in place plans and policies which prepare for the changing future.

The National Positive Ageing Strategy will need to take account of many complex factors. It will have to meet the needs of the current older population, particularly the older old, but also to prepare for a new generation of older people with very different expectations for their later years.

It also needs to address the diversity of the older population, from those who are younger, healthier and more active to those who are frail and in need of a wide range of supports and services; from those living in densely populated areas to those in more remote rural areas; from those seeking to be actively engaged in shaping their communities to those who do not and from those who are socio-economically advantaged to those who are disadvantaged.

Older people are not a homogeneous group and the vast majority of older people (85%) are fit and healthy. This group of older people are a resource to be valued and appreciated. Policy could support innovative ways of using the skills and the experience that older people have developed during their active lives, to the benefit of society by enabling them to continue making a contribution to their communities or workplaces for as long as they wish. Policy could also be aimed at developing interventions that protect their health and wellbeing to ensure that they maintain their good health for longer.

A further 15% have some health problems which impact to an extent on their ability to

remain actively involved in the life of their communities. The focus for this group of people could be on supporting them to maintain an independent life for longer. Effective interventions range from the provision of more home help or technological supports in the home to greater integration of health and social care to ensure that support is provided where and when it is needed. This is particularly important given that increasing numbers of family members and potential carers are now working.

Finally there is a group of older people (approximately 5%) who are very frail and dependent and their need for healthcare is at its most acute. The focus of policy for these people could be on protection and support – putting in place the legal and financial protections necessary to ensure that the vulnerability of this group of people is not exploited and that the healthcare supports are in place to ensure that they have the best possible care and support as they face death.

This document outlines the five key areas in which change, brought about by the National Positive Ageing Strategy, can impact on older people's lives; on their health, wealth, happiness, home and communities.

HEALTH

Health plays a key role in the quality of life and well-being for older people. It affects the extent to which they can enjoy life and participate in the economic, social and cultural life of their community. At present, the level of self-rated health in Ireland for older people is substantially higher than in other European countries and at 71.9% ranks second behind Switzerland.

Planning

Population ageing will have important implications for the provision of health services

in the future. The Department of Finance has estimated that the cost of health and long-term care will rise from 6.6% of GDP in 2007 to 7.9% in 2035, and eventually to 9.7% in 2060.

While there is some debate about whether population ageing or the development of more sophisticated medical devices and processes contribute most to cost increases, concerns have been expressed that the increase in longevity will lead to unsustainable costs and pressure on health services. There is evidence to suggest that age itself is not the main driver of cost in the health service and that it is proximity to death and 'end-of-life' care that contribute more to increases in health care costs.

There is some evidence that there will be an increase in the level of age-related conditions such as dementia, arthritis, sensory and cognitive impairment. Planning for the future will therefore have to take account of needs arising from increased longevity, such as additional demand for geriatricians and psychiatrists of old age, for dementia care and for additional beds in acute hospitals and community settings. This suggests the need to shift the focus of the health system beyond the treatment of particular problems and towards rehabilitation and prevention.

There is a need for innovation in the delivery of services to provide technological responses to the need for care in the community, promoting self-care and facilitating remote monitoring and diagnosis.

Prevention

Increased longevity is largely an outcome of improvements in health care, life-styles and diet. There has been considerable debate about whether increased life expectancy will result in more healthy years or higher levels of disability. The evidence currently supports the view that both the lifespan and the age at which poor health or disability occurs will continue to

extend, resulting in a 'deferral' of disability, so that the priority emphasis for the future will be on finding ways to delay, reduce, and mitigate the major health problems of old age, with a clear focus on the most disabling of those conditions and problems.

Research carried out in the US found that improvements in prevention and treatment of the seven most common chronic diseases could prevent 40 million cases of these diseases by 2023, and reduce their economic impact by 27% annually. However, Irish health services in general are focused on treating conditions once they have arisen, and the current funding of primary care does not reward GPs and other health professionals for achieving better overall health outcomes for their older patients.

Specialist Care

Although many older people live healthy and active lives, as they grow older they become vulnerable to a more diverse set of health issues, and so the care they require is marked by increasing complexity. The 2011 TILDA report revealed that both cardiovascular and non-cardiovascular diseases are common in older adults with the prevalence of most chronic conditions increasing with age. Hypertension, angina and stroke are more common in men; osteoporosis, arthritis and high cholesterol are more common in women.

Ageing tends to be associated with complex and often inter-related health problems. Older people may often have several diseases or conditions co-existing and interacting in non-specific and atypical ways, social and psychological problems may be prominent, functional handicap occurs more frequently, and recovery may take longer than among younger people.

As a result providing health care for older people requires the collaboration of a number of different health care professionals. Irish health services and budgets are currently organised

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by care group, with separate programmes and funding streams for disability services, mental health services and older people's services. While some progress has been made towards reform of the system, the challenge in the future will be to provide integrated healthcare and deliver care in the most appropriate and cost-effective setting for both the older person and healthcare system.

Polypharmacy

Because of the tendency to have more complex or inter-related medical conditions and a different way of metabolising medications (to younger people) there is a need for greater understanding of the responsiveness to and tolerance for drug treatments among older people. Polypharmacy - generally defined as the use of multiple drugs at the same time - is more common among older people. The TILDA study found that one in five older adults takes five or more medications. This proportion rises to almost one in two for those aged 75 years and older and is more than twice as likely in medical card holders compared with adults without cover or with medical insurance.

Hospital Care

Older people as a group are one of the largest consumers of health care services in Ireland, and the largest group of users of hospital services, accounting for 78% of all admissions. They also stay in hospital for longer than other age groups. Despite all of this, hospitals are not designed with the needs of older people in mind.

The development of Age Friendly health care goes beyond the basics of accessible bathrooms and large print signs, and requires a cultural shift in the way healthcare providers think, act and respond to the needs of older people. One crucial dimension of Age Friendly care is the availability of staff who are knowledgeable about the care of older people and understand

the needs associated with old age and what it means to be old, to be suddenly struck by illness, and perhaps to have been rushed to an unfamiliar and often stressful hospital environment in a health crisis.

Discharge from hospital is not always a smooth process, and international studies have reported on the problems experienced by older people in the first weeks after discharge. These include: reduced independence in daily living; difficulty with reading medication instructions; not getting the help they need; not being aware of available services; information needs; symptom-related distress; anxiety and uncertainty. These problems frequently lead to further complications, and can result in unplanned hospital re-admissions.

WEALTH

Having an adequate, stable and secure income during later life can play a crucial role in maintaining good health, facilitating greater engagement in the wider society and promoting a greater sense of security among older people.

Income adequacy and Pensions

The majority of older people in Ireland rely on the state pension to provide most of their income and 24% rely on the state pension for all their income. In recent years the government has made progress in increasing the level of the pension and reducing the number of older people experiencing poverty. However, the current economic difficulties have raised fears that the recent advances may be reversed.

Since the state pension was first introduced a century ago life expectancy has improved to the current level of 76 for men and 81 for women, and all predictions are that medical advances will result in a continued increase. While people are living longer, the length of

the working life has reduced as people spend more time in education and leave the workforce earlier. On retirement they live substantially longer, inevitably putting pressure on the ability of either the state system or the individual to provide an adequate income for longer periods of retirement.

The ratio of people in employment to those in retirement is projected to fall from a peak in 2008 of 6:1 to a low point of less than 2:1 by 2050. Low levels of private pension coverage, along with a growth in the numbers of older people relying on the state pension, have given rise to concerns about the sustainability of state pension provision.

The Department of Finance outlined five options to be considered; increase taxes and/or ease age-related spending pressures; raise the retirement age; increase the share of the population at work; improve the economy's productive capacity and competitiveness; and increase private savings.

Intergenerational Transfers

Not all older people are in need of financial support from the state and many have accumulated wealth or assets throughout their lives through their contribution to their own pensions, their investments or their mortgage which they pass on to the next generation on their death.

Many also contribute financially during their lifetimes to their families through transfers of money or other assets. The TILDA report found that older people are net financial contributors to their families and that nearly one-quarter (24%) have given large financial gifts to their children in the last ten years. In contrast, only 9% of older adults have received financial transfers from their children. This supports the findings of European research that financial transfers from parents to their children are much more frequent and also

usually of much greater worth than those in the opposite direction.

Retirement

Research has shown that many older people feel fit and healthy at the age of eligibility for a pension and have no wish to retire. Others have seen the value of their assets fall dramatically in the ongoing recession, giving rise to increasing concern about their future financial security. Despite equality legislation, which prohibits discrimination in employment on age grounds, many private sector employments either contractually or following custom and practice require employees to retire on reaching the age of 65 and up to now, despite a number of legal challenges, the EU and Irish courts have upheld their right to do so.

There is evidence that many people prefer to phase their retirement and the TILDA report (TILDA 2011) found evidence that many have the opportunity to do so – 23% of men aged 60-64 work part time and 31% of those aged over 65 while the corresponding figures for women are 56% and 71% respectively

Many employers have concerns about employing older workers, fearing higher absenteeism, lower productivity etc. However, research shows that they are less likely to take sick leave than younger workers, and while some abilities such as manual dexterity do decline with age others, such as managerial capability, show no reduction after the early 20s. On the positive side an ESRI survey found that the main characteristics of older workers welcomed by employers were experience, reliability, loyalty to the job, maturity, and having a good influence on younger staff.

Global Markets

The increase in the number of older people across the world living longer, healthier lives, is opening up very large new markets. Some

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multinational corporations are recognising this opportunity and have developed products and strategies to meet those needs. However many companies are either not aware of the potential or have failed to respond and adapt to the changing market and demand for products. Research has found that only 10% of marketing spend is aimed at the over 50s and most communication about brands and services is either irrelevant or insulting to them.

The negative perception of ageing as a burden could be reversed through the development of these new markets for products and services that address the challenges of an ageing population. However there seems to be only limited awareness among businesses of the purchasing power of older consumers. For example those aged 50 and over account for over half of all household spending in the EU and the US, yet only 10% of marketing spend is aimed at that market.

Many people reaching retirement would be interested in starting their own business and there is evidence that the survival rates of businesses established by older entrepreneurs are higher than those of younger entrepreneurs but to date there has been little effort to support or encourage older people to become entrepreneurs. In fact the training and employment agency FAS excludes people aged over 65 from their entrepreneurial training courses.

HAPPINESS

In the future a significant proportion of the older population will be healthy, active and interested in playing an important role in their community, providing significant benefits from their accumulated life skills and experience. Many of the complex societal challenges that we face such as supporting children with special needs in mainstream classrooms or dealing with the needs of immigrants without English

as a mother tongue, would benefit from the mix of life experience, time and understanding that older people often have in abundance.

Volunteering

While many older people already participate in and contribute to society in a variety of ways, the challenge for the future is to develop new social roles that preserve the skills and experience of older people. These new social roles as volunteers or semi-professionals could be supported through the provision of additional training and skills allowing older people to remain fully engaged in their communities through their participation in a range of socially relevant projects.

In addition to formal volunteering, many older people make substantial unpaid contributions within the family by caring for grandchildren or providing long term care to a spouse. The TILDA report revealed that one in five older people aged 65-74 do voluntary work at least once a week or more and that around 10% of older people are involved in high intensity voluntary work. Those with high levels of education are most likely to participate in formal organised activities.

Older people frequently wish to use their skills or share knowledge, to learn, to develop new skills and to be intellectually stimulated, and for many it is important to feel good and to feel needed by others. The most common barriers to older people's volunteering which have been identified are health problems, work commitments, a full schedule, and lack of time.

Ageism, Age Discrimination and Abuse

Many of the factors limiting the participation and engagement of older people in society are linked to ageism or age-related discrimination. Ageist attitudes and assumptions, which can

often be unconscious, can limit older people's opportunities to play their part in organisations or activities. A study carried out in Ireland for the NCAOP found that 57% of respondents considered that society treats older people worse than it treats younger people, while 62% disagreed with the statement that 'Ireland is an Age Friendly society'.

While the Equality Act includes age as one of the nine grounds on which discrimination is prohibited, there are still a number of areas in which access or entitlement can be prevented or made prohibitively expensive on the grounds of age rather than capacity. It is important to acknowledge, highlight and tackle these and any other barriers to full participation for those who are more frail and dependent.

Elder abuse can have a serious impact on the health and wellbeing of older people. While the full extent of the problem may be difficult to determine because of the reluctance of victims to report the problem, the NCPOP carried out a prevalence study which found that the overall prevalence of mistreatment in 2010 was 2.2%. When this percentage is applied to the general population of people aged 65 years or older it amounts to over 10,000 people who have experienced mistreatment. For the vast majority of people (84%) who reported mistreatment its impact was described as serious. Frequently the abuser is a family member or sole care-giver; the NCPOP study found that adult children were the perpetrators in 50% of cases, other relatives in 24% of cases and a spouse/partner in 20% of cases.

Recently, significant progress has been made in the development of structures and services to help older people experiencing abuse. HSE staff working with older people received training, and a major public awareness and information campaign, Open Your Eyes, was conducted in late 2008. However, it is acknowledged that many problems remain.

Loneliness and Social Connection

The positive impacts of social connections and social networks are well known, and several international reports have shown that all people, regardless of age, who have active social networks tend to feel happier about their lives. In fact it has been found that the health risks associated with low levels of social integration are comparable to those of smoking, high blood pressure and obesity.

While older people are no more likely to be lonely than other age groups, life circumstances such as or reduced mobility can limit their opportunities for interaction with others. Loneliness tends to be linked to social factors such as being unmarried and spending a lot of time alone, and to health-related factors such as poor mental health, worse-than-expected health in later life, and a poor current health status. Research shows that 'active interventions' which support older people in developing meaningful social roles and engaging in local community activities have more positive effects than other interventions.

Learning and Technology Use

The outdated view that older people have a reduced capacity for new learning has been overtaken by research findings which show that ageing does not reduce the ability to learn and that the brain needs mental exercise and exposure to new experiences throughout the life-span if it is to remain vital. In addition, there is growing evidence that mental stimulation in later life contributes towards good physical health. Negative attitudes and perceptions about oneself as a learner can act as a barrier to participating in education.

Though the White Paper on Adult Education prioritised lifelong learning, many of the key recommendations made in the paper have yet to be put into practice, and in fact there is no policy or implementation plan. Funding

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for adult education activities and services has tended to focus on preparation for the workplace, and currently stands at just under 2% of the overall annual education budget.

The use of information and communication technology (ICT) and the internet has the potential to be of particular benefit to older people. For example, internet-based communication with other people is convenient and affordable, access to medical or health information can relieve anxiety and on-line shopping, banking, training and learning can offer effective ways to overcome physical handicaps.

Barriers affecting older people's learning about IT are similar to those associated with learning in general. There are attitudinal barriers about age and ability, there may be problems of short-term memory loss, and for some the issues of declining manual dexterity and visual acuity.

Technology designers often do not have sufficient awareness of the needs of older people when creating products. Older people may experience changes in visual acuity, colour perception, and susceptibility to glare, and may have difficulty hearing high-pitched sounds and screening out background noise.

Research has shown that motivation is one of the essential prerequisites to learning and affects how well existing skills and knowledge are acquired, used, and applied to new situations. Many older people do not see the relevance or benefit of IT to their lives, so any approach to teaching IT to older people has to address this central concern.

Involvement in policy development

It is known that policy development is likely to be more effective if the process involves consultation and involvement of older people, who are the experts on their own lives and needs, yet have in the past often been marginalised and

overlooked. The strength of the organisations for older people in Ireland became apparent in 2008 when well-organised and attended rallies and vociferous protests resulted in the Government changing their plans to remove the automatic right to a medical card from people over 70.

While older people have a higher than average rate of participation in the democratic process (86.3% of eligible people aged 65 and over voted in the May 2002 General Election), the political parties have tended not to prioritise older people's issues or invest significantly in developing appropriate policies.

Arts, Culture and Sport

Engagement in the arts, culture and sports at any age pays dividends in relation to both mental well-being and physical health. Evaluations of community-based art and health projects in the UK have indicated that participation in community arts projects may lead to fewer GP visits, particularly for depression, and a reduction in medication usage. In these studies, participation in art projects also helped people feel 'part of a team' and reduced social isolation. The significant increase in the numbers of older people and older artists participating in the annual Bealtaine Festival is evidence of a strong desire among older people to participate in such artistic and cultural activities.

The physical benefits of sport and physical activity are known to enhance healthy ageing. Irish research found that 37% of older people participate in sport and recreational physical activity regularly, but only 15% are 'healthily active', while 58% have a sedentary lifestyle. While the Sports Council and the Go For Life programme have been active in seeking to increase older people's participation, it is still the case that their needs are not sufficiently taken into account in the development of community sports facilities and public spaces.

HOME

In recent decades, there has been a move towards greater emphasis on empowering people to make choices about their own care as well as having the means to purchase the services they prefer. The freedom to make, and continue making, choices is perhaps the greatest single index of well-being and this is especially true when it comes to choice of home and living environment.

Living Independently

Supporting older people to live independently in their own homes can have an important and positive impact on their physical and psychological well-being. Studies have found that most people would prefer to remain at home and that nursing homes are the least-preferred option for the majority of people. Despite this, some feel effectively 'forced' into long-stay nursing homes, because of the lack of sufficient state-funded home-care resources and of access to respite care.

Funding for nursing home care through the Fair Deal scheme also pushes people towards use of nursing homes rather than home care. Developing new models of care and support that can allow older people to remain in their own communities and homes could ensure that needs and preferences are met while the system remains sustainable and able to respond to future demographic changes.

For older people who have lived much of their lives in the same house, the stability and familiarity of their environment can compensate for age-related conditions, such as visual impairments. Staying in one's own community allows people to maintain local friendships and ties in the community, to shop and obtain medical care in familiar places, and to have access to neighbours and friends for emergency support. However many older people and their

families are often forced, in a crisis situation, to come to terms with the fact that their homes, perhaps because of size, location or structure, are not suitable for growing levels of frailty and physical impairment.

A 2010 study (by Conor Skehan and Lorcan Sirr, carried out for the AWN) of older people in Ireland found that their quality of life was compromised for 22% of older people by the location of their home, and by the standard of their housing for a further 13%. If older people are to stay in their own homes as they age, adapting or modifying the house can help them to continue living independently.

Technology has the potential to allow a higher proportion of older people to live independently in their own homes, and to do so for longer. However there is only very limited access to the range of technologies that can greatly assist people to continue living independently in their own homes and communities.

Home Care and Residential Care

As people age, they may develop chronic conditions which require care or they may become increasingly frail and need help with activities of everyday life. This care is frequently given by 'family carers' (sometimes referred to as informal carers) who are relatives, friends or neighbours and who, it has been calculated, save the state more than €2.8bn a year through their support and caring duties.

The Carers Association has predicted that demographic trends will mean that an additional 25,000 carers will be needed by 2016 and over 205,000 carers by 2021. This represents an increase of 28% in carer numbers by 2021. However the number of family carers now in employment has increased from over one third to over one half in the past 10 years and the number is continuing to increase. This will have implications for employers as they struggle to put in place the supports needed. Also with

fewer adult children available to share the care giving it is likely that greater pressure will fall on those who are in a position to provide care. In addition, given the current economic climate, families will find it increasingly difficult to be able to afford to provide care in the home.

Many carers are supporting people with high dependency needs, needing up to 60 hours work each week, as well as 24-hour monitoring and supervision. Research in Ireland and the US has found that the caring role can impact on physical and mental health, can lead to isolation, financial hardship, stress and exhaustion; as well as involving the loss of all kinds of opportunities. In addition, many carers feel their role is not recognised or rewarded by the State.

Respite care is universally regarded as one of the key formal support interventions for alleviating the stress of caring. However, despite increases in the level of the Respite Care Grant, the current level is not sufficient to cover the cost of respite for 20 days per annum, which is the statutory holiday entitlement for employed workers. In addition, the location of respite care in a hospital or long-term care setting can pose a significant risk of 'institutionalising' the older person.

The residential home sector, which caters for around 5 per cent of the older population, is now independently regulated by HIQA. In contrast the home care services sector which caters for about 12.5 per cent of this population group but there are no standards or regulation governing those providing home care.

In Ireland, there are over 7,000 people with dementia living in residential care, a figure which is expected to increase, yet many residential services do not cater for their full range of needs. Specific knowledge, skills, and a real commitment to dementia care are essential in front-line staff and managers who care for people with dementia, and it is vital that

person-centred care is provided in the form of individual care plans.

Older people's health problems and needs are complex, and research indicates a failure to detect treatable functional problems in nursing homes and primary care settings. This can lead to further decline, increased health service use, more disability and a decrease in life expectancy. However, where systems are responsive to the complex needs of older people, outcomes can be significantly improved.

One crucial requirement is that care systems should be designed, and services delivered, in active consultation with older people themselves, in line with the philosophy underlying the Madrid International Plan of Action on Ageing.

COMMUNITY

Research has shown that a number of critical factors have a very significant impact on the quality of life of older people and the extent to which they can participate in the life of their own communities.

The Built Environment, Public Spaces and Planning

Local Authorities have always played a significant role in shaping the built environment through planning for land use and through the provision of facilities. As people age, the distance they can conveniently travel reduces for a variety of reasons such as slower driving and walking speeds and increased use of slower modes of travel. As a consequence older people tend to spend a great deal of time in their local neighbourhood, shopping locally, using public facilities such as libraries and parks and participate in local social and recreation activities.

Planning for an age friendly community will therefore involve recognition of the benefits of

locating services and facilities centrally in the community and a recognition of the need for older people to live close to their existing social networks of family, friends and neighbours. By planning, designing and building environments that are safe and accessible to older people, local authorities can support older people in continuing to live in their own homes and local communities.

Physical environments that are Age Friendly can make the difference between independence and dependence for all people, but especially for those growing older. For example the National Disability Survey (2006) found that almost half of all those with mobility difficulties were aged over 65. Of those who have mobility difficulties 87% experienced difficulty walking for as long as 15 minutes.

These difficulties are compounded for those who live in communities where streets were poorly lit or pavements were narrow or uneven. Simple changes such as level and dished pavements, free from obstruction or safe and accessible public spaces with plenty places to sit down can allow older people be more active in their communities and slow or reverse the process of 'disablement' for those who are at risk of losing their freedom of movement outdoors.

It is important to understand the impact of the physical environment on the quality of life, physical health and social lives of older people. Research on quality of life found that older people feel their home and neighbourhood has a strong influence on the quality of their lives.

While the significance of attachment to place of residence among older people is just beginning to be explored, there is evidence that older people who live in less affluent areas are less likely than others to be socially active, and those who rate the quality of the facilities in their areas as poorer are more likely than others to have worse physical functioning.

Transport

Mobility and transport for people of all ages, and especially for older people, is closely linked to independence, autonomy, and quality of life. Research has shown that access to transport can influence the ability of older people to participate in social activities and to feel secure and independent and to foster their sense of connection and belonging. The absence of an adequate and accessible transport system can contribute to feelings of isolation particularly among older people living in rural areas.

The widely-held view that the physical problems of ageing make it necessary for older people to stop driving, has been found to be untrue and in fact, research found that older people are involved in only 7.7% of collisions as car drivers, and 6.7% as car passengers, compared to those aged between 25-34, who are involved in 25% of accidents as car drivers, and 14.7% as car passengers.

Despite evidence that they are safer drivers, older people are required to undergo age-related screening in order to be able to continue to drive. It is worth noting that countries with age-based screening for driving licences have higher road accident-related death rates among older people than countries which do not have these procedures, and such medical screening systems have been discredited by studies in the US, Australia and Scandinavia.

When older people are involved in accidents they suffer more serious injuries and proportionately higher levels of fatality as a result both of their increased physical frailty and car safety mechanisms which are predominantly designed for younger people.

After the car, the second most frequently used means of transport in Europe and the US among older people is walking. However older adults have the highest involvement in accidents as pedestrians (15%) and of these accidents, 21% are fatal. In contrast, only 2% of

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those in the 25-34 age-group are fatally injured when involved in accidents as pedestrians. Older people also can find that the crossing times allowed for by traffic lights insufficient and therefore stressful.

Public transport routes and facilities often fail to take account of older people's need to access health services and despite a systematic programme of introducing slightly raised pavements at bus stops some remain unsuitable for older people, with inadequate shelters, seating, and lighting. Many older people, for reasons of physical or psychological frailty, cannot use public transport and so rely on private taxis to get out and about. The free travel that those over 65 are entitled to is an important enabler of mobility, but is at present limited to public transport.

Rural Transport

The availability of transport is essential to maintaining social connections between people living in rural areas. Projections indicate that an estimated 450,000 rural dwellers could have unmet transport needs by 2021, including 250,000 people in key target groups such as older people. Research into the needs of rural dwellers found that in three of the four counties studied about 40% of the rural population live in areas without any access to a scheduled public transport service, and in the fourth county the situation was worse, with 60% having no service of any kind. This has led to increased reliance on the car - 83% of all respondents reported that their own car is their primary form of transport. The research also found that many residents within these areas live beyond walking distance from such services and that the situation is worse for people with disabilities or people who are otherwise mobility impaired.

The Rural Transport Programme, launched in 2007 by the Department of Transport, is currently delivered through 37 community-

based groups, all of whom operate on a not-for-profit basis with older people and people with disabilities as the core customer base. One successful initiative is Flexibus, a 'dial-a-ride' service in County Meath, providing transport facilities for pension collection, shopping trips, attendance at activities and local groups, etc. It also provides transport to hospitals and health centres, and has increased its 'clinic runs' from 183 in 2005 to 1,462 as of October 2008. In 2008, the programme delivered 1.24 million passenger journeys, a substantial increase from 650,000 passenger journeys in 2005. Over 76% of these were provided on a door to door basis and free travel pass holders accounted for an average of 64% of passengers.

Despite the fact that the National Disability Authority and the Department of Transport published operational guidelines in 2005 for improving access to bus, rail and light rail services for people with mobility, sensory and cognitive impairments, some transport providers in Ireland do not ensure that their drivers have the necessary skills and awareness to support older people's use of their service (eg. allowing sufficient time for an older person to ascend, sit down, and alight).

Safety and Security

All age groups need to feel safe in their own homes and neighbourhoods. However, there is some evidence that older people are more fearful for their own safety than other age groups, a fear which is linked to their potential vulnerability both within their own homes and in the surrounding environment. Research shows that a majority of older people perceive crime as a serious problem (63% in 2006) and that approximately 45% feel unsafe walking alone in the neighbourhood after dark. However, the proportion of people over 65 directly affected by crime was 1.7%, considerably lower than the average (4.6%) for the general population.

In an Age Friendly community, policies, programmes, services and infrastructure are designed to enable older people to live in security, enjoy good health and continue to participate in society in a meaningful way. Research has found that women are less likely

to feel safe than men, and that people who are physically frail and who have low incomes, are more likely to have a fear of crime. It has also been shown that people who both perceive their neighbourhood as Age Friendly and who are involved in their community feel safer than those who do not. Older people who live in an unsafe environment or areas with multiple physical barriers are less likely to go out, and therefore are more prone to isolation, depression, reduced fitness and increased mobility problems.

There is increasing recognition in Ireland that major complex challenges such as a reframing the ageing agenda, require a partnership

approach of all agencies involved. The OECD study of public sector management in Ireland in 2008, *"Towards an Integrated Public Service"*, suggested the need for a networked approach to achieve an integrated public service and that rather than create new structures, an approach where individuals work together, creating greater connectivity between sectors would be beneficial to all. The current economic crisis while making it more difficult to attract additional funding for new initiatives, is increasing the pressure for more effective and efficient approaches to achieving agreed outcomes and is contributing to a growing realization that significant process redesign is a more desirable way of achieving this.

Chapter 1.

Introduction & Overview

Throughout the developed world, people are living longer healthier lives and as a result the proportion of older people has been increasing steadily over the past century.

The significant demographic changes predicted for Ireland will have major implications for policy development, forward planning and integrated service delivery by Government, state agencies and others involved in provision of services and supports for older people. While Ireland has a short breathing space in which to plan the best possible future for everyone, we need to conceptualise new social roles for older people which take account of their additional healthy and active years and which focus on the opportunities as well as the challenges of an ageing population.

What is needed is new thinking, backed by evidence, that focuses on the 'demographic bounty' by promoting quality of life and well-being, valuing the contribution older people make in their communities, promoting their independence, and removing the barriers, whether legal, attitudinal or income related which limit or inhibit the capacity of older people to live life to the full. Taking this approach will not only benefit older people but will bring benefits to our communities for people of all ages.



The growth in the number of healthy older people, living longer lives, will have significant implications for policy development in Ireland and throughout the world. Population ageing has been on the global policy agenda for at least a decade, and it is likely to become a more important issue in the future as demographic change exerts a greater influence on our systems and services. The key to ensuring that all of us as we age will enjoy a positive ageing experience will be to ensure that we have planned and prepared for the changing future both as individuals and as a society.

The purpose of this report is

- To review the evidence and identify the issues associated with the ageing of the Irish population
- To propose options for change and
- To seek to influence the content of the Government's Positive Ageing Strategy.

Ireland has an opportunity to become recognised as one of the best countries in the world in which to grow old. It is already recognised as a leader in areas such as in the provision of free transport or the quality of palliative and hospice care. It is also known that many aspects of quality of life remain good in Ireland such as family connectedness and neighbourliness and there have been very important improvements over recent years in relation to the tackling of poverty among older people through increases in the state pension.

It is clear that the growing numbers of older people in our society will create an additional demand for pensions, health and care in later life. This in turn will require a re-examination of our systems and structures to ensure that resources are used efficiently and that these systems and structures are prepared to respond to increased demand. By planning for this new future and developing policies which can transform the challenge of ageing societies into

an opportunity, we can stimulate economic growth and improve well-being for all people, not just for older people. However "*the window of opportunity to plan and prepare is, quickly closing*" (World Economic Forum, 2009).

The implication of adopting a 'positive ageing' approach is that it focuses on the broader aspects of ageing and applies to all areas of life. This will impact on the content of the strategy, as well as on the participants and the processes involved in its implementation.

We are seeking to bring about a paradigm shift from thinking of older people as a burden and a cost to seeing the opportunities afforded by these changes. Allowing the skills, knowledge and experience gained by older people throughout their lives to be used, will bring benefits for the individual, the community, and the country as a whole.

This will require transformational change in many areas and will involve the development of policies informed by the voice of older people and implemented through multi-stakeholder collaboration and monitoring of implementation processes. Change needs to happen across a number of fronts and at a number of levels. It needs to happen at policy level to affect priorities and resource allocation; at organisational level to affect quality and range of supports and services and at individual level to change attitudes and behaviours. It will have to happen across the public, private and third sectors, at leadership and front-line level.

This chapter discusses the background to the development of this report. It introduces the Ageing Well framework and explains how it influences the structure of the report. The chapter also sets the scene with an outline of the demographic changes that are impacting on our population structures and will necessitate a reconsideration will result in dramatic changes in the structure of our future population and create the impetus for action on ageing.

1.1 FRAMEWORK

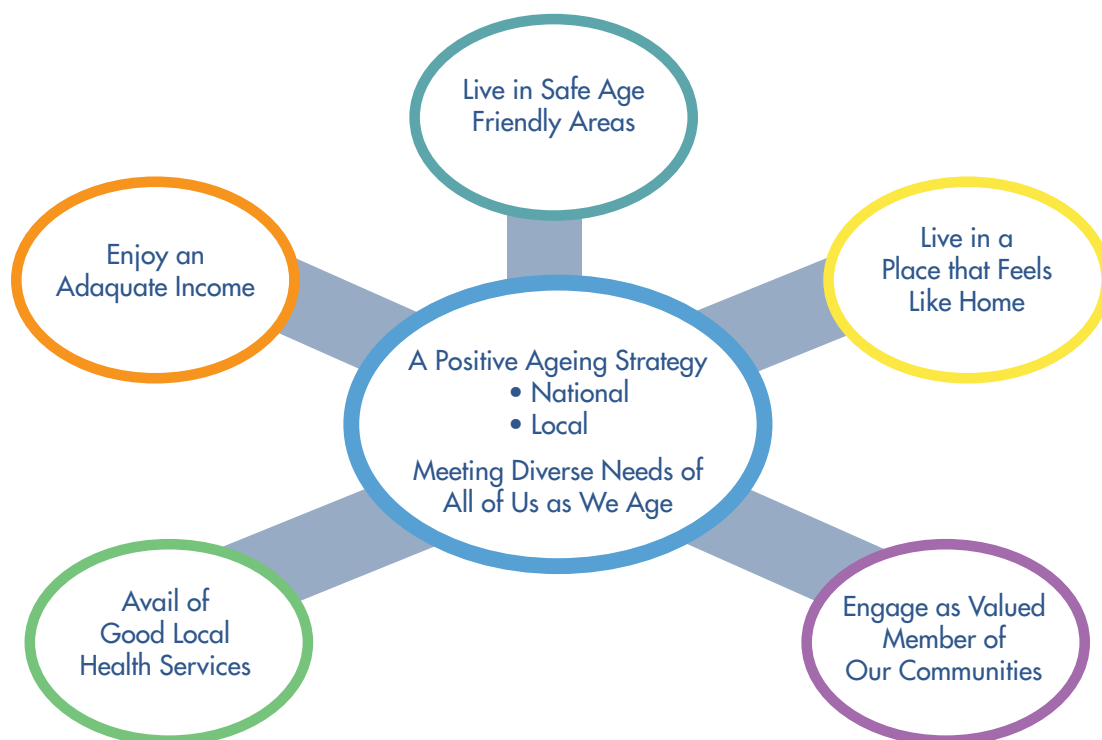
The Ageing Well Network was set up as a ‘think tank’ bringing together the critical leaders from the fields of policy development, academia, service delivery and advocacy, along with other key opinion formers in relation to ageing and older people. On the basis of a shared vision of “*an Ireland that will be a great country to grow old in*”, the Network provides a forum for the collaborative exploration of the critical issues. The network is not an advocacy body, does not take public positions or have a public profile and does not seek to forge agreements among members. Instead, it seeks to influence change ‘within the system’, by providing a forum in which members can exchange information and insights; explore and test new approaches to what needs to be done to make Ireland a great place for us all to grow old.

At the outset, a framework for positive ageing in Ireland was developed, based on a review of key policy documents and position papers. There

are five elements, each with a number of separate components, in the framework’s articulation of a desirable future Ireland, in which each older person will:

- Enjoy an adequate income, free from fear of poverty
- Avail of good local health services
- Engage as valued members of their communities
- Live in a place that feels like home
- Live in safe, Age Friendly areas

This report reflects the views and experience of a wide range of members of the Ageing Well Network, articulated at three working group meetings. These views are supported by evidence from the scientific literature in gerontology and related fields on a range of issues that impact on the ability of older people to maintain a good quality of life during their later lives. The members of the network are experts in a number of professional fields related



to health/social care and the ageing sector as well as representatives from the HSE and five government departments. They have reviewed drafts of this report, identified the key issues, put forward policy options and discussed the potential implications of these options.

This report is not intended to represent a consensus between the members of the Network and it does not necessarily represent the views of the individual members. Instead it aims to highlight the inherent complexities and the potential challenges and benefits associated with the implementation of a Positive Ageing approach. The structure of the report is based on the elements identified in the Positive Ageing Framework in the areas of Health, 'Wealth', Happiness, Home and Community and it seeks to articulate a vision of Ireland as "*one of the best countries in the world to grow old in*".

1.2 POLICY CONTEXT

In the last few years, there have been a number of improvements in policy making and provision for older people in Ireland, which amount to a significant momentum for change.

In 2007 the Government made a commitment to prepare a National Positive Ageing Strategy to 'better recognise the position of older people in Irish society' (Programme for Government 2007-2012). In fulfilment of commitments made they created the portfolio of Minister for Older People and Health Promotion, and established the Office for Older People at the Department of Health and Children in early 2008. More recently, on coming into office in 2011, the Taoiseach Enda Kenny pledged to make Ireland "*the best small country in the world in which to do business, the best country in which to raise a family and the best country in which to grow old with dignity and respect.*"

The 2007 commitment to publishing a new National Positive Ageing Strategy, to replace the most recent strategy (The Years Ahead

- now over 20 years old) resulted in a multi-sectoral approach to the development of this new Strategy. A Cross-Departmental Group was established, chaired by the Director of the Office for Older People, made up of the Departments of Tourism, Culture and Sport; Community, Equality and Gaeltacht Affairs; Education and Skills; Enterprise, Trade and Innovation; Environment, Heritage and Local Government; Finance; Justice and Law Reform; Social Protection; Taoiseach; and Transport. The Central Statistics Office and An Garda Síochána are also represented on the group.

Work to develop the Strategy began with a two stranded public consultation process involving written submissions and the holding of nine regional consultation meetings which took place between June 2009 and June 2010. According to the website of the Department of Health and Children "*...the work of the Cross-Departmental Group to prepare the Strategy has been continuing, with a number of meetings to further progress development held during 2010 and in 2011. Work on development of a draft Strategy is continuing.*" (http://www.dohc.ie/issues/national_positive_ageing)

There has also been an increased research output in the field of ageing and older people, from, among others, the Irish Longitudinal Study on Ageing (TILDA), the TRIL Centre (Technology Research for Independent Living), the Centre for Ageing Research in Ireland (CARDI), National Council for Ageing and Older People (NCAOP), the Irish Centre for Social Gerontology, the Social Policy and Ageing Research Centre, TCD (SPARC), the Mercer's Institute for Research on Ageing, among others. Many public agencies have produced major policy papers on ageing and older people in recent years, including the National Economic and Social Forum, the Economic and Social Research Council, and the Central Statistics Office produced its first statistical report on 'Ageing in Ireland' in 2007,

based on the 2006 Census information and is due to publish its second based on the 2011 census in May 2012.

1.3 POSITIVE AGEING

The 'Positive Ageing' approach to strategy development seeks to take a balanced approach between addressing the opportunities and challenges of an ageing society rather than seeing the increase in longevity as a burden and a threat. It seeks to challenge assumptions about older age as a period of inevitable decline and focus instead on the ways in which lifestyle, attitude, and skills can be supported and changed to create a better quality of life for all older people. The benefits of a positive ageing approach are clear and could include good health, independence, intellectual stimulation, self-fulfilment and friendship (Dalziel, 2001, p.11).

The Positive Ageing approach encompasses the various concepts of 'active ageing', 'successful ageing', 'healthy ageing', and 'productive ageing' which in turn are linked to good health, financial security, having a positive attitude to life, engagement with an activity or with society, feeling connected to and supported by families and friends, and living in a place with which they are familiar.

Positive ageing has been described as a rejection of the 'disengagement' theory of ageing, which suggests that adjusting to old age requires a withdrawal by the individual from society (Cumming and Henry, 1961) and instead the older person remains actively engaged in society in order to adapt successfully to older age (Havighurst and Albrecht, 1953). Positive ageing is supported by international policy such as the UN Principles for Older Persons (1991) and the UN Madrid Action Plan on Ageing. These principles are based on five key areas; Independence; Participation; Care; Self-fulfilment and Dignity (see appendix 1).

The approach to positive ageing seeks to find innovative ways in which we can continue to use the skills and experience of older people and to exploit the advantages of having a large cohort of older people with life experience who have time and talent to give the leadership to enable our communities to flourish. It involves an inversion of the triangle (see Figure 1 below) ie. the promotion of well-being facilitates the majority of the 85% of older people to remain independent resulting in the repositioning of this cohort at the top of the triangle.

1.4 DEMOGRAPHIC CHANGE

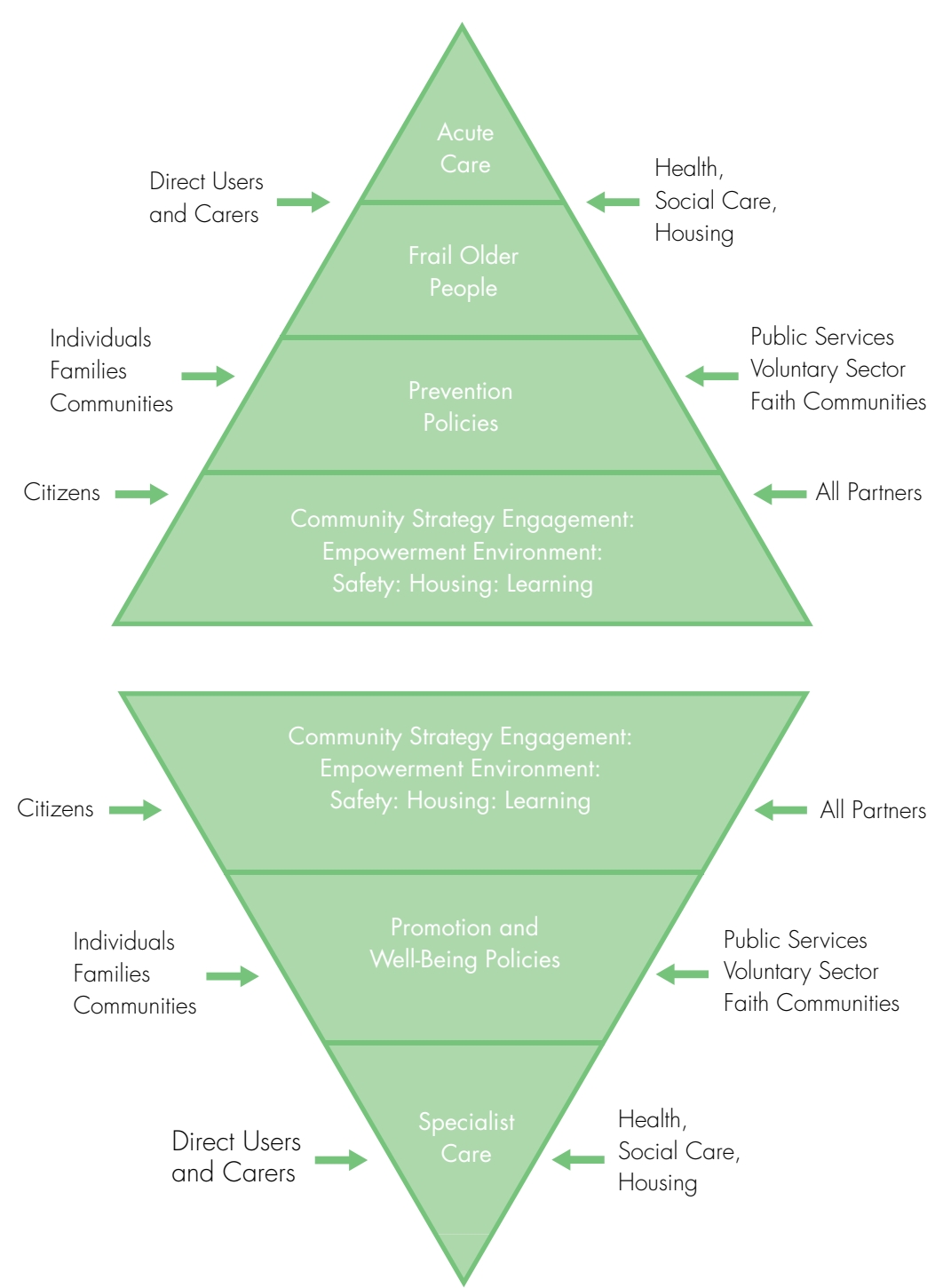
Predictions about population ageing are generally based on a number of assumptions relating to demographic factors, such as fertility rates, mortality rates, and immigration flows. In order to set the scene for subsequent discussions about the impact of demographic change on our systems and structures, it is useful to review in detail the changes currently being experienced at a global and national level and some of the predictions being made.

1.4.1 Global Trends

As mentioned earlier, throughout the developed world people are living longer and the proportion of older people in the population has been increasing steadily over the past century or more. On a global level the main influences on demographic change are changes in fertility and life expectancy while at a national level, migration and factors such as population booms can also play a role. Internationally, it has been predicted that most babies born since 2000 in Europe, the USA, Canada, Japan, and other countries with growing life expectancies will celebrate their 100th birthdays (Christensen et al 2009).

Fertility rates have been falling for a number of decades and in 2011 the total fertility rate worldwide was 2.5 and for the EU was 1.6

Figure 1: Support for People Today



Source; Local Government Association (2003) "All our tomorrows – inverting the triangle of care"

(PRB 2011) The EU experienced a sharp fall in fertility rates between 1980 and the early 2000s, the rate started to increase again in 2003, when it stood at 1.47 children per woman, reaching a level of 1.60 in 2008. In 2009, Ireland had the highest fertility rates in the EU (2.07), followed by France (2.00), the United Kingdom (1.96 in 2008) and Sweden (1.94), all approaching the replacement level of 2.1. (Eurostat 2010)

Improvements in life expectancy are achieved by lowering mortality throughout the life cycle. Significant differences in life expectancy at birth exist throughout the EU-27. For men, the lowest life expectancy in 2009 was recorded in Lithuania (67.5 years) and the highest in Sweden (79.4 years). For women, the range was narrower, from a low of 77.4 years in Bulgaria and Romania, to a high of 85.0 years in France. (Eurostat 2011) The impact of increasing life expectancies and low levels of fertility, sustained for decades, has been a change to the whole structure of the EU population, with an overall increase in the proportion of older people accompanied by a reduction in the proportion of younger people.

A key indicator of population ageing is the median age (the age at which 50 per cent of the population is older and 50 per cent younger). Today, just 11 developed countries have a median age of over 40, but by 2050, 99 countries will fall into that group. In 2009, the median age of the EU-27 national population was 41.2 years, ranging from Germany with a median age of 44.5 years, to Ireland with a median age of 33.9. (Eurostat 2011)

On a global level, the UN's most recent population report points out that 42 per cent of the world's population lives in low-fertility countries, that is, countries not having enough children to reach the replacement level. The report identifies population ageing as an issue that cannot be dismissed. (UN 2011)

In the more developed regions, 22 per cent of population is already aged 60 years or over

and that proportion is projected to reach 32 per cent in 2050 and 33 in 2100. In developed countries as a whole, the number of older persons has already surpassed the number of children (persons under age 15), and by 2050 and 2100 the number of older persons in developed countries will be nearly twice the number of children. In developing countries, the proportion of the older population is expected to rise from about 9 per cent in 2005 to close to about 20 per by 2050. (UN 2011)

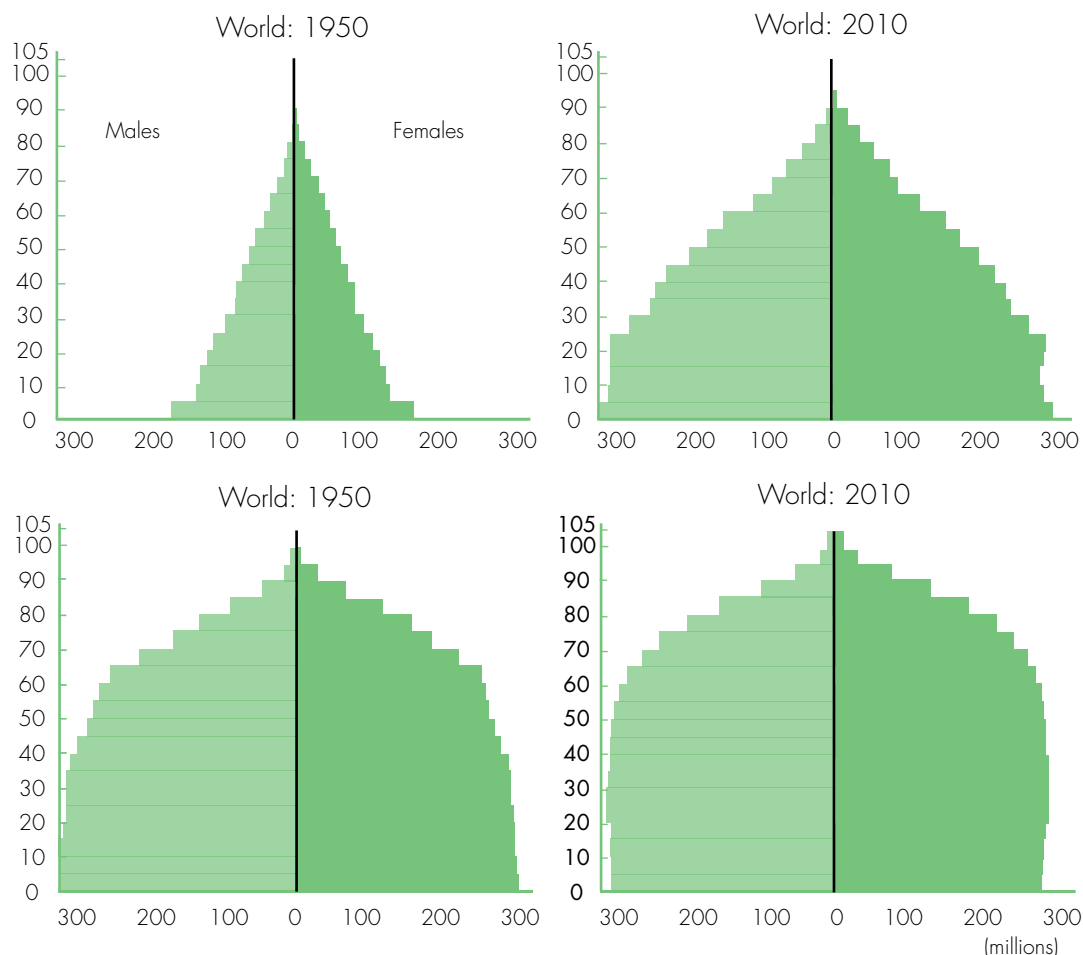
The rate at which population change is occurring is also increasing. The population of those aged 60+ in the developed regions is now growing at a rate of 2.4 per cent annually before 2050 and 0.7 per cent annually from 2050 to 2100. Japan currently has the largest proportion of people in the world aged 60+ at over 25 per cent and it is predicted that the numbers will continue increasing, reaching 44 per cent by 2050. (UN, 2009)

The UN predicts that this age-group will increase by more than 50 per cent over the next four decades, rising from 274 million in 2011 to 418 million in 2050 and to 433 million in 2100. Compared with the more developed world, the population of the less developed regions is ageing more rapidly. In addition the number of people aged 60 and older in the world will increase from 510 million in 2011 to 1.6 billion in 2050 and to 2.4 billion in 2100.

The biggest increase is likely to be among people aged 80 or over (the oldest-old). This age-group is likely to see an almost eight-fold increase, to reach 402 million in 2050 and 792 million in 2100. By 2050, most oldest-old people will live in the developing world. (UN 2009)

The impact of these changes is that, according to the UN, the world population is projected to increase by 3 billion over the rest of this century and will surpass 9 billion people by 2050 and exceed 10 billion in 2100. (UN 2011)

Figure 2: World Population Structures – Past, Present and Future



Source; <http://esa.un.org/wpp/population-pyramids/population-pyramids.htm>

1.4.2 Irish Trends

Ireland's current demographic profile is currently very different from that of the EU 27 (CSO, 2007) a fact which is explained by three factors;

- The relative youth of its population resulting from a high birth rate during the 70s
- An increase in immigration in the past decade, mainly from younger age groups and
- High levels of emigration from the 1930s to the 1950s – a period during which

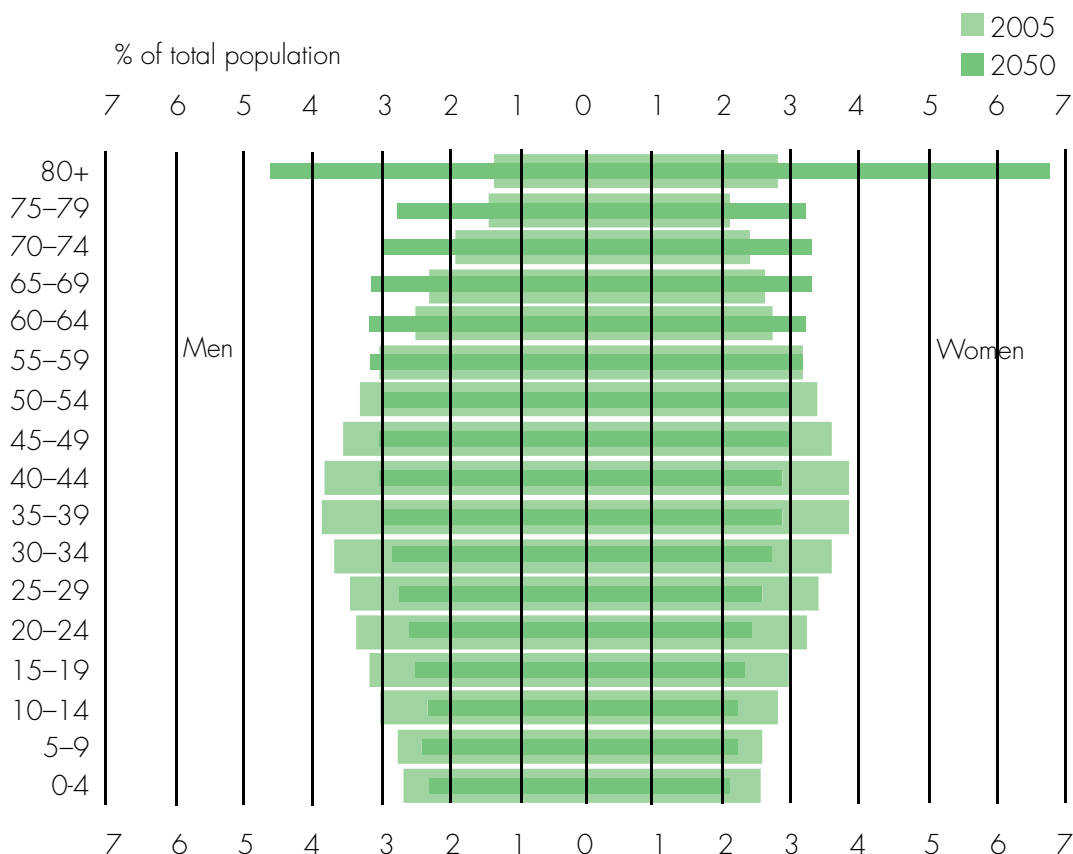
up to half of the working age group emigrated, many of whom never returned.

Historically Ireland's population has grown steadily since 1960 with an average growth rate of 1.35 per cent per year between 1991 and 2006 and a high average annual increase of over 2 percent between 2002 and 2006. The figure below shows the change in population structure since 1950 and the projected change up to 2100 (UN 2011)

1.4.3 Fertility and Mortality Rates

Ireland's fertility rate over the past few decades has had an impact on the current population

Figure 3: EU population projection (EU) - Present and Future



Source; Mamolo and Scherbov (2009) Population projections for 44 European countries. European Demographic Research Papers 2

structure and will impact dependency ratios into the future. During the 1950s, a period of high emigration, the number of births in Ireland fell slightly and the number of females in the population also fell. The number of births increased steadily from the 1960s and 70s to reach a peak of 74,000 in 1980. During the 1980s and 90s the numbers fell sharply to reach a low point of 48,000 in 1994. The number of births increased by 14 per cent between 1994 and 2000, largely due to increases in the population of women of childbearing age rather than to an increase in the fertility rate per woman (CSO 2007).

In recent years the natural increase of the population has continued to be very strong. The

number of births exceeded the previous peak (in 1980) with 75,100 births in the twelve months to April 2011, while deaths stood at 27,400, resulting in a natural increase of 47,700, or just over 1 per cent of the population. (CSO 2011).

In addition to strong fertility rates, Ireland has also experienced an increase in overall life expectancy which is expected to continue. The rate at which mortality improvement has occurred in the recent past is higher than at any recorded period in the past. In 1900 life expectancy in Ireland was just over 49 years and increased (for males) to 76.7 years for men in 2005 and 81.5 years for women. Life expectancy for the population in general currently stands at 80.1 (OECD 2010)

The UN predicts future increases to 84.7 by 2050 and up to 89.7 by 2100. (UN 2011) In 2008 life expectancy for those aged 65+ stood at 20.4 years for women and 17.2 years for men.

As a result of our strong birth rates over the past decade, Ireland has the largest proportion of young people in the EU. The most recent census (2011) revealed that 21.4% of the population is aged under 15 years. The older population also grew steadily over the past few decades. In 2006, there were 467,900 people over 65 in the Irish population, an increase of 54,000 since 1996. The census found that number had risen to 535,393, representing 11.7% of the population. (CSO 2012) This remains the lowest proportion of over 65s across all the EU 27 countries, where the average proportion was 16.8%.

Since 2007 there has been a steep rise in the number of emigrants and in particular, the number of Irish nationals emigrating. After a period of net inward migration which peaked in 2006 at 71,800, the migration trend now shows a net outward total of over 34,000 in 2011. The numbers of Irish nationals emigrating continued to increase from 27,700 to 40,200 over the 12 months to April 2011 while emigration among non-Irish persons fell for the second year in a row. Overall emigration is estimated to have reached 76,400 in the year to April 2011, an increase of 11,100 (or 16.9 per cent) on the 65,300 recorded in the year to April 2010. The combined effect of strong natural increase in births and negative net migration resulted in a relatively small increase in the overall population bringing the population to 4.5 million in 2012.

The 2011 census found that while migration is traditionally dominated by those of working age, there was also an increase in younger and older age groups. The number of non-Irish people aged 65 and over increased by 27 per cent to 19,200, up from 15,100, while the number of non-Irish children increased by 49.7 per cent to 78,600, up from 52,500 (CSO 2012)

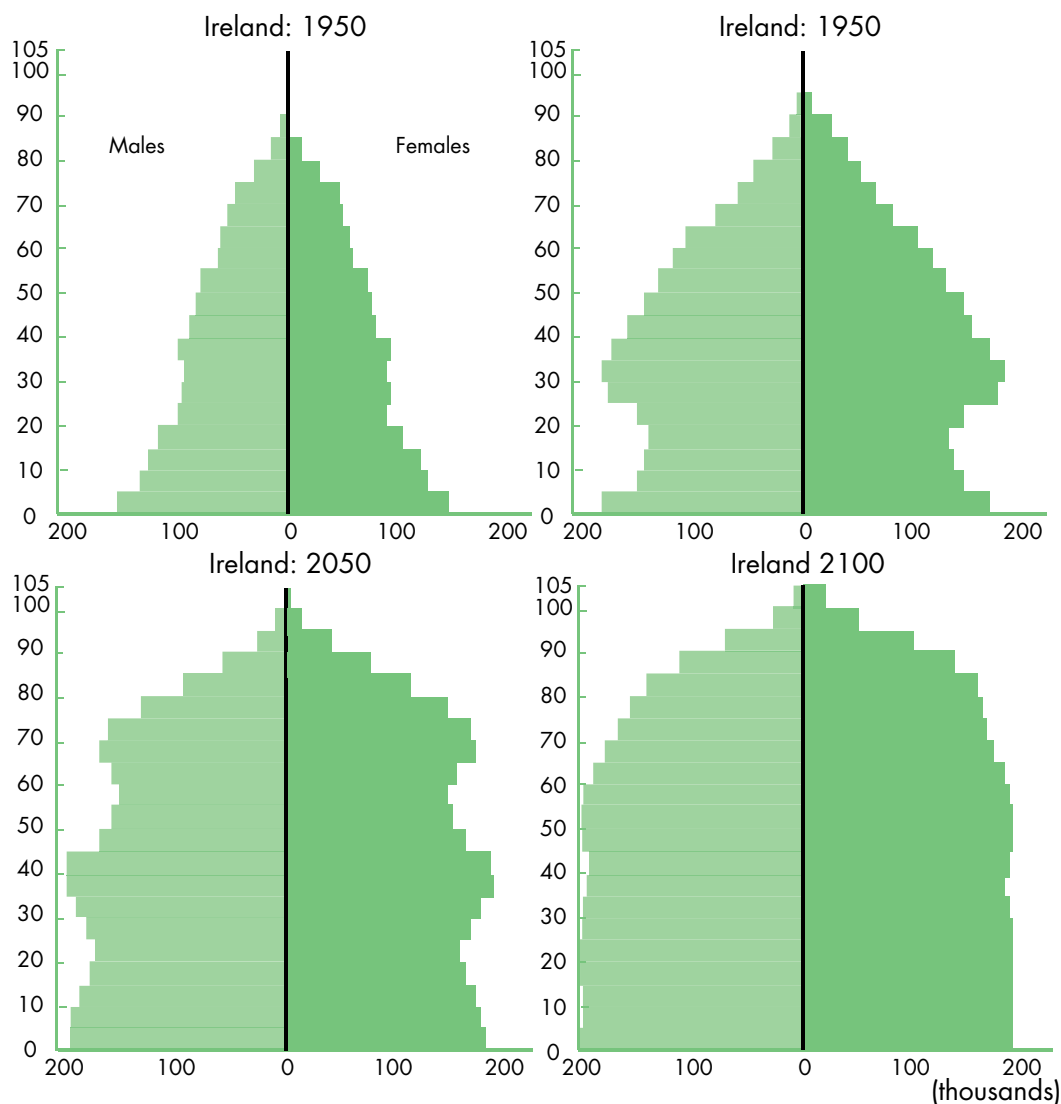
Regional variation can also be found in both the proportion of older people and in the rate of change. In the 2011 census variations in the proportion of older people (those aged 65+) ranged from as low as under 8% in areas such as Fingal and Kildare to almost 15% in Mayo and Leitrim. Cork City has the oldest population followed closely by Mayo and Kerry. The census also revealed that the average age in the country has increased by two years since 1996, when it was just 34.1. This is despite the high inward migration of primarily younger people into Ireland over the past 10 years.

The 2011 census also found that counties differed in their rate of growth and in the age-profile of their populations. For example Laois increased its population by 20% between the census of 2006 and that of 2011 - over twice the growth rate for the country overall (8.2 per cent). The trend of urbanisation is continuing and the number of people living in urban areas has increased by 11%, compared with 8.2 per cent growth nationally. Small towns are now the biggest growth area and have increased their population by 33% since the last census. Many of the cities (excluding suburbs) have lost population share, growing by only 3 per cent collectively and the population of Cork and Limerick fell while Galway, Waterford and Dublin all grew modestly. (CSO 2012)

Population projections

While population predictions can vary, a 2008 CSO report put forward projections of future change in the composition of our population, based on a number of different scenarios (high or low levels of fertility or migration). It found that under all scenarios the overall level of population is due to rise. The structure of the population is also likely to change as the number of older people rises from its 2006 level of 462,000 to between 1.3 and 1.4 million by 2041, depending on the level of fertility and migration.

Figure 4: World Population Structures – Past, Present and Future



Source; <http://esa.un.org/wpp/population-pyramids/population-pyramids.htm>

In absolute numbers it is predicted that there will be approximately 1.1 million people aged over 65 years in 2036 (an increase of almost 250% over the 2006 figure) and between 1.3 and 1.4 million by 2041. The greatest increase is expected to be in the over 80 age group, where numbers are expected to quadruple from 110,000 in 2006 to about 440,000 in 2041 (CSO 2007). Based on figures from the 2006 census, the CSO predicted that the proportion

of older people will reach 20% by 2036 and between 20 and 25 per cent by 2041.

1.4.4 Participation in the Workforce

Much of the concern expressed by commentators regarding population ageing has centred on the fact that in many European countries the balance between the 'active' working population and those who are receiving

pensions has shifted, with possible implications for the old age dependency ratio and the future cost of providing pensions.

EU statistics have shown that employment of the older population has strongly increased over the last decade. While the employment rate for those aged 20–64 in the EU27 increased from 66.5% in 2000 to 68.6% in 2010, the rates for older age groups rose more sharply, from 50.3% to 60.9% and increased by 7.5 % for those aged 60 to 64 (from 23.0% to 30.5%).

The employment rate remained at around 5% for those aged 65 and over. (Eurostat 2102) The 2012 Ageing report – underlying assumptions and projection methodologies (EU 2011) suggests that the increase in employment of older people is likely to continue during the next half a century.

In the recent past Ireland had one of the highest employment rates in the EU for people aged 65 and over. Employment levels for men aged 65 and over fell to 14% in 2011 from a high of 16.3% in 2008. The difference for women between Ireland (4.2%) and the EU 27 (2.8%) was less marked. This fact is partly accounted for by older farmers continuing to work past 65 as in 2006, almost half of all males in employment aged 65 and over were working in agriculture (48.7%) (CSO, QNHS 2007).

The participation rates for those in the 60–64 age group and those over 65 years rose in the five year period to 2008 but since then rates for men have dropped. There are now 55.2% of men aged between 60 and 64 in the labour force – a drop from 60.3% in 2008. The figures for men aged over 65 have also fallen from 16.3% to 14% while the number of women in both age groups in the labour force has remained unchanged at 4.6% (CSO, QNHS 2010).

The proportion of males that are retired is low for those aged 50 to 55 years, at only 1.1%, but rises to 13.2% for those aged 56 to 60 years, to 45.5% for those aged 61 to 65 years,

and to 71.9% for those aged 66 to 70 years. The proportion that is retired continues to increase until the 81 to 85 age group, at which stage all male respondents are retired. Among women, the participation rates are lower but it is clear that significant proportions of both males and females retire earlier than 65 years (Cullinan and Gannon 2009).

Across Europe the workforce participation rates vary greatly in the 55–59 age group. In some countries it has fallen to as low as under 20% (Belgium, Italy, France, and The Netherlands), to 35% in Germany, and to 40% in Spain (Siegrist et al 2006). In the UK about 3 million people move out of the workforce between the ages of 55 and 70 each year which amounts to about half the productive capacity of this group (Gruber and Wise, 1999).

1.4.5 Dependency Ratios

Dependency ratios are a measure of the number of dependent people in the economy as a proportion of those in the working age population – the usual definition is people aged 0–14 years and over 65 as a percentage of those in the working age population – between 15 and 65. At EU27 level, the old age dependency ratio was 25.6 % while in Ireland it was 16.8%. In other words, on average, every 100 persons of working age were supporting 26 aged 65 or more in the EU but only 17 in Ireland.

The old age dependency ratio in Ireland is predicted to rise to 25.1 in 2025 and 33.1 in 2040. The young dependency ratio is also predicted to rise from its 2010 level of 31.9 to 32.4 in 2025 and then fall back to 30.9 by 2040. (HSE 2010)

According to the 2011 census, when the two ratios are combined the total dependency ratio in Ireland increased to 49.3 in 2011 from 45.8 in 2006. This indicates approximately one young or old person for every two people of working age. This is explained by our rising birth rate

Table 1 - Dependency Ratios, Ireland and EU27, 2010, 2025 and 2040

Age Group		2011	2025	2040	2010–2040
0–14	Ireland	31.9	32.4	30.9	-1.0
	EU-27	23.3	24.1	24.0	+0.7
65+	Ireland	17.0	25.1	33.1	+16.1
	EU-27	25.9	34.6	45.5	+19.6
Combined	Ireland	49.3	57.5	64.0	+14.7
	EU-27	49.2	58.7	69.5	+20.3

Source: Central Statistics Office, Eurostat - EUROPOP 2010 Convergence Scenario

and increased longevity, and is despite the fact that the number of persons of working age continued to grow, reaching over three million for the first time in 2011.

Ireland's combined dependency ratio was similar to the average for other EU member states although very different in composition. It is expected that the total age-dependency ratio will rise to 57.5 in 2025 and 64.0 in 2040 compared to 58.7 and 69.5 respectively in the EU27. (HSE 2010) In 2010 France had the highest combined age dependency ratio in the EU at 54.2 while Slovakia had the lowest at 38.1. Germany and Italy had far higher proportions of their population in the 65 and over category (around 31%) in comparison with the 0-14 age group (around 21%). (Eurostat 2011)

1.4.6 Economic Impact

Whether population ageing brings economic and social benefits or turns out to be the 'silver tsunami' that many have predicted, is an issue that has been debated extensively over the past decade. Health economists Murphy and Topel (2006) have argued in favour of the former,

calculating that health improvements have contributed 30 additional years to the average lifespan during the 20th century. They then extend their calculations to establishing the worth of those additional years, in terms of additional lifetime expected utility from goods and leisure. By looking at what people are willing to pay for goods, they arrive at a figure of \$1.2 million for every person who benefits from today's life expectancy (Murphy & Topel, 2006). Other US economists calculate that society realises a return of \$7 for every \$1 that has been spent to date just on heart attack care as a result of the increased lifespan that results from heart attack care (Cutler & McClellan, 2001).

On the 'silver tsunami' side of the argument, concerns have been expressed that;

- The costs associated with providing public pensions to a growing population of older people could place an increasing burden on people of working age, although this burden may be mitigated by increased economic growth and productivity;
- Increasing numbers of older people, needing (but not always getting) more

health care than younger people, could create an unsustainable demand for costly medical services, although current evidence suggests that this trend is not as marked as may be imagined, particularly with good health promotion (Spillman, 2000; Lubitz, 2003) ;

- That, in the future, there may be insufficient people available to provide care and assistance with daily activities
- That reduced participation in the workforce and an older workforce, may have a negative impact on macro-economic performance in the absence of an “age-attuned” work environment (O'Neill, 2010);
- That any shift in resources toward older people will result in new tensions between generations.

Because of the number of ‘unknowns’ in the equation, predictions about the possible macro-economic impact of population ageing can vary greatly and authors have developed competing visions of how ageing might impact on our future economies. A number of questions are raised;

- If people are having fewer children will they then invest more in education and will this increased investment in human capital result in greater productivity?
- If people are healthier for longer will participation rates in the labour force increase?
- Will a reduction in the birth rate result in increased participation in the labour force by women?
- Can policy change halt or slow the decline in the size of the labour force by bringing about an increase in the birth rate, as has happened in France (RAND 2005) or

- Can policy changes promote higher levels of savings at an earlier stage in life, ensuring that the impact of future pension costs on public spending will be less than predicted.

While many of these issues will be addressed in subsequent chapters, it is useful to briefly consider some of the arguments which suggest that the impact may be lessened by a range of behavioural and policy responses. It has been argued, that the exclusively negative focus on older people obscures other relevant changes in society and many of the apocalyptic views of population ageing neglect to take account of potential behavioural or policy changes that will naturally occur in response to population ageing (Bloom, Canning and Fink 2010).

Bloom et al (2010) argue that there is scope for an increase in the labour force participation rates in most developed countries. The frequently express the desire to remain in the workforce for longer has not, up to now, resulted in any significant increase in participation rates; instead, rates have decreased in most OECD countries despite the improvements in life expectancy over the last decades.

Lee and Mason (2010) argue that the reduction in fertility rates throughout the world has resulted in an increase in the number of highly educated young people. This, they suggest will result in higher productivity levels which will contribute to economic growth and reduce the tax burden on future generations. They state: *“The [effects] of population aging are reversed as large cohorts of less productive members are replaced with small cohorts of more productive members.”* (Lee and Mason 2010) Lower fertility rates are also associated with higher labour force participation among women. Bloom and colleagues have argued that these factors will reduce the impact of population ageing on economic growth.

There is also evidence that some older people may, throughout their lives, finance a higher

standard of living during their retirement. Bloom, Canning, and Graham (2003) found that increased life expectancy is generally associated with higher savings rates. Bloom and colleagues also challenge the notion of 'old age dependency', suggesting that there is evidence of substantial government transfers to both younger and older age-groups in most developed economies. While Lee (2000) provides evidence that the net pattern of transfers is towards the older generations in most developed economies, there is also evidence that at the household level in many countries, Ireland included, older people make significant transfers to their adult children. (Lee 2000; TILDA 2011)

Finally it is important to acknowledge that there are a range of behavioural and policy responses that could significantly

alter the impact of population ageing. For example investment in improving the health throughout the life course could impact on the health of future generations. This would reduce the burden on health care and social welfare systems and enable people to work for longer by compressing morbidity into fewer years late in life. Promoting higher levels of savings for retirement, alternate pension funding plans, and (possibly) increased migration can contribute to a lessening of the impact. (Bloom, Canning and Fink 2010). As Lee and Mason have argued "*Population aging will certainly challenge public and private budgets in many ways, but through a combination of reduced consumption, postponed retirement, increased asset holdings, and greater investment in human capital, it should be possible to meet this challenge without catastrophic consequences*". (Lee and Mason 2011 p. 6)

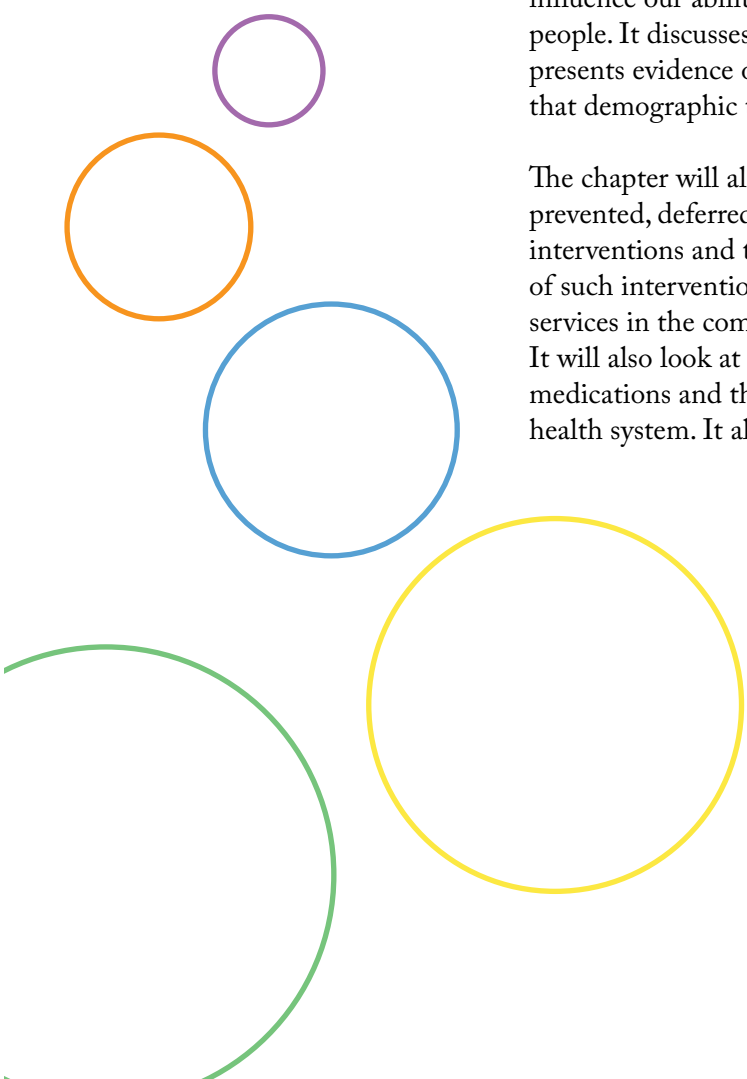
Chapter 2.

Health

Health is a key determinant of quality of life and well-being for older people, impacting significantly the extent to which they can enjoy life and participate in the economic, social and cultural life of their community. An ever-increasing body of gerontological knowledge and science, both Irish and international, can now shape our deliberations on health and ageing, and it is important that strategy and policy are informed by this evidence base as far as possible.

A new approach to health promotion, disease prevention, and the planning and delivery of services will become increasingly necessary in response to societal changes such as increases in longevity, chronic health conditions and levels of disability. This chapter will examine the factors and trends that will influence our ability to develop and deliver a quality health service to older people. It discusses the importance of planning for an ageing population and presents evidence on the prevalence of chronic conditions and the impact that demographic trends will have on healthcare service delivery.

The chapter will also consider the evidence for conditions that can be prevented, deferred or modified. It will examine the effectiveness of interventions and the issues associated with determining cost effectiveness of such interventions. It discusses issues relating to the delivery of health services in the community but also in hospital and long-term care settings. It will also look at issues associated with poor management of prescribed medications and the role that assistive technology can play in reforming the health system. It also addresses end-of-life and disability health issues.



2.1. PLANNING FOR AN AGEING POPULATION

As discussed earlier Ireland is to undergo significant demographic changes which will have implications on the demand for and delivery of services in the health sector. At present:

- The Healthy Ageing Research Project (HARP) estimated that one in ten older people living in the community were in very poor health with the remaining 90% living independent relatively healthy lifestyles (McGee et al, 2005).
- Over one half of people aged over 65 currently report having a chronic illness, (CSO 2007) and this percentage tends to increase with age (Naughton et al: 2009);
- There are 149,000 carers in Ireland, (according to Census 2006) 97,500 of whom care for an older person and approximately one third of all carers are older people.
- Approximately 89,000 older people currently require care in the community (Fahey and Murray, 2003), with 31,000 of them requiring high or continuous care and 13,000 estimated to be in the very high dependency category (O'Shea, 2008).

2.1.1 Health and Chronic Disease Trends

Population ageing will have important implications for the provision of health services in the future. At present, the level of self-rated health in Ireland for older people is quite good. The longitudinal study on Ageing (TILDA) found that 75% of older adults rate their health as excellent (14%), very good (28%) or good (33%) and 25% rate their health as fair (19%) or poor (6%). (TILDA 2011) It is substantially higher than in other European countries (those who state that they are in good or very good health)

and ranks second behind Switzerland. (Eurostat 2007). This holds true for most age groups up to the 85+ age group, which at 53.9% is fourth behind Denmark, Norway and Switzerland.

A steady upward trend has been observed in the number of healthy life years at age 65 for men and women in Ireland. In 2009 it stood at 10.5 years for women and 9.1 years for men which is almost equal to the EU average for men and slightly above the EU average for women (Eurostat 2008). The percentage of life expectancy without disability in Ireland is 82.4% for men and 79% for women, both of which are above the EU average of 79.7% and 75.2%(Eurostat 2009).

While recent trends indicate that disability has fallen in the past decade (McGee et al 2005) the prevalence of diseases among older people has generally increased over time, perhaps because of improved medical knowledge and better screening for health risks leading to increased diagnoses.

