


# Health and Social Services for Older People II (HeSSOP II)

Changing Profiles from  
2000 to 2004



National Council on Ageing and Older People



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On behalf of the Healthy Ageing Research Programme (HARP) Team:  
Royal College of Surgeons in Ireland  
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The Queen's University of Belfast



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As Chairperson of the National Council on Ageing and Older People, it gives me great pleasure to present this study *Health and Social Services for Older People (HeSSOP) II: Changing Profiles from 2000 to 2004*.

The first *HeSSOP* study, which took place in 2000, aimed to consult with community-dwelling older people in Ireland about their health and social needs and service use, and to identify challenges to service delivery and take-up. It was the largest such study of older people ever conducted in Ireland and the first to examine the healthcare views of community-based older adults on a large scale. It also provided the opportunity to consider the health and social profile of older people and challenges to State services in contrasting urban (ERHA) and rural (WHB) regions of Ireland.

This follow-up study, *HeSSOP II*, was commissioned as part the Healthy Ageing Research Programme (HARP), funded by the Health Research Board. HARP is a cross-institutional, cross-border project involving the Royal College of Surgeons in Ireland, Trinity College Dublin, Queen's University Belfast, and the Economic and Social Research Institute. Its aim is to provide continuity in knowledge of health and social service usage for older people in Ireland. The programme undertook to do this by: conducting a four-year follow-up comparison of participants from *HeSSOP I*; repeating *HeSSOP I* with a new cohort of participants of similar age in the same regions four years later; comparing this group with a similarly selected group in Northern Ireland. This study reports on the first two elements of the research programme, while the third element is addressed in a separate study to be published by the Institute for Public Health in Ireland.

The Council is delighted to publish this follow-up to the *HeSSOP I* study as it provides health and social service planners and providers with the most up-to-date information in health status and service usage among a representative sample of older people. It also includes a longitudinal component and, as such, it is the first of its kind to be conducted in an Irish context. The Council hopes that in the light of the experience of this study that a national longitudinal study of older people will be initiated which will, through the inclusion of older people's voices and perspectives as well as holistic consideration of all aspects of ageing, assist in the creation of a truly age friendly society in Ireland.

On behalf of the Council, I would like to thank the authors of the study, Prof. Hannah McGee, Dr Ann O'Hanlon, Ms Maja Barker, Ms Rebecca Garavan, Dr Anne Hickey, Dr Ronán Conroy and Prof. Desmond O'Neill, and the overall HARP team for their commitment and dedication to this project.

A handwritten signature in black ink that reads "Éibhlín Byrne". The signature is written in a cursive style with a small flourish above the first letter of the first name.

**Cllr Éibhlín Byrne**  
**Chairperson**

The Healthy Ageing Research Programme (HARP) is funded by a Programme Grant from the Health Research Board (HRB). It aims to document ageing and health and their interaction with healthcare and social services. This programme of research included a follow-up of participants from the older Irish population who were first interviewed in 2000 in the *Health and Social Services for Older People (HeSSOP)* study. The Health Services Research Centre at the Department of Psychology, Royal College of Surgeons in Ireland, conducted the *HeSSOP* study. The follow-on work (*HeSSOP II*) was completed by Dr Ann O'Hanlon (HARP coordinator), Prof. Hannah McGee (HARP principal investigator), Ms Maja Barker (HARP research officer), Ms Rebecca Garavan (HRB health services research fellow), Dr Anne Hickey (lecturer, Dept of Psychology) and Dr Ronán Conroy (Biostatistician, Dept of Epidemiology and Public Health) at RCSI and Prof. Desmond O'Neill (TCD) on behalf of the HARP team. HARP is a cross-institutional, cross-border project involving the Royal College of Surgeons in Ireland (RCSI); the Department of Gerontology, Trinity College Dublin (TCD); the Economic and Social Research Institute (ESRI); and the Department of Geriatric Medicine, Queen's University of Belfast (QUB). The Steering Group comprises Prof. Hannah McGee (RCSI) (principal investigator), Prof. Desmond O'Neill (TCD – Adelaide and Meath Hospitals Incorporating the National Children's Hospital) (co-investigator), Dr Tony Fahey (ESRI) (co-investigator), Prof. Bob Stout (QUB) (co-investigator), Dr Anne Hickey (RCSI), Dr Ronán Conroy (RCSI), Ms Rebecca Garavan (RCSI), Dr Emer Shelley (RCSI), Dr Frances Horgan (RCSI), Dr Richard Layte (ESRI), Dr Vivienne Crawford (QUB) and Dr David Hevey (TCD). HARP research staff comprise Dr Ann O'Hanlon (RCSI), Ms Maja Barker (RCSI), Ms Karen Grogan (RCSI), Ms Claire Donnellan (TCD) and Mr John Dinsmore (QUB). HARP is a five-year project, commencing in 2003.

The study reported here sought to consult with community-based older adults about their experiences with, and perspectives on, health and social services. It is the largest follow-on study of older people in Ireland to date, with information on a group already interviewed four years previously alongside information on about 1,000 older individuals at two separate time points to determine changes in attitudes, preferences and service use over that time.

We acknowledge the support of many individuals in the consultation and interview process for this study; older people in Carnew Day Care Centre, Leopardstown Day Hospital, Beaufort Day Care Centre, the Federation of Active Retirement Associations (FARA) and Age Concern Northern Ireland took part in interviews and focus groups. Thanks to Ms Janet Convery in the Eastern Regional Health Authority

(ERHA) and staff at these centres for facilitating these groups. We also thank Prof. James Williams and Ms Bernadette Ryan of the ESRI who coordinated interview teams in the ERHA and the Western Health Board (WHB). The original (*HeSSOP*) research report was funded by the National Council on Ageing and Older People (NCAOP) in association with the ERHA and WHB. The original *HeSSOP* report and the current (*HeSSOP II*) report were funded and produced by the NCAOP as part of their publication series. We thank Mr Bob Carroll (Director, NCAOP) for ongoing support of this work. Acknowledgements also to Ms Sinéad Quill and Ms Helen Bradley, and Ms Catherine Conlon (NCAOP) for additional support in *HeSSOP II* and *HeSSOP I* respectively. Anonymous reviewers, through the NCAOP, provided valuable feedback on an earlier draft of the report; thanks for their commentaries and suggestions. The HARP team, and in particular Ms Karen Grogan, are acknowledged for their general input into aspects of the *HeSSOP II* study. Most importantly, we thank the older people who agreed to be interviewed for the study (in some cases twice – four years apart). We hope their efforts can be rewarded through increased understanding of ageing in contemporary Ireland for health care providers, policy-makers and society in general.

Ann O’Hanlon, Hannah McGee, Maja Barker, Rebecca Garavan, Anne Hickey, Ronán Conroy, Desmond O’Neill on behalf of the HARP team  
Health Services Research Centre  
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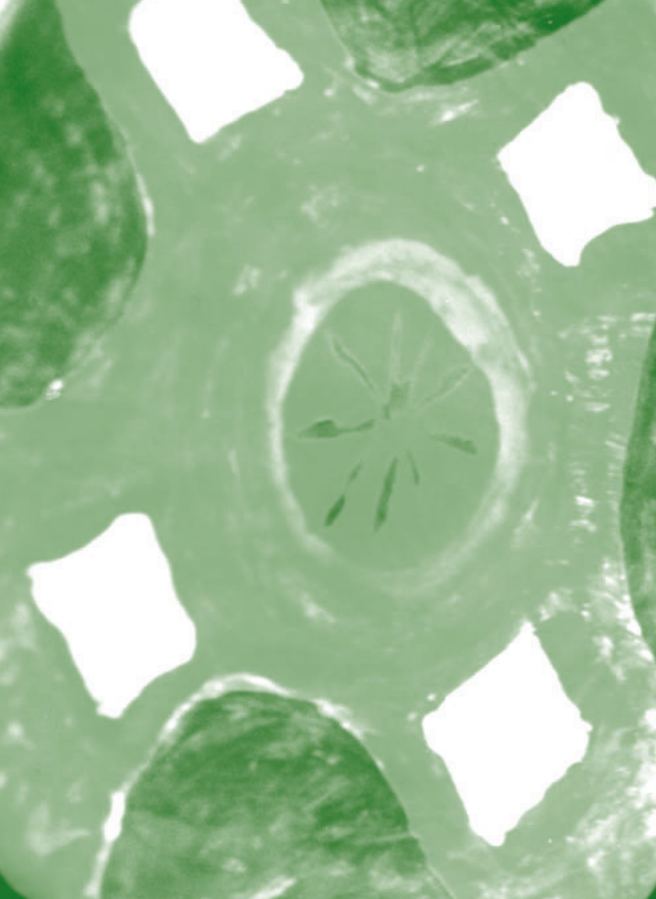


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# 1

## Executive summary

# Executive summary

## Study background

*Health and Social Services for Older People (HeSSOP)* was conducted in the year 2000 and involved 937 community-based older adults in western and eastern health board areas of the Republic of Ireland (Garavan *et al.*, 2001). *HeSSOP* aimed to consult with community-dwelling older people in Ireland about their health and social needs and service use across boards, and to identify any challenges to service delivery and uptake. *HeSSOP* was the largest such study of older people ever conducted in Ireland, and the first to examine the healthcare views of community-based older adults on a large scale. It provided the opportunity to consider the health and social profile and challenges to state services for a predominantly urban (Eastern Regional Health Authority [ERHA]) and predominantly rural (Western Health Board [WHB]) region of Ireland.

A follow-up of this study (*HeSSOP II*) was commissioned as part of a larger programme of research on ageing by the HRB. Its aim was to provide continuity in knowledge of health and social service usage for older people in Ireland. The research programme undertook to do this in three ways: to conduct a four-year follow-up comparison of participants from *HeSSOP* (hereafter called *HeSSOP I*); to repeat *HeSSOP I* in a new cohort of participants of similar age in the same regions (n = 1,000) four years after *HeSSOP I*; and to compare this group of 1,000 interviewed in 2004 with a similarly selected group in Northern Ireland. This latter project, which will be reported separately, provides an opportunity to learn by comparing the health and social status and service experiences of two groups of older people on one island with two differing health and social service systems.

The Republic of Ireland information comprising *HeSSOP II* provides information on progression of morbidity, changes in informal and formal health and social service use, and perceptions of service quality over a four-year period. The repeat study also provides the first evaluation of the changing levels of health, and health and social service use of a community sample of older people in contemporary Ireland.

The aim of *HeSSOP II* was a) to evaluate health and social service provision in Ireland from the perspective of community-dwelling older people needing and/or using these services; and to document continuity and change in this group over time by providing longitudinal data on community-dwelling older adults (age 65+) (n = 937) first interviewed in *HeSSOP I* (four years previously); and b) to repeat *HeSSOP I* four years later (2004) in a new cohort which represents the current population (n = 1,000) to allow for analysis of continuity and change over time in the ageing population. These two components of the study are called the 'longitudinal' and 'repeat' study respectively. Specified objectives in the overall study are outlined as follows:

- to compare information on representative groups of older Irish people across two time points in a *repeat* study (years 2000 and 2004)
- to provide *longitudinal* information on *HeSSOP I* participants and compare their status with four years previously
- to compare information across two health boards (separately representing predominately urban and rural experiences) to identify common and specific areas of achievement and concern
- to document experiences with a broad range of health and social services recently received or required by community-based groups of older individuals in two health boards
- to document use of domiciliary (e.g. public health nursing) and 'social' (e.g., Home Helps/meals-on-wheels) services, and providers of informal care for older people at home
- to assess long-term care preferences (e.g. home v. institutional) in the context of being unable to live independently
- to establish recommendations for service improvements based on the above
- to provide recommendations for future research from the above. A specific focus of research advice will be regarding the lessons to be learned concerning longitudinal follow-up of cohorts of older Irish people for future studies.

Two groups of participants were recruited. The first group (the 'repeat' study) was made up of 1,000 participants selected to represent older (aged 65+) ERHA and WHB residents in 2004. This group also included participants from the second group (the 'longitudinal' study). The second group consisted of individuals who were first interviewed four years previously as part of *HeSSOP I*. In *HeSSOP I*, community-based adults aged 65 years and over were identified from the electoral register and interviewed in their own homes (n = 937). In summer 2004, trained interviewers sought to re-recruit as many of these *HeSSOP I* participants as possible. The group represented older Irish people in a predominately urban health board area (ERHA) and a predominately rural health board area (WHB). The four-year longitudinal study provides information on changes for individuals as they age, while the repeat study four years later provides a profile of how ageing (defined here as experiences of those aged 65+ years) is changing over time in contemporary Ireland.

### Sampling and demographic profile of *HeSSOP II/HeSSOP II*

- Outcomes for 873 of 937 participants of *HeSSOP I* (longitudinal study) were established. Of these, information was obtained on 408 with detailed interviews held with 325 participants. A total of 1,053 participants completed the *HeSSOP II* (repeat study) interviews. Of these, 314 were longitudinal participants from *HeSSOP I* and 743 were newly recruited older adults. The response rate was 71 per cent (longitudinal study) and 61 per cent (repeat study) (combined sample: 64 per cent). The rates for interview completion were 55 per cent (longitudinal study) and 58 per cent (repeat study) (combined sample: 57 per cent).
- WHB participants were significantly older than those in the ERHA at both time points.
- Women in both boards were significantly older than men with 2-3 times as many in the 'old old' (age 85+ years) category. This pattern was similar at both time points.
- A quarter of ERHA and a third of WHB participants lived alone in *HeSSOP II*. Women were more than twice as likely to live alone as men. This pattern was similar in *HeSSOP I*.



- Educational and occupational status and income were higher in the ERHA with significant improvements over the four-year period in the ERHA but not in the WHB region.
- Overall, the demographic and related profile remained reasonably stable over the four-year period from *HeSSOP I* to *HeSSOP II*.

## Results: *HeSSOP II*, repeat study

### Functional capacity and self-rated health

- There were no health board differences in functional capacity at either *HeSSOP I* (2000) or *HeSSOP II* (2004). Neither board changed significantly in the overall functional capacity of its older population over the four years.
- With the exception of walking sticks (used by 12-20 per cent of older people), use of devices was low across boards and time. There was a notable reduction in use of hearing aids in both boards from 2000 to 2004.
- Three quarters of participants in both boards rated their current health as good or excellent in 2004. This is an improvement from 2000, particularly for the WHB where only 59 per cent described themselves as in good/excellent health at that time.
- Comparing current health with health one year previously, most (two thirds of) older people believed their health had remained the same.
- Health expectancies one year from now were very positive with about 90 per cent across boards and time believing their health would be the same or better than now.

### Receipt and provision of care

- Similar levels of informal care were available to residents in the ERHA and WHB in 2004 (up to one third of participants availed of support from one or more groups). Those in the ERHA reported higher levels of informal care in 2004 than in 2000. They received more care from neighbours than did participants in the WHB. Family-provided care was similar across boards.
- Having a primary level of education only was significantly associated with accessing support from spouses/partners ( $p < .01$ ) and relatives outside the household ( $p < .001$ ).

- A significant minority of older people were primary carers for another person. The pattern for the WHB was stable over time with 8-9 per cent acting as primary carers. In the ERHA, 9 per cent were primary carers in 2000 and 5 per cent in 2004.
- Women were more likely to be carers but not all carers were women. One in five carers had their own problems with activities of daily living.

### Psychological and social well-being

- Concerning positive mental health, two thirds of the sample reported high morale with no differences across board or time. Higher morale was associated with younger age and higher income; however, a substantial one in three did not report high morale. For instance, one third did not feel that they contributed to their community and society as much as they would like to.
- One in ten had major difficulty or were completely unable to get out of their homes to attend social events or visit family or friends. There were no board or time differences in the size of this group.
- Seven to fifteen per cent reported feeling lonely quite or very often. Living alone increased the likelihood of being lonely at least threefold.
- The majority in both boards reported high levels of social support: > 80 per cent reported emotional support, > 85 per cent reported informational support and > 75 per cent practical support. Changes over time reflected somewhat improved practical support in the ERHA only in 2004. Practical support was least adequately available over time and board.

### Health behaviours and preventive activities

- Some 17-18 per cent of the sample smoked in 2004; a significant reduction from 20-21 per cent in 2000. Furthermore, over a fifth of ERHA smokers (22 per cent) and 9 per cent of those in the WHB were planning to actively try to quit in 2004. Proportions planning to quit were the same across boards, as in 2000.
- Over 70 per cent in both boards had received the flu injection in winter 2003/4. This was a notable increase from 2000 (when 35 per cent of ERHA and 46 per cent of WHB participants were inoculated).
- At least three quarters of older people believed they took enough physical exercise; there were similar proportions across board and time.

### GP hospital and day hospital/day care centre use

- GP services were used by almost all of the population in the previous year with high levels of satisfaction and a high level of continuity of care as evidenced by patients having a long-established relationship with a particular GP.
- GP visits averaged 6.0 in the WHB and 4.5 in the ERHA in 2004 (5.5 and 4.5 respectively in 2000); a significantly higher level of use in the WHB. There was also evidence of higher use of GP services in those aged over seventy in 2004 compared with 2000, i.e. following the national introduction of free access to GP care for this group between the study periods.
- There was no significant board difference in use of A&E services in either *HeSSOP I* or *HeSSOP II* (10-13 per cent across groups and time).
- Hospital in-patient service use was similar across boards and time (with 15-18 per cent attending across health board and time).
- Out-patient hospital services were used by significantly more ERHA than WHB participants at both times (36 per cent v. 13 per cent in 2000 and 25 per cent v. 14 per cent in 2004).
- The frequency of out-patient appointments per person treated decreased in 2004 in the WHB.
- Day hospital use was similar across boards in 2000 (6 per cent ERHA and 4 per cent WHB) but was significantly lower in 2004 for the WHB (5 per cent ERHA v. 1 per cent WHB). Day care centres were used by a small and similar proportion across time with services used by fewer WHB than ERHA participants. Over 70 per cent of ERHA service users availed of two or more weekly visits, while all WHB attendees had once weekly visits.
- Waiting lists for in-patient services were the same across time and board (4-5 per cent in 2004). Out-patient waiting lists were also similar across boards but with a greater proportion of the sample waiting in 2004 (7-8 per cent) than in 2000 (2-3 per cent). Day hospital waiting lists followed the same pattern as outpatient lists but with very few waiting ( $\leq 2$  per cent).
- Proportions waiting for any hospital-related service were similar across boards but had increased almost twofold in 2004 (from 3 per cent [ERHA] and 7 per cent [WHB] waiting in 2000 to 11 per cent [ERHA] and 13 per cent [WHB] in 2004).

### Primary care service use

- A greater proportion of those in the ERHA availed of meals-on-wheels at both time points. Meals-on-wheels was used more by urban dwellers and those in higher income brackets. A greater proportion of those in the ERHA availed of home help at both time points. The proportion availing of this service did not differ within board over time. Those who used Home Helps were more likely to be older. There were no major increases in use of primary care services such as physiotherapy, chiropody and home help over time. Of 15 primary care services assessed, eight were provided to a greater proportion of ERHA than WHB participants, with none provided more frequently in the WHB.
- Significant board differences were found in both primary and secondary (hospital) care services even when controlling for demographic differences. This suggests substantial inequity, with those in the ERHA more likely to receive services than those in the WHB.
- Primary care use was considered for particular groupings of older people considered to be the most vulnerable. Three factors were selected in three analyses: age (age 80+ years v. younger); living status (living alone v. with others); and functional capacity (significant impairment on the Health Assessment Questionnaire (HAQ) v. none). Of these factors, older age was the factor most associated with increased primary care service use. Those aged eighty years and over received significantly more of many community-based services.

### Preferences for long-term care if needed

- Almost all participants chose living at home with family, with family support as their care preference if they needed long-term care. This preference increased in 2004.
- The least preferred mainstream option if needing long-term care was a nursing home. About half of the ERHA group would not accept a nursing home option at either study time. While resistance was higher in the year 2000 for the WHB, this was halved in 2004 (65 per cent v. 34 per cent did not accept a nursing home as an option in 2000 and 2004 respectively).
- About one in four participants had ever discussed their long-term care preferences with others with marginally fewer WHB participants doing so. Nonetheless, almost 80 per cent consistently across boards and time believed their wishes in this regard would be honoured.

## Transport, barriers to health services and health care funding profiles

- About half of older people were car drivers, with no board or time differences. More ERHA participants walked or cycled than WHB participants (about half did so) but there was a significant ERHA-only reduction over four years (76 per cent to 66 per cent). The number of people availing of lifts from others was similar across boards and increased by about a quarter over time such that about half of the sample accepted lifts in 2004. Public transport was used much more by ERHA participants (about two thirds at both times). WHB uptake decreased from 32 per cent to 20 per cent over the four years. The implications of low use of public transport for the independence of older people, in the WHB in particular, need to be further examined.
- Up to 10 per cent of participants would feel stigmatised and not use meals-on-wheels, home help or personal care assistants even if needed. In general, those in the ERHA feel less stigmatised than WHB respondents in 2000, with WHB respondents becoming less stigmatised over time such that there were no board differences in 2004.
- More WHB than ERHA participants had medical cards at both time points (e.g. 89 per cent in the WHB v. 75 per cent in the ERHA in 2004). Almost all participants aged seventy years or over in 2004 (i.e. 97 per cent) reported having the medical card to which they have become entitled.
- Private health insurance was held by about half of ERHA and a third of WHB participants at both time points with no difference in cover over time (specifically for 52 per cent of ERHA and 30 per cent of WHB participants in *HeSSOP II*).
- About half of those using physiotherapy and chiropody services paid for them. Proportions paying for home help increased substantially in the ERHA over time with a much less notable increase in the WHB. Overall, direct personal payment for primary care services became much more of a feature of the *HeSSOP* samples in 2004, particularly in the ERHA.

## Results: *HeSSOP I*, longitudinal study

- In terms of re-contact, 93 per cent of the original sample were traced, of which 408 provided some information and 314 participants completed detailed interviews.

- The sample interviewed were somewhat younger and in a higher social class than other surviving participants. In other respects the groups were very similar. This allows for cautious generalisability of information from the group.

#### GP service use

- There was some evidence of increased GP use over the four years (means of 4.3 and 5.6 visits in 2000 for ERHA and WHB respectively, and 4.8 and 6.0 in 2004). Increases were more evident in the WHB and in those over the age of seventy. The latter is likely to reflect in part the introduction of free (medical card) access to GP care for those aged seventy years and over in the intervening period.
- Satisfaction with aspects of care, such as access to GP appointments, the quality of information received and feeling one's concerns were taken seriously were very high (all > 90 per cent). There were no differences in those with or without medical cards on satisfaction levels.
- Transport and cost were not barriers to GP services.
- Physical and mental health problems (i.e. higher functional ability and higher anxiety) at *HeSSOP I* predicted rate of GP attendance four years later.

#### Hospital service use

- Use of hospital services (A&E, in-patient and out-patient services) increased for the ERHA and WHB with the exception of A&E in the ERHA. A pattern of higher in-patient and out-patient use in the WHB and higher out-patient use in the ERHA was evident in *HeSSOP I* and increased four years later, e.g. 30 per cent and 50 per cent of *HeSSOP I* ERHA and WHB participants respectively v. 64 per cent and 37 per cent of *HeSSOP II* ERHA and WHB participants used out-patient services. A&E services were used by a quarter to a third (23 per cent of ERHA and 31 per cent of WHB) of participants in *HeSSOP II* (2004). Overall, hospital service use in 2004 for this longitudinal sample had doubled for most comparisons.

#### Primary care service use

- Primary care services other than GP services were used by a minority. In *HeSSOP I*, about one in ten participants had visits by a public health nurse in 2000, rising to one in five in 2004. Those availing of home help services increased significantly in 2004 for the ERHA (to 9 per cent) but not significantly in the WHB (to 5 per cent). This pattern was identical for meals-on-wheels services (4 per cent ERHA and 1 per cent WHB).

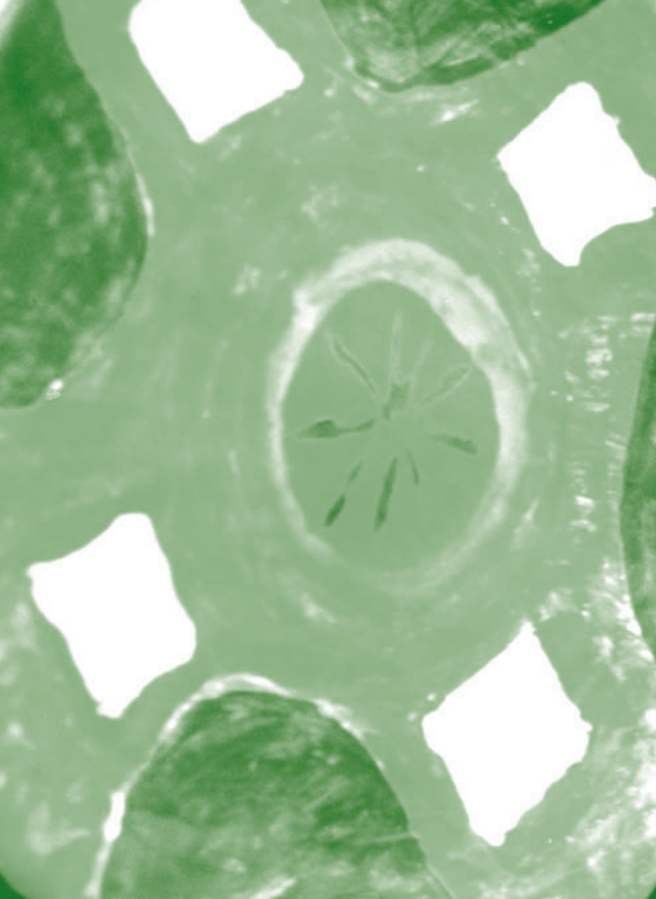
## Conclusions

- The *HeSSOP* studies aimed to provide insights about the experience of ageing and use of health and social services as applied to most community-based adults rather than those assessed in hospital or other care settings.
- In examining health and well-being of participants, *HeSSOP* findings challenge many prevalent negative stereotypes; in the longitudinal study over the four-year period there were few changes in health and psychosocial measures. Many adults continued to function at high levels and without significant disabilities.
- About one in ten participants, however, had major difficulties in physical and psychosocial health (e.g. depression, loneliness or lower levels of support). Thus, while promoting the message that the majority of older people have good health, it is essential to focus adequate resources and care to improve the status of those who are most vulnerable.
- *HeSSOP* offers insights about primary and secondary health service use. Most participants availed of services from their own GPs. A substantial minority came into contact with hospital services in the previous year with at least one in ten attending A&E services. Percentages on waiting lists for in-patient procedures had not reduced significantly from 2000 to 2004. Moreover, the overall number of people waiting for hospital and related services had increased significantly from 2000 to 2004. Thus, there appears to have been little progress made in increasing capacity to meet need in the past four years.
- Significant board differences were found, with participants in the ERHA more likely than those in the WHB to have used hospital and primary care services. Since many of these differences remained after controlling for demographic differences across boards, they signal unacceptable inequality in the services available across boards. Uptake of many health and social services remained low, despite these services being designed to facilitate independent living at home which is the care preference of the majority of older adults. There was also an increasing pattern of direct payment for community-based services, particularly notable in the ERHA region. Coverage by private health insurance was also considerable (52 per cent in the ERHA and 33 per cent in the WHB) with little change in coverage over the four years of the overall project.

