



*THE 2003  
HEALTHY AGEING  
CONFERENCE*

Conference Proceedings



National Council on Ageing and Older People

# 2003 Healthy Ageing Conference

## *Conference Proceedings*

Yvonne McGivern (Editor)



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

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## Foreword



As Chairperson of the National Council on Ageing and Older People, it gives me great pleasure to present the proceedings from the 2003 Healthy Ageing Conference.

The conference took place on 25 November 2003 in the Burlington Hotel, Dublin. It was opened by Dr Michael Loftus, Chairperson of the Council's Healthy Ageing Consultative Committee. Mr Ivor Callely, TD, Minister for Services for Older People delivered the closing address.

The conference attracted over 320 delegates from the statutory, voluntary and private sectors, and provided the opportunity for delegates to familiarise themselves with the Council's Healthy Ageing Programme, the Healthy Ageing Database and the key findings of the report *Healthy Ageing in Ireland: Policy, Practice and Evaluation*. It also allowed delegates the chance to focus on issues facing particular vulnerable groups of older people.

I would like to express my appreciation to Dr Michael Loftus and Mr Ivor Callely for their addresses to the conference. I would also like to thank Prof. Davis Coakley, Trinity College Dublin and Consultant Physician in Geriatric Medicine at St James's Hospital, Dublin who presented the case for a concentrated programme of health promotion for older people. I would like to thank Dr Helen McAvoy of the NCAOP who presented the framework of the Healthy Ageing Programme.

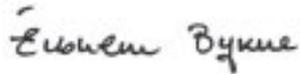
I would like to thank Edel Murphy of iManage and Associates who outlined how she and Dr Eamon O'Shea developed the Healthy Ageing Database on behalf of the NCAOP. I would also like to thank Dr O'Shea for taking us through the key findings of the report. Thanks are also due to Prof. Cecily Kelleher of the Department of Public Health Medicine and Epidemiology at University College Dublin who outlined the findings from the SLÁN studies on the health and lifestyle of older people.

The eight parallel workshop sessions that took place were very informative and of great interest to the delegates. I would like to extend my gratitude to the speakers in these workshops for presenting such excellent papers.

I would like to thank those who chaired each of the plenary sessions (Dr Michael Loftus and Dr Emer Shelley) and those who chaired the workshop sessions (Mary Higgins, Pat O'Toole, Eamon Donnelly, Mary Kelly, Siobhan Weir, Thomas McCann, Sr Stanislaus Kennedy and Enda Egan). I would also like to thank the rapporteurs for collating the information from the sessions and the conference participants for their valuable contributions to the workshop discussions.

I would like to thank the members of Age Rage, for performing their empowerment drama on ageing, and the choir of Navan Travellers' Training Centre and Summerhill Active Retirement Group for their contribution to a very successful conference programme.

The Council would like to thank its Director, Mr Bob Carroll, while a special thanks is due to the Council's administrative staff for their invaluable assistance in organising the conference. Finally, thanks to Yvonne McGivern who prepared the proceedings for publication and to Sandwell Third Age Arts for providing the image used on the cover.



**Cllr Éibhlin Byrne**  
**Chairperson**

## Introduction

### *The structure of the report*

The structure of this report follows the format of the Conference. It begins with the opening address by Dr Michael Loftus, Chairperson of the NCAOP's Healthy Ageing Consultative Committee. The conference presentations, which took place across three sessions, follow.

The Opening Session included presentations on:

- the case for a concentrated programme of health promotion for older people
- the strategic framework for the Healthy Ageing Programme.

The Second Session included presentations on:

- how the Healthy Ageing Database was developed and how it can be used
- key findings from the report into policy, practice and evaluation in the area of healthy ageing in Ireland
- the findings from the SLÁN surveys into the health and lifestyle of older Irish people.

The Third Session comprised a series of parallel workshops focusing on issues facing older people. The aim of these workshops was to identify and discuss the challenges faced by these vulnerable older people and to suggest strategies for addressing the challenges.

The Final Session included a performance of the Empowerment Drama, *Ageing with Confidence*, by Age Rage; a performance by the choir of the Navan Travellers' Training Centre and Summerhill Active Retirement Group; and the launch of the Association of Activity Nurses and Carers. The Closing Address was given by Mr Ivor Callely, TD, Minister for Services for Older People.

### *Opening Session*

**Prof. Davis Coakley** described briefly what health promotion means and why it is important to older people in Ireland. He described the health status of older Irish people, pointing out that life expectancy in Ireland is lower than it is in most other EU member

states. He outlined the factors that affect the health of older people and how these might be addressed. He set out the case for health promotion and active ageing, and suggested some steps towards healthy ageing. Prof. Coakley argued that there are many ways to optimise health and social gain in old age and, that to be successful, programmes must address social inequalities as well as health issues and must encompass the psychological and physical aspects of ageing.

**Dr Helen McAvoy** described the background to the NCAOP's Healthy Ageing Programme, giving the context for the way forward as proposed in the strategic framework. She went on to describe how the strategic framework was designed, and outlined in practical terms what the Healthy Ageing Programme proposes to do. She described how the Programme would act as a resource that would enable health promotion for older people to reach its fullest potential. To do this, Dr McAvoy explained, it was necessary to, among other things, increase public awareness, provide suitable training and materials, provide information on models of best practice, encourage networking and knowledge sharing, and work towards building healthy public policy.

#### *Second Session*

**Edel Murphy** described how the Healthy Ageing Database was developed and how it can be used. She explained that prior to the development of the Database, information on healthy ageing has been fragmented. However, the successful implementation of the Health Promotion Strategy meant that two things were needed: a comprehensive information and support network for promoting the health, welfare and autonomy of older people; and the identification of models of good practice for healthy ageing. To achieve both these goals it was necessary to conduct an extensive consultation exercise with stakeholders in the field of healthy ageing in Ireland.

This exercise consisted of two parts: a series of eight regional seminars with healthy ageing stakeholders and a postal survey of healthy ageing projects. The information provided by the seminar participants forms the basis of the report, *Healthy Ageing in Ireland: Policy, Practice and Evaluation*. Seminar participants also helped to identify healthy ageing projects and initiatives throughout the country. Over 1,400 projects and organisations were sent a questionnaire asking for information. This information was used to create the Healthy Ageing Database. The Database can be accessed via the

Council's website ([www.ncaop.ie/healthyageing](http://www.ncaop.ie/healthyageing)) and via the Health Data website, ([www.health-data.info](http://www.health-data.info)).

**Dr Eamon O'Shea** and **Sheelagh Connolly** presented the key findings from the seminar consultations and from the survey. The findings are set out in full in the report, *Healthy Ageing in Ireland: Policy, Practice and Evaluation*. The report is part of the process of extending and developing a knowledge base on healthy ageing activities in Ireland. It provides some insight on what should be done to improve the position of older people in Ireland in the field of healthy ageing over the coming decades.

In his presentation Dr O'Shea described some of the recurring themes from the seminars: the prevalence of **ageist attitudes**; an acknowledgement of the multi-dimensional nature of healthy ageing and the need for the development of **an integrated holistic model of ageing**; and the importance of **housing** and **transport** to healthy ageing.

In terms of developing healthy ageing initiatives, Dr O'Shea found that participants were particularly concerned about the lack of funding, as well as by the problems encountered in trying to take a holistic approach to their healthy ageing project. Many found their difficulties magnified by the absence of partnership models for public, private and voluntary cooperation.

Consultation with older people was considered by seminar participants to be the most essential element of best practice in healthy ageing. However, there was criticism that the structures necessary to allow meaningful consultation are not always in place.

The postal survey showed that almost half of all healthy ageing projects are concerned with the social environment of older people, while there appears to be a distinct lack of projects in general practice and acute care settings. The survey findings also show that most projects develop from the bottom up, sometimes with little support from official sources. Projects are usually small in scale, with most having less than 50 participants per week, and staffed mainly by part-time voluntary workers.

As to the future of healthy ageing, Dr O'Shea made a number of recommendations, including the following:

- the need for age proofing to be applied to all areas of public policy-making, particularly the areas of health and social care, employment and education, in order to address ageism
- the setting up of a designated and protected Healthy Ageing Fund to encourage innovation and experimentation in healthy ageing projects
- the need to improve the housing stock of older people and to make housing more accessible and barrier-free, in order to ensure that older people remain in their own homes even if they become dependent
- the need for capacity-building for voluntary and active retirement groups at community level to enable them to fulfil healthy ageing goals
- the need for older people to be placed at the centre of decision-making both in the community and in residential care
- The need to ensure that healthy ageing is an integral part of the Primary Care Strategy.

**Prof. Cecily Kelleher** and **Dr Frances Shiely** set out the findings from two SLÁN surveys (Survey of Lifestyle, Attitude and Nutrition) conducted in 1998 and 2002, which demonstrated that the make-up, attitudes and behaviour of the population of older people aged 55 and over changed during the period between the two surveys.

A greater proportion of the 2002 sample rated their quality of life as very good, while more of the respondents rated their health as excellent or very good compared to 1998. More of the 2002 sample reported are suffering from diabetes and high cholesterol levels, while fewer of them reported taking mild exercise.

The research also indicated that social class is a determinant of health and well-being. People in social classes 5 or 6 (that is, with an occupation in the manual and unskilled group) are less likely than those in social classes 1 or 2 (the professional and managerial group) to rate their quality of life as very good and less likely to rate their health as excellent or very good.

Prof. Kelleher also reported that the area in which older people live also plays a part in lifestyle and well-being. For those living in urban areas, for example, house break-ins were more likely to be seen as a problem than for those in rural areas. Those living in rural areas are significantly more likely than those living in urban areas to agree strongly that they could trust people locally.

### *Parallel Sessions*

In Workshop One, 'Homeless Older People', **Pat Doherty** outlined how the Depaul Trust was set up in Ireland. He described the hostels which the Trust runs in Dublin and outlined the health problems – physical and psychological – of the hostel users. Most suffer from poor health, made worse by being homeless. Many also suffer from the effects of drug and alcohol misuse. The challenges for the Trust and its clients are many and varied, including lack of suitable 'move on' accommodation for older people using the hostels and lack of access to healthcare.

**Alice Leahy** described the philosophy of TRUST, which aims to prevent older people who are homeless from becoming outsiders. Using three short case studies, Alice illustrated the support service TRUST offers homeless people and the person-centred approach taken by its staff.

In the discussion that followed, chaired by **Mary Higgins**, workshop participants acknowledged the need to stop older people from becoming homeless and to ensure that for those who do that it is short-term only. It was noted that those who have lived in hostels for many years often see the hostel as home. It was agreed that moving people on was, therefore, not always appropriate and that a new and different approach must be found and applied. Participants agreed that the health care needs of older homeless people should be addressed in a suitable and person-centred way. Every homeless person should have access to mainstream health services. Participants agreed that older homeless people should not be excluded or marginalised because they are seen as difficult.

In Workshop Two, 'Older People in Long-Term Residential Care', **Catherine Lawlor** described Activity Nursing and set out the content of an Activity Programme. She

explained how such programmes create a supportive environment that helps to improve the quality of life for those living in long-term residential care.

**Dr Suzanne Cahill** described the importance of design and layout in enhancing the quality of life of older people living in long-stay residential homes, particularly those with dementia. She described what is widely viewed as best practice in design, and the benefits it has for all involved. Dr Cahill pointed out that until recently few in Ireland had invested in design or in specialist care units. She reported the findings of recent research that shows that few long-stay homes meet best practice guidelines. She acknowledged that there is a need to balance the care home owners' needs – to run cost-effective homes and comply with regulations – with the rights and needs of residents.

The discussion that followed, chaired by **Pat O'Toole**, highlighted the need to foster and support purposeful relationships between patients, carers and staff. Participants agreed that making a long-stay unit a genuine home was essential. To address these issues participants suggested that Activity Nursing be developed and supported with training; that resources be allocated to improve the design of long-stay homes, in particular those for people with dementia; and that public-private partnerships be considered as a way of funding nursing homes and long-stay care.

In Workshop Three, 'Older Men, Including Those Living Alone', **Geraldine Delorey** described the circumstances and health of older men in the north-west. Many of the older men are from farming and fishing backgrounds, many of them live alone and a large proportion of them hold a medical card. Geraldine identified four key transition times in men's lives: retirement or reaching pension age; onset of illness or disability; moving from home; and bereavement; and described briefly the impact of these on the lives of men in the north-west. She suggested a number of things that could be done to lessen the impact, including a focus on men's health before retirement, retirement programmes and the setting up of men's groups.

In his paper **Finian Murray** outlined findings from recent research about men's health and argued that improvements would only be achieved through consultation and partnership with all those involved, including men themselves. He described how the

North Eastern Health Board Area has begun to do this – by research and consultation with men, by developing a Men’s Health Action Plan and by supporting men’s groups and men’s health campaigns. He recommended that a policy be developed to address the health of rural men.

In the discussion that followed, chaired by **Eamon Donnelly**, participants noted the lack of focus on older men’s health; the need for men to take greater responsibility for their health; the risk of social isolation that many men face when they retire and/or when a wife or partner dies; the reluctance of many older men to attend clubs and groups; and the problems faced by rural men in accessing health services, exacerbated by the lack of public transport and the cost of maintaining a car. Participants identified the main challenges as lack of information on men’s health issues; the limited number of health awareness programmes aimed at men; and the isolation of many older men from family and society. A number of suggestions were made to address these problems, including making information on men’s issues available in the workplace; running a greater number of health promotion campaigns aimed at men; and developing activities in clubs and centres that would encourage men to attend.

In Workshop Four, ‘Older Women, Including Those Living Alone’, **Geraldine Luddy** identified four areas of concern in relation to the health of older women: the increase in the number of older people in the population, and the greater proportion of older women compared to older men; poverty, including the fact that households headed by a woman are more likely to be poor than those headed by a man; health inequalities; and the risks to older women because of poor standards of care. Geraldine made recommendations in four areas: health service delivery; personal and community development; policy and legislation; and research and information.

**Louise Richardson** in her paper explained how the Older Women’s Network (OWN) operates and outlined the health issues that are frequently raised by network members. These relate to mental health, community care services, screening and Well Woman check-ups, care home set up, and the involvement of women in debates on issues relevant to them including abortion and HIV/AIDS in particular and health inequalities in general. She described the content of submissions made by OWN to the Draft National Plan for Women and to the National Anti-Poverty Strategy.

In the discussion that followed, chaired by **Mary Kelly**, two main issues emerged: accessibility of health services and the suitability of the service response. Transport was seen as key to the accessibility of services, especially in rural areas. Participants also identified other aspects of accessibility as important, including access to information, to suitable and adaptable housing, and to primary and secondary health care. It was suggested that changes in social policy were needed to address these issues. Participants agreed that co-operation and co-ordination between sectors and between government departments was essential. The prevalence of ageism, and its role as a barrier to health care, was also noted. To address this, 'top down' and 'bottom up' solutions were recommended, including training for health professionals and confidence building for older women. Participants also pointed out the need for policy-makers and service providers to understand that older women are a diverse group with diverse needs and that health care provision needs to take this into account.

In Workshop Five, 'Older People in Deprived Economic Circumstances', **Helen Johnston** described the link between poverty and poor health, and the need to address the issue. She noted that while the proportion of older people in Ireland in consistent poverty is declining, the proportion experiencing relative income poverty is growing. She also noted that older women are particularly vulnerable to income poverty. She outlined the policy responses needed and highlighted areas for action. These include income, public service provision, vulnerable groups of older people, and the health and poverty interface.

**Audry Deane** described the work of the Society of St Vincent de Paul. She outlined the problems that its work with older people uncovers. These include evidence of health inequalities, income inadequacy, fuel poverty and lack of awareness and information on entitlements. She called for action to be taken to change a health system that hurts vulnerable groups including disadvantaged older people.

In the discussion that followed, chaired by **Siobhan Weir**, the importance of addressing the health-poverty interface was noted. Participants agreed that there is a need to implement plans already in place and to address the issue of fixed income versus rising costs that affects many older people. It was suggested that non-contributory and adult entitlements should be reviewed. It was argued that a rights-based approach to health

care should be put in place, to ensure that older people receive the care they need as of right rather than on the basis of what they can pay.

In Workshop Six, 'Older Travellers', **Missie Collins, Molly Collins, Sheila Reilly** and **Caroline Mullen** outlined the health status of Travellers and described the factors that affect it. These include accommodation, racism and discrimination, and access to health services. They described the work done by Pavee Point in partnership with Travellers and with the Northern Area Health Board through the Primary Health Care Project for Travellers. The speakers identified improving the health status of Travellers as the main challenge. To do this, among other things culturally appropriate health care must be provided as well as the chance for Travellers to take part in health service policy, planning and delivery.

In the discussion that followed, chaired by **Thomas McCann**, the need for affirmative action to counteract the years of discrimination against Travellers was noted. It was agreed that there is a need to implement a plan for improving the health of Travellers, and that Travellers and Traveller organisations should be consulted and take part in developing this plan. Participants recognised the need for both targeted and mainstreamed health care services for Travellers, including services for specific groups such as older Travellers. Participants also agreed that there is a need to collect and analyse up-to-date information on Travellers' health.

In Workshop Seven, 'Older People in Deprived Housing Circumstances', **Lillian Buchanan** examined the issue of housing disadvantage among older people, particularly those living in the private rented sector. She noted that a limited amount of information is available on the housing status and living conditions of older people, or on the extent to which housing adds to or detracts from their quality of life. She outlined the concerns: security of tenure; standard of housing and its suitability as a person gets older; and affordability. She described briefly what is needed from housing policy reform to address these concerns. She argued that an adequate home is a basic prerequisite for well-being and for effective participation in society.

**Charles Roarty** described in brief the work of Energy Action. He went on to describe what is meant by fuel poverty, the impact it has on health and well-being, and how to

identify those at risk from it. He stressed the need to address the problem at several levels: by improving heating, insulation and ventilation systems; by providing information on energy efficiency; by ensuring that people get the benefits to which they are entitled. He noted that under-occupation of a dwelling is often an indicator of fuel poverty among older people, but it is difficult to address because older people are unwilling or unable to move.

In the discussion that followed, chaired by **Sr Stanislaus Kennedy**, participants agreed on the importance of enabling older people to stay in their own homes for as long as possible. Suggestions for bringing this about included the provision of suitable housing, support for adapting housing to keep it suitable, and the availability of supported or sheltered housing within the local community. Participants noted a lack of clear and accessible information on rights and entitlements in relation to housing, and to address this suggested that a dedicated housing agency be set up. The poor level of co-ordination, co-operation and integration between agencies and departments that provide services to older people was noted. To remedy this it was suggested that a care case management approach to the needs of older people be put in place.