For instance diseases which are initially silent, such as type 2 diabetes, hypertension, and some cancers, are now diagnosed earlier and receive better treatment than in the past. This progress leads to a longer period of morbidity, but with an improved functional status (Christensen et al 2009). However some diseases such as dementia which are initially 'silent' have still not moved forward in terms of diagnosis, early diagnosis and access to treatment.

A rise in prevalence of chronic diseases, including heart disease, arthritis, congestive heart failure and diabetes, was recorded in older people during the past two decades in the US and in many OECD countries (Crimmins et al 2005; Lafortune et al 2007).

Total cancer incidence has also been rising, mainly because of population ageing, but also because of increases in the rate of occurrence of some cancers, such as prostate cancer, lung cancer, breast cancer, and colorectal cancer

and melanoma. However survival rates for cancer have generally increased due to reduced exposure to carcinogens such as tobacco smoke, earlier diagnosis, and better treatment (Karim-Kos et al 2008).

Notable differences in obesity rates have been observed in recent decades in all OECD countries. A survey carried out by the National Adult Nutrition Survey in Ireland (2011) found that , the obesity rate for men in 1990 was just over 8 percent but reached 26 percent in 2010 while obesity rates among women also increased from 13 percent to 21 percent.

Considerable variation exists throughout the world from a low of 3.4% and 3.5% in Japan and Korea respectively, to a high of 34.3% in the United States in 2007. The rise in obesity is likely to have implications for future increases in the level of related diseases (such as diabetes and asthma) disability levels and consequently for health spending (Christensen et al 2009).

Data for stroke incidence is mixed, results of four studies showed increasing stroke incidence from the 1970s to the 1980s, five showed decreasing incidence from the late 1970s to the 1990s, and eight showed no change. (Paul et al 2007) Conflicting evidence also exists for rates of hypertension and trends in cognitive impairment and dementia.

Since the 1980s research on the extent to which increases in longevity have resulted in an increase in the age at which disability or infirmity occurs has led to the development of the 'compression of morbidity hypothesis. This hypothesis suggests that if the age of onset of disease or disability can be postponed, then the burden of lifetime illness may be compressed into a shorter period before the time of death or in other words that the increase in longevity would result in an increase in the number of healthy years. (Fries 1980)

In a revisiting of his compression of morbidity hypothesis, Fries argued that greater levels of

consensus had emerged over the intervening years. He suggested that compression of morbidity is clearly not inevitable, citing the experience of many Eastern European countries as evidence. Similarly, he argued that most observers agree that average life expectancy from birth, and even from age 65, is expected to continue to increase for many years to come and that research had shown that compression of morbidity can occur in specific settings and under specific circumstances. (Fries 2011)

Longitudinal studies in the US over the past two decades or more have confirmed that there has been an increase in the age at which disability occurs as well as a decline in the level of disability. Subsequent research found evidence that lifestyle and behaviour is linked to the level of disability and specifically that persons with fewer behavioural health risks have only one quarter the disability of those who have more risk factors, and the onset of disability is postponed from 7 to 12 years, far more than any increases in longevity (Fries 2003). A study carried out by Oxford University of 2m pension records, including 500,000 deaths, drew similar conclusions when it revealed that healthy lifestyles contributed as much to extending lives as did high income

Research into the link between chronic conditions and change in disability trends has found a general increase in many chronic conditions but a decline in their link with disability. However while reductions in the level of disability have been reported in many countries the trend is not clear cut. For example an OECD study of 12 countries found clear evidence of a decline in disability among older people in five of the twelve countries (Denmark, Finland, Italy, Netherlands, US). Three countries (Belgium, Japan, Sweden) reported an increase in the level of severe disability, and in two countries (Australia, Canada) the prevalence remained stable. No clear trends could be established in the two

remaining countries (France, the UK) (Rechel et al 2008).

2.1.2 Costs and Service Delivery

For many years concerns have been expressed that – given that sickness and ill health increase with age – the increase in longevity throughout the developed world would lead to unsustainable costs and pressure on health services. It is important however to acknowledge that older people will have contributed to health care through taxes and private health insurance throughout their lives, when they will have been less likely to need health care.

Ireland's public expenditure on health in 2011 was just over €14bn, an increase from €8.4 billion in 2002. Spending on health has reduced from a peak of €15.5 in 2009. On a per capita basis Ireland spent a total of €3,781 in 2009 from both public and private sources (€2,836 from public funds and €945 from private sources) (HSE 2012)

According to the OECD the current recession led to a large increase in the proportion of health expenditure as a share of GDP in Ireland. GDP began to fall sharply in the second half of 2008 and in 2009 while health spending continued to increase in 2008 and only came down slightly in 2009. As a result, the percentage of GDP devoted to health increased from 7.7% in 2007, to 8.8% in 2008 and to 9.5% in 2009.

However, despite the frequently expressed concerns about the impact of ageing on health expenditure there is no clear evidence that age is the primary driver of increases. While Japan's proportion of older people, aged over 65, has increased from 6% to 23% over the last 50 years, its healthcare expenditure – on a system that incorporates a large amount of social care and the promotion of healthy lifestyles – has only risen from 3% to 8% of its GDP.

The evidence suggests that in fact the bulk of expenditure for most people is likely to be

required for the last year or two of life. A study of people aged 65 or more in the UK found that people in their last year of life were significantly more expensive to care for than those who survived the duration of the study and that costs were not related to age but were associated with proximity to death (O'Neill et al. 2000). This applies to healthcare expenditure in managing the final year or two of life in illness for ALL age groups.

A study carried out by Seshamani and Gray (2004) confirmed these findings by tracking hospital costs from 1970 to 1999 and concluded that the pressure on public expenditure resulting from an ageing population will be partially offset by the postponement of the costs which are associated with intensive hospital use prior to death (Seshamani & Gray 2004). The ESRI carried out a similar study for Ireland and found that there was no age gradient in health care costs. It also found that the net marginal affect of proximity to death is almost three times as large as the age-related part of costs (Layte 2007).

The OECD suggests that an ageing population is likely to create a strong upward impact on public spending for long-term care. (See Chapter 6 for further detail).

In 2009 the Department of Health and Children (DOHC) published the Report of the Expert Group on Resource Allocation and Financing in the Health Sector. The report argued for the importance of strategic planning and reorganisation of the health services in order to deliver more and better services with the same resources (ESRI 2009 p.XIII). However they failed to specify some of the established gerontological mechanisms (acute geriatric medicine, stroke units, falls services, gerontological nursing etc) which might accomplish this.

The report (2010) argues that...*“the current way in which care is delivered will be unsustainable within any reasonable budget given the nature of*

demographic change.” To deal with this, the report recommends the development of primary, long-stay and social care services and suggests that it will require an increasing share of national resources to be devoted to health care if we are to avoid a severe degradation of service” (ESRI 2009). Again, the importance of age-proofing of services with gerontological skills was not factored in as a further part of the solution.

The importance of transparency, accountability and the efficient use of public funds tends to become particularly acute during an economic downturn. The Expert Group on Resource Allocation identified a number of key issues relating to the allocation of health resources. It highlighted the absence of structures and systems which would facilitate greater integration of decisions and greater alignment between resources and goals. The Group found that many of the HSE’s payment and reimbursement systems create incentives which run contrary to health policies. For example care can be more cost-effectively delivered in the community but health professionals tend to be located in the hospital system and the absence of many services in the community forces people to access these services and professionals through the hospital. The lack of governance or funding systems to support preventative approaches or management of chronic diseases in the community also pushes people toward the more costly hospital system. Similarly the report argues that current funding systems do not incentivise more efficient use of resources and the absence of resources in the community means that length of stay in hospital is often longer than it should be. (ESRI, 2010)

This is not an issue exclusive to older people and throughout the health service there is a need to establish priorities for human and financial resource allocation as between competing areas ie prevention vs. Primary care. In addition, budgets are generally annualised which can have the effect of limiting investment in long-

term programmes at the risk that funding may not be forthcoming to make them sustainable. A wider introduction of multi-annual funding systems could help to facilitate longer term planning to address known current and future health needs.

There is a need for improved focus on the needs of people with disabilities in the planning and design of healthcare services, including the improved integration of older people’s services with disability services to ensure that people with disabilities are not forced to change services as they age. In 2007 the NCAOP published *The Quality of Life of Older People with a Disability in Ireland*. This report, based on extensive consultations with older people, provides strong support for greater integration of public policy in relation to both ageing and disability services.

2.1.3 Gerontological Focus of the Health Service

Irish policy in the area of health care has repeatedly called for the need for specialist medical, psychiatric and nursing care for older people. It has been argued that older people are not obtaining benefits from many advances in clinical gerontology and in disease prevention. The benefit of access to therapies such as occupational and physical therapies has also been long established. Public health plans and policies addressing the specific needs of older persons, and changes in the way that medical advances are delivered to this population are needed, in order to obtain more efficient, financially sustainable systems of health and social care (Cruz-Jentoft et al 2009).

A major expansion has taken place in geriatric medicine and there are now almost sixty geriatrician posts and every acute hospital in Ireland has at least one specialist geriatrician as a permanent member of staff (O’Neill, Twomey, & O’Shea, 2009). While there has been increased support for geriatric

medicine, gerontological nursing and old age psychiatry, services for age-related diseases such as stroke and dementia are still under-funded and lacking gerontological expertise (Horgan, Hickey, McGee, & O'Neill, 2008). With regard to older people suffering from stroke, death rates and levels of disability are among the worst in Europe (Gray et al., 2006), and service provision compares badly to that in Northern Ireland (Crawford, 2009).

Geriatric medicine has been shown to be effective, with a reduction of 25% in death and disability for older people who are admitted to an acute geriatric medicine ward as compared to those admitted to a general medical ward (Ellis, 2004). Geriatricians and old age psychiatrists have taken a strong lead in certain specific conditions, as well as in the overview of care in nursing homes (O'Neill: 2001).

Assessment is an important component of ensuring effective care delivery and is particularly important when admission to a care home is being considered. A UK study looked at the value of employing a specialist clinician for the assessment of older people prior to entry to a care home. It found that those who had received the clinical assessment discovered conditions previously unknown to care managers particularly in respect of cognitive impairment. Those who received the clinical assessment also experienced less deterioration in their physical functioning, had less contact with nursing homes and emergency services and their carers experienced reduced levels of distress (Challis et al 2004).

2.1.4 Integrated Care

Ageing tends to be associated with complex and often inter-related health problems. A number of particular characteristics of illness in later life have been identified including; rapid deterioration of general health if not treated promptly, frequency of multiple diseases;

high incidence of secondary complications and frequent need for rehabilitation (Grimley Evans 2001). As a result providing health care for older people requires the collaboration of a number of different health care professionals.

Inadequate organisation of healthcare systems and the need to provide integrated healthcare have been identified as being among the most important organisational challenge for healthcare systems all over the world. Irish health services and budgets are currently organised by care group, with separate programmes and funding streams for disability services, mental health services and older people's services.

The PA report *Towards an Integrated Health Service or More of the Same?* (2008) found that 40% of patients in acute hospitals were inappropriately in hospital and that in the future an additional 7,104 acute beds on today's requirement would be needed by 2020. It recommended that in the future resources would move from acute to community care. Considering the recommendations contained within the PA report, it is likely that the integrated approach (advised) will necessitate increased capacity in the community. For example, it is estimated that Ireland will require an additional 10,021 long term care beds in 2021.

Arising from this report the HSE proposed that unless alternative arrangements are made the additional need could be addressed by "*reshaping the balance of care away from acute to primary and community care*". The HSE report, *Quality and Fairness: A Health System for You* (2001) made a commitment to a "holistic approach" to planning and the delivery of services, however a division of services by care group remains central to how the HSE is structured to deliver services.

The Health Services Executive through its Transformation Programme is taking steps to position the health services to deliver care to

the increasing number of people in the ageing population in the most efficient and effective way. The commitment to the development of the integrated health system (IHS) to be achieved through the establishment of primary care teams to deliver services in the community that are currently provided in hospitals, will, when implemented, be a major advance.

Integrated care has been the subject of much research over the past decade or so and a number of definitions and models have been put forward based on the view that they offer the potential to improve service, provide quality outcomes, and increased efficiency. Kodner (2000) described it as a set of *“techniques and organisational models designed to create connectivity and collaboration within and between the cure and care sectors at the funding, administrative and/or provider levels”*.

One issue for which health services have often been criticised is the fragmentation of the health sector into ‘programme budgets’ or ‘budgetary silos’. One consequence of this fragmentation into programme budgets is that allocation and re-allocation of resources commonly occurs within, rather than between, budgetary silos. This is particularly so in relation to how health services are structured. Kodner and Spreeuwenberg

(2002) identified a number of additional areas in which barriers to greater integration can occur in; funding, administrative; organisational; service delivery and clinical areas (2002) For example promoting joint working relationships and networking within and between agencies in the health and social care sectors can optimise resources, facilitate overall efficiency, and enhance the capacity for the smooth and uninterrupted provision of necessary care and the development of a shared understanding of patient needs between different healthcare professionals can have a positive impact on the quality of care delivered. In particular ongoing communication and feedback between the patient and the healthcare provider are essential quality ingredients in integrated care. (Kodner and Spreeuwenberg 2002)

A review by the OECD described a range of approaches adopted in different countries such as care and case management, disease management and patient pathways. They identified a number of areas where reform could improve the co-ordination of care; better information transfer and wider use of IT; increased resources going into ambulatory care; new primary care models based on multi-disciplinary teams and better integration of health systems (Hofmarcher et al 2007).

Organisational and budgetary boundaries such as the inflexible use of age eligibility criteria can impede access to health and social care and may inhibit access by people ageing with disabilities (or by older people with disabilities) to the most appropriate services for their needs. Younger people, for example those affected by stroke and early onset dementia, can be denied access to services which they need on the basis of their age. Older people may experience difficulty in achieving referrals to specialist services and are disproportionately affected by long waiting lists for ophthalmology, audiology and physiotherapy services (McGlone, & Fitzgerald, 2005).

“ it is estimated that Ireland will require an additional 10,021 long term care beds in 2021.”

2.1.5 Intellectual Disability

Data from the National Intellectual Disability Database showed that the number of people with intellectual disability over 50 years of age has increased every year since the establishment of the database and increased by 11% between 2003 and 2007. The HRB predicts that this trend will continue in the coming years (HRB, 2009).

Some age-related health conditions report a similar trajectory with respect to those with and without intellectual disabilities, such as hypertension, diabetes or osteoarthritis. Other conditions, such as neurological anomalies, mobility impairment, poor dentition, epilepsy, and sensory impairment have been reported to occur more frequently among older people with intellectual disabilities (Van Schrojenstein et al 1997). Furthermore, conditions with differing trajectories have also been noted, such as dementia or sensory impairment, which occur at earlier onset among those with intellectual disability. The trajectory of Alzheimer's dementia among those with Down syndrome, for example, and the high prevalence of additional medical conditions occurring within this population, has received considerable attention within the literature (McCarron et al 2005).

In developing policies to support people with intellectual disabilities - including those policy initiatives underway - account should be taken of the fact that the population of adults with ID in Ireland is ageing and this will mean that planning for residential and health services will be needed to support more people. At present, significant work is needed to equip older people's services or our ID services to perform this role.

A lifespan approach to ageing is advocated whereby the impact of interventions throughout childhood and early adulthood is considered within the context of healthy ageing. An example is the association between long term use of neuroleptics or anti-epilepsy medication,

which are commonly prescribed among those with intellectual disabilities, and higher risk of developing movement disorders and bone demineralisation in later life (Evenhuis et al 2000). A lifespan approach would highlight the potential impact of such interventions on later life.

2.1.6 Assistive Technology and Health

There is increasing recognition that new technologies will have to play an important role in reforming health systems and addressing the need for more prevention and self-care. Assistive technology (AT) has been defined as 'any device or system that allows an individual to *perform a task that they would otherwise be unable to do, or increases the ease and safety with which the task can be performed*' (Cowan and Turner-Smith 1999). While assistive technology is dealt with comprehensively in Chapter 6, it is also relevant from a health care perspective, since developments in technology can offer new ways of supporting people with a disability or chronic illness, facilitating them to continue living independently at home.

Technology can play a major role in the three main areas of care for older people; hospitals; primary care and care in the home. However the HSE only invests less than 1% of its budget in assistive technologies and there is an increasing recognition that this will have to change.

Assistive technology can help to prevent accidents such as falls among older people, and advanced monitoring devices and communication technologies can be used in a preventative way. From a health perspective there are a number of types of assistive technology, with different functions:

- Supportive technologies help people perform tasks they find difficult – for example, video entry systems, and medication reminder units.

- Monitoring health – new developments allow for people to monitor their own health through blood tests, blood pressure monitoring etc. They can then send the results down the line to the appropriate medical professional.
- Detection and reaction (responsive) technologies help people manage risks and raise alarms – for example, gas detectors and panic buttons or pendants.
- Prediction and intervention (preventive) technologies help prevent dangerous situations and can themselves raise alarms – examples are falls predictors, monitors for physiological symptoms, and room occupancy monitors.
- Support in rehabilitation following stroke or support in facilitating independent living in people with a disability or with dementia.

Issues Arising

Medium and longer term health system planning:

The health system as currently designed will not be able to cope effectively and safely with the forecasted doubling of the older population and the significant growth in the number of 'older old' over the next few decades. Yet there is no medium or long-term plan in place to introduce the fundamental changes needed to meet their health needs. The ESRI, basing its estimates on population trends and disability projections, forecast a need for an additional 13,324 long-term care places from 2006 to 2021, or 888 each year from 2007 to 2021, for people of 65 and over.

Growth in age related health problems:

Whilst there is some uncertainty about the extent to which increased longevity will be matched by an increased number of healthy and active years, there is clear evidence that there will be an increase in some specific chronic health conditions and problems as people live longer. This will be the case in relation to dementia,

arthritis, diabetes, sensory impairments, injuries from falls, and congestive heart conditions, while numbers with other conditions, such as stroke, may fall (Crimmins et al 2005; Lafortune et al 2007). Again, there are no long-term plans to prioritise and address these specific problems and put in place the best pathways from diagnosis to treatment and care.

Need for more skills and training: The projected growth in the number of older people will require greater investment in training and development of specialists, and in ensuring that health care staff have the skills and awareness necessary to address the specific health and communication needs of older patients.

Assessment: There is a need for the development of a standardised needs assessment which can be used in community, hospital and nursing home settings.

Expansion of Geriatric medicine: Geriatric medicine has been shown to be effective, with a 25% reduction in death and disability for older people admitted to an acute geriatric medicine ward, compared to those admitted to a general medical ward (Ellis, 2004). The expansion in geriatrician numbers will allow the development of sub-specialisation in areas such as continence disorders, falls, fractures and bone health (ortho-geriatrics), heart failure, mental health/dementia care and stroke care alongside generalist expertise.

Investment in Technologies: Making high quality and reliable health services available to older people in hospitals, community care settings and at home will require much greater investment in technologies providing remote monitoring and diagnostics and self-care. The HSE's current investment in new technologies is less than 1% of total budget and to date there has been only limited use made of available tele-health and tele-care technologies.

The use of such technologies will also require the redesign of key processes such as hospital

discharges and communication between primary care providers.

Disability: Ageing and disability services are not sufficiently co-ordinated to ensure the needs of people with lifelong or early onset disabilities are adequately addressed as they age.

2.2 HEALTH PROMOTION AND PREVENTATIVE SERVICES

Many chronic conditions can be prevented, deferred or mitigated through good health promotion, screening and preventative measures.

However the OECD estimates that only 3% of healthcare expenditure in Ireland is spent on prevention and public health programmes. (HSE 2010) In the future, it will become increasingly important to find ways in which health promotion and prevention of disease can reduce overall costs while increasing health and wellbeing.

Over the past few decades public health research has provided new insights into the kinds of interventions or behaviour change that will result in prevention, deferral or modification of health problems in later life.

However there is still a need to gain a clear understanding of the determinants of health, particularly those what works in relation to reducing disability or increasing the number of “disability free years of life” (Payne et al 1997).

2.2.1 Promoting Healthy Ageing

Education about what makes a healthy lifestyle, along with adequate screening – including self-checking for key symptoms (of age-specific conditions) by older people themselves – assessment and treatment for acute and chronic diseases, are important components of an effective health promotion strategy. Many common conditions although

not life-threatening, if left untreated can lead to disability and can negatively impact on older people’s quality of life.

Preventative services are playing an increasing part in primary care for older people, as it is recognised that such services along with rehabilitative care can help to avoid costly and inappropriate forms of institutional care. There has been a welcome increase in services such as influenza immunization (O’Hanlon, 2005) and other preventative interventions among older people such as cancer screening or support for giving up smoking (Fitzpatrick, 2004).

Prevention of conditions that are prevalent in later life could be seen as having three stages;

- Primary prevention, which could take place from teenage years throughout the lifecourse and would focus on improving nutrition exercise, immunisation, prevention of accidents and education about the risks of smoking.
- Secondary prevention, which treats known risk factors such as blood pressure, cholesterol and low bone mass and can be most relevant to people aged 40 to 50 and finally
- Tertiary prevention occurs when the disease is present, such as rehabilitation from stroke etc (Jonsson 2004).

Much preventative health care is carried out by GPs, and multi-disciplinary teams for older people have been established in some regions, enabling older people to be assessed by a team consisting of a GP, nurses, physiotherapist, occupational therapist and social worker. It would be important that the PCTs also incorporate gerontological expertise through the involvement of Geriatricians or specialist staff with gerontological expertise. It is not clear, however, whether all Primary Care Teams specifically recognize both the special needs of care in later life (as recommended by the UN Madrid Declaration), or that older people have

the greatest needs proportionately by age group in the population.

Peel and colleagues (2005) confirmed that the aspects of healthy ageing which are determined by behaviour include; non-smoking, being physically active, maintaining weight within moderate ranges and consuming alcohol in moderation (Peel et al 2005). Research carried out in the US which studied a group of well educated, relatively affluent people with good access to medical services (to remove the possibility of socioeconomic factors influencing the outcome) found that the effects of good health habits on subsequent disability were extremely strong. Their results showed that the cumulative lifetime disability for those who were obese, smoked and did not exercise was four times as great as in those who were lean, exercised, and did not smoke (Fries 2003).

There is considerable evidence supporting the benefits of physical exercise in maintaining virtually all aspects of health and physical functioning as people age; it increases strength and is associated with lower incidence of cardiovascular disease, osteoporosis and bone loss, and certain forms of cancer. It can reduce the risk of falls, lower blood pressure among those suffering from hypertension, and reduce the risk of stroke and of insulin sensitivity. Exercise may also reduce the risk of depression and may decrease the chances of developing dementia, although it is difficult to isolate exercise from other factors that are often associated with other health-ageing policies such as social networks (Callaghan 2004). In fact exercise has been described as the, “*best preventive medicine for old age*”, significantly reducing the risk of dependency in old age (SNIPH, 2007).

However there is evidence from the UK to suggest that older people are not exercising enough. One study found that physical activity declined rapidly at around the age of 55 and a third of people over 55 do not exercise at all

compared with 10% of people aged 33-54. In practice, only relatively few people are doing enough physical exercise to maintain their health whatever the age (Allied Dunbar Health Education Authority, Sports Council, 1992.)

Cruz-Jentoft (2009) has identified a number of areas in which knowledge about health risk could be translated into action and used to promote healthy ageing. They include the following;

- Falls are more common in older people with poor balance; decreased strength and mobility are important risk factors. Falls are not an inevitable consequence of ageing; there is good evidence that progressive balance and strength interventions reduce risk of falls amongst older people
- Maintaining social network and activities is also critical to adapt successfully to ageing health challenges
- Injuries are an important cause of morbidity, disability and mortality among older people, impacting the quality of life and representing an increasingly large proportion of the health expenditure. Despite the fact that almost half of the injuries are now foreseeable and preventable; efforts to reduce the injury toll in this age group have so far been limited, inconsistent, and dispersed across different settings
- Mental stimulation using cognitively challenging activities can be a means to improve neural plasticity, which can maintain or improve cognitive functioning

Success of Health promotion initiatives

Non-compliance with health promotion guidelines and advice can limit the effectiveness of these interventions. The perception of health-risk has been found to be linked to a person's likelihood to respond

to health messages, in other words a person who underestimates their personal risk for a particular disease or condition is less likely to be motivated to change their behaviour or comply with prevention advice (Rosenstock et al 2008). There is evidence that it is difficult to change the behaviour patterns of older people (Oxley 2009) and that the characteristics of successful programmes tended to be those that required minimal change to normal routines but involved frequent professional contact (Hillsdon et al., 1995).

The most predominant health-related activity used in health promotion is the provision of health information. However research suggests that there is no direct link between provision of information and change in health behaviour (Wilkinson 1999). In order to promote behavioural change there is usually a need for a shift from normal patterns of behaviour and it is therefore important to have an understanding of the mechanisms that lead to change when designing a health promotion intervention. For example many people will be aware of the factors that contribute to a healthy life and may have already responded to the health messages that they can easily comply with and therefore discard any that require significant change (Preston 1997).

There are a variety of different theories in the field of social psychology which seek to explain the processes by which health knowledge, attitudes, beliefs and values are linked to behaviour change and in particular to seek to explain why provision of information has not resulted in behavioural change. Many of these theories identify factors such as social norms, cost-benefit analysis, perception of effectiveness/value of interventions and perception of risk and severity of disease, as being important predictors of the behavioural change (Pitts & Phillips 1998). The different theories point the way to more sophisticated approaches that are based on a greater understanding of the

mechanisms behind behaviour change. People generally base their decisions to respond to or ignore health messages on a choice of valuing some aspects of their life above that of their health (Dines 1994).

2.2.2 Health Screening

As discussed above chronic diseases (eg, heart disease, cancer, stroke, and diabetes) are the leading causes of death in most developed countries. Controlling health risk behaviours (eg, smoking, physical inactivity, poor diet, and excessive drinking) and using preventive health-care services (eg, cancer, hypertension, and cholesterol screenings) can reduce morbidity and mortality from chronic diseases (Chowdhury et al 2010).

Monitoring of health-risk behaviours and chronic health conditions are essential to the development of health promotion activities, intervention programmes, and health policies. In the UK population screening for all people over 75 years of age was dispensed with after it was found that it resulted in little or no improvements to quality of life or health outcomes. (Fletcher et al 2004) However there is considerable evidence that focussed needs assessment of older people at the point of contact with services (also known as opportunistic screening) followed by active management by the appropriate medical professionals may improve survival and function (Stuck et al 2004). Findings show it is more important to detect the specific risk factors for health problems that are likely to lead to a reduced quality of life through functional impairment (such as fear of using the bus due to mobility problems) or specific medical problems (fear of leaving the house because of incontinence).

A number of health risk appraisal (HRA) instruments have been developed worldwide and trialled for use with older people. These generally seek to identify risk factors for functional decline or impairment rather than

simply risk factors for mortality (Stuck et al 2007). One example is the 'STEP' tool which was developed between seven European countries and provides for an assessment of 33 possible health problems and evaluates risk factors for health status decline. STEP has been tested in community practice settings in a number of countries (Eichler et al 2007). Another promising approach is the MDS-inter RAI suite of instruments which allows for needs assessment in the community, hospital, and nursing home (see below).

In the UK the Health Risk Appraisal for Older people (HRA-O) system is the most extensively evaluated approach for promoting health and well-being in later life. A self-completion, multidimensional postal questionnaire collects information on health, functional status, health behaviours, preventive care and psychosocial factors. Based on a computer expert system's analysis of questionnaire responses, it profiles individuals' health and lifestyle and gives tailored advice in the form of a printed report on maximising health, lifestyle changes and preventive care and suggests useful local sources of help.

It is widely recognized that the complex care needs of older people are routinely under-detected in the community, hospitals, and nursing homes. Evidence suggests that a twin track approach to this problem is likely to be most successful. In the first instance, training in gerontology for all grades and professions involved in the care of older people will help to develop knowledge, skills and attitudes which will give due recognition and priority to these needs. The second is a systematic and routine assessment of the likely needs of vulnerable older people, which would provide a common language of assessment and treatment. The selection of needs assessment instruments which are used internationally would allow for the benchmarking of quality of care, service developments and the degree to which services

are 'older-friendly'. These assessments could also support the imperative of obtaining high-quality, comparable data for research (Falconer, O'Neill 2007).

Ideally, such an instrument should have a common core of items which can be used in the (multiple) transitions between home, hospital and nursing home. This has been recognized by the HSE and the DoHC in their acceptance of the Minimum Data Set as a part of the recommendations of the Leas Cross report. Ireland is trailing behind North America and the rest of Europe, where for over twenty years determined efforts have been made to validate assessment processes for older people that are relevant, concise and valid. Two main schools have arisen: the RAI/Minimum Data Set family (www.interrai.org) and the European Easycare project (www.shef.ac.uk/sisa/easycare/).

There are differing views in Ireland on the most appropriate instrument but the RAI/MDS set has the longest pedigree, and there is vast experience with this instrument and it has been widely researched and evaluated, largely arising out of the mandatory requirement in the USA that all nursing home residents have the instrument administered on admission and quarterly thereafter.

Federal law in the USA includes the requirement to electronically encode and transmit all MDSs to the State in which each facility is licensed: the equivalent in Ireland would be the HSE. The Minimum Data Set is a standardized assessment instrument which when used with the Resident Assessment Protocols and professional judgment, is a comprehensive assessment and care planning tool.

The MDS collects assessment information on each resident's characteristics, activities of daily living (ADLs), medical needs, mental status, therapy use, and other things involved in comprehensive planning for resident care.

Significant change in a resident's condition causes a new comprehensive MDS (including review of the care plan) to be completed to ensure the resident receives

"Towards 2016", the current social partnership agreement, (agreed in 2006 and revised in 2008/9) identified the need to develop a single assessment tool or suite of tools to be utilised for the care needs assessment of older people nationally. Given the lack of a national ICT system and the differing views amongst health and social professionals regarding a robust Single Assessment Tool, it was agreed with the Minister for Health & Children to implement the CSAR, (CSAR is a summary report and is not an assessment tool), to meet the immediate legislative requirements under the Nursing Homes Support Scheme. A commitment was given by the HSE thereafter to develop a Single Assessment Tool. A working group, chaired by Prof. Brendan McCormack, was established in 2010 and the tool is being piloted in a number of different settings since the end of 2011.

2.2.3 Cost Effectiveness of Health Promotion and Prevention

The OECD has argued that healthy ageing policies can involve costs that, in the early stages, may exceed the potential savings (Oxley 2009). They also assert that not all preventative measures result in health improvements and that health prevention needs to be examined on a case by case basis. For example, they suggest that early detection of cancers, particularly in the early stages prior to the onset of symptoms when followed by appropriate treatment, does prevent or significantly reduce morbidity and mortality. They argue that breast cancer screening with mammography every two years for women aged 40 to 60 is very cost-effective. Other screening programmes such as one-time colonoscopy screening at age 50 or colonoscopy every ten years also appears to be very cost-effective ways of improving population health

(Ginsberg et al., 2004), though they are rarely fully applied.

While the evidence for the cost-effectiveness of health promotion approaches has not been fully developed, some research has been carried out in the US which found that improvements in prevention and treatment of the 7 most common chronic diseases (cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions, and mental disorders) could prevent 40 million cases of these diseases by 2023 and reduce their economic impact by 27% annually. This was based on an assumed "*reasonable improvement in health-related behaviour and treatment*," including weight control combined with improved nutrition, exercise, further reductions in smoking, and more aggressive early detection of disease (DeVol et al 2007). However it is important to bear in mind that disease prevention strategies are difficult to put into practice and that adherence to advice can be difficult to achieve.

Many health experts argue that the key question is not how much money disease prevention saves, but rather how much value it provides and holding preventive services to the standard of saving money may be an unfair assessment. It has been argued that medical treatments do not generally save money, and it is rarely suggested that a new medical device or drug should be purchased because it saves money (Wilson 2009). The questions to consider are whether the benefits to older people, for example in terms of better health and better quality of life, outweigh the net costs for individual programmes or whether short term costs of a screening programme for example can reduce costs over the long term. (OECD 2009)

Issues Arising

Planning for better health outcomes: To date there has been insufficient investment in Ireland on the prevention, delay or mitigation of key

chronic health conditions. According to the WHO, 'a small shift in the average population levels of several risk factors can lead to a large reduction in the burden of chronic disease' (WHO, 2005), yet the OECD estimates that only 3% of healthcare expenditure in Ireland is spent on prevention and public health programmes (DOHC 2008). There is also evidence that, unless there is a significant change to more healthy and active living on the part of the whole population, there will be a significant increase in life-style-related conditions such as obesity and diabetes.

Focus on better health outcomes: Research carried out in the US found that improvements in prevention and treatment of the seven most common chronic diseases could prevent 40 million cases of these diseases by 2023, and reduce their economic impact by 27% annually (DeVol et al. 2007). However, Irish health services in general are focused on treating conditions once they have arisen, and the current funding of primary care does not reward GPs and other health professionals for achieving better overall health outcomes for their older patients.

Screening: There is considerable evidence that focussed needs assessment of older people at the point of contact with services (also known as 'opportunistic screening'), followed by active management by the appropriate medical professionals can improve survival and function (Stuck et al. 2004). Currently there is very limited investment in early detection, despite the evidence that many health conditions of older age can be treated more effectively and cost-efficiently when detected earlier.

2.3 NON-COMMUNICABLE DISEASES OF OLDER PEOPLE

Although many older people live healthy and active lives, as they grow older they become

vulnerable to a more diverse set of health issues, and so the care they require is marked by increasing complexity. The particular characteristics of illness in older people are that several diseases may co-exist, interact and manifest in non-specific and atypical ways, social and psychological problems may be prominent, functional handicap occurs, and recovery may take longer than among younger people (Kafetz et al 1995). There is an increasing need for specialist geriatricians and specialist nurses who are able to respond to the specific characteristics of ill health among older people in order to ensure the efficient delivery of the appropriate health services.

Chronic diseases are common in older people, and large increases in their prevalence are expected in the future. It has been estimated that by 2030, 89% of all diseases will be chronic conditions (as opposed to communicable or other diseases) in high-income countries. (National Institute on Ageing, 2007).

The health conditions most associated with later life include; Dementia, Stroke; Falls; Arthritis, Hypertension; Cancer; Diabetes; Heart Disease; Osteoporosis; and Obesity. A study carried out in Trinity College Dublin on multimorbidity and disability among older people, studied eight chronic conditions: cancer; heart attack; angina; stroke; diabetes; asthma; chronic obstructive pulmonary disease (COPD) and musculoskeletal pain (including rheumatism, arthritis and back pain).

The research found that musculoskeletal pain was the most widely reported condition across the island with a prevalence of 40%, followed by diabetes (7%) and angina (6%). Asthma and COPD have the same levels of prevalence, 5%, while cancer and stroke were reported less frequently (1-2%).

The study also revealed some clear differences in the prevalence of chronic diseases between ROI and NI. Angina was reported far more frequently in NI, 10% compared to 4% in

ROI. So too was musculoskeletal pain, 55% compared to 35% in ROI while asthma was reported more frequently in ROI, 6% compared to 3% in NI.

Much has been written in other publications about each of these conditions. However this section cannot deal with each of these conditions, instead it examines some of the common age-related health problems that impact on large numbers of older people and their families. It also discusses other issues particularly relevant to older people such as polypharmacy and mental health. It looks at prevalence and future trends for the disease or condition as well as risk factors and interventions that may help to delay mitigate or even eliminate the problems experienced.

2.3.1. Dementia

Dementia is an umbrella term used to describe various conditions characterised by progressive and, in the majority of cases, irreversible decline in mental functioning. The loss of cognitive abilities resulting from damage to the neurons in certain areas of the brain is often accompanied by deterioration in emotional control, social behaviour and motivation (O'Shea 2007). According to the WHO, dementia includes: 1) Alzheimer's disease (the most common cause); 2) vascular disease; 3) frontal lobe dementia; and 4) Lewy Body disease, among others.

Symptoms of dementia can include memory loss, difficulties with language, judgement and insight, failure to recognize people, disorientation, mood changes, hallucinations, delusions, and the gradual loss of the ability to perform all tasks of daily living (Mathers and Leonard 2000).

Prevalence

Estimates based on the 2006 census data indicate that there are almost 38,000 people with dementia in Ireland, of whom 4,500 are

under 65, and 20,000 are over 80. It is estimated that this number will rise by over 160% to 104,000 by 2036 (O'Shea, 2007). According to the Alzheimer Society of Ireland this will represent approximately one in 20 people over 60, and one in five over 85, with more women than men affected by the disease.

Dementia affects the lives of individuals diagnosed as well as the experiences and feelings of family members and health service professionals who work in the area. If we assume that each person's experience of dementia will impact on 4 close family members, then it is estimated that approximately 160,000 people in Ireland are currently affected by dementia. With population ageing, these figures are set to more than double within the next twenty five years.

In the United States, Alzheimer's disease (AD) is the leading type of dementia and was the fifth and eighth leading cause of death in women and men aged over 65 years, in 2003. Internationally, according to the Global Burden of Disease (GBD) report, dementia is a leading cause of disability among older people, second only to blindness. In 2006 the worldwide prevalence of Alzheimer's disease was 26.6 million. By 2050, its prevalence is expected to quadruple by which time 1 in 85 persons worldwide will be living with the disease. Brookmeyer (2007) estimates that about 43% of cases need a high level of care equivalent to that of a nursing home and suggest that if interventions could delay both disease onset and progression by one year, there would be nearly 9.2 million fewer cases of disease in 2050 with nearly all the decline attributable to decreases in persons needing high level of care.

The prevalence rate for dementia among people with a learning disability (with causes other than Down syndrome) is higher than the rate found in the general population but not as high as for those with Down syndrome. The table below sets out the dementia prevalence rates at various ages for the general population,

Table 2. Dementia Prevalence Rates

General Population		People with Intellectual Disability		People with Downs Syndrome	
Age Cohort	Percentage	Age Cohort	Percentage	Age Cohort	Percentage
60-64	1.0	Over 50	13	30-39	2
65-69	1.4	Over 65	22	40-49	19.4
70-74	4.1			50-59	19.4
75-79	5.7			60-99	19.4
80-84	1.4				

Source: Kerr, D (2007) Understanding Learning Disability and Dementia

those with an intellectual disability and those with Down syndrome.

The increased prevalence of will have major repercussions on the quality of life for people with dementia as well as their carers. Over three quarters live at home and their families are thought to bear most of the financial burden for their care (O'Shea, 2007). Half of those with dementia are over 80 years of age, suggesting that most family members (both spouses and children) are also advancing in age. The changing demographic landscape expected in the next 20 years will have a significant economic and human impact on the cost of caring for people with dementia.

Screening and Diagnosis

There is a public and professional misperception that dementia is a normal part of ageing. According to the Alzheimer Society report (O Shea 2007) most people with dementia, whether they are living at home or in long-stay facilities have never been formally diagnosed and, for the most part, are not known to the health and social care services.

The World Alzheimer Report 2011 revealed that there are interventions that are effective in the early stages of dementia, some of which may be more effective when started earlier, and that there is a strong economic argument in favour of earlier diagnosis and timely intervention. By receiving a diagnosis people can get access to available drug and non-drug therapies that may improve their cognition and enhance their quality of life and that of their carers. Research from the US, found that early diagnosis of dementia followed by information and support can reduce outpatient costs by almost 30 percent. However O Shea points out that while early diagnosis is critical for the development of an optimal care plan, the reality is that early diagnosis, and sometimes even late diagnosis, is the exception rather than the rule.

Many general practitioners experience difficulties in diagnosing dementia, in communicating this 'bad news' to patients and their family members, and in differentiating normal ageing effects from the signs and symptoms of dementia (Cahill et al, 2006). In an Irish study published in 2008, GPs were more likely to blame themselves than to blame

the health care system, their patients or family members for the late presentation of dementia in primary care. The survey also found that stigma was a major obstacle preventing GPs from being more proactive in this area (Cahill and Clarke, 2008).

Rural GPs felt geographically disadvantaged when seeking to access diagnostic services and both rural and urban GPs experienced considerable time delays accessing specialist diagnostic services (Cahill et al, 2008). Also 'there may well be a reluctance to label someone with dementia because of the negative attitudes and stigma sometimes associated with the disease within families and communities' (NESF 2005:87). A majority of GPs taking part in a national survey reported they would welcome up-to-date dementia care training (Cahill et al, 2006).

In the UK, the National Dementia Strategy has identified the need to improve general practitioners' diagnostic and management skills in dementia. There are a range of cognitive tests that can help GPs when screening for dementia in the 'at risk' older population however many doctors rated them as only 'Good' in terms of perceived effectiveness. The authors concluded that there was a need for the development of a reliable and accurate screening tool to be used in the primary care setting (Iracleous et al 2009).

Dementia Care

The stated public policy objective in Ireland in relation to people with dementia is to encourage and facilitate their continued living at home for as long as is possible and practicable, (as stated in The Years Ahead: Report of the Working Party on Services for the Elderly, 1988). However reliance on home-based care given by family members is only viable if appropriate services and support are developed. There are currently no defined care pathways for people with dementia. Services are often inadequate, inconsistent and

poorly co-ordinated throughout the country (DSIDC 2009).

Where services are provided there are often deficiencies in interventions that would make a real difference in the lives of people with dementia. For example there is growing evidence that creative arts programmes provide many therapeutic benefits as well as adding to the quality of life for people with dementia living in long term care facilities or in the community.

National Policy

Despite public acknowledgment of the need to develop a dementia specific policy, dementia has been slow to move onto the political agenda and Alzheimer's disease and the related dementias are still in Ireland associated with ignorance, stigma, shame and guilt. This means that those affected including family members often keep dementia hidden and may withdraw from social contexts.

The Action Plan for Dementia (O'Shea and O'Reilly 1999), stressed the need for 'a social model, focused on care in the community and developing the "personhood" of the person with dementia'. It made 33 specific recommendations, calling for "*coordinated, multi-layered and well-resourced services responsive to the individual needs of those with dementia and those who care for them*". It also proposed that all care should be delivered within a person-centred framework which focuses on early diagnosis, assessment and care planning, and facilitates inclusive decision-making.

The government's health strategy Quality and Fairness: a Health System for You (2001) accepted the general thrust of the Action Plan for Dementia and made a commitment to its implementation over a seven-year period. Since then progress on implementation has been slow, (O'Shea, 2007). However, specific improvements in recent years are noted, including:

- Enhanced training and educational opportunities for some staff;

- Increased 'at home' respite care provision (but there have been reductions in 'out-of-home' respite care recently);
- Additional specialised dementia units;
- More old age psychiatry consultants.

Internationally, national dementia strategies have been developed in England and Wales and in Norway, France and Australia. National strategies are also currently being developed in Scotland and Northern Ireland. Some third level institutions have developed or are in the process of developing dementia-specific undergraduate and postgraduate courses. Grants (private and public funding) have been made available to research institutes to examine issues relating to biological and psycho-social aspects of dementia as well as technological advances to enhance the quality of life for the person with dementia.

To date however, we have very little information about the impact of dementia in Ireland. Many other areas require significant investigation and analysis including prevalence rates (and related demographic details), needs of people with dementia at all stages of the disease trajectory, the needs of health professionals, best practice models, impact of carer stress, palliative care requirements, special needs of younger people with dementia and people with intellectual disability and dementia etc.

Indeed the conceptual distinction between older peoples' services and dementia services has been a welcome albeit only a recent development in the Irish context, in light of emerging evidence; that current generic services are grossly inadequate, inequitable and often inappropriate for people diagnosed with this illness. Dementia also fails to command suitable budgetary/fiscal resources in Ireland. For example there is currently no ring-fenced budget set aside for dementia. Accordingly, we have no idea what proportion of the Irish health budget or budget for older peoples'

services is spent on Alzheimer's disease and the related dementias.

There has also been public recognition that a Dementia Strategy is needed and a commitment was given by the Government that one would be developed in 2011, as yet the Strategy is still awaited

Issues Arising

Projected increased prevalence:

Estimates based on the 2006 census data indicate that there are almost 38,000 people with dementia in Ireland, of whom 4,500 are under 65, and 20,000 are over 80. It is estimated that this number will by over 160% to a total of 104,000 by 2036 (O'Shea 2007).

It has been estimated that, on average, one person's experience of dementia will impact on four close family members, suggesting that approximately 160,000 people in Ireland are currently affected by dementia. Population ageing means that these figures are likely to be doubled, or more than doubled, within the next 25 years.

Dementia diagnosis: While early diagnosis is critical for the development of an optimal care plan, the reality is that early diagnosis, and sometimes even late diagnosis, is the exception rather than the rule. Many general practitioners report experiencing difficulties in diagnosing dementia, in communicating this 'bad news' to patients and their family members, and in differentiating normal ageing effects from the signs and symptoms of dementia (Cahill et al. 2008).

Poor levels of diagnosis: While early diagnosis is critical for the development of an optimal care plan, the reality is that early diagnosis, and sometimes even late diagnosis, is the exception rather than the rule. Many general report experiencing difficulties in diagnosing dementia, in communicating this 'bad news'

to patients and their family members, and in differentiating normal ageing effects from the signs of and symptoms of dementia (Cahill et al. 2008).

Screening tool; There is a need for the development of a reliable and accurate screening tool to be used in the primary care setting, because the current cognitive tests have been rated by many doctors as only 'good' in terms of perceived effectiveness (Iracleous et al 2009).

Services, supports and funding: Despite some improvements, progress has been slow. Research has shown that there is an insufficient number of specialist nursing home places and major gaps in the level of home help for family members and other carers in the home. There is currently no ring-fenced budget for dementia, so it is impossible to estimate what proportion of the Irish health budget or budget for older peoples' services is spent on Alzheimer's disease and related dementias.

Public awareness: There is very little public knowledge of the trajectories of the illness, of how to seek a diagnosis, and of ways to mobilise health and social care services. Knowledge of patients' attitudes to service provision, including their experience of acute care, community care, residential care, and end-of-life care is also lacking.

Services; The conceptual distinction between older people's services and dementia services is a recent development in the Irish context, as evidence has accumulated that current generic services are inadequate, inequitable and often inappropriate for people diagnosed with this illness. **Policy;** Ireland, unlike other countries does not have any strategy or clearly defined policy for dealing with Dementia

2.3.2. Stroke

According to the Irish National Audit of Stroke Care (INASC) stroke is the third most common cause of death and the most common

cause of acquired major physical disability in Ireland. Stroke prevalence increases with age. More than one in ten adults aged 75 years and over have ever had a stroke.

Worldwide, stroke contributes substantially to the burden of disability for older patients, their carers and the community in general and is the third leading cause of death worldwide (Sarti et al 2000). In many instances strokes are preventable, and when they do occur, early intervention can rescue brain tissue from damage and significantly reduce further damage and residual disability (Horgan et al, 2008).

In Ireland, approximately 10,000 cases of acute stroke on average every year are admitted to hospital, of whom around 2,000 die – more deaths than breast cancer, prostate cancer and bowel cancer combined. It is estimated that over 30,000 people are living with a disability following a stroke. In 2007, a total of almost 59,000 adults in the Republic of Ireland (1.7%) have ever had a stroke. By 2020 this is expected to rise to almost 87,000 (2.1%). This represents a 48% increase – an additional 28,000 adults – in less than 15 years (Balanda et al 2010).

While many survivors of an acute stroke make a complete recovery, for a further 30% their recovery is likely to be incomplete, although they will not necessarily need assistance with their usual daily activities (Cowman et al 2010). This is lower than some international estimates which suggested that following a stroke approximately 51% are disabled in some activity of daily living, and 50% exhibit either cognitive impairment or dementia (Sturm et al 2002; Srikanth et al 2004).

Risk Factors and Knowledge

One way to reduce the number of people experiencing a stroke is through the implementation of good prevention measures at an individual and population level. The individual level approach involves identifying high-risk people and seeking to reduce their risky behaviours. The population approach involves

either mass screening to identify those with risk factors or education campaigns to reduce risky behaviours on a broader level. Screening tools have been developed for use in community settings that identify people with high blood pressure or irregular pulse, both of which could indicate a higher than average risk of stroke.

The importance of knowledge in relation to stroke was highlighted by Irish research (2012) which found that those who suffer a mini-stroke are often at high risk of a second stroke within 90 days, even when treated in line with best practice guidelines. The lead researcher, Professor Peter Kelly warned that *“A mini-stroke usually manifests itself in temporary and transient symptoms like slurred speech, loss of feeling in the limbs or blurred vision. People often ignore the symptoms because they usually disappear quickly, but a mini-stroke is a shot across the bow and should be treated as a medical emergency,”* said Professor Kelly.(www.cardi.ie)

Research internationally has found that the level of knowledge about stroke risk factors and warning signs is low. An Irish study of people aged over 65 years asked respondents to identify stroke risk factors from a provided list (Hickey et al 2009). They found that less than half of the respondents were able to identify established risk factors. Similarly, less than half were able to identify established warning signs (eg, weakness, headache), although slurred speech (54%) was an exception. Overall, the study found that there were considerable gaps in awareness with those with lower levels of education having lowest levels of knowledge about stroke. (Nichol and Thrift 2005).

Research into trends in the level of knowledge revealed that public education campaigns can have some effect but it is still important to target knowledge to subgroups most in need of the information. A study carried out in Michigan found that following public education campaigns which focussed on warning signs, the proportion of respondents

who identified three correct stroke warning signs increased (from 14.3 to 27.6%,) whereas those who could identify three correct risk factors remained almost unchanged (27.9 vs. 29.1%).(Reeves et al 2006).

Interventions and Quality of Care

The Irish National Audit of Stroke Care (INASC) carried out by the Irish Heart Foundation raised serious issues about the level of stroke care in Ireland. They identified only one hospital with a stroke unit in accordance with the recognised international standards. This represents 3 per cent of Irish hospitals in contrast to 91 per cent of hospitals in the United Kingdom which have a stroke unit (Sentinel 2006).

The INASC study considered many aspects of services for stroke patients and concluded that there were substantial deficits in: primary prevention; emergency assessment; investigation and treatment in hospital; discharge planning; rehabilitation and ongoing secondary prevention; and communication with patients and families (Horgan et al 2008).

Performance across a broad range of indicators (of quality in stroke care) was much poorer in Ireland than in the UK. The UK audit system, which has been operating for almost a decade, has resulted in improvements in practice. Therefore the IHF suggested that the Irish audit should be seen as a first step in a cycle of continual planning, intervention for improvement and outcome evaluation (Horgan et al 2008).

The study found that stroke services in the community for persons with stroke were found to be ad hoc and varying greatly from one community area to another. Services were characterised by a lack of coherence, both nationally and regionally. Access to services critical to ongoing rehabilitation post-stroke was weak or non-existent in many areas, and these services were seldom available in nursing home settings.

There are a number of proven therapies for stroke which could help reduce the burden and

the long-term impact of the disease. For one of these therapies, known as 't-PA', patients need to attend hospital within approximately 2 hours of stroke onset but (according to US research) because most patients don't attend hospital in time only about 1%–2% of patients receive this treatment (Birbeck et al 2004). To reduce delays to hospitalization following stroke and to improve risk factor profiles of the population it is important to increase knowledge about stroke and its risk factors.

A study of care of stroke survivors in Irish nursing homes found that 18% of nursing home residents had a diagnosis of stroke. Research evidence suggests that early post-stroke rehabilitation provides best results, including maintaining or improving functioning and quality of life after stroke. This supports earlier findings from research carried out in Denmark and other countries (Ingeman et al 2008).

The Irish study also found that there were no guidelines for stroke rehabilitation in almost all cases (92%) or a formal review process for persons with stroke across the nursing home sector. Many nursing home managers reported that communication with acute hospitals was poor, mainly because hospitals did not send a report and/or care plan when discharging the patient from the hospital to the nursing home (Cowman et al 2010).

The authors recommended a number of changes one of which was the development of the proposed Stroke Liaison Nurse Scheme with a planned 43 liaison nurses across all acute care hospitals by 2011. They also recommended the introduction of the Minimum Data Set, which is used in the US used to provide regular assessment of every resident in State-licensed facilities (as proposed in the HSE report on the Leas Cross Nursing Home, 2006).

The report also found that availability of services of proven efficacy for those admitted to hospital with stroke in Ireland was very

poor and in contrast to the situation in the UK. There was also considerable variation in access to services. In particular, lack of access to acute stroke units, to early CT scanning, and to identifiable local lead physicians with responsibility for developing stroke care should be addressed as a matter of urgency.

2.3.3. Falls

Accidents and falls become more common as people age. However it is the combination of the increase in the number of falls among older people along with their increased susceptibility to injury that makes this an important public health issue. Because of diseases such as osteoporosis and age-related changes, such as slower protective reflexes, older people and older women in particular are more likely to fracture because of osteoporosis and more likely to experience slower recovery after a fall. Decreased sensation in feet arising from diabetes may also increase risk of falls.

An additional difficulty is the post-fall anxiety that can occur, which results in a reduction in the level of activity as a protection against further falls. This in turn can contribute to growing weakness and abnormal gait and in the long run may actually increase risk of falls (Rubenstein 2006). As a result, recurrent falls are a common reason for admission of previously independent people to long-term care.

Prevalence and cost

Research carried out by TRIL (Technology Research for Independent Living) suggests that 30% of people over 65 fall once a year, and 12% of those fall at least twice. The incidence increases with age and frailty, and it is estimated that 50% of older people over 80 years are susceptible to increased falls.

The HSE estimates that significant numbers of older people need treatment every year following an injury (10%) and falls cause 75% of these injuries. Three-quarters of all

fall related deaths occur in older people and this rate has been increasing (ie 250 deaths each year).

Fall related deaths increase with age over 65 years and they are higher in older females. 2-3% of all injured older people need to be admitted to hospital (over 7,000 each year) and their average length of hospital stay is 12.7 days (HSE 2008).

The HSE estimates that one in three women and one in five men over the age of 50 years of age may have osteoporosis in Ireland. This means that up to 300,000 Irish people aged 50 years and over may have osteoporosis. The prevalence is rising as the population ages. However national statistics on osteoporosis are incomplete and many people do not know they have this condition until the first fracture occurs. In 2004 there were 6,113 hospital episodes where a diagnosis of osteoporosis was recorded but this represents the 'tip of the iceberg' (HSE 2008).

Hip fractures are one of the most serious injuries due to a fall, almost 2,800 suffered a hip fracture following a fall, representing 38% of all falls in 2005. Of those 80% are over 75 years of age; their length of hospital stay is 18 days; less than one-third go directly home after their hospital treatment. The inpatient cost of treating a hip fracture is €12,600. (HSE 2008) Hip fractures are particularly serious because research has found that half of those with hip fracture never regain their previous level of functioning and one in five die within 3 months (Todd et al 1995).

According to the HSE (2008) the cost of fall-related hospitalisations among older persons is currently estimated at €59 million and inpatient hip fractures cost is estimated at €35 million. (HSE 2008) However the overall cost of falls is much higher according to a study carried out in Ireland estimating the economic cost of falls and fractures. Gannon

and colleagues have estimated that the annual baseline cost amounts to €404 million, the largest components of which are mortality, lost quality of life, long stay care costs and hospital inpatient costs (Gannon et al 2008).

Risk Factors

Risk factors for falls fall into a number of different areas some of which are more predictive of a fall than others. The most predictive risk factors are muscle weakness, history of falls and gait/balance deficits and medications or polypharmacy. Additional risk factors include; arthritis; depressive symptoms; hypotension; impaired cognition, and vision (www.tril.ie).

Data from 12 different studies of falls identified 'accident' or environment related factors as the most common risk factor, accounting for 30-50% of falls. The second most common cause was gait/balance disorders or weakness. Osteoporosis is one of the main risk factors for falls and injury from falls. The prevention of osteoporosis requires a long term approach and a focus on improving awareness of bone health in particular calcium and vitamin D intake among women.

Muscle weakness can be very common among older people, mostly stemming from disease and inactivity rather than ageing per se. Research has shown a substantially increased risk of falls and fractures among people with gait and muscle dysfunctions. (Rubenstein 2006) Poor vision can also have an impact on stability and significantly increases the risk of falls and fractures in older people. In particular vision problems which reduce the ability of an older person to detect edges and ground level hazards in their environment contribute greatly to the risk of falling (Abdelhafiz 2003; Ivers et al 1998; Lord & Ward 1994).

Prevention and Intervention

Because there are many distinct causes for falls in old people, identifying a single effective intervention has proven difficult. However

there is now evidence from a number of international studies that prevention strategies can be effective in reducing falls among older people (Gannon et al 2007).

One of the earliest studies found that a combination of; modification of medication, behavioural instructions and exercise programmes were successful in reducing the risk of falling. (Tinetti et al. 1994) A more recent study found that interdisciplinary collaboration in assessment and interventions, particularly exercise, attention to co-existing medical conditions and environmental inspection and hazard abatement (Rubenstein 2006).

There is general agreement in the literature that programmes or interventions which combine a number of different factors seem to have the strongest effects. These generally include an assessment for risk factors among those thought to be at risk, followed by targeted interventions, exercise programmes (which include balance, strength and endurance training), and assessment of the home environment along with hazard reduction or home modification where necessary (Gillespie et al. 2003; Waleed, 2006; Tinetti et al 1994; Chang et al 2004 Kenny et al. 2001).

The effectiveness of such interventions may be affected by the level of uptake or adherence to the programmes and there is evidence that in some cases the level of uptake can be quite low ranging from just under 50% to as low as 10% (Yardley et al 2006). A study carried out in the UK aimed to gain an understanding of older people's perceptions of falls prevention advice. They discovered that many older people interpreted 'falls prevention' as meaning hazard reduction, use of aids and restriction of activity.

There is some evidence that the effectiveness of interventions may be reduced by the reluctance of many older people to take part, leading to low uptake rates and significant levels of dropout and non-adherence. (Yardley et al

2007) It has been argued that the perception of hazards, between health professionals and older persons, may be different and it is thought that these differences in perception may account for lack of adherence to advice from health professionals (Todd et al. 2007).

For example, a qualitative study found that there was very little awareness that the risk of falling could be reduced by carrying out exercises to improve strength and balance. Many of the participants also rejected the advice because they felt that it was only necessary for older or more disabled people, and potentially patronizing and distressing. The authors advised that as well as increasing awareness of the physical activities that were effective, interventions needed to promote benefits such as increased independence, increased confidence in capabilities and self-management of health, in order to increase the chance of success (Roger et al. 2001).

Best practice in the prevention and management of falls (AGS/BGS guidelines) recommends the screening of high risk people and an intervention which includes some or all of the following;

- Adaptation or modification of home environment (See Chapter 6 for further discussion of this issue)
- Withdrawal or minimization of psychoactive medications
- Withdrawal or minimization of other medications
- Management of postural hypotension
- Management of foot problems and footwear
- Exercise, particularly balance, strength, and gait training

In 2010 the HSE published a Falls Strategy which made recommendations based on a number of key principles;

- The use of evidence based interventions that are sustainable, provided in an equitable way and available to all.
- Improving awareness of the problems caused by falls and osteoporosis,
- Building health capacity,
- Providing a comprehensive integrated falls and osteoporosis service and
- Developing a safer environment.

2.3.4. Arthritis

Arthritis is a major cause of disability particularly in later life and with population ageing its prevalence is predicted to increase. Arthritis currently affects one in six people or 714,000 people in Ireland making it a major public health issue. 34% of women and 23% of men are affected by arthritis. It is also estimated that there are 1,000 children affected by arthritis.

While there are over 100 different types of arthritis, osteoarthritis (OA) is the most common form of arthritis worldwide. The World Health Organization estimates that globally 25% of adults aged over 65 years suffer from pain and disability associated with this disease. Arthritis affects the majority of people over 55 years to varying degrees. Women are two to three times more likely to be affected by osteoarthritis than men. 40,000 people suffer from rheumatoid arthritis, a more severe inflammatory form of the disease, and of these 70% are women.

Arthritis is the single biggest cause of disability in Ireland and 30% of GP visits relate to arthritis. It can result in chronic pain which has a severely disabling effect and reduces a person's capacity to live their lives. Arthritis Ireland estimates that 70% of people suffering from rheumatoid arthritis are unable to work (www.arthritisireland.ie). Despite its prevalence in the Irish community there is insufficient knowledge about its impact on quality of life,

or its link to depression associated with pain, how it is managed and what factors influence its management. A survey of arthritis sufferers and their GPs found that while arthritis affects one in six people, 25% of those affected have not seen a doctor (Veale et al 2007).

Early detection and treatment of the disease can greatly reduce its impact. Evidence-based guidelines show that there is a 'window of opportunity' to treat rheumatoid arthritis (3 months from the onset of symptoms) and that delays in starting treatment can cause damage, disability, loss of jobs and co-morbidity. As approximately 20% patients wait more than a year for their first rheumatology assessment, damage will already have occurred by the time these patients are first assessed. Arthritis Ireland has identified a number of reasons for delays in rheumatology assessments (Duffy 2009) including lack of capacity to see or follow up new patients, lack of knowledge in primary care about the importance of early treatment or delays in obtaining and reviewing imaging and blood results

Recent research identifies the main problem as access to services. Between 50 and 75% of sufferers either had great difficulty gaining access or could not access community-based services. Ireland has the lowest number of consultant rheumatologists in Europe per head of population, with just one consultant per 400,000 people. There are only twenty rheumatologists currently working in the public sector and of these the majority have combined rheumatology with general medicine. This is significantly behind the World Health Organisation's recommendation of one per 80,000 people.

Many patients experienced waiting periods for a first time consultation, varying from two months to three years. 64% of people surveyed attended a Consultant Rheumatologist privately; of these 45% did so due to delays in being seen publicly. There are limited

acute, day, and rehabilitation beds available, particularly for those suffering from chronic rheumatological conditions (Irish Society for Rheumatology, 2002; Comhairle na nOspideal Report, 2005)

Arthritis Ireland identified the following problems resulting from the lack of rheumatologists; waiting time for patients of up to 4 years; vast areas of the West of Ireland uncovered; clinics running up to 9pm at night and an inability to implement best practice care due to time pressure (Fitzgerald 2009). They proposed the appointment of four more consultants which they argued would; reduce patient waiting times from 4 years to 24mths; eliminate the need for accessing services through A&E; reduce bed stays and improve the overall quality, efficiency and capacity of the service.

Approaches to Treatment

Care of patients with rheumatological illness has changed dramatically over the past decade due in a significant measure to the availability of targeted biologic drugs. These agents target specific proteins involved in the process of inflammation and can produce dramatic results. Their use has even led some investigators to speculate on the possibility of a cure for inflammatory arthritis (Duffy 2009).

Increased complexity has resulted from the use of these drugs however. Many need to be administered by intravenous infusion, leading to increased demand on hospital resources – space and staff alike. Fortunately delivery of such infusions is generally safe and well tolerated by patients. With adequate protocols and supervision, facilities outside of the hospital setting can be leveraged for the delivery of such agents, and “community infusion” is becoming accepted practice in North America. A recent study in Ireland has confirmed the local application of such an approach (Doran et al 2009).

There are a number of possible approaches to the delivery of a community infusion service

and the recommendation from the ISR and Arthritis Ireland is to focus on Community Centres. They argue that this is in keeping with the best practice of trying to maintain as normal a life for people living with arthritis by maintaining their independence and removes the stigma of RA patients visiting acute hospitals. Community Centres offer a flexible model to providing patient care and ensure high-risk patients are not exposed to possible infections in acute hospitals (Duffy 2009).

Duffy (2009) also proposed a model of care using specialist nurses in order to fast track patients to early arthritis clinics, with all the appropriate laboratory and radiology investigations on hand. He argued that using health care providers in expanded clinical roles (Ongoing Management and Triage) had potential to rationalize the use of specialist resources and to decrease waiting times for specialist care, by freeing up specialist time. (Duffy 2009) A study performed in Belfast concluded that diagnostic triage by GPs or RNs improved the positive predictive value of referrals to an EAC with a degree of accuracy approaching that of a group of experienced rheumatologists (Gormley et al 2009).

Issues Arising -Stroke, Falls and Arthritis

Prevalence of Stroke: In Ireland approximately 10,000 cases of acute stroke were admitted to hospital in 2005, and it is estimated that over 30,000 people are living with disability following a stroke. While many survivors of an acute stroke make a complete recovery, the recovery of around 30% of them is likely to be incomplete, although they will not necessarily need assistance with their usual daily activities (Cowman et al. 2010). This is lower than some international estimates, which suggest that approximately 51% are disabled in some activity of daily living following a stroke, and 50% exhibit either cognitive impairment or dementia (Sturm et al. 2002; Srikanth et al. 2004).

Prevention and Mitigation of Stroke: The Irish National Audit of Stroke Care revealed that many strokes are preventable, and that when they do occur, early intervention can rescue brain tissue. However, less than half the respondents in an Irish survey were able to identify established risk factors or warning signs such as weakness or headache, although slurred speech, identified by 54% was an exception. There is also limited public awareness of the need to receive treatment within a specified time period (Hickey et al. 2009).

Stroke Units: The Irish Heart Foundation identified only one hospital (3% of all hospitals) with a stroke unit in accordance with the recognised international standards which is in strong contrast to the UK, where 91% of hospitals have stroke units (Sentinel 2006).

Prevalence of Falls: The HSE estimates that significant numbers of older people need treatment every year following an injury (10%), and that falls cause 75% of these injuries. Three-quarters of all fall-related deaths occur in older people, and this rate has been increasing (currently 250 deaths each year). Fall-related deaths increase beyond the age of 65 and are higher in older women, with 2-3% of all injured older people needing hospital treatment (over 7,000 each year). In 2008, their average length of stay was 12.7 days (HSE 2008).

Prevention of Falls: Many falls can be prevented by the promotion of better awareness among older people themselves, as well as awareness among the general public about the vulnerability of older people to falls, and the significant health implications when they do. The provision of level pavements free from obstructions can make a significant contribution to the reduction of falls in the street.

Recurrent falls: Many older people experience post-fall anxiety, which results in a reduction in their level of activity as a protection against further falls. This in turn can contribute to

growing weakness and abnormal gait, and in the long run may actually increase risk of falls. As a result, recurrent falls are a common reason for admission of previously independent people to long-term care. Issues

Delays in Arthritis treatment: Despite the fact that delays in starting treatment can cause damage, disability, co-morbidity (the presence of two or more coexisting medical conditions or disease processes) and loss of employment, a survey showed that approximately 20% of patients have to wait more than a year for their first rheumatology assessment, with many waiting for up to three years. Between 50% and 75% of people either had great difficulty gaining access to community-based services, or were unable to access them at all.

Rheumatologists: Ireland has the lowest number of consultant rheumatologists in Europe per head of population, with just one consultant per 400,000 people. This leads to long waiting lists and inadequate coverage in large parts of the country, and in these circumstances it is impossible to provide best practice care.

2.4 POLYPHARMACY

Older people have different more complex medical conditions and they metabolise drugs differently to younger people and for this reason there is a need for greater understanding of the responsiveness to and tolerance for drug treatments among older people.

Polypharmacy, generally defined as the use of multiple drugs at the same time, is more common among older people because they tend to have multiple medical conditions requiring medication. However some specific characteristics of ageing and geriatric medicine can make the prescription of appropriate drugs for older people a more challenging and complex process. There is evidence of inappropriate prescribing, over prescribing, under prescribing

and failure to review the continuing need for the drugs prescribed (Hajjar et al. 2007).

Inappropriate prescribing has been described as occurring when medicines are prescribed that pose more risk than benefit, particularly where safer alternatives exist. It also involves the use of an inappropriate dose for an inappropriate duration or the prescription of drugs which may interact with other drugs being taken by the patient.

Impact and prevalence

The fact that people with chronic illnesses may be treated for a number of conditions, often by different medical professionals results in them being prescribed a number of different drugs at the same time. In Ireland approximately 95.5% of drugs prescribed in the public health system are for older people (General Medical Services Prescription Database). In Europe, between 4% and 34% of people aged 65 years and older use five or more prescription medications (Junius-Walker et al. 2007).

Boyd et al. (2005) showed how, by following existing clinical practice guidelines, a hypothetical 79-year-old woman with chronic obstructive pulmonary disease, type 2 diabetes, osteoporosis, hypertension and osteoarthritis would be prescribed 12 separate medications, a mixture that risks multiple adverse reactions among drugs and diseases.

The prevalence of inappropriate prescription has been investigated in a number of different studies and it has been found to occur for up to 24% of people living in the community and 40% of nursing home residents in the United States (Dhall et al 2002) It has also been found that under-prescribing is even more widespread – a recent study found that 58% of older patients do not receive one or more medications that would be beneficial and suited to their conditions (Barry et al 2007).

The prescription and use of drugs in older people can result in a range of different

problems such as adverse drug reactions or interactions between drugs which can cause further health problems, diminished quality of life, and unnecessary drug expense. The most common risk factor for adverse drug reactions is the number of drugs being taken and the risk rises as the number of drugs increases. As polypharmacy increases with age, the potential for drug interactions also increases with age (Veehof et al 2000).

Drug Trials

Chronic conditions have become more complex to manage as new, more potent, but also often potentially harmful or risky, drugs become available. Older people are often excluded, because of their age, from the drugs trials that prove the effectiveness of the drugs (Britton et al. 1999) and those that are included in the research tend to be those who are less frail or have fewer complicating conditions. This raises questions about whether these medications are suitable or effective for older people and whether the risks associated with their use for frailer older people are properly evaluated.

The evidence that older people are being excluded from clinical research can be found in a number of areas. Despite the fact that the prevalence of diabetes among older people is predicted to rise, the average age of participants in the UK Progression of Diabetes Study was only 53 years. A review of cancer clinical trials reported that only little over a quarter of potentially eligible patients aged over 65 were involved in the research. In research on heart disease it was found that 40% of the trials published between 1991 and 2000 had specific exclusions on the basis of age. (McMurdo et al. 2005) There may be legitimate reasons for their exclusion, such as the need to test the product on people with similar characteristics in order to reduce variations in the effects. However it is clear that the practice is a disadvantage to older people and it has been suggested that the evidence base on which clinical decisions are

based is of limited value when many trials do not include older people. (Tinetti et al. 2004).

Interventions to prevent problems - Screening

This problem could be addressed in a number of ways including the use of screening for inappropriate prescribing. Gallagher and O Mahony (2008), identified this as a major, common public health problem in older people - most often resulting from poor choice of medication by the prescriber. They advised that an inexpensive, user-friendly screening tool aimed at assisting in drug selection could reduce inappropriate prescribing in older people. (O Mahony and Gallagher 2008) A number of tools have already been developed to help identify and reduce prescribing errors in older persons, the first of which was the US Beers' criteria (which lists a number of prescribing scenarios which are judged to be inappropriate in older people).

They argued that the effectiveness of the existing tools had not been proven and that use of such tools should translate into positive patient outcomes, such as reduced rates of adverse drug reactions. (Hamilton, Gallagher and O Mahony 2009) They developed a new tool called STOPP (Screening Tool of Older Persons' potentially inappropriate Prescriptions) which they found successfully identified a significantly higher proportion of patients requiring hospitalisation from medication-related problems. (Hamilton, Gallagher and O Mahony 2009)

Issues Arising:

'Polypharmacy': There is evidence that many older people are taking a wide range of drugs, sometimes unnecessarily, that their need for those drugs is not regularly reviewed, and that the interactions between drugs can cause further health problems, diminished quality of life, and unnecessary drug expense. Multiple drug use decreases the ability of older people to carry out basic daily activities and increases the

number of symptoms reported. An Irish study found potentially inappropriate prescriptions in between 18.3% and 21.4% of patients, depending on the evaluation criteria used (Ryan, O'Mahony et al 2009).

Drug Trials: The exclusion of older people from most clinical drug trials limits the evidence available on which decisions can be made regarding the appropriateness or potential effects of a drug on older people.

2.5. MENTAL HEALTH

Mental health is one of the most important determinants of good quality of life in older people, along with cognition, physical health and engagement. Depression one of the most common of mental health disorders and has a negative impact on quality of life. It is often present with other conditions and can exacerbate other medical illnesses while increasing the likelihood of incapacity following physical illness (Stefanatou 2010; Moussavi et al 2007)

Currently, of all illnesses and among all age-groups, depressive disorders cause the largest amount of non-fatal burden, accounting for almost 12% of all years lived with disability worldwide (Ustun 2004). Depression is also associated with higher demands on carers, higher use of the health service, and has substantial economical implications (Schoevers et al 2006).

Prevalence

Major depressive disorder is quite a common disease in old age. The exact level of depression and mental illness among older people can be difficult to establish because of differences in screening criteria or methods (Graham and Robinson 2008) Research suggests that up to 16% of older people are clinically depressed (Livingston et al., 1990; Roberts et al., 1997). A study of mental illness among older people in Dublin (Kirby et al 1997) found that depression is the most common mental disorder among older people in Dublin at just over 10%. The study

also found that those diagnosed with depression experienced anxiety symptoms in 17% of cases and that only 18% of those diagnosed with depression did not have symptoms of other diseases or conditions. (Kirby et al 1997).

When the figures for the prevalence of all cases of mental disorder were compared with other prevalence studies carried out in Liverpool and New York it was found that the prevalence was lower in Dublin (15.3%) than in the Liverpool (19.2%) or New York (26.1%) and the authors suggested that this may be explained by the considerable level of social support from family and friends of the older people in their study (Kirby et al 1997).

Other studies have estimated the prevalence of depression as being between 1% and 4% of older people for major depression and prevalence increases to between 6% and 32% among older nursing home residents (NIH Consensus Development Conference 1992; Dillon et al 2009). Another study found that an additional 8% to 16% have clinically significant depressive symptoms.

Depression and Comorbid conditions

Ageing is associated with chronic conditions, brain disorders or other conditions that may contribute to depression (Dillon et al 2009). One study which analysed data from the WHO's Global Burden of Disease study found that co-morbidity between chronic physical conditions and depression is common, and that people with chronic diseases are significantly more likely to suffer from depression than those without. The study also showed that people with depression and other chronic diseases experience a greater reduction in health than those who have one or more chronic diseases, and that these links occurred regardless of socio-demographic, country of origin, or economic factors (Moussavi et al 2007).

Depression may also be a risk factor for the subsequent development of dementia and a

diagnosis of dementia can also a risk factor for depression and suicide. It is known that people with a history of depression are more likely to be diagnosed as having Alzheimer's disease and that approximately 20% of Alzheimer's patients have been diagnosed with depression. (Ownby et al 2006).

A Danish study looked at the association between dementia and suicide using nationwide data and found that people who receive a diagnosis of dementia in a hospital have an increased risk of suicide compared with the general population (Erlangsen et al 2008).

There is evidence to suggest that depression can be an outcome or a risk factor for stroke. Post-stroke depression (PSD) affects approximately one third of older stroke survivors (Berg et al 2009).

Research has shown that absence of a confidant, having few close friends and few relatives is associated with both higher levels of persistent or recurrent bodily pain and depressed mood (Michael et al 1999) Illiffe and colleagues also found links between those experiencing social isolation and pain with the likelihood of experiencing depressed mood (Illiffe et al 2009).

A study of patients in two London general practices examined the associations between risk factors and onset of depression. It found that depression existed in over 8% of patients aged over 65 and persisted amongst 61 % of those who were depressed at the start of the study. They found evidence of a link between the number of symptoms or the severity of the depression at the start of the study and the likelihood of developing chronic symptoms.

The presence of pain is quite common among older adults ranging from 25–88% (Helme and Gibson, 2001). There is evidence that pain and worsening disability were important predictors for the likelihood of developing depression (Harris et al 2005). The links between pain

and depression have been long established, pain is depressing, and depression causes and intensifies pain. According to the Harvard Medical School, (<http://www.health.harvard.edu/mental>) people with chronic pain have three times the average risk of developing mood or anxiety disorders and depressed patients have three times the average risk of developing chronic pain. One US study found that approximately 35% of participants with chronic pain also had comorbid depression 7.7% (Miller and Cano 2009)

Risk Factors and Prevention

Depression among older people is more common in women and widowers, in people who are isolated or institutionalised as well as in those who are experiencing stressful events. Major depression is more common among women than men and this difference continues into late life (Krause, 1986). Older people with depression usually have a different symptom profile from younger people and possible additional causes. In depressed older adults, depressed mood may be less commonly reported, while symptoms such as loss of appetite, lack of energy, irritability, sleeplessness, worrying, and aches and pains are more prominent (Frazer et al 2005).

One study carried out a review of the impact of a wide range of biological, psychological and social factors. It found that ageing-related and disease-related processes increase vulnerability to depression and that heredity factors might also play a part. It also found that psychosocial difficulties such as financial difficulties, disability, isolation, relocation, and bereavement all contribute to the likelihood of developing depression particularly among vulnerable older people (Alexopoulos 2005).

A review of several studies found that a number of factors - bereavement, sleep disturbance, disability, chronic pain, prior depression, and being female were the most significant risk factors for depression. The

authors pointed out that interventions could help in the case of three of these risk factors; bereavement, sleep disturbance, and disability. For example interventions could include education about the significance of the risk factors, bereavement counselling and support, improvement of social supports, and individual or group therapy to help people adapt to loss of function (Cole and Dendukuri 2003).

Schoevers and colleagues (2006) arguing that prevention is more cost effective than treatment, suggested that even if all patients with depression received the most appropriate and timely treatment, only 34% of the disease burden (in terms of years lived with disability) could be averted and that therefore prevention was likely to be more cost effective and more beneficial (Andrews et al 2004; Schoevers et al 2006).