- There is currently no 'gold standard' against which to gauge service coverage and to plan to meet service shortfalls for older people. If service planning for older people in Ireland is to be meaningful, assessment of the level of health and social service need is urgently needed.
- *HeSSOP I* was not originally designed as a longitudinal study. Nonetheless, 93 per cent of this sample was traced four years later (n = 873) and 408 (71 per cent of those eligible and invited) participated in the second interview. A number of unexpected problems were encountered from which recommendations were made in terms of increasing re-contact and participation rates. These findings can contribute to a knowledge base in terms of planning for maximum participation in future longitudinal studies.
- The *HeSSOP* studies are part of a broader cross-border Healthy Ageing Research Programme (HARP) in Ireland. Its aims include the provision of the 'epidemiology' of health status and service use alongside greater understanding of the psychosocial processes associated with ageing. This involves the development of new psychometric tools which have the potential to facilitate and promote the experiences of older adults across the health continuum. In this way HARP can provide lessons that are 'locally' relevant to the Irish health service, but also lessons which enable greater understanding of ageing *per se* in the contemporary world.
- While many useful points can be made from the *HeSSOP* series and similar occasional surveys, they cannot substitute for regular updates on the status of older people in terms of health and social status and related service provision. Longitudinal study, in combination with the newly developing national information systems, is needed to provide both an analysis of the impact of service provision on the lives of older people and to anticipate trends and their implications for service need in the community of older people into the future.

In summary, vision in planning for health and social services for older people in Ireland is something that the older people of today, i.e. the builders of our present economy, deserve. It is, at the same time, the legacy that the rest of Irish society will inherit, for better or worse, in the coming decades. It, thus, is in everyone's best interest that we provide the ageing services we ourselves aspire to receiving.





# 1

Council  
comments and  
recommendations

# Council comments and recommendations

## 1. Background

The aim of the first *HeSSOP* study (Garavan *et al.*, 2001) commissioned by the NCAOP, the Western Health Board (WHB) and the Eastern Regional Health Authority (ERHA) was to provide a broad-based assessment of health and social services from the perspective of older people living in the community in 2000. The value of this study was that it allowed the views of a large, representative constituency of older people to generate a picture of the situation of older community-dwelling Irish people and provided a basis for service planning.

Action 68 of the National Health Strategy, *Quality and Fairness: A Health System for You* (DoHC, 2001a), proposes that decisions across the health system should be based on best available evidence such as research findings, statistical qualitative and quantitative data, and other documented trends and behaviours. This requirement for evidenced-based planning for older people has been endorsed by the Council in a number of its recent publications (O'Shea and Conboy, 2005; NCAOP, 2005).

The Council therefore welcomes this follow-up to *HeSSOP I* because it provides health and social service planners and providers with the most up-to-date information on health status and service usage among a representative sample of older people in 2004. Furthermore, this research includes a longitudinal component that tracks health status and service use of a sub-sample of the original sample from *HeSSOP I* over a four-year period, and as such, it is the first of its kind to be conducted in an Irish context.

## 2. Challenging negative stereotypes

There is evidence in this report that the majority of community-dwelling older people are physically and mentally healthy and socially supported within their communities. This challenges negative stereotypes of older people and shows that most older people live independently. Recently, the Council has highlighted the

culture of ageism that pervades society manifested by a tendency to equate old age with dependency and burden. As a result, some older people's self-esteem may be diminished, their participation in society reduced and their access to quality services restricted to such an extent that their autonomy is compromised for want of them (NCAOP, 2005). **The Council recommends that the Government take a lead in the elimination of ageism from Irish society.** The establishment of The Equality Authority's programme of work relating to the age ground has been of enormous benefit in raising awareness of the existence of ageism, and of rights and responsibilities in this regard. **The Council further recommends ageing and the concerns of older people be included as a priority in Ireland's social partnership process and in future national partnership agreements.** The representation of older people in their own right in the partnership process would signal a commitment to prioritising their concerns at a national level. **Finally, the Council reiterates its recommendation that future national policy statements, strategic plans and service plans relating to the health and social care of older people should publicly acknowledge the importance of eradicating ageism in health and social services, and advocates that the DoHC and HSE should provide leadership and guidance in this regard.**

### 3. Vulnerable older people

Despite the positive profile of community-dwelling older people in this report, the Council notes that a significant minority of older people are vulnerable and in need of particular assistance to enable them to fulfil their stated preference to remain in their own homes. Approximately one in ten participants in this study were found to have significant functional and psychosocial health difficulties (e.g. depression, loneliness or lower levels of support). The Council is conscious of the need to focus resources to improve the status of those who are most vulnerable in particular.

The Council believes that the ability to identify such people and to target services to meet their needs is critical. This research indicates that the oldest old, older women, those living in a rural location, the never married and those living on a low income are most likely to avail of primary care services. These groups are most at risk of encountering functional and psychosocial difficulties.

**The Council has consistently recommended that a national framework for multi-disciplinary assessment of older people in acute and community care settings be developed.** The Council believes that a standardised, holistic assessment of health and social care needs and preferences is the lynchpin of

service planning and development for older people in Ireland. Without such an assessment, service planning and development can only be *ad hoc* and reactive rather than planned and proactive. An accurate assessment mechanism can tap into a variety of needs of older people and will enable a more effective targetting of resources.

#### 4. Expansion of community care services for older people

The Council welcomes the increasing focus on community care services for older people as a means of ensuring that they are enabled to fulfil their self-expressed preference of living at home for as long as possible. The Council notes that the level of take-up of services that facilitate remaining 'in place' was low in both *HeSSOP I* and *HeSSOP II*. In particular, the Council notes that the use of aids and appliances, and the take-up of respite services decreased over the four-year period between the studies. **The Council recommends that the Health Services Executive (HSE) explore the reasons for such low uptake of this as evidenced by the research. In addition, if community care services are to form a central pillar in the provision of care for older people, the Council recommends that the HSE conduct an audit of existing services to ascertain current levels of provision in order to facilitate the development of service provision indicators and benchmarks.**

#### 5. Inequity in service provision on the basis of residence

In *HeSSOP II*, health board comparisons (between ERHA and WHB<sup>1</sup>) for receipt of services may signify significant inequity in service provision. Where there were health board differences in use of services, those in the ERHA were almost always more likely to have received the service and/or to have received it more frequently. The National Health Strategy (DoHC, 2001a) acknowledged that there may be inconsistencies in eligibility for certain services between health board areas and stated that public patients should have access to the same range of publicly-funded services irrespective of where they live. It is not clear from the data presented in *HeSSOP II* whether the inequity in receipt of services was due to a lack of their availability or restrictive eligibility criteria. **The Council recommends that the reasons for this discrepancy in service use between former health board areas be investigated and addressed by the HSE. Furthermore, the Council recommends the urgent implementation of actions relating to the**

<sup>1</sup> *HeSSOP I* and *HeSSOP II* were both conducted before the restructuring of the health boards.

**promotion of fairer access to services for older people that are detailed in the National Health Strategy (DoHC, 2001a).**

## 6. Payment for services

Figures in *HeSSOP II* signal significant personal investment in health and social services by older people, i.e. direct payment for community services and indirect payment in anticipation of hospital service need (private health insurance). However, *HeSSOP II* also noted a significant number of older people living on 'low incomes'. This is in line with the most recent data on the subject of income poverty from the EU Survey on Income and Living Conditions (EU-SILC) (CSO, 2005), which found that over one third of older people are income poor.

However, little is known about the lived experiences and needs of older people who are in poverty. For example, current consistent poverty measurement tools do not accommodate expenditure on health and social care services, which, on the basis of *HeSSOP II* findings, is significant. **The Council recommends that research should be conducted on the subject of growing older in poverty. This research would address a significant knowledge gap and should inform social inclusion policy, such as the National Action Plan on Poverty and Social Inclusion, as well as tools used to measure poverty and deprivation.**

## 7. Waiting lists

Percentages on waiting lists for in-patient procedures have not reduced significantly from 2000 to 2004, which is surprising considering the establishment of the National Treatment Purchase Fund (NTPF). Moreover, the overall number of people waiting for hospital and related services had increased significantly from 2000 to 2004 despite promises made in this regard in the National Health Strategy (DoHC, 2001a). For example, according to *HeSSOP II*, an older person can wait for between 2 to 52 weeks for in-patient treatment and most people are waiting more than 9 months. **The Council recommends a review of the effectiveness of the NTPF from the perspective of older people, in addition to the review of implementation of actions included in the National Health Strategy (DoHC, 2001a) with regard to waiting times.**

## 8. A&E departments

*HeSSOP II* found that one in ten older people had attended an A&E department during the previous year. **While for some older people, this may be a necessity and in this regard the Council welcomes the Minister for Health and Children's recent action points for A&E, the Council again recommends more investment in the implementation of the Primary Care Strategy (DoHC, 2001b), which was designed to integrate primary care services more fully with the secondary care system.** This would promote the provision of appropriate and timely care, and result in fewer admissions of older people into A&E departments.

## 9. Longitudinal studies

The authors of the report conclude that the longitudinal component of the *HeSSOP II* study is particularly useful in shedding light on four-year health and psychosocial outcomes for older adults. However, the authors also note that the capacity to plan services for older people effectively is severely constrained by deficits in our national framework of information about that population. **In the light of the experience of the *HeSSOP II* study, the Council reaffirms its recommendation that a national cohort longitudinal study of older people should be undertaken to address the information deficit on older people's health and social care needs and preferences.** The Council has already indicated that it is willing to assist in the planning of such an initiative. Given the challenges involved in designing such a study in order to generate data of long-term value, the Council recommends a period of careful planning and preparation before such an initiative is launched. The planning process should draw together a wide range of actors with expertise and commitment in relation to ageing and older people in Ireland. It should also enable consultation with older people and their advocates, and avail of the breadth of international experience in the conduct of longitudinal studies.

**The Council recommends that the formulation of aims and objectives for a national longitudinal study of older people should be the outcome of a broadly-based, open and participatory exchange between all those who share an interest in translating the idea into reality.** In the broadest terms, the Council's own aspiration for such a longitudinal study is that it should – through the direct participation of older people, the inclusion of their voices and perspectives and holistic consideration of all aspects of ageing – assist the creation of an age friendly society in Ireland.

## 10. An age friendly health and social framework

**Finally, the Council again recommends the development of a new framework for the provision of high quality, person-centred, integrated and age friendly health and social care services for older people (NCAOP, 2005). In addition, the Council has made a number of recommendations for the development of a legislative framework governing the provision of health and social services to ensure that the requisite funding is available for the successful implementation of policy.** This would ensure that independence would not be compromised by inequality of opportunity or by differential conditions of access based on age.

### References

Central Statistics Office, 2005. *EU Survey on Income and Living Conditions (EU-SILC)*. Dublin: Stationery Office

Department of Health and Children, 2001a. *Quality and Fairness: A Health System for You*. Dublin: Stationery Office.

Department of Health and Children, 2001b. *Primary Care: A New Direction*. Dublin: Stationery Office.

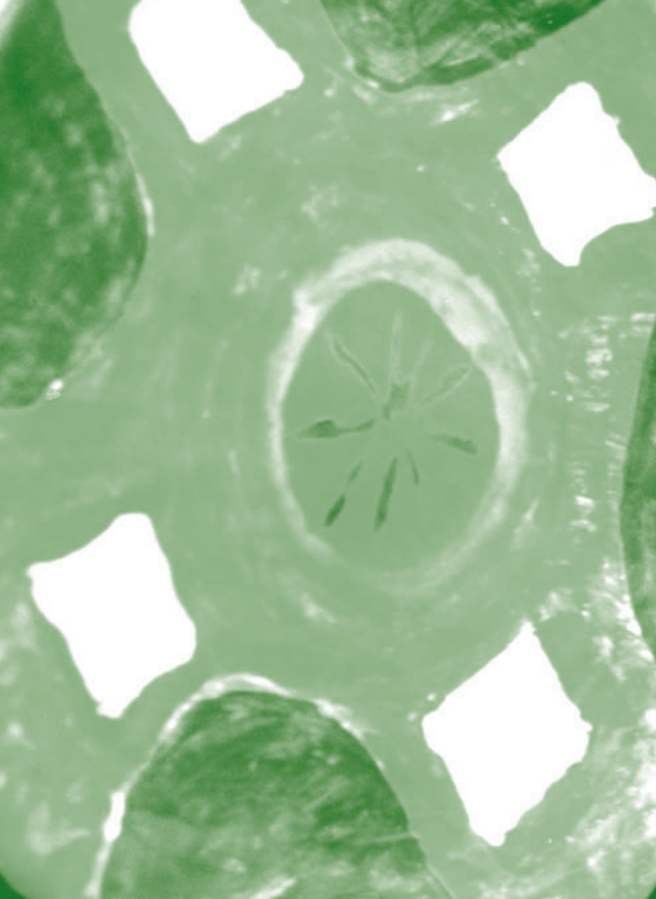
Garavan, R, Winder, R., and McGee, H., 2001. *Health and Social Services for Older People in Ireland (HeSSOP)*. Dublin: NCAOP.

O'Shea, E. and Conboy, P., 2005. *Planning for an Ageing Population: Strategic Considerations*. Dublin: NCAOP.

National Council on Ageing and Older People, 2005. *An Age Friendly Society: A Position Statement*. Dublin: NCAOP.







# 1

## Chapter 1

Consulting older people about health and healthcare quality



# Chapter 1

## Consulting older people about health and healthcare quality

### 1.1 Introduction: Improving consultation with older people

The ageing of populations is assuming increasing importance in healthcare planning and delivery. It provides important challenges for governments to develop strategies aimed at decreasing ill health and disability and maximising quality of life and good health. Research on quality of care is also important because health professionals need to know whether patients are receiving the most clinically effective treatment for their particular needs. Such insights are especially important given growing knowledge about the nature and treatment of different health challenges, and new insights about the positive potential of later years (Coleman *et al.*, 1993; Kirkwood, 1999; Rowe and Khan, 1997). Research on quality of care is also necessary given evidence that adults in later life do not always receive the high quality of care they have the right to expect. For instance, many older adults can be denied adequate care because of practical barriers such as cost and transport, or psychological barriers such as the ageist attitudes of health professionals (e.g. Treharne, 1990). Determining quality of care may be a crucial first step in changing poor practices within the healthcare system and facilitating better health and autonomy for current and future generations of older adults.

Information on quality of care is vital for health professionals who have a responsibility to the public to ensure quality and accountability in the use of public finances. For instance, healthcare systems tend to focus on dealing with more acute health conditions and episodes (Institute of Medicine, 1999); however this model does not adequately serve increasing numbers of older adults who are more likely to have chronic health problems such as heart disease, diabetes and asthma. Healthcare professionals also need information on quality of care to assist in policy development, the development and prioritisation of interventions and programmes, and the provision and management of health services.

Defining quality care is not easy. According to Kizer (2001), high quality healthcare can be understood in terms of care that is 'known to be effective; to produce better health outcomes, greater patient functionality, and improved patient safety; and that is easy to access resulting in a satisfying experience for all concerned'. Health professionals, unsurprisingly, tend to define healthcare in terms of the attributes and qualities provided by clinicians and received by patients. In these instances, the technical aspects of the care are highlighted, along with the characteristics and interactions between clinicians and patients (Blumenthal, 2003; Donabedian, 1988). Growing recognition, however, has been given to the value and importance of the perspective, preferences and values of patients (or more generally of healthcare users), with the views of healthcare users seen as being important indicators of quality of care (Kane, Maciejewski and Finch, 1997; Nguyen Thi *et al.*, 2002). The views and preferences of healthcare users are also seen as being important given a growing interest among patients about clinical outcomes and financial accountability (Cleary and Edgman-Levitan, 1997; Sprance *et al.*, 2000). Similarly, older people and their advocates often actively read, use and demand information in the context of a range of roles, including as patients, research participants and purchasers of healthcare (Kizer, 2001; Davison and Philip, 2003).

Despite the importance of consumer consultation in healthcare, few studies have sought to explore quality of care from the perspective of the patient. The Health and Social Services for Older People (*HeSSOP*) study (Garavan *et al.*, 2001) sought to provide views on services from representative samples of older Irish people from urban and rural settings.

## 1.2 Background to *Health and Social Services for Older People (HeSSOP)* study

### 1.2.1 *HeSSOP I*

The *HeSSOP* study represented a systematic evaluation of health and social service provision for older people from the perspective of community-dwelling older people needing and/or using these services. It was the first large, community-based, cross-sectional study of older people in Ireland.<sup>2</sup> The main objectives were to document experiences with a wide range of health and social services recently received or required; to assess preferences for long-term care; to compare findings across two health board areas; to develop recommendations for service provision based on

<sup>2</sup> Resources did not permit a full random sample of the Republic of Ireland at the time. Comparison of the ERHA and WHB regions allowed for comparison of a predominantly urban and a predominantly rural region.

these findings; to identify areas for further research; and to identify methods for involving consumers of health services more in policy and service development.

### 1.2.2 The Healthy Ageing Research Programme (HARP)

HARP is a five-year, cross-institutional research programme funded by the Health Research Board (HRB) from 2003. The aim of HARP is to outline how health and social services enable or impede successful ageing and the maintenance of quality of life for older people. This information is important if health professionals and others are to provide good quality healthcare for older people.

In the *HeSSOP 2000* study (hereafter referred to as *HeSSOP I*), community-based adults aged 65 years and over were identified from the electoral register and interviewed in their own homes (n = 937). The 2004 *HeSSOP* study (*HeSSOP II*) was coordinated as part of HARP which aimed to provide continuity in knowledge of health and social service usage for older people in Ireland. The research programme undertook to do this in three ways: to repeat *HeSSOP I* in a new cohort of participants of similar age in the same regions (n = 1,000) four years after *HeSSOP I* (repeat sample); to conduct a four-year follow-up of participants from *HeSSOP I* (longitudinal sample); and to compare this group of 1,000 interviewed in 2004 with a similarly selected group in Northern Ireland. This latter project, which will be reported separately, provides an opportunity to learn by comparing the health and social status and service experiences of two groups of older people on one island with two differing health and social services.

*HeSSOP II* allows insights into the healthcare system for a defined group of older people in Ireland. The study sample is selected to be equivalent to that of *HeSSOP I* and so provides a 'repeat sample'. As well as creating a profile of morbidity, informal and formal health and social service use, and perceptions of service quality in older adults in 2004, the repeat study also enables comparisons to be made between two time points (2000 and 2004).

*HeSSOP II* also includes a longitudinal study whereby a sample of *HeSSOP I* participants is interviewed again four years later. This longitudinal study provides information on progression of morbidity, changes in informal and formal health and social service use, and perceptions of service quality.

These two studies are part of the larger HARP, which was developed to examine psychological and social concepts of ageing and to consider the interaction of ageing with the concepts of quality of life and quality of healthcare. These concepts are

being examined in older community-dwelling populations and in older patient populations. The profiles of community-dwelling older people in the Republic and Northern Ireland, and of patients in both regions suffering acute life-threatening illness (stroke) and chronic serious illness (heart failure), will be combined over this five-year research programme to advance understanding of quality of life and quality of health and social services for older people generally. The concepts of this research programme have been developed and included in a refined interview protocol. Thus, interviews in 2004 constitute a combination of the most useful information items originally obtained in 2000 for *HeSSOP I* and the additional materials developed for HARP. New and repeat variables are identified in the methodology section (Chapter 2). The insights gained from a repeat and a longitudinal study are important given the ongoing reform in the Irish healthcare system. Changes since *HeSSOP I* was conducted include the provision of medical cards (i.e. free point of delivery health services for primary and secondary services) to all those aged seventy years and over. The information collected in 2004 is also reflective of the period before significant structural reform of the health services. Specifically, the Health Service Reform Programme includes the abolition of existing health board structures; the consolidation and amalgamation of existing health service agencies; establishment of a Health Service Executive (HSE) to manage and deliver the health service as a single national entity; devolution of responsibility for budgets to service providers; and establishment of a Health Information and Quality Authority (HIQA) to promote high quality and effective healthcare. It was a very good time to consider the evidence base on the current status of services for older people in 2004 and priorities for change.

### 1.2.3 Aims and objectives

The aims of *HeSSOP II* were:

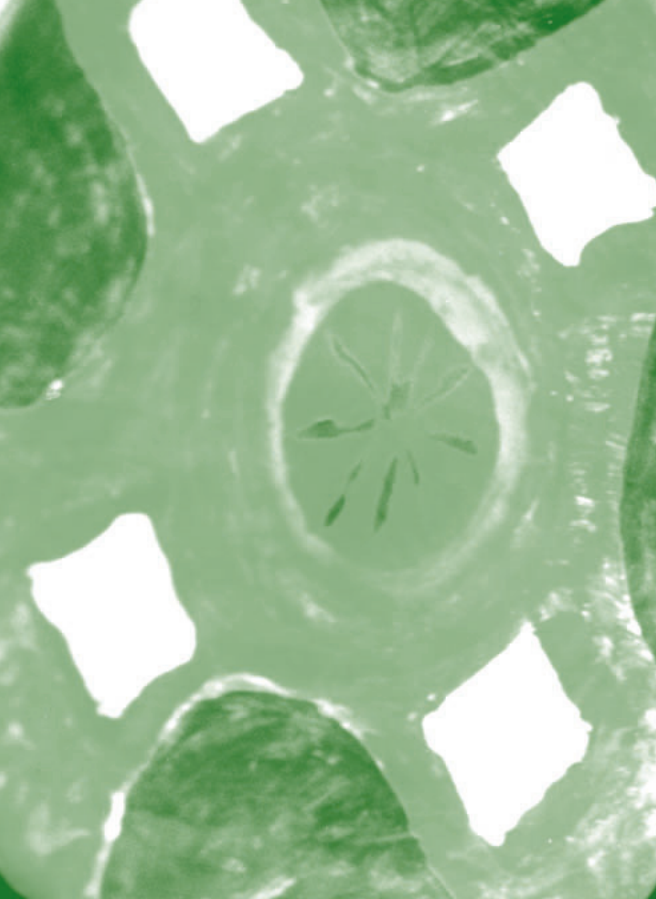
- to evaluate health and social service provision in Ireland from the perspective of community-dwelling older people using these services by repeating a previous study (*HeSSOP I*) with an equivalent sample of community-dwelling older adults (65 years and over)
- to provide longitudinal data on community-dwelling older adults (65 years and over) ( $n = 937$ ) first interviewed in *HeSSOP I*, to document continuity and change in this group over time.

Specific study objectives were:

- to compare information across two health boards (separately representing predominately urban and rural experiences) to identify common and specific areas of achievement and concern

- to compare information on representative groups of older Irish people across two time points or waves (years 2000 and 2004)
- to provide longitudinal information on *HeSSOP I* participants and compare their status with four years previously
- to document experiences with a broad range of health and social services recently received or required by community-based groups of older individuals in two health boards
- to document uses of domiciliary services (e.g. public health nursing), uses of social services (e.g. Home Helps/meals-on-wheels), and providers of informal care of older people at home
- to assess preferences relating to key care issues (home v. institutional care, home services by care professionals and other concerns for future health needs)
- to establish recommendations for service improvements based on the above
- to provide recommendations for future research based on the above, in particular concerning longitudinal follow-up of cohorts of older Irish people.

This report focuses particularly on the east-west health board comparison. Research findings outline the profile of older people by board – their health status, health service use and health service need by board. Controlling for observed population differences in the two boards (e.g. age), analyses then determine if service use differs across the boards and in what directions. This can provide a useful profile of both service uptake and variation and highlight priorities for service planning for either or both regions.



# 2

Chapter 2

Methodology



# Chapter 2

## Methodology

### 2.1 Design

This project involves a cross-sectional, repeat study with a cohort similar to that involved in the 2000 study and a longitudinal study of *HeSSOP I* participants four years apart, in 2000 and 2004. The longitudinal study followed 937 adults, aged 65 years and over, first interviewed four years previously, in 2000, as part of *HeSSOP I*. The repeat study was conducted in order to compare experiences in health and social services of two nationally representative samples of older adults in Ireland at two points in time.

In *HeSSOP I*, a comprehensive consultation process had taken place to decide on the focus and nature of the survey questions. Consultation processes took place again in *HeSSOP II* to decide on survey questions. Many of the measures included in the present study replicated those that had been utilised in *HeSSOP I* in order to facilitate comparison of responses for the two time points. The survey, therefore, included questions about health status, health promoting behaviours, cognitive functioning, psychological well-being and experiences in accessing health and social services. Additional measures administered in *HeSSOP II* (these are part of the larger HARP and will be reported separately) include scales measuring perceptions about ageing, strategies of adaptation and coping, and quality of care indicators based on the Institute of Medicine framework (Institute of Medicine, 2001). Data collection for the *HeSSOP II* survey was completed over a four-month period (May-August 2004).

### 2.2 Sample

#### 2.2.1 Repeat study

Participants for this study were recruited in order to reconstruct a representative sample of the relevant health boards in Ireland. This representative sample would also enable comparisons of experiences of health and social services among a representative group of adults aged 65 years and over at two time points, 2000 and 2004. To recruit participants, names were randomly selected from the electoral register. As with the *HeSSOP I* sample, participants had to be aged 65 years or older



and living in a private household. Where the individual selected to take part in the survey was unable to do so (due to serious illness or cognitive impairment, for example), a primary carer or next of kin living in the same household was invited to participate as a 'proxy' participant. This reconstitution of the group is especially important in order to make a group of 1,000 equivalent to a general older population.

### 2.2.2 Longitudinal study

Participants already interviewed in *HeSSOP I* in 2000 were re-contacted so that they could participate in *HeSSOP II*, a four-year longitudinal study. These participants were from two areas or health boards, the Western Health Board (WHB) and the Eastern Regional Health Authority (ERHA); these two areas represent the most densely populated (ERHA) and one of the most sparsely populated boards (WHB). Together, they represent approximately one third of the population in the Republic of Ireland, with a demographic profile similar to that of the nation as a whole. Where participants were interested in the study but not available for the longitudinal research (e.g. where they were in poor health), a primary carer or next of kin living in the same household was invited to participate as a 'proxy' participant. While there are weaknesses with proxy responding, it was very important to have some representations of service use and needs of those unable to respond, potentially those most needing health and social services in the community. This is because complete exclusion of those unable to participate themselves would under-represent the level of health problems, service need and service provision in the general population. In the previous study (*HeSSOP I*), this method proved very acceptable.

## 2.3 Procedure

### 2.3.1 Consultation process

The consultation process in *HeSSOP I* was based on a comprehensive strategy to determine the most focused themes and questions about health and social services for the survey administered. This consultation process involved key health and social services providers including geriatricians, GPs, directors of nursing and nursing services, long-stay hospital nursing staff, carers' association members, Home Help Managers and health professionals such as occupational therapists, physiotherapists and social workers. The final survey included questions on finances, housing, general health and independence, health behaviours and health promotion activities, social support and utilisation of services, including factors that influence service access and perceptions of acceptability. Questions were also asked regarding older adults' preferences for long-term care.