In Workshop Eight, 'Older Carers', **Brigid Barron** described the setting up and role of the Carers' Clinic in Ennis, County Clare. It aims to ensure that via one-to-one consultation family carers apply for and receive the services and benefits to which they are entitled. She noted that people often call for more information to be made available to older people. She stated, however, that experience at the Clinic suggested that what is really needed is for someone to explain on a one-to-one basis what the information means to that individual older person. Brigid also described the Clinic's other services, which include advice and advocacy in home respite care, the administration of a respite care fund and training for carers. She called for similar services to be made available to all older carers throughout the country.

**Michael Browne** in his paper outlined the issues faced by many older carers. He noted that while the number of people needing care is growing, the pool of carers is declining. He reported briefly the findings from two reports: *Supporting Carers – A Social Policy Report*, produced by Comhairle in 2002 and *Caring in Later Life*, the report of a UK study conducted by the University of Kent and the charity, Help the Aged. He noted that there

is limited information about the experiences of older carers and limited information about their particular needs. Many are sole carers, many experience social and emotional isolation, and many have health problems – often needing help and support to take care of themselves. He made recommendations in relation to the services needed for older carers, including home-support care packages, personal support services, needs-based respite services, and additional income support for those providing the highest level of care. He also suggested, among other things, that the concept of a National Strategy for Carers be examined, a strategy which would contain targets for service development and a plan for co-ordinating support services.

In the discussion that followed, chaired by **Enda Egan**, participants agreed, among other things, that carers must be recognised by the health systems and by health professionals, and that services currently provided on an arbitrary basis should be made statutory. They suggested that research should be carried out to identify and understand the needs of carers, and in particular older carers, and that a National Strategy for Family Carers should be put in place to better address the needs of carers nationwide.

#### *Final Session*

In the Final Session, chaired by **Cllr Éibhlin Byrne, Ann Marie Crosse** introduced Age Rage's performance of *Ageing with Confidence*. She described how the play emerged from Donegal women's experiences of ageism and discrimination. The play brings to life many of the issues faced by older people, particularly those living in rural areas, including access to transport, health care, carers and caring, and sexuality, as well as ageism and discrimination.

In the closing address, **Ivor Callely TD** acknowledged the importance of healthy ageing, and stressed his Department's commitment to health promotion and to convincing health professionals and society in general of its benefits. He welcomed the launch of the Healthy Ageing Database and the report, *Healthy Ageing in Ireland: Policy, Practice and Evaluation*, and acknowledged that both would be useful tools in helping to build a national healthy ageing network. He noted, however, that challenges still remain on the way to achieving a healthy 'third age' for all. He described the setting up of the Inter-Departmental Group, made up of people from the Departments of Environment and

Local Government; Social, Community and Family Affairs; Transport and Public Enterprise; and Enterprise, Trade and Employment; and working under the auspices of the Department of Health and Children. He outlined its aim: to examine the needs of older people and the things that affect their lives, and to ensure that these are addressed in a co-ordinated way. He noted that an interim report of the Group's work would be available in 2004. He congratulated the NCAOP and all involved in healthy ageing projects on the progress made towards a National Healthy Ageing Network.

## Opening Address

***Dr Michael Loftus, Chair, Healthy Ageing Consultative Committee, NCAOP***

It is my privilege to welcome you to the 2003 Healthy Ageing Conference. As a General Practitioner and an older person, I am keenly aware that so much can be done to prevent illness and promote health and well-being in later life. A speaker for the National Healthy Ageing Strategy in 1998 reported that there was much evidence to indicate that a large proportion of chronic disabling conditions associated with ageing are preventable and are *not* the inevitable consequences of ageing. Prevention of these conditions may not only increase longevity, but may also reduce periods of illness, allowing the majority of older people to enjoy high quality lives free of disability for many years.

While improving treatment and care for those with disabilities remains a priority, we must also identify the factors influencing the onset of age-related disability in the entire population. We need to assess the impact of these factors, both in qualitative and quantitative terms, so that we have appropriate strategies to maintain optimal health in an ageing population.

The Healthy Ageing Programme and, we hope, this and future Healthy Ageing conferences will play a big part in helping to achieve our goals of reduced morbidity and increased quality of life in the later years of our lives.

Since mid-2002, it has been my pleasure to be Chair of the NCAOP's Healthy Ageing Consultative Committee. I would like to thank the members of the Committee for their time and expertise, and for overseeing in a consultative capacity the work that will be presented here in the papers of Dr Eamon O'Shea of NUI Galway and Edel Murphy of iManage and Associates.

It must be emphasised that many people contributed to the production of the study and to the Healthy Ageing Database, and I would especially like to thank those throughout the country who took part in the consultation seminars.

Finally, despite the fact that we are from diverse backgrounds, I have no doubt that we are at one in our concern for the health and well-being of older people in Ireland. That concern is made all the more acute by the knowledge that life expectancy in Ireland lags substantially behind the EU average, and that in Ireland, older people experience a greater degree of ill-health and disability than older people in any other developed country. It is very much part of our purpose at this conference to highlight the importance and potential of promoting health in older age. I am certain that you, like me, are looking forward to the papers and workshop sessions, and I wish you all a stimulating, enjoyable and productive day.

# **Optimising Opportunities for Health and Social Gain in Old Age: The Case for a Concentrated Programme of Health Promotion for Older People**

***Prof. Davis Coakley, Trinity College Dublin and St James's Hospital, Dublin***

## *Introduction*

This paper looks briefly at what health promotion means and why it is important to older people in Ireland. It looks at the health status of older people and at the factors that affect their health. It sets out the case for health promotion and active ageing, and suggests some steps towards healthy ageing.

## *Health promotion*

The World Health Organisation (WHO) defines health promotion as the process of enabling people to increase control over their health and to improve their health. Health promotion acknowledges that the main causes of premature mortality and preventable morbidity are linked to unhealthy behaviours and lifestyles. However, individuals wishing to adopt a healthy lifestyle may be impeded by adverse environmental and social conditions that are often beyond their control.

## *Health promotion and the NCAOP*

Over the last decade the NCAOP has paid particular attention to health promotion for older people in Ireland. In 1993 the Council published the position paper, *Measures to Promote Health and Autonomy for Older People*, and in 1994 it published *Health and Autonomy Among the Over 65s in Ireland*. These formed the basis of the health promotion strategy, *Adding Years to Life and Life to Years*, which was jointly published by the Council and the Department of Health and Children in 1998.

### *The importance of health promotion to older people in Ireland*

At the 2002 Census there were 436,000 people over the age of 65 living in the Republic of Ireland, out of a total population of 3,917,203. In other words, just over one in ten or 11 per cent of the population was aged 65 or over. This 11 per cent is low compared to other European states, but we are catching up and estimates show that by 2011, 14 per cent or one in seven of our population will be over 65. Perhaps the most significant expansion will be in the numbers of older old, that is, those over the age of 80. Currently, 23 per cent of older people are aged 80 years and over, and by 2011 this will have risen to around 25 per cent. The female 'advantage' (women have a longer life expectancy than men and so there is a greater proportion of them in the over 65 age group) will still be evident: 29 per cent of older women will be aged 80 and over compared to only 20 per cent of older men.

If we compare 1926, when the first life tables were compiled, to 1996, we can see improvements in the life expectancy of both men and women. The average man born in 1926 could expect to live to be 57, whereas a man born in 1996 can expect to live to be 73. Similarly, the life expectancy of women has jumped from 58 years to 79 years.

We cannot be complacent, however, as life expectancy at birth for men in Ireland is one year less than the European Union (EU) average while for women it is two years less. Life expectancy at 65 for both men and women in Ireland is the lowest in the European Union. Clearly we cannot be proud of this situation.

Many think, including not a few health professionals, that life expectancy at age 75 is just a few years. However, life expectancy at age 75 is, in fact, eight years for a man and ten years for a woman. These are very important figures. They emphasise why health is so central for 75 year olds: decisions made about health matters have implications for on average about ten years. This is a substantial portion of an individual's life span. It should be a high priority to make their quality of life during that period as good as possible.

### *The health status of older people*

In the Council's 1994 study, *Health and Autonomy Among the Over 65s in Ireland*, 47 per cent of respondents reported major illnesses or disability. Despite this, 41 per cent of those who reported these health problems considered themselves to be in good health. This suggests that older people tend to accept disability and ill-health as a normal part of ageing.

Another survey carried out on behalf of the Council (Garavan *et al*, 2001) found low levels of functional disability in the community. Over three quarters (77 per cent) of older people living in the community said that they were self-sufficient in the activities of daily living. Of the remaining respondents, 9 per cent had minor difficulties, 6 per cent had major difficulties and 8 per cent reported that they were severely impaired in the activities of daily living. As you would expect, the problems increased with advancing age – among those aged 80 and over, 31 per cent of men and 36 per cent of women reported significant difficulties. (In the 2002 Census 56 per cent of those aged 80 and over had a disability or long-lasting health problem.) The authors also found that chronic physical illness affected mental health and this was reflected in a more widespread incidence of depression and anxiety.

Other research shows that up to 15 per cent of people over the age of 65 suffer depression and a further 15 to 20 per cent have sub-syndromal depression. Both diminish function and quality of life. Bereavement, physical incapacity and cognitive impairment are significant risk factors for depression in older people.

Cardiovascular disease, cancer and respiratory disease are the principal causes of death in people over the age of 65. Heart disease and stroke account for most of the deaths due to cardiovascular disease and they are a major cause of morbidity and disability. There are 30,000 people in Ireland with residual disability following stroke.

Cancer is primarily a disease of older people, with 70 per cent of all deaths from cancer occurring in the over 65 age group. Around 43 per cent of all cancer deaths in those over aged 65 and over are in the 65-74 years group. Lung, prostate and large bowel tumours are the commonest causes of death in men, while in women the commonest are lung,

breast and bowel cancers. There is also very significant morbidity associated both with the conditions and the treatment.

Diseases of the respiratory system (chronic bronchitis, emphysema, asthma and pneumonia) are responsible for the majority of admissions to hospitals among older people. Older adults who smoke are more likely than non-smokers to have serious disabilities and to die prematurely from smoke inhalation diseases.

Falls are a major cause of death, morbidity and disability in older people. They account for up to 20 per cent of admissions to acute medical wards for older people. Osteoporosis increases the risk of fracture in old age. Nearly half of women aged 50 and over will have an osteoporotic hip fracture in their lifetime; about one in eight men aged 50 or over will have a similar type of fracture. After hip fracture, up to twenty per cent of patients die within a year, 50 per cent of survivors are incapacitated and 20 per cent require long-term residential care.

#### *Attitudes to older people's health*

Until comparatively recent times childhood was associated with high rates of morbidity and mortality. Most people accepted this as a fact of life or the will of God. Today a similar fatalistic attitude exists towards morbidity in older age. Many people believe that little can be done to enhance the quality of life of an older person. Ill-health and immobility are accepted as the natural consequences of ageing. Yet it was possible to revolutionise the health of children by concentrated programmes of maternal health promotion and disease prevention in childhood. As a consequence, serious illness among children is now exceptional. A similar concentrated programme to promote health in older age is now a matter of urgency.

#### *Factors affecting health*

Although any person born into a family of long living, healthy ancestors starts life with an advantage, heredity is only one factor in healthy ageing. Physical, psychological, environmental and social factors all impact on the ageing process. It is, therefore,

possible to achieve health and social gain in old age through improvements in all of these areas.

Biological ageing changes happen gradually. For example, a fit 70 year old person's performance can be equal to that of an unfit 30 year old. Some intellectual capabilities such as learning speed, memory and reaction time can decline with old age. This decline is more than compensated for by gains in knowledge, experience and wisdom. However, decline in cognitive function can occur secondary to disuse, lack of motivation, isolation and depression, rather than ageing. Individuals who are flexible and adaptable are more likely to age successfully.

Social deprivation in old age is linked to an increased risk of chronic illness and dependence. The Council's 1999 study, *Income, Deprivation and Well-Being Among Older People*, found that older people experiencing deprivation were at an increased risk of chronic illness. Older women are particularly at risk as often their only source of income is a state pension. Health issues cannot be seen in isolation from economic factors such as income, work and social protection. Adequate and safe housing and an immediate physical environment that is both safe and friendly are very important factors for health and social gain.

Poor social relationships, lack of involvement in the life of the community and in leisure activities are all likely to impact in a negative way on ageing. People who live alone in isolated conditions are particularly vulnerable.

#### *The case for health promotion and active ageing*

The ageing of humanity is often presented as a phenomenon that will bankrupt our social security and health care systems. The WHO has predicted that this will not happen provided countries and regions enact active ageing policies and programmes. We should, therefore, be adopting measures to help older people remain healthy and involved in society.

We must not fall into the trap of presenting ageing in a negative light and ignoring the valuable contributions older people make to our society. There is an urgent need to

move away from the out-dated view which sees old age as encompassing disability, ill-health and lack of productivity, to a new perspective which presents older people as active members of an age-integrated society, contributing to as well as benefiting from developments. It makes good economic sense to promote healthy and active ageing. Healthy older people means reduced health care costs.

#### *What is active ageing?*

Active ageing is a process of optimising opportunities for physical, mental and social well-being throughout life in order to extend healthy life expectancy, quality of life and productivity in older age. The term 'active ageing' is now commonly used to describe continuing involvement in social, cultural, spiritual and economic areas.

The WHO advocates a broad approach to health promotion, and its programme emphasises a community rather than an individual focus, taking into account social, mental, economic and environmental determinants of health in old age. Health policy-makers should be encouraged to collaborate with other sectors, including education, housing and employment, to bring about changes in society which lead to healthy active ageing.

#### *Making the necessary changes*

Although most of the health care expenses in old age are incurred in the last few years of life, these costs fall in the very oldest groups. It follows that if people live longer with fewer disabilities than originally projected, the predicted explosion in health care costs as the population ages is not likely to occur. There is evidence that indicates a decline in the prevalence of disability in successive cohorts of older people. In developed countries there has been a significant decline in age-specific disability over the past 20 years. For instance, in the USA savings in nursing home costs alone were estimated to be \$17.3 billion in 1994 due to the decline in disability rates between 1982 and 1994.

The origins of many of the problems that cause chronic disability in older people can be traced back to earlier adult life. Health promotional activities should start at a young age and take a lifelong perspective. However, functional disability associated with ill-health

can be prevented or slowed down by taking action at any age. Healthy eating, not smoking, physical activity, good nutrition and appropriate medication in old age can prevent disease and functional decline, extend longevity and enhance quality of life.

Older people are not a homogeneous group and the population aged between 65 and 74 will vary in many ways from those aged 75 and over. Different approaches to health promotion are required, depending on the characteristics of the group being targeted. Moreover, while the cornerstone of health promotion at all ages is about preventing illness, in older people it is also about minimising the consequences of illness or disability for those who are already ill. If disabilities occur which impair an individual's ability to live independently, health promotion and active ageing policies should ensure equitable access to suitable supports to empower the individual to continue to live as independently as possible, whether at home or in a residential care facility.

#### *Steps toward healthy ageing*

There is considerable evidence in medical literature to support the relationship between healthy ageing and regular exercise. Exercise is associated with a reduced instance of coronary artery disease, high blood pressure, non-insulin dependent diabetes mellitus, cancer of the colon, depression and anxiety. Increased physical activity also increases bone mineral content and reduces the risk of osteoporotic fractures. It also increases longevity. In addition, exercise improves mental health and promotes social contact. Group exercise activities can be of particular benefit in combating social isolation and loneliness.

There is evidence that most of the health benefits of exercise can be gained through regular physical activity of moderate intensity, such as brisk walking, rather than formal exercise programmes. There is also evidence to suggest that those who are unfit can regain fitness through regular physical activity even in advanced old age. Moderate regular physical activity can delay the onset of functional decline and reduce the risk of chronic diseases. It has been shown that even frail older people living in the community can improve significantly following a programme of exercise training. Many people associate the image of physical fitness with high-tech workouts in a gym. In order to

correct this image, emphasis should be placed on the positive gains that can be made from activities such as walking and gardening.

Much can now be done for medical conditions that were previously thought to be untreatable or unpreventable. For instance, the outlook for patients suffering from multi-infarct dementia can be improved by treating vascular risk factors. The incidence of stroke can be reduced by up to 80 per cent by early detection and treatment of risk factors. Stopping smoking in old age can reduce the risk of stroke and heart problems, and it can make major differences to people with respiratory problems. The influenza vaccination can also make a difference for people with respiratory problems. Avoidance of risk factors (including smoking) and screening can help prevent cancer. The current practice in this country of confining the breast screening programme to those under 65 is highly regrettable. The incidence of breast cancer increases with age and it is ageist to exclude older women from the screening programme. Age discrimination such as this in health care should be eliminated.

The overuse of medication in old age can lead to serious ill-health that may even precipitate hospital admission. It is therefore wise to review an older person's medication from time to time and stop as many agents as possible.

Bone mineral density can now be measured accurately; measurement of bone mineral density is the single best predictor of fracture risk. The advent of new therapies over the last decade means that osteoporosis can be treated and the risk of fracture very significantly reduced. The ability to treat osteoporosis and prevent fracture was further advanced recently with the availability of parathormone in Ireland. It has been shown to be effective in building new bone and preventing fracture. The risk of hip fracture can also be significantly reduced in frail older people by the use of an anatomically designed external hip protector.

Maintenance of psychological well-being is a key aspect to successful ageing. Diagnosis and treatment of depression can make a major difference to the quality of life of an older person. Research shows that good social support and religious affiliation can protect against depression.

### *Conclusion*

There are many ways to optimise health and social gain in old age. To be successful, programmes must address social inequalities as well as health issues, and must encompass the psychological and physical aspects of ageing.

# **The Strategic Framework for the Healthy Ageing Programme**

***Dr Helen McAvoy, Healthy Ageing Programme Advisor, NCAOP***

## *Introduction*

This paper is divided into two sections. The first section describes the background to the Council's Healthy Ageing Programme and provides the context for the way forward proposed in the strategic framework. The second section describes how the strategic framework was designed and outlines in practical terms what the Healthy Ageing Programme proposes to do.

## *The context for the Healthy Ageing Programme*

The huge potential to keep older people well has been recognised in Ireland for some time. The 1988 report *The Years Ahead*, stated that a successful policy of health promotion would reduce the incidence of disease and disability among older people and increase the number of older people who are healthy and active. Both *Shaping a Healthier Future* (1994) and the *Health Promotion Strategy* (1995) identified older people as a priority group. Indeed one of the terms of reference of the NCAOP is to promote the health, welfare and autonomy of older people. We believe that measures to help older people remain healthy and active are a necessity, not a luxury.