Examples of programmes which seek to prevent depression in persons who lost their spouses include self-help groups of fellow sufferers that convene for emotional exchange and support, specific courses on competences needed to cope with single life, and 'widow-to-widow' programmes in which women who had lost their husbands earlier visit recently widowed women for emotional and practical support. Although these programmes have shown promising results in terms of adaptation following bereavement, evidence of their success in reducing depression is limited (Van Lammeren et al 1995).

Diagnosis, Screening and Treatment

Although research has shown that treatment can be effective, (Unutzer et al 2002) depression is frequently undiagnosed and therefore untreated among the majority of older people (Alexopoulos 2005; Licht-Strunk 2009). Of the 5-10% of people with depression, up to half of these cases are missed in primary care (Gilbody and Sheldon 2008) and in general hospital settings and even for those who have been diagnosed, past research has shown that only

35% of those with depression receive treatment (Murray and Lopez 1996). A study carried out in the Netherlands found that only 40% of the patients with depression were receiving treatment for depression at baseline—31% were taking antidepressants and 9% were referred to specialised mental health care.

In the US, a recent study found that many older people with mental health problems don't feel the need for treatment. Those who do feel the need for care tend to have more symptoms of depression and other chronic health conditions (Garrido et al 2009). Only 7.3 percent of those who took part in the study felt a need for mental health care. Among those who did feel a need, 82.8 percent received services voluntarily from either a primary care or mental health specialist. Another 17% felt the need for mental health care but did not receive it. Those older adults most likely to feel a need for care tended to have had previous periods of depression, anxiety, chronic physical illness, and alcohol abuse.

To deal with the problem of under treatment or under recognition of depression the U.S. Preventive Services Task Force (USPSTF) recommended screening adults for depression in practices that have systems to ensure accurate diagnosis, effective treatment, and follow-up. (Pigone et al 2002) The National Institute of Clinical Excellence in the UK made a similar recommendation in 2004. However subsequent research studies have concluded that screening does not improve health outcomes but that care management systems for depressed patients can help to reduce remission rates for depression (Gilbody et al 2005). In a more recent study Gilbody (2006) and colleagues showed that screening was not a necessary factor in ensuring improved outcomes but that collaborative care can improve the outcome of depression.

Research has found that when treatment is provided at an appropriate level for an adequate period, significant improvements can be achieved by 12-16 weeks and when

medication is continued beyond the acute phase the likelihood of a relapse reduces by 50% compared with those who stop taking antidepressants (National Institute of Clinical Excellence. 2004).

Frazer and colleagues carried out a review of the evidence for the effectiveness of a range of possible treatments for depression in older people. They found that among the best treatments with evidence of effectiveness are antidepressants, electroconvulsive therapy, cognitive behaviour therapy, problem-solving therapy, bibliotherapy (for mild to moderate depression) and exercise (Frazer et al 2005).

Suicide

Suicide is almost twice as frequent among older people as in the general population. According to figures published by the World Health Organization rates of completed suicide in older people, although low, increase with age and older people have a higher risk of completed suicide than any other age group worldwide (WHO 2002; O Connell 2004).

Depression is present in 80% of people aged older than 74 years who commit suicide and among those who attempt suicide, older people are most likely to die. (Conwell et al 1996) It is thought that completed suicides are likely to represent only the tip of the iceberg for psychological, physical, and social health problems in older people (O Connell 2004).

Risk factors for suicide include a range of physical and social factors. One study found that serious physical illnesses were independent risk factors for suicide. (Waern et al 2002) The authors also found that older men who have been diagnosed with a serious physical illness may be at a greater risk of suicide than in women suggesting that more attention should be focussed on such patients by general practitioners (O Connell 2004).

Disruption of social ties is linked to suicide in later life, regardless of whether the person

also has depression, especially in people with particular personality traits (a rigid, anxious, or obsessive personality) (Alexopoulos 2005).

Although fewer older people have suicidal thoughts than younger people, when they do they are more likely to commit suicide than younger people. Suicidal thought is closely associated with severity of depression. Findings of a study show that during an initial assessment of older people with major depression, the severity of their depression symptoms and previous serious attempts could predict the course of suicidal ideation (Alexopoulos 1999).

Alcohol Use Disorders

Although the prevalence of problems associated with alcohol use tends to be lower than among younger people it is known that such disorders among older people are associated with significant health problems (O Connell et al 2003). Alcohol problems among older people can often be under detected or misdiagnosed because of the tendency to focus screening on younger people. The NCAOP highlight this fact and note that ‘the level of alcohol problems among older people is unknown as they often go unrecognised... 11.5 per cent of those in the 64-74 age group and 4.8 per cent of those aged 75 and over who were admitted to psychiatric hospitals in 2000 suffered from alcoholic disorders’ (NCAOP, 2005c: 16). However as population ageing takes effect, greater numbers of older people in our societies is likely to lead to an increase in the absolute number of older people with alcohol problems. Studies in the US have estimated that the prevalence of alcohol dependence can range from 2-4% although it is difficult to assess whether this estimate could be generalised to other countries.

Alcohol problems in later life are associated with significant physical and psychological health problems. Age related changes in body composition means that, equivalent amounts of alcohol produce higher blood alcohol

concentrations in older people (Reid et al 1997) and the health problems associated with misuse of alcohol are more common among older people than among older people who don’t misuse alcohol (Hurt et al 1988).

O Connell et al (2003) recommend that screening instruments and diagnostic criteria should be adapted for older people in order to focus on the more subtle but also more damaging effects of alcohol use disorders on the health of older people. They also suggest that secondary prevention strategies should focus on those older people whose drinking does not fit the criteria for misuse or dependence but who are putting their health at risk because of interactions with medications or other medical treatment (O Connell et al 2003).

Issues Arising

Prevalence: Research suggests that up to 16% of older people are clinically depressed (Livingston et al., 1990; Roberts et al., 1997). A study of mental illness among older people in Dublin found that depression is the most common mental disorder among older people in Dublin at just over 10% (Kirby et al 1997).

Diagnosis: Depression often goes undetected because of the associated stigma, or through GPs’ failure to diagnose the problem in time, with a US research study suggesting that up to half of cases of depression are missed in primary care (Gilbody and Sheldon 2008). Of those who are correctly diagnosed, only 35% receive treatment (Murray and Lopez 1996).

2.6. SOCIAL AND COMMUNITY HEALTH CARE

Older people often have multiple complex disease-related conditions and require comprehensive, integrated physical and psychosocial assessment. Care of older people is most effectively delivered through

multidisciplinary teams of physicians, geriatricians, nurses, therapy professionals and medical social workers located in the community. There is evidence that increased investment in community based health services could significantly reduce the time older people spend in hospital and outpatient hospital services. This would have significant benefit to them, produce better health outcomes and reduce the cost to the state.

Many older people have to access services in hospital settings which could be better devolved to community level. Services in the community can be delivered by GPs, Primary Care Teams or in other settings such as Day Hospitals.

Without the appropriate services in the community older people may be inappropriately admitted, have a delayed discharge from acute hospitals or be admitted to nursing homes because of the unavailability of timely multidisciplinary team care.

Research from the UK has found that GP hospitals save costs by reducing referrals and admissions to higher-cost general hospitals staffed by specialists (Treasure and Davies 1990; Hine et al 1996). Primary care delivered by general practitioners, instead of hospital specialists was shown to be more cost effective with lower referral rates to secondary services, lower prescription levels, and no significant difference in patient satisfaction or health outcomes (Dale et al 1996, Ward et al 1996).

There is evidence that community care can be highly effective for older patients with acute diseases or deterioration of a chronic disease. A study carried out in Norway found that patients who receive care at a community hospital, after an initial period in a general hospital, had lower readmission rates than patients given traditional prolonged care at a general hospital. The study also found that intermediate care at a community hospital increased the number of patients being independent of community care after 26 weeks

of follow-up, without any increase in mortality (Garåsen, Windspoll and Johnsen 2007).

While general practitioners can provide the early management of chronic illness in the community, improved access to multidisciplinary team care, specialist services, rehabilitation units, etc, would enable a greater number of older people to remain living happily and healthily in their own homes.

Primary care teams were launched as part of the National Primary Care Strategy in 2001 and were intended to include health professionals such as family doctors, midwives, social workers, public health nurses and physiotherapists. The aim was that care would be provided to patients in the community from under one roof and at the time.

The plan was to establish 600 teams by the end of 2011; by January 2012, 411 teams have been set up. However according to an Irish Times report the majority of these are virtual teams, having no dedicated building from which to operate.

The development of Primary Care Teams (PCTs) is considered central to a HSE shift from a focus on acute hospital-based care settings to local, community-based services. This move aims to increase cost efficiency and improve the healthcare experiences of patients and health professionals (HSE, 2008).

However, provision of community based care in Ireland to date has been variable, due to a combination of factors, including the lack of legislation on entitlement to particular services, so that in some cases provision is discretionary, rather than entitlement-based. The HSE Service Plan 2009 commits to the appointment of four geriatrician-led teams to work across hospital and community settings by the end of 2009 (HSE Service Plan 2009: 42).

The better use of Day Hospitals offers a partial answer to the growth in demand for institutional care and services. GDHs provide

a setting where care and services for older people with disabilities can be treated on an ambulatory basis, maintaining the older person in their homes for longer. Their programmes generally include patient need assessments, comprehensive patient care coordinated by a multidisciplinary team, extensive retraining to improve functional autonomy, and opportunities for social interactions with staff and other elderly persons

The options around developing community-based health care include the continued development of the Primary Care Teams (PCTs). This would involve migrating further supports and resources to establish PCTs with a view to addressing the health needs of older people. This could be done either by means of geriatrician-led PCTs or PCTs served by visiting geriatricians. It is important to note that geriatrician-led PCTs does not mean that geriatricians would be exclusively based in the community but could maintain their current practice of seeing patients in both hospital and community settings.

In the absence of additional resources, resources may need to come from other care services and decisions regarding potential prioritisation of funds and personnel may be served by a cost-benefit analysis of the gains to be made by the development of community based services. While costs will very likely be saved in the long term, there may be significant transition costs involved in the migrating of resources. An additional implication were this option to be implemented would be increased satisfaction among older people themselves as there has been an expressed preference for services located in the community that mitigate against the need to travel to a hospital.

As mentioned previously, encouraging GPs to work as part of PCTs has posed a significant challenge. This could be remedied by establishing a system whereby GPs only gained access to patients over 70 years and carrying a

medical card if they had formed part of a PCT. A further issue to be considered is the world-wide trend for GPs to be less involved in house calls to frail older people (Joyce and Piterman 2008), particularly in systems like Ireland where the GP acts as gatekeeper (Boerma and Groenewegen 2001) possible solutions include the development of the nurse practitioner role (Edwards et al 2009) or the use of telemedicine (Finkelstein et al 2006) to ensure continuity of medical care to a population with increasing numbers of frail people who would have difficulty travelling to GP surgeries.

Implications of all of the above options will include improved channels of communication through increased and more efficient information sharing between health professionals across acute and community settings. This would be addressed through the establishment of a shared patient record system accessible across primary, secondary and tertiary services as mentioned above in the discussion on data.

Secondly, community-based services, whether provided by the public (PCTs); private (MDTs/specialist Age Friendly clinics); or voluntary (specialist Age Friendly clinics/services carried out by voluntary organisations), will also need to be subject to regulation in the form of quality standards. This could occur through the extension of HIQA standards to this area. Lastly, technology will be a factor in the devolving of health services and procedures from hospital to community settings.

Issues Arising

Primary Care Teams; Care of older people is most effectively delivered through multidisciplinary teams of physicians, geriatricians, nurses, therapy professionals and medical social workers located in the community. The development of Primary Care Teams could offer older people access to a range of services but provision of community based care to date has been variable and many PCTs are only 'virtual' teams.

Inadequate access to community services:

Without the appropriate services in the community older people may be inappropriately admitted, have a delayed discharge from acute hospitals or be admitted to nursing homes because of the unavailability of timely multidisciplinary team care

Inequitable access: Older people Respite Care: There is significant under-provision of non-institutional respite care which can offer short-term rehabilitation to older people and provide respite for carers.

2.7. HOSPITAL CARE

Older people are among the largest consumers of health care services in Ireland (Timonen, 2008). They account for 78% of all hospital admissions and stay in hospital for longer than other age groups and yet hospitals are not designed to meet the needs of older people. Given that older people represent a majority of hospital patients, hospitals, their facilities, the services they provide, and the overall experience of the older patient, should be better designed to cater to their needs.

The acute hospital tends to be organised into 'specialities' such as neurology and orthopaedics which means that staff knowledge and training will tend to lie within these specialities. This can impact on the ability of staff to respond to the complex needs of older people with a number of co-morbidities and complicating factors. Acute hospitals are most suited to single diagnoses, rapid treatments, and short stays, and as a result they are not the best settings for the treatment of older people (Edvardsson and Nay 2007).

The HSE is initiating new forms of management of chronic illness and care in hospital will continue to be an important component of these new approaches. A range of issues specific to the experience of older people in hospital such as inappropriate admissions, reduced stays

and delayed discharges will be discussed in this section as well as ways of reforming systems to better respond to the needs of older people.

2.7.1. Age Friendly Hospitals

While allowing for the fact that better community health services could reduce admissions for older people to acute hospitals, they will still inevitably represent a higher percentage of admissions and have longer stays than younger persons because of the complexity of their health conditions. (Nay and Garratt 2004). There is also evidence that older people admitted to general acute hospital care can be at increased risk of adverse events such as falls, loss of mobility and functional decline (Nay and Garratt 2004; Cassidy 2001).

Many older people presenting to acute medical units have geriatric conditions such as falls, reduced mobility, confusion or incontinence, and where these people are not admitted to hospital, there is evidence to suggest that these patients were at high risk of early re-presentation at hospital, and had a relatively high mortality rate. Because older people tend to suffer from complex conditions and comorbidities lack of specialist geriatric knowledge can result in a less effective treatment of their conditions.

Approximately 25% of all those admitted to hospital have some form of cognitive impairment. As 75% of those admitted are over 65, it can be assumed that a majority of in-patients with cognitive impairments are older people. The impact of dementia on hospital services can be seen in the statistics for dementia-related 'bed days', including time when patients are awaiting transfer to more dementia-specific care settings. O'Shea's 2000 study estimated that 18% of all hospital bed days were dementia-related.

Acute hospitals may also be unable to respond to the additional challenges of caring for people who suffer from cognitive impairment and have a greater need for safety, calmness and

familiarity in their environments (Zingmark et al 2002). The hospitalisation of older people with dementia can therefore often exacerbate distress and dysfunctional behaviours (Miller 1999). The stress associated with hospitalisation for people with dementia can be linked to poor outcomes during hospitalisation, with increased length of stay, mortality, post-hospital institutionalisation, and escalating health care costs (Schofield and Dewing 2002).

The development of age friendly health care goes beyond the basics of accessible bathrooms and large print signs and requires a cultural shift in the way healthcare providers think, act and respond to the needs of older people. Seeking to make hospitals more Age Friendly will require greater recognition of the individual needs of the older person and the development of systems and environments that support Age Friendly care. For example adapting the physical hospital environment to promote independence in finding different places such as the bathroom, the bed space, the dining space or other place could enhance rather than obstruct patient independence (Day et al 2000).

One crucial aspect of the provision of age friendly care involves the availability of staff members who are knowledgeable in the care of older people and understand the needs associated with old age and/or cognitive impairment. This includes knowledge of facts such as symptoms, disease progression, treatment regimens, outcomes, needs, and co-morbidities, but it also includes experience-based knowledge of what it means to be old, struck by illness, and being rushed to an unfamiliar hospital environment (Edvardsson and Nay 2007).

2.7.2 Delayed Discharge and Discharge Planning

There is evidence that a significant percentage of older people may be medically ready for discharge, but have to stay longer because of the

absence of suitable housing or care supports. This has implications both for the patients' wellbeing and cost to the health service. There is evidence that better discharge planning can have positive effects on the efficiency of the discharge and the reduction of problems that often follow from hospitalisation for older people.

Due to a demand for greater turnover in hospital beds the issue of inappropriately delayed discharges has become the subject of discussion in a number of countries including Ireland. According to Activity in Acute Public Hospitals in Ireland 2006 Annual Report, the total in-patient average length of stay generally increased with age for both men and women, peaking at 13.9 days for people aged 85 years and over who were discharged. The average stay for people over 65 was 11.3 days, four times that of the 45 to 64 age-group and over twice the average stay of 5 days for all patients (ESRI 2006).

Discharge preparation generally takes place during the hospital stay and it involves organizing care and preparing patients in such a way that the length of hospital stay is as short as possible for most patients, that the condition of most patients is such that they can be discharged home and not into institutional care, that they regain their independence as soon as possible post discharge.

Discharge support generally takes place after discharge from hospital and aims to ease or solve problems after discharge in order to prevent readmissions to hospital or admissions to institutional care and to maximize recovery and improve functional, emotional, social and health status in the post discharge period. A review of these interventions found evidence that some interventions may have a positive impact, particularly those with educational components and those that combine pre-discharge and post-discharge interventions (Mistiaen et al 2006).

Although there is no agreed definition of what constitutes 'delayed', studies in the

UK show that contributory factors include; delayed placement into institutional care after completion of an assessment; a reduction in numbers of beds available in nursing homes, problems in funding from social service budgets, and delays in assessments from therapists or social services, for community services, or for equipment to be ordered, delivered, and installed (Black and Pearson 2002).

A recent UK study looked at the issue from the perspective of older people and found that many patients actively or passively relinquished their involvement in the processes of discharge planning because of the perceived expertise of others and also feelings of disempowerment linked to poor health, low mood, dependency, lack of information and the intricacies of discharge planning processes for complex community care needs (Swinkels and Mitchell 2009).

Discharge from hospital is not always a smooth process and studies from all over the world have reported that many older people who have been discharged from hospital to home, experience a range of problems in the first weeks after their return home. Problems after discharge include lower levels of independence in activities of daily living, difficulty with reading medication labels, not getting the help they needed, not being aware of available services, informational needs, symptom distress and emotional problems such as anxiety and uncertainty. These problems frequently lead to further complications and unplanned hospital readmissions (Mistiaen et al 2006).

In Ireland, the PA Consulting Acute Hospital Bed Capacity Review found that discharge planning was only in place for 40% of all patients. A number of 'discharge interventions' have been developed in other countries which are aimed at easing the process of the discharge itself or at preventing, easing or solving problems in patient's functioning after discharge or preventing readmission to the hospital and

treatment of post discharge problems. The types of intervention can be classified in two groups: discharge preparation and discharge support.

Community Intervention Teams could also be further developed, as envisaged by 'Towards 2016', to assist in preventing avoidable hospital admission and the facilitation of early discharge from hospitals, operating in addition to existing mainstream community services to address issues such as capacity to fast-track non-medical care or supports for an interim period, while mainstream services are being arranged for the patient (Towards 2016: 66).

Finally, the development of alternatives to acute care, such as the introduction of additional rehabilitation and continuing care beds, could be an option to mitigate against the issue of the delayed discharge of older people. The 2001 Health Strategy stated that there was a need for the introduction of 5,600 step-down beds over a period of seven years. This has not happened. Obviously, there would be significant resource implications associated with implementation.

2.7.3 Rehabilitation and Reablement

Rehabilitation services may enhance an individual's skills to live independently at home and to avoid falls. Some private insurance companies cover private rehabilitation for max of 2 weeks.

In many countries, (frequently for economic reasons) home-care programmes have been designed, not to just support individuals living at home but to assist them to increase their independence, optimise their functioning and thus reduce or limit their demand on services. There has been a growing emphasis on 'reablement' which has been defined as "*the provision of services offering personal care, for a time-limited period, in such a way as to enable users to develop both the confidence and practical skills to carry out these activities themselves*". (Calderdale Council 2010)

Current approaches often lack an emphasis on the promotion of healthy lifestyles and daily routines, social support, exercise, and autonomy and control, despite the strong evidence that these are strongly linked to the maintenance of health and independence. (Ryburn et al 2009)

Research supporting the idea of promoting independence was carried out in the US. (Baker et al. 2001). In the course of a study on the effectiveness of a home-based rehabilitation programme for older people with a hip fracture, researchers found that the home-care workers would often be working at cross-purposes with the programme by providing more assistance than was necessary (Tinetti et al. 1997). They concluded that there was a need for a new model of home care that would focus on improving older adults' functional abilities at the same time as meeting their healthcare needs. The outcome of the programme, which they subsequently developed, was that older individuals who received restorative home care after acute illness or hospitalisation were more likely to remain at home, and had a reduced likelihood of visiting an emergency department, than if they had received 'usual' home care. Patients in the trial also had better scores on self-care, home management and mobility at discharge than did usual care patients (Tinetti et al. 2002).

A review of the literature found a range of positive outcomes for the 'reablement' approach, including improved quality of life and functional status and reduced costs associated with a reduction in the ongoing use of home care services post-intervention. (Ryburn et al 2010)

Many local authorities in the UK are changing their former home-care services to provide intensive, short-term reablement instead. Work carried out by the Care Services Efficiency and Delivery (CSED) Programme in England has demonstrated that reablement teams are most effective where the following conditions apply;

- Staff are fully trained and supported in the new way of working and supervised in a way to ensure that if any individuals find the new approach too difficult they can receive tailored support.
- Regular training is offered to staff as the scheme develops
- The performance of the reablement teams is closely monitored and managed by senior staff to ensure that the service is achieving the expected outcomes and thus delivering the required savings
- Therapists are employed alongside domiciliary care workers to ensure that older people and staff get the right guidance if they come across complex conditions or staff need specific guidance in how to assist a particular service user

2.7.4 Reform of the System

An integrated approach could ensure that the spectrum of health needs of older people are taken into account and training provided to all health professionals. This approach could mirror that taken by the Hospice-friendly Hospitals Programme.

Out-patient facilities are often not Age Friendly due to waiting times and lack of adequate facilities. In November 2006, a rapid access clinic in the community was opened in Smithfield in Dublin to provide care for older people with urgent but non-emergency care on the basis of referrals by their GPs or by emergency departments. The community-based initiative provides access to diagnostic facilities such as X-rays, magnetic resonance scans and computed tomography scans that are usually available only through A&E departments. A review of the clinic by the HSE found that 42% of new patients had avoided hospital admission through an emergency department. The Comptroller and Auditor General, in a review of the use of emergency departments, concluded

that “*it is likely that the clinic has provided significant savings by comparison with the cost of acute hospital care*” (C&AG 2009).

Increased communication and cooperation between hospital authorities and local authorities could also help to prevent or mitigate problems associated with hospital discharge. There is significant developmental work ongoing in the homeless and disability sectors which can inform process of enhanced communication and cooperation.

Earlier and more efficient discharge planning with targeted dates for discharge could ensure that home adaptations are embarked upon sooner and take into account the expected length of hospital stay. Lessons can be learned, for instance, from advances that have been made in the homeless sector where mental health facilities and prisons are communicating with local authorities in accordance with the National Homeless Strategy to establish protocols and arrangements to engage in pre-planning for the integrated provision of housing and care to homeless people.

Similarly, the National Housing Strategy for Disability, published in 2011, sets out a framework for the delivery of housing for people with disabilities through mainstream housing policy by focusing on the interaction of public agencies in addressing the housing needs of people with a disability. While the overall strategic assessment is carried out by the local authority, individual needs are addressed on an individual basis with contact with all relevant agencies and service providers.

Issues Arising

Emergency Department use: There is evidence that many older people who need access to a hospital bed have to go via Accident and Emergency in order to gain admission. ‘A&E’ can be a particularly traumatic environment for many, particularly the ‘older old’ and those with sensory and cognitive impairments

Unnecessary Admissions: The PA Consulting Group’s report, *Towards an Integrated Health Service or More of the same?* (2008), found that 40% of patients in acute hospitals were inappropriately in hospital. This in itself causes unnecessary trauma to them and their families, and involves the additional risk of contracting an infectious disease or ‘hospital bug’. However, the current instruments for measuring ‘inappropriate admission’ do not take account of the more complex needs of older people.

Needs Assessment: Detection of cognitive and functional losses, which are important predictors of complexity of care and length of stay, are not routinely incorporated into hospital admission protocols for older people.

Discharge Planning; In Ireland, despite evidence that early discharge planning can greatly reduce post-discharge problems, the PA report, *Acute Hospital Bed Capacity Review* (2002), found that discharge planning was only in place for 40% of all patients.

Delayed Discharge: Figures suggest that there as many as 750 older people who are not discharged at the appropriate time because of delays in home adaptations, access to suitable rehabilitation, or access to long-stay accommodation. While this is a small proportion of overall admissions, such delays can mean greater risk of infection and of institutionalisation of older people.

Waiting lists: Many older people experience very lengthy delays in getting treatment, particularly ‘elective treatments’ such as hip replacements or cataract operations. These can cause further co-morbidity, and therefore lengthier and most costly treatment.

Age Friendly hospitals Older people account for three-quarters of admissions and in-hospital bed-days, yet in general, hospitals have not been designed to cater for their specific needs, of older people, particularly

those relating to co-morbidity and cognitive and sensory impairments. In addition, not all staff are adequately trained to handle the communication and interaction challenges associated with caring for older people.

2.8. NURSING HOME CARE

The older people living in residential care homes are generally those who are most frail, have most disability and experience the most complex health problems. Although less than 5% of older Irish people are in nursing homes at any one time, international data suggest that up to 29% of men and 40% of women will spend time in a nursing home at some time during their lifespan. This topic is dealt with in detail in Chapter 6 where it discusses the broader aspects of where older people live; this section focuses on the health aspects of long term care for older people.

2.8.1. Care Standards

There has been some disquiet in Ireland for some years over the standards of care provided to older people in residential care, and fears that they have fallen below established levels of best practice - fears which were brought to a head by experiences in the Leas Cross Nursing Home. Many long-term care facilities do not provide the appropriate medical services leading to hospitalisation and the discomfort of the older person. Following the Leas Cross expert review of a nursing home, the Department of Health and Children accepted a set of 12 recommendations which are set out in the Leas Cross Report (O'Neill, 2001).

Many of these relate specifically to health care and include:

- For those who are not looked after by the GP who provided care while at home, the medical cover must be more clearly and unambiguously specified in terms of

relevant training (at least the Diploma in Medicine for the Elderly or the equivalent), responsibilities and supports from the HSE;

- Multi disciplinary team support must be clearly specified both in terms of meeting need and facilitation of team work and requires at a minimum: physiotherapy, occupational therapy, speech and language therapy, clinical nutrition and social work;
- Specialist medical support (geriatric medicine and psychiatry of old age) need to be developed to provide formal support to the medical officer, nursing staff and therapists.
- An electronic version of the Minimum Data Set should be made mandatory for all patients in nursing home care to assist in the development of individual care plans, the monitoring of quality and the provision of national statistics on dependency, morbidity and mortality.

The Department of Health and Children and the National Treatment Purchase Fund (NTPF) have decided to exclude the following areas of treatment and support from the nursing home services which are covered by the Fair Deal Scheme: social programmes; all therapies; incontinence wear; chiropody; ophthalmic and dental services; transport and specialised wheelchairs. Three therapies – physiotherapy, occupational therapy and speech and language therapy – are widely seen as crucial to maintaining independence and mobility and many gerontologists and older people's organisations have argued strongly that these exclusions from the 'Fair Deal' scheme, are a retrograde step.

HIQA Nursing Home Care standards have been operational since 1 July 2009. Inspections have been carried out in a number of nursing homes since 2009 and reports have been published. These reports highlight the successes

and failures of homes in relation to compliance with the standards and there is some evidence that changes are taking place in nursing homes throughout the country in response to the published inspections (www.hiqa.ie).

There is some evidence that many conditions are undiagnosed in nursing homes. Prior to the introduction of the HIQA standards there was no requirement to carry out a health assessment on admission to a nursing home, unlike the US. One of these standards (Standard No. 13 of the HIQA standards), now sets out a requirement that each resident's assessed health needs are reviewed and met on an ongoing basis in consultation with the resident. According to this standard, all policies and procedures, including rehabilitation policies, based on current best practice are developed, implemented and reviewed on an annual basis. In addition, the resident is to be referred where necessary to appropriate and all information is to be recorded.

Where medical care is not provided by the residential care setting team, the resident is to receive high quality service from the GP with whom the resident is registered. In this way, HIQA has not stipulated a minimum level of medical care that is appropriate for provision in long-term care settings and it may be an option to extend HIQA standards to encompass more specific requirements in this area. This would mean much more intensified monitoring of the management of residential care facilities and may have significant resource implications.

Issues Arising

Levels of medical care: Neither the HSE nor the Irish College of General Practitioners (ICGP) has delineated standards of medical care in nursing homes. At present it is unclear how many long-stay nursing homes can provide the medical care older people need, or whether they are being unnecessarily transferred to hospitals with illnesses that could be treated

in the care home. Preliminary data from Cork University Hospital suggests that patients frequently benefited from in-hospital treatment that could not be provided in a nursing home.

Support for Therapies: The Department of Health and Children and the National Treatment Purchase Fund (NTPF) have decided to exclude the following areas of treatment and support from the nursing home services which are covered by the Fair Deal Scheme: social programmes; all therapies; incontinence wear; chiropody; ophthalmic and dental services; transport and specialised wheelchairs. Three therapies – physiotherapy, occupational therapy and speech and language therapy – are widely seen as crucial to maintaining independence and mobility and many gerontologists and older people's organisations have argued strongly that these exclusions from the 'Fair Deal' scheme, are a retrograde step.

2.9. END OF LIFE CARE

There are many complex dimensions to the appropriate provision of end-of-life support and care to older people, including:

- The quality of care received;
- Recognition of the approaching death on the part of the individual, their family and their medical team;
- Individual choice;
- Respect for the older person's dignity; and
- Appropriate responses to their vulnerability at this life stage.

2.9.1 Quality of Care

What determines quality of life for terminally patients has been the subject of much research and over the past decade, several initiatives have focused on optimizing care and the satisfaction with the quality of care. An Irish study into the priorities of respondents when in the last

stages of terminal illness found that the three most important things for people facing death are; to be surrounded by people they love, to be free from pain and to be able to communicate (IHF 2004).

In a study of the care received in the 48 hours before death, participants whose family members were in nursing homes before death identified a number of problems; higher unmet needs for pain, concerns that the resident was not always treated with respect, concerns about communication with the physician and information received about what to expect while the patient was dying, and concerns about the amount of emotional support provided to themselves and their loved one. Overall, care received in the nursing home was significantly rated as the lowest in terms of assessment of the quality of care (41.6% versus 70.7% for home hospice, 46.8% hospital, 46.5% home care with nursing services) (Teno et al., 2004).

Steinhauser and colleagues (2000) examining the factors that contributed to a 'good' death (2000) found that patients primarily identified pain and symptom management, clear decision making, preparation for death, completion, and contributing to others, as key factors. While physicians overwhelmingly focussed on pain and symptom management. Patients also stressed the importance of constant communication and being mentally aware. Providers and families also identified the need for improved communication and clear decision making and feared entering a medical crisis without knowledge of patient preferences.

Studies have shown that large numbers of Americans have substantial pain in the last days of their lives. A pilot study on older patients' end-of-life needs carried out in Sweden found that elimination of physical pain was ranked as the primary need of half of the patients. Only when pain was eliminated or absent were other important needs (psychological, social, spiritual) acknowledged (Wijk and Grimby

2008). Concern about under-treatment of pain is consistent across surveys of physicians, nurses, and recently bereaved family members (Steinhauser 2000) Older people are less inclined to vocalise their suffering of persistent pain with the result that pain is under-recognised and under treated in older people. (Colette et al 2007)

A Canadian study sought to describe what seriously ill patients in hospital and their family members consider to be the key elements of quality end-of-life care. They found that having trust and confidence in the doctors looking after you was the element rated as "*extremely important*" by most patients (55.8%). Fears about being kept alive on life support was also a concern for a majority (55.7%), and concerns about honest communication from the doctor was the third biggest concern (44.1%). Finally, people felt that a sense of completion, a chance to review life, resolve conflicts and say goodbye was also important to many respondents (43.9%) (Heyland 2006).

A large study of bereaved families identified the particular aspects of hospice care that provided most support to family members. They found that respondents were almost four times more likely to be happy with the care received if they were regularly informed about their loved one's condition. They were twice as likely to offer higher evaluations of the care if they felt they received the right amount of emotional support prior to the patient's death. Provision of accurate information by the hospice team also led to higher levels of satisfaction among relatives (Rhodes et al 2008).

2.9.2. Place of Death

Research shows that, while the majority of people would like to die at home, most of the 30,000 people who die in Ireland each year, die in a hospital, or similar setting, outside the home. At least half of all deaths occur in acute hospitals

(48%) or hospice (4%); deaths at home make up a quarter of the total (25%), and a fifth die in long-stay facilities (20%; the remainder are deaths from suicide and traffic accidents (3%). (Irish Hospice Foundation, 2004) Some 40 per cent die in acute hospitals often because they are admitted in the last days of life when care could take place at home. Another 40 per cent die in residential care settings (community hospitals or private nursing homes).

There is evidence that in many cases this care could be provided at home. In the Netherlands, almost 60% of the patients with non-acute illnesses die at home where end of life care is coordinated by the general practitioner (GP); about 30% die in hospitals (cared for by clinical specialists), and about 10% in nursing homes cared for by elderly care physicians. (Rurup et al 2010).

Almost 22,500 people aged 65 or older die in Ireland every year and while most people want to die at home, two-fifths of these older deaths (9,000 approximately) occur in acute hospital settings, with roughly the same number dying in public (5,625) and private (3,375) long-stay facilities. A total of 60 per cent of recorded deaths were in long-stay facilities. The remainder, approximately 4,000 older people, die at home. (O'Shea et al., 2008: 29).

Where comprehensive services have not been developed, it appears that more people die in acute general hospitals. In contrast, where services are better developed, there appears to be an increased incidence of death in a hospice, special in-patient unit or home-care setting (IHF/HSE Baseline Study 2005). Facilities for end of life in many acute hospitals, especially in terms of structure and design, are unsuited for patients and recent research found that more than half of people who died in acute hospitals or psychiatric hospitals died in multi-bedded rooms. (O'Shea 2008).

A study carried out in the UK, asked older people about their views on home as a place

to die. It found that while participants would prefer to be cared for at home when dying, they recognised that there were practical difficulties associated with it. Some had no family carer, others did not want to be a 'burden' to family and friends, or were worried about these witnessing their suffering. Those who had children did not wish them to deliver care that was unduly intimate. They also expressed concerns about the quality of care that could be delivered at home, particularly in relation to providing adequate symptom relief and facilitating the use of health technology. Some expressed mixed views about professional carers in the home, while they recognised the potential support they could offer the family carer, the presence of 'strangers' was regarded by some as intrusive and compromising the ideal of 'home'.

The authors acknowledged that these findings run counter to assumptions that the institutional death must be avoided and argued that it is important to recognise that rather than demonizing the hospital as a place of death the issue is whether the hospitals or other institutions setting can be made to better suit the needs of the older person at the end of life (Seymour et al 2004).

To support this preference for dying at home, a wide range of primary health care services may be required, as well as considerable supports for carers. The availability of such care is very variable at present, with some parts of the country benefiting from better levels of support for patients and their carers than others.

A study carried out in Wales found that there had been an increase in the number of deaths taking place in care homes and hospitals in the last 20 years. The study found that the number of deaths in the community had halved, while the number in hospital has gone up slightly and the number in care homes has nearly trebled (Ahmad and O'Mahony 2005).

In Ireland there are currently eight dedicated specialist in-patient units operating throughout the country, and in addition a network of established home care nursing teams, which may or may not be linked to a specialist unit. Place of death is strongly influenced by the provision of access to the full range of hospice and specialist palliative care services and settings.

2.9.3 Palliative Care

A report by the European Parliament (2007) ranked Ireland second in Europe, after the UK, in its provision of palliative care services. Palliative care was defined by the World Health Organization in 2002 as, 'an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial and spiritual'. In addition, one of the core principles of palliative care is that it should enable people to exercise genuine choice about the care they wish to receive.

Traditionally, palliative care has generally been given to people suffering from cancer because the predictable nature of the illness makes it easier to plan and as a consequence the perception has grown that palliative care is only relevant to the last few weeks of life (WHO 2004).

Palliative care, both specialist and non-specialist, is provided in all care settings, including hospitals, specialist palliative care units and the community. In Ireland, there are currently eight dedicated specialist in-patient units operating throughout the country, and in addition a network of established home care nursing teams, which may or may not be linked back to a specialist unit. Pace of death is strongly influenced by the provision of access to the full range of hospice and specialist palliative care services and settings.

The “*National Action Plan for Palliative Care Services*” which was published as official HSE policy in June 2009, proposes to implement agreed national policy as outlined in the report of the national Advisory Committee on Palliative Care (DOHC 2001). The key element of this five year plan is that it addresses the regional deficits in hospice services. While acknowledging that current financial resources are limited there is a real opportunity to achieve implementation in the context of re-configuration within the HSE at no additional costs as patients can be treated more cost effectively within palliative care services - as more than 80% of care by hospice services is provided in the home.

Although most deaths occur in the over-65 population, comparatively little research has been carried out on their needs for palliative care. A WHO Europe report published in 2004, *Better Palliative Care for Older People*, points out that older people have particular needs and requirements in relation to palliative care, since their health problems are different from, and often more complex than, those of younger people:

- Older people are more commonly affected by multiple medical problems of varying severity;
- The cumulative effect of these may be much greater than any individual disease, and typically lead to greater impairment and needs for care;
- Older people are at greater risk of adverse drug reactions and of iatrogenic (drug-related) illness;
- Minor problems may have a greater cumulative psychological impact in older people;
- Problems of acute illness may be superimposed on physical or mental impairment, economic hardship and social isolation (www.eapcnet.org).

2.9.4 Hospice Friendly Hospitals Programme

Research has consistently shown that hospice use has improved the quality of care patients receive at the end of life. Hospice professionals have long observed that the care they provide appears to reverse the decline of some dying patients and there is even evidence that hospice care also may prevent suicide and suicide ideation among terminally ill persons and their family members suffering from despair, severe pain, and acute depression (Schultz and Beach 1999).

A national initiative in palliative care was initiated by the Irish Hospice Foundation, called the Hospice Friendly Hospitals Programme. In May 2007 the HfH Programme, commissioned a review of the physical environment of hospitals participating in the programme. The review identified a number of issues to be addressed including;

- The lack of facilities for private consultations and conversations in situations where confidentiality is paramount;
- The extent to which already very limited single-room accommodation is denied to the dying and their families because of the priority given to infection control and isolation;
- The lack of facilities for families; the poor quality of mortuary facilities.

The Programme seeks to change the culture of care and organisation provided in hospitals for people who face death, and their relatives who face bereavement. The aims of the Hospice Friendly Hospitals programme are:

- To develop comprehensive patient focused standards for all hospitals in relation to dying, death and bereavement;
- To develop the capacity of acute and community hospitals to introduce and sustain these standards;

- To improve the overall culture in hospitals and institutions in relation to dying, death and bereavement.

There are now over 40 hospitals participating in the programme, of which 20 are acute hospitals.

2.9.5. End of Life Decisions

At end of life there is generally an emphasis on the importance of autonomy and allowing patients to make their own medical decisions and decide on the course of their medical care. However in some cases patients lack the functional capacity to make their own decisions and in these situations doctors frequently rely on next-of-kin or other patient designated surrogates to make decisions.

However decision making by surrogate can often be problematic. A review of the literature in this area found that the decisions made by next-of-kin or other designated surrogates were frequently wrong and did not accurately predict the patients' preferences in one third of cases. In one study, surrogates' decisions were wrong 30% of the time leaning mostly toward over-treatment.

Twelve studies analysed the type of mistake surrogates make when they judge patients' treatment preferences: Three studies found that they provide interventions that the patient does not want; 1 study found that surrogates tend to withhold interventions that the patient does want; and 8 studies found mixed results or no consistent trend (Shalowitz 2006).

Advance care planning therefore is an important care option. However a study of house-bound chronically ill older people in the US revealed that many were reluctant to think about, discuss or plan for serious future illness (Carrese et al., 2002 3). Instead, they described a "*one day at a time*" or "*what will be will be*" approach to life, preferring to "*cross that bridge*" when they needed to. The main reasons supporting the importance of advance care

planning include wanting to preserve dignity, affirm religious beliefs, remain in control during disability, and remain communicative.

Many people would prefer to give up some longevity for quality of life, and regard certain life situations as worse than death. Research has found that many patients choose for particular life-sustaining treatment to be withheld or withdrawn in certain circumstances (Wenger et al. 2000; McCarthy et al 2000). Other studies have shown that physicians choose to withdraw life-sustaining treatments when faced with terminally ill patients.

An Advance Care Directive (ACD) or 'living will' sets out a person's wishes about what should happen to them in the event of an incapacitating accident or illness that makes it impossible for them to communicate their wishes directly. It can be written or verbal and the person will often also nominate someone (a health care proxy) to carry out their wishes.

The Law Reform Commission (LRC) in 2009 published a report on bioethics/advance care directives which made a number of specific recommendations and proposed the introduction of a new Mental Capacity (Advance Care Directives) Bill 2009. One key recommendation is that the principle of autonomy, dignity and privacy of the individual should form part of the legislative framework for advance care directives.

Among its main recommendations are:

- That legislation should be enacted governing ACDs, which does not alter current law on homicide, (under which euthanasia and assisted suicide are criminal offences) and does not apply to ACDs involving mental health care.
- That a person should be entitled to refuse medical treatment for reasons that appear not to be rational or based on sound medical principles, and to refuse medical treatment for religious reasons.
- That an ACD should be applied if the treatment is specified in it and all the circumstances outlined are present. And further that while competent, the author of the ACD said or did nothing which puts reasonable doubt in the mind of the healthcare professional that the author had changed their mind, but did not have the opportunity to revoke the directive. If the ACD is ambiguous, there should be a presumption in favour of preserving life.
- The existence of any ACD should be brought to the attention of the court when it considers the appointment of a personal guardian.
- The Scheme of the Mental Capacity Bill 2008 be extended to allow a person to appoint an attorney under an enduring power of attorney (EPA) to make decisions regarding life-sustaining treatment and organ donation, provided these are provided for in the EPA.
- Basic care such as warmth, shelter, oral nutrition and hydration measures should be defined to include palliative care and should not be refused under an ACD.
- That a refusal of treatment recorded on a person's medical chart may be deemed to be a written ACD and that a clear written statement in the form of, for example, a 'no blood' card can be deemed to be an ACD.
- There should be a code of practice drafted to provide guidance on the creation and execution of ACDs, and ACDs should be able to be revoked verbally (Law Reform Commission 2009)

In May 2012, the Oireachtas Committee on Justice, Defence and Equality published a 740 page report on the Mental Capacity Bill. The report advocated a human rights based approach to the legislation and said that the outdated wards of court system for people with

restricted legal capacity should be replaced with a system of assisted decision making. Emphasis was made on the importance of assisted rather than substitute decision making, and the current 'best interests' approach was described as outdated and paternalistic. The long-awaited Bill is expected to be published in 2012.

Issues Arising

Location of death: Over two-thirds of people surveyed by the Irish Hospice Foundation (IHF) expressed a wish to die at home if possible, but at present most people are denied this choice and die in acute hospitals or long-stay residential settings (Irish Hospice Foundation, 2004). Each year two-fifths of these deaths (9,000 approximately) occur in acute hospital settings, with roughly the same number dying in public and private long-stay facilities (5,625 and 3,375 respectively). 18% (4,000) die at home (O'Shea et al. 2008:29). While some medical conditions will require hospitalisation, many could be responded to at home if better medical care and support could be provided there.

Dying in hospitals: Despite the fact that so many people die in hospitals, end-of-life care is still not seen as a core activity of hospitals, and is not normally included in service plans. Neither is its importance adequately reflected in hospital cultures, systems and structures. Facilities and services tend to be unsuitable for dying patients, with recent research showing that more than half of people who died in acute hospitals or psychiatric hospitals died in multi-bedded wards (O'Shea 2008).

Access to Palliative Care: Palliative care for the management of pain has traditionally been focused on people with cancer, and has rarely been available to older people suffering from chronic illnesses, including those approaching death in long-stay care settings. While there has been significant improvement in the

level of community-based palliative care and hospice services, there are still significant regional variations.

These vary from 5.57 palliative care beds per 100,000 people in HSE West to 2.03 beds per 100,000 in Dublin North East. There is also evidence that older people tend not to report, or to under-report, their pain levels, so that pain is often under-treated (Colette et al 2007). In a recent study on end-of-life care in Ireland, only two-fifths of those surveyed had access to consultant-led palliative care teams, and this was particularly true of long-stay facilities (O'Shea, 2008).

Need for Advance Care Directives: Research by the Law Reform Commission and others has revealed considerable confusion and uncertainty regarding the dying person's right and ability to direct their own care up until the time of death, either through advance care directives, or by retaining that control directly themselves. Frequently, decisions made by next-of-kin or other 'designated surrogates' were wrong and in, one-third of cases, did not accurately predict the patients' preferences. In one study, surrogates' decisions were wrong 30% of the time leaning mostly toward over-treatment or providing interventions that the patient does not want (Shalowitz 2006). Advance care planning therefore is an important care service.

2.10. DISABILITY SERVICES AND HEALTH NEEDS

The 2006 Census found that at least 9.3% of the population have disabilities and that there were 138,300 people with disabilities aged 65 and over or about 35 % of all people with a disability. (Updated figures from Census 2011 are due for publication in November 2012)

The follow-up National Disability Survey by the CSO (www.cso.ie) indicated the prevalence

of disability could be as high as 18.5% - one in six of the population - when those who did not describe themselves as “disabled” in the Census but have equivalent functional difficulties are taken into consideration (National Disability Survey 2006). These were people who reported having a long-lasting condition and/or difficulties with undertaking certain everyday activities.

The National Disability Survey also found that the highest concentration of numbers relate to those with significant difficulties in breathing (4%), pain (8.6%); and mobility (8.3%) (National Disability Survey 2006).

The survey also found that the level of disability varied with age: while approximately 26% of those aged 65-84 reported they had a disability, this applied to almost 59% of people aged 85 and over. Women aged 65 and over were more likely than men to report a disability (CSO 2007).

The data revealed that one-third of adults with a disability had some difficulty doing routine tasks inside their home because of their disability, a further 19% had a lot of difficulty. Overall, 43% of men had difficulty compared with 59% of women. Around 56% of persons with a disability received help with their everyday activities. The most common source of help was from family members who lived with the person - 42% of persons in private households who had a disability received such help.

Bathroom adaptations were the most used adaptation in the home with 20% of persons with a disability in private households using them. This proportion rose to 45% of persons aged 75 & over. A further 12% of persons with a disability in private households needed but did not have bathroom adaptations. A lack of money was the most common reason for not having specialised features in the home with over half (52%) of adults in private households with a disability citing this as a reason.

In Irish nursing homes, approximately 9 out of 10 people have at least one disability (Falconer, 2007). Given the population projections for future years, and the association between increased age and increased disability, it is clear that the number of older people with a disability will increase. Some will have had a disability throughout their lives, whilst others will experience ‘late-onset’ disability. The experiences of these two groups will be very different, and will pose different challenges to the individuals themselves and to services.

It is important to consider the needs of persons with disabilities who are ageing and persons who acquire disabilities as they age. Currently, within the health and social services systems in Ireland, both groups are considered separately and administrative structures reflect this division. Services are managed by the Primary, Community and Continuing Care Directorate (PCCC) and at local level by the Local Health Managers. There is an Expert Advisory Group to offer management expert advice in each area. Differences in the social welfare entitlements of the two groups can create anomalies in provision, for example, when people with lifelong disabilities reach age 65, they no longer receive Disability Allowance but become recipients of the state pension.

Examples of the inflexibilities currently within the system include the exclusion by people over 65 from some allowances and supports such as the Mobility Allowance . People over 65 cannot currently apply for the personal assistance scheme and those under 65 with a disability are often not eligible for the home care package. A number of recent Irish policy documents have highlighted the need for care supports to be integrated at a local level around the needs of the individual rather than be delivered in disjointed way by a number of different agencies (NECS 2005). Whether different elements of care come from one or more agencies or from different care-group

funding streams, that care needs to be delivered in a co-ordinated way to the individual.

2.10.1. Policy and Planning

Policy development within the fields of ageing and disability are traditionally addressed independently of each other (Weber & Wolfmayr, 2006). One consequence of this division is that those with lifelong disabilities who are now experiencing greater life expectancy may be excluded from generic age-specific services, on the grounds that they may be experiencing early onset conditions and therefore may not reach the minimum age criteria for these services.

People with lifelong disabilities may also be excluded from generic age-specific services on the grounds that these service providers feel they lack appropriate disability expertise to adequately meet the needs of this population. A similar barrier to accessing services may also arise for those who are experiencing disabilities for the first occasion during their later years. They may be excluded from generic disability services on the basis of age and be referred to age-specific services for older persons. This 'double jeopardy' of ageing and disability requires appropriate service coordination to ensure that the needs of older persons with lifelong or acquired disabilities are appropriately addressed. (In Ireland the HSE operates two distinct service categories, with separate structures and budgets, for disability and for older persons.)

Despite the typically independent development of these distinct services, a combined field of ageing and disability studies has emerged in response to the growing evidence of increased life expectancy among those with disabilities (Haveman 2008). Advances in medicine, improved lifestyles and the mainstreaming of persons with disabilities into community living are major contributors to this longevity. People with Down syndrome, for example, show marked

gains in life expectancy from an average of 12 years in 1970, to 50 years in 2004 (Kibsgaard Larsen, & Kirkevold, 2008). Moreover, for those with mild levels of intellectual disability, life expectancy is now reported to be similar to the general population (Patia 2004).

Similar patterns of increased longevity are observed for those with a lifelong physical disability, such as those with multiple sclerosis (Putnam, & Tang, 2007), traumatic brain injury (Colantonio et al 2004), and spinal cord injury (Holicky, & Charlifue, 1999). This increase in life expectancy has created a new ageing population of people with lifelong disabilities (Patia et al 2008). It is likely that many of these 'new elderly' represent a healthy cohort phenomenon, that is, they are 'healthy survivors' from limited support services of the past. There is an expectation that those born in more recent times, some of whom will have considerably poorer health status than the healthy survivor cohort (Hogg et al 2000), are expected to join the ranks of tomorrow's adults.

The way in which the National Disability Strategy (NDS) could potentially link in to the National Positive Ageing Strategy, allowing advances made under the NDS to translate into improvements for older people, will be discussed further in the chapter on Strategy Implementation.

2.10.2. Primary Care for People with Disability

Under disability legislation GP clinics are not required to adhere to accessibility requirements and as such are often unsuitable to the needs of older people with a disability. One major concern is that older people with a disability may be excluded from community-based services and that the specialist knowledge which is often necessary to the effective treatment and case management of people with a disability would be unavailable. In this regard there is a need both to improve access

at PCT and GP level as well as to harness the specialist knowledge of the specialist voluntary organisations working in the disability sector.

Voluntary organisations possess highly specialist knowledge regarding a wide range of disabling conditions which would not otherwise be present among the members of a PCT. At the moment, while the majority of voluntary organisations working in the area of specialist health issues relating to disability are funded by the HSE, there is no formal relationship between them and HSE personnel and no automatic referral to specialist organisations and support groups when a person presents at their local GP with symptoms of a particular disabling condition.

2.10.3 Availability of Data

The collection of accurate data concerning older people with disabilities in Ireland is a significant issue that has major implications for analysis of need and planning for services and supports. This is true for older people living independently and for those living in long-term care settings. The NDA and NCAOP drew attention to deficits in information and data on older people with disability. For example, the National Physical and Sensory Disability Database excludes those whose disability arises beyond the age of 66. There are difficulties in relation to services – for example, admission to the National Rehabilitation Hospital is restricted to those aged 65 or under.

While the database model is effective for people with intellectual disability, it is less so for people with other kinds of disabilities as it relies on voluntary participation. There are limitations to the quality of information that can be obtained from the database any complex queries or show co-morbidity of conditions with any effectiveness. The Unique Patient Identifier (UPI) might prove the most effective option in this area.

These databases could be expanded to include older people living with a disability in order to ensure that data is available to facilitate long-term planning and ensure transfer of information.

While this directly addresses the issue of the lack of data, it has further implications for the perpetuation of the artificial separation between services and entitlements for disabled people on the one hand and older people on the other. This separation leads to a situation where a person living with a disability is forced to switch services on turning 66 years. This is often disruptive at best and at worst can have a severe impact on the quality of services received. The fact that there is no information sharing between the sectors also has meant that there is no continuity between services and assessment of need.

There are issues around funding, with the fact that often services for people with a disability and older people are pitted against each other. In addition, there is internal competition within disability services as between intellectual disability on the one hand and physical and sensory disability on the other. A remodelling of funding mechanisms where the money follows the person rather than the sector or sector of the population as defined. This would lead to a mainstreaming of services and a breakdown of funding silos.

The recent National Economic and Social Forum (NESF) review of home care packages was inconclusive with regard to their being used by people with a disability and the service was not confined to older people.

Issues Arising

'Double jeopardy': there are two key consequences of the separation of disability services and older people's services. One is that those with lifelong disabilities – who nowadays have longer life expectancy than in the past – may be excluded from generic age-related services, because they have not reached the minimum age for eligibility for these services. Conversely, a barrier may arise for those who

are experiencing disability for the first time in their later years, but who may be excluded from generic disability services, and referred instead to services for older people.

Specific problems of disability in later years: A related problem is that people with disabilities are in some instances effectively forced to change care providers once they reach 65, resulting in a serious discontinuity in their care.

GP clinics: Under the current disability legislation, GP clinics are not required to conform to accessibility requirements, and so may be unsuitable for older people with a disability, thus effectively excluding them from community-based services, and from the specialist knowledge necessary for the effective treatment and case management people with disability.

Expertise of voluntary organisations: The wide ranges of voluntary organisations and support groups around the country responding to specific disabling conditions have accumulated high levels of specialist knowledge which is not always available within a Primary Care Team. Although the majority of these voluntary organisations are funded by the HSE to provide services, no formal working relationships exist, and there is no automatic referral to the appropriate organisation when a person presents at their local GP with symptoms of a particular disability.

Healthy Life-styles: One research study found that around half of the people with a disability in private households experienced difficulties with various day-to-day activities: 'going to town' shopping (56%), going away for a break or holiday (53%), taking part in community life (54%), and socialising in a public venue (49%). For them to live as actively and healthily as possible with disability requires very specific supports and encouragement.

Specialist Care Providers: Professional care providers are often unaware of the challenges

faced by older people who experience the onset of disability in later life, which are very different from the challenges faced by those whose disability is life-long.

Conclusion - Key Issues

As discussed earlier, the number of older people in Ireland will rise substantially in the next decade. The key issues to be considered are;

Long-Term Planning

There are no medium or longer terms Health Service Plans to address the projected doubling of the 65+ population and the quadrupling of those over 80 by 2030. These demographic changes are linked to a predicted increase in chronic health conditions which will inevitably impact the health services, calling into question the sustainability of the current system. A longer-term strategy will require a change of focus from treating illness to promoting health, from the reliance on acute hospitals as the settings for delivering services to more preventative health measures in community settings.

There will also be a need for large scale increases in gerontologically trained health professionals and for increased specialisms within the field of gerontology. Introducing changes to address these issues take time and resources and need to be planned for in order to ensure a system 'fit for purpose'.

Health Promotion And Prevention

Less than 3% of the health care budget is spent on health promotion and prevention, yet many of the conditions of older age can be prevented or at least delayed through a combination of primary prevention measures, screening and early intervention. While much can be done through such approaches to improve people's health in later years, the real 'prize' is to have people arrive at 'old age' in a healthy condition in the first place.

The research shows that a life-course approach aimed at improving people's health practices and life-styles much earlier in life will do much to increase the odds for healthy longevity. The key elements of an effective prevention approach will combine the classic three levels - primary (healthy diet, regular exercise, no smoking and moderate alcohol consumption), secondary (early screening and diagnosis) and tertiary (early intervention).

Chronic Health Conditions

Chronic diseases already account for between 70-80% of European health care costs amounting to €700bn and 86% of deaths. (Economist Intelligence Unit 2011) While much can be done to prevent, delay or mitigate the conditions, a new approach to the treatment and care of those suffering from them is also required, based on the growing body of evidence of what works best. Effective treatment of chronic conditions differs from the care of acute conditions. Hospitals, apart from being expensive, are not necessarily the best locations for treatment.

Many people suffer from more than one condition and face challenges in coordinating their own care among the silo-specialisms. Instead a patient centred chronic care system would integrate the medical and other social care services and combine a blend of self-care and in-home support as well.

Dementia Strategy

Dementia is a good example of one of the chronic health conditions forecasted to grow significantly

and which requires a new approach. Ireland does not have a National Dementia Strategy, unlike many other European countries such as the UK and France, which have recently been prioritising this issue. The number of people with dementia in Ireland is projected to grow from 38,000 at present to 104,000 by 2050, in line with projected growth across Europe so the need for a medium and long-term plan to address how best to respond to such increases is badly needed.

The Alzheimer's Society has suggested a four pronged approach combining early diagnosis and treatment, provision of more supports to people living independently in their own homes and communities, more effective home-based and nursing home care for those with advanced dementia and adequate support for family carers.

Hospital and Medical Care

The projected increase in the number of older people make the issue of health care reform even more urgent. At present over three-quarters of all admissions to hospitals are of people aged 65 and over and many have to be unnecessarily done through A&E, causing particular stress for older people. We know from the PA Report that 40% of patients in acute hospitals on any one day are inappropriately there. There is a need to begin developing alternatives that reduce the requirement for admission through the provision of day-care specialist services, better use of primary care, and more support for self-care including greater use of diagnostic and monitoring technologies in the home.

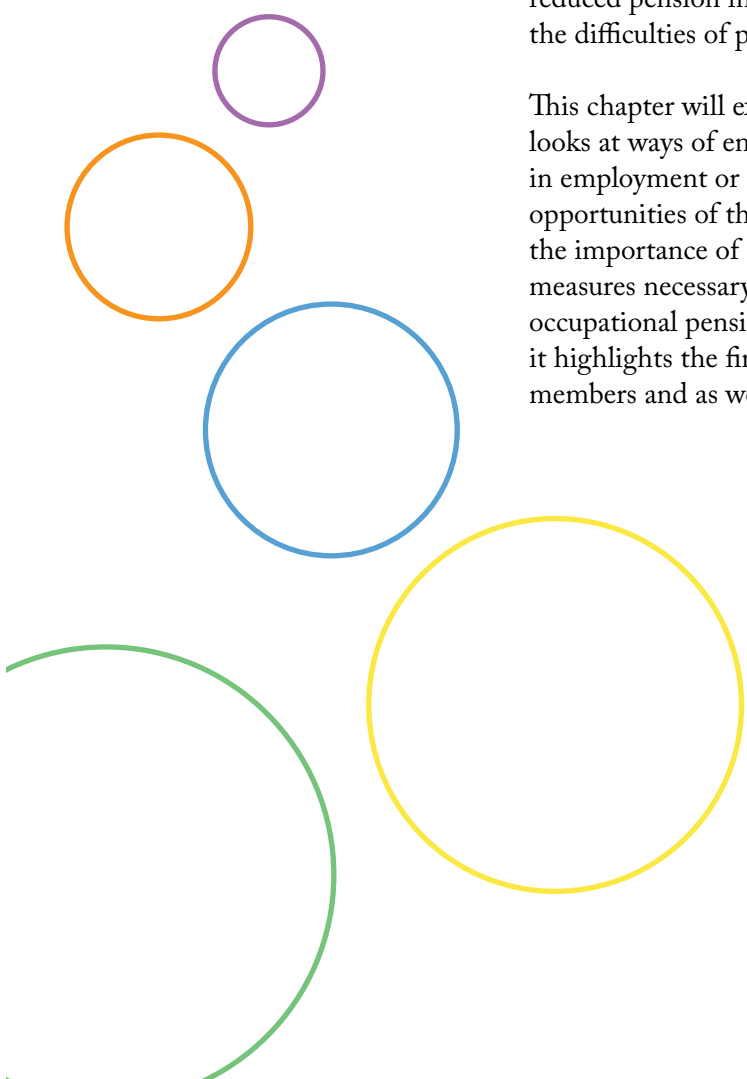
Chapter 3.

Wealth

An adequate, stable and secure income during later life can play a crucial role in maintaining good health, facilitating greater engagement in wider society and promoting a greater sense of security among older people. There are concerns that the predicted change in our population structure is likely to present challenges for our pension system and that our current system is not sustainable. However we are in the relatively fortunate position of having time to consider these issues and implement policy changes to lessen the impact.

The challenges will come at government level from the larger numbers of older people drawing pensions for longer, being funded by fewer people of working age. At the household level these challenges will come from the reduced pension income resulting from the current economic crisis and from the difficulties of planning adequately for a longer than expected retirement.

This chapter will examine the factors contributing to early retirement and looks at ways of ensuring that greater numbers of older people remain in employment or self-employment and explores the key economic opportunities of the silver markets and for silver entrepreneurs. It discusses the importance of the state pension in protecting against poverty, identifies measures necessary to ensure adequate replacement income through occupational pensions and examines possible models for reform. Finally, it highlights the financial contribution made by older people as family members and as workers.



3.1 EMPLOYMENT OF OLDER WORKERS

Pension reforms announced in 2010, increasing the age of entitlement to the state pension on a phased basis to 66 in 2014, 67 in 2021 and to 68 in 2028, will mean that older people in Ireland are likely to remain in the workforce for longer. However postponing retirement age is unlikely to succeed in reducing the cost of pensions to be paid by the state unless the additional working years remain productive. The alternative is an increase in the numbers of unemployed older persons prior to retirement age.

3.1.1. Employers Attitudes to Older Workers

Some Irish employers when surveyed have expressed concerns that older people have inappropriate skills, are less productive, less flexible, less ambitious, and take more sick leave than younger people (quoted in Green Paper Section 14.21). However a 2001 ESRI survey found that attitudes of Irish employers were generally positive and that larger companies appear to particularly value the positive influence that older workers can have. Others have argued that while older workers have more technical and firm-specific knowledge, they say these advantages come only with increased tenure within the firm and that hiring older workers will not bring these advantages (Koller and Gruber 2001).

The HSBC Future of Retirement Survey (2006) – an international study – found that while older workers are seen as more loyal and flexible, younger workers are regarded as quicker learners, more technologically oriented, somewhat more flexible, and somewhat less expensive. However the survey found that the tendency towards negative stereotyping of older workers is relatively weak: 49% of employers feel that older workers are at least as technologically

oriented and 43% find them at least as quick to learn as younger workers. The HSBC research was confirmed by two recent European studies (carried out in Poland and the Netherlands) which found that older workers tend to be valued more for their ‘soft skills’ (ie, social skills, management skills, reliability and loyalty), while younger workers are preferred for their ‘hard skills’ such as creativity, physical health, new technology skills, willingness to learn and flexibility. (Perek-Białas and Turek 2012; Van Dalen, Schippers and Henkens 2010).

Individual level research into the age-related changes that are important for productivity has tended to show that while older people perform less well across some abilities than younger people the trend is not uniform. A distinction must be made between what is known as fluid abilities and crystallized abilities (Schaie 1994). Fluid abilities are those related to the performance and speed of solving tasks related to new material, and they include perceptual speed and reasoning. Crystallized abilities are those which improve with accumulated knowledge, such as verbal meaning and word fluency. Fluid abilities have been found to be influenced by age while crystallized abilities remain at a high functional level until late in life (Horn and Cattell 1966, 1967).

For instance levels of manual dexterity continue to fluctuate until early middle age but managerial ability shows no decline after the early 20s. The level of experience peaks even later – and again shows no decline thereafter. The link between longer experience and higher levels of job knowledge has been explored to determine whether job knowledge can outweigh any decline in mental abilities. It was found that productivity reductions at older ages are linked to work tasks where problem solving, learning and speed are needed, while productivity among older people remained high in jobs where experience and verbal abilities are important (Skirbekk 2003).

The link between ageing, productivity and profitability at the level of the firm or company has also been explored by many researchers, frequently with conflicting results. A number of studies on age and productivity have found evidence that older workers maintain their productivity throughout their working lives. A Spanish study, using employer-employee data spanning over a 22-year period, found that the contribution of older workers to firm-level productivity exceeded their contribution to the wage bill. Their research compared age-wage and age-productivity profiles and found that productivity increases until the age range of 50-54, whereas wages peak around the age 40-44. So while at younger ages, wages increase in line with productivity gains but as they age, wage increases fall behind productivity gains making older workers more profitable. (Cordoso et al 2011) Similarly a Dutch study with a focus on the firm or plant level suggests that companies with high proportions of older workers are associated with higher productivity (Van Ours and Stoeldraijer 2010).

A comparative analysis in Greece, Spain, The Netherlands and the UK (Van Dalen, Henkens & Schippers, 2009) showed that despite knowledge of the perceived challenges presented by an ageing workforce, many employers took no substantial measures to retain and recruit older workers or improve their productivity.

3.1.2 The Age Friendly Workplace

Concerns about the potential impact of an ageing workforce have resulted in a growth in the number of studies looking at the management of older workers and the creation of age-friendly workplaces. Companies that rely on physical work are concerned about their workers' health and possible reduction in physical performance while other businesses with a growing number of older workers are worried about the impact on the company's

innovativeness or loss of valuable knowledge when large numbers retire.

In Ireland the ESRI study (2001) found that few companies (12 per cent) provide special supports aimed at workers aged over 45. Of those that do those that do provide supports, three-quarters provide flexible working, 41 per cent provide retraining in new areas of work and 12 per cent give exemptions from shift work. None of the respondents provide partial or gradual retirement options. Another Irish study looked at the barriers to increasing the participation of older people in the workforce and found that while there is some scope to increase participation of the over 55s, there are also many barriers. These include absence of suitable jobs, lack of flexible working arrangements, concern about the impact of paid employment on pensions and benefits and the existence of age discrimination (PACEC 2001).

Throughout Europe there is evidence that concerns about the impact of an ageing workforce have led to action and in particular to the introduction of a number of human resource and knowledge management initiatives aimed at avoiding the potential downsides of older staff while leveraging their particular strengths such as their experience. (Voelpel and Streb 2009)

A German study looked at the benefits of making workplaces more age-friendly. They identified a range of personnel measures that could help to increase productivity and retain older workers such as flexible working times, physical changes to the work places, a shift of older employees to workplaces with reduced requirements, mixed-age teams, and the inclusion of older employees in continuing training measures. The study compared the age-productivity profiles of companies with and without personnel measures aimed at improving the productivity of older employees. They found that actions such as reducing the work requirements and equipping the workplaces to suit older employees were

linked to a significantly higher level of relative productivity of older employees. They also found that age-mixed teams not only result in higher productivity of older employees but also have a positive impact on the productivity of younger employees. (Göbel and Zwick 2010)

A number of companies have undertaken initiatives, particularly in Germany and Italy, two countries with high proportions of older people. For example in Italy, the energy company ENI has provided training programmes for highly skilled workers over the age of 40. They have been given the title of “Knowledge Owner”, act as mentors to younger staff and also teach at the company’s corporate university to pass on knowledge built up through years of experience through a dedicated intranet accessible to all employees.

Another Italian company, the Ferrero Foundation and the German company BMW have both brought in policies on workplace design and health promotion, in order protect employee health and prevent physical decline. Ferrero has introduced a range of social and medical services available for their workers and created several satellite companies to help its workforce through the transition to retirement. (Voelpel and Streb 2010). BMW undertook a complete renovation of one of their plants, putting emphasis on the ergonomic and motivational needs of older workers. The company made 70 changes to workplace equipment that reduced physical strain and the chances of error. The total cost was €40,000 and a few hours of maintenance time and in return the company achieved a 7% productivity improvement in one year, equalling the productivity of lines staffed by younger workers. The changes also impacted on sick leave and absenteeism, which had stood at 7% prior to the changes — higher than elsewhere in the plant but typical for this mix of older workers. Following the changes absenteeism had dropped to 2%, below the plant average. (Loch et al 2010)

Management in the Mercedes Benz plant in Bremen, concerned about the impact of back injuries on future productivity, introduced the “Kraftwerk Mobil” - a mobile training unit similar to machines found in many gyms for strengthening abdominal and back muscle exercises. Under the full-time supervision of a trainer who, according to a schedule, physically moves it to the shop floor and the production lines, the machine has been found to be a successful tool, improving workers’ physical performance and contributing to motivation and work atmosphere.

There is also evidence that the effects of ageing can be offset, in whole or in part, by targeted training programmes that exercise speed, reasoning, and memory abilities. Research has found that such training programmes can impact on the functional level of those who undergo the training compared to those who do not and that these programmes can apparently slow, halt, or even reverse age-related declines in areas such as inductive reasoning and spatial orientation (Schaie, and Willis, 1986).

The practice of reducing the requirements of older worker (and remuneration) was found to be common in Japan (Conrad, 2009) where employees can be selected by their employers

“there is evidence that the effects of ageing can be offset by targeted training programmes.”

to be re-hired to bridge the gap between the retirement age fixed by the employer and the higher official retirement age determined by the state that grants the full pension.

Example; B&Q's over 50s recruitment policy

Since 1989, B&Q, to help meet the increasing demand for staff, has focussed its recruitment policy on the older generation. In 1989, as an experiment they opened a store in Macclesfield staffed entirely by the over 50s. Some initial concerns were raised which centred on regarding the ability of older workers to adapt to the more physical aspects of the job and working with computerised systems, but an independent survey by Warwick University published two years later showed that in practically every respect - customer service, short-term absenteeism, staff turnover and sales - the Macclesfield store's staff outperformed other stores. In particular they found that; profits increased by 18%; staff turnover was six times lower; there was 39% less absenteeism; there was 58% less shrinkage; there was an improved perception of customer service; and there was a general increase in the skill level of the staff.

In 1999 the company's age restriction was removed to allow older workers the option to review their own working life and also gave them the opportunity to qualify for B&Q's fast-track to management programme. Today, of the company's 37,000 workforce, 21% are aged 50 or more and 7% are over 60 and their oldest employee is 91 years old. He has been working part-time in the gardening section of one of their UK stores since he was 77.

In conclusion, research has identified a number of key actions to be considered by employers who are interested in reducing the potential impact of an ageing workforce. These include;

- A new managerial mindset towards the older workers. Innovation depends on appropriate knowledge management practices and work environments, as well

as employees who are mentally, physically and emotionally committed.

- An approach to management which nurtures an appropriate attitude in the older workforce by providing appropriate work environments, organizational culture, leadership, and applied (physical) tools.
- Health promotion and management is another critical component of successfully managing an aging workforce. Measures include initiatives to improve physical performance, work security, ergonomics, and human resource practices.
- An adaptation of management practices to incorporate issues that go beyond recruitment, retention and retirement to include flexible work practices and accommodation of different needs.
- An appropriate work environment with a focus on ergonomic measures. This does not only apply to organizations that rely on physical labour, but also to any company that wants to maximize retain the knowledge and experience of older workers.

3.1.2 Unemployment among Older People

Aside from those who wish to remain in the workforce there are also those who either through inadequate pension coverage, poor investment returns or other reasons are financially compelled to remain earning past the age of 65. Many of the debates around pension reform have discussed the option of increasing the age at which people are entitled to a pension. However this suggestion is generally based on the assumption that if an older person needs to work, a job will be available for them.

Internationally there is some evidence that older workers are not very likely to lose their job but if they become unemployed in later

life they find it more difficult to get a new job. (van Ours 2010) An OECD report found that “*early exit from the labour market tends to be a one-way street, with very few older workers returning to employment*” (OECD 2006, p. 10). Research from the Netherlands found that only 1 percent of unemployed workers aged 55 years and older found work within a year. (Van Dalen et al 2010)

In Ireland statistics from the CSO showed an increase in the unemployment rate for men aged 60--64 from 8.7% in 2009 to 11.8% in 2011 while the increase for women was similar – from 3.7% in 2009 to 6.1% in 2011. (CSO 2012) Internationally there is evidence that older workers are disproportionately represented among the long-term unemployed in most industrial democracies (Encel 2000; Campbell 1999). It is thought that the rates of unemployment among older people may be understated because many unemployed older workers move directly into retirement and actually represent hidden unemployment (Chan and Stevens, 1999, 2001).

In the US, the Health and Retirement Study found that many more respondents say they expect to work after retirement than actually undertake work (Li 2010). Chan and Stevens (2001) found that a worker who becomes unemployed at age 55 has a 61 per cent chance of being back at work two years later if male and only a 55 per cent chance if female. For those aged 55-64 who lost their jobs (between 2005 and 2007), only 61 per cent were re-employed when surveyed in 2008; among unemployed workers aged 65 years and over, the re-employment rate was only 18 per cent (Bureau of Labor Statistics, 2008). There is no evidence to indicate the likelihood of being re-employed in later life among older people in Ireland.

In addition to difficulties that older unemployed persons may face regaining employment, they may also suffer wage losses (Couch, 1998; Hipple, 1999), diminished occupational status, loss of seniority, and

reduced health and pension benefits if they do regain employment (Beckett, 1988). Moreover, unemployment during the pre-retirement period may disrupt savings that will support retirement, which is especially important, given evidence that a considerable share of wealth accrual occurs in the decade prior to retirement (Mitchell & Moore, 1998).

Job loss which occurs close to retirement age can have a significant impact on mental health. Two American studies (Gallo et al., 2000; Siegel et al., 2003) have examined mental health impacts of job loss among workers nearing retirement using the Health and Retirement Survey (HRS). They found evidence of increases in depressive symptoms in the initial follow-up (Gallo et al., 2000). This may be attributable to a variety of factors, for example older workers may not yet be eligible for the state pension and consequently may experience considerable financial distress in the period of unemployment.

3.1.3. Retirement Legislation

Equality legislation currently prohibits discrimination in employment on age grounds but despite this, many private sector employments either contractually or following custom and practice require employees to retire on reaching the age of 65 as they are legally entitled to do. Others are required or induced to retire because of the terms or conditions of a pension scheme. While many are happy to retire, there are also increasing numbers of people who wish to continue working beyond retirement age and see it as unfair that they can be forced to leave employment without compensation simply because they reach a specific age.

Throughout the 1970s and 1980s early retirement was seen as a convenient solution to widespread unemployment and was supported by trade unions and governments. As a result the effective retirement age is actually below

the statutory retirement age in many countries in Europe. The average exit age from the labour market in the EU increased very gradually between 2001 and 2009, from 59.9 to 61.4 years of age.

Retirement age is generally set out in contracts of employment and the most common retirement age in contracts of employment is 65. Many allow for early retirement from age 60 or in some cases from age 55 and most have provision for early retirement on health grounds. In 2005 the average Irish retirement age was 64.1, compared to 60.9 across the EU (Green Paper 14.4, p.210).

The Employment Equality Act 1998 was amended by the Equality Act 2004, to prohibit discrimination on the grounds of age for everyone above 16. However employers are still allowed to set retirement ages in employment contracts. Those who wish to work beyond 64 however can only avail of the protection of the unfair dismissals legislation up to the normal retiring age for employees in their employment. Employees remaining on in work after that can avail of the employment equality legislation if they believe their dismissal has arisen on one of the nine banned grounds of discrimination, such as age, gender, sexual orientation etc.

As an effect of changes to regulations on social welfare benefits, people up to 64 and unemployed can now to be treated as 'job seekers' rather than early retirees, and so access FAS services. However those over the age of 64 do not have any access to such services.

For some employees the retirement age is established by law. This is most common in the public service, where for example the retirement age for people who joined the public service before April 2004 is 65 years. Under new rules those who joined the public service after that date can continue working, subject to suitability and health requirements, past the age of 65. The minimum retirement age is 55 for people

who joined the Gardai and Fire Service after 1 April 2004, while the compulsory retirement age for Gardai is 60. The High Court in Ireland considered the question of compulsory retirement in *An Garda síochána*. This arose where the retirement age of 65, for Assistant Commissioner rank, had been reduced to 60 and this was contested by a Garda who was compelled to retire at age 60. He claimed that the compulsory retirement age at 60 was in breach of the Framework Directive and the employment equality legislation in Ireland.

The High Court Judge found in favour of the arguments put forward by the relevant Government Department and the Garda Commissioner. They had argued that the main objective for a retirement age of 60 was to create promotional opportunities for less senior Gardai and this was judged to be a legitimate aim. The Judge also referred to the aim of renewing personnel in the organisation at the higher levels in an orderly manner. It is not clear how the age limit of 60 conforms with the principle of EU law which requires any exception to the ban on age discrimination to be proportionate.

There is evidence of age-related discrimination in the workplace and according to the Equality Authority age-related discrimination has overtaken racism as the largest category of complaints about discrimination in the workplace. Of the cases that come before the Equality Tribunal, more fail than succeed. Certain issues continue to recur, such as the appropriateness of questions asked at interview or in application forms but while the Equality Tribunal often finds that there has been discrimination in relation to an inappropriate question, they do not necessarily find in favour of discrimination on the age ground. In 2007, the Equality Authority received 62 age-related complaints out of a total of 264 cases being dealt with. These complaints related to issues of promotion, access to employment, and dismissal. Many cases also involved retirement

ages and age limits for voluntary severance packages (www.equality.ie).

The EU directive Council Directive 2000/78/EC established a General Framework for Equal Treatment in Employment and Education and it requires all Member States to ban direct and indirect discrimination and harassment in employment on the grounds of age. Ireland leaves it open to each employer to specify retirement ages for its own workers and employers do not have to justify their choice of retirement age. This level of latitude may very likely be found to be in breach of EU law and so will require the Irish government to set national social or employment criteria which Irish based employers will be required to satisfy in order to justify a specific retirement age.