Given the comprehensive consultation process for *HeSSOP I*, it was expected that many of the survey questions would be replicated in *HeSSOP II*; this would also facilitate comparisons between the two time points (2000 and 2004). However, to determine if the above questions remained valid for *HeSSOP II*, and to consider possible new themes or constructs that should be measured, consultation was also carried out for *HeSSOP II*. This consultation process involved focus groups with older adults.

### 2.3.1.1 Focus groups with older people

Five focus groups were conducted with older adults, in part to ask about experiences in accessing health and social services and the factors that can help or hinder the experience of ageing. Each group was composed of 8-14 participants aged 65 years and over (n = 41). Focus group participants were contacted through community service managers and other key service providers (e.g. day centre managers) working in Dublin and the ERHA area. Participants represented adults across the health continuum, from adults who were relatively independent with little experience of health and social services to those needing high levels of support and care from social services. Participants in these groups also represented those living in urban and rural locations and different socio-economic groups. Locations for the groups were neutral, i.e. not health board venues. The focus groups were conducted by two experienced researchers and lasted approximately two hours. All participants were asked to give their consent prior to the start and to have the groups audio taped. The aim of these focus groups was to gain insight into the experiences, preferences and attitudes of older people. The main topics investigated were positive functioning and development in later life. Participants were given an honorarium in appreciation for their involvement in the focus groups and to cover travel expenses. Based on data from these interviews, along with consultations and advice from HARP Steering Group members, the final survey was agreed.

## 2.4 Survey

### 2.4.1 Preparatory work

A pilot of the survey was conducted to test the revised questionnaire and to identify how many of the original sample could be re-recruited for the longitudinal study. Of the total of 937 respondents who completed *HeSSOP I*, a random sample of 100 were re-contacted; of these, 41 agreed to participate and 17 declined involvement. The remaining sample were either ill, had moved, had died or could not be traced. Of the 41 older people who agreed to be followed up longitudinally, 30 completed interviews. The remaining participants generally either declined involvement at a later stage or were never available (i.e. 'soft refusals').

The pilot study yielded interesting findings, yet the questionnaire required considerable editing to reduce it to a questionnaire that would work optimally in a large-scale survey, i.e. allowing the maximum amount of quality information to be collected. The final aim was to have a survey of 40-45 minutes duration so as not to tire participants.

## 2.4.2 Selection and interview process

The ESRI's Survey Unit conducted *HeSSOP II* interviews using a procedure similar to that of *HeSSOP I*. For the repeat study, which involved a new sample, names and addresses were randomly drawn from the Register of Electors for the health board counties. Interviewers called on the identified household and if a person aged 65 years or older lived there, he or she was asked to take part in a study on health and social services for older people. Where more than one person aged 65 years or over lived in the household, the person whose birthday was nearer to the interview date was asked to take part. Participants were not offered an honorarium for participation.

## 2.4.3 Longitudinal study

Interviewers sought to follow up as many of the original *HeSSOP I* participants as possible. First, all participants were phoned using the contact numbers that had been recorded for *HeSSOP I*. Sixty per cent were contactable through this means. Individuals who were not contactable by phone were assigned to an interviewer and an effort was made by the interviewer to visit their houses and fill out a contact sheet. Finally, a letter and a four-page questionnaire were sent to the participant's last known address. At the end of this interview process, there were 64 participants for whom it was not possible to gain longitudinal information. Of these, 53 were in the WHB. Isolated addresses made it more difficult to achieve re-contact as, for example, there were fewer neighbours for interviewers to approach to check if the participant still lived at the same address.

Of the original sample of 937, vital status was ascertained for 93 per cent of participants (see Table 2.1).<sup>3</sup> Over a third (34 per cent) of the original group had their status confirmed but were unavailable for interview; 18 per cent were deceased, 2 per cent had moved to institutional care, 8 per cent had moved or were unknown at the address, and 6 per cent were too ill to participate. Two thirds (66 per cent, n = 574) of participants had their status confirmed and were available for interview. Of these participants, 19 per cent refused participation, and 10 per cent

<sup>3</sup> Please note that digits in all tables have been rounded to the nearest per cent.

agreed but were never available for interview or the timing was never suitable. Of those potentially available for interview, 71 per cent (n = 408) were interviewed. This was the response rate for the longitudinal study. Fourteen per cent opted to complete a shortened questionnaire only with 2 per cent of other interviews not completed. For the purpose of this report, complete data for 314 participants is presented. A flow-chart depicting the outcomes of recruitment for the longitudinal sample is presented in Figure A, Appendix 1.

**Table 2.1: HeSSOP I longitudinal sample – response rates: Outcomes of household survey invitation attempts**

	<b>Total</b>	
	<b>%</b>	<b>(n)</b>
<b>HeSSOP I participants</b>	<b>100</b>	<b>(937)</b>
Status known	93	(873)
Status unknown	7	(64)
<b>Status unknown</b>	<b>100</b>	<b>(64)</b>
Not contactable	75	(48)
Other	25	(16)
Status known	100	(873)
<i>Unavailable for interview</i>	34	(299)
Deceased	18	(160)
Moved to institutional care	2	(13)
Moved address	4	(34)
Unknown at address	4	(35)
Too ill to participate	6	(57)
<i>Available for interview</i>	66	(574)
<b>Available for interview</b>	<b>100</b>	<b>(574)</b>
<b>Non-respondents</b>	<b>29</b>	<b>(166)</b>
Refused	10	(108)
No suitable time for interview	10	(58)
<b>Respondents</b>	<b>71</b>	<b>(408)</b>
Willing to do 4-page questionnaire	14	(83)
Interviewed – incomplete	2	(11)
Interviewed – complete	55	(314)
<b>Overall response rate</b>	<b>71</b>	<b>(408/574)</b>
<b>Detailed interview completion rate</b>	<b>55</b>	<b>(314/574)</b>

Note: Information on recruitment for each health board can be seen in Table A1 in Appendix 3.

#### 2.4.4 Repeat study

For the new sample, which was recruited in order to repeat or replicate the *HeSSOP I* study, 4,217 potential addresses were contacted (Table 2.2). Of these, 2,933 homes (69 per cent) were ineligible for interview. The primary reason for ineligibility was not having a household resident aged 65 years or over; in 66 per cent of houses ( $n = 2,774$ ) there was no-one aged 65 years or over. Of the 1,284 eligible households, there were 504 non-respondents. Of these, 93 per cent ( $n = 471$ ) either refused directly or were permanently unavailable for interview, i.e. interviewers could not make contact despite multiple return visits, and 7 per cent ( $n = 33$ ) declined for other reasons. Interviews were conducted with 780 participants. Of these, 739 were complete interviews and so were used for analysis. 732 were completed in person and seven people were interviewed as proxy respondents. The response rate for this sample was 61 per cent (based on number willing to participate of the number of potentially interviewable older people). The completed interview rate was 58 per cent (based on number who completed interviews so that they were usable for analysis). A flow-chart depicting the outcomes for recruiting the sample for this repeat study can be seen in Figure A2, Appendix 2.

**Table 2.2: Outcome of recruitment attempts for repeat sample in 2004**

	<b>Total (N)</b>
<b>New sample recruitment</b>	
<b>TOTAL TARGET SAMPLE</b>	<b>4783</b>
<b>Non contacts</b>	<b>566</b>
Household vacated	161
Could not locate address/no contact despite repeated call-backs	405
<b>Total contact addresses</b>	<b>4217</b>
<b>Not eligible for participation</b>	<b>2933</b>
No one in household aged 65+	2774
Complete refusal: Household composition unknown	22
'Household' was institution (i.e. not private residence)	56
Other	47
Over 65 but too ill/cognitively impaired and no proxy available	34
<b>Eligible households</b>	<b>1284</b>
<i>Non-respondents</i>	<b>504</b>
Refused to participate/permanently unavailable	471
Other reason for non-participation	33
<i>Respondents</i>	<b>780</b>
Interviews incomplete: Insufficient data for inclusion in analysis	41
Total interviews completed and usable for analysis	739
Completed in person	732
Completed on a proxy basis	7
<b>Response rate</b>	<b>61%</b>
	(780/1284)
<b>Completed interview rate</b>	<b>58%</b>
	(739/1284)

Note: Information on recruitment for each health board can be seen in Table A2 in Appendix 3.

Combining response rates for the repeat study and the longitudinal study, the mean response rate in the Republic of Ireland in *HeSSOP II* was 64 per cent  $[(780 + 408) / (1284 + 574)]$ . The rate for interview completion was 57 per cent  $[(739 + 314) / (1284 + 574)]$ . This is comparable to response rates reported in general population surveys in the Republic of Ireland where similar methodologies have been employed;

Kelleher *et al.* 2003, for example, reported a response rate of 62 per cent.

Regarding the longitudinal sample, although a higher response rate would have been desirable, it is important to underline that the data which was collected as part of the follow-up sample for *HeSSOP II* is a highly reliable and representative data source on the Irish population aged 65 years and over. The main aim of the study was to have a representative cross section of this population that could be compared to the *HeSSOP I* population. The sole issue is breadth of research that can be carried out using the longitudinal element from the Republic of Ireland. Here, response rates were lower than expected in terms of achieved interviews, but three points should be noted:

1. The sample of 325 who completed a survey interview (either fully or partially) is just a subset of the useful data available from the survey. A vital result was that it was also confirmed that 160 respondents had died, 57 were too ill to participate and a further 13 had moved into a care institution (and thus were not now in scope). When combined with the 83 respondents who completed a shortened interview (4-page questionnaire), this means that of the 873 respondents whose status was known at follow-up, information was known about 638 or 73 per cent.
2. Tests showed that the valid interviews that were carried out were largely representative of the baseline population with no major systematic bias in response. In this situation, the quality of the data is not an issue but rather the overall number of interviews carried out as this limits the cell size for particular analyses.
3. It should be stressed that the follow-up survey was the first of its kind in the Republic of Ireland and involved methodological problems that were known but not quantifiable beforehand, particularly the issue of tracing respondents in rural areas. Methodologically, this study is innovative enough to warrant a publication in its own right. An unexpected problem has been exposed that will affect future research projects and a methodology to deal with it has been developed which gives the study an unforeseen but very useful additional outcome.

The availability of specialised sample generation software within the ESRI meant that a representative population sample could be built using supplementary recruitment and thus a representative cross-sectional sample was available for the bulk of analyses in the project.

## 2.5 Measures

The final interview schedule was a questionnaire consisting of 421 items (not all participants completed all items and not all items are reported). As with *HeSSOP I*, questions were developed where possible from previously used and standardised tools to aid comparison with data from other studies. Many questions, however, were specifically developed for use in the *HeSSOP* studies. Questions broadly focused on:

- current health status and health and social service experiences over the past year
- satisfaction with current health and social services

### 2.5.1 Demographic characteristics

Specific variables included in this category were age, gender, household composition (living alone, spouse only, number of generations etc.), and geographic location (city, town, village). Questions were also asked relating to household income, final health coverage for care (State-covered medical care, private insurance) and payment for these services. For household income, participants were asked for the amount of net income in Euro per week. Participants were also asked about the highest level of formal education completed and their main pre-retirement occupation.

### 2.5.2 General health status and functional capacity

Functional ability was measured using the Stanford Health Assessment Questionnaire Disability Index (HAQ-DI) (Fries, Spitz and Young, 1982). The HAQ-DI is used to measure levels of physical ability in the general population, in terms of the activities that are performed on a daily basis. Participants are asked to rate on a four-point scale ('without any difficulty', 'with some difficulty', 'with much difficulty' or 'unable to do') their ability to perform seventeen daily tasks within eight activity categories in the past week. For each category of two to five activities, participants are also asked, 'Do you usually need help from another person in carrying out any of these tasks?'. An overall measure of independence (ranging from 0-3) can be calculated from the eight categories, yielding four levels of ability relating to maintaining independence in activities of daily living (ADL). These scores have been interpreted as follows: 0-0.5 – the person is completely self-sufficient; 0.51-1.25 – the person is reasonably self-sufficient and experiences some minor and even major difficulties in performing ADL; 1.26-2.0 – the person is still self-sufficient but has



many major difficulties in performing ADL; 2.1-3.0 – the person may be called 'severely handicapped' (Siegert *et al.*, 1984).

The HAQ-DI scores for *HeSSOP* have been interpreted in this manner. While the HAQ-DI has been widely used in community settings, its primary purpose was for use in the hospital setting amongst rheumatoid arthritis patients. For the purposes of this study, therefore, some amendments were made to the tool to include activities that older people in particular may have difficulty with in their usual (home) surroundings. Additions were made to the questionnaire to incorporate eight items, such as those requiring fine finger movement and sensation, and physical flexibility (e.g. 'taking care of feet and toenails' or 'making a cup of tea'). An extra category was added to address difficulties with concentration, memory and reasoning skills (e.g. 'managing your own affairs' or 'remembering daily plans'). Participants self-reported their abilities, taking into account the use of a device or an aid if one was usually used. Thus, the measure provided a guide to those activities which required extra help to overcome barriers to independence, as well as providing a measure of physical ability itself.

A co-morbidity index (CMI) was also used and calculated by coding self-reported medical problems/illness in accordance with different organs or systems. Organs or systems were those which have been utilised in the modified cumulative illness rating scale (CIRS). In the modified CIRS, the organs or systems being assessed are: cardiac; vascular; hematological; respiratory; otorhinolaryngological/ ophthalmological (EENT); upper gastrointestinal; lower gastrointestinal; hepatic and pancreatic; renal; genitourinary; musculoskeletal/tegumental; neurological; endocrine/metabolic/breast; and psychiatric/behavioural. This modified CIRS is typically used to calculate two scores: a CMI index, representing the number of medical problems identified by the respondent, and a multi-morbidity index, reflecting a quantitative assessment of illness burden. Higher CMI scores indicate greater medical complexity. This method of calculating a CMI index is consistent with previous studies that have used the number of self-reported diseases as an index of health status. As responses in this study were based on free recall and not on the CIRS *per se*, it was not feasible to utilise all of the aforementioned categories individually. Participant responses were often generic; for example, they did not specify whether the upper or lower gastrointestinal system was affected by illness. Thus cardiac, vascular, and hematological categories were merged to represent all cardiovascular factors while upper gastrointestinal and lower gastrointestinal categories were merged to represent all gastrointestinal factors. A separate category was also created for oncological disorders because in many cases participants did not indicate which system was primarily affected by the cancer.

The final set of categories into which responses were coded were: cardiovascular; respiratory; EENT; gastrointestinal; hepatic; renal; genitourinary; musculoskeletal; neurological; endocrine/metabolic/breast; psychiatric/behavioural; and oncological.

### 2.5.3 Psychological well-being

The seven-item depression scale from the Hospital Anxiety and Depression Scale (HADS) (Zigmond and Snaith, 1983) was used to assess depression. A Likert scale ranging from 1 to 5 is used to indicate the extent to which each statement is applicable to how participants had been feeling over the past week. Items 4 and 5 on the scale are reverse scored. The HADS is a widely used self-report instrument (Birks *et al.*, 2004) which has been found to perform well in assessing severity and frequency of anxiety disorders and depression in both somatic and psychiatric cases, not only in hospital practice for which it was first designed but also in primary care patients and the general population (Bjelland *et al.*, 2002). For the depression scale, scores can range from 0 (no symptoms) to 21 (maximum distress); possible clinical cases are reflected in the case of individuals scoring between 8 and 10 points, and probable clinical cases in the case of individuals scoring more than 10 points.

### 2.5.4 Health behaviours and health promotion activities

Exercise and smoking were selected as important health promotion targets for older people. Weekly levels of activity, smoking status and barriers to more healthy behaviours were investigated. Where applicable, the role of health professionals in encouraging smoking cessation and stage of readiness to give up smoking were assessed using concepts from the transtheoretical model. The concepts or stages outlined in this model are precontemplation, contemplation, preparation, action and maintenance (Prochaska and DiClemente, 1983). These items were adaptations of items administered in *HeSSOP I*.

With regard to possible preventive and screening strategies recommended for use with older individuals, frequency of blood pressure measurement and utilisation of general health checkups were investigated. The frequency with which participants had their blood pressure and cholesterol checked was assessed. Specifically, they were asked to indicate when they had last had these checked by their GP on a six-point scale ranging from 'less than three months ago' to 'never'. The variables were taken from *HeSSOP I*.

Participants were asked about levels of uptake of the influenza vaccination ('flu injection'). In the case of a negative response, participants were asked to give their reasons for not receiving it. Response options were preset and were created from the results obtained in *HeSSOP I*.

### 2.5.5 Social contact and support

Social issues assessed included perceived emotional support and level of interest in availing of visiting services/group membership.

Participants were asked about the extent to which they were able to attend social engagements, with respect to their functional capacity to attend them. These items asked whether participants had been able to attend events outside their own home and visit friends or family in their own homes over the last month. Responses were rated on a four-point scale ranging from 1 (without difficulty) to 4 (unable to do).

Loneliness was assessed by asking participants how often they had been bothered by loneliness in the last 12 months. Responses were rated on a five-point Likert scale ranging from 'very often' to 'never'. Fear of loneliness has been shown to be a frequently reported concern in older adults (Beyene *et al.*, 2002). Furthermore, loneliness has been linked to physical and mental health problems (Ye, Loh and Ye, 2004) thus rendering it an important factor for investigation.

The extent to which individuals perceived themselves as being in receipt of social support was assessed using two measures that had also been used in *HeSSOP I*. The first measure was concerned with functional support and asked participants to indicate if they received support necessary for them to maintain their independence from any of five different sources: spouse/partner; other relative in household; other relative living elsewhere; neighbour; or voluntary organisation. If participants indicated that they did receive functional support from any of these sources, they were then asked to specify how often they received it. Responses for this latter question were scored on a five-point scale ranging from 'continuously including night' to 'once weekly or less'.

The second measure of social support was a three-item scale that had been developed for *HeSSOP I*. This scale was concerned with receipt of social provisions, specifically emotional support, informational support and practical support. Responses were rated on a five-point scale ranging from 'none of the time' to 'all of the time'. Scores for items on this scale were combined to give a global level of perceived social support.

### 2.5.6 Use of services

Service use, access and satisfaction were assessed across a wide spectrum of available services and professionals: GP and locum GP, A&E, hospital in-patient and out-patient experiences, day care/day hospital, day centre/club, respite care, public health nurse, care attendant, home help, social work, meals-on-wheels, chiropody, occupational therapy, speech therapy, physiotherapy, and dietary, optical, dental, audiological, psychological and rehabilitation services. Participants were asked whether they had received or availed of the service in the past year, if they had received the service whether they had paid for it and what factors prevented them from receiving the services (more often). Response options were 'never heard of', 'no availability', 'transport', 'cost', 'lack of time', 'on waiting list', 'too much hassle', 'not helpful', and 'other' (to be specified accordingly). These questions were adaptations of items used in *HeSSOP I*.

The findings of *HeSSOP I* revealed that embarrassment (or stigma) associated with a variety of services also posed a barrier to care. Thus, the same services (e.g. meals-on-wheels, continence aids, chiropody services) were assessed in *HeSSOP II*. Other barriers to service use such as cost, lack of information and the role of transport in service access were also examined. To further examine the role of transport in older people's lives, participants were also asked to identify which types of transport they had used in the last six months.

### 2.5.7 Preferences for long-term care

Views on preferences for long-term or high-intensity care, if required, were investigated. Participants were asked whether their preferences for long-term care had ever been discussed with family members or someone else they trusted. Participants were also asked if they felt that their wishes in relation to long-term care would be honoured.

Preferences for various care options relating to living arrangements were assessed by asking participants to rate their acceptability. Examples of care options given are 'living in your current home with medical or health board staff to come in and provide services' and 'moving permanently to the home of a child or other family member with your family to care for your needs'. Response options ranged from 'very acceptable' to 'not acceptable'. Items were taken from *HeSSOP I*.

## 2.6 Proxy questionnaire

Participants who were interested in participating in the study but were unable to take part themselves, for example, due to health problems, were asked if another person could complete the interview on their behalf. Similarly, where an older person lived at the address but could not themselves consent to participation (because of cognitive impairment or serious illness), proxy participants were invited. The proxy questionnaire consisted of practical and factual type questions only. Preference or attitudinal type questions (e.g. HADS, which measured psychological well-being) were not asked since responses would not necessarily represent views of the older person. The number of proxy interviews carried out in *HeSSOP II* was small ( $n = 13$ ).

## 2.7 Data analyses/statistical methodology

As is standard with population survey data, the information collected from the questionnaire was statistically adjusted or 're-weighted' prior to analysis. This re-weighting adjusts the results to compensate for the over-representation or under-representation of particular population subgroups in the sample. Statistically adjusting data prior to analysis is standard practice in surveys and addresses any potential bias which may arise from issues related to sample design and also to differential non-response within subgroups of the population. The re-weighting procedure used was based on a minimum information loss algorithm which adjusts an initial weight so as to ensure that the distributional characteristics of the sample match those of the population according to a set of externally determined controls. These are based on independent national sources such as the Census 2002 and the Quarterly National Household Survey (QNHS), both undertaken by the Central Statistics Office (CSO). The variables used in the statistical adjustment or re-weighting procedure were gender, age cohort, and health board. The satisfactory response rate and subsequent re-weighting meant that results could be considered as broadly representative of the general population in the ERHA and the WHB.

Census data from 2002 was used to weight the data for the *HeSSOP* studies. The two *HeSSOP* studies were carried out in 2000 and 2004 and, while it was clear that *HeSSOP II* would be weighted to the census data of 2002, this decision was not so clear cut for *HeSSOP I*. *HeSSOP I* fell between the census data of 1996 and 2002 (census data was due to be collected in 2001 but was postponed due to an outbreak of foot and mouth disease). The decision was taken to weight *HeSSOP I* data to the census of 2002 not only because this was the closest census to the study (two

years from the data collection time), but also as it would represent an even marker between the two *HeSSOP* studies.

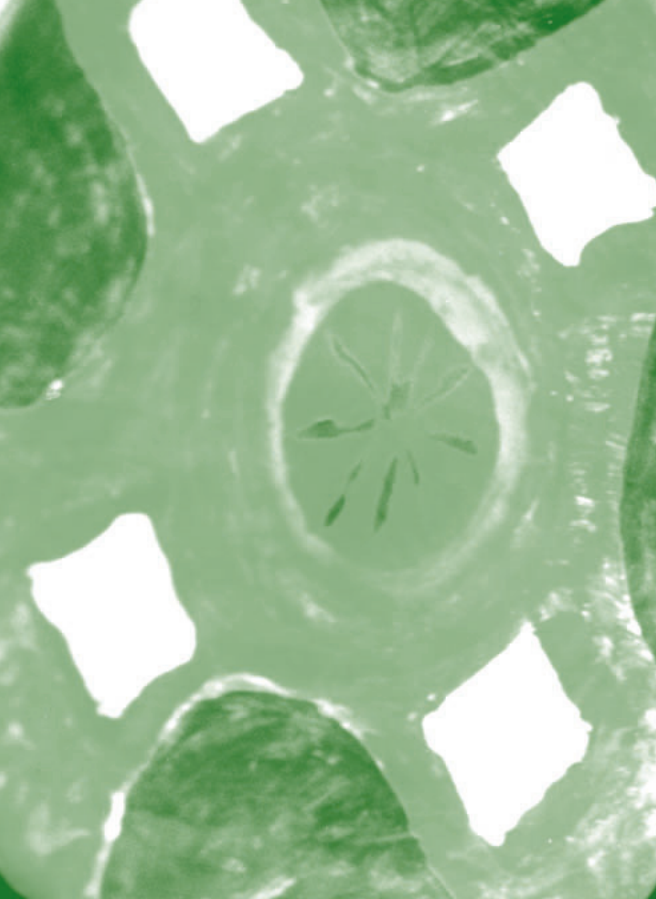
The *HeSSOP II* survey was carried out in two separate geographic areas and has therefore been analysed as two surveys. In the second survey round, some participants from the first round were recontacted. Resampling some individuals leads to a clustering effect in the data which has been adjusted for statistically.<sup>4</sup>

Relationships between variables were analysed using chi-squared tests (unless otherwise stated) as they were considered to give the best measure of significance without making assumptions concerning the direction of any possible relationship. Chi-squared values are not listed since the output for weighted survey data has no interpretation in the conventional sense. Logistic regression was used to explore the relationship between outcomes and major demographic variables. This is one of the most commonly used statistical techniques. It is used with data in which there is a binary (two-option) outcome (response) variable. It estimates a relationship between specific factors (predictors) and an outcome variable. Multivariate results are generally reported for parsimony, given the volume of univariate calculations and the number of these that will be significant solely by chance. The statistical information provided from tests is 'p', the 'probability' that there is a difference between groups. Where p is 1 per cent or less ( $p \leq .01$ ), it is accepted as demonstrating a statistically meaningful difference between the two groups. This means that a real difference is very likely. A p value of 0.01 signifies that there is a statistically significant difference between two groups or variables with 99 per cent certainty and a 1 per cent chance of being incorrect. In this report, because there are so many analyses and because the sample sizes are large,  $p < .01$  is taken as the level to report that there are significant differences. This analysis plan seeks to compensate for the multiple analyses and to increase the probability that robust patterns of relationships can be more clearly observed by the reader.

The statistical analyses to follow are of three basic types:

- Health board differences – comparisons between health boards (i.e. ERHA and WHB)
- Wave differences – comparisons across time (i.e. ERHA at 2000 compared to ERHA at 2004 and WHB at 2000 compared to WHB at 2004)
- Wave 2 – in some instances, further analyses of factors were examined. These involve analysis of differences (e.g. gender or age) related to particular outcomes.

<sup>4</sup>Statistical adjustment involved basing the analysis on the primary sampling unit of the participant, using Stata's robust variance estimators to adjust for repeated data from relevant participants.



## Chapter 3

Profile of  
participants:  
Repeat study

# Chapter 3

## Profile of participants: Repeat study

### 3.1 Demographic profile of *HeSSOP II*: Repeat study sample

#### 3.1.1 Age and gender distribution

A total of 1,053 participants (47 per cent male) took part in *HeSSOP II* (male mean age = 73.6, SD = 6.2; female mean age = 75.3, SD = 7.2).<sup>5,6</sup> The sample was quite similar in terms of age, gender and marital status to the relevant health board region (ERHA or WHB). However, the sample was weighted to best approximate the population samples it represented (Table 3.1).

##### *Health board differences*

The first analyses sought to examine age and gender differences between the health boards in order to control for these confounding influences, if needed, when examining health board differences according to other variables. In this analysis, a

<sup>5</sup> As responders included at both times can reduce the variability in data, all analyses to follow control for this effect. More information on these responders is given in Chapter 7. Of this total, 314 participants had taken part in both *HeSSOP* studies; 52 per cent of these were residing in the ERHA (n = 164, 46 per cent men, mean age = 72.0, SD = 6 years), and 48 per cent were residing in the WHB (n = 150, 50 per cent men, mean age = 72.5, SD = 6 years).