Building on these commitments and on the Council's own extensive research on the health and well-being of older people, *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* was produced in 1998 in conjunction with the Health Promotion Unit of the Department of Health and Children. Its mission statement sets out the following aims:

- to improve life expectancy at age 65 and beyond
- to improve the health status of people aged 65 and beyond
- to improve the lives and autonomy of older people who are already affected by illness and impairment.

These health promotion activities are part of a global movement for healthy ageing. The WHO's *Active Ageing Policy Framework* (WHO, 2002) has influenced the development of the strategic framework for the Healthy Ageing Programme.

The development of healthy ageing strategies has contributed to significant developments in health promotion infrastructure. We now have health promotion departments in every health board. In some health boards we have health promotion officers with a specific remit for older people.

In light of this and other developments, it is fitting that a national survey of activity and a consultation process with practitioners was undertaken in 2003. The key findings from this work are contained in Dr Eamon O'Shea's paper. The full findings are available under separate cover in Dr O'Shea's report, *Healthy Ageing in Ireland: Policy, Practice and Evaluation* (NCAOP, 2003).

### *The Health Promotion Strategy and the Healthy Ageing Programme*

#### *What does it do?*

So what does the Health Promotion Strategy for Older People do? It sets out four arenas through which the health of older people could be improved. For each it recommends goals and action plans. For example, it has as a goal with an accompanying action plan to reduce the prevalence of smoking among people aged 55 and over by at least 16 per cent (in other words, to reduce it from 24 per cent to no more than 20 per cent) by 2005.

The Strategy recognises that a person's health in later life is largely determined by lifestyle and social and environmental factors largely beyond the influence of the health services. For example, research shows that a person's chances of ageing well are challenged by lower educational, literacy and income levels.

#### *How was it designed?*

To design the Strategic Framework for the Programme, the Council established a sub-committee, the Healthy Ageing Consultative Committee. The main role of the Committee

is to guide the development of the Strategic Framework and the Healthy Ageing Programme.

The Committee is made up of key stakeholders and advisors in the area of healthy ageing from the statutory and voluntary sectors. It met on several occasions in 2002 to consider how the Council could best support the implementation of the Health Promotion Strategy for Older People. It reviewed the evidence base for health promotion nationally and internationally, and examined healthy ageing programmes in the USA and Canada. The Committee also considered health inequalities in later life and drew up a list of priority groups of older people, to be afforded preferential effort during the life span of the programme.

The Committee proposed that the Healthy Ageing Programme would act as a resource that enabled health promotion for older people to reach its fullest potential. To do this it was agreed that the programme must address the following key areas:

- networking
- training
- materials
- models of good practice
- building healthy public policy
- public awareness
- research and evaluation

### *Networking*

The need to develop increased communications and networking between sectors contributing to healthy ageing was recognised. Health promotion initiatives for older people have suffered from the 'reinventing the wheel' syndrome. The Healthy Ageing Database and the path to building it (the subject of Edel Murphy's paper) should deliver in this regard.

### *Training*

It was recognised that there is a need to build resources; one way of doing this is through supporting the development of training. Training would assist older people and service providers to achieve their health promoting capacity. The Committee is currently exploring the options for this that emerged from the consultation process.

### *Materials*

The Committee acknowledged that information is power. The Healthy Ageing Programme, therefore, aims to help produce health education materials that will be of use to older people and service providers. There is already a large number of leaflets, brochures and videos produced by a range of organisations. To help disseminate this information the Programme produced the *Directory of Healthy Ageing Information Resources for Older People* (NCAOP, 2003).

### *Models of good practice*

It is the belief of the Committee that the Healthy Ageing Programme should provide information on 'what works' in health promotion with older people. Until the research and consultation was undertaken we knew very little about current practice in healthy ageing and about the evidence base for programmes and services.

### *National initiatives*

The Committee recognises the need to minimise duplication of effort and to encourage the development of national initiatives with a strategic approach, rather than the further proliferation of pilot projects and services. We are, therefore, proposing to support the Health Promoting Hospitals Network in the development of an initiative aimed at older people in residential care, which fits with our commitment to target health inequalities.

### *Building healthy public policy*

One of the Committee's strategic goals is healthy public policy. The Healthy Ageing Programme aims to contribute to the generation of public policy supportive of active ageing through various means, including submissions to bodies in a range of sectors.

### *Raising public awareness*

The aim of the Programme is to raise public awareness of healthy ageing. The 2003 Healthy Ageing Conference and this report on its proceedings are a first step towards this.

### *Evaluation and research*

The Healthy Ageing Programme also aims to build the evidence base for what works in healthy ageing and to fill in information deficits in relation to the health and lifestyle of older people. In 2003 the Council commissioned an in-depth secondary analysis of the National Health and Lifestyle Survey (SLÁN) figures for older people. This provides previously unrecorded data on issues such as sensory impairment, physical activity, sexual activity, alcohol and social engagement among older Irish people and considers the issue of health inequalities in later life. Some of its findings are outlined in Prof. Kelleher's paper later in this report.

## **Second Session**

***Chair: Dr Emer Shelley, National Healthy Heart Advisor,  
Department of Health and Children***

# **Developing and Accessing the Healthy Ageing Database**

***Edel Murphy, iManage and Associates Ltd.***

## *Introduction*

The purpose of this paper is to describe how the Health Ageing Database came about, and how to use it.

## *Background*

Information on healthy ageing has up to now been fragmented. The successful implementation of the Health Promotion Strategy, however, requires two things: the development of a comprehensive information and support network for promoting the health, welfare and autonomy of older people; and the identification and promotion of models of good practice for healthy ageing. To this end it was necessary to conduct an extensive research and consultation exercise with stakeholders in the field of healthy ageing in Ireland.

The aim of the project was therefore:

- to generate a comprehensive Healthy Ageing Database
- to produce a study that would inform practitioners and policy-makers, that would provide criteria for best practice and evaluation and that would result in improved health and social outcomes for older people in Ireland.

We realised the importance of getting input – both qualitative and quantitative – from practitioners directly involved in projects and seminars that promote healthy ageing. Therefore, the approach taken followed a participative model of research, in keeping with best practice in health promotion investigation. This approach consisted of two parts: a series of regional seminars to gather qualitative information about healthy ageing projects and initiatives, to hear the opinions of healthy ageing groups, to share ideas and to document the concerns of people working in the area; and a postal survey to gather quantitative information about projects.

We found that the process of conducting the regional seminars helped to create an awareness of the Healthy Ageing Programme and engendered support for the data collection process.

### *The seminars*

Over a period of six months we held eight regional seminars (one in each health board area and one in the Eastern Regional Health Authority). The aims of the seminars were:

- to bring together representatives of healthy ageing projects from health boards, voluntary groups, community groups, local authorities and older people
- to generate discussion that would inform national best practice in the field of healthy ageing
- to put together a comprehensive list of contacts and addresses for all healthy ageing projects in each region
- to facilitate communication and networking in the field of healthy ageing.

To generate a list of participants for the seminars we met with a senior contact person, appointed by the Chief Executive Officer (CEO) in each of the health boards. We explained the purpose of the seminars and the range of participants we wanted, from both within the health board and outside. Some were obvious, others less so.

In the health boards, we concentrated on specialists in an area, for example, continence promotion, falls prevention or diabetes, as well as the central disciplines associated with the delivery of services to older people. We looked to see whether there was anything innovative in specific areas, for example, audiology, ophthalmics, social workers, arts in care; we asked about health promotion nurses, activity nurses, carers' programmes within the health board and so on.

It was relatively easy to get a list of health board staff. In some health boards, however, it was more difficult to generate a non-health board list of contacts. These came via a combination of leads: health board staff; directories of voluntary agencies in an area; website searches; local knowledge of the project team; and contact with national organisations.

The search was as wide-ranging as possible. We looked at statutory bodies, voluntary organisations, including older people's groups, and commercial organisations. The range of areas included organisations involved in housing, transport, education, community development, social care, nursing care, day care, long-stay care, disability and mental health. Organisations such as Money Advice and Budgeting Service (MABS), Citizens' Information Centres (CICs) and Active Retirement Associations (ARAs) were examined, as well as community-based groups, religious communities, older people's national organisations, retirement planning groups, social economy projects, disability groups and support groups for specific illnesses. We looked at libraries, the Arts, the gardaí/security and activities such as grocery shopping, building and architecture. The aim was not to get every single person involved in these organisations and groups to attend the seminars, but it was important that we had a representative cross-section. As the seminars went on, we also focused on contacting groups that had not yet been represented.

We issued invitations to the potential participants identified. Between 40 and 50 were invited to each seminar and each was asked to bring a list of contacts for relevant projects in the area.

Within each seminar we split participants into groups of six to nine people. We included in each group people from a range of different perspectives – in order to ensure that a range of views were represented and to maximise networking opportunities. Each of these discussion groups was led by a facilitator who also documented the key points arising from the discussion.

Participants were asked to consider four major issues in relation to healthy ageing activities:

- current priorities
- future priorities
- issues in the planning, development and operation of healthy ageing projects
- best practice.

Without doubt, the networking that took place at the seminars was invaluable; we got very positive feedback on this, especially from people in the voluntary sector. We found

that participants were up-to-date with healthy ageing activities in their own area, but often knew little about activities in other areas. Contact with others during the seminar helped to bridge some of these knowledge gaps.

We defined a healthy ageing project as any innovative service or activity designed to improve the quality of life and well-being of older people, that is *in addition* to the normal services provided for older people. We found projects that had their origins in, among others, health boards, local authorities, community development groups, voluntary groups, retirement groups and intergenerational groups. We also identified some projects that were clearly healthy ageing projects, but were not considered by the owners to be so.

We drew up a list of contacts for healthy ageing projects from the information provided by the seminar participants, both at the seminars and afterwards. Health board staff provided additional contact details for health-board run activities and some non-health board activities. Voluntary and community groups provided information about their own work in a particular area. We also looked at areas where there was little activity, and contacted organisations and individuals in order to get relevant contacts. The Council's staff passed on relevant contacts that they had come across at meetings and conferences. We also identified contacts via word-of-mouth. The final list formed the sample for the survey.

### *The survey*

The aim of the survey was to gather information about healthy ageing projects for both the Healthy Ageing Database and the report. We developed a draft questionnaire for pilot testing before the seminars began. We chose nine known healthy ageing projects, including a national project with local implementations, on which to test it. This provided useful feedback, and we modified the questionnaire accordingly.

In Section A of the questionnaire, we obtained the following information:

- introductory information
- contact information
- project description

- categorisation of project
- setting
- current status
- origins of project
- funding
- partners and links
- participants
- staffing
- outcomes.

In Section B of the questionnaire, we acquired:

- confidential information
- information on policy and practice including priority setting and best practice.

Overall, 1,400 questionnaires were sent by post to potential projects. We also posted the questionnaire on the Internet and allowed online returns. Organisations were encouraged to complete a separate questionnaire for each of their healthy ageing projects. Those who responded to the questionnaire did so almost immediately; most of the returns were received within the first month of the data collection process. There was ongoing and selective follow-up of known projects that did not respond to the initial questionnaire.

When data entry was complete we worked with the database development team to design the Database.

#### *How to use the Healthy Ageing Database*

The Healthy Ageing Database is accessible on the Internet via two websites:

- the NCAOP website, [www.ncaop.ie](http://www.ncaop.ie)
- the Health-Data database website, [www.health-data.info](http://www.health-data.info). Whichever method of entry is used, the search may be conducted using keywords such as 'falls', 'activity therapy', 'Go for Life', 'arts' or 'arts in care'. You can also use other types of keyword, for example, location or health board area. The keyword search should bring up details of a project or

a list of projects with information about each, including contact details. Below is a step-by-step guide to accessing the information on the Database via the NCAOP's website.

- Go to [www.ncaop.ie](http://www.ncaop.ie).
- Click on the Healthy Ageing section.
- Click on the link to the Healthy Ageing Database. Alternatively, you can go to [www.ncaop.ie/healthyageing](http://www.ncaop.ie/healthyageing) and from there click on the link to the Healthy Ageing Database.
- You should now be on the Database search page (you can bookmark this to allow you to return directly to it).
- Go to the keyword field.
- Enter simple appropriate keywords, for example, 'falls'.
- Click on Search.
- After a few seconds you should see a list of projects matching the keyword.
- Note the title of the project and the aim of the project.
- Click on whichever project interests you most. The information presented is the information stored on that project in the Database. There may not be any projects in the Database that match your keyword. If you get 'no results', check the spelling of your keyword or use an alternative keyword. Also, consider that perhaps there are no projects about that topic in the Database. If your project is not in the Database, you can add it in using the Health Data interface. To do this both you and your organisation must be registered with Health Data.

### *Conclusion*

From the perspective of the project team, the project is finished. The Database, however, is only beginning. It is up to practitioners and organisations in the field to keep the Database alive and to add more information to it. We constantly complain that lack of information sharing is an obstacle to progress, that we should not be reinventing the wheel by piloting projects that already work elsewhere. The Database gives us the chance to share information and to make contact with people with experience of specific projects. I would like to conclude by thanking again all those who contributed to it through the seminars and via the survey.

## **Healthy Ageing in Ireland: Policy, Practice and Evaluation**

***Dr Eamon O'Shea and Sheelagh Connolly, Department of Economics,  
National University of Ireland, Galway***

### *Background*

The objectives of the Healthy Ageing Programme as stated in *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998) are:

- to improve life expectancy at age 65 and beyond
- to improve the health status of people aged 65 and beyond
- to improve the lives and autonomy of older people who are already affected by illness and impairment.

Information on healthy ageing has up to now been fragmented. It is difficult to envisage these objectives being achieved without significantly improved knowledge of existing activities in healthy ageing, and some discussion of best practice in this expanding and diverse field. To this end, it was necessary to conduct an extensive research and consultation exercise with stakeholders in the field of healthy ageing in Ireland.

Edel Murphy's paper describes how we conducted the consultation and the survey, and how we developed (and how you can use) the Healthy Ageing Database. The aim of this paper is to present the key findings from the seminar consultations and from the survey. A full account is contained in the report, *Healthy Ageing in Ireland: Policy, Practice and Evaluation* (O'Shea, 2003).

### *Key findings from the regional seminars*

#### *General*

One of the recurring themes raised at the seminars was the prevalence of *ageist attitudes*. People felt that multi-sectoral and inter-disciplinary progress in healthy ageing was being impeded by the presence of an ageist culture in Irish society. The view from

the seminars was that ageism can and should be challenged, and participants advocated action to combat it at national, regional and local levels.

Participants were aware of the multi-dimensional nature of healthy ageing, and they emphasised the need for the development of an *integrated holistic model of ageing*. Although many health-related issues were raised and important points made in respect of access to community care and appropriate residential care, people were conscious of the need to look beyond *bio-medical interpretations of well-being*. The importance to successful healthy ageing of *inter-generational relationships* and solidarity between the generations was highlighted during the seminars. *Housing* and *transport* were also seen as important elements of healthy ageing for older people.

#### *Development issues*

Seminar participants were particularly concerned about the *lack of funding* to support innovation and best practice in the formulation and implementation of projects. Concern was expressed that many local communities do not get beyond the general recognition of problems, and, even when they do, their response is often isolated and narrowly focused with poor links to outside communities and agencies. Many of the *integration problems* stem from the fact that healthy ageing tends to cross traditional functional and administrative boundaries, and is not comprehensively dealt with by any one statutory body. Community groups, trying to embrace a holistic model, have to deal with a myriad of organisations, and the process of generating support and resources for healthy ageing projects is enormously time-consuming. These difficulties are magnified by the *absence of partnership models* for public, private and voluntary co-operation in the field of healthy ageing.

#### *Best practice*

*Consultation* with older people was considered by seminar participants to be the most essential element of best practice in healthy ageing. The view was strongly held that older people should be involved in a project from the planning stage through to the evaluation of outcomes. There was criticism that the structures necessary to allow meaningful consultation were not always in place.

*Continuity* and *sustainability* were also mentioned as central to best practice, and were linked to both funding and information-sharing at local, regional and national levels. Participants wanted greater information on good and bad practice in the field of healthy ageing through formal *evaluation* procedures. Currently, good practice is not being replicated because people do not know of its existence or its constituent parts.

There was also support for the implementation of *common standards* with respect to the provision of health board services for older people, which people saw as varying widely across the country.

### *Key findings from the survey*

#### *The settings of the projects*

Almost half of all healthy ageing projects that responded to the survey questionnaire are concerned with the social environment of older people. The social environment category includes such areas as social interaction, public attitudes, retirement issues and income support. Just over 20 per cent of projects occur in active retirement groups or sport/recreation club settings. A further 16 per cent occur in a day care/day centre setting. Ten per cent of projects occur in an older person's own home. There appears to be a distinct lack of projects in general practice and acute care settings.

#### *Origins, staffing and participants*

The majority of projects develop from the bottom up, sometimes with little support from official sources. Some 70 per cent of projects came about because of an initiative taken by the organisation providing the service. Generally, projects are evenly divided between those where some form of needs analysis had been conducted and those where no such analysis took place. Projects are usually small in scale, with two thirds having less than fifty participants per week and one third having less than twenty. The ratio of female participants to male participants in healthy ageing projects is three to one. Projects are mainly staffed by part-time voluntary workers.

With regard to future development and expansion of projects, inadequate funding was regarded by respondents (20 per cent) as the principal obstacle. This was followed by ageist attitudes (13 per cent), the lack of interest in healthy ageing among policy-makers (12 per cent) and the absence of an integrated holistic approach to healthy ageing and well-being (12 per cent).

Increased funding for social interaction and integration, and the promotion of better attitudes to old age and society, were regarded as priority areas for the future by survey respondents, with 16 and 12 per cent respectively of respondents highlighting these two areas. Mental health promotion also scored highly, as did stroke prevention. Personal and creative development for older people was also seen as important.

Older people living alone were regarded as a priority group by survey respondents, with one third suggesting that projects in this category should receive additional funding, if such funding were to become available. Homeless older people, older people in deprived economic circumstances and rural older people were also considered deserving groups, with 35 per cent of respondents indicating that these should receive priority in the future.

#### *Best practice: a checklist*

Criteria for making decisions on best practice in healthy ageing are developed in the full report. Here is a checklist of the critical elements:

- needs assessment undertaken prior to the commencement of the project
- consultation with older people throughout the duration of the project
- participation of older people in the planning and operation of the project
- empowerment of older people through the operation of the project
- partnership models that encourage co-operation and integration of all interested parties
- adequate funding and operating structures to ensure the sustainability of the project over the longer term
- evaluation criteria built into the project from the beginning
- equity criteria to ensure the maximum participation of all categories of older people
- information generation and information-sharing as essential elements of the project.