In the UK the Government abolished the default retirement age in 2011, meaning that any employee forced to retire on the grounds of having reached a certain age, would be considered to have been discriminated against. However, in 2012, the UK Supreme Court held that a mandatory retirement policy would not amount to age discrimination if the employer could show that the decision to retire the employee was proportionate in terms of achieving its legitimate business aims.

Occupational pension schemes contain many provisions that could be considered discriminatory. The Irish Pensions Act 1990 provides that it shall not constitute discrimination on the age ground for a pension scheme to fix age or length of service (or a combination of both) as conditions or criteria for:

1. Admission to an occupational benefit scheme;
2. Entitlement to benefits;
3. Accrual of benefits in a defined benefits scheme or level of contributions in a defined contribution scheme;

The pension legislation also provides that age-based criteria may be used in actuarial calculations

and that the fixing of different retirement ages or age of entitlement to benefits, does not infringe the principal of equal pension treatment.

3.1.4 Attitudes To Retirement

Older people have expressed a strong preference for later or more gradual retirement (Fahey & Russell, 2000). A Euro barometer report (2012) found that six out of ten respondents think people should be able to continue working past the official retirement age - if they want to (61%). Only a third believes that they should have to stop working. In Ireland almost three quarters of respondents believed that people should be allowed to continue working and only 19% believed they should stop working. (Eurobarometer 2012) However many need to continue earning in order to increase their income or to compensate for poor returns from an occupational or private pension.

There is a view that retirement at 65 years can feel like a cliff edge from which older people fall and that other options, such as gradualising retirement, offering options for reducing hours or responsibility levels should be made available by employers. Providing greater flexibility in hours of work would make it easier for those with declining physical health to remain in employment. According to a survey carried out by the National Council on Ageing and Older People in 2001, the majority of those aged 55 to 69 (70%) would prefer retirement to be more gradual to allow for personal choice and to accommodate their own needs and circumstances (Fahey and Russell 2001). However they may experience difficulties in finding suitable employment as few workplaces provide the opportunities or are organised in such a way as to meet the needs of older workers.

A study of the participation rates of the over 55s in the Irish Labour market revealed that about 25% of those aged over 55 who are retired or engaged in home duties are

interested in participating in the labour force, provided certain barriers to their participation are overcome (McGivern 2001:18-19). The issues identified by the study participants include: lack of flexible or part-time hours, lack of appropriate skills and education, low take-home pay, concerns about reductions in pensions income and benefits as a result of taking up paid employment and age discrimination.

The Survey of Health, Ageing and Retirement in Europe (SHARE), a longitudinal, cross-national study involving more than 30,000 people aged 50 or over, looked at factors behind the decision to retire. It found that the decision was largely influenced by four factors: eligibility for public pension, ill health, a wish to spend more time with family, and being offered an early retirement option. It also found that poor quality of work is linked to intended early retirement in countries all across Europe along with an imbalance of effort and reward and low control at work (Siegrist et al 2006).

International research carried out for HSBC bank in 2006, found that most people want to spend their later years involved in a mix of work, leisure and education rather than in passive retirement. The survey, concerned with recording attitudes towards ageing and retirement internationally, found that only 17 per cent were in favour of a mandatory retirement age while 80 per cent believed that people should have the right to continue working as long as they wanted to. In the UK, nine out of 10 were opposed to a mandatory retirement age and more than three-quarters of those surveyed (77 per cent) said they would work in retirement (HSBC 2006).

In the US, many workers have opted to reduce hours and work more flexibly rather than take retirement – a way of working which economists have described as ‘a bridge job’. Research has found that the majority of older Americans leaving full-time career employment (about 60% of those leaving

a full-time career job after age 50 and about 53% of those leaving after age 55) moved first to a bridge job rather than directly out of the labour force (Cahill, Giandrea, & Quinn, 2006: 523). The clear advantage is that such jobs provide the flexibility sought by older people in allowing them to use their skills to choose when and how they will work (Giandrea et al 2008).

In some cases, those who were financially independent chose to transition to a job that they have always wanted – a ‘dream’ job – even though they no longer need to work. Marc Freedman, founder of Civic Ventures in the US, argues that most people who have finished their midlife careers have plenty of years of quality work left in them, and could provide an answer to what he described as the non-profit sector’s leadership deficit. In his book, *Encore: Finding Work that Matters in the Second Half of Life*, Freedman explains that a new stage of life and work is emerging between midlife and true old age. In this new stage of work, which Freedman has dubbed the “encore career,” many older people are seeking jobs that offer not just financial reward, but also an opportunity to use their skills and experience to contribute to the greater good.

According to a survey carried out by Civic Ventures more than 5.3 million Americans have already launched a new career in later life and nearly half of those surveyed between the ages of 44 and 70, are interested in finding a new career that combines continued income, personal fulfilment, and social impact. The survey found that respondents most interested in social purpose careers tend to be the youngest: 50 percent of boomers ages 44-50 say they want new ‘encore’ careers.

Research carried out in the UK for the Department for Work and Pensions found that there were a number of ‘push’ and ‘pull’ factors influencing older people’s decision to leave or remain in the workforce. Push factors

have been defined as negative considerations, like poor health or dislike of one's job, that induce older workers to retire. Pull factors are typically positive such as the desire to pursue leisure interests or volunteer activities that attract older workers toward retirement. The study found that the most important drivers and barriers to working longer were; health status, unemployment, financial factors, type of employment and age. A number of additional factors have also been identified such as reduced job satisfaction, changes in own role or work itself, caring responsibilities, recession and industrial restructuring, and employers' fixed retirement ages (Phillipson and Smith 2005).

Financial security was the most important pull factor; those people who could afford to retire had the choice to work or retire as they saw fit. In isolation however, financial security did not result in early retirement; it was always interlinked with other factors. Other pull factors included proximity to state pension age, looking after the home and/or spending time with family and enjoying quality time and hobbies. Private pension scheme rules frequently stipulate that if the worker wants to combine working with a pension they must change jobs and they may find themselves financially penalised by unfair actuarial adjustment of their pension value when they opt to defer pensions and continue to work (IEA 2008).

These push and pull factors have been found to have an impact on adjustment to retirement and ultimately to health and wellbeing of older people. Although one longitudinal study demonstrated no adverse health effects in forced early retirees in the steel industry (Gillanders, et al 1991), most research to date indicates some adverse effects of forced early retirement (Hanks, 1990; Swan, Dame, & Carmelli, 1991). In a large study carried out in the US, Shultz (1998) found that those who were forced to retire appear to have generally lower self-ratings of physical and emotional health and lower retirement and life satisfaction.

It is also important to note that while many older people have expressed a preference for greater choice and flexibility with regard to retirement, many others in the 55 - 69 age-group who were still in work generally viewed retirement in a positive light, looking forward to more freedom to do things they really wanted to do. In a survey carried out in 2001 the majority (57 per cent) anticipated that they would miss the social aspect of employment but over a third of the group wanted to retire as soon as possible and an even greater proportion (55 per cent) said they were only working for monetary reward (NCAOP 2002).

A report from Older and Bolder emphasized the importance of developing a national occupational health strategy that was both a) age-attuned, and b) accessible to those sectors not usually covered by traditional occupational health – the self-employed, the unemployed, those between jobs (O'Neill, 2010).

The equality authority and NCAOP jointly produced a booklet in 2005 on age friendly provision of goods and services. In it they highlighted the benefits of employing older staff in retail and service industries:

- *“The employment of older people is important in its own right. However, the presence and participation of older staff can enhance the relevance, attractiveness and accessibility of goods and services to older customers. Actions could be taken to recruit and retain older workers, using the kinds of positive action allowed for in the employment equality acts to promote full equality in practice*
- *Providing flexible working arrangements which allow older workers to shape their hours of work and the nature of their job to suit their particular circumstances*
- *Providing training to develop older workers' knowledge and skills so they can play new roles within the organisation”*

Issues Arising

'Cliff-edge' retirement: Many people are effectively left with no choice regarding the timing of their retirement, despite equality legislation prohibiting discrimination on age grounds. This is because many employers and many pension schemes require automatic retirement at 65 or younger, and the current legislation allows this.

While many are happy to retire, there are many others who see it as unfair that they can be forced to leave employment without compensation simply because they have reached a specific age. Others need to continue earning to increase their income or compensate for poor returns from an occupational or private pension. According to a survey carried out by the National Council on Ageing and Older People in 2001, the majority (70%) of those surveyed aged 55 to 69 would prefer retirement to be a more gradual process, which could allow for personal choice and could accommodate their individual needs and circumstances (Fahey and Russell, 2001).

Barriers to extending working life: Research has identified four factors that influence a decision to retire: eligibility for a public pension; ill health; a desire to spend more time with family; and being offered an early retirement option. In several European countries, poor quality of work, along with an imbalance between effort and reward and low control at work, have been linked to intended early retirement. Many older workers would like to work for longer, provided that certain barriers are overcome. These include: lack of flexible or part-time hours, lack of appropriate skills and education, low take-home pay, concerns about reductions in pension income and benefits as a result of taking up paid employment, and age-related discrimination.

Prevalence of Age-related Discrimination: The largest category of cases before the Equality Tribunal relates to age-related discrimination. In 2007 the Equality Authority received 62 age-related complaints out of a total of 264

cases being dealt with, and these related to issues of promotion, access to employment, training and dismissal.

EU Council Directive 2000/78/EC: This EU directive established a General Framework for Equal Treatment in Employment and Education and it requires all Member States to ban direct and indirect discrimination and harassment in employment on the grounds of age. Ireland leaves it open to each employer to specify retirement ages for its own workers and employers do not have to justify their choice of retirement age. This level of latitude may very likely be found to be in breach of EU law and so will require the Irish government to set national social or employment criteria which Irish based employers will be required to satisfy in order to justify a specific retirement age.

Poor preparation of Employers for an ageing workforce: There is little awareness among employers and policy bodies of the benefits of employing older people. There is also evidence that many employers have concerns about issues such as higher absenteeism or lower productivity of older workers. However, the research evidence is inconclusive on the potential for reduced productivity and there is also evidence that many of these issues can be addressed through appropriate changes in human resource management and health promotion initiatives

3.2 OLDER ENTREPRENEURS AND SILVER MARKETS

As people age opportunities for career enhancement and mobility reduce. Growing numbers of older people are therefore becoming self-employed in later life in the US. In 1992 a HRS survey of people aged 51 to 61 years found that 21% of men in a 'full time career' (defined as those who worked at least 1,600 hours per year in a job that lasts ten or more years) were self-employed. This percentage

had increased to 35% of those who were still working by 2004 (Giandrea et al 2008).

However research carried out in the UK found that in general, older people are significantly less likely to engage in entrepreneurial activity than younger people (Curran and Blackburn, 2001; Hart et al., 2004).

A Finnish study compared rates of entrepreneurship amongst those in 'Prime Age' (20-49) and Third Age (50 or over). Their findings supported earlier findings from the UK by showing that entrepreneurial activity rates in the Third Age segment are significantly lower than in the 'Prime Age' cohort (Kautonen 2008). However they pointed out that 16% of fledgling Finnish businesses are started by people aged 50 or over which indicates that older entrepreneurship is still a significant phenomenon.

Research has identified three types of older entrepreneurs: the constrained entrepreneur, who has always wanted to start a business but for lack of finance or family flexibility has been unable to follow through; the rational entrepreneur, who sees self-employment as the next step of their career, or as a way to increase personal wealth; and the reluctant entrepreneur, who is forced into self-employment due to a lack of acceptable alternatives and insufficient wealth to retire early (Singh & De Noble 2003).

Zhang (2009) analysed the factors linked to self-employment in older people and found that self-employment among older people was highest in knowledge-based sectors. Other factors also were found to increase an older person's likelihood of becoming an entrepreneur such as the influence of tax policies or cultural openness. Those who lived in areas with lower taxes and higher levels of cultural openness were found to be more likely to be entrepreneurs because both of these factors contribute to the entrepreneurial milieu (Zhang 2009).

Research in the UK and Australia has identified increased unemployment in later

years as the single most common reason for starting a business (Barclays Economic Reports 2001). In the UK, according to the charity PRIME, between the ages of 50 and 65 almost one person in three is out of work and almost sixty per cent have no pension other than the state pension to look forward to. They point out that people of this age who are out of work for more than six months after being made redundant stand a one in ten chance of ever working as an employee again. In Australia in 1998, nearly fifty percent of all unemployed persons over age 55 had been unemployed for more than one year and 35.9% more than two years (Australian Bureau of Statistics 1999b). These figures would seem a strong indicator that at least some of the long-term unemployed are 'pushed' (Storey 1994) into self-employment.

A number of characteristics of older entrepreneurs and their firms have been identified in the literature. Research evidence shows that the survival rates of businesses established by older entrepreneurs are higher than those of younger entrepreneurs (Cressy and Storey, 1995) perhaps because older entrepreneurs have built up financial, human and social resources over a lifetime career (Singh and DeNoble, 2003).

However a Norwegian study of entrepreneurs over the age of 18, found that while entrepreneurial competencies increase with age, the intention to start a business tended to decrease (Rotefoss and Kolvereid, 2005). The research found that, in line with previous research (Alsos and Kolvereid, 1999; Westhead and Wright, 1998), there were no significant differences in the quality of the businesses established by older serial and novice entrepreneurs in terms of firm size and turnover growth.

3.2.1 Barriers and Facilitators to Entrepreneurial Activity

Older people have a number of natural

advantages for becoming self-employed many of which have been identified in the literature. A factor portrayed as having impact on entrepreneurial success is technical knowledge (Jones-Evans 1996) although this is likely to be affected by the passing of time, particularly in terms of knowledge obsolescence.

Prior industry experience may give older people an advantage in identifying potential gaps in the current market (Storey 1994). Extensive management experience may allow the older entrepreneur to avoid many of the mistakes made by people unfamiliar with the task of organizing and managing a new or growing firm (Steiner & Solem, 1988). Other research has identified the importance of the professional and personal networks built up over the working life. Baucus & Human (1994) suggest that such personal links can help older entrepreneurs gain both finance and marketing support.

Social welfare benefits can have a negative impact on the willingness of older unemployed people to consider self-employment as a late career option. The gap between being outside the labour force (unemployed, benefits recipient or retired) and actually taking the step and contacting an enterprise support agency was also identified by the study as a barrier to entrepreneurship, this was particularly relevant for people who had been employees for 30 years or more. (Kautonen et al 2006).

3.2.2 Silver Markets

The ageing of the population provides opportunities to businesses operating in markets for goods and services aimed at meeting the needs of older people, as the growing numbers of healthier, wealthier older people will create an emerging market known as the “silver market”.

The growth in the number of older households over time, twinned with a continued rise in their spending power relative to other households, may

be expected to lead to increasing expenditure on certain categories of goods and services. There is evidence from analysis of household expenditure in the UK that people in the 50-64 age-group spend more per head on cars, foreign holidays and recreation and culture, including cinema and theatre admissions, than any other age group. They also tend to have fewer debts than do younger age groups (Office of National Statistics, 2004a, b).

Internationally, it has been estimated that older people have considerable economic wealth;

- Wealth and revenues in Europe of persons over 65 is over €3tr
- Wealth and revenues of the baby boomer population in the US is over \$2tr
- The declared revenues of the over 65s in Ireland is €6.6bn
- People age 50 and older control more than 50% of the total U.S. discretionary income
- The discretionary spending power of Australians aged 45+ is predicted to be \$218 billion in 2009, 31% more than adults under 45.
- 50-plus households in the UK spend around £250 billion annually, which equates to over 40% of national household spending.
- In Canada the over 50's control three-quarters of all the personal wealth in the country; buy 30% of all food consumed in the home; have more than \$7 billion in retirement savings; are 97% debt-free, and dine out frequently.
- The United States Census Bureau showed that while 40% of the United States population was 50 or older, this group held 75% of the nation's financial assets and did 55% of all consumer spending

According to a report on the potential of the Silver Markets in the US (Nomura 2009) the generation of people known as the ‘baby

boomers' will be the first generation in history to reach that age with income and significant wealth. It is projected that, by 2010, most US spending (54%) will be by people over age 50, and that this age group will control the bulk of household disposable income (53%) and more than 80% of net worth (Nomura 2009).

An analysis of the UK household income and expenditure among older people (Department for Business Innovation and Skills 2010) found that:

- Older households devote a greater proportion of their total expenditure to necessities like food and drink and housing, fuel and power.
- Luxury items related to recreation and culture are also areas of significant expenditure for older households;
- Net incomes of pensioner households increased by 25 per cent between 1998/9 and 2007/8 compared to real earnings growth of 11 per cent; and
- People aged over 50 bought 80% of all top-of-the-range cars, 80% of cruises and 50% of skincare products.

Many companies are either not aware of the potential or have failed to respond and adapt to the changing market and demand for products. It has been speculated that because many companies are dominated by younger executives they continue to direct their marketing efforts at that segment of the market. Research has found that only 10% of marketing spend is aimed at the over 50s and most communication sent about brands and services is either irrelevant or insulting to them.

Many companies hold incorrect assumptions about older people such as the fact that older consumers don't use new technologies. In fact, Facebook usage amongst the over 64's has surged in the last 12 months - 390% in the UK, 1230% in the US and 1600% in Italy.

There is evidence that older people are consistently more brand-loyal than younger consumers (Lambert-Pandraud et al. 2005).

Assumptions about the kind of products that will appeal to the older consumer have also been found to be incorrect in many cases. Studies show that over half of the 60-75 age group in the US see themselves as middle aged and not old and that older people are living healthier lives for longer. Therefore, products which make incorrect assumptions about their abilities are likely to be unappealing. Instead of zimmer frames and nursing homes a range of products such as self-parking cars, adventure gap years, disease targeting nutrient food products and dating agencies are more likely to be appealing.

In the motor industry, products which would appeal to older consumers could include; thicker steering wheels, wide-angle mirrors, larger dashboard controls, among others and cars that are easy to get in and out of, easy to see out of, easy to operate and manoeuvrable enough to park easily. Some manufacturers have already adapted to the needs of older drivers. Changes will also be needed in industries such as nutritional products, over-the-counter medicines, and 'luxury products'. In addition, pack sizes may need to be reduced to satisfy the 'smaller' appetites of older consumers.

The McKinsey's Consumer and Shopper Insights Center, argued that to address changes in consumer behaviour successfully, companies must innovate, putting greater focus on value and an increased interest in health and wellness and social care. In the UK, around 1.5 million older people currently use community alarms to access a central control centre which in future could be used to provide the basis for a wider range of telecare services.

Issues Arising

Barriers facing older entrepreneurs: The research shows that some people reaching

retirement would be interested in starting their own business or joining others in doing so. A European survey found that 13% of people over 55 were interested in becoming self-employed (Eurobarometer, 2009). Supporting them in doing this could create important employment opportunities, reduce pension costs and provide other important social benefits. However, to date there has been little effort to encourage older people to set up businesses. There are identifiable barriers. For example, only those under 65 are eligible for FÁS programmes such as Start your Own Business or Return to Work.

Tapping into the global silver markets: There seems to be only limited awareness among businesses of the purchasing power of older consumers. For example those over 50, account for over half of all household spending in the EU and the US, yet only 10% of marketing spend is aimed at that market. R & D and marketing strategies remain largely focused on younger markets, which results in a failure to develop and design products and services which will meet the actual needs of older people, for example designing easy-to-open packaging or improving the readability of written information on a product.

3.3. ECONOMIC CONTRIBUTION OF OLDER PEOPLE

It is often forgotten that older people make a contribution to society in a variety of ways. They contribute their time as volunteers (dealt with in detail in Chapter 5) as carers for spouses, grandchildren and other family and friends. They continue to participate in the workforce through employment, entrepreneurship or self-employment. They also contribute financially to their families through transfers of money or other assets passed through the generations,

during life and as legacies and they remain consumers throughout their later lives.

3.3.1 Intergenerational Transfers

Much of the discussion around intergenerational issues has tended to focus on the public aspect of this issue only, especially on the pressure on pensions and health-care provisions resulting from larger numbers of older people. It has been argued however, that this apocalyptic version of reality may be offset to some extent by the impact of private intergenerational transfers of wealth.

Most people throughout their lives accumulate some wealth or assets which they hold against the possibility of living longer. Therefore on their death, they leave a bequest of some value. In cases where social welfare pensions increase but consumption does not increase by as much as the pension does, people accumulate wealth which would also transfer back to the younger generation on their death (Gan et al 2006). It is important therefore to look at the potential value that this transfer of resources can have between generations in families both through financial transfers and transfers of time eg childcare support.

In general, research has found that transfers in the family are given at a considerable rate and mostly flow downwards from older to younger generations. The Irish Longitudinal Study on Ageing, TILDA found that people aged between 50 and 64 are more likely to make transfers than to receive them. The study found that nearly one-quarter (24%) of older households gave a financial or material gift worth €5,000 or more to their children within the last ten years, with this number lowest (16%) in the over 75 age group. Only 9% of the older population received financial transfers from their children, an increase from 7% among people the 50-64 age-group to 12 % among those aged 75 and older. (TILDA

One study looked at financial transfers and social support in ten Western European countries based on the SHARE study (Survey of Health, Ageing and Retirement in Europe) carried out in 2004. The results confirmed that there is a common transfer pattern in European countries. There is a net downward flow from the older to the younger generations. The study found that transfers from parents to their children are much more frequent and also usually much more intense than those in the opposite direction. The positive balance decreases with age but even those over the age of 70 clearly remain net givers. The study also demonstrated that transfers from parents to children are less frequent but more intense in the Southern European countries than in the Nordic ones, with the Continental European countries being somewhere in between the two (Albertini et al 2007).

This confirms the findings of a range of previous studies from different countries including France, where one study found that cash gifts mainly flow to the younger generations, while time transfers are directed both upwards (from children to parents) and downwards (parents to children) (Attias-Donfut & Wolff, 2000). Another comparative study, which looked at findings from the SHARE research, found that people aged 50 and over are at the centre of a complex exchange network within the family where they both give and receive support. Money received by older people from their children or grandchildren tended to be given to 'meet basic needs' in more than twice as many cases while money given by older people to their children tended to be given to help with a house purchase or education. The study also found that there was little variation between countries in relation to time transfers and more than a third (43%) of grandparents were involved in looking after grandchildren (Attias-Donfut, Ogg & Wolff, 2005).

Issues Arising

Invisible economic contribution: There is significant evidence that older people make a

net financial and social contribution to society through financial transfers and bequests to their adult children and other relatives as well as through their volunteering. However the limited awareness of this evidence does nothing to counteract negative impressions that older people are a drain on the economy.

3.4 ADEQUATE SUPPORTS TO PROTECT AGAINST POVERTY

Income for older people is derived from three main sources; pensions, employment, and other sources such as savings and investments. The Irish pension system, in common with the pension systems of the Beveridge type in much of the developed world, is made up of three components or pillars. The first pillar is the state flat-rate pension, which is available to most retirees. The second pillar provides retirees with an additional income from a supplementary scheme which in Ireland can be from public service schemes, funded occupational pension schemes set up by private employers; and personal pensions for which there are significant tax allowances. The third pillar comprises personal savings and investments, which people undertake at their own expense.

In 2007, 73 per cent of older people were dependent on social transfers for three-quarters or more of their household income, which compares to 15 per cent of working age adults. (ESRI 2010) Social welfare pensions account for 54% of gross income, occupational and private pensions contribute 24% of income and income from work and self-employment makes up 11% of income. (Office of Social Inclusion 2008) Figures in the Green Paper show that State pension provision was the main source of income for the 68% of pensioner households who had no income from occupational or personal pension schemes. The support of the Exchequer for private pension schemes is

considerable, at a level greater than the funding of the public pension.

Some progress has been made towards achieving the targets set out in the National Pensions Policy Initiative and the Programme for Government. For example, the level of State Pension has increased by 16.7% in the period from 2005 to 2007, during which time the consumer price index increased by 9.1%. The State Pension is currently approximately 35% of GAIE. For many of those in work at present and contributing to private or personal schemes, current levels of contribution suggest that the State pension will still form the majority of their post-retirement income (Green Paper on Pensions 2007).

3.4.1 Poverty Levels

There are two potential measures of poverty, those “at risk of poverty” and those in “consistent poverty”. The ‘at risk of poverty’ indicator has been defined as all those who fall below a certain income threshold, which, in the EU, is set at 60% of the median income. This measure is a relative measure and the threshold is likely to reduce during times of unemployment increases or wage reductions. It is important to acknowledge that for an individual this relative measure of poverty may not represent any change in income, they may simply become richer or poorer in relation to others in society. Consistent poverty is the official Government approved poverty measure used in Ireland and it identifies the proportion of people, from those with an income below a certain threshold (less than 60% of median income), who are also deprived of two or more goods or services considered essential for a basic standard of living (Office of Social Inclusion 2009).

Social welfare supports are clearly an important factor. All people over 66 in Ireland are entitled to either a contributory or non-contributory pension or other means-tested benefits, though older women are less likely

than older men to qualify for full contributory pension, because they are less likely to have made the required contributions in previous years. The State Pension has increased significantly in real terms in recent years and this has contributed to reductions in the proportion of older people in consistent poverty. The rates of consistent poverty in 2008 were 1.7 per cent among all persons aged 65-74 and just 1.0 per cent among persons aged 75 or over. People aged over 65 living alone had a consistent poverty rate of 0.9% in 2008 (down from 4.1% in 2007).

Significant progress has also been made in relation to the ‘risk of poverty’ measure. According to the CSO approximately 12.1% of persons aged 65-74 were at risk of poverty in 2008, which was substantially lower than the 2004 rate of 27.1%. The figure for people aged 75 and over was 9.9% in 2008 (CSO 2009).

While many of those aged over 65 living alone remain at risk of poverty, the numbers fell by more than half, from 24.3% in 2007 to 11.0% in 2008. However, the CSO advises that income levels for older people living alone are generally close to the ‘at risk of poverty’ threshold and therefore their risk of poverty can change significantly due to either movements in the threshold or their income, even where those movements are relatively low (CSO, Dec 2008).

Disposable income is perhaps the most unambiguous indicator of poverty or wealth and evidence of weekly shortfalls can be found among pensioners who are solely dependent on the state pension. A study carried out by the Vincentian Partnership for Social Justice found that all categories of female pensioners living alone (age 70+) had no discretionary income and instead had income shortfalls of between €11.79 and €63.83 per week. Progress has been made however, and this shortfall represents a reduction from 2008 levels, when it ranged from € 91.99 to €34 per week. Nonetheless it remains a pertinent issue.

Older people tend to spend more on health than do other age groups and many have expressed concern about the need to manage costs associated with major health problems, particularly long-term care and the catastrophic costs associated with chronic and life-threatening disease.

Research has found differences between actual and perceived poverty. A US study found that older people who assessed their health more negatively, or who had experienced a health problem during the preceding year, regarded their financial situation as less adequate than people in better health but with similar income levels. The research found no evidence that the health problems were causing actual financial difficulties, or that there were medications or other essentials they could not afford. There is some anecdotal evidence that this perception of poverty or concern about potential health costs has led to a reluctance to liquidate assets. (Stoller and Stoller 2003)

It is important to recognise that older people receive benefits in Ireland, ones which are not offered to the rest of the population. They are also comparatively better off than older people in other countries. Among the advantages they enjoy include;

- A lower burden of taxation compared to those on equivalent incomes arising from exemption from PRSI contributions, higher exemption limits and age credits.
- A range of benefits eg free travel, fuel allowance, although the actual benefit to the totality of older people is unclear
- Higher income limits for medical cards than the rest of the population.
- On the other hand, some allowances and supports are not available to older people, for example Mobility Allowance and people over 65 cannot currently apply for the personal assistance scheme.

3.5 REPLACEMENT INCOME

Although many older people have accumulated assets through a life-time of contributing to their own pensions, making investments or paying a mortgage, the majority of older people in Ireland rely on the state pension to provide most of their income. The state pension has succeeded in maintaining income levels marginally above the fluctuating poverty level. However the current recession has had an impact on the value of many assets such as property. It has also subsequently affected the financial viability of pension funds, with many reporting large deficits. This has impacted on the security of retirement income particularly for recent retirees.

Pension coverage has remained relatively static over the past few years. In 2008, 54% of people had private pensions - a reduction of 1% since 2005 but still higher than in 2002. In its Annual Review of 2009, the Pensions Board revealed that the number of members in occupational schemes rose by 4,189 members in 2008, to a total of 853,397 across more than 84,000 schemes. At the same time, however, the number of pension schemes in existence reduced by 7,640 (Irish Pensions Board 2010).

3.5.1 Pension Coverage

The level of savings and pensions is considered by many in the pensions industry to be too low to make adequate provision for the expected increase in longevity. As stated in the 2008 Annual Report of the Pensions Board, *“There is a ‘disconnect’ between the pensions many expect to receive and the contributions they make or are being made on their behalf”*. Despite the tax incentives that have been provided to encourage personal pension contributions in Ireland, a CSO survey (the QNHS) in 2007 and 2008 revealed relatively low numbers with some form of private pension plan:

- The NPPI set a target of 70 per cent coverage for those in employment aged 30 to 65. The 2008 figure for this group was 61 per cent, down from 62 per cent in 2005 but up from 59 per cent since 2002.
- Pension coverage for those aged under 30 years remains low at 37 per cent in 2008.
- There are still one million people in the workforce without supplementary pension cover.
- Less than 25% of those working in agricultural industries including farming, and those working in catering and tourism, have private pensions.
- Similarly, less than 25% of seasonal and part-time workers have private pensions .

In 2005, 50% of all persons aged 20 to 69 expected that their 'Occupational or Personal pension' would be their main source of income on retirement (regardless of whether or not they currently have such a pension). Just over 20% expect the 'State social welfare pension' will be their main source of income. Almost 44% of those aged 20 to 24 stated that they 'Don't know' what their expected main source of income will be on retirement compared to just under 5% of those aged 55 to 69. Over 11% of females expected their 'spouse or partner's occupational or personal pension' to be their main source of income compared to just over 1% of men (QNHS, 2006).

In 2009, research carried out by Bank of Ireland revealed that 50% of the Irish adult population under the age of 45 have no personal savings in place to provide for their retirement future. A survey carried out by the company into the aspirations held for retirement, found that half have no pension plan in place to sustain their standard of living and that 35% of those surveyed aged between 35 and 44 don't know how they will fund their lifestyle in retirement (www.bankofireland.com)

In 2008 the Pensions Board found that three out of four people without a private pension felt that they would not be able to survive on the state supports when they retire but 40% of them had no plans to sign up to a supplementary pension scheme in the next three years, and 80% of people thought the Government should introduce mandatory pension plans to provide for the ageing population.

An American study looked at the ratio of post to pre-retirement consumption to explore how well older people are prepared for retirement. It discovered that some of those in the lowest income households can maintain the same level of consumption by relying almost solely on Social Security while many of the most affluent households, despite having a consumption level higher than that of poorer households, will experience a decline in consumption on retirement (Penner 2008).

3.5.2 Dependency Ratios

The demographic changes already discussed may lead to an unsustainable situation in relation to the future funding of pensions. While increasing numbers of older people will in the future be supported by smaller numbers of people of working age, this may be balanced to a certain extent by national growth, changes in employment patterns, migration and other factors including a reduced need for children's and educational services.

However these changes along with Government commitments to increase the level of state payments to pensioners, creates an urgent need to reconsider the pension system. If current expectations about retirement ages are to be validated, that means larger contributions to funded schemes, and larger taxes to support unfunded State schemes. The alternative is either much lower pensions, or an acceptance that current expectations about retirement ages are not realistic."

The cost of both state contributory and non-contributory pensions has increased over the past number of years: rising from €3bn in 2005 to €3.3bn in 2006 and to €3.7bn in 2007 or 24% of overall social welfare expenditure. This currently represents approximately 5% of GDP (6% of GNP) but is estimated to rise to approximately 13% of GDP (15% of GNP) by 2050. Costs relating to public service pensions, paid from current exchequer funding, have also increased substantially, from €985m in 2002 to €1.7bn in 2007 representing a 77.8% increase over the period.

The National Pensions Reserve Fund was established in 2001 with the objective of meeting much of the possible cost of Ireland's social welfare and public service pensions from 2025 onwards when it is expected that these costs will increase dramatically due to the ageing of the population. The NPRF's explicit aim is tax-smoothing, covering future deficits in the pension system. Its mission, as set out in the National Pensions Reserve Fund Act's Art. 18(1) is "*...meeting as much as possible of the cost to the Exchequer of social welfare pensions and public service pensions to be paid from the year 2025 until the year 2055, or such other subsequent years*".

In March 2010 the Fund's value stood at €24.5 billion. Just over €7.2 billion of that amount, or 29.8% of the value of the Fund was used to re-capitalise Allied Irish Bank and Bank of Ireland at the direction of the Minister for Finance during 2009. The total Fund secured a return of 4.8% during the first quarter of 2010 and an annualised performance rate of 2.1% since its inception.(www.nprf.ie)

3.5.3 Adequate Level Of Income

Many economists and policy-makers have expressed concern that households do not save enough to maintain an adequate standard of living during retirement. There is no consensus

however, on what this standard should be or what level of saving is necessary to achieve it. In the literature, the optimum level falls somewhere between two levels of 'adequacy'; - having available retirement income of between about two thirds of pre-retirement earnings (regarded as the level necessary to maintain consumption levels prior to retirement). or having an income equal to or greater than poverty or near poverty levels of income (Binswanger & Schunk 2009).

The question of what represents an adequate standard of living during retirement basically relates to a trade-off between spending during working life and spending during old age (Scholz & Seshadri 2008). There is evidence that retirees may adjust their living standards downwards in order to respond to lessened income (Hooyman & Kiyak, 1999). High rates of home ownership and untaxed income for older people (aged 65 and older) reduce income needs among retired people (Smeeding, 1990).

One study, carried out in the US and the Netherlands, looked at the minimum level of retirement spending below which people would not want to fall and found that a majority of people in those countries aim to achieve in excess of 80 percent of working life spending (Binswanger & Schunk 2009).

Discussing the adequacy of a savings, Moore and Mitchell (1998) concluded that the majority of older households will not be able to maintain current levels of consumption into retirement without additional saving (Moore and Mitchell 1998).

An Italian study found that there is a fall of total consumption at retirement, which they estimated at 5.44%, which is in line with previous research in the UK and US (Miniaci and Monfardini, 2005). Hurd and Rohwedder (2003) argue that the drop in spending can be explained by the drop in work-related expenditures at retirement and market-purchased goods & services are substituted by home-produced goods.

At an individual level, with increases in life expectancy, pension funds will need to provide income for a longer period of time. It is clearly unsustainable to fund pensions at the level people expect unless we save more or extend our working lives. The current trend is towards starting work at a later age so an extension of the working life will need to take place at the retirement end. Barr (2006) has quantified the effect in the UK; in 1950, 53.1 years of working life was expected to pay for 10.8 years of retirement but by 2004, 47.6 years of working life was expected to pay for 20.1 years of retirement. McCarthy (2009) concludes that if such figures were similar in Ireland, “*something’s got to give.*”

The issue of whether to respond to an expectation of longer healthy lives by working longer or saving more was addressed by Bloom, Canning and Moore who argued that it was a question of personal preference. If people work longer they can keep their consumption levels high and need only save at the same rate as before in anticipation of old age. Alternatively, if they decide to take extra leisure and retire at the same age as before they will have lower consumption levels throughout their life and will need higher savings rates while working (Bloom, Canning and Moore 2004 and 2007). They conclude that the best response to increasing longevity is likely to be a longer working life, without the need for higher savings.

Generating a significant increase in personal retirement savings will also help to make PAYG pensions more sustainable. However, current saving reduces the level of current consumption and consequently there tends to be many reasons for people to delay providing for a pension. The real challenge is getting people to plan for longer than a twenty year horizon. It has been suggested that a lack of financial literacy can lie at the heart of the problem. Research comparing case studies

in Germany and the UK found that financial education with regard to old-age provision can be successful if it reaches consumers at life-stages where important decisions need to be made. The authors conclude that to achieve this considerable efforts have to be taken in terms of funding and organizational set-up (Binswanger & Schunk 2009).

3.5.4 Pension Reform In Ireland

The publication of the National Pensions Framework, in March 2010, followed a process of nationwide consultations on pension provision and sustainability, which started with the publication of the Green Paper on Pensions in 2007. The framework set out plans for the future of pension provision and proposes a number of major changes to the existing situation.

In April 2012 the FG/Labour government announced that it had engaged the Organisation for Economic Co-operation and Development (OECD) to carry out an independent review of long term pensions policy in Ireland. It is planned that the study will be a short and focussed review of Ireland’s pension policy and is expected to be completed before the end of 2012. It will encompass the totality of pension provision in Ireland - State, private, occupational and public sector. It will take account of Programme for Government commitments in the pensions area and will be informed by developments at EU level in relation to both pensions and longer working. The focus of the review is to be on issues of sustainability; adequacy; modernity; and equity and the issue of early access to pension savings will also be considered.

The Government has already introduced a number of pension reforms such as the increase in State pension age and new legislation for public sector pensions. It is intended that the age at which a person becomes eligible for the Irish State Pension will increase gradually over

the next 18 years starting in 2014 when the eligibility age will be increased to 66, to 67 in 2021 and then to 68 in 2028.

The reform and strengthening of the Funding Standard by requiring DB pension schemes to hold a risk reserve as a protection against future volatility in the financial markets. This will be done over a long lead in time of approximately 11 years

The Government has also undertaken to preserve the State pension at its present value of 35 per cent of gross average industrial earnings (GAIE).

The 2012 Budget announced its intention to introduce a “total contributions” approach to the State Contributory Pension. This means the amount of pension will be proportional to the number of years that a person has contributed State Contributory Pension.

Currently the contributory pension is paid to people from the age of 66 who have enough social insurance contributions. People who do not have enough contributions to receive the maximum payment, such as people with an average of 10 contributions per year over a minimum five-year working life, a reduced rate is payable. Under changes announced in January 2012 and due to come into force in September 2012, those with the minimum 10 contributions per year will see their pension drop to €92 a week. The five-year working life requirement is being doubled to 10 years.

One of the key changes proposed by the National Pensions Framework, was the introduction of a ‘soft mandatory’ scheme which would see most workers aged over 22 automatically enrolled in a pension scheme which will provide additional retirement income on top of the State pension, unless they are already members of an occupational scheme. Under this proposal employees will contribute 4 per cent of salary to the new defined-contribution scheme with employers paying 2 per cent and the

State another 2 per cent. It was suggested that contributions to the new pension scheme would be made within a band of earnings, with earnings below and above certain thresholds exempt.

Public Service Pensions:

The Government introduced the Public Service Pensions (Single Scheme) and Remuneration Bill 2011, changing the eligibility for pension for future civil/public servants to 66 (with some exceptions). This retirement age will rise to 67 and 68 years of age in the years 2021 and 2028 respectively. These increases are in line with increases to the State pension age.

A further change proposed under the Irish Government’s new pension bill is that the value of pensions attributable to new entrants to the civil/public service will be calculated in accordance with their average career earnings and not their salary at the date of retirement, as is currently the case. The change to the retirement age is intended to help increase the sustainability of the public pension system.

In 2003, the Society of Actuaries had proposed that this would be the most effective way of reducing the cost of pensions (Society of Actuaries in Ireland 2003). The society calculated that if the retirement age was increased to age 70 by 2050 the pensioner support ratio would increase from 2 to 2.78 and to 4.4 following an increase in the pension age to 75. They argued that the State Retirement Age dates back to 1925 when the remaining life expectancy for a 65 year old was substantially lower than it currently is. They estimate that the gains in life expectancy were almost 7 years for men and almost 10 years for women but that these figures were expected to increase for the next 50 years.

3.5.5 Pension Reform In Other OECD Countries

Internationally, the growing cost of paying for pensions into the future has ensured that the

issue of pension reform has risen to prominence in most countries. In many OECD countries this has resulted in major changes. For example, six of the ten countries with the highest public expenditures on pensions – Austria, Finland, France, Germany, Italy and Sweden – have undertaken major pension reforms within the past twenty years. However, the ten OECD countries with the lowest pension expenditures in 1990 have also reformed their pension systems in anticipation of the financial challenges which they will likely face in the future (OECD 2008).

Changes in the pension eligibility age are the most common feature of reform packages with ten countries introducing gradual increases in pension ages for both men and women. When these reforms are complete, most OECD countries will have a standard retirement age of 65 years, although in Denmark, Germany, Iceland, Norway, the United Kingdom and the United States, the pension age is or will be 67 or more. Only France, Hungary and the Czech and Slovak Republics plan to have normal pension ages below 65; in four more countries, only women can retire on a full benefit before the age of 65.

However, effective retirement ages – the age at which people actually stop working – tend to be lower on average than the pension age (OECD, 2006). In response to this, nine countries have encouraged older workers to stay longer in their jobs by changing pension incentives to retire. Incentives towards early retirement, many of which were introduced in the 1970s in response to high and rising unemployment, have been closed to new entrants or restricted severely. Penalties for early retirement in old-age pension schemes have been introduced or increased in many countries, including Austria, Germany and Italy. Similarly, countries such as France and Sweden have increased the number of years of contributions required to receive a full pension. Other countries have introduced

or increased the increments or bonuses paid to people retiring after the normal pension age: Spain and the United Kingdom, for example.

The other changes to pension systems include measures such as changes to the earnings base for pension entitlements. Seven OECD countries have extended the period over which earnings are taken into account instead of just basing the benefit on a limited number of final-years or best salaries. For example, France is moving from the best 10 years to the best 25 years in the public scheme. Finland, Poland, Portugal, the Slovak Republic and Sweden are all moving to a lifetime average earnings measure.

A number of countries opted for more systemic reform. The most common policy has been to remove all or part of the public defined-benefit (DB) pension system and replace it with defined-contribution (DC) provision. In DC schemes, the pension depends on contributions and the interest earned on them. Hungary, Mexico, Poland, the Slovak Republic and Sweden have all introduced mandatory, privately managed individual accounts to replace part of the public pension. Another change of retirement-income paradigm has been the shift in public pensions from DB plans to notional accounts. In these schemes, the pension depends on contributions but the notional interest rate is set by government and is often linked to wage or GDP growth. The schemes remain pay-as-you-go financed: no assets are accumulated. The most radical change took place in Mexico, where all of the pension system was public before the reform and now only a small public component is retained, however, it will be decades before the new system is fully in place.

3.5.6 Pension Reform – Alternative Options

To encourage a higher level of saving a number of alternative approaches have been proposed

and introduced in many countries. This section outlines the basics of two possible approaches. The first (Model 1) was put forward in 2008 and recommends the establishment of a national savings fund to be made up of three pillars - funded by three scales and proportions of contributions (de Buitelir and Thornhill 2008).

3.5.7 Security Of Pension Income

The move among employers away from defined benefit and towards defined contribution schemes places the risk back on the pensioner and undermines the objective of income security in older age. Under defined contribution systems, pension risk tends to be individualised and includes: uncertainty, complexity of products, varying real rates of return to pension assets and uncertain earning trajectories.

Within defined benefit schemes pensions are not based on accumulation but instead on wage history and length of service. While sustainability is an issue, the risk within defined benefit is spread more widely and falls upon employers, current workers, shareholders, taxpayers and customers. Under social insurance, risk is shared even more broadly to include future taxpayers through state borrowing and pensioners themselves, through reductions in their pensions and later retirement.

According to the CEO of the Irish Pensions Board, over the last ten years the typical investment portfolio increased its holdings of shares and property, resulting in a situation where funds with 80% in shares were being offered as medium risk. He raised a number of issues relating to the 'drift to risk' whereby new fund options that were added were always, up to recently, higher risk, so that the 'average' fund got riskier and riskier. This trend towards higher risk funds, he said, resulted from "*trustees in too many cases thinking only about the highest possible investment returns and people in too many cases failing to engage with and take responsibility for their pensions*". (www.pensionsboard.ie)

While the trend is towards the replacement of defined benefit schemes with defined contribution schemes, and with risk shifting to individual pensioners, a strong risk-based argument exists for more not less state-guarantees with respect to pension income. Large risk pools for pensions are more likely to be efficient and equitable in meeting the multiple pension system objectives of consumption smoothing over the lifecycle, dealing with uncertainty, poverty relief and redistribution.

The global recession and the 2009 crisis in the equity markets had implications for the pension income of those close to retirement and also for the ability of many defined benefit schemes to meet their financial obligations to a guaranteed level of income on retirement. The OECD presented its analysis of the impact of the current financial crisis on private pensions and found that it had reduced the value of assets to fund retirement by around 20-25% on average varying from large falls of over 30% in Ireland and the United States to much lower levels in other countries. They also highlighted the concern that the increase in unemployment will reduce the amount of pensions' savings, which will negatively affect future retirement incomes.

The Pensions Act 1990 requires that defined benefit schemes (excluding those exempted by regulations) must submit an actuarial funding certificate (AFC) at three yearly intervals. The scheme actuary certifies whether, if the scheme had wound up at the effective date of the certificate, its assets would have been enough to meet its liabilities. If not, a funding proposal must be submitted which is designed to restore the scheme to solvency. About 25% of the larger defined benefit schemes (over 100 members) have failed the funding standard at the latest AFC filing. Defined contribution schemes have also experienced serious losses.

The OECD reveals that the funding levels of pension funds providing DB pensions have dropped well below 90% in most OECD

countries. This becomes problematic when assets of the company's pension fund fail to cover their pension liabilities. For example, many US companies had funding levels in 2007 that were close to 100%, following the requirement of the Pension Protection Act to bring the funding of their pension plans to at least 92% by 2008 (Antolin and Stewart 2009)

Around 80% of Irish defined benefit (DB) schemes were in deficit at the end of 2009, according to estimates from the Pensions Board. However "very few" schemes have requested approval for extended funding periods or benefit reductions. There are also large underfunded public sector pension liabilities. The Comptroller and Auditor General estimated that at the end of 2008 the net present value of accrued unfunded public pension liabilities amounted to €101 billion.

In January 2009, the Waterford Wedgwood company faced insolvency and hundreds of current and former Irish workers at Waterford Wedgwood faced the potential loss of their pension entitlements because of a shortfall of €110 million in the company's retirement scheme. The workers in the British part of the group were covered by a Pension Protection Fund but Irish employees were not. The company was later bought out but pension obligations were not part of the sale. As a result employees who had been paying into the pension plan are likely to receive only 20 per cent of their expected pension.

Under existing rules if a defined benefit scheme is in deficit and the sponsoring employer becomes insolvent, the trustees must first of all provide pensions for the retired members of the scheme usually by the purchase of annuities. Whatever capital is then left after the purchase of the annuities is distributed among the active and deferred members of the scheme.

The Pensions Insolvency Payments Scheme (PIPS) was established to reduce the cost

of purchasing pensions for trustees where the pension scheme and the employer have become insolvent. This scheme came into effect in February 2010 to ensure a more equitable distribution of assets following the wind up of underfunded pension schemes where both the pension scheme and the employer are insolvent.

In April 2012 the Minister for Social Protection Joan Burton published the Social Welfare and Pensions Bill 2012 to give effect to reforms in relation to Defined Benefit Pension schemes.

Under this legislation the Minister said that the Funding Standard will be restored initially and will provide an allowance for the purchase of sovereign annuities and bonds. The requirement to provide for a risk reserve will take effect from 1 January 2016.

"I am aware that many pension schemes are in deficit. It is, therefore, intended to introduce the risk reserve requirement over an extended time period. Pensions schemes will be given a period of up to 11 years from the re-introduction of the funding standard to satisfy the risk reserve requirement."

Acknowledging that many trustees and sponsors have been working to enhance the sustainability of their schemes and have been making difficult decisions in that regard, the Minister said that the re-introduction of the Funding Standard would require all schemes to examine their position closely and develop realistic proposals to rectify their funding positions.

The Minister said that the introduction of a risk reserve is intended to change how DB schemes are structured, to bring increased stability to DB pension provision and lessen the exposure to risk *"Funded DB pension schemes have persistently been subject to the volatile conditions of the financial markets over the last decade, affecting the security of members' benefits. The introduction of a risk reserve is a "buffer" to assist schemes absorb shocks such as financial downturns and a fundamental change to the way DB pension provision currently operates."* she said.

Case Study

MODEL 1: NATIONAL SAVINGS FUND

Under this plan each person in the labour force would have his or her own unique account with the Fund. Information on contribution details, value and equivalent annualised income values would be regularly updated and available to the account holders ensuring maximum transparency.

Pillar 1: This scheme would be broadly similar to the current PRSI system and would involve compulsory contributions from employees, employers, self-employed and farmers. Funds in this tier, which may need to be supplemented by Exchequer contributions, would be used to fund a basic income for pensioners similar in concept to the current contributory pension. A non-contributory pension scheme would remain in place as a safety net, anti-poverty measure.

Pillar 2: Under this pillar employees and employers would make “soft” mandatory or auto-enrolment contributions according to specified scales to individual accounts. The Exchequer would also make contributions (modelled on the SSIA and PRSA schemes) which would be proportionate to the employee contributions and subject to similar limits as exist at present. A parallel scheme would be available for farmers and the self-employed. Under this proposal people in existing pension schemes would be free to transfer their investments to the new scheme or to opt out of the new system and maintain their present arrangements.

Pillar 3: This pillar would be made up of voluntary contributions from employees, employers, self-employed and farmers. It would provide a mechanism to allow tax incentives or counterpart Exchequer contributions to be targeted on particular groups such as people whose existing pension entitlements or savings are inadequate, including parents who have taken time out of the workforce.

Case Study

MODEL 2: 'SOFT' COMPULSORY SAVING SCHEME - KIWISAVER

An alternative model that could be considered is the KiwiSaver, which is a voluntary long-term savings scheme introduced in New Zealand in July 2007. Employee participants can choose to contribute 2%, 4% or 8% of their gross pay, and can switch rates three months after setting a rate (unless the employer agrees to a shorter time frame). The self-employed and unemployed can choose how much they want to contribute. While most KiwiSaver schemes have minimum contribution amounts for people in this category, there are several schemes that allow any level of contributions.

All New Zealanders aged 18-65 starting a new job, with some exceptions, are automatically enrolled in KiwiSaver, but can choose to opt out from day 14 to day 56 of their employment. Participants choose to put their savings in one of several approved savings schemes, with varying degrees of expected risk and return. If they do not choose a scheme, they will be assigned either to the employer's default fund or to a government-selected default fund. When a person joins they receive a \$1,000 tax-free "kick start" to their savings account from the government. KiwiSaver contributions can only be accessed in particular circumstances such as reaching retirement, purchasing a home or in cases of significant financial hardship.

(<http://www.kiwisaver.govt.nz/media/ks-media-stats-09-03-31.html>).

Issues Arising

Living alone: A study carried out by the Vincentian Partnership for Social Justice found that all categories of female pensioners over 70 living alone had no discretionary income and instead had income shortfalls of between €11.79 and €63.83 per week. The state living alone allowance is therefore insufficient to mitigate the 'dis-economies' of scale experienced by people living alone. As a consequence, increasing numbers of them who are solely dependent on the State pension are unable to pay for basic items.

Fear of poverty: Many pensioners experience a fear of poverty, and there is anecdotal evidence that older people are reluctant to liquidate assets because of fears about the health and care costs they are likely to incur the longer they live.

Support Ratio and policy choices: The ratio of people in employment to those in retirement is projected to fall from a high in 2008 of 6:1 to a low of less than 2:1 by 2050, which is clearly unaffordable (Department of Finance 2009). This will require choices or trade-offs between the five core options identified by the Dept of Finance outlined above.

Reduction in the number of working years: Research in the UK found that the average number of years that people work has fallen significantly from 53.1 in 1950 to 47.6 in 2004 (Barr 2006), as people have tended to enter the workforce later and retire earlier. At the same time, the average number of years spent in retirement doubled from 10.8 to 20.1 in 2004.

Level of pension coverage: Surveys found that in 2008 only 54% of people had private pensions - a reduction of 1% since 2005. The National Pensions Policy Initiative (NPPI) target of 70% coverage for employed people aged 30 to 65 has not yet been met. The figure had risen to 61% by 2008, but there is evidence to suggest the rate of increase has stagnated. However, the National Pensions Framework (2010) could, if fully implemented,

address concerns about low levels of private pension coverage, through the establishment of an auto-enrolment savings scheme.

Level of contributions: The level of individual savings and pensions is widely considered to be too low to make adequate provision for expected increases in longevity. There is considerable research to show that many people are not making adequate provision for their later years, and that many older households will not be able to maintain current levels of consumption into retirement without additional savings (Moore and Mitchell, 1998).

Expectations re replacement income: There appears to be a 'disconnect' or gap between the pensions many expect to receive, and the contributions they make or are being made on their behalf. In addition, the Government has expressed concern that pension coverage has remained relatively static over the past few years, despite the tax incentives that have been provided to encourage personal pension contributions.

Security and pension fund losses: The OECD found that the global financial crisis has reduced the value of assets available to fund retirement by an average of around 20-25%; the rate varied over 30% in Ireland and the United States to much lower levels elsewhere. Its findings highlighted the concern that the increase in unemployment will reduce the amount of pension savings, which will negatively affect future retirement incomes.

Reduced Value of Assets: The current recession has also had an impact on the value of many assets such as property, and this has impacted on the security of retirement income, affecting recent retirees in particular, and giving rise to increasing concern among older Irish people about their future financial security. The erosion of the value of pension funds for current retirees and those soon to retire is now a major concern, and raises questions about how to limit the risk-taking by trustees and pension

funds, to meet some of those concerns. The trend towards Defined Contribution schemes and away from Defined Benefit pensions has increased the impact of these losses, and left many people nearing retirement fearful for their future financial security.

Cost of Private Pensions and Cost of Tax Relief: Private pensions are seen as having high management costs, and there is also some criticism about the cost of providing full tax relief, with some groups arguing that the monies required would be better deployed in providing a universal State-run pay-related pension scheme.

Pension Schemes incentivising retirement: There are a number of factors relating to pension schemes which deter people from continuing to work beyond 65, even when this is their preference. One of these is the fact that, under many pension schemes, the level of retirement income is related to a worker's salary in their final year.

CONCLUSION - KEY ISSUES

In conclusion the key issues to be considered include the following;

Security Of Post-Retirement Income

While there have been significant improvements in Ireland in pensions and a consequent reduction in poverty levels, nevertheless there are a number of important 'income security' issues. The majority of those over 65 still are exclusively reliant on the state pension and while that protects against poverty at its current levels any changes in the level of the pension leave them vulnerable to relative poverty. There are also problems for people living alone - the diseconomies of scale combined with other expenses eg travel if living in isolated areas can leave some more vulnerable.

The shift from Defined Benefits to Defined Contributions pensions also means that the risk is now borne by the individual. The recent

financial crisis seriously depleted the life-savings of many - with the OECD estimating that it reduced the value of assets to fund retirement by 30% in Ireland. One of the key concerns for older people, that emerges from consultation is the fear of facing very high 'catastrophic' costs such as home-care in the event of an accident or serious illness. At present there are no insurance products or systems, such as proposed by the Dillnott report in the UK.

The government has recognised the need to reform the current pension scheme and approaches such as that proposed by Don Thornhill and Donal de Buitler in their 2008 *Life Times Savings Schemes* need to be looked at both because they provide more flexible savings options and because they potentially reduce the high management costs and allow for greater flexibility in people combining work and pension.

Age-Friendly Workplaces

Despite equality legislation protecting people against discrimination on the grounds of age, the current legal situation allows employers insist on retirement at the age of 65. While there have been changes in the public service, for those entering after 2004, Ireland effectively operates a default retirement age, in contrast to other countries such as the UK, Canada and others which have recently removed it. According to the Equality Authority, age-related discrimination has now overtaken racism as the largest category of complaints about discrimination in the workplace.

Evidence from Eurobarometer shows that almost three quarters of Irish people believe they should be allowed to continue working past the official retirement age and want to have the option of working later or gradualizing their retirement. This compares to only 60% of their European counterparts.

While the focus during the economic crisis is on high levels of unemployment, Ireland like

other countries will face a shortage of people in the workplace over the medium term, with projections of a 6:1 ratio of those in employment compared to those in retirement, dropping to 2:1 by 2050. While these figures for 'national dependency' are offset by the projected reduction in the number young people, nevertheless there will be growing pressure on companies to adopt changes in workplace practices that make their companies more attractive for older people to stay working in and there is very little done on this subject - such as allowing people adopt different working roles, reducing stressful responsibilities, more flexible hours.

Economic Contribution of Older People

The general depiction of the issue of population ageing is that of a financial tsunami, with unsustainable health, care and pension costs. These assumptions need to be challenges in a number of ways.

The first wave of The Irish Longitudinal Study on Ageing, TILDA, found that people aged between 50 and 64 are more likely to make transfers than to receive them. The study found that nearly one-quarter (24%) of older households gave a financial or material gift worth €5,000 or more to their children within

the last ten years, with this number lowest (16%) in the over 75 age group. In the UK, the charity AGE-UK conducted research quantifying the 'bounty' that an ageing population offers, both economically and socially. This research estimates the current contribution of older people in the UK, from both paid and unpaid work, at approximately £244bn.

There is growing incidence of people at or near retirement seeking to set up their own businesses. Research on the 'silver entrepreneurs' found that 13% of people over 55 were interested in becoming self-employed (Eurobarometer, 2009). However, in Ireland there are barriers to such initiatives with FAS courses on Setting up your own Business and Return to Work not open to those over 65.

Lastly, the growth in the number of older people, in itself will give rise to significant new business opportunities. This is well evidenced in areas such as the new technologies in tele-health and tele-care, in tourism with significant growth in the number of tourism products structured around this market, and in new product areas such as self-parking cars, adventure gap years, disease-targeting nutrient food products and dating agencies.

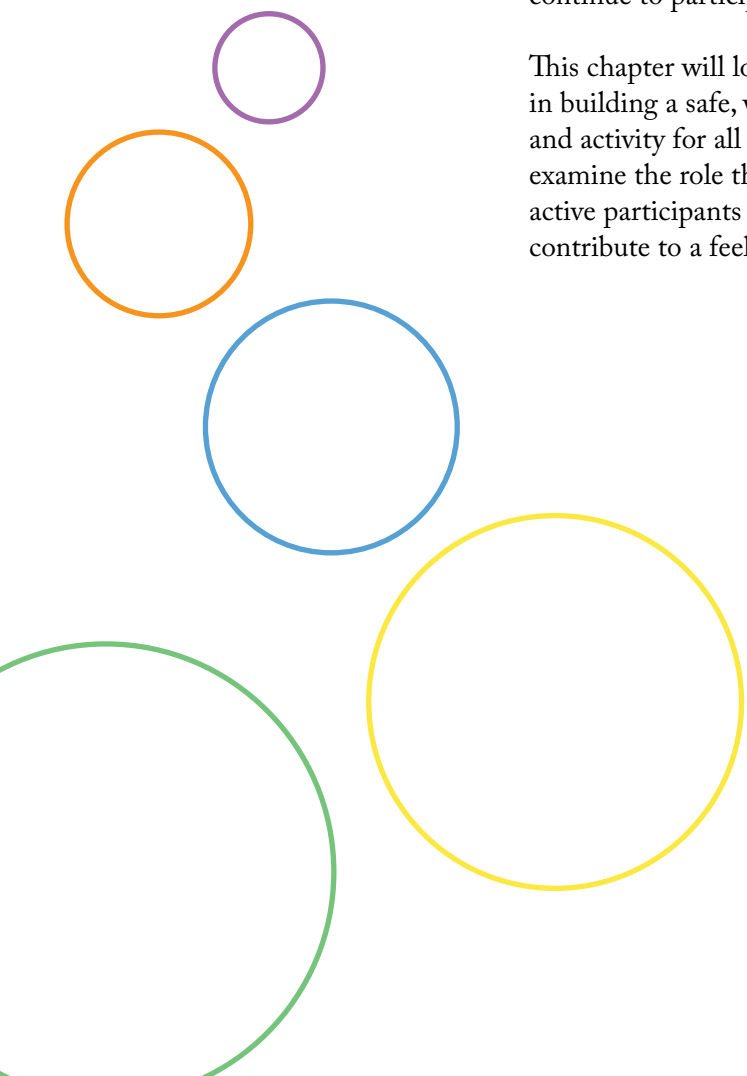
Chapter 4.

Age Friendly Communities

Demographic change has the potential to create opportunities and challenges for communities of the future. To realise the vision of a better Ireland for older people, we need to plan for communities in which older people are enabled to live healthy, active and engaged lives, where they value and, in turn, are valued, for being important contributors to the life of that community.

Older people who live in an unsafe environment or areas with multiple physical barriers are less likely to go out, and therefore are more prone to isolation, depression, reduced fitness and increased mobility problems. In an Age Friendly community, policies, programmes, services and infrastructure are designed to enable older people to live in security, enjoy good health and continue to participate in society in a meaningful way.

This chapter will look at the role of the Age Friendly Counties programme in building a safe, walkable environment which promotes independence and activity for all people, but especially for those growing older. It will examine the role that transport can play in supporting older people to be active participants in their communities and it will discuss the factors that contribute to a feeling of safety within the home and community.



4.1 THE GLOBAL AGE FRIENDLY CITIES PROGRAMME

The concept of an Age Friendly community is linked to an initiative started by the WHO in 2007 called the WHO Global Age-Friendly Cities project. This project took place with participation from 33 countries, including Ireland (where Dundalk was the participating city). It highlighted the need to maximise the health and well-being of the older population in urban environments and involved extensive

consultation with older people. The definition of an Age-Friendly city according to the WHO is one in which “*service providers, public officials, community leaders, faith leaders, business people and citizens recognize the great diversity among older persons, promote their inclusion and contribution in all areas of community life, respect their decisions and lifestyle choices, and anticipate and respond flexibly to ageing-related needs and preferences*” (WHO 2007).

The eight areas covered by the Age-Friendly cities project are: respect and social inclusion, civic participation and employment, housing,



community support and health services, communication and information, outdoor spaces and buildings, transportation and social participation. Based on the consultations with older people, The Global Age-Friendly Cities (2007) argued that simple and cost-effective changes can be enormously beneficial in determining whether older people feel confident in being 'out and about'. The issues raised by older people in their consultations include:

- Level pavements can reduce the number of falls and increase older people's sense of security in walking the streets;
- Good local transport taking older people where they want to go, at times they want to go, and in vehicles they feel secure in, will influence decisions to stay at home or go out;
- Adequate provision of public lighting, access to well-maintained public toilets, and sufficient seating in public places, all help determine how long people will stay out and where they will go;
- The range of housing options and supports for independent living has a significant impact on decisions about moving out of home into a nursing home;
- Opportunities to volunteer time and life-skills to address social and other community problems can make a difference to whether older people enjoy high levels of self-esteem and feelings of usefulness, or feel themselves a burden on others;
- Opportunities to socialise and maintain good networks of friends, family and neighbours contribute to physical and mental well-being;
- Ease of access to information, on matters including entitlements to services and support options, affects service uptake levels and hence general well-being; (WHO 2007)

Many of these areas are dealt with in greater detail in other chapters. One important outcome from the project was the document, Global Age-Friendly Cities: a Guide, alongside a shorter Checklist of Essential Features of Age Friendly Cities, designed to be used by service providers in partnership with older people's groups.

4.1.1 The Age Friendly Counties Programme in Ireland

Following from participation in the WHO project, the Louth County Manager, representing the City and County Managers Association, agreed with the Ageing Well Network, to take the initial lead role in making Louth Ireland's first Age Friendly County and adopt an Age Friendly Strategy – thereby launching phase one of the programme in Louth in November 2008. Since then the programme has developed and regional managers have been appointed to implement the programme in four regions, mirroring the Health Services Executive (HSE) designated regions: Dublin Mid Leinster, Dublin North East, South and West.

The second phase of implementation began with the launch of the programme in the South. This took place in Kilkenny in March 2010 and was followed by the Eastern region, with the launch of the Kildare Age Friendly County Programme in November 2010. The consultation with older people, their advocates, service providers and public representatives has been ongoing since then.

Dublin North East region launched an additional three counties in September 2011, Meath, Monaghan and Fingal and Cavan in October 2011. The Western region launched its two lead counties Galway and Clare in September 2011. The initiative is being overseen by a National Integration and Implementation Group established by the network, comprising seven AWN members. There are currently 10

counties participating in the programme. By the end of 2012 a number of other counties will have joined them. It is envisaged that the programme will be operating in most local authorities

While each initiative can be tailored to address the needs, priorities and preferences of older people in each individual county, they share a number of common features. These include;

- The Programme is always embedded within existing resources and structures
- The Programme finds ways to reconfigure the use of existing resources rather than create new spends
- The Programme always adopts a collaborative and person-centred approach
- Sustainability is core to the success of the Programme in each local authority area

The Programme brings together service providers and relevant organisations across the four regions of Ireland. This ensures that public, voluntary, statutory and private agencies work with older people to deliver age-conscious services. The core infrastructure of the Programme comprises the following key entities:

County Alliances

Each county's programme is led by an Alliance, comprising the most senior decision makers from the key public, private and not-for-profit agencies committed to jointly planning and cooperating to achieve their own Age Friendly County vision. Alliances are made up of the local County Manager, HSE Local Health Manager, and the chairs of three newly created Forums – Older People, Service Providers and Business. They will also include key leaders from the An Garda Síochána, 3rd level institutions, voluntary organisations and other service providers in the area. The Alliance is embedded into the local infrastructure through the County Development Board.

Older People's Forums:

These forums are made up of representatives of all the older people's organisations in the area and all older people in the area can participate through publicly organised meetings. These meetings give older people the opportunity to determine key priorities for the Age Friendly County Strategy. The Role of the Forum is to represent the views of older people within the Alliance and to set up its own initiatives to address many of the issues identified through the consultation process.

Business of Ageing Forums:

These forums are designed to stimulate awareness among the business community about how best to grow their customer base, by deepening their understanding of older people's needs, preferences, behaviours and attitudes. They are made up of business leaders from the area with an interest in responding to those needs and see the opportunities for businesses to benefit from the becoming more age friendly.

Service Providers Forums

These forums bring together all those organisations providing services to older people in the county – across the public, private and not-for-profit sectors with a view to exploring how to improve the range and quality of those services and make them more responsive to the expressed needs of older people.

The forum identifies who provides what services, where and to which groups of older people and reviews those services against the known needs of older people. The Service Providers Forum also seeks to identify ways in which services might be provided in a more cost effective way, removing any areas of duplication and prioritising areas of greatest needs.

Consultation Process:

A comprehensive consultation process is held in each county to establish the key priorities for the area. In some counties this verbal consultation

is accompanied by a base-line survey which is conducted at the start of the programme. While a common survey is made available to each county, the questions can be tailored to the particular circumstances of the county.

The consultation involves a wide representation of older peoples groups including minority and disability groups and those who experience rural isolation. The process also seeks to include groups such as statutory agencies, intergenerational groups and those providing services and supports for older people along with business interests and arts/ sport and cultural interest groups.

The process seeks to find out from older people what they feel is good in the county, what could improve, what they can do to improve things and what they feel that others can do to make life better for older people in the county. It is structured around the eight WHO themes;

- Home: remaining at home when mobility reduces and support needs increase; access to quality supported and sheltered housing, access to residential homes, access to nursing homes, access to home supports and home help
- Engagement in the Community: engagement and involvement with family and friends; for example, opportunities for volunteering, opportunities for participation and community involvement, opportunities for participation in sport, leisure, and sporting events, opportunities for participation in the arts
- Physical Environment, Outdoor Spaces, Public Services, Transport, Public Spaces: street lighting, seating, level accessible pavements, access to parks and gardens; consultation in respect of town planning and access to information on town

planning; availability of accessible, good quality, consumer goods and services; access to transport, availability of public transport, and parking; traffic; sufficient time for traversing at pedestrian crossings; safety and security

- Community Support and Health Services: initiatives to promote healthy living; facilities and supports for dealing with older people living with chronic health conditions; access to good quality healthcare facilities and services in the local community/access to community-based, good quality healthcare facilities and services, access to good hospital services in the county.
- Income: opportunities for older people to set up businesses, opportunities for older people to remain working after 65 if they so wish, opportunities for flexible working; and information on income and entitlements.
- Communication and Information: information on what's going on in your county, Public Service information, Voluntary Service information, Citizens Information; ensuring the AFC initiative is an informative, inclusive and consultative body

County Strategy

The Regional Age Friendly Counties Programme Manager supports each County Alliance to develop their own Strategy, setting out agreed initiatives and targets. There is considerable engagement of key agencies in developing the strategy and once adopted, the strategy is embedded within every area. The Regional Managers support the Alliance in the production of detailed delivery plans that set out lead responsibilities, timescales and reporting mechanisms.

4.2. THE AGE FRIENDLY BUILT ENVIRONMENT

Local Authorities have always played a significant role in shaping the built environment through planning for land use and through the provision of facilities. Development and implementation of housing policy tends to take place independent of land use and transport planning. Disconnection between these areas can lead to policies which are inefficient, expensive, and which fail to realise the potential benefit of harmonized and integrated land use planning, both for communities and individuals.

As people age, the distance they can conveniently travel reduces for a variety of reasons such as slower driving and walking speeds and increased use of slower modes of transport. Consequently, many older people spend a great deal of time in their local neighbourhood, shopping locally, using public facilities such as libraries and parks and participate in local social and recreation activities. Through the planning, designing and building of environments that are safe and accessible to older people, local authorities can support older people in continuing to live in their own homes and local communities. An awareness of the importance of planning for people at different stages of their lives has been growing in relation to the needs of young people within communities. Now, changing demographics and increased citizen expectations are likely to create pressure to address the needs of older people.

4.2.1 Land Use Planning

Accessibility of public spaces, services and facilities is a significant factor for older people, particularly for those with mobility limitations. According to the OECD, (2001) the needs of future generations are often not the main considerations in current land-use planning

practices. They point out that compact communities with locally available facilities and services are environmentally sustainable and are of benefit older people in particular and the wider society in general. Local authorities can therefore improve older people's well-being and quality of life by basing their planning decisions and resource allocations on the known needs of older people.

Physical accessibility can determine whether older people can make regular use of the public spaces, services and facilities provided. For example, one study found that 60-70% of people using a park live within 800m of it (Stoneham, 1996).

The design of the built environment can also impact on the ability of persons with disabilities to be active and integrated into their community. One study found that there are many ways in which independence can be reduced by the characteristics of the built environment. People with reduced or declining physical abilities experience greater dependence in activities of daily life when they live in a community characterized by what they described as 'limited land-use mixtures' (Clarke et al 2005). Such environments mean that older people experience more difficulty travelling independently to shops, pharmacies, and banks, which in turn can prevent independence in activities such as meal preparation, taking medications (obtaining refills from the pharmacy), and managing money (paying bills at the bank). The authors suggested that *"disability can be diminished swiftly and markedly if the physical and mental demands of a given task are reduced"* (Verbrugge and Jette 1994 p.9).

Because the built environment has the potential to limit the choices available to people, it is often the determining factor between a healthy and active lifestyle and one characterised by limited mobility and high levels of social isolation (Sugiyama and Ward Thompson, 2006 and 2007c). If planners

and developers incorporated diversity and accessibility in areas with a high proportion of older adults, disability could be reduced in later life, with potential implications for expenditures in health and long-term care.

There is evidence that remaining in their own community contributes to wellbeing and quality of life by allowing people to maintain local friendships and ties in the community, shop and obtain medical care in familiar places, rely on neighbours for emergency support, etc. As the families become more geographically dispersed, these community relationships may become more important for many older people (Wethington and Kavey, 2000).

One US study asked older people about their attitude to relocating to such environments and found that, while there was evidence that the oldest old were more likely to seek increased accessibility, in general older people preferred to remain in the homes or apartments they had lived in for most of their lives (Giuliano, 2003). Therefore, any policy proposal to encourage older people to relocate to more accessible places must be balanced against the potential loss of an established social network and community.

Some locations are by their nature more Age Friendly than others, so that, while the overarching policy may aim for making all areas Age Friendly, it could also be beneficial to focus on encouraging older people to live in the more Age Friendly areas as they approach older age.

4.2.2 Walkable Environments

Walking is a low-cost, low-impact means of transport which provides the added benefit of promoting good health and social connectivity for older people. However, for too long, health promotion strategies have sought to increase physical activity without any acknowledgement that, in many communities, environmental barriers act to deter or prevent physical activity

(e.g., no parks, inadequate or poorly maintained footpaths, poor lighting etc). In recent years, research has sought to develop an understanding of the influence of particular characteristics of the built environment on the level of physical activity and in particular to walking.

Public spaces that are attractive and have natural environments or natural elements can promote increased physical activity, opportunities for social engagement and increased well-being among users (Sugiyama & Thompson, 2007b; Sugiyama, Thompson, & Alves, 2009). A Japanese study (Takano et al., 2002), found that living in areas with walkable public green spaces increased the longevity of urban older people independent of other factors (Takano et al., 2002, p.913). Time spent in common space with more trees and grass, was found to be associated with higher levels of social integration among older people (Kweon, Sullivan and Wiley 1998).

Availability and accessibility of local shopping areas, pedestrian areas and footpaths are linked to increased levels of activity (Michael, Green and Farquhar, 2006). Similarly, environments with poorer facilities and fewer or no recreational spaces are associated with a reduction in physical function in older people and lower levels of physical activity (Booth et al 2000). Urban design can also influence the level of dependence on cars and other forms of transport which in turn can impacts on the number of crashes or pedestrian injuries (Ewing et al 2002).

Despite the many positive benefits associated with attractive and accessible outdoor environments, many older people experience challenges in accessing public spaces. Research has found that urban and suburban residents living in homes built before 1946 (older communities) were more likely to regularly walk long distances than those living in newer homes, a finding which they attributed to the availability of footpaths, more closely

interconnected streets, and the mix of business and residential uses in older communities (Ewing et al 2003). A US study found that the distance between destinations, difficulty in walking, poor footpaths, lack of places to rest, and fear of crime were among the main barriers to use of public facilities. The study identified a number of design criteria that helped facilitate use of the facilities by older people such as ramps, stairs, pavements, level crossings, under and over pass, and treed streets. (Turel et al., 2007, p.2036).

Public footpaths can be a significant injury hazard for older people, particularly those with limited mobility. The World Health Organisation consultations found that inadequate footpaths were an almost universal problem: 'footpaths that are narrow, uneven, cracked, have high curbs, are congested and have obstructions, present potential tripping hazards and impact on older people's ability to walk around' (WHO, 2007). They are especially problematic for people with disabilities. A survey carried out by Enable Ireland found that footpaths were the biggest barrier to older people's mobility and well-being (Enable 2008).

An American study found that adults with more severe physical impairment were four times more likely to report that they had a lot of difficulty walking 2–3 blocks when they were living in communities where streets were in very poor or only fair condition (characterized by cracks, potholes, or broken curbs). However, when all streets were in good condition, the odds of reporting mobility disability were greatly reduced. The authors concluded that if street quality could be improved, even somewhat, the disablement process could be slowed or even reversed for those adults at greatest risk for disability in outdoor mobility (Clarke et al 2008).

A UK-based study in 2008 found 24% of pavements unfit for use, and established that in one year (2006) a total of 2.5 million older

people fell over on pavements alone. The Center for Disease Control and Prevention (CDC), estimated in 2006 that about six million older Americans (about one in six people over age 65) fell at least once during the previous three months. (Center for Disease Control and Prevention, 2008). Such falls sometimes result in fractures which take months to heal, leaving the older person more frail, physically restricted and socially isolated, and possibly very fearful of falling again. Since dangerous pavements are a significant cause of falls, AGE-UK has proposed that all pavements should be smooth and non-slip, with a maximum difference in slab height of 2.5cm, so that older people are less likely to fall or to fear falling in their local neighbourhoods.

Studies by AGE-UK also found that for older people who are becoming frail or less mobile, public seating can make the difference between living a full life and feeling cut off and isolated. Without the security of knowing there is adequate provision of benches etc. in places such as shopping centres, post offices, supermarkets, bus-stops, and public parks, these older people may be less inclined to go out. As with other forms of Age Friendly provision, improving availability of seating is also in the interests of others, such as younger people with disabilities, and parents with young children.

If designed according to Age Friendly principles, the built environment can contribute greatly to the use of public spaces and the actual and perceived safety of communities. Communities with higher residential density, greater street connectivity, better land-use mix, convenient facilities, good aesthetics and other environmental attributes have higher levels of walking; and can therefore be classified as being more 'walkable' (Cerin, Macfarlane et al.).

4.2.3 Provision of Services

Planning for an age friendly community will involve recognition of the benefits of locating

services and facilities centrally in the community and a recognition of the need for older people to live close to their existing social networks of family, friends and neighbours. Planning permissions in an age friendly community would therefore take account of the distance to shopping, health care, and family or other support networks as well as the impact that the road layout and density of housing can have on mobility and transport.

In partnership with others such as health and other service providers, local planning can bring about important changes to improve the lives of older people in significant ways as well as providing services in a more effective and cost-efficient way, avoiding gaps or duplication. For example hospitals liaising with transport providers to ensure buses stop outside health centres and hospitals or local authorities liaising with the health services to make home adaptation grants available in time so that older people don't have to stay in hospital when they are medically fit for discharge. However, it is important to acknowledge the difficulties associated with ensuring that work is carried out in sufficient time to allow discharge from hospital even if grants are provided instantly.