<sup>6</sup> The population of those aged 65 years or over in Ireland is 436,001 or 11.1 per cent of the total population (the 65-74 years group make up 56 per cent of older people, 34 per cent are 75-84 years old, and 9.6 per cent are 85+ years old). The population of those aged 65 years or over in the WHB is 48,952, or 13 per cent of the total population in the WHB (the 65-74 years group make up 54 per cent of older people, 35 per cent are 75-84 years old, and 11 per cent are 85+ years old). The ERHA area has 136,329 people aged 65 years or over, or 10 per cent of the total population in the ERHA area (the 65-74 years group makes up 58 per cent of older people, 32.8 per cent are 75-84 years old, and 9 per cent are 85+ years old) (Census 2002). In *HeSSOP II*, 32 per cent of older people were 65-69 year old, 32 per cent were aged 70-75, 30 per cent were aged 76-84, and 8 per cent were 85 years old or over.



notable effect was found for age ( $p < .05$ ) but not for gender, i.e. participants in the WHB tended to be older in comparison to their counterparts in the ERHA (mean age for WHB was 74.5,  $SD = 7.0$ ; mean age for ERHA participants was 73.5,  $SD = 6.4$ ) but there were similar numbers of men and women in each of the health boards. These findings were in keeping with those of *HeSSOP I* where participants residing in the WHB were also found to be older than those residing in the ERHA ( $p < .05$ ). In all analyses to follow, this known health board difference in age distribution is controlled when examining board differences in other variables. Controlling for age means that all other differences that are found are not due to this variable.

**Table 3.1: Demographic variables, weighted (compared with 2002 census) and non-weighted by board (ERHA and WHB) in 2004**

	<i>HeSSOP II: Unweighted</i>		<i>HeSSOP II: Weighted</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Age group</b>	*	*	*	*
65-69	31	22	34	30
70-75	35	33	32	30
76-84	27	31	28	31
85+	6	12	6	9
<b>Gender</b>				
Men	50	44	42	46
Women	50	56	58	54
<b>Marital status</b>				
Married	62	46	60	49
Widowed	30	45	32	42
Never married/single	7	10	7	9
Separated/divorced	1	0	1	0

Note: \* significant difference between health boards ( $p < .05$ ).

#### *Wave differences<sup>7</sup>*

When comparing participants from *HeSSOP I* and *II* there were no significant wave sample differences in terms of gender or age group for either ERHA or WHB (for

<sup>7</sup> 'Wave' is a methodological term indicating both a different time of assessment (2000 and 2004) and different groups being interviewed.

details see Appendix 3, Table A3). At both time points, however, women from the ERHA and WHB were significantly more likely to be in the older age groups than men ( $p < .01$ ). In *HeSSOP II*, women in the ERHA were almost three times more likely than men to be in the age group of 85 years and over (73 per cent v. 27 per cent) while WHB women were twice as likely as men to be 85 years and over. These results suggest that age and gender are interlinked and so neither can be examined without reference to the other.

When comparing profiles of participants in the WHB region in *HeSSOP I* and *HeSSOP II*, more similarities than differences were found. The two samples did not differ in the two waves in terms of gender distribution or age group. As was found with the ERHA participants, however, in *HeSSOP II* women in the WHB region were significantly more likely to be in the older age groups ( $p < .01$ ). They were twice as likely as men to be in the age group of 85 years and over (67 per cent v. 34 per cent).

### 3.1.2 Marital status

More than half of all *HeSSOP II* participants reported that they were married (54 per cent), only 8 per cent said that they had never married or were single, and 38 per cent reported that they were widowed. There were very few participants (<10 per cent) who were separated or divorced. For ease of analysis, participants were grouped into those who had a spouse/partner and those who did not have a partner (i.e. were single, separated, or widowed). For analyses examining board or wave differences in the proportion of participants that were widowed, participants were also grouped into those who were widowed and all other marital status groups.

#### *Health board differences*

There were similar relationships between gender and marital status across health boards (for details see Appendix 3, Table A4). The majority of men in the ERHA and the WHB were currently married. Conversely, women in both health boards and particularly in the WHB were less likely to be married but were more likely to be widowed; almost half in the ERHA and just under two thirds in the WHB. Indeed, women in the WHB were four times more likely to be widowed than their male counterparts. In the ERHA, women were more likely to be single than men while the opposite was the case in the WHB. These trends were similar to those seen in *HeSSOP I*.

Health board differences in marital status were examined using survey ordered logistic regression. Even when controlling for known health board differences in age,

a significant relationship between health board and marital status was found ( $p < .001$ ). A greater proportion of participants in the ERHA were married when compared to their counterparts in the WHB in *HeSSOP II* (60 per cent v. 49 per cent) with no significant difference in *HeSSOP I* (50 per cent v. 44 per cent).

A significant effect was found for gender and marital status with men being significantly more likely than women to have a marital partner in both *HeSSOP I* ( $p < .001$ ) and *HeSSOP II* ( $p < .001$ ).

More *HeSSOP II* participants in the WHB were widowed by comparison with *HeSSOP I* participants in the ERHA (42 per cent in the WHB compared to 32 per cent in the ERHA). When this analysis was repeated for *HeSSOP I*, no significant difference was found.

#### *Wave differences*

When examining marital status among participants at the two time points (*HeSSOP I* and *HeSSOP II*), no significant effect of wave was found for either the ERHA or WHB. Specifically, ERHA participants in *HeSSOP II* were no more likely to be living with a partner when compared to their counterparts in *HeSSOP I* (59 per cent and 50 per cent respectively). Similarly, the proportion of ERHA participants who were widows/widowers did not change significantly between *HeSSOP I* and *HeSSOP II* (39 per cent and 32 per cent respectively). Within the WHB, no significant differences in marital status were found between the two time points, i.e. *HeSSOP II* participants within the WHB were not any more likely to be living with a partner or to be widowed when compared to WHB participants taking part in *HeSSOP I*.

### 3.1.3 Living arrangements

There is evidence that adults who live alone are at increased risk of problems of morbidity and mortality (e.g. Lund *et al.*, 2002). In later chapters, the relationship between living arrangements and other outcome variables is examined.

#### 3.1.3.1 Living alone

##### *Health board differences*

Within the ERHA, 24 per cent of participants lived alone ( $n = 123$ ); of this group 73 per cent were widowed, 16 per cent had never married, 9 per cent were legally married (but living alone), and remaining participants were either separated or divorced. In the WHB, 33 per cent of the sample lived alone ( $n = 175$ ); of this group 80 per cent were widowed and 16 per cent had never married. There was a significant association between living alone and marital status ( $p < .001$ ) as people

who were single, widowed or separated/divorced were more likely to live in single occupancy households. In each health board region, those most likely to live alone were women rather than men (ERHA 31 per cent v. 15 per cent,  $p < .001$ ; WHB 41 per cent v. 23 per cent,  $p < .001$ ), and those aged over 75 years old (ERHA 38 per cent v. 28 per cent,  $p < .05$ ; WHB 41 per cent v. 30 per cent,  $p < .02$ ). There was no significant relationship, however, between living alone and either social class or income (all  $ps > .05$ ), i.e. evidence suggests that *HeSSOP II* participants living alone were not necessarily economically disadvantaged.

#### *Wave differences*

Possible differences between the two waves in the proportion of participants living alone were examined. When controlling or taking into account differences in marital status already known to occur between ERHA or WHB participants in both waves (2000 and 2004), no significant effect was found for the proportion of participants living alone in either board at both time points. In both instances between a quarter and a third of the total *HeSSOP* sample were living alone.

### 3.1.3.2 Living with others

#### *Health board differences*

There was no significant difference between the health boards in terms of the number of participants likely to live in multigenerational families. In both boards, the majority of participants lived with others (74 per cent in the ERHA and 67 per cent in the WHB). Within this group, 34 per cent in the ERHA and 31 per cent in the WHB lived only with a spouse, 17 per cent in the ERHA and 13 per cent in the WHB lived with a spouse and a child or children, 10 per cent in the ERHA and 10 per cent in the WHB lived only with a child or children, and 11 per cent in the ERHA and 11 per cent in the WHB lived with children and grandchildren. Approximately 1 per cent of participants reported living solely with a non-relative or friend and less than 1 per cent reported living solely with a parent or parent-in-law in both regions. Women were not any more likely than men to live in intergenerational families (ERHA 38 per cent v. 41 per cent; WHB 38 per cent v. 31 per cent), but in the WHB, a greater proportion of those aged over rather than under the age of 75 years did so (WHB 44 per cent v. 32 per cent,  $p < .05$ ; ERHA 47 per cent v. 37 per cent). There was no relationship between income group and living in intergenerational families.

#### *Wave differences*

When controlling for wave differences in marital status (ERHA) or age (WHB), results showed no significant difference in the number of either ERHA or WHB participants living with spouses only or with multigenerational families in *HeSSOP I* and *HeSSOP II*.

### 3.1.3.3 Living arrangements according to category membership

#### *Health board differences*

Differences in living arrangements according to gender, marital status and age group were also examined descriptively for each health board. In the ERHA, differences were seen as a function of these categories (see Table 3.2). Firstly, focusing on gender, results showed that the highest proportion of men lived with a spouse. Conversely, the highest proportion of women lived alone; women were twice as likely as men to live alone. The proportion of men and women who reported living in multigenerational families was similar as was the proportion who reported living with other relatives or non-relatives.

Differences in living arrangements were found for participants in different marital groups. Specifically, participants who were single, widowed, separated or divorced were most likely to live alone. Single participants who lived with others were most likely to live in a multigenerational household of three or more generations. Widowed and separated participants who lived with others were most likely to live in a multigenerational household of two generations; most married participants were likely to live in a household with a spouse followed by a multigenerational household of two generations. Finally, divorced participants who lived with others were most likely to live in a multigenerational household of three or more generations.

When participants were categorised according to age, there were also differences in living arrangements. Participants in the younger age groups (65-69 years and 70-75 years) were most likely to live with a spouse only, whereas participants in the older age groups (76-84 years and 85+ years) were most likely to live alone. Following this, participants between the ages of 65-69 years, 70-75 years, and 85+ years were most likely to live in multigenerational households of two generations while participants between the ages of 76-84 years were most likely to live in multigenerational households of three or more generations.

Differences according to gender, marital status and age group were also explored for the WHB in *HeSSOP II* (see Table 3.3). Firstly, in terms of gender, the trend was similar to the ERHA in that the highest proportion of men in the WHB lived with a spouse while the highest proportion of women lived alone; furthermore, women were twice as likely as men to report living alone. The proportion of men and women who reported living in multigenerational families was similar as was the proportion who reported living with other relatives or non-relatives.

**Table 3.2: Living arrangements by gender, marital status and age group in the ERHA in 2004 (n = 518)**

Participant group	Living arrangements					
	Living alone %	With spouse only %	Family: 2 generations %	Family: 3 or more generations %	Other relatives and non-relatives %	Other %
<b>Gender</b>						
Men	14	43	30	10	1	2
Women	31	28	26	12	2	1
<b>Marital status</b>						
Single	55	0	0	35	6	4
Widowed	53	3	28	15	1	0
Separated	59	0	41	0	0	0
Divorced	27	0	18	55	0	0
Married	4	59	31	5	1	0
<b>Age group (years)</b>						
65-69	17	40	33	5	2	3
70-75	22	38	29	9	1	1
76-84	30	29	19	21	1	0
85+	53	10	22	15	0	0

Differences emerged as a function of living arrangements according to marital status. In keeping with the ERHA, the majority of *HeSSOP II* participants who were either single or widowed lived alone while all individuals who were separated did so. For participants who did not live alone, differential relationships were also seen as a function of marital status. Specifically, single participants who lived with others were most likely to live in a multigenerational household of three or more generations. Widowed participants who lived with others were most likely to live in a multigenerational household of two generations, married participants (although primarily most likely to live with a spouse) were next most likely to live in a multigenerational household of two generations. These findings were in keeping with those of the ERHA.

When WHB participants were categorised according to age, there were also differences in living arrangements in *HeSSOP II*. As was the case in the ERHA, participants in the younger age brackets (65-69 years and 70-75 years) were most likely to live with a spouse only whereas participants in the older age brackets (76-84 years and 85+ years) were most likely to live alone. Following this profile, participants in all age brackets were next most likely to live in multigenerational households of two generations. This was generally consistent with the ERHA with the exception of the finding relating to participants in the 76-84 year age bracket. The ERHA finding that participants in this age group who lived with others were most likely to live in multigenerational households of three or more generations was not replicated in the WHB.

**Table 3.3: Living arrangements by gender, marital status and age group in the WHB in 2004 (n = 535)**

Participant group	Living arrangements					
	Living alone %	With spouse only %	Family: 2 generations %	Family: 3 or more generations %	Other relatives and non-relatives %	Other %
<b>Gender</b>						
Men	22	46	23	8	1	0
Women	40	20	24	13	1	2
<b>Marital Status</b>						
Single	60	0	0	31	5	4
Widowed	60	0	26	13	0	1
Separated	100	0	0	0	0	0
Divorced	-	-	-	-	-	-
Married	2	68	26	3	1	0
<b>Age group (years)</b>						
65-69	23	43	27	5	1	1
70-75	30	38	21	11	0	0
76-84	40	22	22	13	1	2
85+	42	9	24	20	3	2



Overall, this data suggests that the majority of participants lived in multi-generational households and that this finding does not vary between health boards.

*Wave differences*

There were also no significant differences between time points. At both measurement points the majority of participants lived in multigenerational households.

Further analyses in a later section will examine whether there is a significant effect of household composition on other health, psychosocial and health care outcomes.

### 3.2 Geographic location: Urban v. rural

*Health board differences*

As can be seen in Table 3.4, the majority of *HeSSOP II* participants in the ERHA lived in the city with less than a tenth living in rural settings. In contrast, the majority of WHB participants lived in rural settings while only a tenth lived in the city. This health board difference was highly significant ( $p < .001$ ). Similarly, this difference was significant for *HeSSOP I* participants ( $p < .001$ ).

*Wave differences*

Wave differences in geographic location for ERHA and WHB participants were also examined. Results showed that there was no significant effect of wave for participants either in the ERHA or in the WHB, i.e. the geographic location for ERHA and WHB participants was similar in *HeSSOP I* and *HeSSOP II*.

**Table 3.4: Geographic location (urban and rural) by wave (2000 and 2004) and board (ERHA and WHB)**

Geographic location	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Open country or small village	10	80	9	78
Small town (up to 10,000 people)	3	9	3	10
Large town (10,000+)	7	1	11	3
City	80	10	77	9

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

## 3.3.1 Education

*Health board differences*

For over a third (39 per cent) of *HeSSOP II* participants in the ERHA, primary school education was the highest level of education attained. In the WHB this was the case for the majority (70 per cent) of participants (see Table 3.5). This difference was significant ( $p < .001$ ) and remained even when controlling for known health board differences in age and marital status (living with a partner v. not living with a partner). This pattern of significant difference in levels of education between boards was also found in *HeSSOP I* ( $p < .01$ ). Consequently, health board differences in education are statistically controlled in all subsequent analyses comparing health boards.

*Wave differences*

A significant difference in levels of education was found for ERHA participants in waves 1 and 2 ( $p < .01$ ). A greater proportion of participants in *HeSSOP II* indicated that they had completed post-primary education (61 per cent in *HeSSOP II* v. 54 per cent in *HeSSOP I*). This difference was controlled for when examining ERHA wave differences in other variables. There was no significant difference in levels of education for WHB participants in waves 1 and 2.

**Table 3.5: Educational status by wave (2000 and 2004) and board (ERHA and WHB)**

Educational status	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Education/school level</b>				
Primary education only	46	66	39	70
Post-primary education	54	33	61	30

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

## 3.3.2 Household income

Household income was measured by asking participants about the total income of all members of the household after tax, pay-related social insurance and other

deductions. This question was asked due to evidence that income levels can have a significant effect on other variables and health outcomes. Given variations in household size and types, 'income' can mean different things. For the purposes of this study, therefore, income was 'equivilised' across different sizes and types of households. For instance, a net household income of €300 may be quite large if that person was living alone. However, if there were three adults and one child in that household, €300 may be quite inadequate. Equivalence scales are often used to try to accomplish a more comparative measure by assigning a 'weight' to each household member which takes into account the age category (adult or child) and the number of people in the household. The equivalence scale used in *HeSSOP II* has been used by other Irish research (Garavan *et al.*, 2001; Layte *et al.*, 1999); this scale gives the first person in the household a weight of 1.00, with a weight of 0.66 attached to each subsequent adult and 0.33 to each child under the age of 14 years.

For this analysis, individuals were grouped into three broad income groups (low, medium and high incomes) based on the combined frequency distribution from the ERHA and the WHB in order to have the same cut-off points for each of the regions (see Table 3.6). Participants were grouped into the low income bracket if their equivilised income was up to and including €158.50 weekly; participants were grouped into the medium income brackets if their incomes were between €158.51 and €239.16 weekly; and finally, participants were grouped into the high income bracket if their equivilised income levels were €239.17 or more. The national equivilised median income for an Irish adult population is currently €313.06 a week (Nolan *et al.*, 2002), which is the income of half of the population in Ireland. Therefore, *HeSSOP II* participants living in the low income category can also be said to be those living 60 per cent or more below the equivilised median income.

**Table 3.6: Income by board, gender and age in 2004**

	ERHA – Income			WHB – Income		
	Low	Medium	High	Low	Medium	High
	%	%	%	%	%	%
<b>Gender</b>						
Men	23	25	52	39	31	30
Women	26	29	45	44	29	27
<b>Age (years)</b>						
≤74 years	24	28	48	41	30	29
75+ years	25	27	48	42	30	28
<b>Living alone</b>						
No	23	29	48	42	29	29
Yes	31	23	46	42	31	27

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); low income = <€158.50 weekly, medium income = €158.51-€239.16 weekly, high income = €239.17+ weekly.

#### *Health board differences*

There was a significant effect of health board ( $p < .001$ ), with *HeSSOP II* participants in the WHB being more likely to be in the lower income levels by comparison with their counterparts in the ERHA. There was a trend in the ERHA for women and those in the older age groups to be more likely to be in the lower income categories; however, these trends did not reach significance level. In the WHB region, there was no association between income levels and gender, age, widowhood, or education.

### 3.3.3 Social class

While the incomes of older people can be similar, lifetime occupational categorisation can also be very informative in terms of encapsulating accumulated resources over a person's working life. *HeSSOP II* participants were classified in terms of social class, using the CSO classification system (see Table 3.7).

#### *Health board differences*

Over a third of participants in the ERHA were classified as being professional (higher and lower), while the equivalent was just over a quarter in the WHB. Approximately 40 per cent of participants in the ERHA and the WHB had worked in skilled, semi-

skilled or unskilled manual occupations. Health board differences in social class were examined. When controlling for known health board differences in terms of age, marital status, income levels, education and geographical location, there was no significant effect for board. Nor was there any significant effect for health board when examining data from the *HeSSOP I* sample.

#### *Wave differences*

Differences in social class between the two time points were also examined. There was a significant effect of wave for participants in the ERHA ( $p < .01$ ), i.e. *HeSSOP II* participants from the ERHA were more likely to be in the higher social class groups by comparison with *HeSSOP I* participants from the same area. When this analysis was repeated for the WHB, no significant wave effect was found.

**Table 3.7: Socioeconomic groups (CSO classification) by wave (2000 and 2004) and board (ERHA and WHB)**

Socioeconomic group	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA %	WHB %	ERHA %	WHB %
0 Unclassified	4	6	3	9
1 Higher professional (and managers and farmers with more than 200 acres)	11	7	23	16
2 Lower professional (and proprietors and farmers with 100-199 acres)	13	16	14	11
3 Other non-manual (and farmers with 50-99 acres)	22	17	18	24
4 Skilled manual (and farmers with 30-49 acres)	19	30	21	24
5 Semi-skilled manual (and farmers with <30 acres)	18	17	14	11
6 Unskilled manual	13	7	7	5
<b>TOTAL %</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

## 3.4 Summary

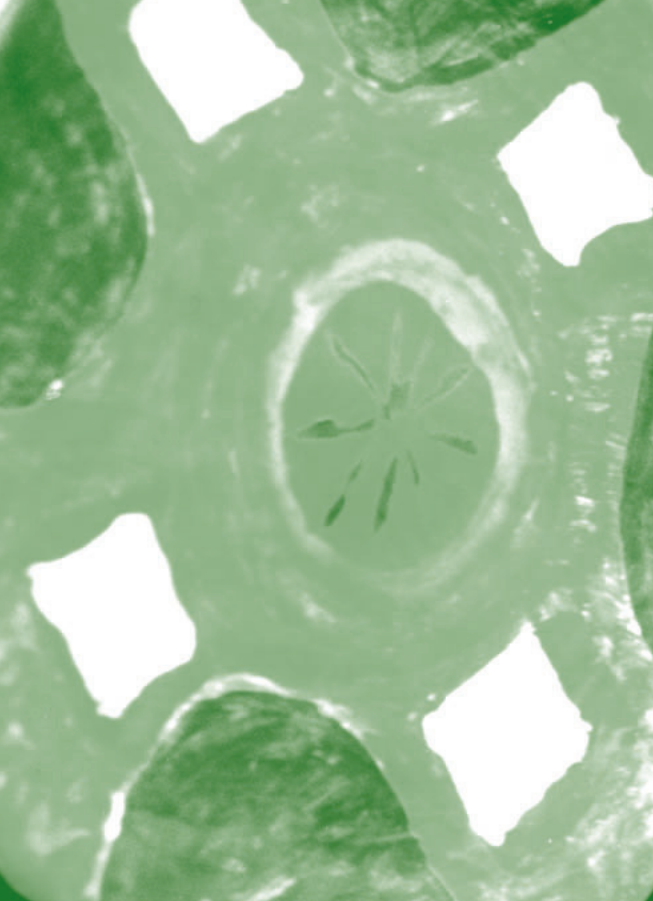
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- WHB participants were significantly older than those in the ERHA at both time points.
- Women in both boards were significantly older than men with 2-3 times as many women in the 'old old' (85+ years) category. This pattern was similar at both time points.
- A quarter of ERHA and a third of WHB participants lived alone in *HeSSOP II*. Women were more than twice as likely to live alone as men. This pattern was similar in *HeSSOP I*.
- Educational and occupational status and income were higher in the ERHA with significant improvements over the four-year period in the ERHA but not the WHB region.
- Overall, the demographic and related profiles remained reasonably stable over the four-year period from *HeSSOP I* to *HeSSOP II*.

# 4

## Chapter 4

Health status and  
health behaviour:  
Repeat study



# Chapter 4

## Health status and health behaviour: Repeat study

### 4.1 Health and functional ability

#### 4.1.1 Activities of daily living

##### 4.1.1.1 Functional ability: HAQ scores

###### *Health board differences*

Table 4.1 shows the distribution of categorical HAQ scores for *HeSSOP I* and *HeSSOP II* participants in each health board. In *HeSSOP II*, 82 per cent of participants in the ERHA indicated that they were completely self-sufficient, while the corresponding figure for participants in the WHB was 78 per cent. In contrast, 3 per cent of participants in the ERHA and 6 per cent of participants in the WHB reported experiencing severe impairment.

**Table 4.1: Functional ability – Health Assessment Questionnaire (HAQ) scores by wave (2000 and 2004) and board (ERHA and WHB)**

HAQ Score (difficulty rating)	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
None (self-sufficient)	80	78	82	78
Some (mostly minor difficulties)	9	9	10	11
Major (some major difficulties with ADL)	6	5	6	6
Severe (severe impairment)	5	8	3	6

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535). None = HAQ score of 0-0.5 indicating self-sufficiency; some = HAQ score of 0.51-1.25 indicating mostly minor difficulties with ADL; major = HAQ score of 1.26-2.0 indicating major difficulties with ADL; severe = HAQ score of 2.01-3.0 indicating severe impairment.



Table 4.2 shows a further breakdown of HAQ scores for men and women, and for adults of different ages. There was no relationship between HAQ group and either age, gender or income group (all  $ps > .05$ ).

**Table 4.2: Functional ability (HAQ scores) by gender, age and board (ERHA and WHB) in 2004**

	ERHA				WHB			
	HAQ Score (difficulty rating)				HAQ Score (difficulty rating)			
	%				%			
	0	1	2	3	0	1	2	3
	None	Some	Major	Severe	None	Some	Major	Severe
<b>Gender</b>								
Men	82	9	7	2	74	12	5	6
Women	80	11	6	3	78	9	7	6
<b>Age group (years)</b>								
65-69	78	12	7	3	78	9	8	5
70-75	87	7	5	1	77	11	5	7
76-84	79	12	6	3	80	11	5	4
85+	84	8	5	3	69	12	8	11

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535). 0 = HAQ score of 0-0.5 indicating self-sufficiency; 1 = HAQ score of 0.51-1.25 indicating mostly minor difficulties with ADL; 2 = HAQ score of 1.26-2.0 indicating major difficulties with ADL; 3 = HAQ score of 2.01-3.0 indicating severe impairment.

Possible health board differences in levels of functional ability were examined while controlling for age and other known demographic differences between the two health board samples. The main factor that was considered was health board. The potential effects of age, gender, marital status (living with a partner v. not living with a partner), income and education were also considered. Results showed that there were no significant effects of health board at either *HeSSOP II* or *HeSSOP I*.

*Wave differences*

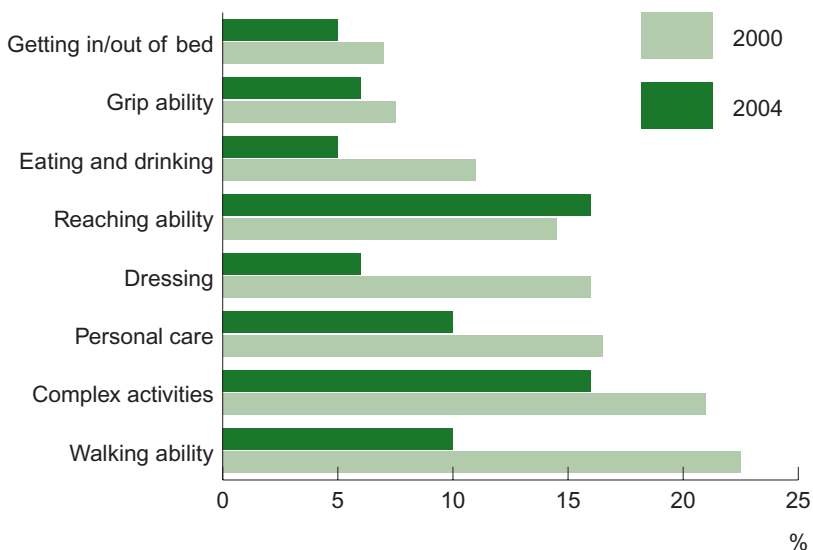
When wave differences within the ERHA were examined, there was no difference in the functional profile of the groups, i.e. for participants in the ERHA, HAQ scores were similar for *HeSSOP I* and *HeSSOP II*. Similarly, HAQ profiles did not change between waves in the WHB.