## *Healthy ageing: the future*

### *Dealing with ageism*

Ageism has been identified as a critical issue for older people. Age proofing should be applied to all areas of public policy-making, particularly the areas of health and social care, employment and education. More resources should be directed towards changing attitudes to ageing in society beginning with the launch of a high profile national advertising campaign designed to challenge existing stereotypes. Training in age equality awareness and the development of skills to combat ageism should be routinely provided in the public service and in the work-place generally, building on recent policy initiatives in this area. Entitlements in respect of community-based social care services should be legislatively-based, to ensure services are available to older people who need them. For example, legislation is required to provide equal and easy access for older people to all primary care services.

### *Investing in healthy ageing*

A designated and protected Healthy Ageing Fund should be established by the Department of Health and Children to encourage innovation and experimentation in respect of healthy ageing projects. There should be a competitive tendering process for large-scale projects and five annual large awards made under each of the five headings of the Ottawa Charter. The annual fund should be in the region of €5 million and could also be used to support small-scale projects. There should be seed capital available for smaller projects and a separate application process for this funding. The Fund should be administered by the NCAOP's Healthy Ageing Programme. Evaluation should also be central to the allocation of scarce resources in the healthy ageing field. The NCAOP should have a role in providing advice and support with the design of evaluations for agencies that need support in this area.

### *Housing*

Housing is a key element in keeping older people well and living in the community. Good housing enables older people to continue living independently and to maintain lifetime social contacts and networks. There is work to be done on improving the housing stock

of older people and in making housing more accessible and barrier-free, so that older people can remain in their own homes even if they become dependent.

There is also a need to provide, through public/private/voluntary partnerships, sheltered accommodation in local settings, which is appropriately designed, monitored and maintained, as a step-up alternative to older people moving from home directly into residential care. Older people and their representatives should be an important part of the partnership process in developing appropriate housing. Community care services should be linked to sheltered housing provision, with the emphasis on health promotion and healthy ageing. Some older people in sheltered accommodation will eventually require nursing-home care, and careful planning should allow for seamless transition between living in the community and residential care living for these people.

#### *Capacity-building*

Capacity-building for voluntary and active retirement groups at community level is also necessary for the fulfilment of healthy ageing goals. The Healthy Ageing Programme can play a major role in this regard by acting as a valuable resource to support voluntary groups in achieving best practice in the operation of healthy ageing projects. Capacity-building could take the form of support for training workshops in planning, running and evaluating healthy ageing projects, and supporting groups in an advisory capacity. Active retirement groups provide a real opportunity for mutual self-help, which is in itself empowering. These groups require greater support, however, through seed funding for innovative healthy ageing projects and training in the area of participation and empowerment.

#### *Placing older people at the centre of decision-making*

Older people should be placed at the centre of decision-making both in the community and in residential care. The hypothetical case studies used to illustrate best practice in healthy ageing in this report should form the basis of two pilot projects designed to explore the implications of providing greater autonomy and choice to older people living at home and in residential care. Funding for community care services needs to be enhanced through the provision of person-centred community-based subventions for

vulnerable older people. These subventions will allow older people more choice and facilitate the development of community-based services, some of which might be provided through an expanded social economy system.

#### *Promoting good mental health*

Social isolation, anxiety and depression are important contributory factors to frailty and loss of function in later life. Mental health promotion can play a key role in healthy ageing for older people. Specific targeting of vulnerable older people through screening and subsequent social interaction and networking projects can reduce isolation. Community activities, accessible transport and life-long learning courses can also help alleviate isolation and anxiety. Local initiatives, based on local knowledge, may be important in developing the social capital necessary to promote better mental health in local communities. For example, providing ongoing and appropriate support during bereavement can have a significant impact on healthy ageing.

#### *Promoting personal and creative development*

The participation of older people in creative activities is also important. It is encouraging to find many healthy ageing projects for older people in the field of the Arts, and that public libraries are important hosts of many creative activities for older people. The exposure of older people to creative and artistic activities should become part of mainstream healthy ageing policy, with increased funding for such activities coming from both the health boards and the local authorities. People in residential care and in nursing homes should be given the opportunity to develop their creative potential. Where this has happened, outcomes and quality of life have improved for both residents and staff.

#### *Primary care and healthy ageing*

Healthy ageing should form an integral part of the Primary Care Strategy. Pilot projects in the form of healthy ageing clinics should be supported in general practice. Specialist advice could be available to older people at these clinics, provided either by a GP or a specialist nurse. These clinics could be used for screening and lifestyle advice, and for the referral of older people to specialist secondary care out-patients if appropriate.

### *Conclusion*

The report, *Healthy Ageing in Ireland: Policy, Practice and Evaluation*, is part of the process of extending and developing a knowledge base on healthy ageing activities in Ireland. It provides some insight on what should be done to improve the position of older people in Ireland in the field of healthy ageing over the coming decades. The development of the Healthy Ageing Database will improve existing knowledge, as well as providing a facility for groups to network and identify areas in need of investment and development.

The identification of models of best practice is the logical extension of the data generation exercise and will be an important aspect of future resource allocation in this field. Similarly, providing an evaluation framework will allow worthwhile projects to be more readily identified and rewarded.

# **The Health and Lifestyle of Older People: Findings from SLÁN 1998 and 2002**

***Dr Frances Shiely and Prof. Cecily Kelleher, Department of Public Health  
Medicine and Epidemiology, University College Dublin***

## *Introduction*

In 1998, the Health Promotion Unit of the Department of Health and Children commissioned the *Survey of Lifestyle, Attitude and Nutrition (SLÁN)*. The aim of the survey was to collect data on the lifestyle of the adult population in Ireland. This was the first time such data was collected. The survey was conducted again in 2002. In each round of the survey a representative sample of the Irish adult population completed the questionnaire, giving a sample size in 1998 of 6,539 and a sample size in 2002 of 5,992.

To get a more detailed picture of the lifestyle and circumstances of older people of different ages and different backgrounds, the NCAOP asked the Department of Public Health Medicine and Epidemiology at University College Dublin to conduct further analysis of those aged 55 and over from the 1998 and 2002 SLÁN datasets.<sup>1</sup>

To do this we divided the 1998 and 2002 SLÁN datasets into five-year age bands. Those aged 55-59 were grouped together, those aged 60-64, those aged 65-69 and so on up to those aged 85 and over.

## *Aims of the analysis*

The aims of the analysis were to see what, if any, changes occurred between 1998 and 2002, to look at indicators of health status and to assess how social circumstances influence health status.

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<sup>1</sup> In the 1998 SLÁN dataset there were 1,634 people aged 55 and over; in 2002 there were 1,754.

### *Summary of key findings*

The findings show that the make-up, attitudes and behaviour of the population of older people aged 55 and over has changed since 1998. A greater proportion of the 2002 sample had completed third level education and a greater proportion of them hold a medical card. More of them, compared to those in 1998, rate their quality of life as very good (and women are more likely than men to say this). More of them rate their health as excellent or very good, yet more of them are suffering from diabetes and problems with cholesterol levels and fewer of them are taking mild exercise.

The findings also show that the older you are, the less likely you are to rate your health as excellent or very good – until you join the 85+ age group. Those in this age band rate their health similarly to the group twenty years their junior.

Whether a person holds a medical card or not tells us quite a bit about them. For example, if you have a medical card you are less likely to be married and more likely to be widowed, you are more likely to live in a multi-storey block of flats or in a mid-terraced house and you are more likely to say that your health is fair or poor; indeed medical cardholders are more likely to say that they experience either moderate or extreme pain or discomfort.

The data also shows that social class is an indicator of health and well-being. If you belong to social classes 5 or 6 (that is, with an occupation in the manual and unskilled group), you are less likely than those in social classes 1 or 2 (the professional and managerial group) to rate your quality of life as very good and less likely to rate your health as excellent or very good. Indeed you are more likely to be affected by long-term illness or disability and you are more likely to smoke regularly.

The area in which you live also plays a part in lifestyle and well-being. For those living in an urban area, for example, house break-ins are more likely to be seen as a problem than for those in a rural area. Those living in a rural area are significantly more likely than those living in an urban area to agree strongly that they can trust people in their area.

## *Findings in detail*

### *Demographics*

The data shows that a smaller proportion of those aged 55 and over in 2002 fall into the category 'no schooling/primary school education/some secondary education' (69 per cent compared to 79 per cent in 1998). Moreover, a greater proportion of them have completed third level education (15 per cent compared to 10 per cent in 1998).

There is also a greater proportion in the professional and managerial social class (SC 1 and/or SC1-2) – 46 per cent compared to 32 per cent of the 1998 sample – and a smaller proportion in the manual/unskilled group (SC5-6) – 20 per cent compared to 29 per cent.

There is no difference in terms of marital status: in both 1998 and 2002 around 50 per cent are married, 25 per cent are widowed and 22 per cent are single or never married. The rest are divorced, separated or cohabiting.

A smaller proportion of the 2002 sample own their houses outright (a drop of 9 per cent from 1998) and a slightly greater proportion (1 per cent more than in 1998) rent their houses from the local authority.

More than half of the 55+ years group live in a detached house, slightly fewer in 2002 than in 1998. In both 1998 and 2002 the data shows that about a quarter live in a semi-detached or end-of-terrace house (23 per cent), and 13 per cent live in a mid-terrace house. The rest live in apartment blocks, multi-storey flats or residential homes. The data shows that if you have a medical card you are more likely to live in a multi-storey flat or in a mid-terrace house.

Just over half (54 per cent) had a medical card in 1998. In 2002, 63 per cent have one. This reflects the change in government policy in July 2001 that made medical cards available to all adults over the age of seventy. In 1998, women were significantly more likely than men to have a medical card. This was not the case in 2002 – men are now just as likely to hold a medical card. The data also shows that medical cardholders are significantly less likely to be married and more likely to be widowed.

## *Health*

A greater proportion of the 2002 group rate their health as excellent and very good (in fact, 72 per cent of them rate their health as excellent, very good or good); a smaller proportion compared to 1998 rate it as good, fair or poor. It appears that the older the person, the less likely they are to rate their health as excellent or very good until they join the 85+ years group. In other words, while there is a general decrease in self-rated health across each age band, there is an increase in the 85+ years group. This is consistent with the findings of other research: most older people tend to assess their health as similar to or even better with increasing age despite an increase in chronic diseases and a decline in performance. In fact, the 85+ years group rate their health similarly to the group twenty years their junior.

There is a relationship between self-rated health and holding a medical card, as well as self-rated health and social class. Those with a medical card are significantly more likely to say their health is fair or poor and more likely to experience either moderate or extreme pain/discomfort. Those who do not have a medical card are more likely to rate their health as excellent, very good or good. Those in social classes 1 and 2 are more likely than those in social classes 3 or 4 and social classes 5 or 6 to say their health is excellent or very good.

Around a quarter (29 per cent) of the 55+ years group say they are limited in their work or daily activity by long-term illness or disability. Three quarters of this group (77 per cent) have a medical card. The data shows that you are more likely to be affected by long-term illness or disability if you are a man, and if you are in social classes 5 or 6. Men in social classes 5 and 6 aged 55-59 and 60-64 are significantly more likely to be affected by long-term illness or disability. Those in social classes 1 and 2 are significantly less likely to be affected.

A greater proportion of those in the 2002 sample compared to those in 1998 rate their quality of life as very good (24 per cent compared to 19 per cent) and a smaller proportion of the 2002 sample rate their quality of life as neither poor nor good, poor and very poor. Women are significantly more likely to say that their quality of life is very good. Those in social classes 1 and 2 are also significantly more likely to rate their quality of life as very good.

Those who have a medical card are significantly more likely to smoke regularly.

There is an increase in the proportion saying that their GP has told them that they suffer from diabetes; up from 5 per cent in 1998 to 6 per cent in 2002. There is also an increase in the proportion being told they have high cholesterol levels (from 12 per cent in 1998 to 16 per cent in 2002). The proportion with high blood pressure, stroke or angina has not changed.

### *Sexual activity*

The data shows that sexual activity decreases with age, but as with self-rated health it increases in the 85+ years group. The proportion of those saying they have never used contraceptives is greatest in the youngest age group, the 55-59 years group. Use of contraceptives decreases with age but increases among those aged 85 and over.

### *Exercise*

The proportion taking mild exercise has dropped from 30 per cent in 1998 to 24 per cent in 2002. The proportion of those taking moderate exercise (around 19 per cent) and strenuous exercise (three per cent) has not changed. One in twenty (5 per cent) attend a gym or leisure centre. This decreases significantly with age but again increases in the 85+ years group. Those in social classes 1 and 2 are significantly more likely to attend a gym or leisure centre. Those who are members of a sports club are significantly more likely to rate their health as excellent or very good.

### *Support*

Half of the sample reported receiving a lot of support from a spouse or partner. Almost half (45 per cent) say they receive a lot of support from children and 30 per cent say they receive a lot of support from friends. Carers are more likely than non-carers not to trust in others and few appear to receive family support. They are also more likely to be involved in charity and voluntary organisations. Also, those aged 55 and over are more likely to take part in religious or voluntary organisations than is the national sample.

### *Physical environment*

Around a quarter of older people (25 per cent) say that poor public transport is a big problem for them. A third (33 per cent) say house break-ins are 'a bit of a problem', with 7 per cent say they are 'a big problem'. This varies according to the health board area in which the respondent lives. The South Western Area Health Board is the area in which break-ins are the most widespread problem, followed by the Northern Area Health Board and the East Coast Area Health Board. Those living in an urban area are twice as likely to rate house break-ins as a problem than those living in a rural area. Those in social classes 1 and 2 are more likely to live in an area where children can play safely.

### *Trust in others*

Those who hold a medical card are significantly more likely than those who do not to agree strongly to trusting people in general. The Southern Health Board Area, which includes Cork City, has the greatest percentage of respondents agreeing strongly that most people can be trusted. The Midwestern Health Board, which includes Limerick City, has the smallest percentage of those who strongly agree and the greatest percentage of those who strongly disagree that, generally speaking, most people can be trusted. Those living in rural areas are significantly more likely to agree strongly that they can trust people in their area than those living in urban areas.

## Parallel Sessions

## **Workshop One: Homeless Older People**

***Chair: Mary Higgins, Director, Homeless Agency***

***Speaker: Pat Doherty, CEO, Depaul Trust***

### *Introduction*

The Depaul Trust believes that everyone has a right to a home and to a stake in their community. Our mission is to offer homeless and disadvantaged people the opportunity to fulfil their potential and move towards an independent and positive future.

The Depaul Trust UK was set up in 1988 by Cardinal Basil Hume, the Society of St Vincent de Paul (SVP) and the Daughters of Charity with the opening of the Passage Day Centre in London. In 1996 another centre was established in Newcastle upon Tyne.

In 2000, the Chief Executive of the Depaul Trust UK came on a three months sabbatical to work with SVP Ireland. As a result the Depaul Trust Ireland was set up in 2002 in partnership with SVP Ireland, the Daughters of Charity and the Vincentian Fathers.

In February 2002 the Depaul Trust opened Clancy Barracks, a 'low threshold' night shelter for rough sleepers aged 18-35 years. In December 2002, a 'low threshold' wet shelter was opened in Aungier Street for street drinkers. The average age of the Aungier Street clients is 45 years. In January 2003, in partnership with SVP, we opened Back Lane, emergency direct access accommodation for men aged 26 and over. Also in January 2003, again in partnership with SVP, we opened Tús Nua, a transitional housing project for women aged 18 and who have just been discharged from prison.

### *Back Lane*

Back Lane, in Dublin City Centre, has 74 bed spaces. It is a high support centre with staff on duty 24 hours a day, seven days a week. The centre offers food as well as accommodation. Just over 40 per cent of Back Lane residents are older men aged 60

and over. Just over one in five are aged 70 or more. Almost 30 per cent are aged between 50 and 59 years.

### *Health issues*

Many residents in Back Lane suffer from poor mental health, which tends to show up as 'challenging' behaviour. Some have been diagnosed with a psychiatric condition; others have not.

Most suffer from poor health; heart conditions, limited mobility and incontinence are common. Many have poor hygiene habits. As well as health problems many residents show signs of substance misuse, mainly alcohol, and many are suffering the effects of long-term alcohol misuse.

### *Challenges*

We face many challenges:

- there is a lack of suitable 'move-on' accommodation and few 'move-on' options available
- City Centre based support networks are limited
- we also come across men who are sex offenders and those who have had a long-term institutionalised existence.

As a community we need to empower older people, and help them to empower themselves. We need to recognise the potential for older people to add value to their community. We need to be able to respond quickly to the needs of older people who are unwell.

### *Solutions*

To address these challenges, better access to mainstream services for older people is essential, as well as suitable and adequate support for older people in the community. There is a requirement for specialist housing projects for older homeless people with mental and primary health care needs.

We need to see the potential in individuals and we all need to think 'outside of the box' to find solutions.

***Speaker: Alice Leahy, Director, TRUST***

*Introduction*

Older people who are homeless are a vulnerable group within a highly disadvantaged sector. They have little or no say in how they are treated or what type of facilities they receive. In many cases, they may be reticent where authority is concerned and fearful that, if they are seen to complain, they may be denied the services they need.

A combination of a shortage of accommodation and reduced services is making conditions for homeless old people increasingly difficult. The recent emphasis on moving people on and resettling them has caused distress and fear among many homeless people. An unwillingness to co-operate with, at times, questionable research or a reluctance to move on to free up beds for the more needy are seen as recalcitrant behaviour or worse. In effect, some agencies are creating structures and methods of operation that are leading to the exclusion of those they have been set up to serve.

*About TRUST*

Our philosophy in TRUST is a simple one – we insist on treating people as people. The stigma of homelessness often blinds people to the uniqueness of each individual. We take a person-centred approach, treating people as people and not as statistics. We believe that no one should be forced to conform where that is not possible. We aim to create opportunities to help everyone realise their full potential, regardless of age.

In TRUST we meet around 35 to 40 men and women every day. They range in age from those in their late teens to those in their late 80s. Some of the older people we meet have become homeless; others have grown old having been homeless for years. Some are proud and independent, know their rights and entitlements, and are often fearful of hospital admission. Others are often ill, but with appropriate support can keep their independence. We see it as our responsibility to help them do that. TRUST aims to work to prevent older homeless people from becoming outsiders. The following case studies give some idea of our work.

### *Jim*

Jim is 78 years of age and is from rural Ireland. He first made contact with us 20 years ago after returning from the United Kingdom where he had lived in boarding houses and worked on building sites. His only social activities were attending Mass and going to the local pub. He kept in touch with home through his local newspaper, which was posted to him.