The National Economic and Social Council's concept of the 'Developmental Welfare State', argued the need to adopt a life-cycle approach to planning, and identified four different life-stages, of which post-retirement is one. It recognized the challenges of delivering change at local level, which will necessitate adopting new styles of partnership involving public sector agencies along with private and non-profit sector bodies. It also identified the need for bolder innovation and new types of relationships between central and local bodies. (NESC 2005)

4.2.4 Universal Design

The principles underlying Age Friendly planning are those of universal design, and they

concern planning which caters for people of all ages, young and old, rather than focusing on an imagined 'average' user. Age Friendly planning should not be seen as focussing exclusively on older people as it will benefit all members of a community by facilitating accessibility, mobility and involvement of people of all ages, including those with disability, for the duration of their lifetimes.

Much has already been done in the area of planning for and provision of accessible buildings and facilities following from recent disability legislation. In Ireland, the accessibility of the built environment for people with disabilities is mainly governed by Part M of the Building Regulations (2000) entitled "*Access for People with Disabilities*". The underlying philosophy of Part M is to ensure that as far as is reasonable and practicable, buildings should be usable by people with disabilities.

The Disability Act 2005 defines Universal Design (UD) as: "*the design and composition of an environment so that it may be accessed, understood and used to the greatest possible extent, in the most independent and natural manner possible, in the widest possible range of situations, and without the need for adaptation, modification, assistive devices or specialised solutions, by any persons of any age or size or having any particular physical, sensory, mental health or intellectual ability or disability*".

Universal Design is based on seven key principles;

- Equitable Use - The design is useful and marketable to people with diverse abilities.
- Flexibility in Use - The design accommodates a wide range of individual preferences and abilities.
- Simple and Intuitive Use - Use of the design is easy to understand, regardless of the user's experience, knowledge, language skills, or current concentration level.

- **Perceptible Information** - The design communicates necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities
- **Tolerance for Error** - The design minimizes hazards and the adverse consequences of accidental or unintended actions.
- **Low Physical Effort** - The design can be used efficiently and comfortably and with a minimum of fatigue.
- **Size and Space for Approach and Use** - Appropriate size and space is provided for approach, reach, manipulation, and use regardless of user's body size, posture, or mobility.

Universal Design therefore promotes accessibility and usability, allowing people with all levels of ability to live independently. A UD approach therefore requires an appreciation of the varied abilities of every person and ensures that the resulting product, service or environment can be used by everyone regardless of age, size, ability or disability.

4.2.5 Service Provision in Rural Areas

Many rural areas have experienced a steady increase in the proportion of older people and while an overall decrease in Europe's rural population is predicted (from 100 million in 2000 to around 75 million in 2030), the proportion of older people is expected to continue to grow because of increased migration of younger people to urban areas and the in-migration of retirees (Klijn et al., 2005). The population of rural Ireland has grown at a slower rate than urban areas between 2006 and 2011 growing by 75,828 persons or 4.6 per cent, from 1,665,535 in 2006 to 1,741,363 in 2011. The proportion of older people living in rural areas was 12.2 per cent of the rural population at the time of the 2006 census, slightly higher than the proportion


in the country as a whole (11.4%) and it is expected that this figure will have grown in the period since then. (CSO, 2006).

Whilst population ageing is often portrayed as a social problem, there is considerable evidence that older people are important social agents, particularly in rural areas. They often provide much 'informal' care and support through their contributions to local economies, social networks, cultural and environmental activities. (Manthorpe, Malin and Stubbs 2004: 102).

Research carried out in three rural areas in Ireland found evidence of 'cycles of decline', where lack of employment opportunities caused the population to decline which in turn led to a reduction of health and social services. However the research also found evidence of strong communities kept alive by the voluntary effort of many of the older people living in them. In each of these communities people spoke about the benefits of providing formal and informal support to others through volunteering and even those who were no longer able to volunteer because of ill health were very clear about the benefits. (HARC 2011)

In general the TILDA longitudinal study found that, in terms of quality of life, there were no major geographical differences between older people living in urban or rural areas except in one area. The research found that the more those living in rural areas felt less control over the negative experiences of ageing and were more aware of the disadvantages of ageing. (TILDA 2011)

There is increasing recognition that some rural older people may be at special risk of social exclusion and disadvantage (Shucksmith 2003). Evidence suggests that there is "*a clear geographical dimension to income in old age [and that] those in remote rural areas are the worst off*" (Gilbert et al 2006: 89). Research from the



“Many communities are kept alive by the voluntary effort of the older people living in them.”

Joseph Rowntree Foundation suggests that in the UK, older people need more income to live on in rural areas than in urban areas. They calculated that the more remote the area, the greater the income disparity - in a rural town, the minimum income standard is 1% higher than urban areas, but in a village it is 19% higher and in a hamlet, 22% higher. The research identified transport as the major factor in the contributing factor to the additional cost of living, representing between 60 and 100% of the additional costs in rural areas. (Joseph Rowntree Foundation, 2010)

Fahey et al (2007) found differences in the quality of housing between rural older people and rural people of working age. The study found that significantly more rural older people did not have central heating (21.5%), compared to rural working age people (9.1%) and urban older people (8.7%).

However, while ageing in rural areas has advantages and disadvantages, and is neither better nor worse than ageing in urban areas, rural service provision demands a different approach from that which is appropriate in urban areas. Most people living in developed countries expect to be able to access the same quantity and quality of services regardless of where they live.

However, the cost of service provision in rural areas is often higher than in urban areas due to the lower population densities, the greater distances that staff have to travel to deliver home-based services or the increased overheads incurred in small rural service centres compared to those in urban areas (Ashana and Halliday, 2004; Bevan and Croucher, 2006; Williams and Cutchin, 2002). Where local services are curtailed or not available, people are expected to travel to the nearest urban centre, which may be some distance away, to receive the care they need, with the cost of travel often falling on the individual.

In an effort to address the particular problems of service delivery in rural areas a policy of ‘rural proofing’ was introduced in the UK in 2000. This requires national and regional bodies, when developing and implementing a policy, to make proper assessments of the impact its introduction may have in rural areas, and, if these are likely to be significantly different from urban impact, the body is required to amend policy and delivery appropriately to meet rural requirements. However, there are some suggestions that ‘rural proofing’ has had a limited uptake and has not been rigorously applied in all appropriate bodies (Commission for Rural Communities 2007b).

As discussed earlier, telemedicine offers the potential for delivery of services in a more cost effective way to rural communities. It has the capacity to allow remote consultation, which can be supported by a trained health worker locally. Evaluations have shown this approach to be more efficient in terms of service delivery with higher levels of patient satisfaction. (Brignall et al 2007)

Access to adequate transport is a major facilitator of social inclusion in rural areas (Manthorpe et al 2008; Wenger, 2001) However, in Ireland, as in many other countries, public transport is a major issue for rural older people. The TILDA report (2011) found that

rural people were more likely to have a negative perception of public transport systems, with over 70% of the rural population describing the local public transport system as 'poor' regardless of age, compared to fewer than 20% in Dublin.

Many older people do not own a car and many others are no longer in a position to drive for a variety of reasons. Research carried out in rural parts of Ireland (ROI and NI) found that for many older people, the unavailability of public transport has meant that they will make sacrifices in order to pay for taxis for what are seen as the essential trips (food shopping and health) but will not do the same for other trips (leisure, social, other shopping) even though these trips can be very important for mental health and social well-being. (Ahern and Hine 2010)

The research also found that rural people voiced a need for greater integration between health providers and transport providers. Very often health providers do not take account of the transport needs of older people when arranging appointments. The potential for loneliness or social isolation is potentially greater for those living in the countryside, particularly for those who live alone, or who are impaired, or have limited access to transport.

As local amenities (e.g. shops, post offices, public transport, doctors surgeries, etc.), diminish, many older people in rural areas are effectively excluded from service provision. Studies in Scotland looked at the potential benefits and costs associated with co-location of services or provision of services in a 'shared' location or premises.

They highlighted the fact that the continued presence of services in rural areas performs the crucial role of maintaining social capital and human interaction between residents – a view which was borne out by research on the role of post offices in rural communities (Hilton, 2006). To address the problems of rural isolation in Scotland the proposal to introduce one stop shops (OSSs) was put forward. The

key is 'bringing services together under one roof'; both for providers to share costs and to make it easier for people to access a range of services in one place.

Issues Arising

County Development Plans: While most County Development Plans (CDBs) have a strong emphasis on meeting the needs of children and young people, there is no corresponding emphasis on longer-term planning to meet the specific needs of the rapidly-increasing older population. This is further complicated by the absence of county-based older people's representative organisations, and the fact that there is no requirement in the planning process for consultations to take place. .

Joint Planning: Structures such as the CDBs allow for multi-agency planning, and one important instance is that local authorities are now required under the National Development Plan to establish multi-agency Childcare Committees, which have a coordinating role locally in the framework of the National Childcare Strategy. There is no such emphasis on joint planning for the provision of services for older people, however. For example, the HSE and local authorities could cooperate to speed up hospital discharges, and transport providers could plan with hospitals for better services.

Aligned catchment areas and 'patches': There is a great deal of variation in relation to the boundaries and borders of the main state agencies at regional and local level, which can lead to overlaps or gaps. This makes it difficult to foster joint planning and budgeting and to develop the relationships between the people who are responsible for particular local areas.

Gaps in relevant expertise: Among planners and service providers, there is not yet sufficient social and health gerontology expertise, which could inform planning decisions about the built environment and social inclusion initiatives in a

way that would optimise the quality of life of older people. Nor is such expertise readily available to them through national statutory agencies, voluntary organisations or private consultancies.

Guidelines for rural and urban planning permissions: Planning permissions for land usage tend not to reflect the various ways in which the built environment can affect the quality of life of older people, and the importance for them of maintaining family and community support networks. Nor do planning proposals for older people's accommodation always take account of the fact that some areas are ideal physical environments for older people (e.g. neighbourhoods with steep hills, or isolated areas).

Poor public facilities: Many studies have confirmed that the most common problem areas for older people in relation to public facilities are: pavement and streets (21%); pollution (21%); safety (18%); poor maintenance (10%); and traffic (8%) (Turel et al., 2007). The public facilities which support older people's outdoor mobility are frequently inadequate; and there are problems in relation to public seating, street lighting, access to toilets, and uneven and obstructed pathways. Facilities such as parks and sports amenities are generally oriented more towards use by young people, and can even be designed or used in such a manner as to deter older people using them.

Footpaths: The maintenance of roads and the quality of footpaths are often inadequate in the towns and villages across Ireland. This can have a significant impact on the ability of some older people to use public spaces. Although the use of motorised wheelchairs has become more common, it can be difficult or impossible to use them, because of the poor condition and design of many roads and footpaths, the existence of obstructions, or the absence of level pavements. The lack of footpaths in most rural areas creates safety and mobility difficulties for older pedestrians.

Public spaces: Consultations with older people indicate that they do not always feel safe in public areas such as parks and sports facilities, and can be fearful of walking in areas used by skateboarders or cyclists. There has been some increase in the provision of 'Tone Zones' for older people, but most public parks have no areas specially designed for older people to exercise.

4.3 MOBILITY AND TRANSPORT

Transport for people of all ages, and especially for older people, is closely linked to independence, autonomy, and quality of life. Research has shown that access to transport can influence the ability of older people to participate in social activities and to feel secure and independent. It can also have an impact on the overall health and wellbeing of older people. Driving in particular has been associated with higher levels of life satisfaction, higher adjustment, less loneliness and better perceived control (Wallace & Franc, 2002).

The National Disability Survey found that a significant number of older people had difficulty walking as much as 15 minutes (CSO 2006). This restricted capacity to walk any distance reduces the numbers of places people can reach independently, particularly those older people who don't drive. If shops, church, park, bus stops etc are outside the maximum walking range of an older person, they become very limited in independently moving about their community.

4.3.1. Older Drivers

Over the past few decades people have become increasingly dependent on the availability of the car. The NCAOP-commissioned study, Health and Social Services for Older People, (HeSSOP) in 2001 found that 47% of older people in Ireland were car drivers. TILDA found that among the participants in their

study (age 50+) a majority use their own car as their usual means of transport (76%), followed by 14% who are primarily driven by a family member. (TILDA 2011)

The 2006 Census figures showed that there was a marked gender difference in relation to driving, with approximately 74% of all men aged 60 or over holding a full driver's licence compared with 40% of all women in this age-group. The differences were greater with increasing age: just over 55% of women aged 60-69 held a full driver's licence compared to 84% of men in this age-group, but in the over-80 age-group, only 13% of women held a licence, while 45% of men did so (CSO 2007).

Access to driving is important for social inclusion and well-being: driving cessation is associated with increased risk of nursing home entry (Freeman et al 2006) as well as lifestyle losses, including lower life satisfaction, reduced role engagement, and restricted activity patterns (Liddle et al 2004). In the future growing numbers of older people will want to continue to lead an active life and transport and mobility are key factors in facilitating active ageing (WHO, 2002). However the absence of alternatives to the car, coupled with land-use patterns that make walking difficult, contributes to the problems experienced by those older people living in suburban and rural areas who have had to stop driving.

There is a widely held, and unfounded, view that the physical problems associated with ageing make it necessary for older people to stop driving. Research in both the US (Dulisse, 1997) and the UK (Maycock, 1997) has shown that older drivers do not present an excessive risk to other road users and according to the OECD report 'Ageing and Transport' (2001) older drivers have fewer reported crashes per capita or as a proportion of all older drivers. In Ireland older people (aged over 65) are only involved in 7.7% of collisions as car drivers and 6.7% as car passengers while those in the 25-34

age-group are involved in 25% of accidents as car drivers and 14.7% as car passengers (RSA 2007). However they are at greater risk of death if they walk or cycle rather than if they use a car.

Brace (2006) found evidence that pressure from family members, health practitioners and police forced older drivers into stopping driving even when the drivers themselves had initially felt confident to continue. Older drivers tend to modify their driving patterns either due to personal preference or as a compensation for increased difficulties they may be experiencing. Research has found that older drivers often avoid driving in situations that may cause stress such as driving at night, or on motorways, during congested periods, through unfamiliar areas and in bad weather. The research also found that older drivers choose routes which allow them to avoid turns across traffic. (Simms, 1993) They tend to drive more slowly, prefer longer time gaps for merging at intersections and avoid simultaneous activities such as smoking or adjusting radio controls while driving (OECD 2001).

Although the evidence shows that older people have fewer accidents than other age groups, when they are involved in accidents they suffer more serious injuries and proportionately higher levels of fatality as a result of a) increased physical frailty with age, and b) car safety mechanisms (seat belts and air-bags) designed for younger populations. The percentage of injuries that prove fatal differs by type of road user, but the increased risk for older people is similar for all.

The most important functional abilities for safe driving that may be affected by age are good vision (day and night), certain aspects of physical fitness (head-neck flexibility, leg strength), and cognitive abilities (working memory, visual search and visualizing missing information (Staplin, Gish, & Wagner, 2003).

Some studies have shown that people with dementia have an increased risk of accident however it has also been shown that many people retain their driving ability for some time after onset of the disease. (Hunt et al., 1997) One study compared crash rates of those with dementia to young drivers and found that those with dementia had fewer crashes than the young people (Drachman and Swearer, 1993). As a result it has been recommended that early or mild dementia should not lead to an automatic loss of driving licence (Breen et al 2007).

However Fitten et al. (1995) found that when compared to others, drivers with dementia had lower levels of ability in visual tracking. Visual spatial skills play a significant role in the safe driving and are required for essential driving tasks such as judging distance when turning left or keeping the car in the appropriate lane. Reger et al. (2004) carried out an analysis of the relationship between neuropsychological tests and the driving ability of people with dementia. They concluded that tests measuring specific areas such as visual spatial and attention skills were more closely linked with driving performance and recommended that any assessment of driving should include measures that assess visual spatial skills, attention, and reaction time.

The most pressing problem for older Irish drivers is the presence of a medical screening system and while it may seem counter-intuitive to those not involved with transportation studies, jurisdictions with medical screening based on age have higher death rates of older people on the road than those who do not, possibly as a result of older people withdrawing from driving rather than being tested, and becoming pedestrians and cyclists. (Hakamies-Blomqvist 1996) Current screening methods have an overall negative impact on older drivers. The driver licensing system does not offer any formal and ongoing medical or gerontological support, and the assessment and rehabilitation

pathways for those with medical conditions which may impact on driving are neither clear nor supported.

An Australian study compared the fatality outcomes of older drivers in two states - one (Victoria) with no age-based assessment for older drivers, and the other (NSW), which requires drivers aged over 80 years to provide annual medical certificates. They found no significant difference in the overall fatality rate between the two groups. They also found that drivers where there was no age based assessment had a lower overall fatality rate and also had a lower rate of fatality for road users not in the older drivers' vehicles. (Langford et al 2008) This medical screening system has also been discredited in studies in the US, Australia and Scandinavia.

Research has also identified the importance of family observations in identifying at-risk drivers (Lloyd et al., 2001; Messinger Rapport & Rader, 2000). This suggests that there may be a value in encouraging physicians to seek to identify discrepancies between the views of family/care givers and the driver's self-rating as part of their checklist for identifying "at risk" drivers.

Reviewing the literature on transportation and ageing, Dickerson (2007) outlines several possible areas of support for safe driving among older drivers – screening, rehabilitation (compensating for limitations), education and training, vehicle modifications, improved roadway design and signage and finally, when necessary, supporting transitioning to non-driving.

An alternative to the present system of medical screening of drivers over 70 includes a) a system of self-report, b) a medical advisory section for the driver licensing section of the RSA, c) updated age-attuned regulations for medical fitness to drive, and d) the development of clear pathways for assessment and possible rehabilitation for those detected on opportunistic screening by healthcare

professionals and families, d) training in traffic medicine for healthcare professionals. Review of NCT charging mechanisms for older drivers might encourage sustained mobility. On the other hand, there is very little by way of a structured system of advice, assessment and rehabilitation for those older drivers who require it when illness develops.

4.3.2. Older People as Pedestrians

After the car, the second most frequently used means of transport in both the U.S. and Europe is walking (Mitchell 2006). In 2001, between 25% and 30% of all journeys in Europe by older people were made as pedestrians, and this percentage increases with age. However older people experience a higher risk of injury or death as pedestrians or cyclists than other road users. According to a recent Irish study based on RSA statistics over 15 per cent of all those involved in accidents as a pedestrians are aged over 65 – the age group with the highest level of involvement in accidents as pedestrians. Older people represented 36% of all pedestrian fatalities and 23% of serious injuries while they only account for 19% of total road traffic accidents. The study found that mortality in a road traffic accident is more than doubled for older pedestrians compared to younger adults. This contrasts with only 2% of fatalities among those aged 25-34 who are the next highest category of accident victims. (RSA 2007; Martin et al 2010).

Crossing at complex intersections with a high volume of traffic presents a challenge for many older people, especially on roads without central islands. Older pedestrians often express concern about the short time programmed for the walk phase at controlled intersections. A recent study carried out in Dublin, compared the walking speed of older people, gained through the Technology Research for Independent Living (TRIL) gait assessments (using GAITRite™) with the standard times allocated by pelican

pedestrian lights in Dublin. The study found that walking speed decreases with age and that pedestrians over the age of 80 are unlikely to have sufficient time, especially when crossing wider roads. The average walking speed of pedestrians aged over 89 was likely to be lower than the minimum speed needed to cross the narrowest standard road, according to the research. The study also found some evidence that younger old people experience difficulties with times allocated by the Pelican crossings. (Romero-Ortuno et al 2010)

One American study which looked at walking speeds of older people found, unsurprisingly, that people over age 60 are not a homogeneous group and they have a range of walking speeds and mobility levels. They reported several problems associated with pedestrian crossing, including difficulty in negotiating curbs and judging the speed of oncoming vehicles, discourteous drivers, turning vehicles and confusion with the Walk, flashing Don't Walk, and Don't Walk pedestrian signal indications. While walking speeds vary greatly by age and by other environmental characteristics such as gradient and weather conditions, US research on walking speeds of older people found that the speed suggested by The Manual on Uniform Traffic Control Devices (MUTCD) of 1.22 m/sec exceeded the speed of many pedestrians. McGee, et al. estimated that this may be up to 30 per cent of the population. The Traffic Control Devices Handbook (TCDH) (4) also notes that one-third of all pedestrians cross more slowly, with 15 per cent at or below 1.06 m/sec. (McGee 1983)

In the EU, pedestrians aged 65 or more accounted for 45% of all pedestrian fatalities, but represented only 15% of the population. Overall, older people have a substantially greater risk of becoming pedestrian fatalities than the population at large in a recent review (OECD 2004). This may be due to difficulties in walking because of narrow pavements with

inadequate surfaces or in poor condition, obstacles blocking footpaths such as parked cars and/or street furniture and inappropriate curb heights. In addition, poorly lit streets or bad weather conditions may cause slips or require additional concentration at the expense of other functions.

Good, safe conditions for walking are therefore an essential element of Age Friendly communities and for people of all ages and the design of roads and traffic facilities can provide an appropriate balance of mobility and safety for all road users. Internationally in recent years there has been a move towards the development of the concept of 'shared spaces'. Shared Space can be seen as a traffic engineering concept which involves removing the traditional separation of motor vehicles and pedestrians, and removal of curbs, lines, signs and signals. The aim is to improve road safety by forcing all road users to negotiate their way through shared areas at appropriate speeds. However, incorporating level surfaces as part of shared space schemes can create navigational difficulties for people with visual impairments and negative views of their own safety among these users.

The provision of pedestrian-only areas can be of benefit for all people in the community and has been found to be effective in reducing accidents. On major roads, the provision of central islands as part of pedestrian crossings allowing older pedestrians to cross in two stages can offer greater safety while maximising safe traffic flows at the crossing point. Other options to promote older pedestrians' mobility and safety include; curb extensions, bollards or other barriers to prevent parked vehicles from blocking footpaths and adequate footpath widths to accommodate all users safely.

Road engineers are often reluctant to introduce 'across the board' increases in signal times because of the possible disruptions to traffic flow, however technology now allows

the green signal to match the time required by pedestrians to cross the road by tracking pedestrian movements through use of infrared detectors or other devices. This type of crossing, known as a "PUFFIN" crossing (Pedestrian User Friendly INtelligent), was first introduced in the UK, where a recent evaluation showed that all pedestrians, regardless of age, took longer to cross the road, which indicates that all users benefited from a reduction in the stress associated with timed crossings. Older pedestrians' crossing time increased the most, a sign that they received most benefit from the change (Reading et al., 1995).

Technological changes have been and are being developed which could help reduce pedestrian casualties such as the infrared detectors which allow the green signal to match the time required by pedestrians to cross the road by tracking pedestrian movements introduced in the UK (PUFFIN" crossings) or microwave pedestrian detectors which would either extend the red signal for vehicles or advance the pedestrian green signal if a pedestrian was detected approaching a crossing at a suitable point of the signal cycle (Ekman and Draskowski, 1992).

4.3.3 Public Transport

Everyone aged 66 and over living permanently in Ireland, is entitled to the free travel scheme. Free travel is available on all State public transport and is also available on a limited number of services that are operated by private bus transport companies. The Free Travel Scheme for Older People, operated by the Dept. of Family and Social Affairs is an important facilitator to mobility among older people and is the envy of many countries. However this scheme relates only to free travel on existing scheduled services.

Accessing public transport can be difficult for people with a disability. A survey carried out in

2006 found that 16% of persons did not use or had difficulty using public transport because of difficulties getting on and off public transport. Difficulty transferring from one service to another was the next most cited reason (12%), while difficulty getting to the public transport was reported by 9%. Around half of persons with a disability experienced difficulty with 'going to town' shopping (56%), going away for a break or holiday (53%), taking part in community life (54%) and socialising in a public venue (49%).

Under the Disability Act 2005, the Minister for Transport is required to prepare and publish a plan in relation to disability matters specified in the Act. The plan "*Transport Access for All*" sets out the proposals of the Minister for Transport in relation to the rolling out over the next number of years of a comprehensive programme of accessible transport for people with mobility, sensory and cognitive impairments, together with older people. In the preparation of this Plan, the Department held a series of public consultation exercises, organised by the NDA, involving disability groups, transport operators and other stakeholders and participated in a series of regional seminars and workshops in 2005.

"*Transport Access for All*" broadens the focus from that of "special" provision for people with mobility, sensory and cognitive impairments to all transport users, even to the most able-bodied. This is based on the view that most people, at some point in their lives, are likely to acquire a physical or other impairment that will make travelling difficult, if not impossible, on what one might call 'traditional' type transport vehicles. This is particularly the case as people get older. It incorporates the lifecycle approach that the delivery of mainstream accessible public transport is to benefit all age-groups and at all stages of their lives. Collaboration and partnership between those with responsibility for public transport and those responsible for

the pedestrian environment and for traffic management is also a key element in transport that is accessible for all.

Some changes have already been made to ensuring the accessibility of transport to older people and people with a disability. The National Disability Authority, in consultation with the Department of Transport, has developed operational guidelines - "*Recommended Accessibility Guidelines for Public Transport Operators in Ireland*" - for improving access to bus, rail and light rail services for people with mobility, sensory and cognitive impairments in Ireland. These Guidelines were published in 2005 and deal with information provision, infrastructure and buildings, vehicle design, customer relations, disability awareness training and procedures for disruption and emergencies.

The recently introduced Certificate of Professional Competence (CPC) requires all professional bus or truck drivers to undertake regular training in areas such as road safety, environmental driving and issues involving the health and well-being of professional drivers. All new drivers will also have to undergo a test to establish their professional competence. The Certificate is intended to enhance the driving skills of bus and truck drivers and lead to fewer casualties on the roads through the creation of awareness of more vulnerable road users such as pedestrians, motorcyclists, cyclists the very young and older people. However, the guidance for drivers makes no mention of developing awareness of the needs of older people as passengers particularly in relation ensuring that older passengers have sufficient time to get to their seat before the bus moves.

4.3.4. Rural Transport

The availability of transport is essential to sustaining rural life and maintaining social connections between people living in rural areas. In 2007, the Department of Transport and the

Department for Regional Development (N.I.) undertook joint research into the provision of rural transport services (Department of Transport 2007). The audits of existing services carried out showed that many people in rural counties have no access to any scheduled public transport services. Projections indicate that an estimated 450,000 rural dwellers could have unmet transport needs by 2021, including 250,000 people in key target groups such as older people. (Pobal 2008)

The research was carried out in four counties Kerry, Mayo, Westmeath and Laois and found that in three of the counties about 40% of the rural population live in areas without any access to scheduled public transport service, i.e. even on a weekly basis and in the fourth county the situation was worse, with 60% having no service of any kind. Reliance on the car was also a key point in the report - over 80% (83%) of all respondents reported that their own car is their primary form of transport.

The report also noted that many residents within these areas live beyond walking distance from such services and that the situation is worse for people with disabilities or people who are otherwise mobility impaired, both for reasons of distance to any service and for reasons of physical access to vehicles. The report found that those who do not have ready access to a car make approximately 70% fewer trips than those who do have ready availability of a car. Older people and those with a disability tend to be among the group who rarely or never have car availability.

The Rural Transport Programme (formerly the Rural Transport Initiative) was launched in 2007 by the Department of Transport, aiming to achieve national coverage on a phased basis. The RTP is currently delivered locally through 37 community based groups, all of whom operate on a not-for-profit basis and older people and people with disabilities form the core customer base. Some of the companies have recently expanded into new trading

activities, for example the Meath Accessible Transport and Clare Accessible Transport have established training units which have improved the local skills base whilst providing another income source for both companies and CLASP (Community of Lougharrow Social Project) and West Cork Rural Transport maximise the usage of existing services supporting the transport associated with Meals on Wheels and Community Laundry services.

In 2008, over 1.24 million passenger journeys were recorded, a substantial increase from 650,000 passenger journeys in 2005. Over 76% of these journeys were provided on a door to door basis and free travel pass holders accounted for an average of 64% of passengers. Of these journeys 13% were made by passengers who required assistance in order for them to travel. Some 1,400 volunteers support the day to day management and delivery of the programme, contributing in the region of 40,000 hours of voluntary expertise and skills each year. Over 6.2 million km of services were provided in 2008 alone, using a combination of community owned buses, voluntary cars and private local providers.

An example of a successful rural transport initiative is Flexibus, a 'dial-a-ride' service in County Meath, providing transport facilities for pension collection, shopping trips, attendance at activities and local groups, etc. It also provides transport to hospitals and health centres, and has increased its 'clinic runs' from 183 in 2005 to 1,462 as of October 2008. Both RTI projects provide community based door-to-door, flexible transport services, scheduled to link with public and private transport services locally. Other services such as a separate 'evening services' scheme is being piloted by Pobal in seven different projects nationwide.

However, problems may still remain for some older people, and the Irish Senior Citizens Parliament (ISCP) has called for the introduction of a voucher system to improve access to transport in rural areas.

Case Study

CASE STUDY: RURAL TRANSPORT PROJECT & HSE CO-ORDINATED MODEL OF TRANSPORT – COUNTY DONEGAL EXAMPLE

For many people in rural communities, access to health care and health related services can be problematic because of the lack of public or private transport alternatives in rural areas. The Rural Transport Programme has been engaging with the HSE at national and local level for some years to try and offer a more co-ordinated and efficient way of providing communities with transport services that are both integrated and accessible to all.

One such model that has been developed is in Donegal where SITT, MFG and more recently Inishowen RTP have begun to work with the HSE to deliver coordinated, accessible transport services to those living in isolated areas. SITT was the first Group in the County to engage with the HSE in 2009. The RTP delivers some health specific services on behalf of the HSE. Transport provision is developed and prioritized around the identified needs of rural communities and those needs identified through consultation with local agencies and organisations.

Services are provided through a network of contracted private operators of which a high percentage of vehicles are fully accessible. This integrated model has taken considerable time and effort to establish but the potential savings for the exchequer and the social impact for individuals of better integration, are significant.

Key Strengths of this Model include:

Service Integration

- Reduced Duplication of existing services
- Central co-ordination & communication
- Transport access and networking of services
- Training and up-skilling of all drivers and passenger assistance
- Efficient service delivery
- Clear tendering process
- Sustainability & smarter travel

Issues Arising

Older Drivers: Older people aged over 65 are involved in only 7.7% of collisions as car drivers, and 6.7% as car passengers, in contrast to those in the 25-34 age group, who are involved in 25% of accidents as car drivers, and 14.7% as car passengers (RSA 2007). Despite evidence that they are safer drivers, older people are required to undergo age-related screening in order to be able to continue to drive.

Screening: Research indicates that screening all drivers at a specific age does not increase safety (Hakamies-Blomqvist, Johansson, & Lundberg, 1996). In fact, such screening practices may cause some older adults to voluntarily surrender their licences prematurely, causing an unnecessary loss of mobility (Charlton, 2002). The driver licensing system does not have any formal and ongoing medical/gerontological support, and assessment and rehabilitation pathways for those with medical conditions which may impact on driving are neither clear nor supported.

Pedestrians: Older adults are the age group with the highest level of involvement in accidents as pedestrians (15%) and of these accidents, 21% are fatal. In contrast, only 2% of the 25-34 age group are fatally injured when involved in accidents as pedestrians (RSA 2007). Older people also can find that the crossing times allowed for by traffic lights insufficient and therefore stressful. In larger urban areas, with broad thoroughfares and no 'islands', the distances to cross are too great.

Public Transport: Many older people experience problems with public transport that limits or prevents their use of it: The design of public transport routes, particularly bus routes, often fail to take account of the older people's requirements to access health services.

Awareness of Older Person's needs; Despite the fact that the National Disability Authority, in consultation with the Department of Transport, published operational guidelines in

2005 for improving access to bus, rail and light rail services for people with mobility, sensory and cognitive impairments, some transport providers in Ireland do not ensure that their drivers have the necessary skills and awareness to support older people's use of their service (e.g. allowing sufficient time for an older person to ascend, sit down, and alight).

Bus Shelters; Many bus stops remain unsuitable for older people, with inadequate shelters, seating, and lighting, although there has been a systematic programme of introducing slightly raised pavements at bus stops.

Availability of alternatives: Many older people, for reasons of physical or psychological frailty, cannot use public transport and so rely on private taxis to get out and about. The free travel that those over 65 are entitled to is an important enabler of mobility, but is at present limited to public transport.

Rural Isolation: In many parts of the country, public transport routes either do not exist or are inadequate to cater for the needs of people living in remote or rural areas

4.4 SAFETY IN THE HOME AND IN THE COMMUNITY

A feeling of safety when out and about or at home is a very important factor in sustaining independence and engagement. While all age groups need to feel safe in their own homes and neighbourhoods, there is some evidence that older people are more fearful for their own safety – a fear which is linked to the potential vulnerability of older people both within their own homes and in the surrounding environment.

Good lighting, well-kept, clean streets and a police presence should all be prioritised, to help people feel more confident about getting out and about. Crime is dealt with in more detail

in a later section of this chapter, but this section summarises the most important elements of safe communities and their ideal built environment.

Research from the US found that living in an area that is perceived to be unsafe at night is a barrier to regular physical activity among older people, especially women, living in urban low-income housing. Feeling unsafe may also reduce confidence in the ability to be more physically active. Both of these factors may limit the effectiveness of physical activity promotion strategies delivered in similar settings (Bennett et al 2007).

The Safe Communities model, promoted by the WHO Collaboration Centre for Community Safety Promotion, creates an infrastructure in local communities to address injury prevention and safety promotion through collaboration and partnership. It recognises that unsafe neighbourhoods limit older people's opportunities to participate actively in the life of the community, making them feel isolated and impacting negatively on their quality of life. Interview-based research with older people found considerable concerns about safety: the most commonly-mentioned places where older people felt unsafe after dark were city or town centres and high streets with pubs, as well as deserted streets and places (OISD, 2007).

According to a survey of perceptions of safety (CSO 2007), approximately 12% of people aged 65 and over either feel unsafe or very unsafe alone at home after dark, and approximately 45% either feel unsafe or very unsafe walking alone in the neighbourhood after dark. However the level of crime experienced by people aged over 65 was 1.7% - lower than the average in the general population (4.6%).

The percentage of people who felt crime was a serious problem was higher among older people than in the general population – 63% among older people but only 46% among all age groups. Older people also feel less safe

walking alone after dark – 52% of those aged over 65 felt either unsafe or very unsafe but the average for all age groups was only 26.4% (CSO 2006). However, low levels of victimization may also be explained by the reluctance of older people to place themselves at risk (Wiles and Simmons, 2003; Blythe et al., 2004).

The increased sense of vulnerability caused by crime against older people also affects those who have not been victims of the crime. A survey looking at the level of fear among 207 older people in County Galway, carried out following a number of crimes against older people, found that while only 5% of respondents had suffered either a physical attack or been burgled, 72% reported feeling upset by the recent crimes (Grimes 1990).

Studies looking at the reasons behind the fear of crime in the general population found that factors such as inability to defend oneself and possible consequences from being a victim of crime can also play a role in the development of fear. Greve (1998) argued that those who are physically vulnerable or are physically weak fear that they will recover slowly from bodily harm and therefore experience higher levels of stress in relation to crime. These findings could help to explain the reasons behind the fear of crime among older people.

In a Belgian study which examined the factors contributing to a fear of crime among older people, interviews with almost 5000 men and women aged 60–103, revealed that demographic variables such as gender, physical vulnerability and income are linked to a fear of crime. Women feel less safe than men and people who are physically vulnerable or have low income are more likely to have a fear of crime. The study also found that where a person lives and the level of involvement they have in their community also plays an important role in the development of fear of crime in other words people who feel that they live in a neighbourhood that is adapted or is more age friendly and who are more involvement in their

community feel safer than those who do not.

Loneliness and lack of participation in both social and cultural life show a strong relationship with fear of crime. The study also found that watching television was linked to an increased fear of crime while the daily reading of a newspaper decreases fear of it (DeDonder 2006).

Fear of crime has been found to be very strongly related to a lack of community cohesiveness, which is the most important variable in predicting fear of crime according to Schweitzer, Kim and Mackin (1999). Surveys also show that local disorder and anti-social behaviour including noise, nuisance, graffiti, rudeness and rowdiness, litter, and cycling on the pavements are significant causes of distress for some older people.

While James (1993) argues that older women's fear is "*real and pervasive*" others argue that for older people it is "time and place specific" (Blythe, Wright and Monk, 2004, p. 403). International studies show mixed results regarding the widely held view that older people experience more fear of crime. For example Ziegler and Mitchell (2003) in a review of research, found sixteen studies that indicated that older people experience a greater fear of crime, two studies do not find a difference between young and older people and a further seven studies find that older people are less afraid than younger people.

The fear may be based on an important reality, in that older Irish people who experience burglary suffer more illness and even nursing home entry than younger people (O'Neill et al 1989). Regardless of whether the fear is real or disproportionate the significant point is that a heightened sense of danger means that decisions are made on the basis of possible risks, and this can have the effect of disempowering older people, preventing them from participating freely in social and diminishing their quality of life by leading to isolation and disengagement from the local community (James, 1993).

Issues Arising

Fears for personal safety: Research shows that a majority of older people perceive crime as a serious problem (63% in 2006) and the fears for their personal safety are perhaps greater than the actual levels of crime against older people warrant. CSO figures from 2007 show that approximately 12% of older people aged 65 and over feel unsafe or very unsafe alone at home after dark, and approximately 45% either feel unsafe or very unsafe at home alone in the neighbourhood after dark. However, the proportion of people over 65 directly affected by crime was 1.7%, considerably lower than the average (4.6%) for the general population.

The low levels of victimisation may be explained by the reluctance of older people to place themselves at risk (Wiles and Simmons 2003; Blythe et al. 2004). Ultimately it can lead to greater isolation and unwillingness to be out and about in the local neighbourhood.

Low levels of reporting crimes: Evidence shows that many older people are reluctant or even fearful to report on crimes or intimidation. For some this is due to not wishing to be a 'nuisance', while others fear retaliation by those they complain about.

Fear of young people and of crowds: Lack of intergenerational contact can lead to suspicion and distrust from both older and younger people. Evidence shows that many older people feel intimidated by the presence of young people in groups and crowds on the streets and this inhibits their range of activities.

Examples of Initiatives:

Bogus Caller Cards & Trusted Tradesmen – These cards, containing important information on how best to deal with callers posing as tradesmen or salespersons, are currently being distributed to a wide audience of older people in the county through the Older Persons Forum network and via community Gardaí.

A list of 'Trusted Tradesmen' operating in the county, along with appropriate prices to pay for particular pieces of work is also being circulated.

The Older Peoples Register – Chief Superintendant McGee is currently working with the Louth AFC Programme to generate a list of the most marginalised and vulnerable older people in the county to be accessed by all relevant agencies.

Conclusion - Key Issues

Where people live has an enormous impact on how they live, on their quality of life and their participation in the lives of their communities.

Until recently there was very little focus on this important area, but the WHO's Age Friendly Cities and Communities Programme and their more recent Global Network of Age Friendly Cities and Communities has usefully shone a spotlight on this area. Ireland in fact is leading the way in this programme, through the Age Friendly Counties Programme, with a highly integrated bottom-up and top-down approach at municipal authority level, and a national Implementation Group bringing together very senior policy makers in four government departments, HSE, Gardai and Local Authority Managers with the AWN.

The WHO's framework for age-friendly cities identifies the key factors that determine an 'age-friendly environment, ranging from public spaces, transport, housing, safety, health services, information etc. This implies a process which engages the decision makers across these domains and across the public, private and public sectors which the Irish Age Friendly Counties Programme seeks to do.

Planning For Age-Friendly Environments

The planning system in Ireland is essentially focused on land-use planning, which is quite different from what is required for planning

for enabling environments, in this case age-friendly environments. Although there have been improvements in response to the needs of children and people with disability, there is very limited training of planners to make them aware of the specific needs of older people. Similarly there tends not to be a joined up approach by those involved in planning at local level for other services such as health and transport.

The area of environmental gerontology is very under-developed in Ireland. There is a need for architects, planners, engineers, transport service providers to understand the extent to which the quality of the physical environment is a determinant of their quality of life.

Transport

The vast majority of older people rely on their own cars as a means of travel. This makes a very important contribution to their independence and participation in society. However, there is a requirement for them to undergo age-related screening, despite the fact that the data shows they are only involved in 7.7% of collisions as car drivers (in contrast to the 25-34 age group who are involved in 25% of accidents) and that screening at a specific age does not increase safety and may cause some older adults to voluntarily surrender their licenses prematurely, causing an unnecessary loss of mobility and increasing the demand for public and other forms of transport.

However, older adults are the age group with the highest level of involvement in accidents as pedestrians - caused by factors such as inadequate crossing times for traffic lights or no central islands in wide thoroughfares.

For some older adults the public transport system works very well and the free travel entitlement is a very important inducement to go out. However, there are some problems within public transport such as routes that don't go to where older people need to go or bus stops with inadequate seating and shelter.

While the Rural Transport Programme has offered a great service for many people in more isolated areas, there is still a need for a personalised service for some people needing to get to appointments at specific times.

Safety

Despite the relatively low level of crime committed against older people they are

understandably fearful about crime and for their own security, mainly because of the devastating impact an attack would have on them if it occurred. There is also some concern that the low levels of crime data against older people camouflage the fact that older adults limit the extent to which they go out at all or in the evenings for fear of such crime. For those living in areas with high levels of anti-social activity, such fears can be very restrictive.

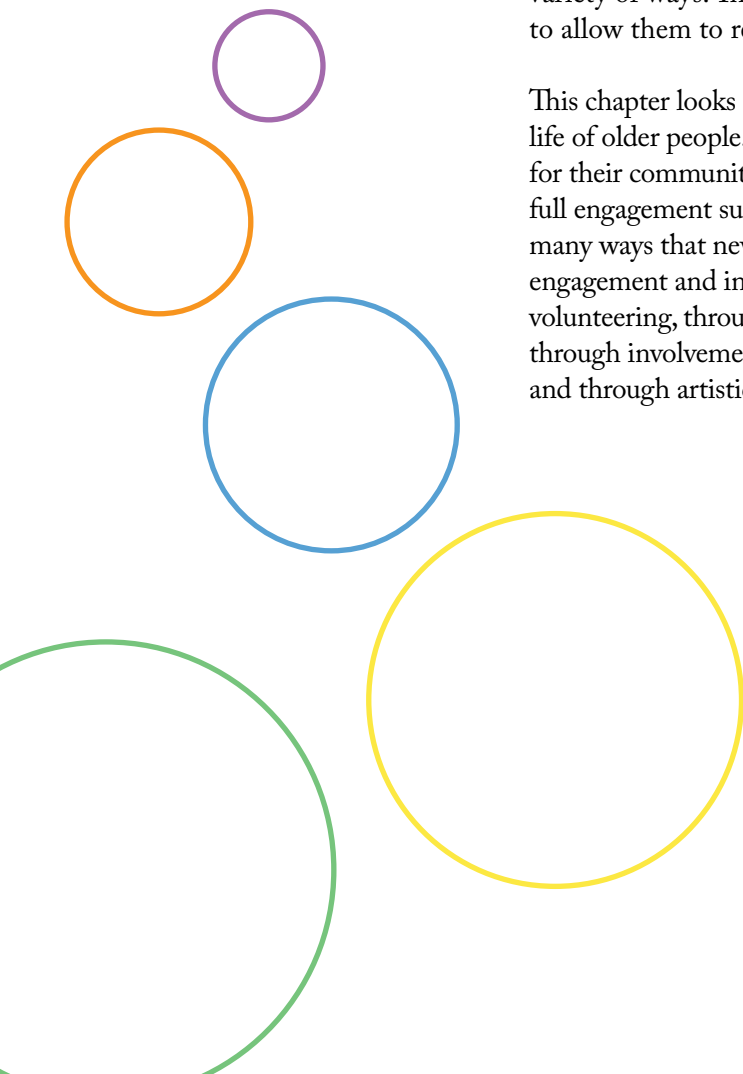
Chapter 5.

Engagement

Changes in longevity, health and patterns of employment are transforming the nature and experience of old age. The main benefit of this change is that a large cohort of the older population will remain active and healthy and will have the potential to provide significant benefits to their communities from their accumulated life skills and experience. Rather than viewing older people merely as high users of services, we need to reconceptualise later life, develop a new language to recognise the fact that older people have a range of characteristics, talents, expertise and interests which should be identified, acknowledged and used to the benefit of society.

Many older people already participate in and contribute to society in a variety of ways. The challenge is to develop new social roles for older people to allow them to remain fully engaged in their communities.

This chapter looks at the factors that contribute to the wellbeing and quality of life of older people. It discusses the benefits of engagement for older people and for their communities and also looks at the potential barriers that may prevent full engagement such as ageism and age discrimination. It also examines the many ways that new social roles can be developed for older people to promote engagement and intergenerational contact in their communities such as through volunteering, through their social networks, through learning opportunities, through involvement in policy development and older people's organisations and through artistic and sporting activities and organisations.



5.1 IMPORTANCE OF ENGAGEMENT

One of the main determinants of health and well being is a sense of social inclusion or feeling part of a network of family, friends and community. In fact research has found that the health risks associated with lower levels of social integration are comparable to those of smoking, high blood pressure and obesity (Cohen, et al 2000). A recent analysis of the Survey of Health, Ageing, and Retirement in Europe (SHARE) data found that social engagement contributes to better health status in all countries in the sample and that the impact of social engagement on health has the potential to raise the number of people in good/very good health from 56.7% to 62.8% on average (IRDES 2008).

Numerous other studies have found links between engagement in meaningful and productive activities and reduced risk of mortality in later life. For instance, Wolinsky, Stump, and Clark (1995) found that involvement in activities such as volunteer work, social contact, and religious activities, significantly reduced the mortality risk in a group of older people. Glass and colleagues showed that social activities (e.g., church attendance, recreation, and group activities), productive activities (e.g., gardening, preparing meals, and shopping), and fitness activities were associated with survival of older persons, even after other factors such as history of several diseases were controlled for (Glass et al, 1999).

Wang (2002) found a link between involvement in stimulating activity and a reduced risk of dementia, suggesting that both social interaction and intellectual stimulation may be relevant to preserving mental functioning (Wang 2002). Other studies found links between engagement in hobbies and recreation, both inside and outside the home, and delayed mortality in older people

and evidence has even been found that simply leaving the house every day can be beneficial (Ljungquist et al 1996; Welin, et al 1992).

5.1.1 New Social Roles

Older people are an asset and frequently an untapped resource in their communities. They have the time, talent and life experience and interest in their communities to play a significant role. The challenge is to make communities more aware of the potential resource that older people represent and to empower older people to take advantage of the challenge and opportunities presented by greater engagement.

Instead of viewing older people merely as high users of services, it is important to develop a new 'language' around the involvement of older people in our communities, a language that acknowledges their expertise and wisdom and sees their involvement as an asset to the community. While there is general acceptance that an ageing population brings with it a large cohort of potentially valuable volunteers, there has been little done to really incentivise older people to bring their experience and expertise to bear on some of the intractable social problems in our society by influencing the policies and plans which address these problems.

Promoting social engagement and community involvement has been found to help foster empowerment which is linked to a range of health indicators. The factors that have been found to be associated with greater levels of social engagement among older people include higher activity levels as well as better overall health. (Richard et al. 2008).

The concept of community development work is an important approach to ensuring that the voices of older people are heard in a variety of local, regional and national decision-making fora. Asset-Based Community Development (ABCD) is a way of re-imagining community

development that seeks to discover and highlight the strengths within communities as a way of ensuring that development occurs in a sustainable way. Central to this is the view that a community in which every member is valued and challenged to contribute--is a stronger and healthier community.

Focussing on capacities or assets is more likely to empower those in the community and therefore mobilize citizens to create positive and meaningful change. Instead of focusing on a community's needs and problems, the ABCD approach promotes greater self-reliance by discovering, mapping and mobilizing all their local assets. The assets a community has can include anything from the skills of its citizens, to the benefits provided by its' associations and institutions such as businesses, schools, libraries, hospitals, etc. (www.abcdinstitute.org)

There is a growing trend internationally towards involving community leaders and voluntary groups or associations in the policy decisions which affect their lives and in the design and implementation of services, especially at the local level. Following from this trend both international and national social policy have emphasised the importance of ensuring that older people's voices are included in the formulation of decision making.

5.2 WELL-BEING AND QUALITY OF LIFE

As people live longer it is becoming more important to ensure that the extra years of life are happy and fulfilled. Research has found strong links between being happy and various other positive physical and psychological outcomes. For example happy people were reported to be psychologically and physically healthier than their less happy counterparts, having stronger immune systems and higher resistance to pain (Pressman & Cohen, 2002; Ryff, 1998).

While policy makers are not responsible for the individual happiness of older people, adopting a '*positive ageing*' approach through the National Positive Ageing Strategy is likely to involve a recognition of the role that societal and external environmental factors such as housing, transport or access to healthcare can play in improving general well-being and quality of life. As subjective well-being and quality of life are referred to throughout the report, it is worthwhile to briefly explore the definitions and meanings attached to them.

Subjective well-being has been defined as "*an umbrella term for different valuations that people make regarding their lives, the events happening to them, their bodies and minds and the circumstances in which they live*" (Diener, 2006 p400). In the literature the terms subjective wellbeing and quality of life are often used interchangeably along with other terms such as life satisfaction (Easterlin 2003).

In an OECD survey, 87 per cent of older people in Ireland report a high level of life satisfaction, compared to an OECD average of 69 per cent (OECD, 2007a). Within Ireland, the SLÁN (2007) survey had a similar finding, 82 per cent of people aged 65 and over rated their quality of life as 'good' or 'very good'. This was slightly below the population as a whole, where overall, 90 per cent of people rated their life as 'good' or 'very good'.

For the over 65s there was little difference between men and women, and in line with other age groups, those in higher social classes tended to rate their quality of life slightly higher than those in lower social classes (Morgan et al., 2008: 41). These findings were supported by the longitudinal study on ageing (TILDA) which found that the older population as a whole experience a high quality of life but that the wealthiest and most educated people experience the best quality of life. (TILDA 2011)

Case Study

New Social Roles for Older People - The Elders

In 2007 an independent group of global leaders were brought together by Nelson Mandela, to work together for peace and human rights. The idea was that just as many communities look to their elders for guidance, or to help resolve disputes, in an increasingly interdependent world a small, dedicated group of individuals would seek to use their collective experience and influence to help tackle some of the most pressing problems facing the world today.

The 'Elders' no longer hold public office; they are independent of any national government or other vested interest. They have all earned international trust and built a reputation for inclusive, progressive leadership. They share a common commitment to peace and universal human rights, but they also bring with them a wealth of diverse expertise and experience.

The Elders work strategically, focusing on areas where they are uniquely placed to make a difference. This can mean engaging in private advocacy, using their collective influence to open doors and gain access to decision-makers. At other times, The Elders work publicly to promote neglected issues and speak out against injustice. The group decides collectively where there is the greatest opportunity to make a real impact. (www.theelders.org)

Research suggests that there are a range of different factors that can contribute to overall wellbeing: circumstances, aspirations, comparisons with others, and a person's baseline happiness or general disposition (Chen and Spector, 1991). Others have suggested that wellbeing is linked to the satisfaction of three needs:

- Autonomy (or having a sense of control over one's life),
- Competence (a feeling of being able to function effectively) and
- Relatedness (having positive interactions with others). (Ryan and Deci 2000)

While other authors propose that psychological wellbeing includes these but also environmental mastery, personal growth and self acceptance (Ryff 1989); feeling fully engaged in one's activities; finding them challenging (Csikszentmihalyi, 1997) and having a sense of curiosity or willingness to learn new things (Kashdan et al, 2004).

Quality of life has been defined by the WHO, which established a working party on quality of life using the following definition;

"Quality of life is defined as the individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by a person's physical health, psychological state, level of independence and their relationships to salient features of their environment" (WHO QoL Group 1993).

In the UK, a national survey looked at the definitions given to quality of life (QoL) by older people themselves. It found that, according to the respondents, the main things that gave quality to their lives were; social relationships, roles and activities; leisure activities; health; psychological outlook and well being; home and neighbourhood; financial circumstances; and independence. The reasons

people gave to explain why these elements were important focused on; the freedom to do the things they wanted to do without restriction; pleasure, enjoyment and satisfaction with life; mental harmony; social attachment, intimacy, love, social contact and involvement, help; social roles; and feeling secure (Bowling 2007).

A review of all the potential influences on well-being that have been discussed in the literature identified seven broad headings:

- Income;
- Personal characteristics;
- Socially developed characteristics;
- How we spend our time;
- Attitudes and beliefs towards self/others/life;
- Relationships; and
- The wider economic, social and political environment (Dolan et al 2008).

This review found a negative relationship between age and subjective well-being (SWB) and a U-shaped curve with higher levels of well-being at the younger and older ages and the lowest level of life satisfaction occurring in middle age, between about 32 and 50 years (e.g. Blanchflower & Oswald, 2004a; Ferreri-Carbonell, & Gowdy, 2007).

Health is consistently found to be linked to SWB, particularly psychological health. Furthermore, specific conditions, such as heart attacks and strokes have been found to reduce well-being (Shields & Wheatley Price, 2005), and the conclusion generally reached is that the health condition causes the reduction in SWB. Research generally acknowledges that personality also plays a role in both SWB and health. Oswald and Powdthavee (2006) found evidence that people adapt somewhat to disability status, finding that the length of time an individual has experienced the disability reduces the negative impact of the disability.

There is evidence that even simple types of exercise such as gardening (Ferrer-i-Carbonell & Gowdy, 2007) may be associated with higher life satisfaction and that this may be especially important for the over 60s (Baker et al., 2005). The amount of time engaged in physical activity among the over 60s was also linked to a reduction in depressive symptoms (Baker et al., 2005).

The findings of the Dublin Healthy Ageing study suggest that it is the mental and emotional status of older people that plays the most significant role in determining life satisfaction. While research has consistently found that depression had an important influence on life satisfaction (Ghubach et al., 2009), the Dublin Healthy Ageing study also found that older people who feel lonely but not depressed are more likely to have a reduced satisfaction with life. (Ni Mhaolain et al 2012)

5.3 BARRIERS TO ENGAGEMENT

Older people cannot be seen as a homogenous group and various factors such as the level of each person's independence, educational attainment, social inclusion and geography (e.g. rural or urban) can have a major impact on their ability to participate in society. Older people who don't have access to proper health care or transport are unlikely to be able to participate fully in activities. Caring responsibilities, poor health and low income can also act as barriers to full participation and it must also be remembered that not everyone wishes to participate or be active in their communities in the same way.

In research on participation in activities, motivation is generally seen as one of the forces that will increase the likelihood of participation and there is an assumption in much of this research that engagement, through participation

in activities, is most likely when motivation is high and barriers are low (Ajzen, 1991).

5.3.1 Ageism

Changes in attitudes across all population groups, including among older people themselves, will be necessary to counteract the misconception of the older population as mostly frail and dependent. In reality, the majority of older people lead healthy and active lives and many organisations are working to raise awareness to change these negative and largely inaccurate perceptions.

Older people can often be stereotyped in a number of ways often based on assumptions about their competencies, beliefs, and abilities across different areas (Cuddy & Fiske, 2002). When these assumptions are based on one of the negative stereotypes about older people, ageism can result (Greenberg et al 2002). Research has found that stereotypes about older people have been identified across different cultures as being a combination of warmth and incompetence, ("doddering but dear", according to Cuddy & Fiske, 2002, p. 3).

In an international study of ageism, (carried out in five countries), older people were given far higher scores in benevolence but lower scores in competence (Hardwood et al., 1996; Koyano, 1989; Tien-Hyatt, 1986–1987).

There are conflicting research results on attitudes towards older people in Ireland. Recent research (2012) on active ageing showed that 76% of people in ROI perceive people over the age of 55 in a positive light, compared to an EU average of 61%. In the UK, 68% of respondents perceived the over 55 age group in a positive light. A 2007 study carried out in Ireland on behalf of the NCAOP found that 57% of respondents felt that society treats older people worse than it does its younger people while 62% disagreed with the statement that Ireland is an Age Friendly society. The over 80 age

group (63%) and the group under 20 years old (81%) recorded the highest level of consensus in subscribing to the view that Ireland is not an age friendly society (NCAOP, 2007).

However there are positive and negative aspects to relations between young and old generations. When asked in 2009, a clear majority in the EU (85%) disagreed that older people are a burden on society, but significantly a majority (69%) agreed that young and old people do not easily agree on what is best for society.

Media depictions of older people frequently fail to reflect any positive contributions, strength or resourcefulness of older people. Instead they are often depicted as weak and dependent while positive developments in relation to mortality and longevity of older people in western societies is frequently negatively referred to as a 'demographic time bomb' raising questions over older people's share of public resources relative to younger groups (United Nations, 2002, p.38).

A UN Working Group is, at present, considering proposals for the enhancement of the rights of older people. In an address to the Seanad on the merits of such an approach, Professor Gerard Quinn of NUIG asserted that the traditional focus of policy in the past was on the 'maintenance' of older people and the delivery of public services. However, when this becomes the sole focus it tends to reinforce dependence, passivity and negative stereotypes.

Arguing that the real problem has to do with the fact that the universal norms are heavily distorted, discounted and diluted by decades of cultural assumptions about older people, Prof Gerard Quinn said that *"the ageing process seems particularly captive to the tendency we have to 'exclude' and to discount the personhood of certain vulnerable groups and individuals through cultural assumptions that need to be dissolved". "Culture sees capacity as declining inexorably in old age. Culture does not see any use value for older persons in the*

economy. Culture does not see the value of social connectedness for all – not to mention for the elderly themselves" he said.

Arguing in favour of the proposed UN treaty on the rights of older persons Professor Quinn said that any new treaty should *"... be the paradigm shift of the treaty on the rights of the elderly."* He argued that social connectedness is the key to maintaining a positive sense of self and personhood and the right to live independently and be included in the community is vital.

Dr Maureen Gaffney has argued that ageism today is where sexism was in the 1970s. Arguing for a new 'language' in relation to older people she said that in the 1970s when women began to try to change their position in a radical way in society, it started with the language. *"I think that ageism is a bit like the sexism that remains, it's very rarely explicit, but it coils around policies, its hidden in weasel words like concern, it fogs up discussion and I think it makes older people actually invisible"* she said.

Discussing the importance of taking a 'life cycle approach', Dr Gaffney argued *"The whole idea of the life cycle is that is emphasizes that development occurs at all points of the life cycle, from conception to death. In order words, that development and ageing should be seen as similar or maybe even synonymous terms, not as contrasts...if we start thinking about ageing as being simply another progression of development of capacities, development of needs etc. it gives a seamless integrity to approaching it."*

5.3.2 Age Discrimination

Many of the factors limiting the participation and engagement of older people in society are linked to ageism or age discrimination. It is important to recognise the distinction between age discrimination and ageism. Age discrimination is an unjustifiable difference in treatment based solely on age and can result in exclusion of older people from employment or the purchase of goods and services. Ageism is

essentially an attitude of mind towards older people, seeing them as weaker, less capable or a potential drain on society's resources. Ageism is a form of discrimination that, according to some, is widespread, overlooked and accepted in western cultures (Cuddy et al, 2005; Nelson, 2005). Age discrimination can be tackled through legislation prohibiting such actions. However ageism requires an approach which seeks to change attitudes and perceptions.

Discrimination in relation to ageing can be both positive and negative and it must be acknowledged that there are significant benefits provided for older people in Ireland (such as free travel) that are more advantageous than those provided to younger people and must be protected. Many older people do not experience any barriers to full engagement in their communities. However others report experiences of higher costs or restricted access to particular goods and services or expectations of their ability to participate in activities.

The study '*Perceptions of Ageism in Health and Social Services in Ireland*' found that, despite the prohibition of discrimination in access to goods and services on the basis of age in the Equal Status Act 2000, there was evidence of direct discrimination in the upper age limits for breast screening and certain treatments, lack of referrals for some specialist services; and prejudicial attitudes by some staff towards older people.

While it can be difficult to quantify cases of age discrimination in relation to the purchase of goods and services, the UK charity AGE-UK recently carried out a survey which found that 10% of people aged 75 and over were refused motor or travel insurance on the grounds of their age, while 13% have entirely put off travelling to see family and friends purely because of the difficulty in obtaining insurance or because of prohibitive age-based pricing.

There is evidence that despite legislation against it, discrimination on age grounds

continues. The Equality Authority recently reported that 27% of their case files are age-related and that this is currently the highest proportion of cases under the Employment Equality Acts (Equality Authority 2008). (Discrimination in relation to employment is dealt with in greater detail in Chapter 3)

Through workplace workshops participants learn to understand the personal, cultural and structural effects of ageism to identify instances of discrimination against older people and to devise strategies to counter age discrimination in their workplace or community. Both the Equality Authority and the NESF have already recommended that staff engagement in age awareness training is necessary to address age inequality. Age & Opportunity also provides the Ageing with Confidence programme for groups and individuals and has developed a unique FETAC accredited arts in care programme called Creative Exchanges.

Issues Arising

Ageist attitudes: Ageist attitudes and assumptions, which can often be unconscious, can limit older people's opportunities to play their part in organisations or activities. A study carried out in Ireland for the NCAOP found that 57% of respondents considered that society treats older people worse than it does its younger people, while 62% disagreed with the statement that 'Ireland is an Age Friendly society' (NCAOP, 2007). Negative images, stereotypical portrayal of older people as a homogeneous group which is cognitively or physically dependent, and the language used to describe older people frequently go unchallenged in the media and wider society.

Age Discrimination: While the Equality Act includes age as one of the nine grounds on which discrimination is prohibited, there are still a number of areas in which access can be prevented or made prohibitively expensive on

the grounds of age rather than capacity. Some examples are: access to training courses, and provision of goods and services such as car and travel insurance.

5.4 SOCIAL CONNECTIONS AND LONELINESS

The positive impacts of social connections and social networks are well known and international research found that people, regardless of age, with rich networks of active social relationships tend to be happier with their lives (Phillips, 1967; Burt, 1987). Older adults may have experienced a shrinking of their social network because of the death of family and friends and at the very time when they need support, it is often lacking.

TILDA found that most older Irish people are regarded as 'moderately integrated' while 6% of women and 7% of men are classified as being most isolated – a further 26% of men and 23% of women are considered to be most integrated

Social connectedness, which is necessary for engagement in community service, is also strongly linked to the health and welfare of the people in a community. Providing help and being engaged in political or charitable organisations and performing voluntary work strengthens civil society structures and is often regarded as promoting social capital and the social cohesion of a society.

The impact of social engagement, which is defined as the maintenance of many social connections and a high level of engagement in social activities, and its link to cognitive decline in older persons was the subject of a longitudinal study in the US. The study found that compared with persons who had five or six social ties, those who had no social ties were at increased risk for incident cognitive decline (Bassuk et al 1999).

Happiness among older people tends to increase with the number of people available for discussing important matters. Pinquart and Sorenson (2000) show that the frequency of contact with friends is more closely linked to self-reported life satisfaction than having contact with adult children. However another study (Shaw et al 2007) found that with increasing age, older adults tend to report substantially less contact with friends but relatively stable levels of contact with family, suggesting that as people grow older, they invest increasingly scarce resources in maintaining relationships with more intimate social ties.

EU research has found that loneliness and social isolation increase the risk of mental health problems, including depression and self-harm; these feelings may be felt more often by older persons who remain house-bound. A survey carried out in 2007 found that almost one in ten (9.6 %) persons aged 65 and over in felt left out of society, a figure which was slightly higher than the rates for other age groups, although the differences were small. Those least likely to feel left out of society were among the 18-34 age group (8.0 %). (Eurostat 2011)

5.4.1 Loneliness and Quality of Life

Loneliness can be defined as a deficit between a person's actual and desired quality and quantity of social engagement while social isolation is the absence of sufficient opportunities for integration with individuals and groups in the social environment (Victor, Scambler and Bond 2005). There are two types of loneliness, emotional and social loneliness.

Emotional loneliness occurs due to the loss of a significant person such as that which occurs after the death of a loved one. Social loneliness is caused as a result of isolation and a lack of social integration within groups or communities. While social loneliness is often more prevalent in adolescence than in older

age, instances of emotional loneliness do seem to increase with age in line with the likelihood of bereavement.

The prevalence of loneliness varies widely between different countries with between five and fifteen per cent of older adults experiencing frequent loneliness (Pinquart and Sorensen 2001). Most international research indicates that the majority of older people are not lonely and in one English study, older people reported lower levels of loneliness than younger people (Victor, Bowling and Bond 2002). In the US however studies found higher levels of loneliness, Dugan and Kivett (1994) reported that 21 per cent of rural older Americans experienced 'much loneliness'.

Research carried out in 2008 has shown that loneliness results in adverse mental and physical health conditions, increasing the risks of depression and cognitive decline (O Luanaigh & Lawlor, 2008). In a review of 149 studies in the US examining loneliness in older persons, women, those over 80, and those with lower incomes, were more likely to be lonely (Pinquart & Sorenson, 2001).

A number of Irish studies have examined the links between loneliness and social isolation. Of the 10 per cent of older Irish people in a recent study who reported being 'bothered by loneliness', four-in-ten spent an average of 10 to 14 hours alone each day (Garavan, et al 2001) However Fahey and Murray (1994) in a study of social contacts and the experience of loneliness concluded that the quantity of social contact may have little bearing on the experience of loneliness, and that a single strong bond may be more important than multiple weak social relationships.

Other researchers have found a link between loneliness and the health of those who experience it (Forbes 1996, Holmen and Furukawa 2002). They discuss how physical disabilities and mobility difficulties

are associated with increased loneliness, and loneliness may in turn impact on levels of depression, sleep patterns, and appetite (Tijhuis et al. 1999). Mobility problems may reduce an individual's ability to interact with others, which in turn may exacerbate social isolation and loneliness (Kileen 1998).

Loneliness tends to be linked to social factors such as not being married and spending time alone or health resources such as poor mental health, worse than expected health in later life, and poor current evaluation of health status. An Irish study which looked at the social and emotional dimensions of loneliness through a series of interviews with people aged 65 or more years, found that levels of social and family loneliness were low, but that romantic loneliness was relatively high. They identified greater age, poorer health, living in a rural area, and lack of contact with friends as predictors for social loneliness and concluded that loneliness for older people is variable and frequently linked to life events, with, for example, the death of a partner being followed by the experience of emotional loneliness, or the loss of friends or declining health leading to social loneliness (Drennan et al 2008).

5.4.2 Interventions to Tackle Loneliness

In recognition of the impact that loneliness and social isolation can have on health and longevity, social and health services in many countries have developed programmes that are designed to promote the development of new relationships in later life and to tackle or prevent loneliness among older persons. These programmes are frequently based on the premise that home visitation improves the wellbeing of housebound older people. However there is conflicting evidence on the effectiveness of such approaches. One systematic review (van Haastregt et al. (2000) concluded that no evidence could be found for the effectiveness of home visits, while

another (Elkan et al. 2001) argued that home visiting could reduce mortality and admission to institutional care. It is important to note, however that neither of these studies examined the alleviation of loneliness as an outcome measure. A further review of interventions that target social isolation also found little evidence of effectiveness (Findlay 2003).

O Luanaigh and Lawlor (2008) have noted the weakness of assessment tools used to measure loneliness in Ireland. These tools are in the main limited to subjective reporting where people are asked whether they are lonely or not. In order to ascertain the type of treatment that is most appropriate, it may be necessary to apply more comprehensive methods of analysis. In general, O Luanaigh and Lawlor called for an increased focus on initiating intervention strategies targeting loneliness to determine if decreasing loneliness can improve quality of life and functioning in older people (O Luanaigh & Lawlor, 2008).

Among the interventions used are services that match older persons who are looking for companions to take part in leisure activities. In a small study of older persons who had been matched through such an agency. Bodde (1994) found that simply bringing people together is not sufficient to reduce loneliness as few lasting relationships were developed as a result of the 'matching' procedure.

A review of the literature suggests that interventions which promote active rather than passive social contact are more likely to impact positively on health and well-being. Passive interventions, such as one-to-one social support, home-visiting and health needs assessments have been shown to have only limited effectiveness. However, "active" interventions that promote the development of meaningful social roles and active engagement in local communities have demonstrated positive impacts on older people's quality of life and health (Greaves & Farbus, 2006).

Overall, successful interventions may include elements of gate-keeping (identifying problems and connecting people with appropriate services), group support which enriches friendships and empowers participants, and other methods of active social network building (Greaves & Farbus, 2006).

A study being carried out by Prof Brian Lawlor from the Mercer's Institute for Research on Ageing, is seeking to determine whether a volunteer network programme that targets those at risk of loneliness and isolation can improve mental and physical health outcomes. As part of the programme, older people at risk of social isolation or loneliness living in one of the counties in the National Age Friendly Counties Programme have been invited to participate. Volunteers delivered a programme involving weekly contact by the same volunteer either on the phone or in person.

Furthermore, counteracting loneliness can be addressed by ensuring appropriate local delivery of services, e.g., educational, community, and rural transport. Therefore, an approach that fosters social cohesiveness could lay emphasis on older people (building capacity and confidence), on communities (fostering programmes that increase networking and community spirit) and on service deliverers (raising their awareness of all older people and their capacity to include older people in their work – and not just the easy to reach groups). For example, the Bealtaine festival, working with networks of social and cultural organisations around the country, has been proven to enhance social cohesion. In the O'Shea evaluation (2008), nearly 90% of participants felt that participating in Bealtaine increased their level of involvement in their community.

A survey conducted by Active Retirement Ireland with its 23,000 members in 2009 showed that being part of a social network reduced loneliness and contributed to a more

active lifestyle among older people. There are already a range of programmes organized by voluntary organisations such as Senior Helpline or Active Retirement Ireland which help tackle social isolation and loneliness. Active Retirement Ireland supports nearly 500 local self run associations of older people who plan and deliver a range of programmes and activities in the social, learning and physical areas and the Senior Helpline offers a national service taking in excess of 10,000 calls per year.

Age & Opportunity runs an educational programme, *Ageing with Confidence*, aimed at enhancing the confidence of people by providing health education, developing life skills and promoting positive mental health and self-confidence to counteract social isolation and thus leading to a better quality of life.

Issues Arising

Loneliness: While levels of loneliness among older people are often not as high as among other age groups, some older people, particularly those living alone and in isolated areas, face particular problems and those problems can impact on their health and wellbeing.

5.5 ABUSE OF OLDER PEOPLE

Elder abuse (which refers to abuse of people over 65) is a complex phenomenon, which encompasses physical, sexual, psychological and financial and material forms of abuse. It also includes neglect, acts of omission, and 'discriminatory' abuse including ageism, sexism, racism or that based on a person's disability' (HSE 2009, pp. 5-6).

According to the HSE, the definition of Elder Abuse is "*A single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person or violates their human and civil rights.*" (Protecting our Future, DoHC 2002). Elder abuse is known to cause injury, illness, lost productivity, isolation

and despair. It may go unreported because of fear, and because of the social stigma attached to it (WHO/INPEA 2002).

5.5.1 Policy Development

In 1996 a briefing to the then Minister for Health by the National Council on Ageing and Older People (NCAOP) outlined a number of issues relating to elder abuse. This was followed by the publication of an exploratory study, *Abuse, Neglect and Mistreatment of Older People* (O'Loughlin & Duggan, 1998) which set out suggestions and guidelines on how to tackle the problem. One of its key recommendations was the establishment of a Working Group on Elder Abuse (WGEA) to progress the issue.

The Working Group on Elder Abuse was established in 1999 by the Department of Health, chaired by an academic geriatrician and made up of representatives from older people's advocacy organizations, geriatric medicine, old age psychiatry, general psychiatry, social work, public health nursing, clinical psychology, the police (Gardai), health boards, and family medicine.

The WGEA made a number of recommendations and established two pilot projects in 2000 in the south and southwest of Ireland. A Senior Case Worker was funded for each of the two areas (one a senior nurse with gerontological experience, and one a social worker).

The findings from the pilot projects indicated a number of problems such as concerns over methods of reporting and fear that formal or written reporting might have negative legal consequences. In contrast to the special legal provision for the protection of people who report concerns about child abuse in good faith, no such provision exists to protect those reporting elder abuse concerns in Ireland.

In 2002 the Working Group published a report outlining 29 recommendations for

tackling Elder Abuse - Protecting Our Future (Working Group on Elder Abuse, 2002). These recommendations are grouped into a number of different categories: context; policy; staffing of elder abuse services; legislation; awareness, education and training; financial abuse; advocacy; impaired capacity; research and education; reporting; and review.

The report also recommended that a National Implementation Group should be established to guide the implementation of the recommendations and that a formal review of the recommendations be undertaken in 2007. Since then some progress has been made; the group to oversee implementation of Protecting Our Future, the Elder Abuse National Implementation Group (EANIG), drew up a plan of action for the implementation of the recommendations.

The Law Reform Commission has adopted the recommendations of the Working Group (The Law Reform Commission, 2003), and the Health Services Executive has undertaken a significant amount of training in elder abuse in the 4 years since the report's publication. The review of the implementation of Protecting Our Future was published in 2009, and further details from this report will be outlined below (PA Consulting/NCAOP 2009).

5.5.2 Prevalence and Data

The actual level of elder abuse is difficult to determine as often victims themselves are reluctant to report or acknowledge the problem, perhaps because the abuser is a family member or sole caregiver on whom the victim depends for fulfilment of their basic needs. Many older adults are also reluctant to report abuse because of fear of losing the close personal ties with the family member. When the abuser is a member of the family, there can also be a tendency for other family members to cover up the situation.

Systematic collection and analysis of data relating to elder abuse referrals/allegations

was initiated in 2007, in the context of new health service staffing structures and reporting procedures. The most recent HSE report indicates that in total, there were 2,302 referrals made to the Elder Abuse service in 2011, an increase of 9% from 2010. Of these 1,867 had an alleged person causing concern, 429 were self-neglect cases and 6 represented organisational abuse. (HSE 2012) They acknowledge that given estimated international prevalence rates of between 1% and 5%, it would appear that there is under-reporting of elder abuse. They also report that the most common forms of abuse were psychological abuse (35%), followed by financial abuse (23%), neglect (19%) and physical (12%).

Abuse can occur anywhere, but the HSE analysis indicates that most of these involved older people living in their own homes (81%) with small percentages of cases involving people living in other settings including hospitals, nursing homes, and relative's homes. Consistent with the ongoing trend, in 95% of cases in 2011, the abuse was alleged to have happened in the person's home.

In over half of cases, the alleged abuser and alleged victim are living together. In keeping with international literature, the alleged perpetrators are son/daughter (44%), other relative (18%) and partner/husband/spouse (16%). Nationally, most referrals were for women (63%) and 51% of all referrals relate to clients over 80 years. The over 80 year referral rate/1,000 population increased from 8.54 in 2010 to 9.47 in 2011 and was over three times the referral rate in the 65-79 year olds. (HSE 2012)

If WHO statistics were applied to Ireland the level of abuse of older people would stand somewhere between 5,000 and 21,000 older Irish people, (www.irishhealth.com) while Age Action's estimate is between 14,000 to 23,000 possible victims. The Senior Helpline reported that 26% of its calls currently relate to elder abuse. Information from the Courts

Service indicates that in 2006, 102 parents were granted a safety order against an adult child, compared to 91 in 2005, and 200 barring orders were granted in 2006, compared with 173 in the previous year.

5.5.3 Risk Factors

The risk factors for abuse have been summarised as including; gender, age living arrangements, poor mental or physical health, cognitive deficits and lack of social supports (Help the Aged 2008). A 2005 study identified a number of factors as predisposing an older person to abuse or exploitation. They include; being of advanced age (75+); being female, unmarried/widowed/divorced; having cognitive impairment; having physical, mental or emotional dysfunction (especially depression); the recent loss of spouse or divorce; living alone; being socially isolated or estranged from children; being financially independent with no designated financial caretakers; being in the middle or upper income bracket; taking multiple medications; and frailty (Hall et al 2005).

End of life can increase the vulnerability of older adults particularly for potential financial abuse because many of the risk factors increase as the person health status declines. Family members who financially abuse a dying patient often express the attitude, 'it's all going to be mine soon anyway' (Jayawardena & Solomon, 2006).

5.5.4 Services To Deal with Elder Abuse

In recent years significant progress has been made in the development of services to help older people experiencing abuse. Over 7,000 HSE and related staff working with older people received training regarding elder abuse in the two years 2007-08. A major public awareness/information campaign, Open Your Eyes, was conducted in late 2008 in collaboration with a wide range of statutory

and voluntary agencies, and the HSE has been one of the main sponsors of the annual Say No to Ageism week, recognising that ageism and ageist attitudes can encourage 'a culture which creates a fertile environment in which elder abuse can develop' (HSE 2009, p.21).

Local Health Offices have now appointed Senior Case Workers (Elder Abuse) who are focused on safeguarding the well-being of clients and, in collaboration with the older person and their families, determining what supports and interventions may be needed. Where necessary, safety plans are drawn up in collaboration with the multidisciplinary team involved, and may include liaison with voluntary and statutory agencies as appropriate. Examples of interventions include increased monitoring of the client in the community, increasing home support, providing counselling and, less often, respite and admission to long-term care.

In addition to the appointment of Senior Case Workers, Dedicated Officers for Elder Abuse have been appointed who are responsible for development, implementation and evaluation of the HSE's response to elder abuse and work within the framework of existing policies including, 'Protecting our Future', 'Trust and Care' and legislation. The HSE has also established an information databank in relation to referrals of alleged cases of Elder Abuse. This information will be a valuable indicator of the extent of the problem in Ireland and will inform future planning for services for older people. A National Steering Committee on Elder Abuse has been established to oversee and ensure a nationally consistent approach in the provision of Elder Abuse services by the HSE and a National Research Centre for the Protection of Older People (NCPOP) has been established in UCD.