#### 4.1.1.2 HAQ tasks

##### Health board differences

Each of the tasks within the nine HAQ categories was also examined individually, to understand better the types of activities which were difficult for older people in each of the boards. For all nine daily activity categories, between 7 and 22 per cent of *HeSSOP I* and 5 and 16 per cent of *HeSSOP II* participants across both health boards had significant difficulty with one or more of the tasks (Figure 4.1). For instance, 8 per cent and 12 per cent of *HeSSOP II* participants in the ERHA and the WHB respectively were severely impaired in their ability to reach or extend their arms above shoulder level, and/or reach up and get down a 5lb object. Nine and 12 per cent of participants in the ERHA and the WHB respectively were severely impaired in their ability to engage in activities such as shopping and vacuuming (Tables A5-A8 in Appendix 3 provide details of the percentage of participants in each health board and wave reporting difficulty in these tasks).

**Figure 4.1: Percentage of participants in 2000 (n = 937) and 2004 (n = 1,053) reporting major or severe difficulties in conducting tasks**



In *HeSSOP II*, there were no significant differences between the health boards in any of these tasks or activities. When controlling for other demographic differences between the health boards (age, education, gender, marital status, and income), only educational status was significant; those in lower educational groups had more difficulty walking.

In *HeSSOP I*, a significant difference was found between the health boards for the category eating and drinking ( $p < .01$ ). There was a significant effect for age with increasing age also being associated with more difficulties in all nine daily activity categories (all  $p < .001$ ). A significant effect for gender was also found for reaching ( $p < .01$ ), dressing ( $p < .01$ ) and more complex activities such as shopping ( $p < .01$ ), with women in these instances reporting more difficulties than men. Other studies have found that older women have the most difficulties in many activities of daily living (Garavan *et al.*, 2001). These results remained even when controlling for known demographic differences between the samples in each of the health boards.

#### *Wave differences*

Within the ERHA, a significant effect was found for dressing ( $p < .01$ ), eating and drinking ( $p < .01$ ) and reaching ( $p < .01$ ). In all instances, except for reaching, there was an improvement in activities from wave 1 (*HeSSOP I*) to wave 2 (*HeSSOP II*). For example, 16 per cent had moderate to severe difficulties in dressing in *HeSSOP I*; the corresponding percentage in *HeSSOP II* was 4 per cent.

A significant effect was found between *HeSSOP I* and *HeSSOP II* participants in the WHB in terms of activities such as getting in and out of bed ( $p < .001$ ), reaching ( $p < .01$ ) and shopping ( $p < .02$ ). For instance, while 21 per cent of WHB participants in *HeSSOP I* reported major or severe difficulties in activities such as shopping, the corresponding figure for *HeSSOP II* was 18 per cent.

#### 4.1.1.3 Support needed with tasks

##### *Health board differences*

It is important to note that in *HeSSOP II* the majority of participants in each board reported carrying out self-care activities without any difficulties. These findings indicate that many older people live independent lives. Focus group interviews (see 2.3.1.1) that specifically investigated issues relating to positive functioning and development had been conducted in our earlier consultative work, and in light of this it was possible to draw upon qualitative data to corroborate the present findings. The following are some of the statements relating to positive functioning and development that were offered by older adults in the focus groups:

*Well the way I look at it, if I can get out and meet people, it keeps you fit in mind and body.*

*Well you get up and you might cut a bit of grass, mow the lawn or something like that; you would clean the windows if you were able to reach up to them.*

*If you're in the form for doing one thing you do a lot of work, and if you're not it's a big job to wash a cup.*

*I have quite accepted the fact that I am getting old and I am managing fairly well on my own.*

*My daughter comes into me a couple of times a week but I prefer doing things myself. I like to be as independent as I can and I manage to look after myself.*

*Well after my wife died in 1994 I developed osteo-arthritis in my back which disabled me quite a lot – but I don't get any pain with it, none at all, so I took up painting as a hobby.*

As can be seen in Table 4.3, between 8 and 30 per cent of *HeSSOP II* participants in each health board tended to avail of help from others for a range of activities of daily living. There were no significant health board differences in any of these variables for the *HeSSOP II* sample. When these analyses were repeated for the *HeSSOP I* sample, a significant health board difference was found for reaching and picking things up ( $p < .01$ ) with participants in the ERHA being more likely than those in the WHB to avail of help from others.

**Table 4.3: Support usually needed with tasks by wave (2000 and 2004) and board (ERHA and WHB)**

Task	HeSSOP I		HeSSOP II	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Dressing	14 Δ	16 Δ	8 Δ	12 Δ
Arising, e.g. getting in and out of bed	5	7	7	9
Eating and drinking	10	9	7	7
Walking ability	7	11	7	13
Personal care e.g. washing entire body	7	12	8	12
Reaching or picking up things	9 *Δ	15 *	18 Δ	21
Grip ability, e.g. jars	6	9	23	27
Complex activities, e.g. shopping	19	18 Δ	19	30 Δ

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); \* between health board difference where p<.05, Δ indicates wave difference between *HeSSOP I* and *HeSSOP II* (p<.05).

#### *Wave differences*

For participants in the ERHA, a significant effect was found for dressing (p<.01) with fewer ERHA participants in *HeSSOP II* availing of help from others. Significantly more ERHA participants in *HeSSOP II* needed support for activities such as reaching or picking things up from the floor (p<.001). For participants in the WHB, a significant wave effect was found for complex activities such as shopping and housework (p<.001) with more WHB participants in *HeSSOP II* availing of help than was the case in *HeSSOP I*.

#### 4.1.2 Use and need of devices

Participants were asked if they currently used a range of aids or devices to help maintain their independence. Devices can play a major role in improving quality of life and well-being, as participants in the focus groups noted:

*I use my stick to put on the lights because I can't reach the light switch.*

*She has something with a little crunch thing at the end of it that picks up the paper or whatever off the floor.*

Devices included in the survey included walking sticks, Zimmer frames, crutches, wheelchairs and hearing aids.

#### *Health board differences*

The proportion of the *HeSSOP II* samples using each of these devices can be seen in Table 4.4. The most used device was a walking stick, while a minority of participants used a wheelchair (2 per cent in the ERHA and 3 per cent in the WHB). A small percentage of *HeSSOP II* participants in each of the health boards also used a hearing aid. Health board differences in use of devices were not found.

**Table 4.4: Use of aids and devices by wave (2000 and 2004) and board (ERHA and WHB)**

Aid/device	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Walking stick	12	20	17	20
Frame/Zimmer/crutches	4	5	6	4
Using wheelchair	3	3	2	3
Ownership of hearing aid	8	9	4	4

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

#### *Wave differences*

*HeSSOP II* participants in both boards were less likely than those in *HeSSOP I* to report owning hearing aids (ERHA 8 per cent v. 4 per cent; WHB 9 per cent v. 4 per cent, both ps <.01). It is unclear why there are significantly fewer people with hearing aids in the more recent study (*HeSSOP II*). There was no significant wave effect, however, in terms of the use of walking sticks, frames or crutches, or wheelchairs.

## Wave 2

To consider the meaning of these data further, analysis was conducted to examine the relationship between use of devices and level of disability as measured by the HAQ, to determine whether those with the greatest level of disability were using devices which have the potential to improve their quality of life. The outcome variable was level of disability (no or some disability v. moderate to high disability), while the predictor variables, i.e. factors that could potentially have an effect, were the devices just discussed. In neither health board region was there a significant relationship between devices (i.e. walking stick, frame, crutches or wheelchair) and level of disability. These results raise the possibility that the most physically vulnerable adults are not making use of devices which could possibly improve their independence and quality of life. Caution, however, is needed in interpreting the sensitivity of HAQ scores in identifying those in need of aids or devices.

### 4.1.3 Perceived health status

Self-assessed health ratings are simple but important health indicators in population settings. For instance, self-assessed health has been found to predict a range of health outcomes including healthcare utilisation, morbidity, recovery from illness, decline in functional ability and mortality (see Benyamini, Leventhal and Leventhal, 2003). Surprisingly, little is known about the ways older adults perceive their own health, the factors that can influence those perceptions or the effect perceptions of health have on quality of life and well-being.

To examine self-assessed or perceived health status, *HeSSOP* participants were asked to rate their health currently and compare it to one year ago; participants were also asked what they expected their health to be like one year from now. Ratings for participants in each health board region can be seen in Table 4.5.

**Table 4.5: Self-ratings of health by wave (2000 and 2004) and board (ERHA and WHB)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Ratings of health</b>	*	*	*	*
Good/excellent	76	59	74	67
Fair	18	31	20	26
Poor/very poor	6	9	6	7
<b>Health compared to year ago</b>				
Better/much better	7	11	12	7
Same	78	65	65	74
Worse/much worse	15	23	22	19
<b>Health one year from now</b>				
Better/much better	9	9	6	4
Same	84	79	85	87
Worse/much worse	6	12	10	9

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); \* between health board difference where  $p < .001$ .

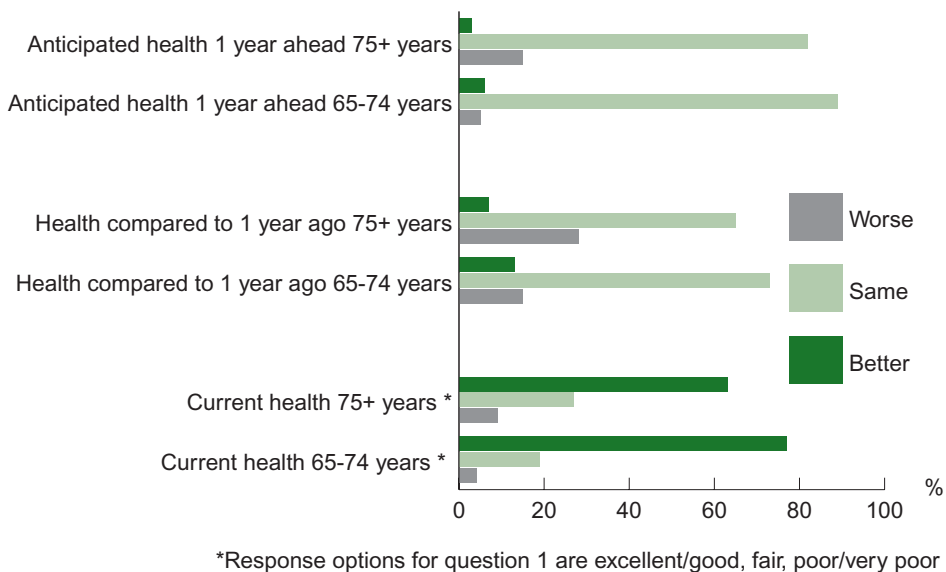
#### *Health board differences*

Ratings of current general health were compared between the two boards. These analyses were carried out while controlling for known differences between the two health boards (age, marital status, education and income). No significant health board difference was found for the *HeSSOP II* sample in terms of self-rated current health. A significant effect, however, was found for age ( $p < .001$ ) and education ( $p < .001$ ); among the *HeSSOP II* sample, increasing age and lower education only were associated with more negative self-ratings of current general health.

When this analysis was repeated for *HeSSOP I*, again controlling for demographic sample differences, a significant effect in health board was found ( $p < .001$ , see Figure 4.2); *HeSSOP I* respondents in the ERHA had higher self-ratings of current general health when compared with their counterparts in the WHB.



**Figure 4.2: Rating of health among *HeSSOP II* participants aged 65-74 (n = 823) and 75+ years (n = 230)**



Health board differences in self-ratings of health in the previous year were examined, controlling for known differences between the boards. No significant health board differences were found in either *HeSSOP I* or *HeSSOP II*. The majority of participants rated their current health as being the same as one year earlier. In both *HeSSOP* studies, increasing age was the only demographic variable associated with poorer ratings of current health by comparison to a year previously ( $p < .001$ ).

Participants rated their beliefs about what they expected their health to be like one year ahead; ratings by board and wave can be seen in Table 4.5. Controlling for known differences between the health boards as above, no significant difference was found for health ratings one year ahead in either *HeSSOP I* or *HeSSOP II*. Participants in both health boards were relatively positive in their expectations for their future health, with 91 per cent of the ERHA and WHB participants in *HeSSOP II* believing future health to be as good as or better than current health. A significant effect was found, however, for age ( $p < .001$ ) and education ( $p < .001$ ) but not for income or marital status in *HeSSOP II*; increasing age and lower level of education were associated with less positive ratings of future health.

#### Wave differences

Differences in ratings of health between the two time points were examined while controlling for known wave differences in social class. No significant wave differences were found either for ERHA or WHB participants on self-rated health now

or compared to one year previously. However, for future health ratings, a significant wave effect was found for participants in the ERHA ( $p < .01$ ); ERHA participants in *HeSSOP II* rated their future health more negatively when compared to their counterparts in *HeSSOP I*. Among ERHA participants, lower level of education only ( $p < .01$ ) explained more negative ratings of future health. There were no wave differences in future health ratings for WHB participants.

#### 4.1.4 Informal receipt of care

For many older people, household companions, relatives, neighbours and friends provide an important role in helping them maintain their independence. For some, this informal care may be a vital support without which they would be unable to continue to live in the community. In both *HeSSOP* studies, participants were asked about support they received from informal sources on a regular basis, which were necessary to maintain their independence. Participants were then asked how often they received this help from a predetermined list of potential helpers.

##### 4.1.4.1 Sources of support

###### *Health board differences*

As can be seen in Table 4.6, up to a third of participants in each of the health boards availed of support from others. Most support for *HeSSOP II* participants came from spouses or partners and others living in the household (36 per cent in both the ERHA and the WHB). Relatives living in the household or elsewhere also provided valued support (ERHA 28 per cent; WHB 30 per cent). Voluntary organisations provided needed support to a small group of participants in each health board region (4 per cent in the ERHA and 1 per cent in the WHB).

**Table 4.6: Ratings of support received by wave (2000 and 2004) and board (ERHA and WHB)**

Support provided by:	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Spouse/partner	27 $\Delta$	26 $\Delta$	36 $\Delta$	36 $\Delta$
Other relatives in household	22	30	28	30
Other relative living elsewhere	22 $\Delta$	26 $\Delta$	30 $\Delta$	34 $\Delta$
Neighbours	12	12	22 **	7 **
Voluntary organisations	2	1	4 *	1 *

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); \* between health board difference where  $p < .005$ , \*\* between health board difference where  $p < .001$ ,  $\Delta$  wave difference ( $p < .005$ ).

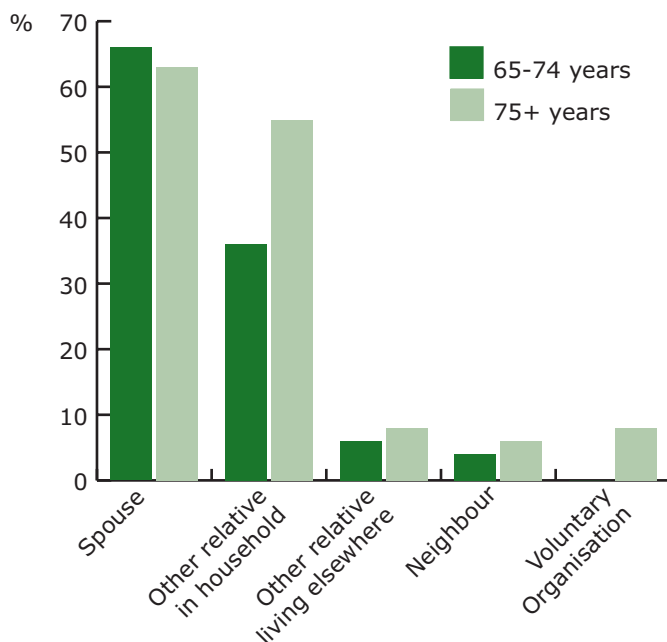
A significant effect was found between the health boards for the proportion of participants receiving care from neighbours ( $p < .001$ ) and voluntary organisations ( $p < .005$ ); more *HeSSOP II* ERHA participants availed of support from neighbours (21 per cent in the ERHA v. 7 per cent in the WHB) and voluntary organisations (4 per cent in the ERHA and 1 per cent in the WHB) by comparison with *HeSSOP II* WHB participants. These significant differences remained even when controlling for known sample differences between the boards. No significant differences were found between the boards in terms of the percentage of *HeSSOP II* participants receiving support from partners or spouses, other relatives in the household, or other relatives living elsewhere. In these analyses, increasing age was significantly associated with receiving care from a spouse or partner ( $p < .01$ ), relatives inside the household ( $p < .001$ ) and relatives living elsewhere ( $p < .001$ ). Increasing age, however, was not associated with receiving care from neighbours or voluntary organisations. When controlling for all other variables, a lower level of education was significantly associated with accessing support from spouses/partners ( $p < .01$ ), and relatives outside the household ( $p < .001$ ).

No significant differences were found for the proportion of *HeSSOP I* participants in each health board receiving support from any of the sources examined.

#### *Wave differences*

Differences between the two time points in the percentage of people availing of support from these sources were examined. *HeSSOP II* participants in each board were more likely than those in *HeSSOP I* to avail of support from two sources including spouses or partners ( $p < .05$  [trend] ERHA;  $p < .01$  WHB), from other

**Figure 4.3: Sources of continuous help among *HeSSOP II* participants aged 65-74 (n = 823) and 75+ years (n = 230)**



relatives living elsewhere ( $p < .01$  ERHA;  $p < .01$  WHB), and from neighbours ( $p < .001$  ERHA;  $p < .01$  WHB). These findings might be indicative of a changing attitude towards receiving support; older people may currently either be more willing to avail of support or more willing to admit that they do so. On the other hand, the providers of support may be more able or willing to provide support in the more recent survey.

#### 4.1.4.2 Frequency of support

The most frequent support came from partners and spouses followed by others in the same household. Adults over rather than under the age of 75 years were significantly more likely to avail of support from others (see Figure 4.3).

#### *Health board differences*

Of the *HeSSOP II* sample who received support from partners or spouses, 69 per cent in the ERHA and 58 per cent in the WHB received this support continuously, i.e. through the night and most of the day (see Table 4.7). Although there was a trend in the ERHA for participants to avail of support from partners and spouses more frequently, this trend did not reach significance level; when this analysis was repeated for *HeSSOP I*, there were also no significant health board differences (see Table 4.8). Health board differences were not found for the frequency in which support was accessed from other sources.

**Table 4.7: Frequency of support received by board in 2004**

Support by	ERHA Frequency of support			WHB Frequency of support		
	Sample	Often	Infrequent	Sample	Often	Infrequent
	%	%	%	%	%	%
Spouse/partner	36	69	30	36	58	42
Other relatives in household	28	51	49	30	43	56
Other relative living elsewhere	30	6	94	34	9	91
Neighbours	22	5	95	7	5	95
Voluntary organisations	4	-	100	1	33	67

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); often = support which is continuous (including at night) or most of the day; infrequent = support received 1-2 times a day, a few times a week or once weekly.

**Table 4.8: Frequency of support received by board in 2000**

Support by	ERHA Frequency of support			WHB Frequency of support		
	Sample	Often	Infrequent	Sample	Often	Infrequent
	%	%	%	%	%	%
Spouse/partner	27	75	25	26	68	31
Other relatives in household	22	47	53	30	60	50
Other relative living elsewhere	22	10	89	26	18	83
Neighbours	12	10	90	12	5	95
Voluntary organisations	2	25	75	1	-	100

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); often = support which is continuous (including at night) or most of the day; infrequent = support received 1-2 times a day, a few times a week or once weekly.

### *Wave differences*

There were no differences between *HeSSOP I* and *HeSSOP II* in terms of the frequency with which support was received by any of the sources examined.

### 4.1.5 Care giving

In 2002, there were an estimated 149,000 carers in Ireland, of which about 50,000 were caring full-time (see [www.irishcarers.ie](http://www.irishcarers.ie)). Carers can face physical, emotional, social and financial problems as a consequence of their role (Travers, 1996). Older carers may be at particular risk of depression and other psychiatric problems (Livingston, 1996). In this study, the proportion of older people providing support to others and the relationship between care giving and health was of interest. Participants were asked whether they were the main care givers to other people in their homes. When administering this question, care giving was defined to exclude child minding for adult children or others, because in these instances the main care giving responsibilities were seen to lie with others. Care giving was defined as a situation where the respondent took responsibility for the main care of another individual, including taking responsibility, as appropriate, for major decisions relevant to that individual.

### *Health board differences*

As can be seen in Table 4.9, 5 to 9 per cent of the *HeSSOP II* sample across health boards were the main providers of care for someone else. Three per cent of all carers in the ERHA and 8 per cent in the WHB were aged over 75 years. There was no relationship between age and the provision of care, but women were significantly more likely than men to be carers ( $p < .001$ ). Although there was a trend for *HeSSOP II* participants in the WHB to be more likely than their counterparts in the ERHA to care for others, this trend did not reach a significant level. These results are comparable to *HeSSOP I* in which no significant difference was found between the health boards in terms of the percentage of adults who were carers. These analyses were carried out while controlling for known health board differences between the samples (age, marital status, education and income).

**Table 4.9: Provision of care to others by wave (2000 and 2004) and board (ERHA and WHB)**

Participants providing care	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Whole sample</b>	9	8	5	9
<b>Age group (years)</b>				
65-69	11	10	4	12
74-75	10	9	9	10
76-84	5	6	3	8
85+	7	8	-	-
<b>Gender</b>				
Men	6	5	3	7
Women	11	11	6	11

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

#### *Wave differences*

After controlling for wave differences in social class there were no wave differences for participants in either the ERHA or the WHB, i.e. *HeSSOP II* participants were as likely to be carers as participants from *HeSSOP I*.

The relationship between care giving and the survey participant's own health was examined, the latter being defined in terms of functional health as measured by the HAQ-DI (activities of daily living). Most carers had no difficulties maintaining their own independence and there was no statistical relationship between functional health and being a carer. Nevertheless, 20 per cent of carers in the ERHA and 22 per cent in the WHB had HAQ scores indicating that they were experiencing minor or even major difficulties themselves in activities of daily living. When asked about respite care, a very small percentage of carers (1 per cent of carers in both health boards) said that they had been provided with respite from caring within the last year. These findings suggest that there is a need to promote greater understanding in carers of the services and supports such as respite that are available to them. Also of potential concern is the apparent low uptake rate for respite care services.

### 4.1.6 Prevalence and impact of health conditions

In order to gain an understanding of the types of illnesses and medical conditions which affect the lives of older people, *HeSSOP II* participants were asked to indicate if they had suffered from longstanding illness, disability or infirmity, i.e. any condition that does or is likely to trouble them over a period of time. In *HeSSOP II*, this question was a free recall question whereby participants simply listed any illnesses or disabilities they had. In *HeSSOP I*, participants responded to this question from a lengthy predetermined list. Data from both waves were collated into major categories, e.g. cardiovascular conditions. This difference in question format means that comparison of health conditions between the two time points should be made with caution. In general, open-ended questions of conditions will yield a lower prevalence than a yes/no checklist of conditions.

#### *Health board differences*

As can be seen in Table 4.10, while absolute prevalence varies somewhat, the most common ailments across boards were musculoskeletal (e.g. joint problems and arthritis) and cardiovascular (e.g. high blood pressure and coronary heart disease).

**Table 4.10: Major health conditions by wave (2000 and 2004) and board (ERHA and WHB)**

Health condition	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Musculoskeletal	50	51	24	26
Cardiovascular	44	46	34	26
Respiratory	12	14	8	6
Gastrointestinal	11	13	5	4
Kidney/urological	11	12	1	3
Cancer	3	3	6	6
Diabetes	8	4	7	6
Neurological	2	1	5	3
Vision and hearing	31	32	6	8
Psychological/psychiatric	12	12	3	1
Other	8	12	9	4

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535). Further analysis of health conditions is carried out in the next chapter using a comorbidity index.



### Wave differences

The most common conditions across waves were also musculoskeletal and cardiovascular (Table 4.10). While 50-51 per cent of participants in *HeSSOP I* reported some kind of musculoskeletal problems (e.g. arthritis or back pain), just 25 per cent of those from *HeSSOP II* did so. A sizeable group of participants in *HeSSOP I* also reported having hearing or vision problems (31 per cent in the ERHA and 32 per cent in the WHB), but in *HeSSOP II* just 6 per cent of participants in the ERHA and 8 per cent in the WHB did the same.

### 4.1.7 Pain

Participants in both *HeSSOP* studies were asked about pain experienced in the past week. As can be seen in Table 4.11, two thirds of the *HeSSOP II* sample in each health board reported experiencing no pain in the previous week. However, 7 per cent of participants in the ERHA and 8 per cent of participants in the WHB reported being in severe pain.

**Table 4.11: Experience of pain by wave (2000 and 2004) and board (ERHA and WHB)**

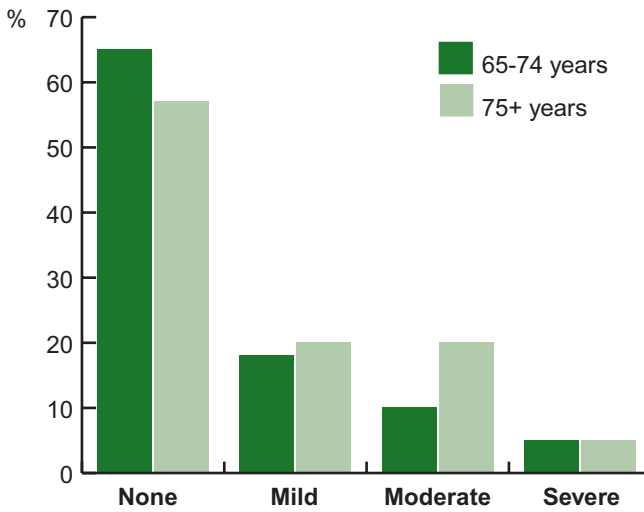
Pain	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
No pain	65	63	62	63
Mild pain	17	17	15	18
Moderate pain	11	14	16	11
Severe pain	7	5	7	8

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

### Health board differences

Ratings of pain were compared between the boards; this comparison was carried out while controlling for known differences between the boards (age, marital status, education and income). No significant health board difference, however, was found for the *HeSSOP II* sample. When considering all variables, i.e. age, marital status, education and income, only increasing age was associated with chronic pain ( $p < .01$ , see Figure 4.4). These results are comparable in *HeSSOP I*; no significant difference was found between the boards in the experience of pain.

**Figure 4.4: Levels of pain among *HeSSOP II* participants aged 65-74 years (n = 823) and 75+ years (n = 230)**



*HeSSOP II* participants only were further asked how long they had had this pain (38 per cent in the ERHA and 37 per cent in the WHB). Of those who had had pain, 12 per cent had had it for less than a month (13 per cent in the ERHA and 11 per cent in the WHB), but 77 per cent (76 per cent in the ERHA and 78 per cent in the WHB) had had their pain for more than six months. As noted in *HeSSOP I* (Garavan *et al.*, 2001), the management of chronic pain is something that needs to be addressed in the community; this argument would seem to remain valid four years later.

#### *Wave differences*

There was no significant difference in the experience of pain in either health board.

## 4.2 Psychological health

It is important to assess the psychological well-being of respondents in a community type survey such as *HeSSOP*. Two concepts, depression and morale, were the focus of this study.