In Ireland he was the victim of a physical assault in a hostel that led to facial injuries and hospitalisation. This is how he came into contact with services including TRUST.

Some years ago a new project was seen as being suitable for him. Jim was fearful to refuse although it meant disruption. As a result we intervened and he stayed put. On another occasion a new social worker, without consulting him, decided that he should move back to his place of birth. He pleaded to be left in the hostel he calls home – he is known there, he has his own room, he can back a horse, he can attend mass in the church he knows and likes. Again we intervened.

We look after Jim's personal care and general welfare needs, including contact with his family. The hostel staff ensure he has his medication. He has respite care every four to six months. While his quality of life may not be what those who do not know him would recommend, he is content – and what is wrong with that?

### *John*

When John was in his late 70s he decided to move to a hostel. Living alone had become difficult for him, but he wanted to keep his independence. John settled into hostel life, having the choice to mix with other residents or not. The hostel became his home – meals were cooked, laundry done and his only responsibility was to pay his rent, which was subsidised by the ERHA.

After a number of years, John's health deteriorated. He had difficulty walking to the local shops, to his GP; even walking to the toilet was difficult, and created problems, which led to soiled clothes and bed-wetting. TRUST moved in and began to take care of his

personal care needs, including weekly baths, changes of clothes, check-ups for pressure sores, chiropody and an eye test for new glasses.

John's health, however, continued to deteriorate rapidly. This coincided with the expiry of his medical card. To renew it, despite having had a medical card for many years, he was asked to submit his birth certificate as proof of age. To get a birth certificate meant calling at the Birth Registrations Office, some miles away from the hostel with no direct bus service.

The completed medical card renewal forms were submitted to the local welfare office where they were mislaid twice. John was asked to call at the welfare office but his rapidly failing health meant that he could not do this, despite the office being a short distance from the hostel. A TRUST volunteer dealt with the welfare office staff. After three visits and numerous phone calls, John got a medical card number.

His GP, at our request, arranged a day hospital appointment. Numerous appointments and numerous tests followed. The procedure in an Out-Patients Department is not always patient-friendly so, on all his hospital and GP visits, John was accompanied by TRUST staff or someone from the hostel.

It was obvious that John was in severe pain and needed care delivered by trained staff in a proper setting with at least some basic comforts. So eventually he was admitted to hospital. TRUST staff visited him there. One afternoon, three weeks after being admitted, he was transferred to the Hospice. No one was informed. He died there less than a week later.

Involvement of TRUST staff meant that John spent his last days in comfortable surroundings. At times this is all we can do, but even that requires tremendous involvement. This is never adequately described in current nursing literature or in recent research findings.

### *Tom*

Tom is 87 years old this month. He is from a farming background, but moved to Dublin many years ago and lived in a workman's hostel. He worked as a night watchman until he retired.

*In general I am fair enough for my age – I have a little arthritis. A good while out of the country, Dublin is my home. I send Christmas cards to my cousins, the only ones left, listen to the radio, especially the news, watch TV. I read the papers and occasionally go to the library. When I didn't move earlier, why would I now?*

### *Conclusion*

We must address the nature of homelessness as a form of social exclusion. Unless we create a welcoming and sensitive environment, the exclusion of older people from our society will become more serious and many will continue to die alone and excluded.

I conclude with a plea that we do not rush to advocate research, we have done enough research already. I would recommend that we focus on the personal needs of each older person and not just see them as homeless, but as unique human beings, the same as everybody else.

### ***Discussion: challenges and strategies***

It was noted that for many, homeless people are those they see on the streets. Few realise that many older people who are homeless live in hostels and that many of them are long-term residents. Workshop participants highlighted the need to prevent older people from becoming homeless, and for those who do become homeless, to ensure that it is short-term rather than a way of life.

It was noted that those who have lived in a hostel for a long time have become institutionalised, used to hostel life and its routine, and accepting of it. Therefore, solutions that involve moving them on are not appropriate and do not work. Participants agreed that there is a need to find and apply a different approach.

Many older people who are homeless have serious health problems, and some suffer mental health problems. A key challenge, participants noted, is to address these health needs in a way that suits the older person and meets their needs. Older people, who are homeless, should not be marginalised because they are seen as a 'challenging' group. They should have access to mainstream services. Workshop participants agreed that care and case management gave the best chance of providing the person-centred, tailored care required, because it was based on an assessment of individual needs and circumstances and the development of a co-ordinated care plan designed to meet these needs.

## **Workshop Two: Older People in Long-Term Residential Care**

***Chair: Pat O'Toole, Council Member, NCAOP***

***Speaker: Catherine Lawlor, St Mary's Hospital, Dublin***

### *Introduction*

In this short paper we explain what Activity Nursing means and we describe briefly how it can help to create a supportive social environment for older people in long-term residential care.

Each person in long-term residential care is a unique individual with physical, emotional, social and spiritual needs. The care that he or she receives should not just be planned in accordance with a medical diagnosis and treatment, but should also take into account his or her personal needs.

In a long-stay ward environment, nursing care can be task-orientated with little or no individual care. As a result of routine and lack of stimulation, the quality of life of a long-stay resident can be extremely poor. This can lead to feelings of apathy and low self-esteem. If the quality of life of a long-stay resident is to improve, activity must become an integral part of his or her care.

### *About Activity Nursing*

Activity Nursing is a form of therapeutic care designed to meet a person's psychological and social needs through physical, mental and social stimulation, and individual care. The underlying philosophy of Activity Nursing is that an older person, in spite of physical decline, illness and increasing dependency, has the capacity for growth. To quote George Bernard Shaw, 'Man doesn't cease to play because he grows old – man grows old because he ceases to play'.

The therapeutic care of Activity Nursing is delivered in the form of an activity programme designed and adapted to suit a person's functional level. It combines stimulation,

reinforcement of functional ability and, most of all, enjoyment. A programme will include several different types of activities in order to be balanced – to stimulate as many senses as possible.

The main aim of an activity programme is to improve the person's quality of life, to help them to accept long-stay care and to make that care as creative as possible. It aims to promote self-esteem and to stimulate meaningful relationships. In this way it aims to meet a person's psychological and social needs, and to create a supportive social environment.

### *Examples of activities*

Examples of the activities that might be included in an activity programme are:

- physical e.g., exercise and movement, ball games
- mental e.g., quizzes, word games
- social e.g., sing-alongs, outings, parties, coffee mornings, concerts, bingo, shopping, newspapers, television, video, poetry, storytelling
- cultural e.g., music, art, drama, library
- spiritual e.g., church services, Holy Hour
- educational e.g., presentations, discussions, talks
- individual e.g., reminiscence, crafts
- sensory e.g., aromatherapy
- beauty e.g., make-up, manicure, massage
- animals e.g., budgie, fish.

Physical activities can help to improve a person's mobility, co-ordination, respiration and circulation. Mental activities can help to improve concentration and memory, encourage initiative, and enhance orientation. Social activities encourage communication, interaction and involvement, and can enhance self-esteem, reduce boredom and stress, and provide fun and relaxation. Creative activities can help develop self-expression.

### *Conclusion*

With the help of Activity Nursing and a tailored activity programme, we believe that it is possible to create a supportive social environment and an improvement in the quality of life of those living in long-term residential care.

**Speaker: Dr Suzanne Cahill, Director, Dementia Services Information and Development Centre, St James's Hospital, Dublin**

*Design makes good care easier. It does not make it happen.*

(Marshall, 2001)

*Introduction*

Design guidance has long suggested that building layout may significantly affect orientation and social interaction among people with dementia (Hiatt, 1991; Lawton, 2001). In fact, a consensus exists on what constitutes best practice in design (Judd *et al.*, 1998). Yet adapting long-stay environments to address the needs of persons with dementia has not been a priority for planners or owners of long-stay care in Ireland. It is said that neither the public nor private residential sector has been prepared (until recently) to invest in specialist facilities (O'Shea and O'Reilly, 1999). As a result persons with dementia are often placed in unsuitable environments that may accentuate the disability associated with dementia (O'Shea and O'Reilly, 1999).

The published research shows that:

- personalised rooms and domestic furnishings can improve intellectual and emotional well-being and reduce agitation (Day *et al.*, 2000)
- where residents with dementia can smell food cooking and choose favourite types, they eat more and spend longer in dining rooms (Altus, 2002)
- light deprivation, glare, excessive noise, unsuitable seating and poorly selected floor covering can be hazardous to persons with dementia (Brawley, 2001)
- music therapy is associated with a decrease in depression in nursing-home residents with dementia (Denney, 1997).

In Scandinavia, the provision of Specialist Care Units (SCUs) for persons with dementia is a long established tradition, and having private bedrooms with ensuite bathrooms is considered the norm (Eek *et al.*, 1999). The key characteristics of these units include:

- specialised design
- dementia appropriate activities
- small group of residents (eight to ten)

- family involvement
- specialist training of staff
- careful staff selection.

The benefits of this approach include:

- improvements or the slowing down of decline in communication and self care skills, social functioning and affective responses (resident)
- increased competence and job satisfaction (staff)
- reduced emotional strain (family caregivers)
- improvements in mental and emotional status (other residents).

This short paper presents some findings from exploratory research conducted in 2001 in private and voluntary nursing homes in Ireland. A total of 29 in-depth interviews were carried out with Directors of Nursing in these long-term care environments. The study was supported by grants from the Health Research Board and from the Alzheimer Society of Ireland.

#### *Aims of the research*

The research set out to investigate the architectural design and cultural environment of long-stay homes in which dementia care was provided and to examine the extent to which these homes complied with an international consensus on best practice and dementia design (Judd *et al.*, 1998).

#### *Findings*

The 29 residential facilities included in the research are home to 1,202 residents, 390 of these residents being persons with dementia. However, we found only one Specialist Dementia Unit. The size of the facilities varied; the largest had 157 residents, the smallest had 14.

We asked the Directors of Nursing in each home about the nursing-home environment, including room configuration, age of building, ensuite arrangements, staffing ratios, activity programmes, use of signage and cueing, integrated versus segregated

environments, access to multi-sensory gardens and safety features. We also asked about admission policies and cost of care.

### *Environment*

In terms of the environment, here is a summary of what we found:

- 41 per cent had some bedrooms with ensuite bathroom
- 21 per cent had separate rooms for separate functions
- 24 per cent had a quiet room
- 14 per cent used colour cueing
- 75 per cent had gardens (but not all gardens were safe or usable).

While most Directors of Nursing (79 per cent) said that the external environment of the long-stay home was safe, a minority (7 per cent) rated their gardens very unsafe. We heard detailed descriptions about the problems experienced by staff trying to provide dementia care in places that were not designed accordingly:

*It's very unsafe and there are no gates and a person can wander out onto the road. The back area of the garden is unsafe as well.*

*As the building isn't custom-built, it works against us not with us in providing care. In specialist units you can give specialist attention and look at individual skills and staff and resident issues.*

### *Activities*

We found that 90 per cent of the nursing homes offered at least one therapeutic activity:

- 86 per cent offered music
- 41 per cent offered art
- 38 per cent offered exercise
- 34 per cent offered crafts
- 28 per cent used reminiscence therapy
- 21 per cent offered massage therapy.

Allowing residents with dementia access to kitchens and laundry and allowing them to take part in normal domestic activities was quite uncommon. In only one third of the nursing homes were residents with dementia encouraged to help set up tables. Very few encouraged residents to wash or dry dishes, or help with food preparation or cooking. Directors of Nursing appeared to be limited by health and safety regulations and by health board inspections. Repeatedly inspections were given as the reason why persons with dementia were not allowed to take part in more domestic/recreational activities.

*Health boards told me not to let patients make their own beds. Health boards are too rigid in their inspections and there should be a lot more humanity to them. They never really ask about how the patients are.*

#### *Cost of care*

The average cost of care per person per week was €505; the lowest cost was €349 and the highest was €863. There was a big difference in the cost of care depending on its location (urban versus rural) and on whether the nursing home was private or voluntary. Voluntary homes cost on average €100 per week less than those that were matron-owned or privately run.

While we found a range of design features and a range of activities in Irish nursing homes offering dementia care, we did not find a link between the cost of care and its quality in terms of the activity programmes delivered. We did find major inequalities in relation to access to long-term care and the range and frequency of multi-sensory activities available to residents.

#### *Conclusion*

The ideal long-stay environment for persons with dementia is a building that feels like home; one that is small, safe and domestic in its layout. It is suggested that buildings should 'speak to' the person with a cognitive impairment. The design should be used to compensate for the disability of dementia and should adequately support the person, who may be prone to feeling anxious (Calkins, 2001). Buildings, therefore, need 'to make sense' to the individual and incorporate all features of best practice and design

including contrasting colour, natural lighting, noise control, texture, cues, era-appropriate furniture and creative signage.

Our findings show that while most nursing homes provide some form of therapeutic activity to those with dementia, opportunities to engage in more domestic activities are very limited.

### *Recommendations*

We would recommend that the use of normal domestic activities in residential care settings be encouraged; that inspection procedures be amended to ensure that the person with dementia is placed at centre stage; and that nursing homes offering dementia care comply with design guidelines. Finally, there is a need to balance residents' rights and needs with proprietors' need to comply with legal and organisational requirements and the necessity to operate cost-effective nursing homes.

### *Acknowledgements*

Thanks are due to Ms Anne Timoney, Research Assistant and Project Co-ordinator, who conducted the research interviews for this study.

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### ***Discussion: challenges and strategies***

The discussion that followed highlighted the need to foster and support purposeful relationships between patients, carers and staff. Participants agreed that making a long-stay unit a genuine home for its older residents, with an individual focus, is essential. There is a need to address both the failings in the design and layout of many long-stay environments, especially those for people with dementia, and the gaps in the therapeutic environment. Participants mentioned the need to recognise the individual, to see patients, carers and staff as individual people and to ensure that the care given is person-centred.

To address these issues, participants suggested that Activity Nursing be developed and supported with appropriate training; that resources be allocated to improve the design of long-stay environments, in particular those for people with dementia; and that public-private partnerships be considered as a way of funding nursing homes and long-stay care.

There were also calls for the inspection process to be revised, to give equal and fair assessments to both private and public nursing homes; for equity in the subvention to private and public nursing care; and for the learning and knowledge gained in the different sectors to be shared.

## **Workshop Three: Older Men, Including those Living Alone**

***Chair: Eamon Donnelly, Men Against Cancer and  
Consultant, Retirement Planning Council of Ireland***

***Speaker: Geraldine Delorey, Health Promotion Officer for Older People,  
North Western Health Board (NWHB)***

### *Introduction*

The NWHB covers a largely rural region served by two main towns, Sligo and Letterkenny. It has a significantly older population than the country as a whole, with a total of 29,119 in 2002 (Census 2002, CSO). A large number of these older people live alone. Around 78 per cent are medical cardholders compared to 75 per cent nationally. A large proportion of the older men are from farming and fishing backgrounds.

We have only limited knowledge of older men's health. We know that on average men live six years less than women; they are almost twice as likely to die before the age of 65 and they are six times more likely to die of a heart attack before the age of 65. We also know that older men living alone are at particular risk.

### *Key times in men's lives*

There are a number of 'transition times' that are important in men's lives:

- retirement and reaching pension age
- onset of illness or disability
- moving from home
- bereavement.

### *Retirement and reaching pension age*

We have found that many older men, particularly farmers who have taken up the Early Retirement for Farmers Scheme, are not prepared for leisure and a different way of life. Many have been used to working two thirds of their waking hours, seven days a week,

every day of the year. Many feel a great sense of loss from changing their role and giving up their land. When they retire they also lose their social outlets – the marts and the pub. Most do not join active age groups, finding it difficult to fit in and seeing these groups as more for older women than for them.

#### *Onset of illness or disability*

Many older men are reluctant to visit their GP and often reluctant to talk about illness. For married men, it is their wives who encourage them to attend. Poorer health often sets in after a wife dies. There is a lack of information about men's health. It seems that preventative and health promotion initiatives for men get less attention than those for women.

#### *Moving from home*

The following quotations from older men in the north-west illustrate the feelings of many.

*The house that I know is where I want to stay.*

*I would prefer to stay here than live with the younger ones.*

*Don't like to think about it.*

*I wouldn't want them moving in.*

#### *Bereavement*

Men tend to become more isolated when a wife dies. Many find that it was their wives who maintained their friendships and their social networks. Male friendships tend to be more sociable than intimate. Men's coping skills are not as good as women's.

### *Other issues*

We also found a range of other issues that impacted on the lives of older men. Many, such as transport and access to services, were interlinked and compounded by the isolation of the rural setting in which many live.

### *Recommendations*

To address the issues that we have come across in the north-west we would recommend the following:

- retirement programmes
- a focus on men's health in the pre-retirement phase
- improved and targeted information for older men
- development of men's groups.

**Speaker: Finian Murray, Men's Health Development Officer, North Eastern Health Board (NEHB)**

*Introduction*

Information on men's health is available from a range of sources including the NEHB's *Health Status* report and from the SLÁN surveys. We know that men have lower life expectancy than women; that they have higher levels of health damaging and risk behaviour; and that they are less likely to use primary health care services. We know that men take much less physician time than women do in their health visits, receiving less information with fewer and briefer explanations; and that most of them admit to waiting too long before seeking treatment. The occasions that spark an interest in health for men are when an issue is raised in a television soap opera; at the birth of a first child; at the untimely death of a friend or colleague; and at redundancy or retirement.

We believe that significant improvements in men's health will only be achieved through consultation and partnership with men, men's groups and other statutory and voluntary agencies with a responsibility for men's health.

To understand in greater detail the issues men face in relation to health, the NEHB in 2000 commissioned a programme of qualitative research into men's health. The main aims of this research, entitled *Men Talking*, were as follows:

- to engage in consultation with men in the North Eastern Health Board region in order to explore their health beliefs, attitudes and perceptions (submissions were also sought from the public)
- to gain insights into the health-seeking process adopted by men in times of illness
- to explore men's views and experiences on current health service provision in the NEHB region
- to identify men's suggestions for improvement and changes for the future
- to elicit men's reaction to suggestions or new ideas.

A full version of the report is available from the NEHB ([www.nehb.ie](http://www.nehb.ie)). The aim of this short paper is to outline the key findings.

## *Key findings*

The research identified six key areas:

- masculinity and its impact on men's health ('masculinity uncanned')
- men's conceptions of health and illness ('boys don't cry')
- men's health and illness behaviour ('the peril of the stiff upper lip')
- risk behaviour as a component of men's health ('give 'em Hell')
- men's emotional health and well-being ('suffering in silence')
- promoting change.

To illustrate the issues that arose in each of these areas we quote the men themselves.