COSC the new National Office for the Prevention of Domestic, Sexual and Gender-based Violence, recently published a report

on nation-wide consultations held in 2008. This report emphasised the need for inclusion of violence against older people specifically in discussions of domestic and gender-based violence, as it can often be omitted, and the importance of considering their specific needs in relation to accessing information and help (COSC, 2009, pp.11-12).

5.5.5 Financial Abuse

Financial abuse is the second most prevalent forms of abuse of older people and until relatively recently it was not officially recognised as a problem in Irish society. The impact of financial abuse for older people can be devastating. In addition to the loss of financial resources, it also has the potential to cause extreme emotional distress or depression, increased dependence on others, a change in residence, decreased resources for medicines and health care, and a diminished quality of life (Kemp and Mosqueda 2005).

Financial abuse is a form of elder abuse which has been defined as “*the illegal or improper exploitation and use of funds, property, or assets of an older person*” (Wolf, 1996). Examples include, but are not limited to, cashing an older person’s cheques without authorization, forging an older person’s signature, misusing or stealing an older person’s money or possessions, coercing or deceiving an older person into signing any document (e.g., a will), and the improper use of guardianship or power of attorney (Gordon, 1992). The HSE’s document, Protecting Our Future also uses a similar definition of financial or material abuse.

Financial abuse can also occur when older people are overcharged or pressurised into paying for unnecessary work or encouraged to divulge financial details, to invest in scams or investments that are not suited to them. It can range from failure to access benefits, through to inadvertent mismanagement and

opportunistic exploitation, deliberate and targeted abuse, often accompanied by threats and intimidation. The Help the Aged report (2008) highlights the fact that new technology provides opportunities for identity theft and other internet scams to which older people may be particularly vulnerable.

Older people whose assets are being managed by others (asset managers) and family members or friends involved in management of the older person’s finances can through inappropriate practices place the older person at risk of financial abuse or can at worst be guilty of financial abuse.

These risky/abusive practices include:

- Inadequate or no accountability procedures particularly for cash payments;
- Giving power of attorney to people who may lack the personal or financial skills to take on the responsibility, or who may be subject to influence by a spouse or other significant person whom the donor feels hesitant about;
- Asset managers taking over full control – supposedly to make it easier for the older person – but effectively denying the level of control over money sought by the older person;
- Mis-selling or selling high risk or time inappropriate products to older people
- Asset managers being overly generous with an older person’s money – for example, by using a gifting option excessively;
- Fraudulent use of authority such as falsifying a signature or continuing to use an Enduring Power of Attorney after the donor has died or revoked the document.

5.5.6 International Prevalence

Internationally, financial abuse is one of the more common forms of abuse perpetrated against older people. In a study of financial

abuse in the US it was found to account for about 20% of all substantiated elder abuse perpetrated by others (after excluding self-neglect). It is also estimated that, for every known case of elder financial abuse, four to five go unreported (Hannigan et al 1998).

Studies from other countries reveal higher levels of financial abuse. For example, a 1999 study of older adults identified as potential victims of mistreatment in Quebec found financial exploitation in 41 per cent of cases. More than half of cases of abuse by an adult child involved financial abuse (59%) with the same percentage including some form of psychological abuse. Again the study found that the majority of victims were women (75%) and the majority of the perpetrators (65%) were men (Lithwick et al., 1999).

A UK report (Cambridge et al., 2006) supports the finding that abuse type is related to location and that financial abuse is more likely to occur within the home. In residential care only 7 per cent of abuse is financial whereas at home financial abuse and exploitation make up 25 per cent of cases. It also revealed that financial abuse is more likely to be carried out by males in the home and females in residential care settings. Financial abuse at home is more likely to be by family members while in a residential care setting it is generally carried out by paid staff. Fifty per cent of financial abuse is carried out by family/partner/carer, 36 per cent by domiciliary or residential care staff and 5 per cent by home managers.

A UK study by Rowe, Davies, Baburaj and Sinha (1993), investigating the financial affairs of 25 older people with dementia who were in-patients or attending hospital, found that their financial affairs were apparently 'handled inappropriately' in 24 of the cases. A study by Langan and Means (1995) reported concerns expressed by residential care staff that older people in their care often experience difficulty accessing their financial details. In this study

several homes' managers report concerns such as money being siphoned off; relatives keeping back some of the personal allowance; difficulty getting relatives to pay for items and so on. Relatives and residents were not interviewed, and financial accounts were not examined.

Indicators of Financial Abuse/Exploitation

Identification of financial abuse can often prove difficult. Financial exploitation can be indicated by: sudden changes in banking practices, the inclusion of additional names on an older adult's banking card, unauthorized withdrawals, abrupt changes in the person's will, the unexplained disappearance of funds or valuables, unexplained transfers of funds to family members, and forged signatures on financial documents (NCEA, 1998).

Friends or family may also come to suspect financial abuse through: a change in the vulnerable adult's living conditions; inability to pay bills or an unexplained shortage of money; unexplained loss/misplacement of financial documents; isolation from family/friends/social network; or an improvement in the carer's lifestyle;

Other potential indicators identified by Rabiner et al (2004) include bank statements no longer coming to the older person's home; new 'best friends'; overcharges for, or non-delivery of, care-giving services; use of legal documents such as powers of attorney that the older person did not understand when they signed; family members who live with the older person and refuse to pay rent or coerce the older adult to care for grandchildren without payment; use of the power of attorney and other legal devices for purposes beyond those for which it was originally intended.

Brown (2003) suggested that identification of financial abuse involves a complex process of assessment taking into account factors such as the intentions of the (potential) abuser and their relationship with the vulnerable person;

the nature of the transaction(s) whereby the mechanisms were put in place to access the money; the extent to which the money is being used properly to meet the vulnerable individual's needs; the degree of harm of loss to the vulnerable person; any conflicting interest the attorney/receiver has in terms of eventual inheritance; any competing claims from other relatives/associates that are being overlooked or sidelined (Brown 2003).

Mis-selling of Financial products

In 2008 and 2009 a number of instances of mis-selling of financial products by financial institutions to older people were reported and investigated by the Financial Services Ombudsman. However there were no statistics available on the level of financial abuse experienced by older people or an age-breakdown of complaints received.

In 2009 a 'mystery shopping' exercise, carried out by the Financial Regulator, involving people who were mainly aged between 72 and 79 years of age, uncovered attempts by four financial institutions to persuade the customers to invest in six-year bonds, rather than put their money in deposit accounts. While in the majority of cases mystery shoppers were recommended a deposit option where the term was no longer than three years, some banks had sought to advise older shoppers to invest their savings in products that could not be accessed for an overextended period.

Other issues uncovered during the exercise included a failure on the part of many financial institutions to allocate an accurate risk profile for older clients. In his Annual report the Ombudsman (Financial Ombudsman 2007) recommended that a family member or independent professional third party be present (or at least evidence that this option was offered by the financial institution) when a policy is sold and that a senior member of management sign-off on the relevant documentation. A checklist

(signed by the policyholder and approved at senior manager level) could serve as an additional control when advising on investments.

Law Reform Recommendations

The Law Reform Commission has raised a number of issues relating to the possible financial abuse of older people. For example the Commission suggests that financial abuse may arise because of inability to deal personally with finances or because an older person may have chosen another person to handle their finances perhaps because of physical infirmity or a lack of transport. This may occur in relation to Social Welfare entitlements or to the establishment of joint accounts by an older person.

The decision to create a joint account may be based on convenience and the person using the account may not have been intended to benefit financially from it. However this may give rise to abuse of the older person's finances. In the absence of adequate training and awareness in the banking or financial services of the law relating to such arrangements, the potential for abuse remains and anecdotally it is known that there have been cases of persons named on a joint account transferring money from the older person's account to their own or using the older person's money for purposes other than the care of the older person without any agreement or permission to do so.

The Law Reform Commission has recommended that financial institutions should be obliged to give clear information or possibly warning notices to people (other than spouses) opening joint accounts. Alternatively, they suggest that the Irish Financial Services Regulatory Authority could be asked to issue codes of conduct and to encourage financial institutions to provide different kinds of joint accounts. These could provide for greater clarity about the purpose of the account, for example the account could have endorsements to the effect that the second named account holder would

only be allowed to withdraw a certain amount each week or that the first named holder would have to be contacted personally if there was any attempt to withdraw over a certain amount.

In some countries legislation provides for the making of a 'statutory will' on behalf of a person who lacks the requisite capacity to do so themselves. This process allows a substitute decision-maker to make a will on the person's behalf or to alter the provisions of an existing will. However the Law Reform Commission believes there is a strong potential for abuse of this provision and does not believe that adequate checks and balances could be put in place to prevent the possibility of abuse of a statutory wills procedure and to detect the existence of such abuse. Instead, the Commission recommends that in exceptional circumstances, the High Court could be given the discretionary power to order the alteration of a will of an adult who lacks capacity (Law Reform Commission 2006).

The Law Reform Commission also warned about the potential abuse of older people through the aggressive marketing of specific financial products directly to older people which may not be in their best interest or may increase the risk that they will be unable to fund their care in later years. For example they suggest that equity release schemes, cheque book mortgages and schemes whereby older people – usually parents – give guarantees or borrow against the equity in their own homes in order to assist younger people in buying houses. While they acknowledge that the products may be quite useful in allowing older people to use the value of their assets for their own care (or for their own enjoyment) or to facilitate the younger generation in buying their own homes, they point out that older people are not always fully advised of the risks. (Law Reform Commission 2003).

In relation to social welfare pensions, the Law Reform commission suggests that appointing a

person associated with a care facility to collect the pension is inappropriate and inconsistent with the Ward of Court legislation and recommend that such arrangements, where they exist, should be changed.

Revised Consumer Code

Since its establishment in 2005, the Financial Ombudsman's Office has published eight case studies about the unsuitability of investment products sold to older people, and made awards in favour of older people to compensate them. Despite repeated warnings, the Financial Regulator's report shows continuing failure by institutes to adhere to the Consumer Protection Code. In July 2009, the Financial Services Ombudsman called on Irish financial institutions to carry out a review of all investment products sold to older people since 2006, in order to prevent the selling of inappropriate products.

The Consumer Protection Code (the Code) was introduced in August 2006 to ensure a consistent level of protection for consumers (not just older people) regardless of the type of financial services provider they choose. The Consumer Protection Code has now been updated and this revised Consumer Protection Code is effective from 1 January 2012.

The revised code includes a new definition of 'vulnerable persons' to provide protections to all consumers, regardless of capacity, capability or circumstance. The definition of vulnerable consumer included in the code is '*a consumer that is vulnerable because of mental or physical infirmity, age, circumstances or credulity...*' The new code includes considerations of;

- The findings during themed inspections (particularly those focussed on the provision of financial products and services to older persons),
- The recommendations made to us by the National Financial Abuse Working

Group established by the HSE to reduce the incidence of financial abuse of older persons, and

- The findings of complaints investigated by the Financial Services Ombudsman

The revised code also addresses the question of suitability of products for particular consumers by strengthening the suitability provisions. It provides that in order to ensure that adequate consideration is given to the information provided by the consumer, *“the regulated entity must, at a minimum, consider and document whether:*

- *The product/service meets the consumer’s needs and objectives,*
- *The consumer is able to meet the financial commitment associated with the product on an ongoing basis and/or is financially able to bear any related risks consistent with their needs and objectives,*
- *The consumer has the necessary experience and knowledge in order to understand the risks involved, and,*
- *The consumer may be a vulnerable consumer, and as such, has particular needs and circumstances that require due consideration”.*

Issues Arising

Elder Abuse: There are grounds for believing that there is substantial under-reporting of elder abuse in Ireland. If WHO statistics were applied here, there would be between 5,000 and 21,000 older Irish people experiencing some form of abuse, while Age Action’s estimate is between 14,000 to 23,000 possible victims. Figures released in 2012 showed more than 1,867 cases of alleged ill-treatment were referred to the HSE in 2011. The most common forms of abuse were psychological abuse (35%) followed by financial abuse (23%), neglect (19%), and physical abuse (12%). In over half of cases, the alleged abuser and alleged victim

are living together and the alleged perpetrators are son/daughter (44%), other relative (18%) and partner/husband/spouse (16%).

Difficulties of reporting: Current legal provisions require formal reporting of an incident or case of abuse before an investigation or interview with the older person can take place. There is evidence that older people are ashamed and often reluctant to report abuse especially within the family. Victims are often unaware of their rights, and of the supports and services available to them, and may not themselves perceive the abuse as a crime, especially when the perpetrator is a family member.

General Awareness of the problem: There is limited public awareness of the extent and nature of abuse of older people, as well as limited knowledge about what can be done, and what resources and supports are available.

Financial Abuse: Statistics published by the HSE indicate that financial abuse has become the second most common form of elder abuse (23% of referrals) although it is likely that this figure under-represents the extent of the problem.

5.6 INTERGENERATIONAL CONTACT

For centuries intergenerational relations were central to the transfer of knowledge, norms and values between the generations within the family structure. As proportion of older people in society grows over the coming decades, development of positive attitudes and mutual understanding between young and old will become increasingly important.

The potential for intergenerational conflict is frequently expressed in concerns about the dominance of older people through their greater numbers and more active political involvement. The concern is that greater numbers of older people will lead to increased spending on

pensions or a veto on the reduction of spending on older people to the detriment of spending on younger people or those of working age. This unfounded theory has been around for quite a while and as far back as 1948 it was suggested that as the median voter grows in age, *“age-biased policies will become the norm and the generations will pursue their own respective self-interests at the expense of others”* (Black 1948).

In recent years a number of factors have contributed to an increasing social distance between generations. There has been a growing tendency for the generations to associate with and value their contemporaries to the exclusion of other age groups; an increased emphasis on self-sufficiency also contributes to intergenerational ‘distance’ and finally as families become more geographically dispersed, intergenerational contact within the family has reduced, leading to a gap in understanding between old and young.

EU data shows there are few opportunities for old and young people to meet and exchange ideas. In a survey carried out in 2009, 63.8 % of the EU-27 population (aged 15 and above) agreed that there were not enough opportunities for older and younger people to meet and work together in associations and local community initiatives. (Eurostat 2011)

Research in the UK found that significant numbers of younger people are isolated from older people in their communities: a third (36%) say they ‘never’ or ‘hardly ever’ speak to people over 40, other than parents, teachers or people at work, while older people often have very little personal contact with younger people outside their immediate family circle (Prince’s Trust, 2008). Since age segregation contributes to a lack of understanding people tend to fall back on stereotypes, which in turn reduce the possibility of contact between the generations. (Moore and Statham 2006)

Most Europeans do not believe that their governments are doing enough to promote a

better understanding between the young and the old. In a Euro-barometer study an average of 27% of respondents said that they thought their government was doing a good job. A higher proportion of Irish respondents to the study (45%) strongly disagreed that the Irish government was doing enough to promote intergenerational understanding. (Eurostat 2011)

There is evidence from a UK study that younger people feel that they are negatively perceived by older people and that older people regard them as ‘hoodie-wearing, knife-wielding, label obsessive’ (London Youth, 2010: 2). In turn, younger people think older people are: ‘boring, very grumpy, weak and unkempt, with *“one foot in the grave”*. One younger person said that older people have ‘lost touch’ with what it was like to be young. (London Youth, 2010: 9)

In some communities this distance between generations contributes to a sense of distrust and manifests in a fear of crime and feeling of lack of safety among older people. Psychologists argue that perceptions of risk are linked to a person’s understanding of the social and physical make-up of their neighbourhood’. (Holloway and Jefferson 1997) This may help to explain why many older people have a fear of crime that is not linked to their actual statistical likelihood of being a victim of crime and can often be associated with older people’s perceptions of young people as a threat.

Differences between the generations become apparent in the priority they give to various community issues. Young people express concern about road accidents, teenage pregnancy, education, and safe public spaces while older people tend to prioritise transport and other services, fear of crime and anti-social behaviour. (Pain, 2005). One shared priority is the lack of safe public spaces in which to congregate (Pain and OPDM 2005). Regeneration projects are viewed as a context for nurturing intergenerational cooperation (Pain and OPDM 2005).

5.6.1 Benefits of Intergenerational Activities

Intergenerational programmes first originated over forty years ago in the United States. They can now be found in a wide range of settings such as schools, child/adult day-care programmes, youth community programmes, universities, and others (Hanks & Ponzetti, 2004; Hatton-Yeo & Ohsako, 2000).

The International Consortium of Intergenerational Programs (ICIP) defined them as “*social vehicles that create purposeful and ongoing exchange of resources and learning among older and younger generations.*” The Beth Johnson Foundation definition is also frequently used “*any activity which aims to bring people together in purposeful, mutually beneficial activities which promote greater understanding and respect between generations and contributes to building more cohesive communities.*” (Beth Johnson Foundation, 2001).

Intergenerational programmes have been shown to offer many benefits for young and old, including; building better more cohesive communities; improving the physical and mental health of older people and the academic performance of young people and children. In addition they have the potential to improve the economic viability of service provision and the coping skills of families.

Evaluation of one programme found that young people involved in intergenerational mentoring programmes were less likely to get involved in violence and drug abuse and were more likely to attend school, have more solid academic outcomes and be able to build healthier relationships (Tierney, Grossman & Resch, 1995). A Canadian study showed that such programmes enhance literacy development in the children and young people involved (Ellis, Small-McGinley and Hart cited in Intergenerational Strategies, 2004).

In the US many programmes are sponsored by schools and day-care facilities and their

primary aim is to reduce distrust between children and older people (McCrea & Smith, 1997, and Newman 1997). Pain (2005) suggests that negative attitudes among young people are not difficult to overcome and what is needed is greater levels of contact between the groups. Greater understanding can lead, in some cases, to a reduction of misunderstanding and tension between groups. Whitworth (2004) describes a project involving young people and residents of sheltered housing, which engaged them in activities together. Following the project, the number of complaints to police from the sheltered housing regarding ‘youth disorder’ dropped significantly, as residents became more tolerant of young people.

Societies/communities benefit from the contribution of older people who have the time, experience and leisure to offer a particular perspective in this time-poor and work pressured society (Third Age). Many older people are fit and healthy and want to be valued for their potential to contribute now and in the future, rather than being seen only in the context of their past. (When I’m 64 or more, 2003:19) Older people have learnt from life and have imbibed values such as patience, endurance, taking the long-term view which can be missing from modern debate (Third Age).

5.6.2. Intergenerational Initiatives

Many older people are involved in intergenerational projects as informants on local history or forgotten crafts etc. and are valued as educators who provide a wealth of knowledge, skills and experience to pupils in primary and secondary schools (AONTAS, 2007). The value of promoting intergenerational solidarity is recognised in the Madrid International Plan of Action on Ageing (MIPAA, 2002). It recommends the following to strengthen solidarity between generations;

- Public education to promote understanding;

- Policy reviews to ensure that they promote social cohesion
- Initiatives aimed at promoting mutual, productive exchange between the generations, focusing on older persons as a societal resource
- Consideration of the needs of carers who have to care, simultaneously, for their parents, their own children and their grand children
- Research on the advantages and disadvantages of different living arrangements for older persons, including familial co-residence and independent living in different cultures and settings

There are a number of very good initiatives in Ireland at present although there is no over-arching policy to connect the various programmes and give coherence to the area. For example, Age & Opportunity is involved in an annual Grandparents Day in schools at end of April. This is a nearly nationwide programme, which also involves Mayo Education Centre and Castleknock Community College. Age & Opportunity can provide guidelines on planning intergenerational projects.

DCU established a Centre for Intergenerational Learning in 2008. The aim of the Centre is to bring together students and older people in a teaching and learning opportunity that values the equitable role of both participants as tutors and learners. The DCU students participate in a volunteering capacity and are drawn from both undergraduate and postgraduate courses and from all faculties. The older students are invited to participate and subjects studied include “Introduction to...” modules such as “*Understanding the Media Today*”, “*Introduction to Science*” and “*Introduction to Creative Writing*”. The modules were designed to meet the teaching and learning needs of both the older participants and the DCU students, and to take account of their interests, knowledge and skills.

The Ballymun Intergenerational Local History Programme is another Irish example. In this programme older members of the local community (over 55s) volunteer to visit primary school students in their classroom to tell them what life was like when they were in school. The volunteers receive training in Child Protection and Storytelling. This aim of the programme is to build a connection between young people and older people from their own community and reduce the isolation of older people by encouraging them to become involved in voluntary activity. It also seeks to increase knowledge of local history among the children and their teachers.

The evidence suggests that the programme offered benefits to the volunteer, student, and teacher. The school was supported in meeting objectives of the history primary school curriculum; volunteers gained many benefits from sharing their knowledge and stories and students gained great knowledge of what life was like in the past as well as many interesting stories relating to sites and events in their locality. Evidence suggests that even greater preparation and follow-up visits might help to enhance the learning experience for students. (Finn and Scharf 2012)

A Changing Ageing Partnership (CAP) in Northern Ireland published a report in April 2008 which provides a systematic review of existing literature on children’s perceptions of ageing. The report discusses the potential for intergenerational activities to reinforce negative stereotypes of older people if children are exposed mostly to passive nursing home residents; the benefits of combining interaction with older people with education on the ageing process and the importance of evaluating intergenerational programmes (<http://www.cardi.ie>).

The NCAOP have published four reports on intergenerational activities including guides for teaching in schools. A report was conducted on school leavers’ attitudes to ageing in 1987.

A number of inter-generational arts projects have taken place in County Sligo including a 2008 Bealtaine project called Magic Me that was jointly organised by Age & Opportunity and Sligo Co. Council Arts Office. This was both an intergenerational and an intercultural programme.

Magic Me is a British company specialising in intergenerational work, which was brought to Ireland for the Bealtaine Festival 2008 and they worked with groups over a period leading to an exhibition. Maugherow Intergenerational Arts Project and the Abbey Quarter Intergenerational Arts Project.

5.7. VOLUNTEERING

Older people are involved in a wide variety of voluntary and productive activities. In addition to formal volunteering, many older people make substantial unpaid contributions within the family in both caring for grandchildren and providing long term care to their spouse. While there is a growing body of international research valuing the voluntary contribution of older people there is no data in Ireland quantifying the financial value of support given by older people within their families and communities.

5.7.1 Importance of Volunteering

Volunteering activity can have important psychological and other health benefits for the volunteers themselves. Research has found positive effects on the well-being, quality of life, health and longevity of older people as a result of their volunteer activity (Onyx & Warburton, 2003; Warburton, 2006). According to the TILDA study (2011) the lowest quality of life was found in people who never volunteer. (TILDA 2011)

Researchers in the US (Ageing Today, 2004) found that in addition to feeling better about themselves, older volunteers experienced

additional mental and physical health benefits, felt happier, and enjoyed a better quality of life than non-volunteers. A further study claims (Carlson 2002) an improvement in 'cognitively complex activities' on the part of older volunteers, following their volunteer activity in schools. Two further studies found that volunteering acts as a protective factor in relation to mortality. Oman and colleagues (1999) reported that older volunteers experienced 44% lower mortality rates over a 5-year period than those who did not volunteer (van Willigen, 2000; Musick & Wilson, 2003).

In addition to health benefits, Hinterlong and Williamson (2006) found that volunteering can enhance social support networks, increase social status, and reinforce knowledge and skills. Volunteering is also said to provide a role identity and sense of purpose for those retired from paid work (Greenfield & Marks, 2004). Musick and colleagues (1999) found that the positive effects of volunteering had the strongest effect among people with low levels of social interaction.

Volunteering by older people is also of significant benefit to others in the community and a study which examined the kind of informal assistance given between friends and neighbours found that two thirds of older Americans (over 60 years of age) give help to friends and neighbours, a service that reduces social isolation and delays the need for formal paid services for those supported. The study looked at the link between time spend in 'productive activity' such as volunteering or employment related volunteering and found that as time committed to productive activities increased, life satisfaction also increased and that involvement in a greater number of productive activities was linked to higher levels of happiness (Baker et al 2005).

5.7.2 Level and Value of Volunteering

In the UK, the charity AGE-UK conducted research quantifying the 'bounty' that an

ageing population offers, both economically and socially. This research estimates the current contribution of older people in the UK, from both paid and unpaid work, at approximately £244bn. They call for recognition of the many unseen and undocumented ways in which older people in the UK contribute. They estimated a total of £23.9bn is given by older people in unpaid care (by people over 50 years) for people who are sick or have a disability at (£15bn), care for grandchildren (£3.9bn) and unpaid voluntary work at (£5bn) (Age-UK 2008).

The TILDA study found that one in five older people do voluntary work at least once a week or more. (TILDA 2011) The study also revealed that over one third (36%) of older people provide household help to their (non coresident) adult children and nearly half (47%) provide childcare for their grandchildren. The number providing household help reduces with age, dropping to 20% of those aged 75 and over.

Among EU countries there are wide ranging differences in the rate of volunteering. In countries such as the Netherlands and Finland more than half of all retired people make a contribution as volunteers (52.2% and 50.3% respectively) while Ireland's rate of voluntary work by retired people is above the EU average at 37%. (EC

According to the 2006 Census, involvement in a religious group is the most common choice for older people. Of those who participate in voluntary work, 46.7% are involved in a religious group while 9.9% are involved in a political or cultural organisation. Involvement in social or charitable organisations is also one of the most popular choices for voluntary work (41.4%) while only 15% of people are involved in sporting organisations (CSO, Ageing In Ireland 2007).

The CSO research also found that older people are most likely to be involved in religious groups while younger people tend to get involved in sports groups. Almost one-fifth (18%) of those aged 15-24 were involved in

sports groups, compared with 2% of people aged 75 years and over. Just 1% of 15-34 year olds were involved in religious groups, compared with 9% for those in the 65-74 year age group. Greater numbers of women participate in religious groups (10-12% of females aged 55-74 years were involved in religious groups). In fact they found that engagement levels were higher in older age groups than younger age groups across most types of group involvement, excluding sports and political groups.

Engagement in unpaid charitable work was most common among the 45-54 year olds with almost 40% of women in this age group reporting engagement in informal unpaid charity work. Among older people the level of engagement dropped to under 25% for both men and women in the 65 to 74 age group and further to under 20% of the over 75 age group.

There has been some debate about whether the rates of volunteering have declined over the years. However information from the Taskforce on Active Citizenship (2007) would suggest that this is not the case for older people. In a comparison between 2002 and 2006 they found that the number of regular volunteers among people aged over 65 years increased from 6.1% to 14.8% and the level of engagement in the community increased from 7.3% to 19.1% during the same period.

5.7.3 Reasons for Volunteering

A general study of volunteering in Ireland has indicated that most volunteers (39%) find out about volunteering opportunities through family and friends and that 58% of people get involved with voluntary work because they are asked; (Ruddle & Mulvihill, 1999) which has implications for maximising voluntary activity by older people.

According to a recent US study, 68 percent of older people said that their main reason for volunteering was a desire to contribute to

society. An AARP survey found that the two most commonly given reasons for volunteering among adults ages 45 and older were to make life more satisfying (58 percent) and out of a sense of personal responsibility to help others (65 percent). Gaskin and Smith (1997) found additional reasons why people decide to volunteer; 36 per cent saw it as a way to make new friends; 34 per cent got satisfaction from seeing the results of their work; 29 per cent as way to stay active; 24 per cent volunteered for the experience gained; 18 per cent for the social recognition they gain in the community, and 18 per cent because of religious or political values. The reasons for not volunteering were: lack of time (41%), never having been asked (28%), and never thought about it (18%) (Gaskin and Smith, 1997).

A study of volunteering was carried out by the UK Home Office which found that engagement in informal volunteering is significantly more widespread than engagement in formal volunteering, (William, 2001, p.287). The study also found that informal volunteering is higher in disadvantaged areas than formal volunteering, with less than a third of the population in deprived areas involved in formal voluntary activity. This suggests that formal volunteering is more characteristic of the volunteering culture in affluent areas than disadvantaged areas.

Although older people should not be regarded as a homogenous group with identical motivations some research has found that there are differences between the motivations of older volunteers and those of younger volunteers. For example, Omoto et al. (2000) found that while older volunteers were more likely to be motivated by service or community obligation concerns, younger volunteers tended to be motivated by concerns related to interpersonal relationships.

Research has found that the most common reason for volunteering among older people is the social aspect of volunteering and the desire

to make a contribution to their community or society. Recruitment and retention strategies in voluntary organisations need to be based on an understanding of what people are seeking from their volunteer activities as well as what might be preventing them from volunteering. Older people frequently wish to use their skills or share knowledge, to learn, develop new skills and be intellectually stimulated, or to feel good or feel needed. The most common barriers to recruitment of potential older volunteers are health problems, work commitments, full schedule, and lack of time (Petriwskyj 2007).

5.7.4. Promoting Volunteering

Despite the beneficial effects of volunteering and civic engagement for older people there is evidence that older people are not considered enough as volunteers and their potential contribution discounted, Hinterlong and Williamson (2006) found the talents and capabilities of older people are often systematically discounted because of societal attitudes that can negatively impact individual choices for participation. Demographic change will mean in future that younger and middle aged women, who have commonly been the main source of volunteers for voluntary organisations, will be more likely to be engaged in the workforce. Because older people are more likely to live longer healthier lives for many years after retirement, voluntary organisations will need to consider ways of engaging this age group in order to sustain their voluntary effort in to the future.

In the past decade there has been much discussion of the increasing isolation, disconnection and passivity of civic life developing in our communities. Evidence suggests that older people are more likely to remain involved in the life of the community if they remain in their own homes and are more likely to disengage if they move away at this stage of their lives (Prisuta 2004). This issue is dealt with in greater

detail in the chapter dealing with Age Friendly Communities (Chapter 4). Volunteer Ireland (formerly Volunteer Centres Ireland), established in 2001, is the national body with responsibility for developing volunteering both nationally and locally and now has sixteen centres throughout Ireland. It works to promote volunteering, support the development of sustainable local volunteer centres, promote and develop volunteering best practice and influencing policy in relation to volunteering.

The Volunteer Ireland centres act as brokers in the volunteering context; those interested in becoming involved in volunteering are matched with those who are seeking volunteers. Volunteer Ireland has suggested that it is important for organisations to have clear policies and procedures with regard to volunteers, their training, re-payment of expenses and required commitment. Many organisations have such policies in place, but others have yet to develop them.

The St Vincent DePaul through their extensive membership in every parish in the country offers supports to older people by organising projects such as painting and decorating the homes of older people who can't do the job themselves, and also offer opportunities to older people to become volunteers. Active retirement Ireland is a national network of 500 local associations run by voluntary committees. There are 2700 volunteers in the organisation at national, regional and local levels all ensuring that the members are enabled to lead a full and active life.

Issues Arising

Promotion of volunteering: While the level of volunteering among older people is above the EU average, considerable numbers do not for time reasons or simply because they have not been asked. Much more could be done to engage older people in a broader range of activities, particularly before retirement, or shortly thereafter.

Untapped resource: There is general recognition that older people represent a huge resource of life-skills, empathy and time, and that this resource is under-utilised in relation to addressing many apparently intractable social problems. In addition, older people themselves are often unaware of how they as people can make an effective contribution.

5.8. LEARNING IN LATER LIFE

As people age, they are less likely to participate in formal education, especially in education leading to qualifications. In the past a view existed which held that older people had a reduced ability to learn new things. However in recent times it has been shown that ageing does not diminish adults' capacity for learning and that the brain requires mental exercise and exposure to new experiences throughout life to remain vital (Hill 2000).

The share of adult learners (aged 40 and above) in Ireland is one of the lowest in the EU at less than 0.5% (Eurostat 2011). The highest rate was seen in countries such as Belgium, Finland, Portugal and Sweden, (5%).

The European Commission adopted a Communication on adult learning, followed by an action plan endorsed by the education ministers of each Member State in 2008. The action plan called for:

- Skills to be upgraded so that potential labour shortages due to demographic changes could be met;
- Action to reduce poverty and social exclusion through the promotion of adult learning to improve skills and personal autonomy;
- Increased participation in lifelong learning, particularly among older workers, as the average working age is likely to rise across Europe in the coming decades. (Eurostat 2011)

There is growing evidence of the benefits of continued mental stimulation in later life with regard to the maintenance of good physical health (Khaw, 1997). Recent neurological research also suggests that mental training in later life can boost intellectual power, assist in maintaining mental function and help to reverse memory decline. (Kotulak, 1997). In fact evidence shows that there are four factors linked to retention of mental agility: (1) education level, (2) strenuous activity, (3) adequate lung function, and (4) the absence of chronic disease (Singh Kalsa, 1997).

Research carried out by the Institute for Public Health in Ireland - *Health Impacts of Education* has also identified a link between lower levels of education and poor health and showed that taking part in some form of educational activity helps keep body and mind healthy and active (Higgins et al., 2008). Education can also help to combat social isolation and help older people face change in their lives and communities (Mercken, 2004).

Participating in learning also provides many intrinsic rewards for older people. Successful participation in educational and learning programmes can reinforce a sense of self-efficacy for older adults (Mehrotra, 2003, p651) as well as enhancing quality of life, increasing motivation, coping skills, maintenance of independence and gains in knowledge. As the number of older people increases and people live longer, developing and implementing strategies for maintaining cognitive health should be a priority for both individuals and societies (Butler 2004).

5.8.1 Needs and Motivations of Older Learners

There is a wide gap in the educational attainment levels of younger and older people in Ireland. Older people in Ireland were disadvantaged through the absence of free

secondary education (until 1967). Over 50% of the 75 & over age groups had only attained primary level or had no formal education. This compared with only 13.2% of those aged 25-64. Only 16.5% of the over 65s have completed third level education, compared to 42.4% of the younger age group (CSO 2007).

In challenging economic times, and following from recent pension reforms, older adults may find themselves needing to stay in the workforce for longer or return to the workforce during retirement to make ends meet. Approaches to learning for older people will have to take account of the fact that some older people may wish to return to education in order to up-skill before re-entering the workforce or pursuing a new career path by improving their computer skills or taking language classes.

Irish research which involved older and younger students in the Waterford Institute of Education looked at the motivations for learning among older people. It found that personal development and making up for lack of opportunities in the past was one of the main reasons for participating in education. Many also participate for social reasons whereas the younger students participate predominantly to enhance their career prospects. Participating in education for instrumental reasons, such as career advancement is less important to older learners. Some of the older men who participated in the Waterford research study were pursuing higher education qualifications to enhance their careers while the majority of older women said that they would be pleased to gain employment after their studies but did not pursue education for that reason (Bunyan 2005). This confirms earlier research which found that older women are more likely to return to education for personal reasons whereas older men are more likely to pursue job-related qualifications (Scala, 1996).

Research carried out in the UK found that the most important reasons for learning were

intellectual. Learners reported wanting to increase their knowledge, to keep their brain active, to enjoy the challenge of learning new things and to learn about something they had always been interested in. The second most important group of reasons were personal. People wanted to gain qualifications for personal satisfaction, to do something with their time and to take their life in different directions. Finally, instrumental reasons, such as having to do some learning for work, to help the family and to help with voluntary or community work were less important (Dench 2000).

5.8.2 Barriers to Learning

Identifying the barriers to participation in educational courses is an important part of the process of promoting opportunities for learning among older people. In the UK research found that the most commonly reported reasons for not learning were a lack of time and a lack of interest in learning. A quarter of non-learners said they had done enough learning in their life and 22 per cent felt they were too old to learn. Seventeen per cent reported that a health problem or disability made it difficult for them to learn. Having a disability or health problem can limit activities in many different ways. For example, some people have limited mobility; others have difficulties with communication, limited energy or are unable to look after themselves (Dench 2000).

In general, barriers to education are defined by Cross (1981, p.98) as dispositional, institutional and situational. Dispositional barriers are *“related to attitudes and self-perceptions about oneself as a learner”*, institutional barriers are of *“all those practices and procedures that exclude or discourage working adults from participating in educational activities”* and situational barriers are *“those arising from one’s situation in life at a given time”* (Cross, 1981, p.98). More recent research (Slowey 2008) describes attitudinal barriers as including perceptions about a lack of ability to learn among older people, lack of

education when younger, lack of confidence, interest and motivation, wanting to rest, or avoiding new commitments after a lifetime of work, and fear of technological failure.

Situational barriers highlight personal factors which are beyond the learner’s control and are related to the individual’s life situation at a particular time. These include issues such as time scheduling, illness, hearing, vision, fatigue, and impaired memory, fear of leaving home, language problems, financial costs and lack of time due to child care or elder care. Institutional barriers consist of various organisational practices and procedures which discourage adults from participation in adult education (Slowey, 2008).

Adults’ expectations about the learning process are usually based on former educational experience (Rogers, 1996). In research carried out in Waterford (Bunyan 2005) older adults identified attitudinal barriers as being significant and stemming frequently from negative memories of former education. Older adults had reservations about entering the classroom again and some found that these negative feelings are a significant barrier to learning. Some of their tutors also identified confidence is a major barrier to learning as the older students who are more relaxed are more willing to question and will therefore learn more. They also noted that fear of failure is a major issue with the older learner. Additional barriers identified include practical difficulties such as note taking and multi-tasking, for example, taking notes while listening to the tutor.

AONTAS, the National Adult Learning Organisation, conducted research on the preferences of older learners. Stakeholders contributing to the AONTAS report (*The Lifelong Needs of Older People in Ireland*) revealed that one of the greatest barriers to participation for older people was ageism, which, it was felt had been internalised by older people and had the effect of preventing many older people from engaging in social or educational activities.

AONTAS (2007) also identified difficulties with literacy levels as contributing to a lack of confidence among older people about taking part in any form of learning including creative, sporting and recreational activities. Their study also identified institutional barriers such as the use of entry criteria which are labour market focused and geared towards up-skilling and employability. AONTAS produced a further report in 2008 which built on the findings of their discussion paper (2007) and was funded by Age & Opportunity's Get Vocal programme.

5.8.3. Approaches to Learning

Older adults' preferences in learning styles vary greatly and range from reading classes and class-based learning, to workshops, seminars, and discussion meetings, and an increasing number of people also show a preference for distance and internet-based learning. (Slowey 2008).

The AONTAS research also found that older learners learn differently from other age groups and often learn better from other older people or in groups of their peers rather than intergenerational groups. Certain courses and computer skills training in particular are considered more suitable to undertake with peers, as it can build confidence to be surrounded by people of the same generation, who learn at the same pace. For other courses, however, such as creative, sporting and recreational activities, an intergenerational setting may be more appropriate (AONTAS, 2007).

Throughout the world a number of different approaches have been developed to meet these needs including Universities of the Third Age [U3A], Elderhostels, and Institutes for Learning in Retirement. The Elderhostel movement in the US provides travel opportunities combined with education. Learning opportunities are usually provided through week-long, low-cost, non-credit courses by academics on academic campuses (Stephan et al 2004, Baires 1996). The

Institutes for Learning in Retirement (ILR), also US-based, are organisations affiliated with a college or university which offer college-level courses with members responsible for all aspects of curriculum design, instruction and administration (Nordstrom 2002, Manheimer et al 1995).

The first University of the Third Age was developed in France in 1972 and in 1981 the British version of the U3A was established in Cambridge. This model is based on 'self-help' and 'self-sufficiency' (Laslett 1996:228) and is not usually affiliated with traditional education institutions. There are neither academic admission requirements nor examinations and a key principle is that...*'The university shall consist of a body of persons who undertake to learn and help others to learn. Those who teach shall also learn and those who learn shall also teach'* (Laslett 1996:228).

The British U3A and the ILR are both based on peer teaching and the self-help philosophy and there are now U3A universities in Australia, New Zealand and South Africa. The Universities of the Third age are generally administered by older volunteers who manage, teach and administer the courses with minimal operational costs (Swindell 1999). The peer teaching aspect allows members to take an active part in teaching on a voluntary basis keeping membership costs affordable for all.

In Ireland the U3A (University of the Third Age) is a project within Age Action Ireland. Each U3A group is organised as a self-help learning cooperative with a focus on learning not for qualifications but for fun. It draws on the knowledge, experience and skills of its own members to organise and provide interest groups at a time and place convenient to all.

Age & Opportunity has an ongoing partnership with the UCD Equality Studies Centre based in the School of Social Justice. A new modular course commenced in 2010,

introducing students to the practice of equality-based action for social change.

Issues Arising

Implementation of Policy: Ireland has one of the lowest proportions of people aged over 40 participating in education (0.5%) and although the White Paper on Adult Education prioritised lifelong learning, many of the key recommendations made in the paper have yet to be put into practice. In fact there is no policy and implementation plan. Funding for adult education activities and services has tended to be focus on preparation for the workplace, and currently stands at just under 2% of the overall annual education budget.

Limited opportunities: There are insufficient opportunities available to allow older people to learn alongside their peers, despite evidence suggesting that older people often learn better from other older people, and are therefore more likely to take part in such learning.

5.9. INFORMATION TECHNOLOGY

Technology plays an increasing role in enabling people to interact with each other and to access information and services through the internet. For older people technology can play a vital role in their daily lives in monitoring their health, creating social networks and increasing engagement in society. The use of technology can also facilitate social inclusion, improve their professional engagement and quality of life and ultimately enhance independent living.

5.9.1. Levels of ICT Use

Older people are less frequent users of computers than other age-groups. EU statistics showed that in 2010 around 17 % of the EU-27's population aged 65 to 74 made daily use of the internet; this share was 36 percentage

points below the average for all age groups. The most common activities carried out by persons aged 65 to 74 included: sending and receiving e-mails; finding out information about goods and services; seeking health information; and reading online newspapers or news websites. (Eurostat 2011)

A similar gap in usage rates was revealed by CSO data which found that computer and internet usage rates in 2007 for those in the 16-49 years age range were 61.8% (computer use) and 57.5%, (internet use), compared to 18.0% and 14.3% for those aged 65 to 74 (CSO 2007). Those in the 50-64 age-group were more frequent users with rates of 37.9% and 31.7% for those aged 50 to 64. The average internet users spends almost one hour a day online; again the figure is higher among younger users (as high as 9 hours a week for under 25 year old males, but only 3 hours for those over 65 years).

Interest in social media is still relatively low among older people, although Facebook advertising information revealed that there had been a significant increase in older facebook users between 2008 and 2009. Although coming from a low base (0.5%) the increase to 2.7% is an indicator of a growing familiarity with IT among older users. The increase in the UK went from 0.85% to 4.1% while in the US it jumped from 0.57% to 7.5% (CIA 2008 World Yearbook).

One area where internet services could be particularly useful for older persons is in services that allow them to avoid carrying out daily tasks such as shopping or dealing with a bank. EU statistics found that, of those who use the internet, 48% of persons aged 65-74 years made use of internet banking, compared with a 52% average for all internet users (16-74 years), while 46% of older internet users made online purchases, compared with a 57% average. A higher than average proportion of internet users aged 55-64 booked travel or holiday accommodation online. This data supports

earlier findings from a survey carried out by Age Action Ireland and the Work Research Centre which also revealed an age-related divide and the findings of several international studies (Lloyd and Hellwig 2000).

5.9.2. Benefits and Barriers

There is general acceptance that the use of IT and the internet is of benefit to all people but has the potential to be of particular benefit to older people. For example, internet-based communication with other people is convenient and affordable and can provide older people with important links to family and friends, particularly in times of increased emigration. Access to medical or health information can relieve anxiety. Online shopping, banking, or learning are effective ways to overcome physical handicaps and also offer the advantage of facilitating shopping around to purchase cheaper goods and services online. Research confirms the benefits to those experiencing increased vulnerability as they age. In residential care situations, for instance, computer-learning programmes were found to be positively linked with skills and confidence in spite of older adults own health perceptions (Timmermann, 1998).

An Australian study looked at predictors of technology use and sought to build a picture of the type of person who is most likely to engage with technology. They found that technology users tended to be those who have a positive, self-motivated engagement with life and an ongoing interest in future goals, either in pre-retirement or early retirement age groupings. They also found that well-educated men were more likely than women to be interested in computer use which is a little different from the predictors for learning generally (Boulton-Lewis, et al., 2006) where being female was linked to greater likelihood of undertaking educational courses.

Barriers to learning about IT are similar to those associated with learning in general such as attitudinal barriers - feeling too old to learn, embarrassed with their lack of abilities, short-term memory loss, declines of manual dexterity and visual acuity (Timmerman 1998 p. 62). In a study carried out in Northern Ireland other attitudinal barriers were identified, including lack of interest in using computers, dislike of computers or unwillingness to see any need for or value in the use of computers. A study of older adults in South England and Wales also found that older people's non-use of computers was due to the perceived irrelevance of ICT in their lives, with 78% of non users stating they had no need, and no interest, in using computers (Selwyn, Gorard, Furlong and Madden, 2003).

There is evidence that age is not the primary factor and in fact Hawthorn's (2007) research found that older people's negative attitudes may be caused by their level of experience with computers. Fear of computer use included a range of anxieties such as a fear of breaking the equipment, losing information, getting viruses and concerns about security online. Ellis and Allaire (1999) found in a sample of older people aged between 60 and 97 that computer anxiety and age were predictors of interest. Similarly, Marquie et. al (2002) found that age-related negative stereotypes, attitudes and lack of confidence also impacted on the ability to use technology.

Situational factors such as transport difficulties, particularly in rural areas and access to computers were also found to be barriers and that irregular access to computers created difficulties in retaining IT skills. Access to classes or other situational issues were also cited. For example the class was too big, the venue was not accessible, the time of the class did not suit, the pace of the class was too quick or the content of the class was not relevant. Physical or health issues were also mentioned along with mobility or dexterity problems, poor

eyesight and concerns about posture while using a computer.

One potential reason for anxiety concerning technology and consequently a potential barrier to adopting it – is that it can be poorly designed for the capabilities of older people. When designing technology for older adults, age-related changes in perceptual, cognitive, and motor systems are important considerations (Fisk et al., 2009).

Older people can experience changes in visual acuity, colour perception, and susceptibility to glare. They may also face greater difficulty hearing high-pitched sounds and experience greater interference from background noise. Coordination difficulties and the onset of disease such as arthritis, can change the way older adults are physically able to interact with technology. Ageing is also associated with general slowing of cognitive processes and decreased memory capacity which may impact on the ability to learn and use technology.

These changes in function can slow performance and result in a greater number of errors as older adults interact with technology that was not designed with their capabilities in mind. However by designing with older users needs in mind designers can create better products for older adults (Charness and Boot 2009). For example, interfaces should place minimal demands on working memory and supports such as reminders or navigational aids should be provided (see Fisk et al., 2004).

Selwyn (2004) suggests that one important option to improve this situation is to involve older people in changing IT, and IT education to become more attractive and useful to them rather than to expect older people to adjust to the complexities of prevailing IT. Older people's participation in the design process can help achieve the requirements formulated by Rogers & Fisk (2006): to meet their needs, match their capacities and be acceptable for

them. The accessibility of websites is also important in order to ensure that older people can enjoy easy access to online information. Elements of website accessibility include: options for increasing text size, avoidance of animation features which may be either indecipherable/ uncomfortable for viewing for those of impaired vision and computer reader features which assist in reading documents on-screen.

It is also important to acknowledge that age related differences in the use of technology may be linked to a generational effect rather than age-related declines per se. Today's older adults have matured in a time when computer technology was introduced, as they grow older, today's younger adults are likely to have very different patterns of prior experience with, and attitudes toward, computer technology.

5.9.3. Approaches to Learning ICT

Research has shown that motivation is one of the essential pre-requisites to learning and has been shown to affect (a) how well existing skills and knowledge are acquired, used, and applied to new situations. (Dweek 1986) If, as the studies referred to above indicate, many older people do not see the relevance or benefit of IT to their lives it is important that any approach to teaching IT to older people address this central concern. Motivational factors should be stressed when designing a learning programme in order to reduce or mediate anxieties associated with computer use. For example the teaching programme could be focussed on practical benefits such as use of a computer to e-mail grandchildren or play computer card games (Chaffin and Harlow).

In designing a learning programme, the particular needs of older people should also be recognised. For instance because ageing causes physiological changes that slow the learning process and sensory changes also impact ability to

learn, older adults need more time to acquire basic computer skills, make more mistakes, and need more teacher support in lessons than do younger adults (Clark, 2002; Nahm & Resnick, 2001).

The teaching method should be problem orientated and instructions should involve carrying out tasks rather than memorizing content (Hendrix, 2000; Jacko & Vitense, 2001). Other research has found that familiar terminology and simple teaching materials as well as time spent on each module and class exercises, play a key role in improving a person's learning ability (Gagliardi 2008).

Several studies have shown that providing supportive training can reduce anxiety about using technologies such as computers (Campbell, 2004; Jay & Willis, 1992). For example, it is important that training is carried out in a relaxed and supportive environment and that sufficient time is allowed so that older people do not feel rushed (Fisk, Rogers, Charness, Czaja, & Sharit, 2004). In fact, a recent study exploring the effects of training and instruction method on the performance of the older learner found that the pace of the class accounted variance in performance and that self-paced classes were most effective for older learners (Callahan, Kiker, & Cross, 2003; Beier and Ackerman, 2005).

There are now a number of initiatives that can serve as models for helping older people to become comfortable with the use of technology in a supported environment of their peers such as the An Post scheme 'Log and Learn' or the Third Age computer courses and internet café. Public libraries can play a role in making computers available widely and with minimal cost to the older user.

It also may be helpful to provide older people with some form of stress training that helps reduce their performance anxiety in relation to computers. This type of training has been shown to result in improved performance

among older adults (Hayslip, Maloy, & Kohl, 1995). As level of belief in the ability to use computers is linked to anxiety about using computers, it is critical to ensure that older people receive encouraging feedback during training and experience some level of success. Interface design can help to reduce computer anxiety by increasing the apparent ease of use of computers (Brosnan, 1999).

Issues Arising

The 'digital divide': Many older people who lack computer skills and/ or access to the internet are effectively excluded from much of the information and services that are increasingly only being offered on-line, such as purchasing of travel tickets.

Disability: Many older people with disabilities face particular challenges in accessing ICTs. This situation is exacerbated by the fact that EU member states are currently applying the provisions of the Disability Directives differently, thus fragmenting the market for accessible technologies.

Access: The markets have tended to overlook older users' ICT needs, with the result that many of the products they develop are overly complex and difficult to use (Charness and Boot 2009). There are few guidelines, voluntary or mandatory standards or related regulatory frameworks in place to improve this situation.

5.10 ORGANISATIONS FOR OLDER PEOPLE

Organisations for older people provide a vehicle for older people to engage with others and to play a role in shaping their communities. There are a range of nationally-based representative organisations and support groups which over the last fifteen years or so have been growing in strength in vocalising the needs and issues of older people in Ireland. They include the following

organisations (this list is not exhaustive): Active Retirement Ireland, Age Action, Age & Opportunity, Older and Bolder, The Care Alliance, The Carers Association, The Irish Senior Citizen's Parliament, The Irish Association of Older People, The National Federation of Pensioner's Associations, The Older Women's Network and the Senior Help Line.

Age & Opportunity has developed a grant scheme called Get Vocal, aimed at enabling older people to contribute to their local communities. One such grant-aided project in Co. Wexford has implemented the ABCD approach in their project design.

5.10.1 Older and Bolder

Older & Bolder is an alliance of eight non-governmental organisations that aims to champion the rights of older people and to combat ageism. They perform the vital function of helping older people to engage as active members of their communities and older people in turn play leadership roles in their own communities as part of these organisations, coming together to have their voice heard on matters of common interest, become part of artistic, sporting or leisure organisations, volunteering, and having opportunities for learning and participating through use of technology.

Older & Bolder represented a new departure in the Irish context in 2006 when, for the first time, a group of five age NGOs, supported by The Atlantic Philanthropies, came together to campaign jointly for a political commitment to a national strategy on ageing. In the run-up to the General Election in June 2007, Older & Bolder conducted public meetings with older people, ran a national advertising campaign and lobbied politicians. The campaign led to the FF-Greens Programme for Government incorporating a commitment to the development of a National Positive Ageing Strategy. The Office for Older People

was subsequently established and work is now ongoing on the development of a National Positive Ageing Strategy.

Older & Bolder has become an alliance of eight NGOs. The member organisations are: Active Retirement Ireland, Age & Opportunity, Alzheimer Society of Ireland, Carers Association, Irish Hospice Foundation, Irish Senior Citizens Parliament, Older Women's Network and Senior Help Line. The aims of the alliance are to champion the rights of older people, to situate older people's voices and perspectives at the heart of Older & Bolder's activities and to facilitate the direct participation of older people in campaigns to secure their own rights and entitlements. Older & Bolder does this by acting as a catalyst for the mobilisation of older people, combating ageism and promoting age friendly public policy and practice.

Older & Bolder conducted two campaigns in 2009. In the run-up to the local and European elections, the "*On the Doorstep*" campaign invited all voters and older voters in particular, to use their opportunity on the doorstep with canvassers to promote meaningful consultation with older people on the development of the National Positive Ageing Strategy. Older & Bolder also carried out a process of consultation with older people between November 2008 and June 2009 (eight regional meetings) to inform older people about the National Positive Ageing Strategy, promote discussion and ensure that the Older and Bolder submission on the strategy was informed by older people's needs and preferences. The second campaign in 2009, focused on protecting older people's basic supports in the aftermath of the McCarthy report, was conducted in the run-up to Budget 2010 in December of last year and revolved around the theme: "*My pension is my shopping, heating, independence, my dignity.*" The State Pensions were not cut in that budget.

The strength of the organizations for older people became apparent in 2008 when well-

attended rallies and vociferous protests forced the government to change their plans to remove the medical card from some older people. The Government was taken aback by the strength and rapidity of the protests and the income limits were revised to allow older people to keep their cards.

Age & Opportunity

Age & Opportunity works to promote greater participation by older people in society. Its most prominent activities include Go For Life, the national programme for sport and physical activity for older people, and Bealtaine, an annual festival celebrating creativity in later life (www.ageandopportunity.ie). The organisation carries out a training programme called AgeWise which aims to raise awareness of attitudes to ageing and older people among public service workers and organisations whose work affects the lives of older people. The programme also encourages action on how ageism may be countered within organisations and workplaces.

Active Retirement

Active Retirement Ireland was founded in 1978 and its mission is to be an attractive and inclusive, membership-led organisation for older people, which supports members to realise their full potential. Active Retirement Ireland works on a two pronged approach- at national level as a voice for older people and at grassroots level as active participants in developing responses to local needs.

With 540 local active retirement associations and a membership of 23,000 our philosophy is based on older people doing things for themselves. These local associations aim to help older people lead a full, happy and healthy life by offering organised opportunities for a wide range of activities that enable older people to become active agents in their local communities.

Each local association plans and delivers a range of social, cultural, learning and physical activities based on what their members would like to do and their ability to participate. These activities include social networking through

- Social activities such as tea dances, evenings out and short breaks;
- Physical activities such as swimming, bowls and walking;
- Cultural visits to museums etc;
- Learning activities such as IT, intergenerational projects, art and crafts.

www.activeirl.ie

Age Action

Age Action is a charity which promotes positive ageing and better policies and services for older people. Working with, and on behalf of, older people the organisation aims to make Ireland the best place in the world in which to grow older.

Age Action's vision is that Ireland would become the first country to apply fully the United Nations Principles for Older Persons into our national way of life in order to improve the quality of life of all older people and to transform all our attitudes towards ageing and older people.

Third Age

Third Age is a national voluntary organisation celebrating the third age in life when people may no longer be in paid employment, but can remain healthy, fulfilled and continue to contribute to society. Third Age, through a variety of local and national programmes, demonstrates the value of older people remaining engaged and contributing in their own community for as long as possible.

Programmes and services are designed so that members have a real say in their development, thus instilling a sense of ownership, responsibility and mutual support.

Third Age plays a role in the championing of older people locally, nationally and internationally in an interconnecting range of initiatives, including the challenge of negative perceptions and the representation of older people at policy-making fora.

- Senior Help Line is a confidential listening service for older people by trained older volunteers for the price of a local call anywhere in Ireland, LoCall 1850 440 444.
- Fáilte Isteach is a community project with older volunteers welcoming new migrants through conversational English classes.
- The Third Age National Advocacy Programme was established in 2008 to provide an independent advocacy service for older people in long-stay nursing home care.

5.10.2 Engaging Older People in Policy Development

Internationally, it is now a widely accepted practice that policy development will be more effective and successful if the process involves consultation and involvement of those who will be affected by the policy and this is similarly true for older people who are the experts on their own lives and needs. In the past, older people have often been marginalised and overlooked in the development of policies that affect them.

Many older people's organisations have argued that it is important that the process in which the views of older people are sought is managed properly in order to ensure that it performs a real function and that it does not become a meaningless exercise. They suggest that it is important that those who are consulted are also made aware of the impact of their contribution through feedback on the actions taken following from the consultation.

- Older people's ability to participate actively in society may be affected by barriers created by society.
- Many older people report feeling that their contributions to the community are unrecognised or undervalued as they experience a loss of independence and personal control.
- Older people are frequently seen as a homogeneous group and negatively stereotyped as being mentally or physically dependent and frail;
- Consultation strategies may fail to maximise the input of older people either because physical constraints prevent them from full participation or because inadequate financial reimbursements for transport or expenses for support of people with a disability may limit their participation. It is important that the timing, format and safety of consultations are also considered.
- Sometimes consultation processes rely on representatives of service providers ('gatekeepers') to speak on behalf of older people. While they may have valuable insights, they do not directly represent older people's perspectives and their voices should not be the only ones to be heard.

Other barriers to effective participation can include geographical and socio economic issues. Transport is of particular importance in rural areas for both facilitating participation and also as a means of social interaction. The nationwide roll out of the Friendly Call Service (which is mainly funded by the HSE) is assisting in the identification of people who have a need for rural transport and can assist with the development of older people's participation in society.

County and City Development Boards (CDBs) are required to engage in local consultation with the community and voluntary sector, but the inclusion of older

people in these processes is not specified. Without a rigorous structure to ensure this inclusion, arrangements vary from one area to another. A report published by NCAOP in 2005, *The Social Inclusion of Older People at Local Level*, assessed the presence of the 'voice' or recognition of the needs of older people in relation to local decision-making structures i.e. the report found that a common understanding of the full range of concerns of older people was lacking; direct actions tended to be in the area of more basic needs such as housing, health and community services, safety and security. The inclusion of older people in CDB strategies pertaining to them was uneven, and the report recommends that this be undertaken in a systematic manner in future.

In the UK, a review of older people's 'Engagement with Government' identified changes needed to ensure that engagement was properly structured and resourced to avoid tokenism. The view was expressed that Older People's Forums were not being used to their full potential. It was felt that older people's groups should have some input into the setting of agendas, and that consultation should be a two way process. In line with this it was recognised that older people's groups require feedback and confirmation that they are being heard and their views appropriately acted upon. Training issues were also raised as people who have not previously had dealings with the public sector may find attendance at council meetings intimidating. Older people may need to develop skills to assist in order to be able to fully contribute to service planning and delivery.

5.10.3 Older People as Voters

There is general agreement that older people vote more regularly than younger people and a number of reasons have been put forward to account for this. Older people are more likely to be registered to vote. This in turn, is linked to the fact that they are more likely to be resident in

their homes for longer, and also are more likely to be better informed about politics which also contributes to likelihood to register and vote. A further factor influencing likelihood to vote is identification with political parties and it has been found that older people are more likely to be supporters or members of a political party (Binstock 2007).

In Ireland it has been found that people aged 65 and over also tend to participate politically in greater numbers than their younger counterparts. In the 2007 general election 88% of voters aged 65 and over voted, compared to a general turnout of 74% of those aged between 18-64 years eligible to vote (CSO: 2007).

There is an assumption among politicians in many countries that older voters base their voting decisions on self-interest and this self-interest is uniformly applied across all older people. As a result there is a growing view that older voters are an important segment of the electorate. One reason for this assumption is that older voters constitute a substantial proportion of the voting-age population and tend to vote at a higher rate than younger age groups. As a broad group therefore, they are potentially a very powerful and influential political lobby.

However this assumption has been questioned in research carried out by Binstock (2000). He found that old age is only one of many personal characteristics with which older people may identify. He argued that even if some older voters do identify themselves in terms of their age, it does not necessarily follow that it is the main factor in determining their voting behaviour. This view was supported by Walker who stated that "*age is only one of several forms of socio-political consciousness such as socioeconomic status, race, gender, religion and locality*" (Walker, 2006, p. 350).

Similar research carried out in Germany and Britain rejected the notion that older people

would block any political changes likely to impact on them by voting as a homogenous group. It also found that age is only one of many personal characteristics with which older people may identify and it is these differences, such as an individual's experience of politics in their formative years or their socio-economic background, which account for the differences between the voting behaviour of older or younger voters (Goerres 2009).

An international study analysing surveys from 41 countries in Europe, Latin America and Asia supported the view that socio-economic wealth and education are usually more important than age in determining voting behaviour. In general, the wealthier and better-educated people are, the more likely they are to vote, be interested in politics, and have a positive attitude about democracy. The difference is most marked in established European democracies, where the most educated older people's interest in politics is 38 per cent higher than for the least-educated older people (Lagos and Rose 1999).

Despite evidence which supports the view that older people are a diverse group with different voting intentions and interests, a survey of Australian older people found that only 50% agreed with the statement *"Ageing/older persons' issues don't affect the way that I vote."*

During an election in which the major parties made significant efforts to capture the 'silver vote', research found that in the case of marginal seats with a high proportion of older voters there was some evidence that a critical number of those older voters were convinced to change the way they vote compared with the previous election. The campaign strategists for the main parties revealed that many of their proposals were aimed at the potential 'silver' swing voters who had the potential to tip the balance in the marginal seats (Borowski, et al 2008). This suggests that when politicians specifically target older voters in their election manifestos and put forward proposals aimed at

persuading them to vote in a particular way, age can have an impact on voting behaviour.

5.10.4 Examples of Programmes to Promote Active Citizenship

There have been a number of different initiatives to encourage active citizenship. One example is 'Fáilte Isteach' run by the Third Age Foundation. It involves older people volunteering their time to teach conversational English classes to non-Irish nationals from all over the world. The programme is run by over 200 volunteers on a nationwide basis.

The most significant impact of the Fáilte Isteach programme is the improved level of integration that it has helped bring about for the newcomers who now have friends and contacts to which they can turn in time of difficulty or stress. They are made to feel part of the community and feel welcomed and understood. Local employers have recognised the value of the volunteers' contribution and have sent some of their staff along to improve their language skills.

The SVP has expanded their range of activities recently and is now involved in a wide variety of support projects, including tackling rural isolation and assisting older people in enhancing their involvement in local communities. One example of this is the community centre for Older People in Lixnaw, County Kerry. Some Conferences (Units of SVP) also participate in Rural Transport Initiatives to facilitate access to other non-Society goods and services in remote rural areas. A significant cohort of SVP membership is older and they play key roles, both in their communities visiting people in need and in senior voluntary positions within the Society.

Atlantic Philanthropies is piloting a range of grants schemes for older people to be channelled through some of the key actors in the sector. Part of the funding is a small grants scheme which is administered by Age and

Opportunity, whilst another part will focus on the encouragement of participation and promoting the voices of older people. Age & Opportunity's Get Vocal project works to build capacity for advocacy amongst local groups working closely with partnership companies and the community development sector and encouraging relationship-building with the statutory sector.

5.10.5 Political Priorities

Although older people are more likely to vote in local and national elections than younger age groups (CSO 2007), it is not clear how far the main political parties have prioritised their concerns and needs. The 2011 Programme for Government made the following commitments in relation to older people

- *"We will complete and implement the National Positive Ageing Strategy so that older people are recognised, supported and enabled to live independent full lives."*
- *Local Authorities will be required to establish Older People councils, where members of the community can raise local concerns or issues of importance.*
- *We will support older people in living in their own homes and communities for as long as they wish and will facilitate this by ensuring that the eligibility criteria for the home help and the Home Care Package Scheme are applied consistently. We will also develop and implement national standards for home support services which are subject to inspection by the Health Information and Quality Authority.*
- *We will reform the pension system to progressively achieve universal coverage, with particular focus on lower-paid workers, to achieve better risk sharing, and to provide for greater flexibility for those who wish to retire on a phased basis.*
- *Investment in the supply of more and better care for older people in the community and in residential settings will be a priority of this Government.*
- *Additional funding will be provided each year for the care of older people. This funding will go to more residential places, more home care packages and the delivery of more home help and other professional community care services.*
- *The Fair Deal system of financing nursing home care will be reviewed with a view to developing a secure and equitable system of financing for community and long-term care which supports older people to stay in their own homes.*
- *Within the Health capital budget, the immediate priority areas will be primary care centres, step-down and long-term care facilities, and community care facilities such as day centres for older people."* (Programme for Government 2011)

Issues Arising

Stigma: Many older people's organizations argue that there is a stigma involved in identifying with older people's issues, which can affect anyone speaking as an older person on older people's issues. As a result these organisations find it difficult to attract talented people with a strong track record in achieving change.

Weak Voice of Older People: While there are a number of national older people's organisations with a strong track record in campaigning on older people's issues and lobbying for change, the national voice of older people remains relatively weak in comparison to that of the disability sector, for example, or lobby groups on women's issues.

Engagement in Politics: While older people have a higher than average rate of participation in the democratic process (86.3% of eligible people aged 65 and over voted in the May 2002 General

Election), the political parties have tended not to prioritise older people's issues or invest significantly in developing appropriate policies.

Barriers to political engagement: The evidence shows that physical barriers such as health or disability can act as deterrent to voting.

5.11 ARTISTIC AND SPORTING ACTIVITIES

Engagement in the arts, culture and sports at any age pays dividends in relation to both mental well-being and physical health. The benefits of engagement in these activities can include a sense of well-being, friendship, development of creativity, increased social interaction, and increased physical and cognitive health benefits.

Research has suggested that engaging in creative activity has benefits for psychological well-being through an increase in social interaction among older people (Wikstrom-Britt 2002). Evidence of the value of participation in the arts was found in a study carried out by Matarasso (1997) which identified the effects of participation such as increases in people's confidence and sense of self-worth, increased involvement in social activity/reduced isolation, encouraging self reliance, facilitating health education and building social capital.

The mechanism by which such involvement translates into changes in health has not been fully explained. However evaluations of five community-based art and health projects in various parts of England indicate that participation in community arts projects may lead to less visits to GPs particularly for depression, and a reduction in medication usage. In these studies, participation in art projects also helped people feel 'part of a team' and reduced social isolation (Everitt and Hamilton 1997).

The arts are an area in which older people are often revered as masters of their craft. This is particularly true in areas such as sean-nós singing in Ireland, but is also generally true for the visual arts, as well as for musicians and writers. In a discussion on late-life creativity, commissioned by Older and Bolder Professor Des O'Neill highlighted the abundance of artists and musicians who created some of their most memorable and innovative works in late life.

Painters such as Monet, Rembrandt, Picasso, Miró and Titian, and musicians such as Handel, Haydn, Bach, Schütz, and others created some of their most innovative works in later life, according to Professor O'Neill. Evidence of late life creativity in Ireland can be found in the unique and striking tapestry by Louis le Brocquy, in the National Gallery of Ireland, which was created in his 82nd year. Professor O'Neill also presented evidence of achievement in late life from a range of other fields including architecture (Frank Lloyd Wright who started designing the Guggenheim at the age of 73), politics (the considerable political achievements in later life of Churchill, de Gaulle, Mannerheim and Reagan), business (Warren Buffet) or the commerce of popular music (the considerable success of Leonard Cohen's recent oeuvre, estimated to have raised \$9.5 million in his 2009 tour). (O'Neill 2011)

The Bealtaine Festival, organised by Age & Opportunity, is designed to encourage older people to become involved in a range of arts activities. In 2009, approximately 57,000 older people took part nationally, with the assistance of 400 organisers. Partners included the national cultural institutions, public libraries, co. council arts offices, and regional arts centres as well as local community groups and care centres. Activities include all art forms including theatre, literature, dance, drama, film, storytelling and music.

In an evaluation of the Festival published in 2008 (O'Shea and Ni Leime) it was found

that the involvement of older people in creative activities is a key factor in adaptation to ageing. Research has found that involvement in the Festival strengthens self-confidence, morale and improves psychological outlook, contributes to physical health and enriches relationships through greater social connectivity. Eighty six per cent of participants in the Bealtaine Festival agreed with the statement '*Engagement in Bealtaine has improved the quality of my life*'.

The research also found that the festival is beneficial for communities and that involvement in local arts projects is a popular way of integrating into the community and extending social networks. The evidence suggests that greater involvement with the community has helped break down barriers between old and young and between those in residential care and the wider community.

Having an outlet for social connections enriches the experience of ageing and provides hope and expectation. Eighty seven per cent of participants agreed to the statement 'Engagement in Bealtaine has increased my level of involvement in the community' (O'Shea and Ni Leime 2008). This also counteracts indirect discrimination against the participation of older people, through lack of targeted initiatives, where arts policy to date has focused on certain groups like children and young people.

Music is often used in reminiscence work with older people. Musical memory is said to be one of the last areas of memory to be lost and it can help provoke happy memories and social interaction amongst older people. The development of music therapy is relatively embryonic in Ireland still, though some hospitals and rehabilitation units now employ music therapists.

5.11.2 Examples of Arts Initiatives

Age & Opportunity, in conjunction with the Midland Health Board and Laois County

Council, pioneered a programme, Arts in Care (now called Creative Exchanges) which provides training to staff employed in residential care units to promote engagement in the arts for older residents. This course is FETAC accredited and enables the staff to develop skills in the implementation of arts into their work with residents. This programme has now been extended to include staff in care settings, not only residential units.

There are many other arts and community arts initiatives throughout the country aimed at older people, such as community choirs, drama groups and art groups. 'The Combined Choir', run through the Summerhill Active Retirement Group, is a choir for local older people, Travellers, and some residents of a local residential unit for older people.

Many theatres have promotional opportunities for older people (for example in Dublin the Abbey, the Gate, the Irish Film Institute offer performances at reduced rates, or for free). The Irish Museum of Modern Art (which has a long-standing partnership with Age & Opportunity) has a long-established Older People's Programme which is part of their Education and Community Programme. This programme was evaluated in a report entitled 'Even her nudes were lovely' (IMMA/NUI Maynooth 2000), which illustrates the success of the programme as having a transforming effect on participants. The National Gallery has a programme 'Art for All Ages', which is organised as part of its Education and Outreach Services and aims to encourage creativity and life-long learning. Up until recently the programme comprised of week-long events in May, September and February. It will now be expanded and enhanced to include a monthly event for older people interested in learning more about the Gallery and its collection.

As the result of collaboration between Age Action and Galway City and County Councils, an artist-in-residence was identified to work

in nursing homes in the Galway area. Reading groups have generally become very popular, and they generally tend to attract more mature readers. Some groups cater for older people specifically (LV Book club in Cork for example). The availability of book groups tends to depend on the librarian in situ in any particular library.

5.11.3 Sports and Leisure

The physical benefits of sport and physical activity are known to be beneficial for healthy ageing. Research has shown that a regular exercise programme can slow down or prevent functional decline associated with ageing and improve health among older people. The benefits for those who regularly take part in endurance, balance and resistance training programmes include improved muscle mass, greater energy levels, cardiovascular fitness, muscle strength, and overall functional capacity (Lemura, 2000).

Studies have also found that aerobic fitness may also help maintain good cognitive function in older people. The brain gradually loses tissue from the third decade of life onward and this is associated with a gradual decline in cognitive performance. A study which examined the relationship between aerobic fitness and brain tissue density in older people found that losses in brain densities were substantially reduced as a function of cardiovascular fitness. (Colcombe et al 2003). More recently a review of eleven studies of aerobic physical activity programmes for healthy people over the age of 55 years found that of these 11 studies reported that aerobic exercise interventions resulted in increased fitness of the trained group and an improvement in at least one aspect of cognitive function. The largest effects were on cognitive speed, auditory and visual attention (Angevaren et al 2009).

The Irish Sports Council and Age & Opportunity's Go for Life programme commissioned a report on physical activity and

sport in 2007. It found that 37% of older people participate in sport and recreational physical activity regularly but only 15% are 'healthily active'. Fifty eight per cent are classified as having a sedentary lifestyle and those who were least likely to participate were those who were 'disconnected' from social club membership, had lack of internet access, and their location posed a difficulty (either urban or rural). The conclusion is that those older people most in need of opportunities to engage in physical activity or sport may also be the most difficult to reach.

The report made a number of additional recommendations in relation to the communication of messages to older people: that walking is 'enough', that just doing household chores or gardening is not sufficient for healthy activity which requires intensity and duration and that reaching out to 'disconnected' older people who may lack the opportunity or ability to access current programmes is important.

5.11.4 Examples Of Sports Initiatives

The Irish Sports Council funds 'Go for Life' (referred to above), the national programme for sport and physical activity for older people, administered and run by Age & Opportunity. Under this programme Age & Opportunity work in partnership with other relevant organisations (such as the HSE and local sports partnerships) to promote increased involvement in physical activity and sport amongst older people. Its work is based on the following three strands:

- The Leadership programme which offers workshops to older Physical Activity Leaders (PALs) aiming to promote greater participation by independent older people in all aspects of health-enhancing physical activity and recreational sports including planning, organising and leading. Approx 1,300 active PALs lead groups in physical activity around the country on an ongoing basis.

- The National Grant Scheme which assists local clubs and organisations for older people to increase physical activity opportunities for their members. The allocation in 2009 brought to 5,160 the number of grants made, totalling almost €3 million under this scheme over the past nine years.
- The Irish Sports Council's Engagement Unit assists in the development of local sports programmes including an initiative called '*Sports for Older People*'. The Unit provides support and assistance to the Local Sports Partnerships (LSPs) in the form of strategic guidance documents, quarterly workshops and ad hoc support assistance.

Waterford Institute of Technology runs a physical activity programme called the Activity in Care Training Programme (ACT) aimed at older people in residential and day care. This programme trains staff to safely deliver physical activities in these settings. It was initiated by Waterford Institute of Technology in collaboration with the (HSE) Health Promotion Unit in the South East, and Age & Opportunity.

Other examples of innovative approaches being taken around the country include:

- A programme run by Dublin City Council entitled '*Passport for Leisure*' aimed at people over 55 years. For a nominal fee (€5) participants receive vouchers and discounts, and free access to Dublin City Council sports, leisure and recreation facilities including a couple of public golf courses.
- There are two adult gyms aimed at older people in Ireland in Dunshaughlin, and another in Galway.
- The Extend programme, recreational movement-to-music classes for men and women over 60, has recently been introduced to Ireland.
- Dance Ireland includes older people in its outreach initiative for older people. 'Macushla' is a free dance club for residents of North Inner city Dublin which has 300 active participants.

Issues Arising

Arts: While the success of initiatives such as Bealtaine prove a high level of interest among older people in participating in the arts, the Arts Council and others could do more to promote the engagement of older people as participants or audiences in the arts.

Sports: Recent Irish research found that 37% of older people participate in sport and recreational physical activity regularly, but only 15% are 'healthily active'; while 58% have a sedentary lifestyle. While the Sports Council and the 'Go for Life' programme have been very active in seeking to increase the participation, it is still the case that their needs are not sufficiently taken into account in the development of community sports facilities and public spaces.

Conclusion - Key Issues

In conclusion, the key issues to be considered in relation to the promotion of greater engagement among older people include the need for a new approach to ageing, barriers to greater engagement, and the areas in which older people can become involved in the lives of their communities.

New Paradigm Required

There is general recognition that older people represent a huge resource of life-skills, empathy and time, and that this resource is under-utilised in relation to addressing many apparently intractable social problems. In addition, older people themselves are often unaware of how they as people can make an effective contribution.

One of the key 'gifts of longevity' is that it provides for the first time in human history a very large cohort of people with experience, wisdom, time and capacity, seeking 'life with purpose and fulfilment' that allows a blend between social, economic or cultural contribution, leisure, personal development and family commitments. There is a need for a shift in thinking, in culture, in social institutions and public policies, a whole new way of defining this group, and a new language to herald the changes.

Effectively there is a need to develop a new stage of life, a new map of life fitted to the new length of life and to the particular circumstances of the 21st century. Marc Freedman talks about the opportunity to *"make a monument from what used to be the 'left over' years, a second chance for people of all stripes to ascend the ladder of contribution and fulfilment"*.

There is a need to also create the opportunities for this group of people to engage - to play meaningful roles, shaping and improving the lives of their own communities, in ways that recognise and appreciate the value of such contributions.

Barriers

There are a number of factors that act as barriers to the full participation of older people or their exclusion from much of societal engagement. Ageism and ageist attitudes and assumptions, can limit older people's opportunities to play their part in organisations or activities. Analogies with the women's movement can be seen - where the prevailing culture and assumptions are that age (like gender) is a limiting factor, negatively associated with loss, deficit and decline. Like sexism, these views are often internalised with self-limiting consequences. However as Dr Maureen Gaffney argues, age is increasingly an empty variable in terms of explanation and an empty variable in terms of planning good policies.

Age discrimination.

While there have been many improvements in the area of age-related discrimination, there are still many areas in which age instead of capacity determines entitlement. Examples include Driving fitness Assessment by doctor, retirement, insurance etc.

Abuse:

There is growing awareness of the level and types of abuse against older people - financial, physical and psychological. Quite often it is not recognised as abuse by the person doing it or the older person and they may be reluctant to report abuse because of concern about familial relations.

Loneliness & Isolation:

Data from TILDA and other studies are very disconcerting and worrying about the extent to which many older people lack contact with others. It is important that research identifies best practice in addressing both social and emotional loneliness.