### 4.2.1 Depression

Rates of depression are less frequent in later life than earlier in the lifecourse (Charles, Reynolds and Gatz, 2001), but its occurrence can impair quality of life among older people and have major consequences for morbidity and mortality (Blazer, 2003). *HeSSOP II* sought to examine the prevalence of depression among older adults in Ireland. The HADS is a particularly useful scale in distinguishing three levels of depression (normal, borderline and clinical). Scores in the borderline range may be interpreted as meaning that the person is at risk of developing the disorder, while scores that reach the clinical levels suggest that the person may meet the criteria for diagnosis of the disorder and requires a professional formal assessment.<sup>8</sup>

#### *Health board differences*

Two per cent of *HeSSOP II* participants in the ERHA and 3 per cent in the WHB had scores on the HADS which were indicative of clinical depression; a further 8 per cent and 9 per cent respectively in each of the health board regions had scores which suggest borderline levels of depression.

There were no significant differences between *HeSSOP II* participants in each of the health boards or for equivalent *HeSSOP I* comparisons.

#### *Wave differences*

There was no significant wave effect for participants in either board. Analysis was carried out to determine which groups were more likely to feel depressed. Possible predictor variables included age, gender, marital status, household composition (living alone, living in intergenerational families) and geography (living in urban v. rural settings). The only variable to be significant was gender ( $p < .01$ ); while 14 per cent of women reported experiencing some level of depressive symptoms (borderline or clinical), the corresponding percentage for men was 9 per cent.

<sup>8</sup> Depression scores are not available for the small number of cases where interviews were completed by proxy.

**Table 4.12: Ratings of depression with the Hospital Anxiety and Depression Scale (HADS) as a screen by wave (2000 and 2004) and board (ERHA and WHB)**

Depression (HADS)	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA %	WHB %	ERHA %	WHB %
Non-clinical	94	88	90	88
Borderline	4	6	8	9
Clinical disorder	2	5	2	3

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

Those who screened as depressed did not tend to avail of counselling services more often in the previous year. Of those who were indicated as borderline or clinically depressed on the HADS, none had used counselling services. There are many possible explanations. Firstly, they may not have defined the problem as requiring or being amenable to professional intervention. Secondly, they may have been prevented from doing so because of financial reasons, waiting lists or stigma-related barriers. Other possible reasons are that they live in areas without convenient transport to counselling services or that they managed their depression through a GP or other unspecified hospital service. Further analysis was carried out to consider factors that might explain uptake in counselling services. Possible predictor variables were age, gender, income, marital status, and social class. There were no significant relationships.

#### 4.2.2 Morale

In keeping with *HeSSOP I*, a measure of morale was used to complement scores on the HADS and to consider positive aspects of psychological functioning and health (as distinct from the absence of pathology). These items were based on items from a questionnaire used in the 1993 study on health and autonomy in the over 65s in Ireland (Fahey and Murray, 1994). Items included: 'I often find that I am bored or have time on my hands that I don't know how to fill' and 'I feel I still contribute to my community and society in general as much as I would like to do'. Participants responded to these items on a five-point scale from strongly agree to strongly disagree. Participants were then grouped into three categories based on the totalled scores from these items: those with low, moderate and high levels of morale.

### Health board differences

Levels of morale were generally high among participants, with just 4 per cent in each health board being classified as having low morale (Table 4.13). For instance, many *HeSSOP II* participants in both health boards (62 per cent in the ERHA and 68 per cent in the WHB) agreed with the statement 'I feel I still contribute to my community and society as much as I would like to'. However, this still leaves about a third feeling that they do not. Sixteen per cent of *HeSSOP II* participants (17 per cent in the ERHA and 15 per cent in the WHB) agreed with the statement 'I often find that I am bored or have time on my hands that I don't know how to fill'.

**Table 4.13: Ratings of morale by wave (2000 and 2004) and board (ERHA and WHB)**

Depression (HADS)	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Level of morale</b>				
Low	3	5	4	4
Moderate	18	18	16	22
High	79	78	80	74

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

Possible differences between the health boards in levels of morale were examined as in previous analyses. A significant effect was found for age ( $p < .001$ ) and income ( $p < .001$ ); higher levels of morale were associated with younger age groups and higher income levels (see Table 4.14). There was no significant effect for health board, i.e. levels of morale were similar for *HeSSOP II* participants in the ERHA and those in the WHB. These results were similar in *HeSSOP I* (data not shown).

**Table 4.14: Ratings of morale by age and income group in 2004 (n = 1,053)**

	Levels of morale		
	Low	Moderate	High
	%	%	%
<b>Age group (years)</b>			
65-74	2	15	83
75+	7	30	63
<b>Weekly equivalised income</b>			
<€158	5	25	70
€158-239	2	23	75
€240+	3	12	85
<b>Geographic location</b>			
Rural (open country/village)	4	23	73
Small town	0	23	77
Large town	11	22	67
City	2	14	84

*Wave differences*

There was no difference in levels of morale between the two waves for participants in either health board. In both analyses, social class was found not to be related to levels of morale.

*Wave 2*

Further analyses were carried out to better understand what factors were associated with high levels of morale. In these analyses, the outcome variable was morale. Predictor variables included age, gender, functional capacity (HAQ scores), marital status (living with spouse only, being widowed), household composition (living alone, living in intergenerational families) and geography (living in urban v. rural settings). In *HeSSOP II*, when controlling for other variables, higher levels of morale were associated with lower age ( $p < .001$ ) and greater income ( $p < .001$ ). When this analysis was repeated with the *HeSSOP I* sample, relationships were similar with one addition; functional ability as measured by the HAQ was associated with lower morale ( $p < .001$ ), i.e. individuals who had lower levels of functional ability had lower levels of morale.

These results indicate that morale among contemporary older Irish adults is quite high and that these levels do not differ between health boards or waves. These findings contribute to a broader debate in gerontology about the positive outlook of older people despite challenges and difficulties being experienced. Nevertheless, some groups of adults were at risk of lower levels of morale in this study; these included those in higher age groups, with lower incomes, and in *HeSSOP I*, with lower functional ability.

## 4.3 Social contact and support

The issue of social contact and support came to the fore during the earlier focus groups with older adults. Participants made several comments and statements that highlighted the important role that other people played in determining health and well-being:

*Well the way I look at it, if I can get out and meet people it keeps you fit in mind and body.*

*It's very important (to get out); people are more important in this world than anything else.*

Yet in *HeSSOP II*, many respondents reported life situations that could indicate being at risk of problems such as isolation or lack of social support. Almost half of all *HeSSOP II* participants (79 per cent in the WHB and 9 per cent in the ERHA) lived in rural settings. Many lived alone (25 per cent in the ERHA and 32 per cent in the WHB), were widowed (35 per cent in the ERHA and 41 per cent in the WHB) or had serious limitations on everyday independence due to mobility problems (20 per cent in the ERHA and 23 per cent in the WHB).

### 4.3.1 Social contact

#### *Health board differences*

Participants were asked about the level of difficulty they had in attending events outside their homes (e.g. community or social events) and visiting friends or family in their homes. The majority of participants in each health board had no difficulties in attending events and family gatherings (Table 4.15). However, 11 per cent of participants in both the ERHA and WHB said they had a lot of difficulty or were unable to attend events outside their home. A further 10 per cent (8 per cent in the ERHA and 12 per cent in the WHB) could attend, but with some difficulty. Similarly,

7 per cent of *HeSSOP II* participants in the ERHA and 10 per cent in the WHB said that they had great difficulty or found it impossible to visit the homes of friends or family, and 11 per cent experienced 'great difficulty' in visiting family and friends in the last month.

**Table 4.15: Difficulties in social contact by wave (2000 and 2004) and board (ERHA and WHB)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Difficulty in attending events outside the home</b>				
No difficulty	84	82	84	79
Some difficulty	9	8	9	11
A lot of difficulty/impossible	7	10	7	10
<b>Difficulty in visiting friends or family in their homes</b>				
No difficulty	84	81	81	77
Some difficulty	8	7	8	12
A lot of difficulty/impossible	8	12	11	11

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

Health board differences in social contact were examined. In keeping with previous analyses, this analysis was carried out while controlling for age and other known demographic differences between the two health boards. Greater levels of difficulty attending events outside the home were associated with increasing age ( $p < .001$ ) and lower levels of education ( $p < .001$ ). While 3 per cent of participants in the 65-69 years group had difficulties attending events outside the home, the corresponding figure for adults aged 85 years and over was 37 per cent. Similarly, while 5 per cent of those with a post-primary level of education had difficulties, the corresponding figure for people with a primary level of education was 15 per cent. There was no significant effect for health board in either *HeSSOP II* or *HeSSOP I*.

Health board differences in visiting friends or family in their homes were also examined. There was no significant effect for health board but a significant effect,



as above, was found for age ( $p < .001$ ) and education ( $p < .001$ ). Results were similar when this analysis was repeated for the *HeSSOP I* sample; again, there was no significant effect for health board but there was a significant effect for age ( $p < .001$ ) and education ( $p < .001$ ). Increasing age was associated with greater difficulties in visiting friends or family; of those who had difficulty in this area, 4 per cent were aged 65-69 years, 8 per cent were aged 70-75 years, 17 per cent were aged 76-84 years, and 33 per cent were aged 85 years and over. Similarly, participants with lower levels of education were associated with greater difficulties visiting the homes of friends and family; of those who had difficulty in this area, 77 per cent had solely primary level education and 23 per cent had post-primary level education.

#### *Wave differences*

Wave differences in attendance at events outside the home and visiting family or friends were examined separately for participants in the ERHA and WHB. For participants in both the ERHA and WHB, there was no difference in *HeSSOP I* and *HeSSOP II* in level of difficulty. Social class did not have a significant effect on these social contact variables.

Further analyses were carried out to examine whether greater difficulties in gaining social contact were associated with other variables such as reduced levels of disability, difficulties in accessing transport or living in rural environments. Factors of interest included age, gender, marital status, household composition (living alone, living in intergenerational families), geography (urban v. rural settings) and being a car driver. There was a significant effect for being a car driver ( $p < .001$ ), i.e. those who were able to drive had significantly fewer difficulties in accessing contact with others when compared to individuals who were unable to drive (see Table 4.16). There was no significant effect for gender, marital status, income or geography.

**Table 4.16: Driving and difficulty in accessing social contact in 2004**

Difficulty in accessing social support?	ERHA		WHB	
	Drive car?		Drive car?	
	Yes %	No %	Yes %	No %
No difficulty	94	68	91	64
Some difficulty	3	13	6	18
Much difficulty/impossible	3	19	3	17

Note: ERHA n = 518 (car drivers = 262), WHB n = 535 (car drivers n = 238).

A wide range of factors may influence whether older people will attend social events. Apart from health and transport, attitudes and beliefs are important, as highlighted in focus group comments:

*You wouldn't think of going into town ... because people would say that you are silly because you are only going to be mugged.*

*Well it is not everybody who is old; I mean you are sticking out like a sore thumb when you go for a drink now days ... it has become a young people's pleasure.*

### 4.3.2 Loneliness

Loneliness can be a substantial risk factor for health problems including depression (Heikkinen and Kauppinen, 2004) and physical health problems (Hawkey *et al.*, 2003). Participants were asked how often in the previous 12 months they had been affected by loneliness.

#### *Health board differences*

Loneliness can be a problem for many people but, as can be seen in Table 4.17, over half of *HeSSOP II* participants were not bothered by loneliness (66 per cent in the ERHA and 56 per cent in the WHB). However, between 9 and 12 per cent of *HeSSOP II* participants reported being bothered by loneliness 'quite' often and 3 per cent of participants in each region reported being bothered by loneliness 'very' often. Clearly this is an issue which has worrying implications for the health and quality of life of older adults.

Health board differences in levels of loneliness were examined. In keeping with previous analyses, this analysis was carried out while controlling for age and other known demographic differences between the two health boards. Marital status was significant in explaining variance in loneliness ( $p < .001$ ); 4 per cent of those with a partner reported being lonely quite or very often, while the corresponding figure for those without a partner was 21 per cent. There was no significant health board difference in levels of loneliness at either *HeSSOP II* or *HeSSOP I*.

**Table 4.17: Ratings of loneliness by wave (2000 and 2004) and board (ERHA and WHB)**

Loneliness frequency	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Very often	3	4	3	3
Quite often	4	8	9	12
Not very often	24	30	25	29
Never	69	58	66	56

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

#### *Wave differences*

Differences in the experience of loneliness between the two time points were also examined separately for the ERHA and the WHB. These analyses were carried out while controlling for known wave differences in social class. Social class was not related to loneliness. There were no significant wave effects for participants in either board.

Further analyses were carried out to understand if any particular groups were more likely to experience loneliness. Age, gender, marital status, household composition (living alone, living in intergenerational families) and geography (urban v. rural settings) were considered. The only variable to contribute significantly to the variance in loneliness scores was household composition ( $p < .001$ ); people living alone were more likely to describe feeling lonely when compared to other groups (Table 4.18).

**Table 4.18: Loneliness and living alone in 2004**

Loneliness Frequency	ERHA		WHB	
	Live alone?		Live alone?	
	Yes	No	Yes	No
	%	%	%	%
Very often	6	2	7	1
Quite often	21	5	25	5
Not very often	33	23	30	29
Never	39	70	39	65

Note: ERHA n = 518 (live alone n = 123), WHB n = 535 (live alone n =175).

### 4.3.3 Social support

Relationships with others have protective value throughout the lifecycle. Emotional support available in relationships can enable people to take on new projects and activities; informational support means that people have access to information to help solve challenges and dilemmas, while even limited practical support can mean the difference between living independently at home rather than moving into residential care. *HeSSOP* participants were asked about these different types of support: emotional support ('someone who makes you feel loved and appreciated'); informational support ('someone in whom you can confide and who will give you advice or information'); and practical support ('someone who will help you with practical tasks like preparing meals, household chores or shopping'). The scores from all items were averaged for each person and recategorised into low, moderate and high levels of social support.

**Table 4.19: Ratings of support by wave (2000 and 2004) and board (ERHA and WHB)**

Support	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Emotional support</b>				
None/little of time	5	7	7	3
Some of time	8	7	8	6
Most of time	87	87	84	91
<b>Informational support</b>				
None/little of time	4	6	6	5
Some of time	6	5	9	5
Most of time	90	88	86	91
<b>Practical support</b>				
None/little of time	12	13	15	10
Some of time	4	5	10	7
Most of time	84	81	75	83

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

#### *Health board differences*

As can be seen in Table 4.19, the majority of *HeSSOP* participants felt supported – emotionally, practically and in terms of information. A large group of people, however, (15 per cent in the ERHA and 10 per cent in the WHB) felt they had very little or no practical support, defined as 'help with practical tasks such as preparing meals, household chores or shopping'. Differences between the health boards in emotional support were examined; this analysis was carried out while controlling for age and other known health board differences (age, marital status, income and education). The main predictor variable was health board. In *HeSSOP II*, marital status was the only demographic variable to be significant ( $p < .001$ ) with married adults more likely to experience emotional support when compared to adults who were single. No significant effect was found for emotional support for health boards at either *HeSSOP I* or *HeSSOP II*.

Health board differences in informational support were examined. The main predictor variable was health board. In *HeSSOP II*, marital status was the only

demographic variable to be significant ( $p < .001$ ) with married adults more likely to experience informational support than single adults. No significant effect was found between health boards in *HeSSOP I* and *HeSSOP II* for informational support.

Health board differences in practical support were examined; this analysis was carried out while controlling for age and other known health board differences (age, marital status, income and education). In *HeSSOP II*, a significant effect was found for marital status ( $p < .001$ ) with adults living with a spouse experiencing the most practical support. No significant health board effect was found in *HeSSOP I* and *HeSSOP II* for practical support. When this analysis was repeated for the *HeSSOP I* sample only, results were similar, i.e. there was no significant effect for health board.

#### *Wave differences*

Wave differences were examined separately for participants in the ERHA and in the WHB. In both analyses known wave differences in social class were controlled. No significant wave differences were found in emotional or informational support for participants in either board.

Differences by wave in terms of practical support were also examined separately for participants in the ERHA and the WHB. Both analyses were carried out while controlling for known wave differences in social class. For practical support, a significant effect of wave was found for participants in the ERHA ( $p < .01$ ), i.e. participants in *HeSSOP II* were more likely to experience practical support. There was no significant effect of wave in the WHB.

Further analysis was carried out to examine which groups of participants felt more supported. In these analyses, the three types of support were combined. Predictor variables included age, gender, marital status (living with spouse only, being widowed), household composition (living alone, living in intergenerational families), geography (living in urban v. rural settings) and carers. The only significant variables were education ( $p < .01$ ) and marital status ( $p < .001$ ). Adults with lower levels of education experienced more support than others. Being married was also related to higher levels of support.

These findings suggest that social exclusion can impede quality of life and well-being. Although the vast majority of *HeSSOP II* participants in each health board experienced quality of life and well-being, there were some who experienced difficulties; for example, between 10 and 15 per cent reported having little or no practical support, between 9 and 12 per cent reported being lonely quite often, and 11 per cent had major difficulties in accessing contact with other people.

Furthermore, specific groups have also been identified as being more at risk of experiencing difficulties; for instance, older participants, particularly women, reported less support than younger participants, and participants who lived alone reported higher levels of loneliness.

## 4.4. Health behaviours and health promotion

A selected range of activities were evaluated: two areas concerned people's own health-related behaviours (smoking and physical activity), and three represented possible preventive and screening activities provided by health professionals (the flu injection, blood pressure monitoring and general health checkups).

### 4.4.1 Smoking

Smoking among older people receives little attention despite clear evidence of the benefits of quitting at any time in the lifecycle. Table 4.20 shows that less than a fifth of the *HeSSOP II* sample were current smokers (18 per cent in the ERHA and 17 per cent in the WHB). In the ERHA, similar numbers of men and women smoked (17 per cent of women and 18 per cent of men), but in the WHB, more men than women smoked (13 per cent of women and 21 per cent of men). In terms of readiness to quit smoking, a small group of participants, mostly in the ERHA (14 per cent v. 4 per cent in the WHB), indicated that they were currently trying to quit smoking, and another 8 per cent in the ERHA and 5 per cent in the WHB indicated that they were actively planning to quit smoking. Fifty-two per cent of smokers were spoken to by a medical doctor in the past year about quitting smoking; a further 3 per cent were unsure if their GP had advised them about smoking.

**Table 4.20: Smoking status by gender and intention among smokers to quit by wave (2000 and 2004) and board (ERHA and WHB)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Smoke</b>	20	21	18	17
<b>Intention to quit</b>				
Trying to quit	16	3	14	4
Actively planning to quit	4	7	8	5
Thinking about quitting but not planning to	15	12	29	15
Not thinking about quitting	64	77	48	77

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

#### *Health board differences*

Health board differences in smoking behaviours were examined but none were found. A significant effect was found for age ( $p < .01$ ) with increased age being associated with a lower probability of smoking. For instance, while 21 per cent of those aged 65-69 years smoked, the corresponding figure for those aged 76-84 was 15 per cent, and for those aged 85 years and over it was 9 per cent. This pattern was repeated in *HeSSOP I* ( $p < .001$ ).

Health board differences in intention to quit smoking were also examined. A significant effect for health board was found in *HeSSOP II* only; participants in the WHB were less likely to be thinking or planning to quit smoking by comparison to their counterparts in the ERHA ( $p < .01$ ).

#### *Wave differences*

Differences in smoking behaviours between the two time points were examined while controlling for known wave differences in social class. For participants in the ERHA, a significant wave difference was found ( $p < .001$ ) with *HeSSOP II* participants in the ERHA less likely to smoke by comparison with their counterparts in *HeSSOP I*. A similar wave effect was also found for participants in the WHB ( $p < .001$ ). No significant wave differences, however, were found regarding intention to quit smoking in either health board.



## 4.4.2 Flu injection

Inoculation against influenza (flu injection) is an important preventive measure, particularly for older people. Participants were asked if they had received the flu injection in the previous year.

### *Health board differences*

The majority of participants in each of the health boards had received the flu injection (72 per cent of participants in the ERHA and 71 per cent in the WHB) and no health board differences were found (Table 4.21). When this analysis was repeated for *HeSSOP I*, a significant health board effect was found ( $p < .01$ ); in *HeSSOP I*, participants in the WHB were more likely to have received the flu injection by comparison with their counterparts in the ERHA.

There was also a trend for increasing age being associated with increased uptake of the flu injection. In the ERHA, for example, 53 per cent of those aged 65-69 years had the flu injection. This figure rose to 77 per cent for those aged 70-75 years, and 82 per cent for those aged over 75 years. Similarly, just 57 per cent of WHB participants in the 65-69 years group reported that they had had the flu injection. The corresponding figure for those in the 70-84 years groups was 74 per cent, and 92 per cent for those aged 85 years and over.

**Table 4.21: Uptake of flu injection by wave (2000 and 2004) and board (ERHA and WHB)**

	<i>HeSSOP I</i> *		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Flu injection</b>				
Yes (overall sample)	35	46	72	71
Men	67	58	71	68
Women	62	50	73	73

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); \* board difference where  $p < .01$ .

Health board differences in flu injection uptake at *HeSSOP II* were examined while controlling for known board differences in age, marital status, education and income. Flu injection uptake was significantly related to age ( $p < .001$ ), with

increasing age being associated with increased flu injection uptake. There was no significant effect for health board.

#### Wave differences

Wave differences in flu injection uptake were also examined. A significant effect for wave was found for participants in both the ERHA ( $p < .001$ ) and the WHB ( $p < .001$ ). In both boards there was a significant increase in the percentage of older people who had had the flu injection in the more recent survey.

Participants who had not received the flu injection in the previous year were asked about this decision; they could choose reasons from a list of seven or give their own reason(s). As can be seen in Table 4.22, the main reasons for not having the flu injection were not knowing they should have this and not believing that the risk of flu would be reduced. Nine per cent of participants in the ERHA and 12 per cent of participants in the WHB gave other reasons for not having the flu injection; these included not bothering or not thinking it important, feeling they did not need the injection or forgetting about it. These results suggest that many older people still need to be convinced about the benefits of flu injections.

**Table 4.22: Reasons for not receiving flu injection by wave (2000 and 2004) and board (ERHA and WHB)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Did not know entitled to it	4	2	7	7
Did not believe that it would reduce the risk of flu	14	11	7	7
Doctor said I did not need one	4	2	1	1
Concerned about side effects	8	9	3	5
Previous negative experience with flu injection	5	3	3	2

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

Further analyses were carried out to examine factors that might influence or predict which groups of people are more likely to have flu injections. Predictor variables were age, gender, education, marital status (living with spouse only, widowed),

household composition (living alone, living in intergenerational families), finances (as measured by income, social class and medical card ownership) and geography. Age was the only variable found to have a significant effect ( $p < .001$ ); increasing age was associated with an increasing probability of flu injection uptake.

### 4.4.3 Physical activity

Physical activity has been found to be a significant factor in disease prevention and health promotion in later years. Physical activity can reduce levels of cardiovascular disease (Wannamethee *et al.*, 1998), diabetes (Manson *et al.*, 1991), cancer (Bernstein *et al.*, 1994) and osteoporosis (Dalsky *et al.*, 1988). Physical activity can also improve psychological well-being (Morgan *et al.*, 1991). Questions, therefore, were included on physical activity. Participants were asked, 'all things considered, do you think you exercise enough at present?'. If they responded 'no', they were asked to choose from a list the barriers to physical activity they had experienced.

#### *Health board differences*

As can be seen in Table 4.23, the majority of *HeSSOP II* participants (over 75 per cent in each board) believed that they exercised enough at present. There were no significant gender differences or board differences in either *HeSSOP I* or *HeSSOP II*.

**Table 4.23: Engagement in physical activity by wave (2000 and 2004) and board (ERHA and WHB)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA %	WHB %	ERHA %	WHB %
Participants believing they exercise enough at present	77	79	75	81
<b>Gender</b>				
Men	82	81	78	83
Women	73	78	72	72

Note: *HeSSOP I*  $n = 937$  (ERHA  $n = 401$ , WHB  $n = 536$ ); *HeSSOP II*  $n = 1,053$  (ERHA  $n = 518$ , WHB  $n = 535$ ).

#### *Wave differences*

Also examined were wave differences for the ERHA and the WHB. There were no significant wave differences in estimates of physical activity for either board. Over

20 per cent of participants in each of the health boards indicated they were not engaging in enough physical activity at the time of the interviews. These participants were asked about this decision and possible barriers to physical activity. As can be seen in Table 4.24, health was the main reason given for not engaging in physical activity (14 per cent in the ERHA, 12 per cent in the WHB). Not being interested was also a barrier to physical activity for many participants.

**Table 4.24: Barriers to physical activity by wave (2000 and 2004) and board (ERHA and WHB)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Health reasons	15	14	14	12
Areas for walking not safe/ accessible/easy	1	1	1	1
Afraid of 'overdoing it'	2	2	3	2
Not interested	4	3	4	2
No time	2	1	3	1

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

Further analyses were carried out to determine which groups of people were more likely to engage in physical activity; such insights could have implications for interventions aimed at promoting more active lifestyles. Demographic predictor variables included gender, age, education, marital status (widowed, living with partner), household composition (living alone, living with spouse only, living in intergenerational family), social class and income. Additional variables were social support, functional ability and morale. When all variables were entered into the model, only two variables were predictive of engagement in physical activity; these were age ( $p < .01$ ) and morale ( $p < .001$ ) with the most active adults being those of younger age and higher morale.

## 4.5 Summary

### 4.5.1 Health status and self-rated health

- There were no health board differences in functional capacity in either *HeSSOP I* (2000) or *HeSSOP II* (2004). Neither board changed significantly in overall functional capacity of its older population over the four years between the studies.
- With the exception of walking sticks (used by 12 to 20 per cent of older people), use of aids and appliances was low across boards and time. This may be due to difficulties in accessing such equipment both due to lack of adequate financial resources and lack of occupational therapists who can carry out assessments for such equipment. As many aids contribute to maintaining older people at home this is an area that warrants further investigation.
- Use of hearing aids by the samples in 2004 was half that of the equivalent 2000 sample (from 8-9 per cent in 2000 to 4 per cent in both boards from 2000 to 2004). This indicates that there is an unmet need in relation to the ownership of hearing aids which might imply a reduction in services over the four-year period.
- Three quarters of participants in both boards rated their current health as good or excellent in 2004. This is an improvement from 2000 particularly for the WHB where only 59 per cent described themselves as in good/excellent health at that time.
- Comparing current health with health one year previously, most older people (two thirds) at both time points believed their health had remained the same.
- Health expectancies one year from now were very positive with about 90 per cent across boards and time believing their health would be the same or better than now.
- Education is a significant factor in determining people's self-rated current health and their ratings of future health; specifically, having a primary level of education only was associated with more negative self-ratings of health and expectations regarding health. These findings underscore the important role that education can play in facilitating health throughout the lifespan.