*There was an awful lot of taboo about our own personal health in schools, and then you had this kind of macho image to live up to.*

(retired man aged 76; 'masculinity uncanned')

*I don't like to see boys crying really, not men I mean. Who would want to see him, I wouldn't want to look at him.*

(retired man aged 72; 'boys don't cry')

*I'd say it goes back to the hidden problem. There is some hidden problem there. An awful lot of fellas is carrying a hidden problem, but nobody knows anything about it.*

(man aged 64; 'the peril of the stiff upper lip')

*I don't smoke, it's the only social life I have. I wouldn't get a taxi to it. I would if I was going to a wedding ... but I wouldn't get a taxi if I was going to the local pub ... I'd chance it.*

(rural bachelor aged 62; 'give 'em Hell')

*One time when people got sick, if the doctor came to the village ... someone was going to die, everyone was their own doctor ... you mended yourself ... you had to be really sick to go to a doctor.*

(man aged 83; 'suffering in silence')

### *Promoting older men's health*

In the NEHB region, the *Men Talking* research was followed up with a Men's Health Consultation Day in November 2002. Following this, a Men's Health Consultative Group was established and a regional Men's Health Action Plan was developed.

In Ireland there are now a number of initiatives aimed at promoting older men's help. These include a number of self-help groups and Well Man clinics, as well as various targeted campaigns such as: *Keeping It Up*, a campaign to promote weight loss in men aged between 40 and 50; and Men's Cancer Action Week, to raise awareness of incidence of cancer amongst men and to address skin cancer prevention among outdoor workers.

### *Recommendations*

We believe that it is important to encourage the development of further initiatives to address the issues that older men face, including issues around isolation, transport, personal security and access to relevant information on health and services. One such initiative is the recently established Older Men's Organisation. We also recommend that a policy be developed to address the issues of men's health in rural areas.

### ***Discussion: challenges and strategies***

Many issues emerged in the discussion that followed the papers. These included the lack of focus on older men's health issues; the need for men to take greater responsibility for their health; the risk of social isolation that many men face when they retire and/or when a wife or partner dies; the reluctance of many older men to attend clubs and groups; and the problems faced by rural men in accessing health services, exacerbated by the lack of public transport and the cost of maintaining a car.

The main challenges agreed by participants were the current lack of information on men's health issues; the very limited number of dedicated health awareness programmes aimed at men; and the isolation of many older men from family and society. To address these challenges a number of actions were suggested: that information on men's issues should be disseminated in the workplace; that there should be a greater number of health promotion programmes and campaigns targeted at men, and encouraging them to take greater responsibility for their health; and that clubs and groups and centres should aim to attract more men by including activities that appeal to them.

## **Workshop Four: Older Women, Including those Living Alone**

***Chair: Mary Kelly, Chairperson, National Women's Council of Ireland***

***Speaker: Geraldine Luddy, Director, The Women's Health Council***

### *Introduction*

In this short paper we look at some of the key concerns in relation to older women's health and put forward some recommendations as part of a framework for development of services for older women.

### *Key concerns*

The four areas of key concern in relation to the health of older women are:

- demographics
- poverty
- health inequality
- nursing homes.

### *Demographics*

According to data published by the CSO in 2003, of the 11 per cent of the total population in Ireland aged 65 years and over, 53 per cent are women.

### *Poverty*

Households headed by an older woman are two and half times more likely to be poor than those not headed by an older person. In Ireland the average income of a woman aged 65 and over was found to be 40 to 50 per cent below the average for people aged less than 65 years of age. Many older women receive inadequate retirement benefit. In many cases this is because they left employment to fulfil family duties or were forced by the marriage bar, still operating in 1979, to give up their jobs.

### *Health inequality*

Older women are more susceptible to death from accidental fall, due to osteoporosis and living to an older age, than men are to coronary heart disease and to osteoporosis.

### *Nursing homes*

Many older women in residential care suffer because of a lack of standards of care for nursing homes, the absence of an official database for nursing homes and inadequate subvention funding arrangements.

### *Recommendations*

In terms of health service delivery we recommend:

- the promotion of innovative and good practices
- the development of advocacy services for older women
- that services for older women are made more accessible and more representative.

In terms of personal and community development we recommend that:

- older women become actively involved in community development
- the burden carried by informal carers be addressed
- information support mechanisms be put in place.

In terms of policy and legislation we recommend that:

- a legislative framework for quality assurance practice for nursing homes or other long-stay institutions be established
- a universal health care system be set up
- work be done to promote independent living.

As for research, we recommend that data be collected on mortality and morbidity and that this data be analysed by gender and by socio-economic group or social class. We also recommend that researchers in Ireland collaborate with international bodies that represent the interests of women in general, and older women in particular.

**Speaker: Louise Richardson, Co-ordinator, Older Women's Network**

*Introduction*

The Older Women's Network (OWN) Ireland is a national network of individual older women and organisations. It is part of the Anti-Poverty Networks Programme funded by the Combat Poverty Agency. It provides a forum for discussion and action to address the social exclusion of older women. The aim of this short paper is to outline the issues that OWN members have raised in relation to the health of older women.

*Older Women and health*

Health is one of the key areas of concern among OWN members. These concerns have been expressed in submissions to the *Draft National Plan for Women (2002)* and to the *National Anti-Poverty Strategy 2003-2005*, and at the most recent OWN conference (2002) as well as at OWN meetings throughout 2003.

*Issues included in the submission to the Draft National Plan for Women*

In its submission to the *Draft National Plan for Women*, OWN recommended the following:

- an enlightened policy on older women's mental health be put in place
- comprehensive community health care services be available as an alternative to hospital care
- a more flexible service in care homes be instigated so that, for example, couples can live together
- that older women have access to advocacy on matters relating to their health.

On specific issues OWN recommended that:

- the policy of not screening women over 65 for breast and cervical cancers be changed
- easily accessible Well Woman clinics providing total check-ups on a yearly basis be set up
- older women be included in debates on issues such as abortion and informed about HIV/AIDS.

*Issues included in the submission to the National Anti-Poverty Strategy 2003-2005*

OWN's submission to the *National Anti-Poverty Strategy 2003-2005* included a recommendation that the age limit of 65 for breast cancer screening be reviewed as soon as possible. As the submission noted, 'This policy disregards the key principle of equity underlying the Health Strategy'.

This submission also noted that older women experienced ageist or dismissive attitudes when presenting health problems to health professionals. Women found that their health conditions and treatments were not adequately explained to them because of assumptions about older people's intellectual ability and health awareness.

In its submission OWN also endorsed the central role given to primary care and a people-centred approach, and recommended that this policy incorporate age awareness and, where necessary, an advocacy service for older people.

*Issues arising at OWN conference and meetings*

At its conference in October 2002, OWN identified the following key issues:

- the lack of adequate health and social care support in the community which prevents older people from remaining independent and living at home for as long as possible
- the need for accurate and up-to-date health and social welfare information
- difficulties of maintaining health and well-being on a low fixed income
- the ageist attitudes of some GPs
- the need for routine health screening of older people
- removal of the age limit on the Breast Check screening service.

During 2003 issues that have arisen at OWN meetings and consultations have included the following:

- problems of accessing services at community level
- the rising cost of health care medical insurance excluding more women from this tier of the health system
- anxiety about maintaining independence, whether living at home or in residential care

- the need for more support for community health networks including carers in the home.

### *Recommendations*

To address the inequalities in health service provision that we at OWN have identified, it is essential that older women have a voice on all policy-making bodies. OWN is constantly lobbying for representation so that the issues of concern to older women are heard. In addition, we have recommended that health forums for all stakeholders be established to promote change at local level and to provide transport so that people can get to health services. Using this approach we hope to achieve equal health outcomes for all older women.

### ***Discussion: challenges and strategies***

Two of the key issues identified in the workshop were the accessibility of health services and the appropriateness of the service response. Key to the accessibility of services is transport, especially in rural areas, and income. Other aspects of accessibility include access to information, access to suitable and adaptable housing, and access to primary and secondary health care. A solution to these issues was suggested at social policy level, where participants agreed that it was essential to have inter-sectoral and inter-departmental co-operation and co-ordination in the design and delivery of health service responses and health promotion.

The prevalence of ageism was identified as a barrier to obtaining health care. Participants gave examples of being spoken about and not to, of being patronised, of being treated as if they did not have ownership of their bodies or their minds. For many, being treated in this way meant a loss of self-esteem, increased vulnerability and a lack of opportunity to ask the questions they wanted and needed to ask. To address ageist attitudes and treatment it was suggested that top-down and bottom-up interventions are needed. Top-down solutions include training for health professionals in order to create an awareness of age issues, to engender respect for older people and to ensure that services provided are person-centred. Bottom-up approaches should include confidence-building training for older women to enable them to challenge ageism.

Another issue that the workshop participants agreed should be tackled is the view that older women are a homogenous group. Participants pointed out the necessity for policy-makers and service providers to understand that older women are a diverse group with diverse needs. To this end, they suggested that research findings on the health of women be split out by age, and within age by the nine grounds of inequality, so that it is clear to all what service responses are required to meet these needs.

## **Workshop Five: Older People in Deprived Economic Circumstances**

***Chair: Siobhan Weir, Health Promotion Manager for Physical Activity,  
Health Promotion Agency, Northern Ireland***

***Speaker: Helen Johnston, Director, Combat Poverty Agency***

### *Introduction*

With a growing number of older people and with older people living longer, the focus on healthy ageing is vital. Research shows that there is a link between poverty and poor health. In Ireland we see growing poverty rates among older people and a lower life expectancy, compared to other countries. To address this we need to tackle poverty and inequality, poor health and health service responses. The aim of this paper is to look briefly at the extent of poverty among older people and at the policy responses to this, and to identify some of the key areas for action.

### *Poverty rates among older people*

Poverty is about more than not having the physical requirements of food, water, clothing and shelter. A relative definition of poverty recognises that people have social, emotional and cultural needs as well as physical needs. An understanding of relative poverty recognises that poverty involves isolation, powerlessness and exclusion from participation in society as well as lack of money. The unequal distribution of resources and opportunities contributes to poverty.

Two measures of poverty are commonly used in Ireland:

- *consistent poverty* exists where a person has less than 70 per cent median income (that is, an income in the region of €190 per week) and does not have one of eight basic items such as one substantial meal each day or is unable to pay everyday household expenses without falling into debt
- *relative income poverty* measures poverty as falling below a certain income alone, usually 60 per cent of median income (in the region of €160 per week).

There is a decline in the percentage of older people experiencing consistent poverty – from 6.6 per cent in 1998 to 3.9 per cent in 2001 (the most recent data available).<sup>2</sup> This is similar to the decline for the overall population, although consistent poverty rates are slightly lower for the older population. In general, older people tend to lack less of the basic deprivation items, which to some extent reflects their stage in the life cycle.

A different picture emerges, however, when we look at income poverty. Income poverty is rising among the older population, from 32.9 per cent in 1998 to 44.1 per cent in 2001. While income poverty in the overall population has also been increasing, this has been at a lower and slower rate. Many older people rely on social welfare pensions as their main or only source of income. While social welfare pensions have been increasing at a greater rate than inflation, they have been lagging behind the increase in incomes in the population generally, hence the increase in income poverty rates.

So while older people are less likely to be deprived, that is, living with debt and without basic necessities such as food, clothing and heat, they have a relatively high risk of income poverty. At 44 per cent, just under half of pensioners are at risk of living on a low income. Older people are not a homogeneous group, so when we look further we see that some older people have a particularly high risk of poverty: older women have a 50 per cent risk of living on a low income.

#### *Policy responses to address poverty among older people*

As well as cash incomes from pensions and other sources, older people's resources can include asset holdings, public social services and benefits in kind.<sup>3</sup> Home ownership is relatively widespread among the older population, but often their homes do not adequately match their needs. In relation to public social services, the most important forms are social housing, free schemes, and health and social care entitlements. Benefits are mainly provided by family supports and networks. Households that lack some of these resources are more vulnerable to poverty.

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<sup>2</sup> Government of Ireland, 2003. *National Action Plan against Poverty and Social Exclusion 2003-2005: Ireland*. Dublin: Stationery Office.

<sup>3</sup> Layte R., Fahey, T. and Whelan, C. 1999. *Income, Deprivation and Well-Being among Older Irish People*. Dublin: NCAOP.

As a proportion of Gross Domestic Product (GDP) or Gross National Product (GNP), Ireland spends less than most European countries on social welfare, especially on old age pensions. This is partly because of the smaller proportion of older people in the population. Nevertheless, the fact that the State provides only a flat rate pension under the social security system is significant; most other EU member states provide supplementary pensions. In Ireland supplementary pensions are provided exclusively under occupational and personal pension schemes. The relatively recent extension of social insurance to all categories of the work force means that a large proportion of pensioners receive pensions under social assistance, which are means-tested.<sup>4</sup>

The main policy instrument to address poverty in the State is the National Anti-Poverty Strategy. The revised Strategy, *Building an Inclusive Society*, was launched in 2002. It set targets for the elimination of consistent poverty by 2007. This was recently updated through the two-year *National Action Plan against Poverty 2003-2005*.

This Plan sets social welfare and pension targets, including commitments:

- to achieve a rate of €150 per week, in 2002 terms, for the lowest levels of social welfare payments by 2007 – the lowest levels are currently €124.80 per week (personal rate)
- to improve social welfare pensions to €200 per week by 2007. The means-tested non-contributory pension is currently €144.00 per week (personal rate) and the contributory pension is €157.30 per week (personal rate)
- to improve widow(er)'s pensions and increase the level of qualified adult allowance for pensioner spouses to the level of the old age non-contributory pension (qualified adult allowance is €95.20).

The Plan states that the policy task for older people is to increase income support in real terms and ensure that the range of State services is accessible. Special reference is made to those living alone, especially the risk of poverty for older women living alone. In this context there is a focus on the provision of care for older people. Specific targets are:

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<sup>4</sup> Government of Ireland, 2003, *National Action Plan against Poverty and Social Exclusion 2003-2005: Ireland*. Dublin: Stationery Office.

- to put in place national guidelines for the provision of respite care services to carers of older people by 2003
- to improve access to orthopaedic services so that no-one is waiting longer than twelve months for a hip replacement. This is to be reviewed in 2003
- to provide adequate heating systems in all local authority rented housing occupied by older people by the end of 2007.

While some progress has been made in working towards meeting these targets, there are a number of other issues that require attention.

### *Income*

The first issue to be addressed is to ensure an *adequate income* for older people. A priority must be to work towards meeting the targets relating to social welfare benefits and pensions.

Another step towards the provision of an adequate income is to *improve eligibility*. Initiatives are being taken on this, for example, encouraging supplementary pension cover and increasing the level of the qualified adult allowance. If the issue of poverty among older people, particularly older women living alone, is to be addressed, these measures must receive priority, particularly increasing the level of the qualified adult allowance.

### *Public service provision*

Public service provision is particularly important to older people on low incomes, especially the free schemes and access to health, social and community care services. These are important in addressing the exclusion and isolation of older people, who may be living alone and have limited access to social networks. Further attention needs to be given to improving access to these services, which should be poverty proofed. The Quality Customer Service (QCS) initiative provides an important context for this. Standards must be set and progress towards meeting those standards monitored. Services should not be cut without assessing their impact on older people.

### *Vulnerability of some groups*

Some groups of older people are particularly vulnerable. These include:

- older people living alone (mainly women)
- older people living in rural areas
- the very old and frail
- older people from minority ethnic groups, including Travellers.

While many of the current initiatives are relevant to these groups, additional targeting may be required. This will demand good service provision.

### *Health and poverty interface*

Finally, it is important to acknowledge the health/poverty interface. The evidence strongly suggests that poverty leads to poor health and that in addressing poor health we need to tackle poverty and income inequalities first. Any response needs to take this into account and should be multi-dimensional and integrated for maximum success.

### *Conclusion*

In conclusion, it is clear that poverty is bad for health, particularly in the case of older people. It is pertinent that we seek to eliminate consistent poverty and reduce income poverty among older people if we are to maximise their opportunities and quality of life.

***Speaker: Audry Deane, National Social Policy Officer, St Vincent de Paul***

*Introduction*

The Society of St Vincent de Paul (SVP), a Christian lay order, has been working in Ireland for 160 years and currently has around 9,000 members. It works with disadvantaged people, its mission being to promote self-sufficiency, friendship and social justice.

SVP volunteers visit people (at home, in hospital, in prison), provide material assistance, provide transport to hospital appointments, and help towards costs of education, holidays and health care. They also work in SVP day centres, hostels, youth clubs, holiday homes and shops.

SVP is a social partner and its social policy staff are involved in and have contributed to the Medical Card Review, the Partnership for Prosperity and Fairness, the Health Strategy Consultative Forum, the National Anti-Poverty Strategy and various working groups including the Community and Voluntary Health Group (Primary Care Steering Group).

The aim of this short paper is to highlight the health inequalities in the Irish health system, from the St Vincent de Paul perspective.

*Health and poverty in Ireland*

Ireland does not compare favourably with other EU member states when it comes to life expectancy. In addition, we have the highest rates of winter mortality in the EU. Research shows that winter mortality rates are lower in countries with greater levels of health spending and better quality housing than we have in Ireland.

According to the OECD in 2003, Ireland has the second highest income inequality in Europe. Consequently, there are huge differences between different income groups in terms of health, economic and life opportunities.

Spend on social protection in Ireland as a percentage of GDP is below the EU average. A large percentage of social welfare benefits are means-tested – one in three in Ireland compared to one in ten in the rest of EU. This means that different groups are treated differently by our health, social welfare and education systems.

Health spend in Ireland is also lower than the EU average; we spend less per head on health than most other European countries (we come eleventh out of fifteen). Until recently there has been little serious debate on why it is acceptable that income, not need, is the basis for accessing our health system.

We also have unacceptable inequities in access to both acute and community based health services. These inequities hurt vulnerable groups, in particular older disadvantaged people. This is particularly sad when one considers that these people experienced a tougher, less prosperous Ireland, and now find their fixed low incomes being eroded by the various and growing forms of indirect taxation.

#### *The Irish health system – an SVP perspective*

As a social partner we in SVP have been involved in areas of health service reform. We regret the very slow progress on a range of health related targets and actions, because we know the realities of life for those who struggle to get by in poor health while the reforms are designed and developed. We feel the pain, disappointment and stress of those whose quality of life is affected while they wait for a procedure, therapy or much needed home-based service.

When the current Health Strategy was being developed, 60 per cent of submissions received referred to special needs groups; 15 per cent focused on older people. Key issues were quality of life for older people and support for their carers.