Technology:

While the number of older people using new technologies such as email, mobile, ipads etc, Skype, has increased, there are a large enough number excluded from a world in which access to information and services is increasingly by internet and mobile technology etc.

Enablers

There are a number of factors that significantly increase participation;

Political engagement: There is a strong group of NGOs in Ireland which have done much to raise the profile of older people's issues and draw attention to the many opportunities of an ageing population and to get their voices heard and represented at the decision making tables. There is also a potential 'tipping point' happening internationally with institutions such

as WHO, UN, and EU waking up to the need for a new approach to ageing issues. However, in Ireland issues relating to older people are seldom priority areas in manifestos or Programmes for Government. In effect it is only when a government seeks to remove an entitlement, as happened on the issue of the Medical Card, did the protests of thousands of older people, alert us to the potential 'silver power'.

New Social Roles and Models:

There is a strong tradition of volunteering and the TILDA data shows that one in five older people do voluntary work once a week or more. We need to invent new opportunities and structures to enable older people participate and contribute in ways that are meaningful to them and important for the wider community.

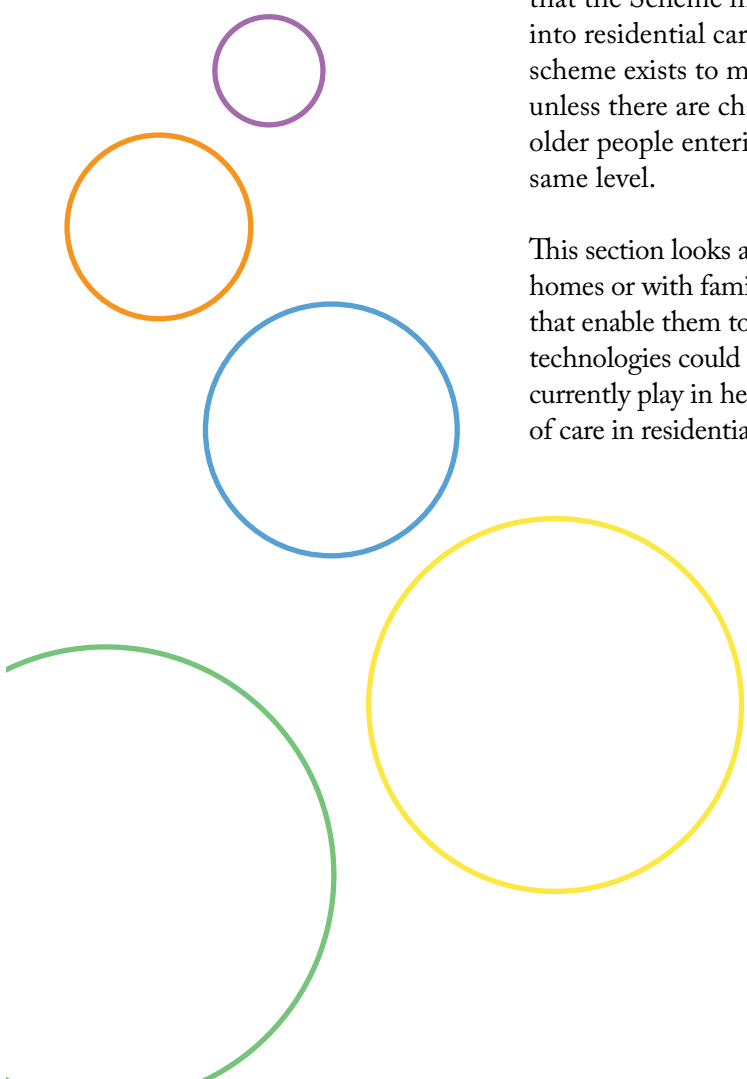
Chapter 6.

Home

Consultations with older people have consistently shown that older people want to be able to stay living at home. At present 4.5% of the older population are living in long-term residential care. There is some evidence, backed by the views of many professionals working in this field, that this percentage could be reduced with the provision of adequate home-care and community support.

The Fair Deal Scheme was designed to provide the most frail and dependent older people with the financial security to ensure that their nursing home care would be affordable. However there is some evidence that the largest cohort using it is those who can't access adequate home-care provision and that the Scheme may effectively be financially incentivising people to move into residential care – despite the significant costs of such care. No similar scheme exists to make the costs of home-care affordable for all and therefore unless there are changes to the structure of the system, the percentage of older people entering nursing homes will either increase or at best stay at the same level.

This section looks at the needs of older people living independently in their own homes or with family members and explores the factors and support structures that enable them to continue doing so. It looks at the potential role that assistive technologies could play and the crucial role that family and informal carers currently play in helping people to remain at home. Finally it looks at models of care in residential settings and the quality standards introduced.



6.1. INDEPENDENT LIVING IN OWN HOME

Longevity rates are set to exert a profound influence on the housing needs of older people and on the design of services that are to meet that need. While older people will constitute a larger percentage of the population, they are also living longer. For many these extra years will be fit and healthy ones during which they can live independently or with minimum support, only requiring support following a crisis such as a fall or the sudden onset of illness. However, just over half of people over 65 years in Ireland describe themselves as having a chronic illness which limits their activities (CSO 2005). This was also echoed in the findings of the 2007 SLAN survey and highlights the need for an increase in the supports for those living at home.

An Irish Hospice Foundation survey confirmed that, for most people, the preferred location in later life was their own home, with only 1% preferring a retirement community and none opting for either sheltered housing or a nursing home (IHF 2009).

Demographic change will mean that today's figures of 400,000 older people living at home is likely to increase to 1 million by 2022, one third of whom will have a disability (Connell and Pringle, 2004). Older householders, and in particular, those over 65 years, are likely to own their homes outright (O Shea 2005).

The 2011 census revealed that 27.7% of older people lived alone. Just over one tenth (10.8%) of older people lived with other family members - two-thirds of these were one parent living with one of more of their children. Women were more likely to be living alone with a total of over 87,000 females living alone compared with almost 49,000 males. This number increased with age with women accounting for almost three quarters of all persons aged 85 and over living alone.

Women were also more likely to be living in nursing homes with 14.3 per cent of all

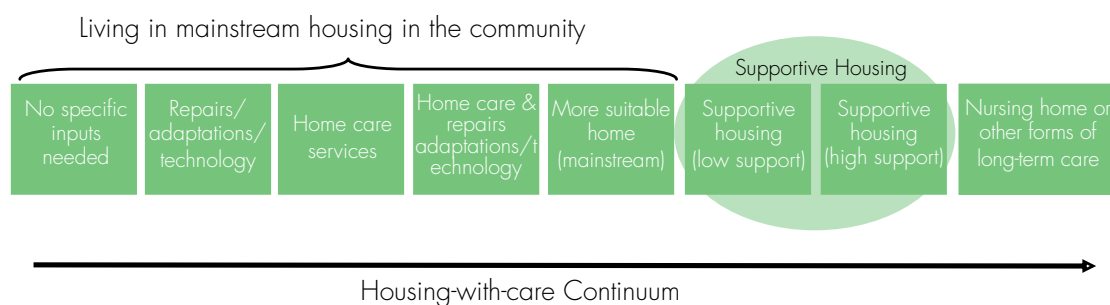
females aged 80 and over living in nursing homes compared with 8.6 per cent of males. The proportion of older people living in nursing homes increases with age. According to the Census report (2012) the percentage of all people aged 80 and over who were living in communal establishments starts out at just over 7 per cent of eighty year olds but gradually increases to a peak of 55 per cent of all persons aged 100. (CSO 2012)

While facilitating older people to live independently in their own homes can have an important and positive impact on their physical and psychological well-being, it is important to remember that home in old age can also be a place of negative experiences, such as isolation and loneliness or poor physical environment of the home and neighbourhood, which undermine the person's ability to live independently.

Research has shown that as people grow older, they spend relatively more time in their homes; on average, very old people tend to spend 80% of their time at home (Baltes, et al 1999). The conditions in which people live and the appropriateness of the home environment to the older person's needs are therefore likely to have a big impact on their quality of life and health. In addition, supporting independence amongst older people enables them to remain active members of their communities to the benefit of the society at large; *"well designed, easy to manage, affordable, warm and safe housing is as important to independent living as inputs of care"* (Dwyer et al. 2000).

Strong ties to the home environment are formed as people age, and, as a consequence, preventing relocation can be among the strongest needs of older adults as well as their families (Gitlin, 2003). The concept 'ageing in place' is often used to denote the policy ideal of being able to remain at home while ageing (Cutchin 2003). Environmental gerontologists have suggested that increased attachment to one's community is accompanied by sensitivity to one's social and physical environment, both of which increase

Figure 5: Housing with Care Continuum



Source; The Role and Future Development of Supportive Housing for Older People in Ireland. Cullen et al, 2007.

with age (Gilleard et al 2007). Facilitating older people to live independently can therefore have an important and positive impact on their physical and psychological wellbeing.

Irish people in particular have a strong regard for being assisted to remain in their homes for as long as possible. A recent Eurobarometer report (2008) found that virtually all Irish people were in favour of using public budgets for support services allowing older people to stay longer in their homes - 76% felt that this was very important and 22% felt it was fairly important. This was significantly higher than the EU average of 61% who felt that this was very important. When asked about their preferences for moving house during retirement only 31% of Irish people would consider moving to a smaller house in the same location (compared to almost 60% of Danish people or 57% of Dutch people). Only 4.5% of Irish people would consider moving to sheltered housing, compared to 40% of Slovenians or 24% of Austrians (Eurobarometer 2008).

Prof. Eamon O'Shea (2009) discussed this strong connection between home and self and suggests that home is about connectivity and that we are 'at home' when we have the

capacity to live connected, socially engaged lives. If this connectivity is threatened and people become isolated and disconnected their sense of self is damaged and though they may be living in a nursing home or in some other form of accommodation, they are nonetheless "*psychologically homeless*" (O Shea 2009).

To facilitate the general preference of older people to continue to live in their own homes, we need to focus on the alternatives to residential care (NESF, 2003). This implies a need to diversify in the provision of housing; mixing and increasing housing options according to people's housing needs and blurring the distinctions between categories. For example retirement homes can have elements of supportive accommodation and supportive housing facilities may be on the grounds of a nursing home to facilitate easy migration across housing categories. This blending of options creates a continuum of care (see diagram) where people can move from low to medium or high dependency settings as smoothly as possible.

6.1.1 Suitable Housing

Meeting the demand for independent living from the increasing number of older people

presents a challenge for society, the government and the building industry. If people are to live safe, independent, active lives in their own homes and communities, as is government policy, then the provision of adequate, high quality and suitable housing is essential. Good housing needs to be valued and planned for, so that, as years go by there is a choice of desirable housing with the technological and other supports required to match changing capabilities and needs.

Ireland is unique in having a statutory Centre of Excellence in Universal Design as part of the National Disability Authority. The Centre has an important role on guiding and promoting the achievement of accessibility in the built environment, products, services and ICT. The concept of universal design that caters for people of all ages, rather than focusing on an imagined 'average' user, will benefit all members of a community as it will facilitate mobility and involvement of people of all ages for the duration of their lifetimes.

Older people may often have lived for large parts of their lives in the same house. Evidence from one German study found that the average length of time spent in the same home for people aged 70–85 years was on average 31.6 years in the same home and 50.3 years in the same town (Motel et al. 2000).

Stability of housing can play a role in compensating for or alleviating the symptoms of age-related conditions. For example the familiarity with the interior of a house that develops over a lifetime living in the same home can play a significant part in helping to compensate for vision impairment or for the early stages of dementia (Boerner, 2004).

Activities of daily life (or ADLs) take place in all parts of the home and the design and construction of most housing tends to be based on standardised heights and widths. Because older people, in general, tend to be less flexible, shorter and not as strong as younger people,

housing areas and features which do not take account of these differences will compromise the ability of an older person to remain living independently (Janssen et al., 2000).

The condition and quality of the home can impact on physical and mental health (Thompson, et al 2002). In one German study, substandard housing conditions were found to be linked to restrictions in activity among older people. Older people are especially vulnerable to inadequate heating and cold has been found to be a predictor of poorer overall health status among older people (Windle, Burholt & Edwards, 2006).

The ability to remain living independently in one's home is also impacted by the physical location of the home e.g. within walking distance of a shop, bus stop, church, and close to family and friends. According to a study carried out in Ireland, the location of 22% of older people's homes impacted negatively on their ease of living – this affects around 90,000 people nationally – around 60,000 to a significant degree. If this situation persists and if the proportion of older persons increases, as projected, then as many as 286,880 people could be affected by 2041.

A further 13% reported that the dwelling itself had a negative effect on their ease of living. This suggests a need for raising awareness of the consequences of ageing in an unsuitable house or an unsuitable location, perhaps far from essential services or without adequate public transport. Many people are in their 'home for life' by the age of 40 so therefore these messages should ideally targeted at groups with a very low awareness of the need to plan for ageing such as those in their early 40s. (Skehan and Sirr 2010)

6.1.2 Home Modifications or Adaptations

Older people's ability to live independently can be affected by the design and layout of their

home. Alternatively it can work to limit and in worst case scenarios isolate people, preventing them from living active, healthy lives. Housing therefore needs to be built to 'lifetime' standards and older people need access to the necessary repairs and adaptations to make their homes suitable for living in their later years, especially where they become frail or lose mobility.

There are three different strategies that can be used to change the home environment in order to support and enhance the everyday abilities of persons with physical or cognitive difficulties; home modifications, assistive technology, and other adjustments such as removal of potential obstacles and barriers (Gitlin, 2009).

Injury in the home environment is very common and accounts for around a third of injuries in all age groups and more than half of injuries for people aged 75 and over. (Lyons et al 2009). Older people with age-related functional loss can be vulnerable to challenges or barriers in their homes, such as placement of sinks and bath tubs, heavy doors and lack of handrails (Gitlin et al. 2006). Homes with proper design with fewer physical barriers can ensure that the environment accommodates to the older person bringing about greater self-reliance and independence. Particular areas of difficulty include using stairs, getting in and out of bath, changing bed clothes and DIY.

Many studies have focused on the impact of home hazards on negative health events such as falls (Gitlin, 2003; Oswald & Wahl, 2004). There is evidence of a positive link between home adaptations and a reduction or alleviation of functional difficulties (Gitlin et al., 2006; Oswald & Wahl; Spillman, 2004). Following a series of prevention initiatives a Falls Strategy was published in 2010. (see Ch 3)

As people age therefore, adaptation or modification of housing becomes important to compensate for the loss or reduction of functional capacity. Home modifications can

also increase accessibility and usability of the home for older people (Fange and Iwarsson 2005a, 2005b), as well as increasing safety and reducing difficulties in the ability to carry out activities (Petersson et al. 2007).

A UK study carried out for the Office for Disability Issues (Heywood and Turner 2007) found significant evidence of potential cost savings that can be made for the state by home adaptations and modifications. In particular, they provided evidence of instances where an adaptation removed or reduced the need, either for intensive home care or for the costs of a residential placement. The authors found several ordinary examples where the savings brought about by supplying suitably adapted and equipped housing to seriously disabled people, so that they are able to live independently saved the State money even in the case of a very old person with limited life expectancy.

Heywood and Turner (2007) also found evidence that preventative adaptations could save money. For example ensuring safety in the home could prevent falls, or providing support to a carer could prevent admission to a nursing home. The study also outlined a number of areas where money was spent with no useful outcome perhaps through under-funding e.g. supplying things that do not work or delays that result in an assessment being out of date by the time the equipment or adaptation is supplied. They warned that delays could result in people of all ages developing habits of dependency when they have no choice, which are then very hard to break.

Finally they argued that the benefits of supplying the appropriate adaptations in a timely way could bring about quality of life benefits for the individual as well as financial benefits for the government and argued that even when costs of home-care or costs of home modifications are similar, the modifications are usually better value for money.

For example the cost of providing a carer to help a disabled person use the toilet and wash may be similar to that of installing an automatic toilet and level access shower but allowing a person to remain independent is an additional benefit that cannot be measured financially. They concluded *“for older and disabled people, the choice between adaptations/equipment and other options is a choice between independence and dependence. For Government, the choice is a one-off capital outlay or ongoing revenue costs.”* (Heywood and Turner 2007)

The housing adaptation grant schemes for older people and people with a disability, introduced in November 2007, replaced three separate grant measures - the mobility aids grant scheme; the housing aid for older people scheme; and the housing adaptation grant for people with a disability. According to the Minister for State, each local authority decides the specific level of funding to be directed to each of the various grant measures. However because of funding constraints since early 2012 many local authorities had either closed their schemes, were only accepting high priority applications or were warning that applicants faced long delays for the processing of their claim.

6.1.3 Individualised Funding

Control over the important aspects of one's life has repeatedly been identified as being essential for psychological health and for successful ageing. It has long been known that, for people of all ages, Approaches to the delivery of such services are increasingly linked to choice and independence and a recognition that the development of individualized services may make the difference between being able to continue living independently at home and or having to move to an institutional setting (LaPlante et al 2002).

Feelings of self-efficacy, (or ability to bring about the outcomes you desire) contribute

to psychological health (Bandura 1977) and that autonomy (or being in control of one's own activities and goals) is similarly linked to satisfaction with life (Sheldon et al 1996). There is a considerable amount of research linking the feeling of control with both physical and psychological health (Rodin, 1986). Believing that one can control aspects of one's life is central to concepts of independence and is associated with better mental well-being, general health, fewer and less severe symptoms, faster recovery from illness, and greater longevity (Lachman, 1986; Rodin, Timko, & Harris, 1985; Boyle, 2005).

Choice tends to be limited by age much more than is really necessary (Marmot & Wilkinson 2005) However the ultimate way to maximize choice is to ensure that there are a wide range of options available and people are empowered and have the means to choose and purchase the services they prefer. This approach to the delivery of services has been developed primarily in relation to young adults with disabilities in many countries. However it is less common in relation to older adults with disabilities or with care needs.

Models of individualised funding

A new model of provision has been developed in many countries which supports people in arranging, supervising and funding their own personal assistance services and it has slowly become an international policy trend. This approach is currently being offered in a number of European countries, including France, The Netherlands, the United Kingdom, Austria, and Germany (Tilly et al, 2000; Wiener et al, 2003). In the US the 'independent living' movement, for example, has focussed primarily on consumer control and community participation to ensure rights and citizens (DeJong, 1993; Hutchison et al., 2001). In the UK the system is known as 'direct payment's while in other countries terms such as 'consumer-directed services' or 'self-purchasing' systems have been used.

In the UK, local authorities have put in place a new scheme of direct payments, which allows an older person to create their own 'care package' by purchasing the services they want, with guidance available in the process of making choices, if required. This method of service delivery has had a mixed reception, with some criticising it on the grounds that some older people may find the management of their own care unduly burdensome, and may suffer as a result.

It is often assumed that consumer-directed home care is primarily of interest to younger people with disabilities and that older adults are not interested. However in an evaluation of the Cash and Counselling programme in Washington it was found that although younger people with disabilities were more likely than older people to choose that option, a very substantial minority (38%) of older beneficiaries (compared to 54% of the younger population) chose the scheme. The study found a substantial difference between the older and younger persons' satisfaction levels with older people being significantly more satisfied with consumer directed care than younger people (Wiener et al 2007).

Research in Scotland into the obstacles to self-directed support for older people found that funding, training and confidence issues among users and social workers alike have been identified as current obstacles in Scotland. (Riddell et al 2006) However they report that users' believe that self-directed support is manageable with support. Glasby and Littlechild (2001) highlighted the importance of the attitudes of social work professionals as well as availability and access to appropriate information as key factors influencing the users attitudes. Other research concludes that although resource constraints do impact on delivery of self-directed support, there is also a need for a cultural change, incorporating a shift in values and attitudes if user choice is to become more commonly used (Pearson 2006).

Issues Arising

Longer-term planning for one's future home:

According to a study carried out in 2010, quality of life was compromised for 22% of older people by the location of their home, and by the standard of their housing for a further 13%. There is a need for greater awareness, of the potential impact in later life of the location and layout of a home.

Preference for living in one's own home: An Irish Hospice Foundation survey confirmed that, for most people, the preferred location in later life was their own home, with only 1% preferring a retirement community and none opting for either sheltered housing or a nursing home (IHF 2009).

Public support for home care: A recent Eurobarometer report (2008) found that the vast majority of Irish people were in favour of using public budgets for support services allowing older people to stay longer in their homes: 76% felt that this was very important and 22% felt it was fairly important. While this is now Government policy, it is not backed by funding and many older people are effectively forced into long-term residential care because of the lack of adequate home care support.

Financial considerations and fear of poverty:

Many older people are unwilling to 'trade down' because of the costs associated with property transactions. In addition, there is anecdotal evidence to suggest that older people are unwilling to liquidate assets because of anxiety about future medical needs and other costs.

Suitability of housing: Many older people and their families are often forced, in a crisis situation, to come to terms with the fact that their homes, perhaps because of size, location or structure, are not suitable for growing levels of frailty and physical impairment. While some will be capable of appropriate adaptation and can be made safer, others will not, and in this situation people may go into long-term

residential care prematurely or unnecessarily. Others may have to make adaptations urgently and therefore more expensively.

6.2. HOME CARE SERVICES

Age-related chronic and debilitating conditions can result in functional disability or difficulties performing activities of daily living. These difficulties, in addition to diminished quality of life, can trigger the need for additional personal assistance or relocation to a family member's home or residential facility. Most people with personal assistance needs receive help from unpaid family members, but other options have emerged for those without adequate sources of informal assistance.

In response to the preference for older people with care needs to remain in their own homes, the number and range of support service providers has been growing. Services, such as prepared meals, house cleaning, help carrying out personal activities of daily living have been found to be effective and are commonly used. Private home care agencies offer paid personal assistance in the consumer market, and public programmes (such as Home Care Packages, Home Help service, Day Care and Meals on Wheels) provide other supports to those with low-incomes and limited capacity to purchase the necessary help privately.

Approaches to the delivery of such services are increasingly linked to choice and independence and a recognition that the development of individualized services may make the difference between being able to continue living independently at home and or having to move to an institutional setting (LaPlante et al 2002).

6.2.1 Demand for Home Care

Most home care is provided by the HSE, some by the voluntary or non-profit sector, and about 4 per cent is provided by private operators. A

report commissioned by the IPHCA (2009) revealed that an estimated €340 million is spent annually on home care in the State.

The recent PA Consulting report indicated that based on population growth alone, the number of home care recipients could increase from 57,581 to 96,250 by 2021. Connell and Pringle (2004) noted that the 400,000 older people living at home are likely to increase to 1 million by 2022, one third of whom will have a disability. This growing demand does not take account of the HSE's desire to reduce the number of nursing home residents by 20% to 4% of the older population in the medium term.

6.2.2 Home Care Packages

Home Care packages have been developed by the HSE to acknowledge both the trend towards leading independent lives in their own home for as long as possible and the likelihood that greater numbers of older people will in the future be capable of being treated at home. This will be the likely result of continuing advances in medical knowledge and treatment. As the numbers of older people increases it has been recognised that the current treatment model, which is focused primarily on delivery of services in the hospital or long term care facility, will become difficult to sustain. Their purpose is to enable older people requiring medium to high levels of care to continue living in their own homes, thus reducing the number of people entering acute hospitals and long-term residential care settings (PA Consulting 2009).

The Home Care Package Scheme itself is the responsibility of the Health Service Executive (HSE), which has a dedicated budget for the purpose. The 'package' of services provided is tailored to the needs – and means – of the individual, following assessment and means-testing by the HSE, usually carried out by the Public Health Nurse in consultation with the older person and their family.

A Home Care Package may include the services of nurses, home care attendants, and home helps, and can include therapies such as physiotherapy and occupational therapy. Home help may be provided by the HSE as part of a home care package, or separately as a 'stand alone' service, since the home help service itself has a statutory basis. Home helps do light housework, shopping, cooking and cleaning for older people, but generally do not provide nursing or medical care for clients. However, many home helps are also paid carers, so will undertake personal care tasks, such as help with showering, applying ointments etc., alongside their household duties. It is important that the supports can respond to needs e.g. in some cases changing bed linen is excluded and considered outside its remit.

The service is generally free to medical card holders, but in some areas older people are required to make a contribution. The home care support scheme may be delivered by the HSE directly, or by voluntary or community organisations on behalf of the HSE, or in some cases a private paid carer or home help service. The average value of packages in place in 2009 was €319 per week.

According to the HSE National Service Plan 2012, 10,870 people benefited from home care packages in 2011. The HSE annual report (2010) said that 11.68m home help hours were provided to over 54,000 people.

The HSE National Service Plan (2012) has said that outside of the Nursing Homes Support Scheme (NHSS), the cost reduction required is on average 2.3% in 2012. The Plan makes a commitment that Home care packages will not be reduced in 2012 and the number of people in receipt of them will be the same as in 2011. The report states *"there will be reductions of 4.5% nationally in the level of home help hours provided but this reduction will be compensated by a more rigorous approach to the allocation of these supports to ensure that the people most in need*

receive them by deprioritising non-personal care. (HSE 2012). This suggests that the Health Service faces a considerable challenge to meet the growing needs from the available resources.

An evaluation report published in September 2009 by the National Economic and Social Forum (NESF) indicated significant implementation problems affecting the success of home care packages in achieving the aim of enabling older people to continue living in their own homes. These problems included:

- Difficulties accessing information on eligibility for, and availability of, services;
- Significant regional variations in the operation of the scheme;
- Considerable differences in the quality of services, and their funding, with some Local Health Offices providing as little as €70 per week and others paying more than €400;
- Lack of coordination among the medical teams delivering services with cases of duplication arising.

The PA Consulting evaluation (2009) found similar implementation difficulties and in particular they identified the following;

- The absence of national implementation guidelines.
- A need for the linkages with the acute sector.
- The inadequacy of management information
- The need for an improvement in ICT systems and supports to support operational staff (PA consulting 2009).

However, despite the problems identified, the evaluation found that good progress had been achieved in relation to the five principal objectives of Home Care Packages; to facilitate timely discharge of older people from acute

hospitals; to reduce inappropriate admission; to reduce pressure on A&E Departments; to support older people to continue to live in their own community and to support carers so that they might be able to continue to provide care.

In early 2010 published the HSE National Guidelines & Procedures for Standardised Implementation of the Home Care Packages Scheme. The revised guidelines incorporate recommendations from the National Economic Social Forum (NESF) Report and from the DoHC commissioned Evaluation Report (PA Consulting 2009)

6.2.3. Private Home Care

Home Care clients have varying levels of need and depending on the quality of the care they receive, they may be helped to return to a level of functioning that allows them to live relatively independently in the community, or they may go through a deterioration which may lead to further dependency or even institutionalisation.

It has been argued that some home care programmes lean too far towards an outdated 'dependency' model of service provision rather than a new focus on activity, independence and successful ageing. Instead the approach should be towards an emphasis on the promotion of healthy lifestyles and daily routines, social support, exercise, and autonomy or control (Kane 1999, World Health Organisation, 2002, Glendinning et al. 2008).

There are a growing number of voluntary and private home-care providers, catering for about 12.5 per cent of the older population but these are unregulated and the quality of care and value for money can vary significantly. The residential home sector is now regulated following high profile controversies in the sector despite the fact that it only caters for around 5 per cent of the over-65 population.

A report commissioned by the Irish Private Home Care Association (IPHCA), warned

that draft national quality guidelines for home care support services, developed for the HSE in 2008, were never implemented. Plans are however currently being developed by the HSE to commence implementation of the quality guidelines during 2010.

The IPHCA report points out that "*there is no minimum requirement for vetting and training of staff*". Furthermore, it highlights the need for the monitoring of time spent on client care, a practice proven in the UK to increase client contact time by up to 12 per cent, saying "*In the absence of guidelines and monitoring, there is no visibility of the quality of care delivered*". It is important that all home helps, whether in the public or private sector, have undergone appropriate training and are subject to Garda vetting and to nationally agreed and audited quality standards (PA Consulting/IPHCA 2010).

Research in the UK on older home care customers' views on service quality has identified priorities like receiving service from familiar staff, reliable and punctual visiting, being kept informed about changes, and help with miscellaneous household problems like house-cleaning, changing light-bulbs or obtaining a trustworthy plumber (Patmore 2004). This echoed the findings of an earlier study on home care quality which found that older people defined 'quality' in terms of many of these dimensions. It also identified the need for services to help older people get out of their homes and carers trained in the tasks they have to do and trained to listen to clients.

To evaluate the effectiveness of interventions by home care agencies and to ensure a uniform standard of care among the different providers of services, standardised quality indicators were developed when researchers, clinicians and policy makers from Canada, the US and Japan came together in 2003. Using what is known as the Minimum Data Set for Home Care (MDS-HC), which is essentially data compiled on home care service users following a structured

screening questionnaire, the quality indicators were developed (Hirdes et al 2004).

Several studies have proved the value of using quality indicators for improving the quality of care in nursing homes. However, research on quality indicators for home care agencies has been less widespread.

One study looked at Home Care Quality Indicators (HCQIs) for home care organizations in 11 European countries. It examined the variation in the level of support provided and found that there were substantial differences in quality of care between different home care sites, suggesting the possibility of learning from the experiences of the sites with better scores (Bos et al 2007).

The difference between lowest and highest percentages varied considerably (from 4.4% which is at the level of “Neglect or abuse” to 75.9% which offers “Rehabilitation potential in Activities of Daily Living and no therapies”). The indicators covered areas such as; neglect or abuse, inadequate meals; weight loss; social isolation; adequate or inadequate pain control; assistive devices for those with mobility difficulties; injuries; delirium; negative mood; falls; dehydration; receipt of the flu vaccine; medication review when at least 2 medications are taken, hospitalisation, therapies needed received or not; and disruptive or intense pain (Bos et al 2007).

Although the quality indicators have not yet been extensively examined, the authors concluded that they do seem to be capable of discriminating between good quality home care service providers and those who offer very little to their clients. These indicators, they suggest offer the potential to target quality improvement actions for home care organizations identified as having particularly unwanted care outcomes and they propose that within Europe, a “European average performance” for each QI could be developed, in order to ensure equal quality standards (Bos et al 2007).

6.2.4 Assistive Technology in the Home

Assistive technology, defined as, ‘any product or service designed to enable independence for disabled and older people’, has the potential to facilitate people of varying levels of dependence to remain in their own homes, merging different services within the same home setting. A smart home is one equipped with technology that is aimed at enhancing the safety of older people living independently and monitors their health conditions.

The potential uses of assistive technologies to support older people to receive care in their homes are varied. Technologies have advanced in many fields and in combination with advances in sensor development, miniaturisation of electronics and extended battery life, offer enormous opportunities in healthcare, especially for older people. Health providers at both national and European levels now appreciate the need to introduce new paradigms of healthcare delivery to meet the challenges of the changing demographics. Technological solutions such as remote monitoring are being viewed by many as one of the most promising solutions to this challenge, facilitating improved quality of life and community care.

Overview of Products

The areas of daily living activities where assistive technology can play a role include stair lifts, hoists and bath lifts. The promotion of independence using assistive technology, however, relies on an increasingly wide range of devices which cover an equally wide range of individual situations.

Products can range from the low-tech (walking sticks) to the high tech (satellite-based navigation systems to help find someone who has got lost). It represents a convergence of three emerging sectors telehealth, telecare and home automation/smart homes in three sectors – ICT, medical devices and pharmaceuticals.

Three of the key functions performed by assistive technologies include

- Diagnostics
- Monitoring and
- Information provision

One of the broadest categories may be viewed as activity recognition which monitors the activities of the user within their home and based on this information the environment can be modified or activity assistance provided within the home. Another widely used technology can record vital sign based information and in conjunction with other activity-related information, can provide a broader overview of the status of the person within their own environment.

Because successful ageing also depends on the psychological health of an older person, technologies that provide social connectedness would be an important component of any home-based care system. These technologies might include computer-based products designed to assess cognitive decline or help older users enhance memory, entertainment systems that offer both physical and mental stimulation and highly complex systems that provide important reminders to older people with memory loss. In addition, cell phones, video telephones and communications software could be adapted for older people so they are easier to use and, therefore, more useful in reducing isolation among this population.

Evidence of the Benefits of Assistive Technology

There is now a growing body of literature and pilot studies indicating that assistive technologies can improve quality of life (physically, mentally and socially); reduce health care cost; and help create a proactive and preventative health service (Bauer, 2007).

Telemonitoring or the use of communication technology to monitor patients' health status

has been found to improve the care of patients with chronic disease. A number of devices have been developed which allow clinical data to be collected without the need for face-to-face contact with patients. In this way telemonitoring can make care more accessible for patients and has the potential to improve outcomes.

A number of studies have shown that these technologies can have a significant impact by reducing hospital admissions and time spent in hospital. They can also reduce the number of GP visits and the use of Accident and Emergency. For example telemonitoring offers potential for supporting patients with heart failure, who often experience deterioration in their health status with an increase in weight and symptoms over a period of days and weeks before presenting to medical services and requiring hospitalization. A system of frequent monitoring can alert their doctor to the early signs and symptoms, providing time to intervene before patients become severely ill and require hospitalization.

One review of research in this area looked at telemonitoring systems which all used an intervention based on symptom monitoring by nurses via live one-on-one telephone calls with patients. It found that three of the five trials showed decreased rates of hospitalisation for heart failure and two studies showed reductions in the level of hospitalisation for all causes (Chaudry et al 2007).

Automated systems also showed positive results and Benatar et al (2003) compared the effectiveness of daily self-monitoring of weight, blood pressure, heart rate and oxygen saturation with home nurse visits. The self-monitoring was performed by patients in their homes, with the information transmitted to a secure internet site for review by patients' cardiologists. Home visits were scheduled as part of the programme and they included discussion of diet, symptom recognition and adherence with medications. The study found a 40% reduction in heart

failure admissions among the tele-monitored group compared with the nurse home visit group (Benatar et al 2003).

Developments to date fall mainly into addressing the three areas of safety, security and social needs (Astell 2005). For example, the issue of falls in the home is being addressed through the development of systems which can automatically detect if a fall has taken place and notify a relative or other carer. The main overall benefit of such support is to extend the time that people can remain safely at home and reduce the burden on the carers and the healthcare sector.

Work is also progressing on the development of sensor technology which would be placed all over the home to register patterns of activity, and detect possible departures from the usual patterns (for instance by noting that the living room has not been entered that day). Such systems provide support to carers by alerting them to a range of potentially dangerous situations (Astell et al 2009).

The potential of technology to provide solutions to the problems faced by older people with dementia is increasingly being recognised. Wandering is associated with dementia and can cause considerable distress and worry to the carer and may lead to earlier institutionalization (Balestreri et al., 2000). Electronic tracking devices have been developed to promote safe walking for people with dementia but ethical questions have been raised about their impact on the autonomy of the person with Dementia. (Robinson et al., 2007a).

The use of technology has also been found to reduce the number of hours of help needed by older people. One study provided evidence that technological assistance could substitute for at least some personal assistance in coping with disability and that people who did not use equipment used about 4 more hours of help per week compared with those who do use equipment (Hoenig et al 2003).

Telemedicine can also improve the delivery of care by specialist medical professionals and increase the overall efficiency of the system. For acute stroke patients, access to a hyper-acute care (thrombolysis/clot-busting) is an important therapy, but is limited by access to specialist care. The use of telemedicine allows for the pooling of geriatrician and neurologist expertise to provide this service over a network of hospitals, and has already been successfully trialled in a network involving Tallaght, Naas and Mullingar Hospitals. (www.irishtimes.ie).

Scotland's Telecare Development Programme is the most developed pilot programme in the UK and has shown positive results. In its first full year the programme is estimated to have saved £11m and is thought to be improving the health of its users. The data estimates that 81,000 bed days were saved; through speedier discharge, reduced unplanned admissions and care home bed days saved by enabling people to stay at on their own home rather than care homes. The study also found that 93% of telecare service users felt safer as a result of having telecare services in place and 87% also felt their families worried less as a result (Scottish Government, 2009).

A small telemonitoring pilot study in North London found hospital admissions were reduced by 38% in a four month period. The study also found that there was increased patients' and carers' confidence in managing diseases, and that home monitoring helped patients communicate more effectively with the primary care team, thereby enabling the care team to provide an improved response to the patients needs (Proctor & Single 2006). Similarly, in Germany it is estimated that early patient discharge from hospital due to the introduction of mobile health monitoring would save €1.5bn per annum (European Commission, 2007).

In the period 2000 to 2004, Ireland was one of five European countries which participated

in ENABLE - an EU project (funded under the 6th framework), examining the use and usefulness of assistive technologies for people with dementia and their family caregivers living at home. Overall the results from this study showed that the technology developed by ENABLE produced savings and improvements for both dementia sufferers and carers across a broad spectrum of socio-economic factors. From the data measuring expectations and outcomes, both carers and persons with dementia reported between one and three positive benefits from using the devices at a personal level (i.e., the positive benefits for the person with dementia) and at the family level (i.e., positive benefits for the person with dementia's family).

Almost half of all carers reported that the ENABLE device supported independence and more than one-third reported that the ENABLE device reduced the general emotional burden of worry for the family (ENABLE, 2007). The ENABLE data showed that it would take only one overnight stay in an Irish hospital to cover the cost of each of the ENABLE technologies. Devices that can prevent a person with dementia from injury and having to spend time in hospital, have the potential to offer significant savings to healthcare economies (ENABLE, 2007).

The Alzheimer Society of Ireland is undertaking a project to support people with dementia and their carers in the community through the use of telecare technology. The project is supported through the Dormant Accounts Fund and to date over 90 packages have been installed in people's homes throughout Dublin, Wicklow and Kildare. An interim evaluation provided positive results in terms of people's experience of technology, their re-assurance levels increased, in some instances accidents were clearly avoided through the use of the technology and in other instances the carers' sleep patterns improved. A

final evaluation is expected to be published on completion of the project.

Respondents in the Alzheimer Society's study indicated that assistive technology devices should not only be easy and convenient to use but also reliable. The study obtained positive feedback about the benefits of assistive technology from people using services. People indicated that assistive technology promoted independence, enabled them to remain in their own homes, helped them to perform daily tasks and made them feel more safe and secure. It is important to note that these aspects are fundamental to users' perceptions of assistive technology and are likely to influence their willingness to accept assistive technology interventions.

In both Norway and Finland national legislation governs the provision of assistive technology. The responsibility for this provision lies at municipal level. Assistive technologies are generally provided free or on loan and are funded by tax revenues and state grants. In Norway, each municipality has Technical Aid Centres (TACs) which are responsible for the provision, purchasing, storing, distribution, and re-circulation of assistive technologies. Re-circulation ensures maximum use of resources. In Finland, technical aid units are attached to central hospitals to provide consulting services to local health centres which deliver technologies to older people. In Norway and Finland distinctions are not made between older people, people suffering from dementia, and people with a disability with regard to assistive technologies (Craddock, 2003).

It is important to note that although assistive technology can have many benefits across all care services; this does not make redundant face-to-face care and human contact. Technology can, in many cases, keep people in their communities, enabling independent living, for instance, and facilitating social networking. However, it can also have the opposite impact and there need to be safeguards in place to ensure that the

increased use of technology does not mitigate against human contact and bring about social isolation, whereby technology replaces services and supports that previously were the responsibility of people.

Attitudes to Assistive Technology

The importance of assistive technology in contributing to older people's independence and autonomy is increasingly recognised, but there has been little research into the acceptability of AT to older people. Assistive technology devices have been developed in response to issues identified by research as being important. These issues include concerns about being unable to undertake household chores, not wanting to be a burden on family members, fear of being taken ill when alone, and fear of accidents such as falls. Care packages involving assistive technology will be improved if shaped by the desires and goals of people who use services.

One study looked at differences in technology usage among people with a disability and found a tremendous variation in usage according to the nature of the disability. On the one hand, people with physical and sensory disabilities are most likely to use assistive devices but those with a cognitive or mental health disability were not (Kaye et al 2008).

The ENABLE study in Ireland raised much public and professional awareness about the role assistive technology has in promoting more independent living in people with dementia (Cahill et al 2007).

It found that in general most of the products involved in the trial were used and considered useful by both people with dementia and their caregivers; however it seemed that items with the highest level of technical difficulty (item locator and night lamp) had the lowest level of use and usefulness. The unfamiliar design of a product can be a major deterrent for people with dementia, for whom new learning may be extremely difficult as the disease progresses. The

study also found that there was a considerable gap between the cost of the items and the amount that the people with dementia and their carers were prepared to pay for them, in some cases the gap was 4 or 5 times the cost of the item (Cahill et al 2007).

A UK study found that older people were very positive about the use of AT if the technology was straightforward, reliable and met a need (McCreadie and Tinker 2005). A case study of the introduction of smart home technology in Australia found that many older people did not see the benefits of the assistive technologies to them but felt they would be of benefit to those older people who have significant disabilities. This may reflect denial of ageing, fear of stigma if they accept assistive technologies, or a determination to maintain independent living without technical aids (Soar 2007).

Older people can also sometimes feel stigmatised by the presence of assistive technologies in their homes and are thus less likely to participate in pilot projects. In this sense, the design of these technologies is key to their success. A recent study funded by a consortium of home appliance manufacturers found that people are not seeking automated lights and appliances; they want instead a single, portable, user-friendly tool that can allow them to manage tasks, access home controls, communicate with others, and operate entertainment devices (Gentry et al 2009).

A French study investigated the views, wishes, and fears of family carers (FCs) regarding fourteen new technologies aimed at alleviating the burden for carers, and the very slow uptake of these technologies. The most appreciated technology, the tracking device collected the greatest number of favourable responses with female carers appreciating it significantly more than male and younger carers more than older. The second most appreciated technology for all groups was the videoconferencing device for social connectedness. The personal pocket

video conferencing device for mobile private remote surveillance of the patient also received favourable responses (Rialle et al 2008).

Irish Projects

The TRIL Centre (Technology Research for Independent Living) was launched in 2007, as three year research collaboration between Intel, University College Dublin, Trinity College Dublin, National University of Ireland (NUI) Galway and Irish research hospitals. Addressing the physical, cognitive and social consequences of ageing, the research aims to invent and test new technologies for supporting older people to live independently at home, despite age-related illness or injury. This should improve the quality of life of older citizens, while reducing the burden on carers and on the healthcare system.

The Nestling Technology for Wellness (Netwell) Centre, established in 2006 in Dundalk Institute of Technology, aims to be a regional centre of excellence for applied research and development of new technologies which can support older people's independence and quality of life. Its work is focused on 'home-health technologies' – including applications for those with disability or cognitive impairment – and post-diagnostic interventions, and it aims to influence national health policy, and reduce the need for institutional care.

The Dublin Mid-Leinster Stroke Network is trialling robotic telemedicine for stroke treatment and in conjunction with National University of Maynooth examining the use of biosensors in stroke rehabilitation, with a specific focus on older people.

Issues Arising

Home Care Packages; The government's Home Care Package (HCP) Scheme was a much welcomed development. However, the recent NESF report (2009) has revealed a

number of critical weaknesses in the scheme – inadequate provision, significant regional variation in levels of support, unclear eligibility criteria and an inflexible mix of supports which have led to inconsistencies, inequities and duplication of work in the implementation of the HCP scheme.

Blend of Services: The current Home Care Schemes don't enable older people to access the flexible and limited or intermittent supports they need in order to enable them to continue living in their own homes and to be able to flexibly blend the combination of family, voluntary and professional carers. They also need to be able to access a mix of supports eg physical support to get up, dress, cook as well as other supports such as small repairs, gardening, etc.

Assessment: There is no comprehensive system of assessment which would take in assessment of means, care needs assessment, and the range of social, health and other needs older people may experience. Older people face double or even triple assessments of their care needs before receiving a home care package.

Standards and Regulation; The residential home sector, which caters for around 5 per cent of the older population, is now regulated while the home care services sector caters for about 12.5 per cent of this population group but there are no standards or regulation governing those providing home care, the standard of care they provide.

Tele-care and tele-health: Despite the numerous benefits and potential cost savings there is only limited access to the technologies that can greatly assist people continue living independently in their own homes and communities.

6.3. SUPPORTED ACCOMMODATION

According to the NCAOP, supportive housing includes low support clustered homes and sheltered housing. Low support housing

schemes generally consist of 1-2 person dwellings of between 5-20 units. They are self-contained units that are often, although not always, built around a day centre which may or may not provide additional services such as communal meals and recreational facilities. Sheltered housing generally involves a higher level of support. Again, dwellings consist of 1-2 person units but are grouped together, along with on-site communal facilities.

Services provided can include the provision of meals, laundry, visiting health professionals and recreational activities. These schemes tend to include a full time warden, caretaker or other support staff. Due to the high level of service provided, sheltered housing projects tend to include upwards of 20 units, as otherwise it is unlikely that they would be financially viable (NCAOP 2007: pp. 52-3).

One example of supported accommodation provision is the Sue Ryder Homes in Ireland which provide sheltered housing for older people, with homes in Ballyroan in Co. Laois; Owing in Co. Kilkenny; Dalkey in Co. Dublin and Holycross in Co. Tipperary. Houses are fully equipped and residents pay a monthly contribution based on their income which covers rent and utilities. 24-hour security is also provided (<http://homepage.eircom.net/~sue-ryderfoundation/sue-ryder-homes.htm>).

In the private sector retirement villages provide self-contained housing units alongside long-stay provision. Medical facilities are usually available on a round-the-clock basis. Other facilities such as meals, entertainment, exercise and day care provision can also be provided. Residents generally buy into the schemes with the proceeds of the sale of their homes, or some operate a lease scheme.

According to Retirement Care Services, (a website providing information on the range of private retirement homes,) there are approximately 42 retirement villages in Ireland

at present. This sector is developing relatively quickly due to a number of reasons including an ageing population; the entry of major nursing home providers into the Irish market such as UK based Barchester.

There are currently no requirements that retirement villages adhere to good practice norms, one of which is to locate near towns and villages. However, there is a trend toward locating retirement villages both within access of nursing homes and near communities, such as in the location of Morehall Lodge which is next to the Moorehall Lodge Nursing and Convalescent Centre.

The Joseph Rowntree Foundation is positive about retirement villages, arguing that they bring opportunities for health and social care providers to deliver community services more effectively and efficiently, and can generate cost savings to acute health services through the provision of intermediate care. For these reasons, retirement villages effectively serve current policy agendas (Coucher 2007).

6.3.1 Supply and Demand

While there has been a rapid growth in the provision of supported accommodation by private, voluntary and statutory agencies, there is no clear policy or guidelines to inform such developments. Planning regulations don't generally take account of the range of needs of older people prior to the granting of permission for housing intended for them e.g. retirement villages in order to avoid the situation where they are provided in isolated areas, with no/limited medical or other supports available.

The area of supportive accommodation is relatively undeveloped in Ireland as compared with the rest of Europe (EAPN, 2008). It has been identified as a significant growth industry in Ireland, as indicated by favourable conditions to obtain credit for supported and communal living developments. Voluntary housing bodies

Case Study

Example - The Great Northern Haven

Great Northern Haven is a demonstration project set up as part of Louth 'Age-Friendly' County and for the Netwell & CASALA research centres at the Dundalk Institute of Technology. The project uses sensor technologies in a community and research context and is a collaborative venture between the Louth Local Authorities, local Health Service Executive, industry partners, research & development and the older residents. The project is a purpose-built development of 16 smart apartments constructed specifically for Ambient Assisted Living (AAL) applications. Fifteen of the apartments are occupied by older residents who are actively involved on research projects and one is maintained as a demonstration and transitional unit.

The Netwell Centre set up an ageing-in-place research project to exam the impact of the housing on the quality of life of residents, while CASALA manages the technology, collates the data and adapts the systems to meet the unique needs on individual occupants. A wide and rich data set is continuously being gathered from Great Northern Haven, from consenting residents, internally within the apartments and from the grounds of the development. Each apartment has 100+ sensors, connected TV's, touch screen devices and a core network infrastructure throughout. In total there are over two thousand (2000) sensors and actuators throughout the development.

The project seeks to enhance the quality of life of older people through ambient assisted living (AAL) technologies, using the best of sensor and healthcare technologies currently available and as part of a living lab for new technologies and services developed through research collaborations. Ongoing research at Great Northern Haven will inform national policy and provide international experience in relation to services for older people, and has a wide range of potential commercial applications

can qualify for Capital Assistance Scheme (CAS) to build appropriate and affordable housing for older people. However the capital funding programme for social housing has been reduced dramatically by 72% since 2008 from €1.38bn to €390m. In a recent (April 2012) comment the Executive Director of the Irish Council for Social Housing, Donal McManus said *“Social housing output is now at the lowest levels in a generation which will directly affect people with disabilities, the elderly, homeless persons and low income families especially those who require specific support services”*. (<http://www.icsh.ie>)

The NCAOP, in their assessment of the provision of supported accommodation by local authorities and voluntary housing, found that a total of 9,232 units of accommodation were provided across Ireland. This translates into a level of provision equal to 19.8 units per one thousand older people. However, the report points out that there are wide variations across the country, ranging from 1.1 to 59.7 units per one thousand older people. This, the authors argue is lower than would be desirable on the basis of the experiences in other countries (Cullen et al 2007).

A number of voluntary sector organisations, housing associations or housing co-operatives provide housing for older people. A survey carried out by the Irish Centre for Social Housing (ICSH) in 2005 identified 79 ICSH member housing associations providing a total of 3,165 units of accommodation in either low support group housing or high support sheltered housing for older people. A total of 84 associations were identified as having plans to develop schemes for older people, which were expected to provide 2,413 further units of accommodation (NCAOP 2007b, page 59).

The NCAOP (Cullen et al 2007) found that there was a good level of interest among older people for supportive housing and there are waiting lists in many areas. Their research

with older people living in mainstream housing identified low levels of awareness and a lack of information about supportive housing. They concluded that the extent to which demand for supportive housing in Ireland is based on choice or by a lack of alternatives is not known.

Discussions with residents of supportive housing schemes found that most residents are positive about the experience. This is in line with evidence from other studies, although larger-scale studies in the UK have found that up to one in five residents express the wish that they had remained in their own homes (Cullen et al 2007).

The NCAOP study found that the preference of participants would be to stay in their original homes for as long as possible. Supportive housing was seen, however, as preferable to admission to long-stay care and was described by one focus group participant as particularly useful for those who have no family or whose family are not in a position to care for them.

Residents in the group and sheltered housing schemes were very positive about where they were living. Residents in the sheltered housing project identified friendliness, the quality of care and facilities, and compassion as some of the most positive aspects of their scheme. Participants did not feel that they could access information about accommodation options and most of the participants who were resident in the group housing scheme had not been aware of the development before being placed there.

6.3.2 Clustered or Dispersed housing

There has been little debate at policy level also as to whether providing clustered supported accommodation is a suitable and desirable longer term policy. In other areas such as homelessness, the move is away from providing group schemes and instead to provide supports to people living in their own homes in the community. In the disability sector a

review, undertaken by the National Disability Authority, of the research carried out into the benefits of dispersed housing or clustered housing found that dispersed housing is superior to clustered settings in many domains (Mansell and Beadle-Brown, 2008).

Generally, the studies found that clustered housing provides poorer outcomes than dispersed housing for people with intellectual disabilities. In terms of quality of life issues such as social inclusion, material well-being, self-determination, personal development and rights, none of the studies found benefits of living in clustered settings. Clustered settings were found to be superior in the number of hours of recreational activity, contact with dentists, psychiatrists and psychologists, some health screening, some aspects of safety, contact with family and friends, visitors to the home and satisfaction with relationships. However, in many of these cases the better results refer only to village communities and not to campus housing or clustered housing which serve only a minority of the less disabled population and are unlikely to be a feasible option across the board for disabled people.

The research also found that in terms of costs clustered housing is less expensive than dispersed housing. However, this cost difference appears to be due to differences in staffing levels – i.e. fewer staff are provided to support people in clustered housing than in dispersed housing. In two of the three studies which examined costs controlling for staffing levels, there was no significant difference (Mansell and Beadle-Brown, 2008).

A report published by the Homes and Communities Agency in the UK “*Housing our Ageing Population Panel for Innovation*” outlines core issues to guide housing policies. It was informed by extensive consultation and covers design and planning issues, sharing space or private space and the role of local authorities and local strategic partnerships.

Issues Arising

Absence of Policy: There has been little debate at policy level also as to whether providing clustered supported accommodation is a suitable and desirable longer term policy. In areas such as homelessness and disability, the move is away from providing group schemes and instead to provide supports to people living in their own homes in the community. This does not preclude developing ‘life-long neighbourhoods’. There has been little government research into the needs and preferences of older people themselves on this issue.

Planning: Planning regulations don’t generally take account of the needs of older people when considering planning permissions for supported housing e.g. retirement villages and as a result many have been developed in unsuitable locations eg too far outside towns to allow older people access facilities.

National standards: The provision of supported accommodation is not planned on any national or systematic basis leading to areas where very few suitable housing options are available. There is no evidence that the provision of supported accommodation is informed by standards of universal design or lifetime standards.

6.4 FAMILY CARE AND INFORMAL CARE

As people age, many develop chronic conditions which require higher levels of care and may become dependent on others for help in carrying out the activities of daily life. Family carers or informal carers are relatives, friends or neighbours who provide unpaid care for people with a disability, mental illness, chronic condition or frail older people. Because carers must be constantly available due to the heavy demands and responsibilities of caring, many are unable to take up employment and so are reliant on Government supports. Family care giving is not generally a role that

is aspired to or anticipated (Moen, Robison & Fields, 1994). Family members often find themselves undertaking the role following very little consultation, education or preparation for the task.

6.4.1 Family Carer Statistics

According to the Census of Population 2006, there are 160,917 family carers in Ireland, representing 4.9% of the total population. Of these 40,883 provide full-time care i.e. over 43 hours of care each week. Statistics on carers from Census 2011 are due for publication in Nov 2012. However there is evidence that the number of carers is likely to have increased in the intervening period. The CSO carried out research in the Quarterly National Household Survey in 2009 which found that overall 8% of respondents provided unpaid help, 10% of women and 6% of men. The gender difference was evident for both caring for someone in the same household, 4% of women and 2% of men and in caring for someone living elsewhere, 6% of women and 4% of men. (CSO 2010)

In Census 2006 most carers (84.2%) were in the working age population though not all were actually in paid work. Carers are found in all age groups and Census 2006 found that there were 18,152 Carers (11%) aged over 65 years, of whom 8,819 were providing more than 43 hours of care each week. The QNHS research found that the highest proportion of adults who were carers was among those aged 45-64 (13%).

Thirty-seven percent of carers aged 65 years and over provided up to 14 hours of unpaid help per week, compared to 48.6% providing 43 hours or more (CSO 2007). Most were married (62%) and female (62%) and provided on average 24 hours of care per week. However within those statistics it was found that many carers were supporting people with high dependency needs, needing up to 60 hours hands-on work per

week as well as monitoring and supervision at all hours of the day and night.

Research shows that older carers often experience unique challenges, they generally do not receive any outside help, have often neglected their own health for the sake of the person for whom they provide care and are more at risk of experiencing social and economic deprivation. In addition, older Carers face the stress of planning for the future and ensuring that their loved one continues to receive quality care after their death or when they are no longer able to provide care.

6.4.2 Impact of Caring on Family Carers Health and Wellbeing

Although there is some evidence of positive aspects of caring such as personal satisfaction among carers (Raschick & Ingersoll-Dayton, 2004), there are also many adverse effects experienced by many who provide care.

Carers have been found to experience high levels of psychological distress and depression; increased rates of physiological illness; lower rates of engaging in preventive health behaviours; disruptions to paid employment; and personal, financial, family, and social problems (Fortinsky et al., 2007; Wakabayashi & Donato, 2006). The *Health and the Carer in Ireland* survey carried out by the Royal College of Psychiatrists in 2009 found that almost half the 2,500 Irish carers interviewed experience being mentally or physically drained by their role as a Carer and 50 percent have been diagnosed with a mental health problem.

The CSO's QNHS also looked at the impact of caring on the life of the carer, by using a "strain index" score. Two thirds of those surveyed reported that their own lives had been affected by their responsibilities. The problems they experienced included disturbed sleep, coping with distressing behaviour, financial strain, and an adverse effect on their own

mental and physical health. More than a third of those surveyed admitted “*feeling completely overwhelmed by their caring responsibilities*”.

A similar study carried out in Northern Ireland investigated the emotional impact that the caregiver role can have on a family member. The study found that for the majority of carers their experience was one of constantly searching for support and information, resulting in anxiety and frustration. The study also found that the Carers used a number of positive coping strategies to deal with the stress associated with the caring role (Chambers et al 2001). The study revealed that none of the Carers had received any formal training in moving or handling, administration of medications or the management of incontinence but instead gained their skills by trial and error or from friends and neighbours in a similar situation. A US study found that Family Carers perform a variety of roles, acting as geriatric case managers, medical record keepers, paramedics, and patient advocates (Bookman, 2007).

One study looked at the factors contributing to adverse effects for carers and found that living with the care receiver, caring for a younger person, and caring for someone with memory problems all predicted depressive symptoms. However it found that not all carers experienced these problems and that the fact of care-giving was not necessarily detrimental to the physical and mental health of the carers. Instead it found that carers who had inadequate income and did not receive the services they needed experienced more stress and depression. The results also showed that among carers who work, women missed work due to care-giving responsibilities twice as often as men, and those who did not receive the support services they needed missed work twice as often as those with adequate services. Finally the authors found that carers who lived with those who are receiving the care are over twice as likely to feel isolated (Robinson et al 2009).

In Ireland, 38% of Carers are male. A study undertaken by Care Alliance Ireland showed that male carers are 1.6 times more likely to have a lower quality of life than female carers. Studies have also shown that male carers can be more vulnerable to social isolation, are not adequately recognized as carers, have inadequate social support, and were more likely to use destructive coping mechanisms (particularly alcohol).

The caregiver role can dramatically impact on a family member and a family. In economic terms, according to a 1994 report from the ‘SUPPORT’ study, (or Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment) one-fifth of all family members of seriously ill patients had to give up work or make another major life change in order to care for their family member. Almost one-third reported the loss of all of their family savings, and 29% reported the loss of the major source of family income (Covinsky et al 1994).

6.4.3. Impact of Caring on Work

The statistics show that over half of all carers (56%) were in employment and one fifth (21%) were working looking after a home and family as well as providing an average of 34 hours of caring per week. (ICA 2009) Many find themselves torn between family obligations and duties at work, working what is often the equivalent to two full-time jobs at the same time with predictable stresses and fatigue from over-work (ICA 2009).

According to the European Observatory on Ageing and Older People (2003), all Western European countries with the exception of Denmark, rely on families to provide the bulk of care. The OECD estimated in 1996 that approximately three-quarters of all care for frail older persons is provided by family carers.

Timonen notes that even where formal public or private care services are available, family carers

Table 3. Carer Demographics

	Total	% of all Carers
Female Carers:	100,214	62%
Male Carers:	60,703	38%
Carers 15 – 19 years:	5,433	3.4%
Carers 20 – 39 years :	40,263	3.4%
Carers 40 – 64 years:	95,069	26%
Older Carers 65 years and older:	18,152	59%
Total Carers	160,917	
Source: CSO Census of Population 2006		

often perform an essential ‘care management’ role that enhances the integration of otherwise fragmented structures of service provision.

The generation who have become known as the ‘sandwich generation’ or those who are caring for both children and an older relative tend to experience higher levels of role overload. Those who do not live with their care receiver have reported high levels of work interference with family (39%) (Duxbury et al. 2009). Many workers end up bringing work home to compensate for the lost time at work (Higgins and Duxbury 2002).

Research has identified a range of other negative impacts on work. In the US, a study by the National Alliance for Caregiving and AARP, found that 11 percent of these workers tend to take a leave of absence and 10 percent ultimately will quit their jobs. People who provide four hours or more of care per week are more likely to reduce their work hours, change their work patterns, or turn down job offers and promotions as a way of managing their dual roles (Pyper 2006). Older workers who provide

four or more hours of care per week are more likely to report work-life conflict (Uriarte-Landa and Hébert 2009).

Canadian research found that 6% of retirees would have continued to work if suitable care in the community had been available (Morrisette et al. 2004). Sixteen percent of retired care giving employees said that their care responsibilities were one of the reasons they retired (Humble et al. 2009).

The research also found that employees with care giving responsibilities in Canada reduce their work hours by 2.2 million hours per week and miss nearly 1.5 million work days per month due to their role as carers. This is equivalent to 157,000 full time employees in lost productivity (Fast et al. 2011). Similar estimates are not available for Ireland, however it can be assumed that care giving does impact on productivity and work-life conflict.

Financial estimates of financial loss attributable to care giving vary from the US company MetLife which carried out a Care giving Cost Study (2006), and put the estimate

at between \$17.1 and \$33.6 billion per year, while the U.S. Bureau of Labor Statistics estimated that absenteeism due to care giving costs employers nearly \$5 million and that work day interruptions due to care giving of adults cost employers around \$3 billion.

Sherman and Reed (2008) demonstrated that the combination of stress from work and care responsibilities was linked to decreased work performance. However when support is provided by the employer, carers did not suffer such effects. Research found that employees who felt that their organizations provided high levels of support were more likely to have better work performance as compared to their counterparts who felt that their organizations provided low levels of support. (Riggle, Edmonson, and Hansen 2008)

Interruptions to the working day are common among caregivers, particularly those working full-time (Reid, Stajduhar, & Chappell, 2010) and such interruptions contribute to feelings of inadequacy in their employment. Both interruptions and feelings of inadequacy contribute to increasing stress levels. (Kim et al 2011)

In the US many employers have developed employee assistance programmes or provided flexible hours to employees who have care giving roles. However it has been pointed out (Neal 2000) that some carers prefer not to highlight any conflict in their home/work roles. Research has even found that some fear retributions for revealing their caring responsibilities and they do not see themselves as belonging to a special group called caregivers (Wagner & Hunt, 1994).

6.4.4 Contribution of Family Carers to Irish Economy

Based on figures from the Census of Population 2006 the Carers Association have calculated that Family Carers provide over 3.7 million hours of care each week and save the State more than €2.8

billion a year, meaning that the average full-time carer saves the State €44,616 per year.

The total financial contribution is calculated using the HSEs current lowest hourly rate of €14.28 as paid to Home Help workers. These calculations are set out in Table 4 (over)

The contribution made by carers, and the subsequent value to the State in supporting them, has been acknowledged by government policy in the National Action Plan for Social Inclusion 2007-2016 and Towards 2016, Ten-Year Framework Social Partnership Agreement 2006-2015, both of which commit to supporting Family Carers through the development of community and home-based care.

Research in the US found that older people with a neurological condition and with no relative nearby were 15 times more likely to enter residential care than those with the same condition who had relatives living nearby (Jette et al 1992) (USA). Similar research in New Zealand has shown that the existence of strong support networks, such as the presence of a family carer, can have many benefits including reducing the likelihood of the older person entering residential care (Keeling, 2001).

6.4.5 Interventions

Because of the significance of the carer's role it is important to investigate ways of alleviating the burden or intervening to provide support. The range of support services that can be offered to carers include; 1) information about available services; 2) assistance in getting access to support services; 3) individual counselling, support groups, and training to help with problem solving related to their roles; and 4) respite care.

Research shows that support services for carers such as counselling, respite care, education, and training can help to reduce the level of stress, and depression experienced and can improve overall well-being (Mittleman, et al., 1995; Zarit et al 1998). Providing caregiver support services can

also delay nursing home placement of persons with Alzheimer's disease (Mittleman et al. 1996).

One US study found that patients whose spouses received support experienced a 28% reduction in the rate of nursing home placement compared with other groups. The study also found an improvement in carers' satisfaction with social support, better responses to patient behaviour problems, and a reduction in symptoms of depression. They concluded that greater access to effective programmes of counselling and support could bring about considerable benefits for carers, patients with Alzheimer disease, and society. Although the study did not include a cost-benefit analysis the authors argued that the average nursing home cost savings would be far greater than the annual salary of a full-time counsellor (Mittleman et al 2006).

Schofield and colleagues found that two factors that contributed to a positive experience of caring were having the support of other family members and having a sense that there was some choice in the decision to provide care (Schofield et al 1997). Interventions for carers can have a number of components such as individual or family counselling, case management or skills training. Research found that interventions with a number of different components tend to generate larger effects than narrowly focused interventions. Similarly, single component interventions with higher intensity (frequency and duration) have a more positive impact on the caregiver than interventions with lower intensity (Gitlin et al 2003).

Another review of research found that approximately two-thirds of the interventions did not show improvements in any outcome measures. Of the studies that did bring about improvements, the inclusion of social support or a combination of social support and problem solving seemed to be more effective. In particular group-based interventions had

a greater positive impact on psychological problems (Thomson et al 2007).

The caring role can be both physically and emotionally demanding and research has shown that carers suffer health problems related to their caring role, in particular high blood pressure; back pain; tiredness; and stress and anxiety which all have a negative impact on their quality of life and well-being. In addition, many carers are often unable to pursue recreational or social activities, the absence of which in turn can lead to isolation and poor health in the form of depression. Research conducted by the Care Alliance in 2008 showed that family carers were much more likely to report health problems where they were restricted in terms of opportunities to engage in activities outside of their caring responsibilities.

In this regard, one option is to increase the availability of home support and respite care in order to improve the health and well-being of carers and thus enable them to continue in their role. The Carers Association argue that the development of night-time respite services could have an important role in relation to lack of sleep. They also suggest that developments in technologies can provide support to carers by monitoring the person being cared for so that the carer can get enough sleep. It is important to note that it is vital that respite services respect the needs of both the carer and the care recipient.

The implication of not providing sufficient supports to carers is that the carer themselves may become ill leading to a situation where the older person may need to be placed in institutional care. For example carers who have a high burden level may be unable to function effectively and the care recipient may have unmet needs if their carer has a high degree of burden. Since a carer is a critical element of home care, if the burden on a carer becomes too great, the home care support may be seriously threatened and lead to increased use of formal, paid helpers and possibly earlier

Table 4. Contribution of Family Carers to the Irish Economy

Hrs per Wk	Ave hrs	No. Carers	Carers by Av. hrs/ week	52 wks/year	€14.28 per hour
1–14 hrs	7 hrs	93,363	653,541	33,984,132	€485 293 405
15–28 hrs	21.5 hrs	17,093	367,499	19,109,948	€272 890 057
29–42 hrs	35.5 hrs	9,578	340,019	17,680,988	€252 484 509
43+ hrs	60 hrs	40,883	2,452,980	127,554,960	€1 824 035 928
Total		160,917	3,814,039	198,330,028	€2.8 billion

Source: National Carers Association

institutionalization of the older person in a nursing home (Covinsky 2003).

6.4.6 Future Care Needs

As discussed earlier demographic predictions suggest that Ireland's older population (i.e. those aged 65 years and over) will increase significantly to around 1.4 million by 2041. The very old population (i.e. those aged 80 years of age and over) is set to rise even more dramatically, showing a four-fold increase. Arising from these projections the Carers Association predicts that an additional 25,000 carers will be needed by 2016 and if current ratios persist, there will be a need for over 205,000 carers. This represents an additional 40,000 Carers from the 2006 count, or an increase of 28% in Carer numbers by 2021.

Social trends raise concern about the availability of family carers to care for older people. The number of family carers now in employment has increased from over one third

to over one half in the past 10 years and the number is continuing to increase.

The implications of fewer adult children available to share care giving tasks means that the responsibilities for providing care may place greater pressures on individuals within families. In addition, given the current economic climate, financial demands on families are likely to grow meaning that families will find it increasingly difficult to be able to afford to provide care in the home. Recognizing the vital role played by carers and providing supports to assist them in their role can play an important part in ensuring that older people's wishes to be cared for at home is realized.

6.4.4 Policy on Carers

Since the publication of *'The Years Ahead: A Policy for the Elderly'* in 1988, it has been Government policy to favour home and community care over long term residential care. There is a recognition that in-home

supports such as home care packages, home help provision and assisting family and friends to provide care is vital if older people are to continue living independently in their own homes and communities.

The contribution made by carers, and the subsequent value to the State in supporting them, has been acknowledged by government policy in the *National Action Plan for Social Inclusion 2007-2016* and *Towards 2016, Ten-Year Framework Social Partnership Agreement 2006-2015*, both of which commit to supporting Family Carers through the development of community and home-based care.

The development of a National Carers Strategy 'to support carers and to address issues of concern' is a key commitment in the current Programme for Government. In a response to a Dail question (March 2012) the Minister of State at the Department of Health said that work on the Strategy was ongoing and it was hoped that a draft would be "*completed shortly*".

Acknowledging the challenges faced by the state in maintaining existing levels of services from within limited resources the Minister said that it "*will not be an operational plan but will set the strategic direction for future services and supports for carers in recognition of their role and contribution to maintaining children, adults and older people with physical or mental health difficulties in their own homes*". (<http://debates.oireachtas.ie>)

The Carers Association believe that the publication of the Strategy is particularly significant in times of economic difficulty, when carers need some form of recognition from Government and a sharing of the responsibility for the care of older people.

Issues

Isolation and Loss of Independence: The *Health and the Carer in Ireland* survey carried out in 2009 found that almost half the 2,500

Irish Carers interviewed experience being mentally or physically drained by their role as a Carer and 50 per cent have been diagnosed with a mental health problem (Carers Association 2009). Caring on a regular basis often leads to isolation, financial hardship, stress and exhaustion; it can create major risks to the carer's own health and involves the loss of all kinds of opportunities – for employment, education, time off, holidays, rest and ordinary family life. In addition, many Carers feel their role is not recognised or rewarded by the State.

Supporting Carers' needs; Most carers in a recent study had not received any formal training in moving or handling, administration of medications or the management of incontinence but instead gained their skills by trial and error or from friends and neighbours in a similar situation. Research shows that support services for carers such as information, counselling, respite care, education, and training can help to reduce the level of stress and depression experienced and can improve overall well-being. Male carers in particular tend to be more vulnerable to social isolation, are not adequately recognized as carers, and are more likely to use destructive coping mechanisms

Family Carers: Family Carers can significantly reduce the strain on Ireland's healthcare system while also providing quality care that greatly benefits the person receiving care. However this often comes at a high personal cost for the Carer who may experience lost income and reduced employment opportunities. This is compounded by the struggle to meet increased living expenses and extra medical costs.

Lack of Awareness of Carer Work-life conflict; There is limited awareness of the impact of caring on employees, compared with employees' childcare responsibilities. Therefore, support programmes for employees with caring responsibilities are not common as support programmes for employees with childcare responsibilities

Availability of Respite and Emergency Care:

Respite care is universally regarded as one of the key formal support interventions to alleviate the stress of caring. However despite increases in the level of the Respite Care Grant the current grant is not sufficient to cover the cost of respite being provided by a home help worker for a period of 20 days per annum which is the statutory holiday entitlement for workers. In addition the location of respite care in hospital or long-term care settings can pose a significant risk of 'institutionalising' older people.

Standards of Care: The Law Reform Commission has called for the regulation of carers who look after older people in their own homes and for independent inspections and care standards to help protect against abuse and mistreatment of older people. Concern has also been expressed that those in the professional care market often frequently don't have status, recognition, qualifications etc.

6.5 RESIDENTIAL CARE

In Ireland, the majority of older people (94%) were living in private households at the time of the 2011 census with the remainder, 31,054 persons, in communal establishments e.g. nursing homes, community hospitals, long stay units in hospitals.

The percentage of all people aged 80 and over who were living in communal establishments in the 2011 census starts out at just over 7 per cent of eighty year olds but gradually increases to a peak of 55 per cent of all persons aged 100. Approximately 4% of older people are living in nursing homes. (CSO 2012)

Research into the preferences of older people for care in the future and found that the least preferred option was a nursing home. A large proportion of participants (39% in the RoI and 42% in NI) reported that they would find this option unacceptable. However some (14%) in

the RoI would find this care option acceptable and 21% in NI. (McGee et al 2005).

The Eurobarometer Survey on Health and Long-term Care (2007) found that only 6% of Irish people would prefer to be cared for in a nursing home. This was the lowest preference expressed for nursing home care among all EU member states, apart from Poland, Greece and the UK (Eurobarometer 2007).

There is also little evidence that older people have prepared for or discussed their preferences for long term care with friends or family. The HARP survey in 2005 found that 74% of all over 65s had never discussed these matters with family or health professionals and only 48% of those over 90 had done so (Garavan et al, 2009)

Long term care is provided in three sectors – public (HSE), voluntary and private. The number of people aged 65 years and over in publicly provided services has decreased from 41.1% to 36.3% in 2005. In contrast, the use of voluntary and private provision in long-stay care has increased during that period from 13.6 to 16.1% and 45 to 47.5% respectively (CSO 2007).

Statistics compiled by the DoHC showed that 12.6% of people in long stay care are classified as 'low dependency' and a further 21.3% as 'medium dependency', (DoHC 2011) suggesting significant scope to reduce the level of residential care with enhanced community-based services. While the current government target is 4%, it may be a desirable option to reduce this even further.

The DoHC statistics also identify the main reasons for residence in a nursing home and the category with the largest proportion of patients was chronic physical illness (34.0%) followed by dementia (27.5%).

Together these two reasons accounted for over half of cases in all categories of long-stay units except for voluntary welfare homes where nearly a third (34.9%) of patients were resident for intellectual disability and just over one-fifth

(21.1%) of patients were resident for social reasons. HSE welfare homes have the next largest percentage (8.8%) of patients resident for social reasons.(DoHC 2011)

6.5.1. Trends and Future Demand

Changes have been observed in recent years in relation to long term care services for older people. For example policy changes in Denmark have meant that community-based services have more clearly replaced institutional care. During the 1980s and 1990s a freeze on nursing home construction and an expansion of community-based services led to significant drops in institutionalization.

In 1982, 20 percent of persons age eighty and older were in nursing homes, by 1996 this had dropped to 12 percent. For those aged 67 and older the rate dropped from 6.6 percent to 4.6 percent. This resulted in significant savings which funded an increase in the provision of provision of community based services to nearly a quarter of all elderly persons, while long term care spending dropped from 2.6 percent of GDP in 1982 to 2.3 percent in 1994. (Merlis 2000)

Long term care funding in Europe is mostly allocated to care institutions, except in the UK, where formal care delivered at home is given three times more funding. In many European countries there has been that an increase in the number of places in nursing homes. (Mansell et al 2007)

The number of LTC beds has been reduced in both hospitals and nursing homes in Sweden, where the trend has been towards the provision of long term care at home. In Iceland, the reduction in the number of long term care beds in hospitals has been accompanied by an increase in nursing homes. Germany followed a similar pattern, with the number of beds increasing in nursing homes after the introduction of a new insurance programme. (European Social Network 2008)

According to the ESRI, the forecasted increase in numbers of people living to older ages in 2021 will mean that there will be a growth in the numbers of people needing long-term care. By 2021, capacity in care facilities will have to grow to meet this need as well as current unmet need.

The ESRI estimated the need for long-term care places, based on population trends and disability projections in the future. They stated that there was a need for an additional 13,324 long-term care places from 2006 to 2021 or 888 places per annum from 2007-2021 for people aged 65 years and over. This is because frailty and disability rises at older ages, especially amongst the very old (aged 80+) which will be the fastest growing segment of the population in the decades to come (OECD 2006).

Any projection of future demand needs to take into account the potential reduction in the availability of family carers because of increased female labour force participation and should also take account of the changes in the system of acute care delivery, envisaged by government and the HSE.

Based on other countries' experience, this would substantially increase requirements for residential LTC and formal community carers. There is an opportunity to ensure that long-term care facilities are well-planned, close to communities in need of care, and as much as possible take the form of sheltered housing or so-called "extra care".

6.5.2 The Nursing Home Support Scheme

The Nursing Homes Support Scheme (Fair Deal) was introduced to address the needs of all older people to access to affordable long-term residential care, if needed. The scheme provides State support for public and private long-term residential care recipients. Eligible people receive financial support towards the

cost of their long term residential care with a co-payment arrangement between the person and the State. People who require long-term residential care are required to contribute 80% of their assessable income, e.g. their pension(s) and 5% of the value of any assets per annum. The State meets the balance of the cost of care thereafter in the public/voluntary or private nursing home.

The contribution in relation to a person's principal private residence is 5% a year, capped at three years, but this contribution can be paid at the time when care is received, or may be deferred until the settlement of the person's estate if they so wish. This aspect of the Scheme is known as the Nursing Home Loan (Ancillary State Support). The families of care recipients will not be means tested or requested to contribute to the cost of the patient's care.

A fundamental component of the scheme is confirmation in legislation of a resource cap with the overall budget for long-stay residential care, now being managed as a separate sub-head of the Vote.

In order to receive State support, an applicant must have their care needs assessed and be determined to need long term residential care. A person can choose any approved nursing home subject to a) its ability to meet their care needs and b) it having a place for them. National, standardised processes have been introduced for both the care needs assessment and the financial assessment which ensures that applicants receive equity of access regardless of where they live. Furthermore, nationally organised processes ensure that applicants living in the community have the same level of access as those occupying an acute bed; thereby reducing the need for older people to enter a Nursing Home from an acute hospital.

There have been mixed views on the scheme. Many have welcomed it as an important step in addressing older people's fears about funding of

the residential care costs. It has been praised for placing a cap on what people and their families have to pay for care and equalising the position of people in state-run and in private nursing homes as regards subventions. Others have raised particular concerns about adequate levels of funding, eligibility criteria, and entitlement to particular levels of service and to asking older people to pay for the cost of their care through their own means or a % of their estate.