### 4.5.2 Receiving and providing care

- Similar levels of informal care were available to residents in the ERHA and WHB in 2004 (up to one third of participants availed of support from one or more sources). Those in the ERHA reported higher levels of informal care in 2004 than in 2000. They received more care from neighbours than did participants in the WHB. Family-provided care was similar across boards.
- Having a primary level of education only was significantly associated with accessing support from spouses/partners ( $p < .01$ ) and relatives outside the household ( $p < .001$ ). This may be indicative of the increased dependency of this group which in turn provides further support for the protective role that education can play in facilitating health and maintaining independence.
- A significant minority of older people were primary carers for another person. The pattern for the WHB was stable over time with 8-9 per cent acting as primary carers. In the ERHA, 9 per cent were primary carers in 2000 and 5 per cent were primary carers in 2004.
- Women were more likely to be carers, but not all carers were women. One in five carers had their own difficulties in carrying out activities of daily living.
- Only a small percentage of carers said that they had been provided with respite care within the last year. This suggests that there are a large number of people who are in need of this service but are not availing of it. The reasons for this need to be explored.

### 4.5.3 Psychological and social well-being

- Concerning positive mental health, two thirds of the sample reported high morale with no differences across board or time. Higher morale was associated with younger age and higher income. However, a substantial one in three did not report high morale. For instance, one third did not feel they contributed to their community and society as much as they would like to.
- One in ten had difficulty or were unable to get out of their homes to attend to social events or visit family and friends. There were no board or time differences in the size of this group. The importance of education is also underscored in this regard; while 5 per cent of those with a post-primary level of education had

difficulties in attending events outside the home, the corresponding figure for people with solely a primary level of education was 15 per cent.

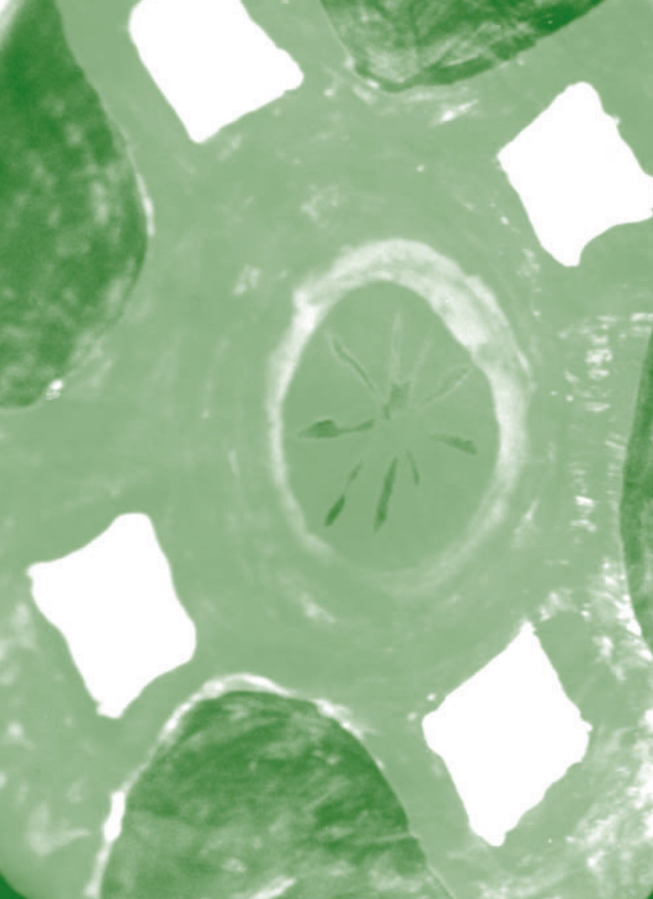
- Seven to fifteen per cent reported feeling lonely quite or very often. Living alone increased the likelihood of being lonely at least threefold.
- The majority in both boards reported high levels of social support: over 80 per cent reported emotional support, over 85 per cent reported informational support and over 75 per cent reported practical support. Changes over time reflected somewhat improved practical support in the ERHA in 2004. Practical support was the type of support least adequately available over time and board.

#### 4.5.4 Health behaviours

- Quitting smoking is beneficial at any age; fewer participants were smoking in 2004 than in 2000. Although nearly one in five people over the age of 65 are current smokers, over a fifth of ERHA smokers (22 per cent) and 9 per cent of those in the WHB were actively planning to quit in 2004. These planning rates were the same across boards, as in 2000. The evidence is that GPs are actively involved in smoking prevention, with over half of patients advised to quit smoking in the previous 12 months.
- Over 70 per cent in both boards had received the flu injection in winter 2003/4. This was a notable increase from 2000 (when 35 per cent of ERHA and 46 per cent of WHB participants were inoculated).
- At least three quarters of older people believed they took enough physical exercise - there were similar proportions across board and time.







# 5

## Chapter 5

Perceptions and  
use of health and  
social services:  
Repeat study

# Chapter 5

## Perceptions and use of health and social services: Repeat study

### 5.1 GP services

Assessing the quality of care received is vital if health professionals are to ensure that individuals get adequate access to healthcare. Determining quality of care is a crucial first step in encouraging good practice and a continuous quality improvement approach within healthcare.

In *HeSSOP*, participants were asked about the extent and quality of contact with GP services. Almost all *HeSSOP II* participants (99 per cent in both boards) had access to a personal GP. Participants typically reported having a long association with that doctor; 36 per cent in the ERHA and 45 per cent in the WHB were with their GP for more than twenty years. A further quarter of the sample (21 per cent in the ERHA and 28 per cent in the WHB), were with their GPs for between ten and nineteen years.

#### 5.1.1. Use of GP services

##### *Health board differences*

Use of GP services over the previous 12 months varied considerably among *HeSSOP II* participants. A small percentage of *HeSSOP II* participants had visited their GPs over twenty times in the previous year. In contrast, some participants had reported no visits to a GP in the past 12 months (6 per cent in the ERHA and 4 per cent in the WHB). For *HeSSOP II* participants in the ERHA, the mean number of visits to any GP in the past year was 4.6 (SD = 4.2, median = 4.0); for participants in the WHB, the mean number of visits was 6.2 (SD = 6.3, median = 4.0, see Table 5.1). In *HeSSOP I*, the mean number of GP visits for those in the ERHA was 4.5 (SD =

4.2) while the mean number of visits for those in the WHB was 5.5 (SD = 4.5). Differences between the health boards were significant in both *HeSSOP* studies. There was also a significant wave increase in GP visits.

It is clear from Table 5.1 that medians are identical across time and board (i.e. the number of visits undertaken at the 50th percentile). Differences emerge in the range of visits. In *HeSSOP II*, the ranges are notably higher than in *HeSSOP I* with the range in the WHB more than twice that in the ERHA.

These findings are similar to those of previous Irish research with older people (Garavan *et al.*, 2001; Layte, Fahey and Whelan, 1999). In 2000, average GP visiting rates for adults in Ireland were 3.6 per year, with higher attendance for those with medical cards (free GP care). It has been estimated that, controlling for other variables including health status, those with a medical card average 1.6 more GP visits per year (Madden, Nolan and Nolan, 2004).

Cost may significantly influence GP service use. In the time period from 2000 to 2004, a Government initiative to provide free GP care (through a medical card) to all citizens aged seventy years and over provided a 'natural experiment' to investigate this issue. In *HeSSOP I*, there was no significant difference in GP visits among those over and under the age of seventy ( $p > .05$ ). In *HeSSOP II*, however, a significant effect was found for participants in the ERHA ( $p < .001$ ) and the WHB ( $p < .05$ ), with people under the age of seventy having significantly fewer visits (see Table 5.1).

**Table 5.1: Use of GP services in the previous year by board (ERHA and WHB), wave (2000 and 2004) and age (<70, ≥ 70)**

GP attendance	HeSSOP I		HeSSOP II	
	ERHA %	WHB %	ERHA %	WHB %
<b>Age &lt; 70 years</b>				
Mean	4.3Δ*	5.9*	3.5Δ*∪	5.1*∪
SD	4.3	4.5	4.0	4.6
Median	3.0	4.0	2.0	3.9
Range	0-25	0-18	0-24	0-24
<b>Age ≥ 70</b>				
Mean	4.6*	5.4Δ*	5.0*∪	6.6Δ*∪
SD	4.0	4.4	4.2	6.8
Median	4.0	4.0	4.0	4.0
Range	0-30	0-30	0-40	0-84
<b>Total</b>				
Mean	4.5*	5.5Δ*	4.6*	6.2Δ*
SD	4.2	4.5	4.2	6.3
Median	4.0	4.0	4.0	4.0
Range	0-30	0-30	0-40	0-84

Note: HeSSOP I n = 937 (ERHA n = 401, WHB n = 536); HeSSOP II n = 1,053 (ERHA n = 518, WHB n = 535); Δ wave difference where p<.05; \* between health board difference where p<.05, ∪ age group difference where p<.05.

## 5.1.2 Attitudes and satisfaction with GP services

### 5.1.2.1 Attitudes

#### Health board differences

The freedom to move services if dissatisfied with care received is an important aspect of choice in healthcare. Approximately half of the HeSSOP II sample in each health board said that they would definitely consider changing GPs if dissatisfied (see Table 5.2). Approximately a fifth of the sample in the ERHA and in the WHB said that they would not consider changing their GP even if they were dissatisfied with the quality of care received.

**Table 5.2: Attitudes towards changing GP if dissatisfied with care by wave (2000 and 2004) and board (ERHA and WHB)**

Attitude	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Yes definitely	57	49	52	49
Yes possibly	25	24	25	33
No	18	27	23	18

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

In *HeSSOP II*, attitudes towards changing GP if dissatisfied with care did not vary by health board. When this analysis was repeated for the *HeSSOP I* sample a significant difference was found ( $p < .01$ ); at this point, participants in the ERHA were more likely than those in the WHB to change GPs if dissatisfied with the quality of care received.

#### *Wave differences*

There were no significant differences between the two time points in attitudes towards changing GP if dissatisfied with care in either the ERHA or the WHB. Analyses were carried out to examine demographic factors that might influence the decision to change GP if dissatisfied with quality of care. Predictor variables included gender, age, marital status, geography (living in urban v. rural areas), social class, and income. None were significant.

Reasons for not changing GPs if dissatisfied can be seen in Table 5.3. Reasons included worries about offending GPs, not having information about other GPs in the area, barriers to moving to another GP, and not being able to get onto another GP's list.

**Table 5.3: Reasons for not changing GP if dissatisfied with care by wave (2000 and 2004) and board (ERHA and WHB)**

Reason	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Would not like to offend GP	6	6	5	4
Do not know other GPs in this location	3	6	3	2
Not easy to move to another GP	4	7	6	5
Could not get onto another GP's list	0	0	1	0
Afraid new GP would not approve	1	2	1	0

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

#### 5.1.2.2 Satisfaction

*HeSSOP II* participants were also asked about their level of satisfaction with aspects of their GP care, including satisfaction with the availability of their GP (e.g. can get appointments when needed), with the quality of information they received about health, and with the interpersonal components of the consultation (particularly that their GP takes their concerns seriously).

##### *Health board differences*

The majority of participants (about 90 per cent of participants in each board) were either satisfied or very satisfied with all of these components of care, while about 2 per cent of participants were dissatisfied or very dissatisfied (Table 5.4). Controlling for known health board differences in demographic factors, there was no significant difference between the two health boards on ratings of satisfaction with GP availability, quality of information received about health, and having concerns taken seriously in either *HeSSOP I* or *HeSSOP II*. Participants in both health boards reported similar, positive ratings for GP services. These results are similar to *HeSSOP I* in which no significant effect for health board was found.

##### *Wave differences*

In keeping with the findings for health boards there were no wave differences on ratings of satisfaction when examining data from either the ERHA or the WHB.

**Table 5.4: Satisfaction with components of GP care by wave (2000 and 2004) and board (ERHA and WHB)**

Satisfaction	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Satisfied or very satisfied</b>				
With availability of GP (e.g. that can get appointments when needed)	95	95	94	95
With the quality of information received about health	95	93	94	92
That GP takes concerns seriously	95	95	95	94

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

### 5.1.3 Barriers to GP services

Older adults may be denied adequate care given practical barriers such as cost and transport, or psychological barriers such as the ageist attitudes of some health professionals (e.g. Treharne, 1990). Participants in *HeSSOP II* were asked about barriers to care with their GP.

#### *Health board differences*

Almost all participants indicated that 'nothing' prevented them from seeing a GP as much as they would like. Barriers that existed are outlined in Table 5.5.

Health board differences in *HeSSOP II* could not be computed because of small percentages. In *HeSSOP I*, there were no significant differences between the health boards in any of the GP barriers assessed with the exception of cost ( $p < .001$ ); in *HeSSOP I*, participants in the ERHA were more likely than their counterparts in the WHB to say that cost prevented them from availing of GP services as much as they would like.

#### *Wave differences*

Wave differences in barriers to GP services were also examined by board. A significant wave effect was also found for cost ( $p < .001$ ); ERHA participants in *HeSSOP II* were less likely than in *HeSSOP I* to report experiencing cost as a barrier to accessing GP services. These cost results could be explained by the introduction

of a non-means-tested medical card to all adults aged seventy years and over in late 2001. No other significant ERHA wave differences were found. When examining wave data for participants in the WHB, the same pattern was found. WHB participants in *HeSSOP II* were significantly less likely than in *HeSSOP I* to report transport as a barrier to accessing GP services ( $p < .001$ ). No other significant WHB wave effects were found.

**Table 5.5: Barriers preventing access to GPs by wave (2000 and 2004) and board (ERHA and WHB)**

Barrier	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Transportation	3	5	1	1
Cost	8*	2*	1	0
Takes too much time	1	0	0	1
Too much hassle	1	0	1	1

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); \* between health board difference where  $p < .01$ .

#### 5.1.4 Blood pressure checks

Blood pressure management is an important goal for GPs. In *HeSSOP I*, participants were asked about the last time they had had their blood pressure checked by a medical practitioner. In *HeSSOP II*, this question was amended to ask specifically about the last time a GP had checked their blood pressure.

##### *Health board differences*

The majority of participants in each health board had had their blood pressure checked by a GP in the previous year (see Table 5.6). There were no significant board differences on this measure for the *HeSSOP II* sample.

When this analysis was repeated for the *HeSSOP I*, however, a significant difference was found ( $p < .01$ ); *HeSSOP I* participants in the WHB were more likely to have had their blood pressure checked by a medical practitioner when compared to their counterparts in the ERHA.



### Wave differences

Because of the difference in phrasing between the two *HeSSOP* studies (blood pressure checked by a medical practitioner v. blood pressure checked by a GP), it was not possible to examine wave differences in blood pressure checks.

Nevertheless, it was possible to compare factors that might explain which groups of people were more likely to have had their blood pressure checked. In conducting this analysis, the outcome variable was blood pressure check. Analyses showed that none of the predictor variables, i.e. age, gender, marital status, household composition (lives alone, lives in multigenerational household), geography (living in urban v. rural areas), social class and income, significantly explained blood pressure checks.

**Table 5.6: Blood pressure checks by wave (2000 and 2004) and board (ERHA and WHB)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Yes, had blood pressure checked</b>				
Less than 3 months ago	63	71	65	68
Up to 1 year ago	26	20	26	22
Up to 3 years ago	7	6	7	4
3-5 years ago	3	1	1	2
Over 5 years ago	1	1	1	1
Never	–	–	1	2

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

## 5.2 Hospital services

Participants were asked about their use of hospital services over the past twelve months, including visits to accident and emergency (A&E), scheduled in-patient admissions and hospital out-patient appointments. Participants were asked if and how often they had used the services and, where relevant, about their satisfaction with their visit.

## 5.2.1 Use of services in A&E

### *Health board differences*

Between 10 and 13 per cent of *HeSSOP II* participants in each health board attended A&E in the previous year (see Table 5.7).

**Table 5.7: Hospital service use by wave (2000 and 2004) and board (ERHA and WHB)**

Hospital service	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA %	WHB %	ERHA %	WHB %
A&E	13	11	13	10
Scheduled hospital in-patient	15	18	16	16
Scheduled hospital out-patient	36* $\Delta$	13*	25* $\Delta$	14*

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); \* health board difference where  $p < .01$ ,  $\Delta$  wave difference where  $p < .001$ .

*HeSSOP II* participants in the ERHA were no more likely than those in the WHB to access A&E services ( $p < .05$ ). Similarly, health board differences in A&E attendance were not found for *HeSSOP I* participants. Of those attending A&E for services, the majority attended just once in the previous year (see Tables 5.8 and 5.9); health board differences were not found for participants in either *HeSSOP I* or *HeSSOP II*.

**Table 5.8: Frequency of hospital visits by board (ERHA and WHB) in 2004**

Hospital service	HeSSOP II					
	ERHA			WHB		
	1	2-3	4+	1	2-3	4+
	visit	visits	visits	visit	visits	visits
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
A&E	78 (53)	18 (12)	4 (3)	89 (61)	10 (7)	0 (0)
Scheduled hospital in-patient	78 (61)	20 (16)	2 (2)	87 (68)	9 (8)	4 (4)
Scheduled hospital out-patient	52 (70)	26 (34)	22 (28)	46 (31)	35 (26)	19 (14)

**Table 5.9: Frequency of hospital visits by board (ERHA and WHB) in 2000**

Hospital service	HeSSOP I					
	ERHA			WHB		
	1	2-3	4+	1	2-3	4+
	visit	visits	visits	visit	visits	visits
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
A&E	71 (39)	21 (12)	8 (4)	73 (38)	15 (9)	12 (6)
Scheduled hospital in-patient	86 (48)	10 (6)	4 (2)	74 (65)	21 (21)	5 (5)
Scheduled hospital out-patient	27 (38)	45 (64)	28 (38)	37 (27)	27 (21)	36 (29)

*Wave differences*

There was no significant difference between the two time points in frequency of attendance in A&E when examining data for participants in either health board. Analyses were carried out to determine which groups of adults were most likely to access services via A&E. Predictor variables were age, gender, household composition (living alone, living in multigenerational homes), income, social class, geography and education. None of these variables were significant in predicting A&E use.

## 5.2.2 Use of in-patient services

### *Health board differences*

Fifteen to sixteen per cent of *HeSSOP II* participants across health boards availed of in-patient hospital services in the previous year (see Table 5.7). Of those attending hospital in the previous year, the majority received treatment just once (see Table 5.8). The number of visits, however, for in-patient hospital treatment ranged from one to four for *HeSSOP II* participants in the ERHA and one to eight for *HeSSOP II* participants in the WHB. There was no significant health board difference in hospital in-patient attendance. In keeping with this, there was no significant difference between the health boards in terms of the frequency in which *HeSSOP II* participants attended in-patient hospital care. When these analyses were repeated for the *HeSSOP I* sample, results were similar.

### *Wave differences*

There were no significant differences in hospital in-patient use for participants in either the ERHA or the WHB between the two time points. Wave differences in frequency of attendance for in-patient treatment were also examined and found for participants in the WHB ( $p < .001$ ), with more *HeSSOP II* participants attending in-patient hospital services less frequently than in *HeSSOP I*. Further analyses were carried out to determine which groups of adults were most likely to avail of in-patient services. Predictor variables included age, gender, household composition (living alone, living in multigenerational homes), income, social class, education and geography (living in urban v. rural areas). None of these variables, however, were significant in predicting in-patient service use in *HeSSOP II*.

## 5.2.3 Use of out-patient services

### *Health board differences*

The range of visits for out-patient hospital care ranged extensively among *HeSSOP II* participants, from 1-32 visits for participants in the ERHA (median = 2) and 1-78 visits for participants in the WHB (median = 2). The majority of the sample in each health board, however, had six or fewer appointments. A quarter of *HeSSOP II* participants in the ERHA reported attending hospital out-patient appointments during the past year. This was almost twice as many as in the WHB; this difference was statistically significant ( $p < .001$ ). When examining data for participants in *HeSSOP I*, a significant health board difference was also found ( $p < .001$ ); *HeSSOP I* participants in the ERHA were almost three times as likely to attend out-patient hospital services by comparison with WHB participants. There was no significant health board difference in terms of frequency of receipt of out-patient services;

*HeSSOP II* participants in the ERHA did not attend for treatment more frequently by comparison with WHB participants. This effect remained even when controlling for known health board differences in demographic variables between the samples. When this analysis was repeated for *HeSSOP I* participants, no significant health board effect was found.

#### *Wave differences*

Fewer participants in the ERHA attended out-patient services in *HeSSOP II* by comparison with ERHA participants in *HeSSOP I* ( $p < .001$ ). No significant wave difference was found for participants living in the WHB. Differences in the frequency of out-patient hospital visits between the two time points were also examined, whilst controlling for known wave differences in social class. When examining wave data for participants in the ERHA only, a significant effect was found ( $p < .001$ ) with ERHA participants in *HeSSOP II* attending more frequently than in *HeSSOP I*. There was no significant effect of social class on frequency of out-patient services. When examining data for participants in the WHB, no significant effect was found. Further analyses were carried out to determine which groups of adults were most likely to avail of out-patient services. Demographic predictor variables included age, gender, household composition (living alone, living in multigenerational homes), income, social class, education and geography (living in urban v. rural areas). Only geography was significant in predicting out-patient services ( $p < .01$ ); while just 15 per cent of *HeSSOP II* participants living in rural areas had attended out-patient services, this proportion increased to 24 per cent for those living in urban areas, defined as towns or cities with 10,000+ people. Similarly, while 16 per cent of *HeSSOP I* participants living in rural areas attended out-patient services, this percentage increased to 34 per cent for those living in urban areas.

### 5.2.4 Adequacy of out-patient appointments

One marker of quality of care is patient perception of adequacy of access to services. Participants were asked if they felt the number of out-patient appointment's was about right, not enough, or too many.

#### *Health board differences*

The majority of *HeSSOP II* participants (approximately 90 per cent in each health board) who attended out-patient appointments believed the number of appointments they had was about right (see Table 5.10). In looking at perceived adequacy of out-patient appointments according to health board, no significant differences were found. These data are similar to *HeSSOP I*.

### Wave differences

No significant wave effect was found for either board.

**Table 5.10: Perceived adequacy of out-patient appointments scheduled in previous year by wave (2000 and 2004) and board (ERHA and WHB)**

Number of out-patient appointments were	HeSSOP I		HeSSOP II	
	ERHA %	WHB %	ERHA %	WHB %
Not enough	4	2	8	11
About right	95	96	92	89
Too many	1	3	-	-

Note: HeSSOP I n = 937 (ERHA n = 401, WHB n = 536); HeSSOP II n = 1,053 (ERHA n = 518, WHB n = 535).

## 5.2.5 Barriers to out-patient services

### Health board differences

Participants had been asked about barriers to out-patient services; few barriers, however, were found. Of those attending out-patient hospital services, 30 per cent in the ERHA and 24 per cent in the WHB reported transport to be a problem. Twenty-five per cent in the ERHA and 12 per cent in the WHB noted the 'hassle' involved in using out-patient services, and 44 per cent reported that illness was a barrier to out-patient service use.

## 5.3 Day services (day hospital, day centre/clubs)

Day services offer an important opportunity to enable older people to remain in their own homes by facilitating social interaction and/or management of health needs. In earlier focus groups, many older people commented on the value of day care services:

*Well I think older people are much happier now because they have so much help. Say for instance coming here (to day-care centre) for the day, it is a wonderful thing that is being done for us there, you get a lunch and you are meeting people and you can share your problems with each other. That is a wonderful thing; my mother didn't have things like that. We are very well looked after, it is something we cannot complain about ... I think it is marvellous if you're well enough in your mind to enjoy it.*

In addition to GP and hospital services, participants in both *HeSSOP* studies were asked about their experiences with day services. Of particular interest in *HeSSOP II* were services at day hospitals and day centres. The former provide more medically focused services, e.g. blood pressure checks, physiotherapy or chiropody. In contrast, day centres provide a more social focus, offering a range of activities that may include services such as meals or baths which are not primarily medically focused. As noted in *HeSSOP I*, however, this distinction is a loose one and some day care centres can have a more medical focus than others and vice versa. To differentiate in so far as was possible, interviewers were briefed about this distinction and asked to clarify it with participants.

### 5.3.1 Day hospital services

#### *Health board differences*

A small percentage of *HeSSOP II* participants used day hospital services in the previous year (see Table 5.11). In most cases, day hospitals were attended just once each week (by 80 per cent in the ERHA and 100 per cent in the WHB of those attending) (see tables 5.12 and 5.13). In terms of estimates of unmet need, just 1 per cent of participants in both boards reported that they were not currently receiving day hospital services but would like to do so.

Analysis was carried out to examine board differences in attendance at day hospital while controlling for known health board differences in age group, marital status, education and income. No demographic variable was significantly related to day hospital use. Even when controlling for known demographic differences, however, a significant health board effect was found ( $p < .01$ ) with *HeSSOP II* participants in the ERHA being more likely to attend day hospital in comparison with *HeSSOP II* participants in the WHB. This analysis was repeated for *HeSSOP I* only and no significant difference was found.

#### *Wave differences*

Wave differences in day hospital attendance were also examined. There was no significant difference in day hospital use when examining data at the two time points for participants from the ERHA. However, a significant wave effect was found for participants in the WHB ( $p < .01$ ); *HeSSOP II* participants had fewer visits to the hospital.

**Table 5.11: Use of day hospitals and day centres by wave (2000 and 2004) and board (ERHA and WHB)**

Used in past 12 months	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Day hospital	6	4 $\Delta$	5*	1* $\Delta$
Day centre	5	5	3*	2*

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); \* health board difference where p < .01,  $\Delta$  wave difference where p < .01.

**Table 5.12: Visits per week to day hospital or day care centre by board (ERHA and WHB) in 2004**

Used in past 12 months	<i>HeSSOP II</i>					
	ERHA			WHB		
	1 visit	2-3 visits	4+ visits	1 visit	2-3 visits	4+ visits
	%	%	%	%	%	%
Day hospital	80	14	6	100	-	-
Day centre	30	42	28	100	-	-

Note: ERHA at tenders at day hospital = 25 and day centres = 15. WHB at tenders at day hospital = 3 and day centres = 11.



**Table 5.13: Visits per week to day hospital or day care centre by board (ERHA and WHB) in 2000**

<i>HeSSOP II</i>						
Used in past 12 months	ERHA			WHB		
	1 visit	2-3 visits	4+ visits	1 visit	2-3 visits	4+ visits
	%	%	%	%	%	%
Day hospital	51	36	18	65	27	8
Day centre	54	33	13	65	27	8

### 5.3.2 Day care services

#### *Health board differences*

As shown in Table 5.11, a small percentage of *HeSSOP II* participants used day care services in the previous year. When asked about barriers that prevented them from availing of (or more frequently receiving) services at day care centres participants reported few of these. Transportation difficulties were reported by 2 per cent of participants; other barriers included inconvenience (2 per cent), illness (1 per cent), and not enjoying day care services when they did attend (1 per cent). Two per cent of participants reported that being limited to just one session per week was a barrier.

Participants in the ERHA tended to go to day centres two to three times per week (42 per cent, median = 1 visit, SD = 1.2, range one to five visits per week), but all participants in the WHB attended one day per week. There was no significant difference between the health boards in terms of attendance at day care services. When this analysis was repeated for *HeSSOP I*, no significant health board effect was found.