It is our view that the method used to decide eligibility for access to much needed care is crude and cruel. The current structures add to and perpetuate health inequalities. It is also the case that there are many discrepancies; even if someone is eligible for a service there is no guarantee that they will receive it.

### *Health inequalities and income inadequacy*

Despite the fact that everyone over 70 is entitled to a medical card, health inequalities due to income remain and older people are disproportionately affected. There are many older people under the age of 70 who struggle to afford basic health care. A typical GP's fee and prescription costs can put a large dent in a small fixed income. As a result many people forego medical help when they need it. Delaying treatment can and does lead to more serious illness and the need for acute attention.

The Equality Authority's 2002 report, *Implementing Equality for Older People*, recommended that as a minimum the old age pension should be set at 34 per cent of average industrial income. Unfortunately, in the current economic climate, this is unlikely to happen.

Currently 80 per cent of older people living alone rely on social welfare pensions. Almost 7 per cent are living in consistent poverty (the national average is 5.5 per cent). In terms of household income, 38 per cent of pensioners fall into the poorest 20 per cent of households.

### *Issues noted by SVP volunteers*

The problems that SVP volunteers encounter most frequently include the following:

- fuel poverty – often linked to poor housing conditions, this is a major problem for many older people, with obvious implications for health. The cost of warm clothing further causes strain on the budgets of older poorer people
- food poverty – SVP helps out with food for older people and their pets. Many volunteers comment on the cost of keeping pets while appreciating their value to their owners
- lack of awareness about entitlements – we find that many older people know little about their entitlements. Greater awareness is needed, while information on services should be in user-friendly format and accessible to potential users.

### *Conclusion*

Martin Luther King said, 'Health inequalities are the most inhumane'. Let us use our collective energy and commitment, to offer some solutions to the health system that hurts disproportionately vulnerable groups such as older disadvantaged people.

### ***Discussion: challenges and strategies***

There was much support for the sentiment expressed in Martin Luther King's dictum that health inequalities are the most inhumane. Other areas that received particular attention during the discussion were the health-poverty interface; the need to implement the many plans already in place in relation to poverty and older people; and the fixed income versus rising costs issue, in particular how to cope with the unexpected.

It was agreed that there is a need to empower older people by way of meaningful consultation and collaboration. This could be achieved in part, it was suggested, by setting up local and regional advocacy groups. The need to ensure an adequate income for older people was discussed and it was suggested that non-contributory and adult entitlements, in place since the foundation of the State, should be reviewed. A rights based approach to health care for older people was advocated. It was argued that this would ensure that older people immediately receive the care they need as of right rather than on the basis of what they can pay. It was suggested too that the necessary supports should be put in place to keep older people at home in their own communities; the costs involved are a fraction of what it costs to provide residential nursing care.

## **Workshop Six: Older Travellers**

***Chair: Thomas McCann, Equality Officer, Irish Traveller Movement***

***Speakers: Missie Collins, Molly Collins, Sheila Reilly and Caroline Mullen,  
Pavee Point***

### *Introduction*

Travellers are a small indigenous minority ethnic group, part of Irish society for centuries. They have a long shared history and value system that makes them a distinct group. They have their own language, customs and traditions.

Pavee Point is a partnership of Irish Travellers and settled people working together to address the needs of Travellers, especially in relation to their experiences of exclusion and marginalisation.

The health status of Travellers is a major concern. The most recent national study was carried out in 1987. It showed that the health status of Travellers is well below that of the majority population. Traveller women live, on average, 12 years less than settled women and Traveller men live ten years less than settled men. Census 2002 data confirms this. It shows 776 Travellers aged 65 and over out of a total population of 23,681 Travellers. In other words, 3.3 per cent of Travellers are over the age of 65. This compares to 11.1 per cent among the population as a whole.

The distinct characteristics of Travellers and their different perceptions of health, disease and care needs mean that innovative approaches to service organisation, content and delivery are required if health conditions are to improve. There are many factors which influence the health status of Travellers including discrimination, racism and accommodation, so a holistic approach needs to be taken.

### *Older Travellers*

Older Travellers have a place of respect within their community. They are seen as mediators and their wisdom is respected. Most older Travellers are married or widowed; there are very few older Travellers who have never married. Most married young and had larger families than most couples today. They also have a large extended family. Older Travellers tend to be very religious and believe strongly in cures and blessings, especially by 'curing' priests and nuns. While the poor health status of many older Travellers is certainly related to difficulties with access to health services, other factors also have an effect.

### *Contributing factors*

#### *Accommodation*

While Travellers may choose to be nomadic, they do not choose to live without access to basic services. Currently, there are around 1,200 families living on roadside sites with no facilities because of the failure by local authorities to implement plans for suitable accommodation. The location and design of some official halting sites is poor, while group housing schemes for Traveller families (where the extended family can be together) are being overbuilt and becoming overcrowded. Inadequate provision and poor accommodation have an adverse impact on health. Improvements could and can be made in consultation with Travellers.

#### *Racism and discrimination*

This can be direct or institutional. Exclusion from a range of services is a common experience for Travellers. In everyday life, Travellers may be followed around in shops, unable to gain access to pubs and hotels, and suffer objections by local residents to the development of Traveller sites or to Traveller neighbours. Findings from a survey for the Citizen Traveller Campaign 2000 shows the extent of the problem:

- 36 per cent of Irish people would avoid Travellers
- 97 per cent would not accept a Traveller as a member of their family
- 80 per cent would not accept a Traveller as a friend
- 44 per cent would not want Travellers as a member of their community.

### *Access to health services*

Travellers are often blamed for their own ill-health. However, they face many barriers in getting access to health care:

- many do not have access to a GP
- many are unaware of their entitlements or the provisions of the health service
- there is a lack of understanding of Traveller culture by health care providers
- appointments may not be kept because of problems with mail delivery, for example, non-delivery of letters to roadside sites or incomplete addresses where persons have similar names
- appointments may be too early for roadside Travellers with no washing facilities
- Written communication does not take account of the fact that 90 per cent of adult Travellers are pre/illiterate
- health promotion material is often culturally inappropriate and not accessible to the majority of Travellers, particularly in the case of older Travellers.

### *Action taken to date*

#### *Primary Health Care (PHC) Project for Travellers*

Pavee Point in partnership with the Northern Area Health Board set up a PHC Project for Travellers in Dublin in 1994. The aim of the project was to improve the health status and quality of life of the Traveller community in Community Care Area 6.

The Project has trained sixteen Traveller women to work as Community Health Workers (CHWs) in this area of Dublin. Half the women trained were grandmothers with little or no literacy or formal education. They are highly effective CHWs and the Project won a WHO award for community participation in 1998. We now have fourteen women and two men working on the Project. Their work includes the following:

- in-service training for health professionals
- community-based health liaison work
- on-site health education sessions
- co-ordinating visits to a variety of clinics
- production of Traveller-specific health promotion material
- research on and survey of Traveller health

- media work
- organising seminars and conferences
- representing Traveller health issues on the National Traveller Health Advisory Committee.

The PHC Project for Travellers model is currently being replicated by 28 projects across Ireland. These Projects are endorsed and promoted as a model in the Government's recent National Traveller Health Strategy 2000-2005.

#### *All-Ireland Traveller Health Needs Assessment and Health Status Study*

The consultation phase for the All Ireland Traveller Health Needs Assessment and Health Status Study has just been completed. Consultation with Travellers and Traveller organisations is key to all aspects of the study, including data collection. It is expected that the study will provide data that will inform health service provision for Travellers in the future.

#### *Challenges and responses*

##### *Challenges*

Challenges in improving the health status and life expectancy of Travellers remain,. It is important that the 122 recommendations made in the National Traveller Health Strategy are implemented. There is a need to provide:

- more opportunity for Travellers and Traveller organisations to take part in health policy, planning and service delivery
- more culturally appropriate health care for Travellers
- more targeted and mainstream health responses for Travellers
- data on Travellers' health status and health needs.

##### *Responses*

We therefore recommend the following responses:

- ethnic equality monitoring
- support for targeted initiatives

- mainstreaming of Travellers and Traveller issues into all policies and services
- initiatives to address the needs of specific groups of Travellers
- facilitating the employment of Travellers, including older Travellers, in health services
- effective participation of Travellers and Traveller organisations in policy development and in the prioritisation of resources
- availability of advocacy to improve access to health services
- greater resources for in-service training of health care professionals.

### ***Discussion: challenges and strategies***

It was agreed in the discussion that there is a need for affirmative action to counteract the years of discrimination against Travellers. The workshop recognised the need to challenge, and to improve, the status and the image of Travellers in Irish society. One way of achieving this, it was suggested, is to encourage the media to promote a more positive image of Travellers.

In terms of health care, participants agreed that there is a need to implement a policy and strategy for improving the health of Travellers. It was agreed too that Travellers and Traveller organisations should be consulted and should participate in the development of this policy and in the planning and delivery of health services, and that these services should be culturally appropriate for Travellers. The need for both targeted and mainstreamed health care responses was recognised; and given that Travellers are not a homogenous group, services should be provided to meet the needs of specific groups, including older Travellers. The workshop participants also acknowledged the need to identify, collect and analyse data on health of Travellers as a whole and by specific groups, for example, gender and age.

## **Workshop Seven: Older People in Deprived Housing Circumstances**

***Chair: Sr Stanislaus Kennedy, Chairperson, Social Innovations Ireland and  
Life President, Focus Ireland***

***Speaker: Lillian Buchanan, Threshold***

### *Introduction*

The aim of this paper is to look at the issue of housing disadvantage among older people, particularly those living in the private rented sector. We note the limited information currently available and we look briefly at what is needed in policy reform.

### *Housing deprivation*

An initial consideration of housing disadvantage from the perspective of older people reveals the complexity of the issue. For example, as a group, older people in Ireland hold disproportionately more of the wealth in the form of housing assets while at the same time a disproportionate number experience income poverty. Thus while they may own their home outright, they may be unable to maintain or heat it adequately. We know that older people may suffer because the needs that come with age are not being addressed by local public services. We do not know, however, the extent to which existing housing arrangements contribute to or detract from the quality of life of people over 65 years. While we will be better informed when the 2001-2002 Housing Condition Survey Report is published at the end of 2003 and when we have greater detail from Census 2002, we currently have few facts about the housing status of older people or the conditions in which they live.

### *The private rented sector (PRS)*

Since 1975, Threshold has provided information and advice to tenants and landlords in the PRS. In recent years our mandate has expanded although work in this sector, and in

particular advocacy, remains a central feature. The PRS, according to Census 2002, accommodates 141,459 households (or 11 per cent of all households).<sup>5</sup>

Older people rarely contact Threshold for help. This may be because few old people live in private rented accommodation, and those who do tend to move house less often than their younger counterparts. It may also be the case that the free services which Threshold offers are not well known. However, Threshold constantly reaches out to those who might benefit.

Within the PRS there is a small, declining niche with statutory protection in which older people are disproportionately represented – the ‘controlled dwellings sector’. Long-term tenants in this group are most likely to contact Threshold.

Some of the occupants of controlled dwellings, so-called successor tenants, were subject to considerable worry and stress recently. Some background:

- successor and original tenants are two categories created under the *Housing (Private Rented Dwellings) Act (1982)*. The Act was designed to ‘decontrol’ dwellings regulated under rent restriction legislation, which had been declared unconstitutional.<sup>6</sup> To soften the blow, occupants of these dwellings were to continue to enjoy tenure and rent protection, subject to conditions including time limits
- original tenants are those who were tenants in a rent-controlled dwelling on 26 July 1982. Successors are members of the original tenant’s family (other than spouse) who succeeded to the tenancy. The Department of Environment, Heritage and Local Government estimated that there were 1,100 to 1,500 original tenants and about 700 successor tenants in 2001
- for twenty years both original and successor tenants enjoyed a relatively privileged position. They had secure tenure under the 1982 Act because the scope for landlords gaining possession of a 1982 Act dwelling is very restricted. Rents were subject to independent review based on several non-market criteria.<sup>7</sup> Moreover, if the amount of rent was considered likely to cause hardship, the tenant was eligible for an

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<sup>5</sup> Some 57 per cent of units in the sector are detached, semi-detached or terraced houses rather than apartments or flats.

<sup>6</sup> Decontrolled dwellings were old (even pre-1915) and had been catering for the cheap end of the rental market.

<sup>7</sup> From 1983 the Rent Tribunal replaced the District Court in mediating on rents and other terms, at the initiative of the landlord or the tenant.

uncapped, means-tested rent allowance from the Department of Social, Community and Family Affairs (DSCFA)<sup>8</sup>

- the protection of original tenants and their spouses continues for the rest of their (and their spouses') lives. However, from 26 July 2002 the special status of successor tenants began to end; it will disappear completely after five years. No more succession is possible. While security of tenure could be obtained by successor tenants going to the law, affordability was a concern since landlords could immediately raise rents to market levels. Threshold lobbied for Government to subsidise rents where tenants would otherwise be forced to leave their homes. A new means-tested rent allowance was set up and successor tenants were able to access legal aid to negotiate the transition out of 1982 Act tenancies.

The main issue now for tenants in de-controlled buildings is often health and safety. The buildings are apt to be run down; landlords have little incentive to maintain them. They are therefore unlikely to be suitable for someone getting older. Dwelling standards are also a concern in the rest of the private rented sector, as is affordability.

### *Standards*

We know, from tenants coming to Threshold for help, that many private rented units at the low end of the market fail to measure up to even the basic minimum regulatory standards. This is borne out by recent local authority inspections. In 2002, of the 5,059 private rented premises inspected more than half (2,558 units) did not meet the regulatory standards. Yet only 17 legal actions were initiated.

### *Affordability*

During the recent economic boom, while homeowners saw the value of their assets rise dramatically, tenants saw their rents skyrocket. A paper by the European Central Bank showed rent inflation in Ireland during 2001 at 14.4 per cent compared with the EU average of 1.3 per cent.<sup>9</sup> An ESRI study reports that among private renters the share of their household expenditure on rent rose from 12.5 per cent in 1987 to 21 per cent in

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<sup>8</sup> About one third of all 1982 Act tenants receive a rent allowance.

<sup>9</sup> European Central Bank (March 2003) Structural Factors in the EU Housing Markets page 9.

1999-2000.<sup>10</sup> For older people in the sector, who were living on fixed incomes, this inflation was catastrophic.

### *Housing reform*

Threshold's Strategic Plan has key objectives relating to housing rights, access and sustainability, all relevant to older people experiencing poverty or social exclusion. Our approach to policy reform reflects these objectives.

Threshold has been actively involved in getting, and now strengthening, legislation to protect tenants and to regulate better business practices in the sector. The Residential Tenancies Bill currently being debated in the Dáil, will give greater security of tenure and rent certainty to tenants. It will also establish machinery for fast and relatively inexpensive dispute resolution between tenants and landlords. Threshold is proposing amendments to the Bill to ensure that tenants' rights cannot be avoided in practice.

Rent supplement is a discretionary payment to ensure that people have a basic (albeit small) income to spend on other necessities besides shelter. It has filled the gap created when social housing investment failed to keep up with the growth in housing need. The rent supplement scheme is deeply flawed as a social housing measure and reform is urgently needed.

The main method of tackling housing deprivation is through social housing. Unfortunately, Government's commitment to increased investment in social housing has weakened in the harsher economic climate. The promise of social housing on new privately-owned estates under Part 5 of the *Planning and Development Act (2000)* (as amended) has faded.

### *Conclusion*

Until a right to housing is put into legislation, progress in combating housing deprivation will be limited. Our main challenge at Threshold is to show that an adequate home is a basic prerequisite for well-being and effective participation in Irish society.

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10 Fahey, T. and Nolan, B., January 2003. 'Housing Costs and Social Inequality in Ireland.' ESRI Seminar Paper

***Speaker: Charles Roarty, Secretary, Energy Action***

*Introduction*

Energy Action is a charity which was established in 1988. Its main aim is to alleviate fuel poverty among older people and other vulnerable groups, including single parents, families with young children and those with a long-term illness or disability. It provides an in-home insulation service to homes in the Greater Dublin Area and supports a network of locally-based domestic energy conservation initiatives throughout rural Ireland. Energy Action is also a training centre for unemployed people, providing a range of accredited training programmes in energy and related services; at any given time there are about sixty people in training.

*Fuel poverty*

Fuel poverty is the inability to afford sufficient fuel for health and comfort, arising from a combination of low income, poor housing (including poor insulation), under-occupation, and inefficient and uneconomic heating systems. It is important to understand the distinction between poverty and fuel poverty. Householders may be able to buy clothing or food but not warmth. The cost of warmth is dependent not only on the cost of fuel but also on the efficiency of the heating system and the insulation standard of the building.

Fuel poverty occurs in households where heating costs (that is, the cost of providing adequate warmth rather than actual expenditure on heating) are high, relative to household income. It will tend to occur in households with high warmth requirements, and among those living in dwellings with poor fuel efficiency characteristics. Warmth requirements will tend to be high for people who, due to their circumstances, spend much of their time at home. So, the 'fuel poor' in Ireland includes older people and those restricted to home with long-term illness or disability, as well as the unemployed and those at home with young children.

*The health impact of cold and damp*

Poor quality housing – and the cold and damp conditions associated with it – is a cause of ill-health for thousands of people in Ireland every year. Cold temperatures cause and

exacerbate physical problems such as heart attacks and strokes, respiratory illnesses such as bronchitis or pneumonia, hypothermia and avoidable slips, trips and falls, as well as mental health problems such as depression.

Up to 2,000 people die each winter in Ireland due to fuel poverty. An estimated 650 lives would be spared if people were taken out of fuel poverty. Around 3,000 cases of cardiovascular and respiratory disease are due to fuel poverty. This represents half of the excess winter hospitalisation cases in Ireland each year and half of the winter drugs expenditure associated with these diseases.

A temperature of 21°C (69.8°F) is the recommended room temperature for vulnerable people. At 16°C (61°F) many people suffer reduced resistance to respiratory infections such as bronchitis. At 12°C (54°F) cardiovascular changes increase risk of stroke. At 9°C (43°F), core body temperature drops and increased cardiovascular problems can occur if the person is exposed to this temperature for more than two hours. At 5°C (41°F) there is a significant risk of hypothermia.

Dampness can take the form of rising or penetrating damp. It can be caused by long-term condensation and plumbing defects. Condensation is caused by excessive moisture production (for example, from cooking, bathing and drying clothes indoors, and from paraffin and bottled gas heaters), poor heating, lack of adequate ventilation, cold surfaces and low levels of insulation. The areas of the home where condensation and dampness commonly occur are the kitchen, the bathroom, hallways, spare bedrooms, bay windows and behind large items of furniture set against external walls.