In early 2012 the Minister of State for Older People Kathleen Lynch announced that the nursing home support scheme is to be reviewed, including the amount of funding taken from the family home after a persons' death to pay for their care. Questioning the logic behind some of the fundamentals of the scheme, she said the contribution of 15 per cent of the value of a home towards the cost of care six years ago was "*an entirely different scenario*" to 15 per cent of the value of a home today. (www.dohc.ie)

6.5.3 Models of Care

In the past decade a movement for change in nursing homes has gathered momentum and different models of care provision have been developed to address the problems associated with institutional care. Policy-makers and service providers in Ireland are engaged in a growing debate with regard to the viability of the institutional or County Home model of long term residential care. Models using an acute hospital setting can reduce residents to patients and can thus be at odds with the concept of living in a place that feels like home.

In many countries small-scale and homelike facilities have been established, such as group living in Sweden, Green Houses in the United States, residential groups in Germany and in the Netherlands 'group living facilities' (Verbeek et al 2009). In these facilities, a small number of residents live together and form a household with staff. Normal, daily life and social participation

are emphasized with a view to improving quality of life for residents and increasing job satisfaction among staff. In Ireland one example of this approach has been called the ‘Teaghlach’ or ‘household’ model. It has been suggested that such an approach can potentially significantly improve the quality of life of older residents and that its capacity to promote the familiarity of the home environment can prevent against memory loss and disorientation.

Many of these homelike facilities involve changed physical environments (e.g., smaller-scale, more-private rooms and baths and household-type settings for dining and cooking), transformed staff roles with more empowerment of staff, and a philosophy of individualized care.

In the US, one model which was developed in the 1990s called the “Eden Alternative,” aimed to develop a set of principles to be introduced to existing nursing homes which would invest decision-making in residents and frontline staff, and normalize nursing home life, as well as addressing the psychosocial problems of residents, such as loneliness, boredom, helplessness, and lack of meaning. Evaluations of this model (Kane et al 2007) concluded that the quality of life for residents improved.

Recent research by Cahill (2010) found that approximately two thirds of people in residential care have some form of dementia. This suggests the need for the development of specific knowledge, skills and commitment to dementia care among staff and management. The development of person-centred care with greater emphasis on relationships between staff and residents and individual care plans could improve the quality of care and quality of life for residents. (Cantley and Wilson: 2002). It has also been shown to be important to maintain links with the local community as far as is possible in order to prevent against deterioration of dementia as well as to achieve a balance between the protection of residents

and the quality of life gains that come from taking some risks (Cantley and Wilson: 2002).

A dementia residential care unit was opened in Mount Carmel Hospital in 2008 which facilitates residents looking after their own personal needs where possible and appropriate. The unit has a kitchen where residents can make themselves something to eat or drink rather than having to adhere to strict communal meal times as well as facilitating the increased involvement of families with relaxed visiting hours and policies regarding residents going out with family members.

The unit has been positively evaluated in a report by the HSE South and the Alzheimer Society which stated that in some cases the shift from a traditional hospital ward to this new specialist care unit had resulted in the re-learning of skills; improved sleeping patterns; reduced aggressive behaviour; and a general improvement in functional independence. It may be an option for this model of dementia-specific care to be developed on a national scale.

Finally, it may be useful to separate respite care from long-term care settings as there is a danger that it may be inappropriate for someone who does not have high dependency needs. In this way, capacity to deliver respite care services could be developed in supported housing areas.

6.5.4. Problems Associated with Residential Care

The move to residential care can be a painful and bewildering experience both for the older person entering care and for their carers, family and friends. The feelings experienced can be mixed, involving feelings of loss, guilt, and perhaps relief for the family. Problems associated with long-term care facilities frequently include feelings of abandonment in the older person, and concerns about reduced privacy, having fewer opportunities to contact family or friends and a loss of independence.

Practices such as very early evening meal times, very early 'getting-ready-for-bed times' can serve to disorient and infantilise older people and can be counterproductive to the objective of making long term residential care settings as home-like as possible (NCAOP 2007a). Research in the US comparing those living in institutions and non-institutionalised persons found that non-institutionalised people were more socially active and had a more positive quality of life than those who were institutionalised (Borge et al., 1999).

For many family care-givers the main reason for seeking a residential place for their relative is due to concerns about their safety. This can lead to a tension between the safety of the older person and their ability to exercise choice, control, and individuality. But in situations where the nursing home is modelled on the medical or hospital approach to care, staff routines and efficiency can take precedence over the individual's preferences (Kane et al 2001). Research found that the very regulations meant to protect people and improve quality of care contribute to residents' dehumanization. In McColgan's study of people with dementia (2005) she talked about a 'surveillance culture' and discussed the resistance strategies used by residents to create private space in a public place while staff attempted to deny even their choice of a place to sit (McColgan 2005).

Older people's health problems and needs are complex, and require health and social care structures and systems which can sensitively address the 'detection and management of this complexity' and can provide integrated health and social care responses. Recent research indicates a failure to detect treatable functional problems in older people in nursing homes and primary care settings, which leads to further functional decline, increased health service use, more disability and a decrease in life expectancy (O'Neill, 2008 [2]).

O'Neill also suggests that in situations where systems are adapted to respond to the complex

needs and wishes of older people, outcomes can be significantly improved. One important element is that care systems should be designed, and services delivered, in active consultation with older people themselves. Such an approach would be in line with the philosophy underlying the Madrid International Plan of Action on Ageing. Ireland is one of the few European countries that has not responded to the plan (O'Neill, Twomey, and O'Shea, 2009).

In a person-centred care system, services meet the needs and preferences of the older person therefore there should be a clear understanding of those needs and preferences. The public perception of residential care as institutional has become firmly rooted in collective consciousness and despite the fact that many of the hospital-like nursing homes of the past are being replaced by small-scale, skilled nursing-care facilities, there is a general acceptance of the fact that the current model of residential care does not always support older people to continue to lead a full life no matter what their level of dependency.

6.5.5 Quality of Care

In Ireland and internationally, evidence has emerged of quality shortfalls within residential care, ranging from poor physical infrastructure to the more serious problem of neglect and abuse of residents (O'Neill 2006, OECD, 2005). The OECD report identified a large number of problems ranging from inadequate housing, poor social relationships, lack of privacy (shared multi-bed rooms and wards), inadequate treatment of pain, persistent bed sores and depression, inappropriate use of chemical and physical restraint and problems with staffing such as shortage or inadequate knowledge or qualifications. In Ireland, similar problems were identified by the Leas Cross Report (O'Neill 2006) commissioned by the HSE and written by consultant geriatrician Prof. Des O'Neill. It found that Leas Cross

was not an isolated incident and that a number of other deficiencies were widespread such as failure of management to give sufficient weight to concerns expressed by interested parties; weak policy, legislation and regulation and deficiencies in funding.

The Health Information and Quality Authority (HIQA) was established in May 2007 and has assumed responsibility for inspections of residential care for older people. The Authority published 32 draft standards covering the following areas: rights; protection; health and social care needs; quality of life; staffing; care environment; management and governance. The standards establish rights for residents in residential care settings and include their entitlement to high quality safe and respectful care (<http://www.hiqa.ie/>).

HIQA recognised the importance of quality of life measures for ensuring quality and have extended the range of measures to include; routines and expectations, meals and mealtimes as well as autonomy, independence and ability to maintain social contacts.

Since then a number of inspections have taken place and while areas for improvement have been identified it is likely that these systems of inspection will bring about change and contribute to a general greater awareness of standards in residential homes. In the US quality standards were introduced in 1986 but by 2001, although improvements in health care were observed, there was no marked improvement in the perception of nursing homes or in the quality of life of residents. (Kane et al 2007).

The idea of defining and understanding quality from the perspective of people receiving services has become accepted within care provision. Research carried out in the US into the aspects of care that residents most valued found that kindness, caring, compatibility, and responsiveness were among the interpersonal

qualities of staff most appreciated by older people. Nursing home residents also valued privacy, control and choice on aspects of their daily lives, particularly with reference to leaving the facility from time to time. They also found that a majority of older people surveyed would prefer a smaller private space than a larger shared one and would trade off activity programmes for privacy.

A number of studies have adopted a consumer approach to measure quality of care and identified the following as being central to residents' satisfaction; staff dependability and trust, longevity of personnel, mealtime experience, personal control, recreational activities, residential environment, and the complaint process itself (Chou et al. 2003; Peak & Sinclair 2002; Faulkner et al. 2006). An earlier study found that the key dimensions of quality included: staff, care, family involvement, communication, environment, home, and cost (Rantz et al 1999).

A number of studies have identified a link between negative resident outcomes and poor working conditions for staff, inefficient work organizations, inadequate staffing, and managerial practices that devalue staff leading to rapid staff turnover. Researchers in the US have also found a link between staffing levels and the level of complaint regarding deficiencies of quality (Stevenson 2006). It is significant that work environments that foster staff job satisfaction and commitment have been associated with greater staff retention, higher resident satisfaction, and better quality of care (Sikorska-Simmons 2006, Chou et al. 2003). Similarly, to achieve positive changes, staff management issues were considered most important; in particular leadership that is willing to undertake quality improvement and see that the basics of care delivery are carried out for residents is a necessary prerequisite for quality standards.

Research carried out in Denmark compared nursing homes rated as 'excellent' or 'ordinary'

(Andersen 1987) and found that the single most important factor in determining excellence was seen as resident-oriented care focused on quality of life, with contributing factors including activities for residents, their social contacts and staff knowledge and evaluation of people. In a study in the Netherlands, carried out in three Dutch nursing homes it was reported that implementation of resident-oriented care also had an impact on staff; lower frequency of sick leave was reported, although effects on job characteristics (job autonomy, job demands and social support) were limited (Berkhout et al. 2001).

Research by Eamon O'Shea et al, commissioned by the Irish Hospice Foundation and the NCAOP (2007a), considers a range of quality of care and end of life care dimensions in residential settings. The research highlights four domains of quality of life in long-stay care: independence and autonomy of the resident, a resident's ability to maintain his/her personal identity and sense of self and a resident's ability to maintain connectedness, social relationships and networks within and outside of the care setting and a resident's engagement in meaningful activities. Research carried out in Ireland, found that among the factors that nursing home staff and management can control in order to influence the quality of life for older people are: the 'ethos of care' 'sense of self and identity', 'connectedness' and 'activities and therapies' (Cooney et al 2007).

For example, nursing homes that were less routinized allowed residents to make choices about the time they were woken, went to bed, had meals and what they did, and were viewed as contributing to autonomy and independence. Nursing homes that recognised residents' need for personal space and which allowed participants to personalize their own space, to maintain their personal appearance, offered residents the opportunity to maintain a sense of self. Purposeful activity concerned

the way in which activities were structured, the extent to which participants were consulted in determining appropriate activities and the issues that influenced their participation.

Research found that in some sites, there was planned provision of activities which changed daily while other facilities provided little in the way of meaningful activities. Provision of therapeutic services across the 12 sites was also found to differ greatly. Three therapies – physiotherapy, occupational therapy and speech and language therapy – were generally seen as essential to maintaining resident independence, but they were not always available (Cooney et al 2007).

Issues Arising

Planning for future needs: Currently there are 4.5% of older people living in long-term residential care – a further 1% are in hospitals. The policy is to reduce this number to 4%. The ESRI Report (October 2009) has forecast a need for an additional 13,000 to 21,000 long-term care places by 2021. In the context of residential care being the least favoured option for older people, it is possible that the current target of 4% might be too high and that with better home-care support and supported accommodation the target might be reduced.

Inappropriate admissions: Research has found that the least preferred option if needing long-term care was a nursing home. A cross-border survey found that 39% of respondents in the RoI and 42% in NI would find this option unacceptable (McGee et al 2005). Despite this some older people and their families feel effectively 'forced' into long-stay nursing homes. While long-stay institutional care is the appropriate and better choice for many, inadequacies are observed, for instance, insufficient state-funded home-care resources, and lack of access to respite care or the entitlement to either, to give older people and

their families the choice to remain living in their own communities.

Range of Models of Care; there has been little debate about the models of long-term care needed. At present, planning stipulation does not differentiate between the provision of purely 'residential care' and the more resource intensive 'nursing care' that must be available in nursing homes. It also fails to address the issue of how best to provide specialist care e.g. dementia care.

Perception of Residential Care; The public perception of residential care as institutional has become firmly rooted in collective consciousness and despite the fact that many of the hospital-like nursing homes of the past are being replaced by small-scale, skilled nursing-care facilities, there is a general acceptance of the fact that the current model of residential care does not always support older people to continue to lead a full life no matter what their level of dependency.

Specialised provision of care; In Ireland, there are over 7,000 people with dementia living in residential care settings, many of which do not cater for many of their needs, and this figure is set to increase. Specific knowledge skills and commitment to dementia care is needed among staff and management and it is important that person-centred care is provided in the form of individual care plans.

Quality standards: While very significant progress has been made since the Leas Cross Report and the establishment of the HIQA standards, the application of the standards has resulted in the closure of certain homes which has caused considerable upset to some very frail older people and their families.

Planning and Locations: There is a significant shortage of nursing home places in major urban areas, and an over-supply in some other areas, with significant under-investment in public nursing homes. In addition, there is a shortage

of dementia-specific units. The location of long-stay institutions away from urban settings and public transport systems can make it difficult for families and friends to visit and for others who provide professional and voluntary supports. They are also not required to provide some normal services eg hairdressing, shops etc.

Funding for Long-term care: There are very mixed and quite strong views on the recently established 'Fair Deal' Scheme, which was introduced to facilitate the access of all older people to affordable long-term residential care. However the 'Fair Deal' only covers the cost of bed and board and nursing care. The National Treatment Purchase Fund (NTPF) documentation makes it abundantly clear that the 'Fair Deal' specifically excludes social programmes, therapies, dental treatments, chiropody and the list goes on. This is in direct contravention of many of the national quality standards. There is some concern also that there may not be sufficient funding to cover the costs of the scheme if there is widespread adoption of it.

CONCLUSION - KEY ISSUES

In conclusion, the key issues that arise in relation to the home and living situations of older people relate to planning for housing, the provision of home based supports, support for carers and nursing home care.

Housing Planning

Planning for housing needs must be tackled at two levels - at the system and individual level. Planning should address current housing mix needs and also to take account of the fact that in medium and longer term, the needs and requirements of the next generation of older people will be very different.

The projected increase in the number of older people, particularly the 'older old' with people increasingly living into their 90s and beyond,

requires a planned approach to ensuring there is the optimum mix of housing options to meet their needs. This mix, the combination of privately owned houses, apartments, high, medium and low levels of supported congregated settings, nursing homes - needs to be informed by the preferences of older people themselves.

There is a clear desire among Irish people, more so than their European counterparts, to stay living in their own homes and communities. This is based on a strong attachment to home as a place - not a building and Irish people move homes only 1.8 times in their lives on average. However, the research by Conor Skehan showed that the location of the home had an adverse impact on quality of life for 22% of people, while the quality of home impacted 13% of people. This points to the need to develop awareness, on a personal level, of the need to begin planning for housing needs in later life, so that house moves do not happen in the midst of a crisis.

Home-Based Supports and Services

Given that so many people want to stay living in their own homes, a more strategic and concerted approach to providing effective supports to doing so is needed. This is also the policy of the current government.

The Home Care Packages Scheme was introduced in 2007 and has been a widely welcomed and appreciated initiative. However, the NESF report of 2009 shows that there are a number of significant limitations to the scheme, for example it is not entitlement based, and both access and support levels vary considerably throughout the country.

The recent so-called 'Fair Deal' scheme appears to have had the unintended consequence of effectively incentivising people to move into nursing homes.

The need for home-based services often arises in a crisis and at present there isn't a single system

that provides information on entitlements and services. This creates significant stress on the individual and their immediate family and friends as they try to navigate their way through the different silos of hospitals, primary care teams, public health nurses, GPs, home-care services etc to coordinate the responses needed.

One of the key issues relating to home-based services is the need for some regulation around the standard of care provided, similar in many ways to the assurances provided by the HIQA standards for nursing homes.

While home-care supports are a vital ingredient in the mix of what is needed to enable people live independently, relatively little attention is paid to the very important issue of home-adaptation and the range of technologies that support independent living. In many cases the adaptations or the technologies, whilst representing once-off capital costs, can play a vital role in enabling the person themselves take care of themselves, maintaining their sense of independence and confidence.

This is also an area in which a more joined-up approach is required - between the supports and services provided by statutory services, private providers and voluntary organisations. What is often needed is a single system, with multiple access points but where the coordination can be done within that system.

Carers

The role of carers is critical in supporting people to stay living in their own homes and communities and there is a huge dependency on them, which is why it is important to ensure they get the support they need such as training, respite, and recognition. This is particularly critical as the majority of carers are now working with the potential for stress and stress related illnesses a real cause for concern.

Indeed this is an area that should be of more concern to employers. More research needs to

be done on the impact of caring roles on people within the workforce giving consideration to the conflicting roles of home and work.

Nursing Homes

At present 4.5% of older people living in long-stay care facilities and the government has a declared target to reduce this to 4%. Most of those are the 'older old', over 80. With the numbers projected to quadruple over the next thirty years, this calls into question whether this is a desirable target and more work needs to be done to explore this.

While there have been very significant improvements in this sector, partly as a consequence of the 'Leas Cross Report and the subsequent introduction of a standards based approach administered through HIQA, there are still issues that need to be addressed. These include; the provision of more medical services when they are required in the nursing home itself – and a more vigilant planning system that provides planning permission only in locations that are more suitable than the out-of-town locations that were developed under the tax incentive schemes.

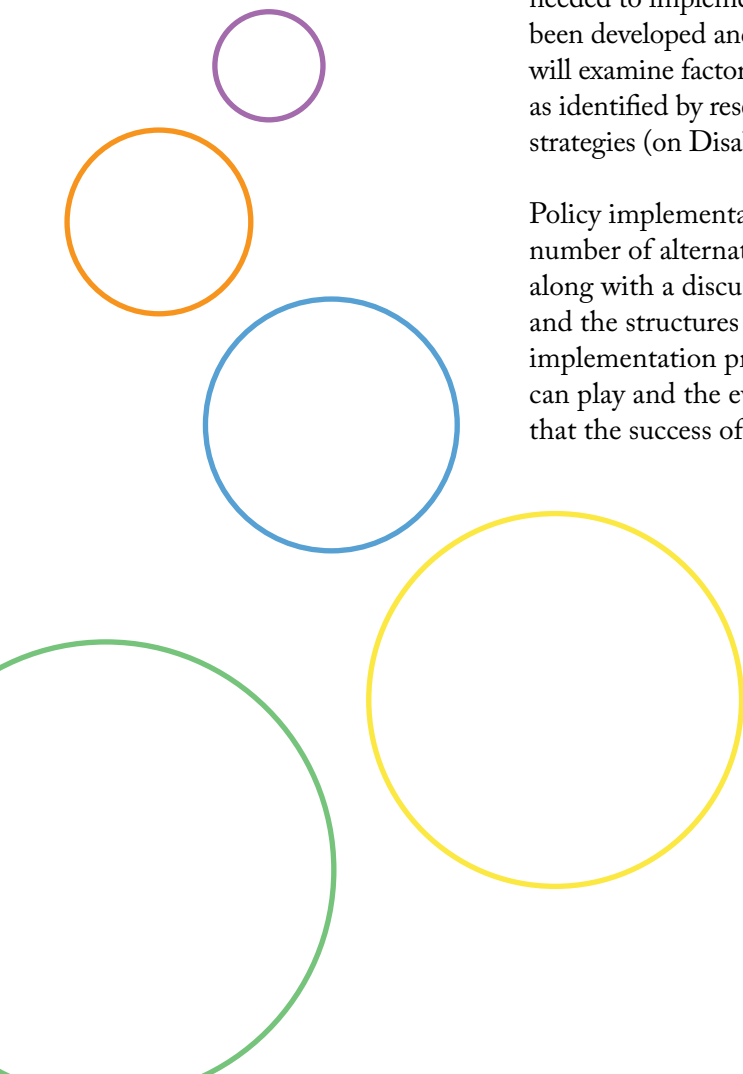
Chapter 7.

Strategy Development and Implementation

There is growing recognition that an effective response to a complex social issue, such as the changing age profile of Irish society, requires that all the relevant actors – organisations in the public, private and third sectors as well as the research community, to align their strategies with each other and with an over-arching governmental strategy as it develops.

Successful action on ageing is not just about drafting a strategy, policy or plan. It is also about gaining the political, institutional and community support needed to implement it. This chapter will look at the way that strategies have been developed and implemented in other countries and other sectors. It will examine factors necessary for the successful implementation of policy as identified by research and by reviewing the experience of two national strategies (on Disability and Children).

Policy implementation presents challenges for governments and a number of alternative approaches to implementation will be examined along with a discussion of the challenges that apply to the Irish situation and the structures and processes that may be necessary to support the implementation process. Finally it will look at the role that research and data can play and the evaluation mechanisms that can be put in place to ensure that the success of the process can be measured and guaranteed.



7.1 SUCCESSFUL POLICY IMPLEMENTATION

The implications of the findings from previous chapters is that both short term improvements and long term transformational changes will be required to address the challenges of enabling people live in their own homes, enjoying an adequate and secure income in later life, living fully-engaged lives in Age Friendly communities, using a health service that can support a significantly increased and older old population.

The difficulty of turning policy into action has been identified in research since the 1970s. When implementation was first studied there was an assumption that implementation would follow automatically once the appropriate policies were set out. However when this did not happen research sought to explain implementation 'failure', and concluded that implementation was a political process similar to policy formulation. (McLaughlin 1987)

As implementation research evolved, two schools of thought developed as to the most effective way of describing implementation processes, either top-down and bottom-up. Those who support top-down approaches see the policy designers as the main actors and policy implementation processes as flowing downwards from the state structures. Those who support 'bottom-up' approaches argue that the target groups and those who deliver the services should be seen as central to the process (Matland, 1995).

While it is important to acknowledge that no specific combination of factors can accurately predict success and that the success of an implementation process can vary according to the context, the level of ambiguity and conflict, policy researchers have identified a number of key factors that can contribute to ensuring success. Landry et al (2011) identified five;

- Flexibility;
- Cultural change,
- Resources and Capacity
- Leadership.
- Goal consensus

Organizational research has found the consensus within the leadership team about the strategy can help or hinder its execution and that successful implementation requires that all those in a leadership position effectively communicate the strategy and take actions to ensure its implementation. (O Reilly et al 2010)

Resources and Capacity

It may seem obvious that a minimum condition for successful implementation is to have the necessary administrative and other abilities to do the job. Roughly half of the 300 studies surveyed by O'Toole (1986: 189) feature resources, and in particular administrative resources, as a critical variable.

It is argued that the capacity of political, administrative, economic, technological, cultural and social environments must frequently be built up to be capable of delivering the policy (Grindle 1980). Capacity building has been defined by Savitch (1998) as "*the total (structural, functional and cultural) transformation of government in order to mobilise all available resources to achieve policy objectives.*" (Savitch 1998)

Mc Laughlin (1987) discussed the difficulties associated with policy implementation and argued that, capacity, although a potentially difficult issue to overcome, is something that can be addressed through training, funding or the employment of consultants to provide missing expertise. But in the absence of commitment or motivation, very little can be done to ensure the successful implementation of the policy intervention (McLaughlin 1987).

Leadership

Without effective and committed leadership, policy implementation, particularly that which involves several organizations, can be hindered by an inability to make the structural and cultural changes needed to bring about cooperation and collaboration among participating parties. (Mischen 2007) Organizational research has highlighted the need for leaders throughout organisations to allocate resources to strategy implementation, deal effectively with resistance to it, and convince others that the new initiative is important (O Reilly et al).

The vital contribution individuals can make in the implementation process has been highlighted by other authors who suggest that change is frequently a problem of the smallest unit. At each point in the policy process, a policy is transformed as people interpret and respond to it. What actually is delivered or provided under the aegis of a policy can often depend on the individual at the end of the line, or the “*street level bureaucrat*” (Weatherley & Lipsky, 1977).

Case study research carried out to examine the factors that contribute to successful implementation of a major policy decision in Malta identified three decisive factors:

- The decision taken to locate political responsibility for the initiative in the Office of the Prime Minister;
- The presence of a strong project management/team dynamic; and
- The type and level of commitment shown to the policy initiative at all levels (Giacchino 2003).

The findings of previous research studies were supported by the NESF (McGauran and Moore 2007) which identified the key issues for implementation of policy as being Management; Accountability; Resources and Engagement. The NESF has referred to

Ireland’s record in the design of social and economic policy as progressive and innovative but implementation has been described as ‘piecemeal’ and at best ‘incremental’ by the NESF (NESF, 2007).

Ireland is not alone in this and in practice the implementation stage is often the most difficult one facing governments. The NESF has stressed the fact that implementation does not happen in a vacuum but rather is constrained both by the external environment and by the institutional context within which the policy is being implemented (NESF, 2007, McGauran & Moore).

7.1.1 Implementation Challenges

In its 2008 report, *Towards an Integrated Public Service*, the OECD cited a lack of implementation skills as one of the main challenges facing the Irish public sector (OECD, April 2008). The organisation drew attention in particular to the segmented nature of the public service and the challenges this posed for policy development, implementation and service delivery. It suggested that responding to more complex, cross-cutting issues will require an integrated public service that acts increasingly through networks rather than top-down structures and further interaction is needed between public service organisations and with stakeholders at local, national and international levels, and across these levels (p. 25)

The report recommended the deepening of project management and implementation skills across the public service, in particular for smaller government agencies and for local government. It defines the implementation challenge facing Ireland in the coming years as stemming from the necessity of meeting increased expectations with constrained resources. In order to meet these expectations, responsiveness will be essential and mechanisms for incentives will have to be developed.

The OECD report summarised the key issues for successful implementation in Ireland in the areas of management, accountability, budgeting, engagement, innovation and politics. It called for government bodies to develop their capacity in the area of implementation and to undertake reform initiatives similar to those carried out in Denmark, Canada and the Netherlands (p. 35) including the development of;

Clearer objectives and related, measurable targets as well as accountability for delivery;

More guidance and technical tools;

Sharing of good practices and good practice criteria (perhaps leading to the establishment of centres of excellence

On the other hand, implementation failure has been found to be linked to an inability to identify clear goals and outcomes in advance of implementation or to fully supervise the implementation of the goals. Policy makers who clearly identify the behaviour change needed and the agent or agencies charged with responsibility to make that change, tend to have higher levels of success in implementation. (Spillane et al 2002).

The magnitude of the change sought and the type of behaviours that need to be changed can also impact on success rates. Spillane argues that policies that can be implemented by means of incremental changes are more likely to be positively received. Successful implementation is also associated with a clearly identified process for change and a way of measuring that change (Mazmanian & Sabatier, 1983).

In a summary of implementation literature Matland (1995) outlines the advice given for successful implementation of public policy goals;

- Ensure that policy goals are clear and consistent
- Aim to minimize the number of actors involved in the implementation process

- Seek to limit the extent of change necessary and
- Ensure that responsibility for implementation is located in an agency supportive of the goals of the policy (Van Meter and Van Horn 1975; Sabatier 1986).

7.1.2. THE MAINSTREAMING APPROACH

The UN suggests that the design of policies and programmes on ageing cannot be undertaken in isolation of the wider policy environment. Integration or “mainstreaming” must be the starting point (MIPAA 2002). The Government has committed to the United Nations Principles on Ageing in the development and implementation of its Strategy. The Madrid International Plan of Action on Ageing, (MIPAA) which followed from the adoption of the UN Principles, calls for a change in attitudes, policies and practices at all levels. (See Appendix 2) It proposes that a necessary first step in the successful implementation of the Plan will be to mainstream ageing and the concerns of older persons into national frameworks and strategies.

The UN defines mainstreaming as “*a methodology for ensuring that issues of ageing and older persons are brought into the mainstream of the policy-making process rather than simply being treated as an add-on*” (UN 2008 p.12). They argue that mainstreaming ageing is not an attempt to make older persons another ‘new’ beneficiary group or give them preferential treatment. Instead it is an attempt to ensure that people of all ages are involved in decisions and actions to promote change and can enjoy the benefits of that change (UN 2003). In practical terms this could mean that bodies with policy-making roles in fields that impact on older people’s lives such as planning, transport, education and health would have representation from organisations of older people.

Mainstreaming is an approach which was widely used for gender equality issues and is aimed at ensuring that issues of ageing and older persons would be incorporated into the activities of all Departments. Using the 'mainstreaming' approach all Departments would examine how policies could affect older persons and how to improve their activities to ensure a more positive impact on older persons.

The guidelines issued by the UN recommend that to be successfully implemented, a strategy on ageing will need political, institutional and community support. A necessary first step involves identifying the Government departments and the potential partners for collaboration. In addition, the existence of collaboration within and between Departments is essential for policy and programme implementation. Structures that support collaboration between relevant staff in various Departments are essential to successful implementation.

In order to achieve this, the UN has suggested that the following steps be followed;

- Collecting and using age disaggregated data (quantitative information);
- Collecting and using analytical information (qualitative information);
- Analysing the particular situation of older persons;
- Analyzing the impact of policies and programmes on older persons;
- Providing information and training to relevant officials of ministries, non-governmental organizations and others on what mainstreaming entails;
- Establishing implementation arrangements and institutional frameworks for mainstreaming;
- Establishing focal points or advocates in relevant offices and organizations;

- Encouraging coordination among representatives of Governments, international agencies, donors, NGOs and older persons.

A study which examined the process of mainstreaming in the disability sector (using Japan and Finland as case studies) found that the process of mainstreaming policies is quite complex and that while both countries have experienced progress in mainstreaming, implementation has been rather limited. The study identified four sets of factors which affect the progress and stagnation of mainstreaming: 1) individual factors, 2) national factors, 3) international factors, and 4) disability-specific factors. Further analysis revealed that in order for stakeholders to be able to mainstream disability both in policies and practices, their ability to do so needed to be strengthened by training, additional resources or other ways of building capacity. They conclude by identifying the most important implications for mainstreaming disability:

- Disabled people have to be empowered,
- The relevance of the strategy has to be understood by key people,
- The political will of the governments is necessary, and
- Lessons should be learned from bad practices and best practices identified (Katsui 2008).

Laws, policies and programmes are important tools for successfully mainstreaming ageing policies. The implications of any planned legislation, policy or programme, for different age groups, including older persons, could be assessed through an impact analysis to ensure that existing policies and programmes as well as laws and regulations adequately reflect the concerns of persons of all ages, not just older people. This means that the concerns of older persons should not be seen in isolation or in competition with other social groups. (UNECE 2009).

7.2 IRISH APPROACHES TO STRATEGY DEVELOPMENT

Whole system change and long-term planning will be required to realise the vision of becoming the best country in the world to grow old in. It needs to happen at policy level to affect priorities and resource allocation; at organisational level to affect the quality and range of supports and services and at individual level to change attitudes and behaviours. It will have to happen across the public, private and third sectors, at leadership and front-line level.

Whole system change following from the development of a strategy has occurred in both the disability and children's sectors in Ireland as well as in many other countries internationally. Much can be learned from the experience of the implementation of the different policy strategies, the National Disability Strategy - launched in 2004 and the National Children's Strategy - published in 2000.

7.2.1 Disability Sector

The way in which change has come about in supporting people with disabilities may provide a useful model for the way forward in addressing the rights and needs of older people. There was a fundamental change in thinking about disability from a 'charity' perspective and to a 'social model' based on concepts of equality, and rights and statutory entitlements. The rights-based approach supported by legislation was a core element sought by groups representing people with disabilities and the strategy gave statutory effect to the policy of mainstreaming public service provision. In addition to the National Disability Act, the government also committed to multi-annual investment for disability support services.

Key to such an approach is the idea that the inability of disabled people to participate fully in the life of their communities can be

attributed more to the limitations placed on them by societal factors rather than from their impairment. Disability activists, influenced by this understanding of disability, have campaigned for laws and policies designed to tackle the barriers lying at the root of the exclusion of people with impairments.

The National Disability Authority was established as an independent statutory body in 1999 with a remit including policy development, monitoring the implementation of standards and codes of practice, and promoting the full equality of people with disabilities. Members of the Authority include people with disabilities as well as their parents and carers and people working in the disability field (www.nda.ie/).

In 2004, the National Disability Strategy was published which built on existing policy and legislation and included commitments to new services and supports and to mainstreaming service provision. Among the key elements of the strategy was the Disability Act of 2005 which established a statutory basis for the provision of a range of specific rights and entitlements, and required six key Government Departments to prepare sectoral plans for full access to services and facilities, in consultation with disability organisations.

The National Disability Act 2005 aimed "*to advance and underpin the participation of people with disabilities in everyday life*". It established a statutory basis for an independent assessment of health and social service needs and "*where appropriate, educational services for persons with disabilities over age 18 years*". It allowed for each person to receive a 'Service Statement', setting out the services they would receive following consultation with the relevant bodies eg HSE. Once in the Service Statement, these became legally enforceable entitlements. The Act allowed for complaints, appeals and enforcement mechanisms where entitlements are not delivered. It also provided for

- Access to mainstream public services and actions to support access to public buildings, services and information.
- Obligations on public bodies to be proactive in employing people with disabilities and the monitoring of compliance with those obligations.
- The establishment of a Centre for Excellence for Universal Design in the National Disability Authority to promote best practice in the design of the environment and products
- Other provisions including amendments of the Broadcasting Act to facilitate access to programmes by persons with sensory impairments

Since then some progress has been made towards implementation. Consultation took place with people with disabilities, their families, carers, advocates and service providers on the content of the plans before they were finalised for submission to the Oireachtas and published in December 2006. The plans include specific targets, where practicable, and timescales against which progress can be measured across a range of services delivered to people with disabilities including health and education services, employment and training, income maintenance, housing and access to the built environment.

A new Office for Disability and Mental Health was established in 2008 to ensure that the delivery of health, education, employment and training services is consistent with the Disability Strategy.

The Disability Act 2005 also required each Department to submit reports of progress on the implementation of the Sectoral Plans by the end of 2009 and each of these reports have been submitted within the time frame. The Act also requires that a progress report on the implementation of the plans must be published every three years. Progress reports on

the Sectoral Plans were published in 2010 and further reviews are due in 2012.

In 2011, the Minister of State at the Department of Justice and Equality, Kathleen Lynch established the National Disability Strategy Implementation Group (NDSIG). The Group is made up of representatives of the relevant Government Departments as well as from the NDA, the County & City Managers Association, the Disability Federation of Ireland; Inclusion Ireland; Mental Health Reform; National Federation of Voluntary Bodies; National Service Users Executive and the Not for Profit Business Association as well as a number of service users who are serving as individuals in a personal capacity.

Under its terms of reference it aims to

- *“Re-energise the National Disability Strategy, maximising what can be realistically achieved within available resources, towards enhancing the quality of life of people with disabilities;*
- *Guide the development of an Implementation Plan for the NDS in accordance with the commitments in the Programme for Government, setting actions and targets that can be realistically achieved as a three year programme of work; and*
- *Collaborate and monitor the implementation of the plan”.*
(<http://www.inis.gov.ie>)

Applying the rights-based approach to the implementation of change in ageing policy, similar to the taken in the disability sector, would involve the removal of exclusionary barriers whether they are physical, financial, social or psychological by the introduction of laws and policies.

The ESRI carried out a review of policy approaches taken in the USA, Australia, New Zealand, Sweden and the UK, and found that none of the countries had linked independent

assessment of need with legal rights to services. Instead services are generally delivered on the basis of available resources.

In the USA, people with disabilities have a right to assessment by health care and social services providers, but anti-discrimination legislation does not provide a generalised right to a particular health or support service or standard of service. In Australia levels of service delivery are set by the relevant Minister, in the light of available resources. New Zealand has a needs assessment and co-ordination system which assesses needs without reference to resource availability, but these assessments do not entitle people to the services identified as needed.

In Sweden, social rights covering health and social services are enshrined in law, but in practice the services available differ substantially from one area to the next. Finally in the UK, entitlement to services is based largely on eligibility criteria set at local level and assessment of need carried out by the relevant local authority setting those criteria. Councils are obliged to assess everybody who presents as needing their services, regardless of resources. Councils thereafter have to meet the person's "reasonable needs", they must have transparent eligibility criteria that enable them to prioritise what needs it is reasonable to meet, and in establishing those criteria they can account for discretionary resources (ESRI 2003).

7.2.2 The Children's Sector

The Irish government signed the United Nations Convention on the Rights of the Child (UNCRC) on 30 September 1990 and ratified it on 28 September 1992. The Convention protects children's rights by setting minimum standards that governments must meet in providing healthcare; education and legal and social services to children in their countries. By ratifying the UNCRC, the Irish State committed itself to promote, protect and fulfil these rights and meet these standards and

since then Ireland has submitted two national reports to the UN. However in the area of ageing, less progress has been made and Ireland has yet to report to the UN body responsible for monitoring implementation of the Madrid Action Plan on Ageing.

Key legislation and policy measures, many of which were undertaken as a consequence of UN recommendations include: The Equal Status Act, and the Education (Welfare) Act of 2000; The Human Rights Commission Acts of 2000 and 2001; The Children Act of 2001; The Ombudsman for Children Act of 2002; The Education for Persons with Special Needs Act of 2004; The National Children's Strategy, (Our Children – Their Lives) of 2000, the National Play Policy of 2004 (Ready, Steady, Play) and the National Anti-Poverty Strategy reviewed in 2001;

The National Children's Strategy was published in 2000 after a process of consultation with children, parents and groups working with children. The strategy was a 10-year plan of action, including a range of actions across with three National Goals:

- Children would have a voice in matters which affect them and their views would be given due weight in accordance with their age and maturity.
- Children's lives would be better understood; their lives would benefit from evaluation, research and information on their needs, rights and the effectiveness of services.
- Children would receive quality supports and services to promote all aspects of their development.

The strategy was underpinned by the UN Convention on the Rights of the Child and adopted a 'whole child perspective', with implications for the direction of public policy-making and the integration of services relating to children.

This led to the establishment of a number of critical elements of infrastructure. The National Children's Office, established in 2001, initially had overall responsibility for co-ordinating the implementation of the strategy. The office was given responsibility for children's participation (Goal 1) and research (Goal 2). To implement goal 3 - the improvement of supports and services - the NCO was given responsibility for progressing the priority policy issues and those which require cross-departmental/interagency action. Progress reports on the implementation of the strategy were published for 2002, 2003 and 2004.

In 2005 the National Children's Office became part of the Office of the Minister for Children and Youth Affairs. When first established, the position of Minister of State for Children was appointed across the Departments of Education and Science, Health and Children, and Justice, Equality and Law Reform.

The Office of the Minister for Children and Youth Affairs (OMCYA) was intended to play a key role in supporting the implementation of the National Children's Strategy. In June 2011, the Department of Children and Youth Affairs was established, with the Minister for Children and Youth Affairs becoming a full cabinet minister. Certain units from other Departments also became part of the new Department.

The National Children's Strategy Implementation Group (NCSIG) was established in 2006. Prior to the establishment of the Department of Children and Youth Affairs, it was chaired by the Office of the Minister for Children and Youth Affairs. Its membership is drawn from the relevant Government Departments, the Health Service Executive (HSE), representatives of local authorities, the education sector and other key agencies.

The role of the NCSIG is to ensure implementation of all the strategic plans and policy documents. As part of the process of

achieving its goals, the NCSIG has committed to establishing a network of Children's Services Committee under each of the 34 city and/or county development boards in the country. It is intended that all major organisations and agencies working locally on behalf of children and young people are to be represented on Children's Services Committees (CSC).

The role of the CSCs will be:

- To coordinate the implementation of national and regional policies and strategies, which relate to children, young people and families, in the area covered by the CSC
- To plan and co-ordinating services for children in the area covered by the CSC, in order to improve outcomes for children
- To eliminate fragmentation and duplication of services by ensuring more effective collaboration between children, young people and family services within the area
- To influence the allocation of resources across the area covered by the CSC with a view to enabling the effective use of resources at local level
- To strengthen the decision-making capacity at local level.

Since 2007, ten CSCs have been established in Dublin City, South Dublin, Limerick City, Donegal, Kerry, Fingal, Kildare, Longford/Westmeath, Carlow and Louth. An additional six CSCs are at various stages of development in Wicklow, Waterford, South Tipperary, Meath, Sligo/Leitrim, and Cavan/Monaghan.

The National Children's Advisory Council was an additional part of the infrastructure established in 2001. The Council, made up of 30 members from government agencies and NGOs, has an independent advisory role in relation to the implementation of the Strategy, reporting to the Minister for Children. It

includes representatives of the statutory agencies, voluntary sector, research community, parents and young people.

An additional part of the infrastructure is the Ombudsman for Children's Office (OCO) which was established in 2004 under the Ombudsman for Children Act, 2002. The office has responsibility for promoting and safeguarding the rights and welfare of children and young people. The Ombudsman for Children is independent of Government and is accountable to the Oireachtas. The main functions of the Ombudsman's office are;

- To provide an independent complaints handling service regarding public bodies;
- To promote children's rights, including through participation and communications activities;
- To monitor and review legislation relating to the rights and welfare of children;
- To advise any Minister on any matter relating to the rights and welfare of children; and
- To ensure that law, policy and practice meet the highest standards and obligations in accordance with the UN Convention on the Rights of the Child (www.oco.ie).

The fifth key structure is the establishment of Dáil na nÓg (or youth parliament), which meets annually to debate issues of importance to children and young people, and Comhairle na nÓg, the parallel structure at county level. These provide real opportunities for children and young people to debate key issues affecting their lives, to vote on them and, in principle at least, to have their voices listened to. For example, the voices of children and young people in both the development of the National Children's Strategy and also through these and other structures has highlighted the need for, and contributed to, the development

of national policies on play (OMC, 2007) and recreation (OMC, 2004).

The Agenda for Children's Services, published in 2007 by the Office of the Minister for Children & Youth Affairs, provides a framework for the relevant Government Departments and agencies in all policy considerations and services related to children and families. It identifies the seven key desired outcomes in relation to delivery of services for children. These are that children would be...

- Healthy, both physically and mentally
- Supported in active learning
- Safe from accidental and intentional harm
- Economically secure
- Secure in the immediate and wider physical environment
- Part of positive networks of family, friends, neighbours and the community
- Included and participating in society.

The Department is currently developing a new strategy for children and young people to build on *Our Children - Their Lives*, Ireland's first children's strategy. The new strategy will cover the period from 2012 to 2017. In 2011 almost 67,000 children and young people throughout the country participated in a consultation process and it is intended that the views of a wide range of interests including children themselves will continue to shape the development of the children and young people's policy framework throughout 2012.

7.2.3 International Approaches - New Zealand

The trend towards viewing ageing from a positive perspective has informed the approach towards policy development in many other countries including New Zealand which launched its Positive Ageing Strategy in 2001.

The determinants of positive ageing identified in the New Zealand strategy include; a stable and secure income in retirement as well as good health and appropriate access to health and social support services and supports to facilitate 'ageing in place' (or being supported to continue living in their homes and communities). The strategy also identifies the issue of safety and security as a determinant of positive ageing (New Zealand Positive Ageing Strategy 2001).

The approach taken by the New Zealand Government in developing the strategy involved the following steps:

- Developing a set of principles and goals which form a strategic framework for government policies and services;
- Seeking the views of community and stakeholder groups on the principles and priority areas for government action;
- Establishing goals for positive ageing according to the priority areas raised in consultations;
- Undertaking a stock take and assessment of existing government policies and services from the perspective of the positive ageing principles;
- Compiling an inter-departmental action plan to work towards achieving the goals and addressing issues identified in the consultations and the policy stock take exercise; and
- Identifying mechanisms for regular monitoring, reporting and review of progress on the Strategy (New Zealand Strategy on Positive Ageing 2001).

The Government of New Zealand adopted a mainstreaming approach to the design, implementation and monitoring of their policies on ageing, through their Positive Ageing Strategy, which was launched in 2001. The approach to implementation taken in New Zealand involves the identification of goals with

measurable indicators which are set out in the strategy progress reports and reviewed regularly, so that the Office can assess achievement at the end of each year. In order to keep the momentum working across different Ministries, the Office of Senior Citizens organizes quarterly Interdepartmental Network meetings to exchange information and check on progress. The Office also provides comments on proposed policies, programmes and services in other areas across the policy sphere.

The Ministry of Social Development believes that this approach, which sees the Office of Senior Citizens taking the lead role in implementation but not acting as its sole implementer, is most effective in ensuring action from a variety of actors from across the policy spectrum (UN 2008).

7.2.4 Northern Ireland

In June 2004 the Northern Ireland Office of the First Minister and Deputy First Minister (OFMDFM) published the Older People Strategy document, "*Ageing in an Inclusive Society*" which sets out the Government's approach to promoting and supporting the inclusion of older people in Northern Ireland. This document sets out the NI Government's strategic vision and key recommendations to improve the lives of older people in Northern Ireland. The strategy was accompanied by an Implementation Plan, which sets out how these recommendations will be taken forward in the future.

The strategy identified six key objectives to provide the policy framework within which departments work on behalf of older people;

- To ensure that older people have access to financial and economic resources to lift them out of exclusion and isolation;
- To deliver integrated services that improve the health and quality of life of older people;

- To ensure that older people have a decent and secure life in their home and community;
- To ensure that older people have access to services and facilities that meet their needs and priorities;
- To promote equality of opportunity for older people and their full participation in civic life, and challenge ageism wherever it is found; and
- To ensure that Government works in a co-ordinated way inter-departmentally and with social partners to deliver effective services for older people.

The Strategy was accompanied by an action plan which translated the key recommendations into a programme of work for NI government Departments. In November 2011, Claire Keatinge was appointed as the Commissioner for Older People for Northern Ireland. The Commissioner for Older People Act 2011 identifies a range of promotional, advisory, educational and general investigatory functions, duties and powers to be deployed in the interest of older people both generally and individually. The principal aim of the Commissioner is to safeguard and promote the interests of older people.

7.2.5 Scotland

In 2005, the Scottish Parliament established the Futures Forum, a body bringing together members of Parliament, policy makers, business leaders and the wider community, with a brief to reflect on critical issues for Scotland's future and to stimulate informed and participative public debate. Its first project was on positive ageing and it produced a report in 2006, *Growing Older and Wiser Together*, which looked at possible scenarios developing in Scotland over the next 25 years, and highlighted questions for all levels of government and the business sector to consider and take action on.

An extensive public consultation then led to the publication in 2007 of a Scottish Strategy, *All Our Futures: Planning for a Scotland with an Ageing Population*. This strategy plan identifies six priority areas for action:

- Improving opportunities and removing barriers
- Forging better links between the generations
- Improving and maintaining health and well being
- Improving care, support and protection for older people
- Developing housing, transport and planning services
- Offering learning opportunities throughout life

To achieve effective implementation, the Strategy proposed the establishment of a National Forum on Ageing, to champion the Strategy; raise public awareness; provide advice and assistance to all sectors in developing their responses to the Strategy; and develop measures to monitor success in all sectors toward the strategic outcomes .

It is important to note that these engagement mechanisms were established in the context of a radical programme of public service reform. The new system is designed to increase cooperation and mobility of resources across departments and agencies as the achievement of the five strategic objectives necessitate working together on issue areas rather than operating within defined jurisdictions. As part of this restructuring, power was devolved to local authorities which were given increased control in decision-making, including decisions pertaining to spending priorities.

Scottish local authorities have responsibility for producing Single Outcome Assessments using outcome and performance indicators

agreed at a national level. In order to facilitate integration and cooperation in the area of implementation, practical implementation groups were set up by the Joint Future Implementation Advisory Group (JFIAG). These groups provide guidance and advice on the practical aspects of implementation of Joint Future as well as indicating opportunities for shared learning.

7.3 THE VOICE OF OLDER PEOPLE

Participation is seen as fundamental in the United Nations Principles for Older Persons (United Nations, 1991), along with independence, care, self-fulfilment and dignity. Current thinking supports the inclusion of older people's voices in decision-making fora at all levels, and supporting them to inform planning, policy, strategy and research processes on issues that affect their lives.

The concept of community development work is an important approach to ensuring that the voices of older people are heard in a variety of local, regional and national decision-making fora. Community development work can be defined as the process of developing active and sustainable communities based on social justice and mutual respect. It is about influencing power structures to remove the barriers that prevent people from participating in the issues that affect their lives. These barriers can include issues such as transport, mobility, access to information, lack of consultation, suitability of venue, timing and cost

Currently, at a local level, County and City Development Boards (CDBs) are required to engage in local consultation with the community and voluntary sector, but the inclusion of older people in these processes is not specified. The same applies to the local Strategic Policy Committees, set up in each area on a statutory

basis in 2001, which develop policy in areas including housing, transport, the environment, and cultural and social development.

Without a rigorous structure to ensure this inclusion, arrangements vary from one area to another. Effective consultation with older people will require an appropriate structure, plus investment in resources and infrastructure to encourage community links and build capacity for full participation. The OECD 2008 report, *Towards an Integrated Public Service*, recommended the reinforcement of CDBs and both the National Development Plan and the Partnership Agreement Towards 2016 have committed to achieving this.

In Ireland, there is as yet no systematic approach to ensuring that older people have a voice in regard to decision-making processes, either locally, regionally or nationally. However the voice of older people is promoted through Older & Bolder which is the collaboration of eight member organisations working with older people. Older and Bolder is working to secure the rights of older people and to ensure that older people's voices are heard in campaigns conducted with, for and by older people. The political commitment to a National Positive Ageing Strategy followed one such campaign.

At national level, older people were included in the discussion and negotiation leading up to National Partnership Agreements via two organisations, Age Action and the Irish Senior Citizens Parliament, which are members of the 'community and voluntary pillar' representing a range of national-level non-governmental organisations in the Partnership structure. The Irish Senior Citizens Parliament currently has 400 affiliated organisations representing over 100,000 older people (<http://iscp.wordpress.com/>). Older people are also represented on the National Economic and Social Forum (NESF) by a representative of Age Action/Irish Senior Citizen's Parliament (www.nesf.ie).

7.3.1 International Examples for the Inclusion of Older People - Wales

In January 2003, the Welsh Assembly launched its Strategy for Older People in Wales. A central part of this Strategy was the establishment in 2005 of an independent advisory body, the National Partnership Forum for Older People. This includes all the key stakeholders, including substantial representation of older people themselves, and is specifically intended to link the various levels of decision-making.

Meeting four times a year, it is made up of a Chair, five lay members representing older people across Wales, and 15 nominated members from sectors including housing, education, the voluntary sector, employment, transport, older people's groups, health and social care. A series of smaller sub-groups meet to focus on specific issues or particular areas of work. Its roles are:

- To provide expert and informed advice to the Welsh Assembly Government on the development of its policies for older people;
- To provide a focus and impetus for the debate of and support for the development of effective policies at all levels of government to benefit older people;
- To provide an effective channel of communication from older people and their representatives to local government and the Welsh Assembly Government and through the Assembly Government to UK Government (Progress Report to Cabinet Subcommittee on Older People; paper OP (05-06) 14, 2006).

In addition to the National Partnership Forum, the voice of older people is being facilitated through the development of '50+ Forums' at local level. Many local authorities have appointed Older People's Champions from within their local Cabinet to progress the aims of the Strategy. Older People's Champions

can help to ensure that whatever the issue, the needs, wishes and preferences of older people are fully taken into account in the planning and implementation of policy and services in the local authority area.

The Champion is also a strategic leader campaigning for older people across their local authority, raising and promoting older people's issues. In 2008, a Commissioner for Older People in Wales was appointed to safeguard and promote the interests of older people in Wales.

7.3.2 New Zealand

The New Zealand Volunteer Community Co-ordinator (VCC) Programme was set up in 1999 as part of the UN Year of the Older Person and is a network of approximately 50 volunteers who have been nominated by a local charity or voluntary organisation with an interest in older people, to work with the Office for Senior Citizens.

The aim of the VCC programme is to promote positive ageing and to inform central and local government about matters affecting older people. VCCs use their knowledge of their communities to help them to make a contribution to policy development. The role involves working with the Office for Senior Citizens on a part-time basis to carry out projects on behalf of the Minister for Senior Citizens.

The programme provides a link between the Minister for Senior Citizens and older people throughout New Zealand. It supports the Minister in advocating on behalf of older people at Cabinet and also ensures that all policy development is informed by the views and experiences of older people. The VCCs represent different parts of the country and have access to a wide range of local networks, including people from different cultures and backgrounds, from rural and urban areas, community organisations and local government (Office for Senior Citizens, 2002).

7.3.3 Irish Examples

Consultation with older people and with organisations representing older people has formed a vital component of the Age Friendly Counties Initiative and community forums and other consultation mechanisms have been used in the development of the initiative in each participating county. These processes of consultation will continue to be part of the planning and development of the Age-Friendly County Strategies as the Initiative is extended to other counties.

Consultation initiatives have also been conducted by independent national agency Age and Opportunity which promotes positive attitudes to ageing, participation of older people and intergenerational solidarity. Older and Bolder was formed in 2006 to improve the engagement of older people in Ireland and to mobilise support for a new national strategy to reflect the current needs and preferences of older people.

7.4 STRATEGY REVIEW AND EVALUATION

Experience from other countries suggests that the effectiveness of any strategy will be strengthened by the creation of a strong monitoring and reporting framework. Returning to the examples of the Disability and Children's Strategies it is useful to identify the specific aspects of the implementation processes that contribute to effective implementation and evaluation of progress.

The National Disability Strategy Stakeholders Monitoring Group was established for a three year term and has responsibility for monitoring the implementation and progress of the Strategy. It includes the Disability Stakeholder Group representing the disability sector and the Senior Officials Group - representatives

from other relevant government departments. It meets twice yearly and is chaired by the Assistant Secretary in the Department of An Taoiseach with the Chair of the NDA as Vice-Chair. The NDA is involved in gathering data on a suite of indicators to examine progress to date on the implementation of the Strategy.

Under "*Towards 2016*" the government established new cross-departmental and monitoring structures to monitor and support the implementation of the Disability strategy. Each of the six departments named in the legislation must draft their own sectoral plan. A Senior Officials Group which comprises officials from the six departments and a number of others including Finance and Education, meet every two months to review implementation.

The implementation of the National Children's Strategy was initially monitored by the Office of the Minister for Children and Youth Affairs (OMCYA) and since 2006 by the National Children's Strategy Implementation Group (NCSIG). It includes representation from the relevant Government departments, Health Service Executive (HSE), local authorities, the education sector and other key agencies as appropriate, which link with the Expert Advisory Group on Children.

The approach to monitoring progress involved identification of the strategy's three goals: ensuring that children have a voice in matters which affect them; that their lives will be better understood through evaluation, research and information on their needs, and the effectiveness of services; and that they will receive quality supports and services to promote all aspects of their development.

In addition to these goals the implementation process identified 14 objectives and 135 actions under the Strategy dealing with all aspects of children's lives. Reporting on the progress of the implementation involved the identification of progress made under each of these headings.

At local level, implementation of the strategy is supported by the creation of multi-agency Children's Services Committees which were established in 2007/2008. These committees were intended to meet the "implementation gap" (Burke et al 2010). Research was carried out in 2010 to evaluate and consolidate the learning from the early implementation of the Children's Services Committees in the four pilot areas. One of its key findings was that in order to be successful there was a need for strong sustained leadership both nationally, from government and locally. The report also called for the development of a national framework for the successful development of CSCs, a clearly defined mandate and remit and the clarification of the lines of accountability for CSCs. (Burke et al 2010)

7.4.1 Key Performance Indicators

Developing quantitative and qualitative performance indicators to measure progress will be central to the successful implementation of the strategy. Indicators will also facilitate the final evaluation of the success of the strategy. It is important to first establish a baseline or starting point prior to the implementation phase in order to establish that progress has been made or to plan for a change in approach.

The UN proposes that appropriate indicators must also be Specific, Measurable, Available, Relevant and Time-bound (S.M.A.R.T.) and they could either measure the overall effectiveness of the strategy in improving the lives of older people or it could measure the effectiveness of the implementation process in fulfilling the objectives in relation to its key goals or actions (UN 2003).

Central to the standardisation of data collection is the use of commonly agreed key performance indicators (KPIs) with which to analyse the information obtained and assess the success of the implementation process. KPIs are also increasingly used by governments as metrics

against which targets are set for achieving progress. In the UK, for example, there are now 32 higher level national targets and central government negotiates with local authorities about how these will cascade to local level.

Indicators could seek to measure improvements in individual wellbeing such as quality of life indicators as well as the success of overall policy. For example, one indicator could assess quality of life through the level of satisfaction expressed by older persons about overall conditions (economic, social, and cultural). A success indicator regarding policy directed toward older persons would be a measurable increase in various services provided to older persons. A time line for the implementation of each change could be built into the strategy, progress monitored regularly and outcomes acted upon.

The Madrid Action Plan on Ageing identifies a number of indicators in the areas of demography, income and wealth, labour market participation, and social protection and financial sustainability. It also proposes a 'bottom-up' approach which would see older persons as active participants in the review and appraisal process. This could be ensured by establishing procedures for regular communication between policy makers and older persons regarding the impact of policies that affect them.

In relation to the Disability Strategy indicators have been developed that are not intended to capture every aspect of progress, but rather to signal progress in key areas. Indicators relating to health status, for example, cover areas such as routine health care and checks (taking dental visits as the indicator), health-promoting behaviours (diet and exercise), and health outcomes (life expectancy of people with cystic fibrosis in Ireland).

For the monitoring of the implementation of the National Disability Strategy, many of the indicators being used to measure progress are derived from existing data sources such

as: Quarterly National Household Survey (QNHS) the EU -Survey of Income and Living conditions (EU-SILC) and others.

The development of a national set of child well-being indicators was identified as a key action under the National Children's Strategy. The aim was to develop indicators which would contribute to the assessment and description of the lives of children growing up in Ireland. These indicators allow for the monitoring of child outcomes over time to support the setting of goals and the planning of more effective services. It is also intended that these indicators will contribute to the evaluation of the impact of policies and investments in selected programmes, services and initiatives on the lives of children in Ireland (www.omc.gov.ie).

In 2005, the Report on the Development of a National Set of Child Well-Being Indicators was published (Hanafin and Brooks, 2005). A multi-stage approach was taken to the development of the indicators with four main components;

- A background review of indicators sets in use elsewhere and the compilation of an inventory of key indicators, domains and indicator selection criteria;
- A feasibility study of the availability of national statistics to construct the indicators identified in the previous step;
- A study on Children's Understandings of well-being; and
- A consensus process referred to as a Delphi technique, where participants on 'a panel of expertise' agreed indicators for use in the Irish context.

7.5. INFORMED BY RESEARCH AND DATA

In order to ensure that the implementation process is effective, it is important that policy

and strategy be clearly linked to the achievement of positive outcomes and not merely to the articulation of objectives or the establishment of structures. The setting of goals and targets are an essential part of an effective system of monitoring. Elements of a cohesive national research strategy include the promotion of coordination and linkage among new research programmes and projects, and the dissemination of findings in appropriate form to all stakeholders – including older people themselves.

The National Council on Ageing and Older People (NCAOP) has argued for new research to provide more 'person-centred data' as the basis for a broad and informed understanding of the diversity of experiences, needs and views of older people in Ireland (NCAOP, 2005). Applied research, which is research used to solve practical problems rather than acquire knowledge for its own sake, will increasingly play a crucial role in influencing the formation and development of public policy and planning for an ageing population.

The UN Programme on Ageing, in cooperation with the International Association of Gerontology, produced a joint project entitled 'Research Agenda on Ageing for the 21st Century'. The Agenda supports the implementation of the Madrid Action Plan on Ageing (MIPAA) through policy-related research and data gathering based on the priorities identified. They identify research 'arenas' such as social participation, economic security, healthy ageing, physical and mental functioning, quality of life, care systems and policy evaluation. More specifically the plan identifies the following priorities;

- Links between population ageing and economic development,
- Current practices and options for maintaining financial security into old age,
- Changing family structures, financial transfers between generations and emergent patterns of family dynamics,

- Determinants of healthy ageing,
- Basic biological mechanisms and age associated diseases, and
- Quality of life and ageing in diverse cultural, socio-economic and environmental situations.

(UN programme on Ageing 2007)

Best practice in research into aspects of personal and social life and experience involves the active participation of those who are 'researched' in the processes of research itself. This applies particularly to a population group as diverse as 'older people'. There is, as yet, no coordinating mechanism in place which is aimed at prioritising research agendas, including enabling the voice of older people to be heard in determining priorities, and monitoring the extent to which research impacts on policy and practice. In this regard, Atlantic Philanthropies has funded the establishment of CARDI.

In Ireland, in recent years there has been significant growth in research into the lives of older people in a number of different contexts including academic institutions; public bodies; state agencies, particularly the NCAOP; and community and voluntary bodies. Many of these research initiatives have been supported by private philanthropy.

There is general agreement among many stakeholders that this essential data infrastructure is not yet in place. In the area of health, for instance, while over one third of Irish people report having a chronic illness - and it is known that this percentage increases with age-specific data is unavailable and there is little or no baseline information with regard to the prevalence of chronic disease among older people in Ireland (HSE: 2009; Naughton, Bennett and Feely: 2009). This lack of information about health trends can have a negative effect on the capacity of policy-makers to successfully formulate strategies which provide for the health care needs of older people (Naughton, Bennett and Feely: 2009).

7.5.1 Data Collection Initiatives

The Development of a Draft Framework for the Collection of Information about the Older Population (unpublished) was completed in 2006 by the Economic and Social Research Institute (ESRI) and Trinity College Dublin for the National Council on Ageing and Older People (NCAOP).

The framework was designed as a resource for practical and coordinated initiatives in data collection and provision on the part of key actors including government Departments, the Central Statistics Office, the HSE and Health Research Board, the National Disability Authority and others, all of whom had been consulted for their views. It had a specific focus on information and data collection, particularly the type of information needed to assess progress on the policy objectives defined in the social partnership agreement Towards 2016.

The paper distinguished between the gathering of new data on the older population and their lives through large-scale surveys and the better utilisation and integration of existing administrative information from various sources (p. 7). Research reports into specific topics of interest also need to be included in any overall framework and shared in a systematic way. The paper also noted unevenness in the information available for providing a picture of older people in Ireland: while there is substantial information on health and formal health care, there are major gaps in other areas such as family care, retirement decisions and processes, and coping with bereavement. It also noted the various new initiatives that were then at an early stage which have since been progressed (Health Atlas of Ireland, the National Disability Survey, and the longitudinal surveys SHARE and TILDA).

Its recommendations for the short term were focused on existing sources of information: they should be fully documented, made

more accessible to legitimate users, and improvements in quality should be sought. A lack of comprehensive quantitative data was noted. Due to the lack of representative data sources on many aspects of ageing, most studies have had to generate their own data. As a result of the high cost of doing this and the qualitative focus of many projects, the data generated is rarely representative of the older people population generally.

For the longer term, priority was given to providing new and improved information on the lives and characteristics of the older population. Recommendations included:

- The creation of a central repository of statistical information;
- Longitudinal data collection;
- The use of a 'unique personal identifier' to allow for linking of different administrative data-sets (taking into account data protection and technical issues);
- A large scale time-use survey to give a better picture of older people's lives;
- The development by the CSO of indicators relating to health and social circumstances of the older population.

7.5.2 NCAOP Information Report Workshop (2006)

The NCAOP in 2005 prepared a discussion paper "*The Older Population: Information Issues and Deficits*" (O Shea and Conboy 2005). The authors conducted a review of existing data and collection systems in respect of older people, concluding in its position paper *An Age Friendly Society* that the significant existing gaps and deficits require the putting in place of 'a new national framework of information about the older population' (NCAOP 2005, p. 34)

This was followed by a workshop in December 2006. The workshop, entitled *The*

Development of a Draft Framework for the Collection of Information about the Older Population 2006 was attended by 37 researchers and representatives of government and agencies, health providers and the voluntary and community sector. The NCAOP identified a number of priority areas for the short term:

- Income of older people, additional to the data in EU-SILC, especially as it relates to their contributions to the cost of health and social care.
- A time-use survey of older people, as suggested in the ESRI/TCD report, would be most valuable if it also identified the determinants of time use, such as health status, access to transport and local availability of cultural, leisure and educational opportunities.

The workshop then discussed the six priority areas set out in *Towards 2016* (the social partnership agreement) which can be summarised as follows:

- Income support: What is lacking, and critically important in relation to older people, is information about assets, particularly in housing, and the role they play. TILDA is to provide information in this area.
- Long-term care services: There is a need for more statistical data, particularly on numbers of home-care grants and services; levels of dependency of recipients; outcomes of provision of care; availability of formal and family carers; as well as a national map of publicly-financed services at cost. Concern was expressed at the difficulty of linking data on public, voluntary and private aspects of provision, particularly in relation to sheltered or supportive housing. Further data collection and evaluation is also required on different financial options such as co-payments, additional sources of

funding beyond existing taxation sources, a financial insurance type arrangement and pre-funding mechanisms. In this context, the report noted that the lack of accepted disability prevalence statistics for Ireland represented a significant problem.

- **Housing:** Research is needed on definition of housing need, which is currently considered purely in terms of local authority housing needs assessments. There is insufficient evaluation of the precise impact of housing schemes and a need to build measurement of the impact of particular policies and types of funding into information requirements. There is a need for data about adaptations of existing houses which can allow people to remain living in their own homes and maintain independence. The disabled person's grant schemes currently show a wide diversity in how they are implemented locally and better data could improve this situation.
- **Mobility:** There is an urgent need for a new national transportation survey. Questions on transport in the census are oriented either toward transport to work or to school and there is a severe lack of data on other aspects.
- **Health:** Research is needed on ensuring quality in health services and social-care services including the collection of information about older people's experiences of quality of care in the community and in long-term settings. More research is required in relation to home-care packages especially regarding targets and impact. The report noted that surveys in acute health care tended to focus on cost rather than on the quality of the information that they might generate.
- **Education and employment:** Research is required on the needs and preferences

of older people in adult and continuing education. It was noted that there is no national picture of local or community level computer projects for older people, since the data on the Community Application of Information Technology (CAIT) schemes is not disaggregated by age. Volunteerism is increasingly seen as important in terms of physical and mental health, yet there is little information on older people as volunteers, both within and outside the home.

7.5.3 Additional Data Sources

The CSO published in 2007 its first summary of relevant information on older people, *Ageing in Ireland*. It is structured around a set of specific indicators in relation to: demographic information; health and care; accommodation; economic situation and lifestyles, including areas of travel, voting, crime, educational attainment, internet connection and voluntary work.

The Institute of Public Health (IPH) is dedicated to the enhancement of health intelligence and the sharing of information between the Republic of Ireland and Northern Ireland with a view to the development and maintenance of effective policy and practice. The IPH is engaged in collaborative initiatives of information gathering and recording. Given the relatively small populations and geographical area; the similarities in the gene pool; and the fact that there are two distinct health systems in operation, this area provides a 'natural experiment' and a unique opportunity for research into factors affecting health.

Questionnaires, conducted on both sides of the border asking the same questions, and surveys using common indicators to analyse data obtained constitute standardised methods of data gathering which can be easily used for comparative study. An example of recent North-South collaborative research is *One*

Island – Two Systems report published by the Institute of Public Health in 2005 (McGee et al). As mentioned in the previous section, CARDI, an affiliate organisation of the IPH, is the depository for research into age and ageing on the whole island of Ireland (www.cardi.ie).

CONCLUSION - KEY ISSUES

In conclusion the key issues to be considered in relation to the development and implementation of the National Positive Ageing Strategy are the following;

Prioritisation of policy issues.

Ireland has once been described as suffering from ‘Implementation Deficit Disorder’ by Dr Eddie Molloy. Ireland is not alone in this and policy implementation has not generally had a successful history. Clearly not all of the issues discussed in this report can be addressed in a single strategy - there needs to be a set of clearly identified priorities. Some changes will need to be addressed urgently, such as measures enabling greater numbers of older people to stay living in their own homes, or the development of a strategy to respond to Dementia. Others need commitments to the long-term planning.

Implementation Infrastructure

Some new approaches have been tried in areas such as Disability, with new structures such as Stakeholder Implementation Groups with senior officials and NGOs monitoring implementation and different Government departments being required to produce statements of progress.

Implementation of a new strategy will require a strong implementation infrastructure, potentially including an Office for Older Adults with authority to bring relevant departments

together in joint execution planning eg transport, social security, jobs, education, transport, environment. This structure could be potentially augmented by leaders or champions such as an Ombudsman. There is evidence that successful strategy implementation requires strong and committed leadership at government level but older people’s issues have not up to now, been prioritised by the political parties.

Multi-stakeholder roles; There is strong evidence and general acceptance, that successful change implementation, especially changes requiring a ‘whole system’ approach, requires the active engagement of those stakeholders who will have a strong role to play in implementing the changes needed. A Positive Ageing Strategy will clearly have to rely on the active engagement of organisations across the public, private and voluntary sectors. However, Ireland doesn’t have a strong track record of engaging players across those three sectors in joint planning and implementation.

International commitments; The *Madrid International Plan of Action on Ageing* was signed in 2002 and provides UN members with a clear framework and toolkit for bringing about change but Ireland is one of the few countries that has not as yet formally committed to a Plan of Action aimed at implementing the changes needed to give affect to the eighteen Principles.

Voice Of Older People; Priorities and plans need to be informed by the needs and preferences of older adults, with account taken not just of the current generation but also the next.

Life Course Approach; As is evident from much of the report, planning for an ageing population and planning by individuals for their own old age, needs to take place much earlier in life.

APPENDIX 1

BACKGROUND TO THE STRATEGY

While there have been ageing-specific policy initiatives undertaken by government branches, in particular, in the area of health, the general level of awareness of ageing as a core issue for government policy is low (O'Neill et al: 2009). Ireland is one of the few European countries that has not responded to the UN Madrid Action Plan on Ageing, and the key UN concept of intergenerational solidarity is not widely reflected in official national policy (O'Neill et al: 2009).

However, Ireland's policy record is not all negative. Ireland was one of the first countries in Europe to develop a strategic plan for the development of services for older people in *'The Years Ahead'* and many of Ireland's welfare provisions for older people are very generous when seen in a wider European context, including universal entitlements to free travel. In addition, Ireland is recognised as a model for the development of palliative service, ranked second only to the UK in a recent report by the European Commission. While in the UK provision is largely voluntary, in Ireland it is mainly state-funded having been successfully integrated into the public health system.

The following is a summary of the two main policy initiatives which have preceded the proposed Positive Ageing Strategy: The Care of the Aged report and The Years Ahead – A Policy for the Elderly.

Previous Strategies

The Care of the Aged report, which was published in 1968, was one of the earliest policy documents on older people. The report placed emphasis on 'community' care, arguing advantages both for the well-being of the older person and also for economic cost-cutting principles. The Inter-departmental committee

that prepared it acknowledged for the first time that... 'it is better, and probably much cheaper, to help the aged live in the community than to provide for them in hospitals or other institutions' (Inter-Departmental Committee on the Care of the Aged 1968: 10).

The Care of the Aged report was followed in 1988 by the publication of *The Years Ahead – A Policy for the Elderly* in 1988. As mentioned above, Ireland was one of the first countries in Europe to develop a strategic plan for the development of services for older people and *The Years Ahead* was adopted as official government policy in 1993. While it has been influential in shaping policies for older people in the area of health, many of its recommendations were not implemented and almost no extra spending was directed toward older people as a result of the strategy (NCAOP Implementation Review; Ruddie, Donoghue, & Mulvihill, 1997).

The *Years Ahead Report: A Review of the Implementation of its Recommendations* (Ruddie et al., 1997) reviewed the implementation of the recommendations from the 1988 report, and highlighted the slow pace of implementation as well as the validity of certain recommendations nearly ten years after the initial report. Despite the recommendation that a legislative framework be put in place for the development of services to older people, by 1997 this had not materialised, and services for older people were still provided on a discretionary basis.

There was little or no mention of information needs in any of these reports, although more recent statements of strategy from the Department of Health and Children have recommended a more integrated approach to the gathering and processing of information, in the context of an increasing focus on evidence-based decision making (see for example, Department of Health and Children, 2001a, 2001b, 2001c, 2003c and 2005a). In this regard, it is essential that policy decisions be based on

comprehensive research and data informing decision-makers of the needs and priorities of older people and the ways future services can best meet these needs.

APPENDIX 2

INTERNATIONAL STRATEGIES FOR OLDER PEOPLE

The UN convened the first World Assembly on Ageing in 1982, which produced the “Vienna International Plan of Action on Ageing”. It called for action on issues such as health and nutrition, protecting older consumers, housing and environment, family, social welfare, income security and employment, education, and the collection and analysis of research data.

In 1991, the General Assembly adopted the United Nations Principles for Older Persons (see below), which outlined 18 entitlements for older persons relating to independence, participation, care, self-fulfillment and dignity. Continuing on the path of policy development, the Second World Assembly on Ageing was held in Madrid in 2002 and adopted the Madrid International Plan of Action on Ageing. The Plan of Action identified three priority areas; economic and social development; health and wellbeing and supportive environments.

Under these priority headings a further eighteen issues were agreed upon: (1) active participation in society and development, (2) work and the ageing labour force, (3) rural development, migration and urbanization, (4) access to knowledge, education and training, (5) intergenerational solidarity, (6) eradication of poverty, (7) income security, social protection/social security and poverty prevention, (8) emergency situations, (9) health promotion and well-being throughout life, (10) universal and equal access to health-care services,

(11) older persons and HIV/AIDS, (12) training of care providers and health professionals, (13) mental health needs of older persons, (14) older persons and disabilities, (15) housing and the living environment, (16) care and support for caregivers, (17) neglect, abuse and violence, and (18) images of ageing.

Ireland is one of the few European countries that has not responded to the UN Madrid Action Plan on Ageing (O'Neill, Twomey, and O'Shea: 2009).

Following from signing of the Madrid International Plan of Action on Ageing (MIPAA), the Implementation Strategy for Europe was outlined which stated as its first commitment the need “*To mainstream ageing in all policy fields with the aim of bringing societies and economies into harmony with demographic change to achieve a society for all ages*”. It also set out additional key principles including;

- To ensure full integration and participation of older persons in society
- To promote equitable and sustainable economic growth in response to population ageing
- To adjust social protection systems in response to demographic changes and their social and economic consequences
- To enable labour markets to respond to the economic and social consequences of population ageing
- To promote life-long learning and adapt the educational system in order to meet the changing economic, social and demographic conditions.
- To strive to ensure quality of life at all ages and maintain independent living including health and well-being
- To mainstream a gender approach in an ageing society
- To support families that provide

care for older persons and promote intergenerational and intra-generational solidarity among their members

- To promote the implementation and follow-up of the regional implementation strategy through regional co-operation

Madrid Principles for Older Persons (1991)

- Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
- Older persons should have the opportunity to work or to have access to other income generating opportunities.
- Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.
- Older persons should have access to educational and training programmes.
- Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
- Older persons should be able to reside at home for as long as possible.
- Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
- Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
- Older persons should be able to form movements or associations of older persons.
- Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
- Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
- Older persons should have access to social and legal services to enhance their autonomy, protection and care.
- Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
- Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives
- Older persons should be able to pursue opportunities for the full development of their potential.
- Older persons should have access to the educational, cultural, spiritual and recreational resources of society.
- Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
- Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution

APPENDIX 3

NATIONAL COMMITMENTS TO OLDER PEOPLE

Towards 2016: Ten-Year Framework Social Partnership Agreement 2006- 2015

The Partnership Agreement's social policy commitments are founded on a new 'lifecycle approach', set out by the National Economic and Social Council in its report, *The Developmental Welfare State* (2005). This model identifies four life stages: children; people of working age; older people; and people with disabilities. For each stage the document lists innovative measures intended to respond to emerging needs, and also outlines the governance and monitoring framework.

Section 32 Older People: 32.1 Vision

The parties to this agreement share a vision of an Ireland which provides the supports, where necessary, to enable older people to maintain their health and well-being, as well as to live active and full lives, in an independent way in their own homes and communities for as long as possible.

- Every older person would be encouraged and supported to participate to the greatest extent possible in social and civic life;
- Every older person would have access to an income which is sufficient to sustain an acceptable standard of living;
- Every older person would have adequate support to enable them to remain living independently in their own homes for as long as possible. This will involve access to good quality services in the community,

including: health, education, transport, housing and security, and;

- Every older person would...have access to a spectrum of care services stretching from support for self-care through support for family and informal carers to formal care in the home, the community or in residential settings.

Priority Actions

Six priority action areas are identified as steps to achieving the long-term goals, and indications of specific actions intended in each area are provided:

- Pensions/Income Supports
- Long-Term Care Services for Older People
- Housing and Accommodation
- Ensuring Mobility for Older People
- Ensuring Quality Health Services for Older People
- Promoting Education and Employment Opportunities for Older People

http://www.taoiseach.gov.ie/attached_files/Pdf%20files/Towards2016PartnershipAgreement.pdf



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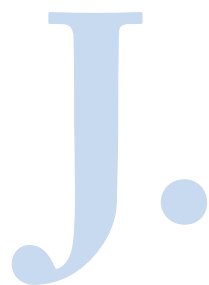
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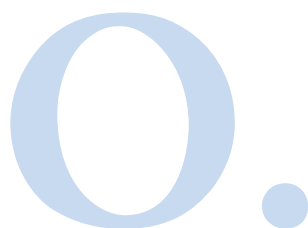
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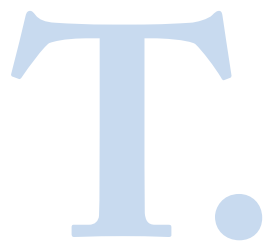
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