Dampness alone can be linked to coughing, aches, excessive tiredness and stomach pains in adults and children. Humidity plus warmth can lead to dust mites, and condensation dampness leads to growth of mould. Mould produces microscopic spores that can cause allergies and infections. The more damp there is, the more mould, the more illness there is likely to be. Dust mites thrive in warm, damp, poorly ventilated dwellings. The faecal pellets they produce can lead to respiratory problems such as wheezing and asthma. Research suggests that exposure to dust mites in a child's first year may increase the risk of asthma in later years.

### *Identifying those at risk*

In order to tackle the problems of poor housing and fuel poverty it is necessary to identify those at risk. Below is a checklist to help identify people suffering, or at risk of suffering ill-health because of the condition of their home.

Person has health problems affected by cold/damp:

- asthma or other respiratory illness, heart disease, stroke.

Person is vulnerable to cold:

- older person
- person with mobility problems or poor circulation
- pregnant or at home with young children
- tendency to colds and coughs
- recovering from hospital treatment

What the person says:

- complains of being cold or feeling draughts
- fuel bills too high, owes money for fuel
- uses prepayment meter to avoid running up debt
- stays in bed to keep warm
- sits with hot water bottle to keep warm
- wants to stay in hospital because more comfortable
- uses only part of the house to keep warm.

What might be noticed:

- home feels cold or draughty, or smells of damp
- no visible form of heating, or only heating is open fire, electric fire, fan heater, oil-filled radiators or bottled gas
- ventilators have been blocked up
- client wears lots of clothes indoors
- curtains closed in day to keep in heat
- signs of condensation dampness.

### *Recommendations*

The key steps in addressing the health impact of fuel poverty are to identify those at risk and to implement improvements to heating systems, to insulation and to ventilation to provide warm, dry homes. It is also important to give advice and information on energy efficiency, to help encourage people to change their behaviour.

It is important to address income issues and to ensure that people have access to the benefits to which they are entitled. In addition, aspects of fuel price could be tackled by encouraging the use of off-peak electricity or mains gas, where possible. Under-occupation of a dwelling is one issue that is often hard to address, with many people reluctant or unable to move house.

### ***Discussion: challenges and strategies***

The main challenges identified by workshop participants included enabling older people to remain in their own homes for as long as possible; addressing the lack of clear and accessible information on rights and entitlements; and addressing the poor level of co-ordination, co-operation and integration between those involved in providing services to older people.

Participants suggested that to help maintain older people in their own homes it is necessary to provide appropriate housing, support for adapting housing to maintain its suitability, and supported or sheltered housing within the local community. In addition, it was agreed that appropriate community nursing care should be made available. To address the issue of lack of information, it was suggested that a one-stop shop or dedicated housing agency be set up to provide people with information on housing and on housing grants, and to help them apply for these grants. To address the issue of lack of co-ordination in the provision of services, the workshop participants recommend that a care case management approach be adopted. Above all they stressed the need for action and the need to take preventative measures to ensure that the needs of older people are met before they get old.

## **Workshop Eight: Older Carers**

***Chair: Enda Egan, CEO, Carers Association***

***Speaker: Brigid Barron, Director, Carers Clinic, Caring for Carers Ireland***

### *Introduction*

The Carers' Clinic in Ennis, Co. Clare is a unique service. It was set up in 2001 and is funded by the Mid-Western Health Board (MWHB). The role of the clinic is to provide one-to-one consultation with family carers in order to ensure that they are applying for and receiving the services and benefits to which they are entitled. In addition, the clinic provides a range of services including advice and advocacy, home respite care, and a training programme, *Caring in the Home*. It administers a Respite Care Fund to which carers can apply for financial assistance, allowing them to buy in independent respite help, and supports a network of carers' groups throughout the county.

When a carer first comes to the clinic, a needs assessment questionnaire is completed. To understand the issues faced by family carers, 94 of these questionnaires were analysed. The aim of this short paper is to present the key findings from this analysis.

### *Issues for carers*

The analysis showed that we had referred many carers to other agencies and services. We directed around half (48 per cent) of them to welfare schemes, just under half (43 per cent) to health services, and around one in six (17 per cent) to other voluntary agencies. In addition, we referred around one in seven (14 per cent) to housing services.

Many of the clinic's own services were used, too. All 94 carers received advice or advocacy; two thirds (67 per cent) received respite and home support; six out of ten received financial assistance from the Respite Care Fund; a quarter (26 per cent) attended the clinic's *Caring in the Home* training; almost half (45 per cent) were referred to a carers' group; and around one in six (16 per cent) received home visits from clinic staff.

### *Circumstances of the carers*

We found that these 94 carers were caring for 110 people. Most (75 per cent) were caring for one person only. Quite a few, however, were caring for two (16 per cent) or three (9 per cent) people and one carer was caring for four people. Most (82 per cent) were looking after older people, and most of these older people (88 per cent) had high dependency needs. We found that many of the carers were older people themselves: 43 per cent were aged 60 or over, and another 29 per cent were aged between 50 and 59. Not everyone told us whether or not they were getting help from other family members but of the 24 who did tell us, 13 were getting help and 11 were not.

Most carers had spent many years caring: 40 per cent of them had spent up to five years looking after someone; 14 per cent had spent more than 20 years doing so.

We asked carers about their own health. Around half (51 per cent) rated it good or very good and another quarter of them (26 per cent) said it was fair. Quite a few, however, said that it was poor or very poor (23 per cent). Many carers declined to comment on how stressed they felt, but among those who did, few (8 per cent) said they had no problems. Almost four out of ten (37 per cent) said they had some difficulties and the same proportion said they felt under stress. One in six (17 per cent) said they could not cope.

### *Conclusion*

We know that many older carers are living in poverty and many suffer because of poor housing. We also know that in caring for others, carers are putting their own health at risk. To improve the lives of carers, and those dependent on them, we recommend that the following be made available to all older carers:

- carers' clinics
- home-based respite care
- adequate home supports
- health promotion programmes.

People often call for more information about services and benefits to be made available to older people. In our experience it is not more information that is needed. What is

needed, is that someone should take the time to sit with the older person and explain what the information means for them, for example, to reassure them that it is safe for them to give personal information on a form and to reassure them that in applying for a service or a benefit that they will not be penalised in any way.

**Speaker: Michael Browne, Research Consultant, Comhairle**

*Introduction*

In this paper we look at some of the key issues faced by older carers. We look briefly at the findings from two reports: *Supporting Carers – A Social Policy Report*, produced by Comhairle in 2002 and *Caring in Later Life*, the report of a UK study conducted by the University of Kent and the charity, Help the Aged. We make recommendations in relation to the services needed for older carers.

*Issues for carers*

*Background*

Research undertaken by Comhairle (*Supporting Carers – A Social Policy Report*), shows that current demographic trends are likely to lead to both an increase in the need for care services and a decrease in the supply of those services by the traditional care providers (mostly women). In other words, the number of people needing care is increasing and the pool of carers is decreasing.

Until recently, the relatively low proportion of older people in the Irish population and the low labour market participation rates among women provided the underpinnings of the informal care model in Ireland. However, changes in family structures, women's labour market participation and population ageing are making this model less sustainable.

*Older carers*

Census 2002 shows that there are 149,000 carers in Ireland, 5 per cent of the total population. Women account for 61 per cent of these carers and one in ten women aged between 40 and 59 is a carer.

We know that the number of older carers in Ireland is increasing. According to the 2002 Census, there are 16,571 carers (4 per cent) aged over 65. About half of them (8,273 people) provide more than 43 hours of care a week. There are 2,207 carers over the age of 80 and 1,111 of these provide more than 43 hours of care per week.

There is, however, limited information about the experiences of older carers, and limited information about their particular needs. We know that they are not a homogenous group: some are spouse carers; some are older adult children; some are parent carers or other relatives; and some are friends or neighbours. We know that they are more likely to be sole carers and also more likely to have health problems themselves. They tend to have smaller support networks; many experience geographical, social and emotional isolation, and often need help and support in taking care of themselves. Many have had negative experiences of the 'system', and so are reluctant to seek help.

### *Older carers in the UK*

The UK study, *Caring in Later Life*, found that 36 per cent of all older people are cared for by older carers (those aged 60 or over). Indeed, 88 per cent of those receiving care from older carers are older people. The study found that older care recipients have a greater incidence of both physical and mental impairment.

Four out of ten of the older carers (40 per cent) are co-resident, living with the person for whom they were caring. Those receiving care are spouses (33 per cent), friends or neighbours (22 per cent), parents (20 per cent), other relatives (18 per cent) and adult children (7 per cent). The study found that spousal carers are the primary co-resident carers and that equal numbers of spousal carers are male and female. Spousal caring is viewed as an extension of the marital relationship and spousal carers are unlikely to ask for support from services.

The research found that the type of care provided included personal care (31 per cent), other practical help (26 per cent), help with paperwork (17 per cent) and help with mobility problems (13 per cent). While both men and women provide personal care, men provide this sort of care to wives only.

Many carers were caring for a period of 15 years or more. The carers involved for the longest period, many of whom are aged 75 and over, receive the least support from services. It also found that 75 per cent of co-resident carers receive no support from services. Furthermore, older carers caring for 20 hours or more per week receive lower levels of service than those providing less than 20 hours per week.

While for many, caring is a source of satisfaction, it also carries a social cost. The study found that many carers were at risk of poverty and that caring often puts the carer's own health at risk.

### *Recommendations*

Based on what we know about older carers we would recommend the following be made available to them:

- comprehensive home support care packages, for day and night time, weekdays and weekends, based on an integrated approach to care planning for individuals, as proposed in the National Health Strategy
- more personal support services for individual carers and families, including key workers, and a social work support service for carers
- comprehensive, needs-based respite services
- more opportunities to be involved in the process of policy-making and service planning, for example, in the form of consultative forums
- integrated information services run jointly by health boards, CICs and other relevant statutory and voluntary bodies
- an additional income support for those providing the highest level of care, the so called 'continual care payment', as recommended in the *1998 Review of the Carer's Allowance*.

In addition, we recommend that the role of the Health Board Co-ordinator be expanded to ensure that statutory and voluntary services are streamlined and better co-ordinated; and that development workers be appointed to enhance the work of the voluntary organisations working with carers. We also suggest that the set-up of a dedicated carer helpline be explored. The concept of a National Strategy for Carers should be examined: such a strategy should contain targets for service development and a plan for co-ordinating support services.

### ***Discussion: challenges and strategies***

The principal challenges identified by workshop participants included: the need for carers to be recognised by the health systems and by health professionals; the need for services that are at present provided on an arbitrary basis to be provided on a statutory basis; the need to keep the issue of carers on both the political and public agendas; and the need for funding.

To address these challenges, it was suggested that: a programme of research be implemented to identify and understand the needs of carers, particularly older carers; and a national strategy for family carers be put in place in order to better plan the support, training, respite, information and income needs of carers nationwide.

## **Final Session**

***Chair: Cllr Éibhlin Byrne, Chairperson, NCAOP***

## **Ageing with Confidence – An Empowerment Drama By Age Rage**

***Introduced by Ann Marie Crosse, Co-ordinator, Voice of Older People Project, Co. Donegal***

### *Introduction*

The Voice of Older People is a project started by the Health Promotion Department of the NWHB. It brings together people from the whole county of Donegal. The diversity of the Donegal landscape is reflected in the social and cultural diversity of the older people involved in the project – in their experiences, their situation, their age and gender, their identity, their needs, and their dreams and aspirations.

The project is based on the principles of active participation. The aim is to develop older people's capacity to identify, articulate and be actively involved in decision-making about issues that affect their health and quality of life. We take a partnership approach, working together across generations, with the community, with voluntary and private sector organisations, and with State agencies. We work towards equity, based on the principles of human rights, social inclusion and equality.

Five local networks have been developed throughout Donegal as well as a representative countywide network. Each is 'owned' and led by older people. These older people have been developing action plans and community and county strategies in partnership with State agencies and other organisations.

### *How Age Rage came about*

Members in all of the networks have come across ageism and discrimination. The southern network decided to bring these issues to the attention of a wider audience through drama. The Bundoran and Ballyshannon Active Age Groups worked with Maura Logue and me, Ann Marie Crosse, to research, script and develop the play you will see today.

I would like to thank the NCAOP for giving us the chance to perform the play. It has a serious message. I am sure that you will recognise many of the issues, including transport, social isolation, sexuality and carers and, of course, ageism and discrimination.

## **Closing Address**

### ***Ivor Callely, TD, Minister for Services for Older People***

#### *The importance of healthy ageing*

The 2003 Healthy Ageing Conference has been a memorable and worthwhile day.

Healthy ageing is increasingly important as we live longer and strive to enjoy that longer life. The goals of health promotion are to promote good physical and mental health, reduce preventable illness and increase life expectancy. My Department is committed to health promotion. It is the vision of the National Health Strategy, *Quality and Fairness*, to provide 'a health system that supports and empowers people to achieve full health potential.' It is a key aim of the Strategy 'to enhance the quality of life and improve longevity for older people'.

We face a major challenge: the life expectancy of Irish people at age 65 is one and a half years lower than the EU average. Irish people are more likely to suffer diseases and accidents; they are more prone to cardiovascular and respiratory diseases and cancer, all of which are linked to lifestyle and health-related behaviour. It is therefore our duty to promote healthy lifestyles among older people.

#### *The Healthy Ageing Database and the report, Healthy Ageing in Ireland: Policy, Practice and Evaluation*

I would like to congratulate those at community, regional and national levels whose commitment to promoting good health never fails to impress me. The launch at the conference of the Healthy Ageing Database is noteworthy, not least because it highlights the amount of work already under way throughout the country. It is the first information-sharing resource of its type, providing information to people interested in healthy ageing and those interested in setting up local initiatives. The report, *Healthy Ageing in Ireland: Policy, Practice and Evaluation*, also launched today, is a useful follow-on from the Database in its strategic analysis of the scale and direction of healthy ageing initiatives nationally. It gives us a map to enable us to develop a more coherent approach to

healthy ageing initiatives; it identifies ways of sharing resources and working to build a cohesive national healthy ageing network; and is a useful document for any group planning an initiative, providing as it does invaluable information on best practice.

### *Challenges*

Despite work to date, many challenges remain. Older people are a diverse group. We need to open our minds to the need for greater flexibility in our approach to the 'third age'. While health promotion for some is about keeping fit and healthy, for others it may be about lessening the effects of illness or disability. In all cases, however, health promotion must focus on encouraging active participation in society. Older people have a lot to contribute and it is a key goal for health promotion to find ways to help this along.

My Department is committed to convincing health professionals and society in general of the benefits of health promotion. In promoting healthy ageing everyone wins, even the exchequer, as health care costs associated with an ageing population will be reduced.

### *The Inter-Departmental Group*

It was a key aim of this conference to provide a forum for the exchange of views on the challenges in promoting health among particularly vulnerable groups of older people. My Department is committed to promoting the interests of these groups and to that end I have set up an Inter-Departmental Group. The aim of the Group is to examine the needs of older people, including vulnerable older people, and the matters that impact on their lives, and to ensure that a co-ordinated approach is taken in relation to these matters. The Group operates under the auspices of the Department of Health and Children and is made up of people from four other Departments:

- Department of Environment and Local Government
- Department of Social, Community and Family Affairs
- Department of Transport and Public Enterprise
- Department of Enterprise, Trade and Employment.

Representatives from health boards, local government and the Equality Authority are invited on a regular basis. Many interested parties, including the NCAOP, have joined

the Group to discuss the issues facing older people. An interim report is currently being prepared.

### *Conclusion*

To conclude, I would like to congratulate again all those involved in Healthy Ageing programmes around the country. The National Health Strategy specifically refers to the need for a partnership approach in achieving greater health gain and recognises the need to step out of the health sector to achieve this. This conference and the NCAOP's progress towards a National Healthy Ageing Network continues to promote collaboration between interested parties. A heartfelt thanks to the Council for its work for older people and for this showcase of healthy ageing projects from around the country.

## Contributors

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Anne Marie Crosse, Co-ordinator, Voice of Older People Project.

Audry Deane, National Social Policy Officer, St Vincent de Paul.

Geraldine Delorey, Health Promotion Officer for Older People, NWHB.

Pat Doherty, CEO, Depaul Trust.

Eamon Donnelly, Men Against Cancer and Consultant, Retirement Planning Council of Ireland.

Enda Egan, CEO, Carers Association.

Mary Higgins, Director, Homeless Agency.

Helen Johnston, Director, Combat Poverty Agency.

Prof. Cecily Kelleher, Department of Public Health Medicine and Epidemiology, UCD.

Mary Kelly, Chairperson, National Women's Council of Ireland.

Sr Stanislaus Kennedy, Chairperson, Social Innovations Ireland and Life President, Focus Ireland.

Catherine Lawlor, Activity Nurse, St Mary's Hospital, Dublin.

Alice Leahy, Director, TRUST.

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## Terms of Reference

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

The functions of the Council are as follows:

1. To advise the Minister for Health on all aspects of ageing and the welfare of older people, either at its own initiative or at the request of the Minister and in particular on:
  - (a) measures to promote the health of older people;
  - (b) measures to promote the social inclusion of older people;
  - (c) the implementation of the recommendations contained in policy reports commissioned by the Minister for Health;
  - (d) methods of ensuring coordination between public bodies at national and local level in the planning and provision of services for older people;
  - (e) methods of encouraging greater partnership between statutory and voluntary bodies in providing services for older people;
  - (f) meeting the needs of the most vulnerable older people;
  - (g) means of encouraging positive attitudes to life after 65 years and the
  - (h) means of encouraging greater participation by older people;
  - (i) whatever action, based on research, is required to plan and develop services for older people.
2. To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:
  - (a) undertaking research on the lifestyle and the needs of older people in Ireland;
  - (b) identifying and promoting models of good practice in the care of older people and service delivery to them;
  - (c) providing information and advice based on research findings to those involved in the development and/or implementation of policies and

- services pertaining to the health, well-being and autonomy of older people;
- d) liaising with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for older people.
3. To promote the health, welfare and autonomy of older people.
  4. To promote a better understanding of ageing and older people in Ireland.
  5. To liaise with international bodies which have functions similar to the functions of the Council.

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

## Membership

Chairperson Cllr Éibhlín Byrne	
Mr Bernard Thompson	Ms Mary O'Neill
Mr Eddie Wade	Cllr Jim Cousins
Mr Michael Dineen	Dr Ciaran Donegan
Fr Peter Finnerty	Mr James Flanagan
Mr Eamon Kane	Dr Michael Loftus
Mr Michael Murphy	Ms Mary Nally
Mr Pat O'Toole	Ms Rosemary Smith
Ms Pauline Clancy-Seymour	
Director Bob Carroll	