#### *Wave differences*

Wave differences in the proportion of people availing of day care services were also examined separately for the ERHA and the WHB. A significant wave effect was found for the WHB ( $p < .01$ ), with participants in *HeSSOP II* less likely to avail of day care services than participants in *HeSSOP I*. Analysis was also carried out to examine possible predictors of day care service use. Predictor variables included age, gender, marital status, household composition (living alone, living in intergenerational families), geography (living in urban v. rural areas), income and social classes. Age

was found to be a significant predictor ( $p < .001$ ); increasing age was associated with a greater probability of attendance at day centres.

## 5.4 Waiting lists

Waiting times are one of the leading reasons that adults do not access healthcare (Schoen *et al.*, 2002). In addition to the inconvenience and distress they cause, long waiting lists for treatment can result in harm through delays in diagnosis and treatment, and through preventable complications arising. According to the US Institute of Medicine (2001), high quality healthcare involves reducing delays and waiting times for healthcare users. *HeSSOP* participants were asked if they were currently on waiting lists for a range of services: hospital in-patient, hospital out-patient, day hospital and day centre.

### 5.4.1 In-patient hospital waiting lists

#### *Health board differences*

Between 4 and 5 per cent of *HeSSOP II* participants across health boards were waiting for in-patient hospital treatment (Table 5.14). Waiting times for in-patient hospital treatment ranged from 2-156 weeks for participants in the ERHA, and 2-520 weeks for participants in the WHB, but the majority of participants (60 per cent in the ERHA and 47 per cent in the WHB) were waiting for more than nine months (see Table 5.15 and 5.16).

In relation to waiting for in-patient treatment, there were no statistically significant health board differences on this variable in either *HeSSOP I* or *HeSSOP II*. There was also no significant health board difference in the percentage on waiting lists for in-patient treatment. This was also the case when this analysis was repeated for *HeSSOP I*.

#### *Wave differences*

Differences in waiting lists for in-patient treatment were examined separately for the ERHA and the WHB between the two time points. No significant wave effects were found for either health board. Wave differences were examined for participants in the ERHA and the WHB but in neither case were results significant. Further analysis was carried out to examine possible predictors of being on a waiting list for in-patient treatment. Predictor variables included age, gender, marital status, household composition (living alone, living in intergenerational families), geography (living in urban v. rural areas) and social class. Social class ( $p < .001$ ) was the only

significant variable. Those from lower social classes were more likely to be on a waiting list for in-hospital services.

**Table 5.14: Waiting lists for treatment by wave (2000 and 2004) and board (ERHA and WHB)**

Type of treatment	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
In-patient treatment	2	4	4	5
Out-patient treatment	2Δ	3Δ	6Δ	8Δ
Day hospital	1Δ	1Δ	3*Δ	2*Δ
Day care centre	0	1	1	0
Waiting for any of the above services	3Δ	7Δ	11Δ	13Δ

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); \* health board difference where p<.01, Δ wave difference where p<.01.

**Table 5.15: Time on waiting list for services by board (ERHA and WHB) in 2004**

Type of treatment	<i>HeSSOP II</i>							
	ERHA				WHB			
	1-4*	5-12*	13-32*	33+	1-4*	5-12*	13-32*	33+
	weeks	weeks	weeks	weeks	weeks	weeks	weeks	weeks
	%	%	%	%	%	%	%	%
In-patient services	4	22	14	60	18	17	18	47
Out-patient services	23	48	21	8	44	36	10	10
Day hospital	34	44	11	11	100	-	-	-
Day centre/club	90	10	-	-	-	-	-	-

Note: \* corresponds to 1 month, 3 months and 9 months respectively.

**Table 5.16: Time on waiting list for services by board (ERHA and WHB) in 2000**

<i>HeSSOP I</i>								
Type of treatment	ERHA				WHB			
	1-4*	5-12*	13-32*	33+	1-4*	5-12*	13-32*	33+
	weeks	weeks	weeks	weeks	weeks	weeks	weeks	weeks
	%	%	%	%	%	%	%	%
In-patient services	15	26	32	27	32	22	10	36
Out-patient services	61	25	14	-	24	41	14	21
Day hospital	-	-	-	-	-	100	-	-
Day centre/club	-	-	-	-	95	5	-	-

Note: \* corresponds to 1 month, 3 months and 9 months respectively.

## 5.4.2 Out-patient hospital waiting lists

### *Health board differences*

Between 6 and 8 per cent of *HeSSOP II* participants across health boards were waiting for out-patient hospital treatment (Table 5.14). Waiting times for out-patient hospital treatment ranged from 1-24 weeks for participants in the ERHA and 2-200 weeks for participants in the WHB. The majority of participants were on waiting lists for less than three months (71 per cent in the ERHA and 80 per cent in the WHB), (see Tables 5.15 and 5.16). There was no significant health board difference in the percentage of people on out-patient waiting lists, either in *HeSSOP I* or *HeSSOP II* (Table 5.15).

### *Wave differences*

When examining wave differences for participants in the ERHA, a significant effect was found ( $p < .01$ ) with *HeSSOP II* participants in the ERHA being more likely to be on a waiting list when compared to *HeSSOP I*. When examining data for participants from the WHB region, a significant effect was also found ( $p < .001$ ); again *HeSSOP II* participants from the WHB were more likely than *HeSSOP I* participants to be on a waiting list for out-patient treatment. Further analysis was carried out to examine which groups, if any, were most likely to be on a waiting list for out-patient treatment. Predictor variables included age, gender, marital status, household composition (living alone, living in intergenerational families), geography (living in urban v. rural areas) and social class. There were no significant relationships.

### 5.4.3 Day hospital waiting lists

#### *Health board differences*

Between 2 and 3 per cent of *HeSSOP II* participants in each health board were on a waiting list for day hospital services (Table 5.14). Waiting times for day hospital services ranged from two to forty weeks for participants in the ERHA, with the majority (71 per cent) waiting less than one month. No participants in the WHB were waiting for more than a month. Health board differences in the percentage of people on the waiting list for day hospital services were found ( $p < .01$ ); *HeSSOP II* participants in the ERHA were more likely than *HeSSOP II* participants in the WHB to be on a waiting list for day hospital treatment ( $p < .01$ ). When this analysis was repeated for *HeSSOP I*, no significant health board difference was found.

#### *Wave differences*

When examining differences between the two time points, significant effects were found for the ERHA ( $p < .01$ ) and the WHB ( $p < .001$ ). *HeSSOP II* participants were more likely to be on a waiting list for day hospital services than their *HeSSOP I* counterparts in both regions. Analysis was conducted to determine what groups of people were most likely to be on a waiting list for day hospital. Predictor variables included age, gender, marital status, household composition (living alone, living in intergenerational families), geography (living in urban v. rural areas) and social class. There were no significant differences.

### 5.4.4 Day care centre waiting lists

#### *Health board differences*

The percentage of participants on waiting lists for day care centres was very small (1 per cent in the ERHA and 0 per cent in the WHB). These differences were not statistically significant.

#### *Wave differences*

Differences in the percentage of people on waiting lists did not vary significantly between the two time points; findings were similar to *HeSSOP I* (0 per cent in the ERHA and 1 per cent in the WHB). Further analysis was conducted to identify factors that might be predictive of being on a waiting list. There was no relationship between being on a waiting list and either gender or age. Waiting lists for day care services were typically less than one month. It is possible that the failure of people to avail of these services may be related to the absence of extensive knowledge about these services among older people.

## 5.4.5 Overall hospital-related waiting lists

Proportions waiting for any service were similar across boards but had increased about twofold from 2000 to 2004 (Table 5.14): 3 per cent (ERHA) and 7 per cent (WHB) in 2000; 11 per cent (ERHA) and 13 per cent (WHB) in 2004.

## 5.5 Use of other health and social services

Health boards provide many services to facilitate better health and quality of life among older people living in the community. Some of these services are available to respondents in their own homes, while others have to be accessed through hospital or health board facilities.

### 5.5.1 Use of home services

Participants were asked about their preferences and experiences of home services. These included home help, meals-on-wheels, public health nurses and personal care attendants.

#### 5.5.1.1 Public health nursing services

##### *Health board differences*

Twelve per cent of *HeSSOP II* participants in the ERHA and 13 per cent in the WHB were availing of services from a public health nurse.

##### *Wave differences*

There were no significant wave differences in the number of participants who were availing of services from a public health nurse; this was the same for both the ERHA and the WHB. Analysis was undertaken to determine which groups of adults were most likely to avail of the services of a public health nurse. Predictor variables included age, gender, household composition (living alone, living in multigenerational homes), income, social class, geography (living in urban v. rural areas) and education. Increasing age ( $p < .001$ ), female gender ( $p < .01$ ), having a primary level of education only ( $p < .01$ ), being widowed ( $p < .001$ ), and living with spouses only ( $p < .01$ ) were all associated with availing of services from a public health nurse.

### 5.5.1.2 Services from Home Helps

#### Health board differences

Between 5 and 9 per cent of *HeSSOP II* participants across health boards had availed of the services of a Home Help in the past year (see Table 5.17).

Even when controlling for known health board differences in education, age, marital status and income, a significant effect of board was found ( $p < .001$ ); *HeSSOP II* participants in the ERHA were more likely to avail of services from Home Helps when compared with their counterparts in the WHB. This pattern was not significant in *HeSSOP I*.

**Table 5.17: Currently using services by board (ERHA and WHB) and wave (2000 and 2004)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Home services</b>				
Public health nurse/district nurse	15	14	14	13
Home help	7	4	9 *	5 *
Meals-on-wheels	2	1	4 *	1 *
Personal care attendant	1	<.5	1	2
<b>Therapies</b>				
Chiropody services	25 *	9 *	24 *	8 *
Physiotherapy services	4 Δ	3	9 *Δ	2 *
Social work services	2	1	3 *	1 *
Occupational therapy	1	<1	2	1
Psychological/counselling services	<.5	<.5	2	1
<b>Out-patient services</b>				
Optician services	18 Δ	14	33 *Δ	16 *
Dental services	11 *Δ	5 *	20 *Δ	6 *
Hearing services	6 *	3 *	8 *	3 *
Dietician services	4	1	5	3
<b>Respite services</b>				
Respite care as a receiver of care	1	1	2	1
Respite care as a carer	1	1	<.5	<.5

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); \* health board difference where  $p < .01$ , Δ wave difference where  $p < .01$ .

### *Wave differences*

When wave differences in the use of home help services were examined, no significant effect was found for participants in either the ERHA or in the WHB, i.e. within boards, *HeSSOP II* participants were not any more or less likely to avail of home help services than *HeSSOP I* participants. Further analysis was undertaken to determine which groups of adults were most likely to avail of home help services. Predictor variables included age, gender, household composition (living alone, living in multigenerational homes), income, social class, geography (living in urban v. rural areas) and education. Only age ( $p < .001$ ) and geography ( $p < .001$ ) were associated with use of home help services. While just 3 per cent of participants aged 65-69 years availed of home help services, this figure rose to 9 per cent for those aged 76-84 years, and was 27 per cent for those aged 85 years and over. Similarly, while 5 per cent of those in rural areas received home help services, the corresponding percentage for those in urban areas was 11 per cent.

#### 5.5.1.3 Meals-on-wheels

##### *Health board differences*

Four per cent of *HeSSOP II* participants in the ERHA and 1 per cent in the WHB were using meals-on-wheels.

Significant differences were seen in the number of participants who used meals-on-wheels ( $p < .01$ , see Table 5.16). There was no significant effect for *HeSSOP I*.

##### *Wave differences*

There were no significant wave differences for participants in either the ERHA or the WHB, i.e. no changes were found in the percentage using meals-on-wheels from *HeSSOP I* to *HeSSOP II*. Further analysis was undertaken to determine which groups of adults were most likely to avail of meals-on-wheels services. Predictor variables included age, gender, household composition (living alone, living in multigenerational homes), income, social class, geography (living in rural v. urban areas) and education. Social class was significant ( $p < .01$ ); while 15 per cent of those in the highest social classes were receiving meals-on-wheels, the corresponding figure for those in the lowest social class was just 5 per cent.



#### 5.5.1.4 Personal care attendant services

##### *Health board differences*

One per cent of *HeSSOP II* participants in the ERHA and 2 per cent in the WHB were availing of services from a personal care attendant.

##### *Wave differences*

The percentage of individuals in the ERHA who availed of services from a personal care attendant did not differ significantly between the two time points. For the WHB, however, the difference was significant ( $p < .01$ ), i.e. *HeSSOP II* participants in the WHB were more likely to avail of a personal care attendant by comparison with *HeSSOP I* participants in the same health board area.

Further analysis was undertaken to determine which groups of adults were most likely to avail of services from personal care attendants. Predictor variables included age, gender, household composition (living alone, living in multigenerational homes), income, social class, geography (living in urban v. rural areas) and education. Only age was significant in predicting usage of personal care attendants ( $p < .001$ ); while 8 per cent of those receiving support from a personal care attendant were in the age group 65-69 years, the corresponding figure for those aged 85 years and over was 49 per cent.

#### 5.5.2 Therapies

Participants were asked about their experiences of a range of therapies including physiotherapy, occupational therapy, chiropody, speech therapy and psychological therapy or counselling.

##### 5.5.2.1 Chiropody services

##### *Health board differences*

Twenty-four per cent of *HeSSOP II* participants in the ERHA availed of services from chiropodists, as did 8 per cent of participants from the WHB.

There was a significant difference between health boards in the number of participants who availed of chiropody services, i.e. ERHA participants were more likely to avail of these services in both *HeSSOP II* and *HeSSOP I* ( $p < .001$ , see Table 5.17).

### *Wave differences*

There were no significant wave effects found for either the ERHA or the WHB in the number of participants who availed of chiropody services, i.e. *HeSSOP II* participants in each board did not differ in chiropody service use from their *HeSSOP I* counterparts. Analysis was carried out to examine which groups of people were more likely to avail of chiropody services. Predictor variables included age, gender, household composition (living alone, living in multigenerational homes), income, social class, geography (living in urban v. rural areas) and education. A significant effect was found for age ( $p < .001$ ) and geography ( $p < .001$ ) indicating that those most likely to avail of chiropody services were those in the oldest age groups and residents of rural areas.

### 5.5.2.2 Physiotherapy

#### *Health board differences*

Nine per cent of participants in the ERHA and 2 per cent of participants in the WHB had availed of physiotherapy services in the previous year. The difference in the number of participants who received physiotherapy services was statistically significant ( $p < .001$ ). When this analysis was repeated for *HeSSOP I*, no significant effect was found.

#### *Wave differences*

A significant wave effect was found for participants in the ERHA ( $p < .01$ ); *HeSSOP II* participants were more likely than *HeSSOP I* participants to avail of physiotherapy services. No significant wave difference was found for participants in the WHB.

#### *Wave 2*

Analysis was undertaken to determine which groups of adults were most likely to avail of physiotherapy services. Predictor variables included age, gender, household composition (living alone, living in multigenerational homes), income, social class, geography (living in urban v. rural areas) and education. The factor that was related to use of physiotherapy services was living in intergenerational families ( $p < .01$ ). Additionally, there was an effect of geography favouring those living in rural areas ( $p < .01$ ); of those using physiotherapy services, 52 per cent lived in rural areas and 36 per cent lived in urban areas.

### 5.5.2.3 Social work services

#### *Health board differences*

A small proportion of *HeSSOP II* participants reported using the services of social workers (3 per cent in the ERHA and 1 per cent in the WHB). Health board differences in uptake of services from social workers were significant ( $p < .01$ ). ERHA

participants in *HeSSOP I* were also more likely than those in the WHB to avail of services from social workers, but this trend did not quite reach significance level.

#### *Wave differences*

No significant wave differences were found for the ERHA or the WHB in use of services from social workers. In looking at predictors of social work service uptake, gender, age and social class were investigated. There was a significant gender effect, with women being more likely to avail of these services than were their male counterparts ( $p < .01$ ); of those who availed of services from social workers, 81 per cent were female and 19 per cent male. There was no significant relationship between uptake in services from a social worker and either age or social class.

### 5.5.2.4 Occupational therapy

#### *Health board differences*

Just 1-2 per cent of *HeSSOP II* participants in each of the health boards reported availing of occupational therapy services. There was no significant difference between health boards for either *HeSSOP II* or *HeSSOP I*.

#### *Wave differences*

There were no wave differences found for the ERHA or the WHB in the use of occupational therapy services. Analysis was undertaken to determine which groups of adults were most likely to avail of occupational therapy services. Predictor variables included age, gender, household composition (living alone, living in multigenerational homes), education, income, social class and geography. A significant effect was found for geography ( $p < .01$ ); of those receiving occupational therapy, 21 per cent lived in rural areas (open country or small villages) while 51 per cent lived in large urban areas.

### 5.5.2.5 Psychological/counselling services

#### *Health board differences*

The proportion of people using counselling services was very low (see Table 5.17) and no significant differences were found across health boards for the proportion of participants using counselling services.

#### *Wave differences*

There were no wave differences in the proportion of participants using counselling services. Analysis was undertaken to determine which groups of adults were most likely to avail of counselling services. Predictor variables included age, gender, education, income, social class and geography. However, none of these variables were significant.

### 5.5.3 Out-patient services

Participants were asked about their experiences of a range of other primary care services including those of dietitians, opticians, dental specialists and hearing specialists.

#### 5.5.3.1 Optician services

##### *Health board differences*

One of the most widely used primary care services was optical care. Thirty-two per cent of *HeSSOP II* participants from the ERHA and 16 per cent of those from the WHB availed of this service in the past year. There was a significant difference in the number of individuals using primary care services ( $p < .001$ ). When this analysis was repeated for *HeSSOP I*, however, no significant health board difference was found. In looking at the number of individuals who were willing to avail of these services there was no significant difference between health boards at either time.

##### *Wave differences*

A significant wave effect was found when examining data from the ERHA ( $p < .001$ ); *HeSSOP II* participants in the ERHA were more likely to have availed of services from opticians than in *HeSSOP I*. No significant wave effect was found for people residing in the WHB. Analysis was undertaken to determine which groups of adults were most likely to avail of services from opticians. Predictor variables included age, gender, household composition (living alone, living in multigenerational homes), income, social class, education and geography. Uptake of services from opticians was associated with increasing age ( $p < .001$ ), being female ( $p < .01$ ) and geography ( $p < .001$ ); while 16 per cent of those availing of services from opticians were residing in rural areas, this percentage increased to 25 per cent for those living in urban areas.

#### 5.5.3.2 Dental services

##### *Health board differences*

Twenty per cent of *HeSSOP II* participants from the ERHA and 6 per cent of those from the WHB had been to the dentist in the previous year.

There was a significant difference in the number of participants who had been to the dentist in the previous year ( $p < .001$ ); ERHA participants were more likely to have attended the dentist. When this analysis was repeated for the *HeSSOP I* sample only, a significant effect was also found ( $p < .01$ ) with ERHA participants being more likely than those in the WHB to have availed of dental services.

### *Wave differences*

Wave differences were examined and found to be significant for the ERHA ( $p < .001$ ); *HeSSOP II* participants in the ERHA were more likely than *HeSSOP I* participants in the ERHA to have availed of dental services. No significant wave differences were found for participants in the WHB. Analysis was undertaken to determine which groups of adults were most likely to avail of dental services. Predictor variables included age, gender, household composition (living alone, living in multigenerational homes), income, social class, education and geography. The only variables to be associated with uptake of dental services were education ( $p < .01$ ) and geography ( $p < .001$ ). Those with a primary level of education only were less likely to avail of dental services; of those attending for dental services, 66 per cent had a post-primary level of education and just 33 per cent had a primary level of education only.

### 5.5.3.3 Aural (hearing) services

#### *Health board differences*

Only a small percentage of participants used aural or hearing services (see Table 5.17). A significant health board difference in those availing of hearing services was found for *HeSSOP II* ( $p < .01$ ) and *HeSSOP I* ( $p < .01$ ); in both instances, participants in the ERHA were more likely to avail of hearing services by comparison with those in the WHB.

#### *Wave differences*

No significant wave effects were found for the proportion of participants using hearing services in either the ERHA or the WHB, i.e. *HeSSOP II* participants were not any more or less likely to avail of hearing services in comparison with *HeSSOP I* participants. In looking at factors that might be predictive of using aural services, age, gender and social class were examined. Results showed that increasing age was associated with a greater probability of availing of hearing services ( $p < .01$ ); of those availing of hearing services, 1 per cent were in the 65-69 years group, 3 per cent were in the 70-74 years group, 8 per cent were in the 76-84 years group and 15 per cent were aged 85 or over. There was no relationship between availing of hearing services and either gender or social class.

### 5.5.3.4 Dietetic services

#### *Health board differences*

Only a small proportion of participants used services from dieticians (see Table 5.17). No significant health board differences were found for the proportion of *HeSSOP II* participants using services from a dietician. However, when this analysis was repeated for *HeSSOP I*, a significant board difference was found ( $p < .01$ ) with

participants in the ERHA being more likely to avail of services from a dietician when compared to participants in the WHB.

### 5.5.3.5 Respite services

#### *Health board differences*

Less than 2 per cent of *HeSSOP II* participants in each health board reported availing of respite care as a receiver, and even fewer participants reported availing of respite care as a carer (see Table 5.17). As noted in Chapter 4, 7 per cent of the *HeSSOP II* sample were carers (5 per cent in the ERHA and 9 per cent in the WHB). Of this sub-sample, however, just 2 per cent received respite care in the previous year. It was not possible to examine health board differences in respite care uptake because the percentages were low.

#### *Wave differences*

As the percentages of individuals receiving respite care were low, it was not possible to calculate wave differences.

## 5.5.4 Service use by vulnerable groups

Older adults are not a homogeneous group of individuals; while the majority remain active and healthy into their later years, others can be in need of focused attention and support from healthcare professionals, not least because some groups of older people have greater difficulties in accessing and using services, including services designed to help them live independently at home. To assist in conceptualisation of vulnerable groups and in service planning, three potentially vulnerable groups were examined on the basis of previous research profiling them as comprising vulnerability factors (e.g. Lund *et al.*, 2002). Groups were also selected to reflect the diverse types of information obtained in the *HeSSOP* studies, i.e. groups were based on a demographic variable (those aged 80+ years v. those aged  $\leq$  79 years), a social-psychological variable (those living alone v. all others) and a health status variable (those scoring 2 or 3 on the HAQ which is indicative of moderate to severe impairments in physical capacity).

### 5.5.4.1 Age: Comparing those aged 80+ years with those $\leq$ 79 years

*HeSSOP II* adults aged 80+ years were more likely than those  $\leq$  79 years to avail of home services including public health or district nurses, Home Helps, meals-on-wheels (ERHA only) and services from personal care attendants (See Tables 5.18 and 5.19). A significantly greater proportion of adults aged 80+ years also availed of chiropody (ERHA 48 per cent v. 19 per cent: WHB 11 per cent v. 7 per cent) and physiotherapy services (ERHA only). There were no other age differences in use of

therapies, including counselling services, social work services and occupational therapy services. Few age differences were found in use of out-patient services. However, adults in the older age group were more likely to avail of optician (ERHA only) and hearing services (ERHA 20 per cent v. 5 per cent; WHB 6 per cent v. 2 per cent); the latter trend was similar to *HeSSOP I*, in which adults aged 80+ years were also more likely to have availed of hearing services (see Tables 5.20 and 5.21). Although there was low uptake of respite care services, users of this service were significantly more likely to be those aged 80+ years.

**Table 5.18: Current use of primary care services by selected vulnerable HeSSOP II groups in the ERHA (n = 518)**

Received in past 12 months	Yes % (n)	Age group %		Living alone %		HAQ %	
		≤ 79 years	80+ years	No	Yes	Low <sup>a</sup>	High
<b>Home services</b>							
Public health/district nurse	14 (69)	9*	35*	12	18	13	20
Home help	9 (46)	6*	23*	6*	19*	9	8
Meals-on-wheels	4 (19)	2*	10*	2	7	3	4
Personal care attendant	1 (5)	0*	5*	1*	3*	1*	0*
<b>% receiving at least 1 home service</b>	<b>19 (99)</b>	<b>13*</b>	<b>46*</b>	<b>16*</b>	<b>29*</b>	<b>19</b>	<b>25</b>
<b>Therapies</b>							
Chiropody services	24 (123)	19*	48*	22*	32*	23*	37*
Physiotherapy services	9 (45)	7*	18*	9	9	8	18
Counselling services	2 (12)	2	4	2	2	2	6
Social worker	3 (12)	2	7	2	4	3	0
Occupational therapy	2 (11)	2	4	2	3	2	4
<b>% receiving at least 1 therapy</b>	<b>29 (149)</b>	<b>24*</b>	<b>54*</b>	<b>27</b>	<b>36</b>	<b>29</b>	<b>39</b>
<b>Out-patient services</b>							
Optician services	32 (164)	30*	45*	30*	41*	32	40
Dental services	20 (103)	21	16	20	22	20	19
Hearing services	9 (45)	5*	20*	9	7	8	8
Dietician services	5 (28)	5	5	5	6	5	6
<b>% receiving at least 1 out-patient service</b>	<b>41 (214)</b>	<b>38*</b>	<b>53*</b>	<b>39</b>	<b>49</b>	<b>40</b>	<b>47</b>
<b>Respite services</b>							
Respite care as receiver of care	2 (10)	1*	6*	2	2	2	2
Respite care as a carer	1 (1)	1	0	1	0	1	0
<b>% receiving at least 1 service</b>	<b>4 (20)</b>	<b>2*</b>	<b>13*</b>	<b>4</b>	<b>6</b>	<b>5</b>	<b>2</b>

Note: <sup>a</sup> Low HAQ = mild/no impairment (grading 0 or 1), High HAQ = grading of some/substantial impairment (grading 2 + 3); \* significant group difference (p<.01).



**Table 5.19: Current use of primary care services by selected vulnerable HeSSOP II groups in the WHB (n = 535)**

Received in past 12 months	Yes % (n)	Age Group %		Living alone %		HAQ %	
		≤ 79 years	80+ years	No	Yes	Low <sup>a</sup>	High
<b>Home services</b>							
Public health/district nurse	13 (76)	7 *	32 *	13	12	13	11
Home help	6 (34)	3 *	14 *	4	8	5	5
Meals-on-wheels	1 (3)	0	2	1	1	1	0
Personal care attendant	2 (12)	1 *	6 *	2	2	2	3
<b>% receiving at least 1 home service</b>	<b>17 (93)</b>	<b>9 *</b>	<b>38 *</b>	<b>14</b>	<b>18</b>	<b>16</b>	<b>12</b>
<b>Therapies</b>							
Chiropody services	8 (45)	7 *	12 *	7	10	7	11
Physiotherapy services	2 (11)	2	1	2	2	2 *	0 *
Counselling services	1 (5)	1	1	1 *	0 *	1	0
Social worker	1 (3)	1	1	1	0	1 *	0 *
Occupational therapy	1 (3)	1	1	2 *	0 *	1 *	0 *
<b>% receiving at least 1 therapy</b>	<b>10 (54)</b>	<b>9</b>	<b>12</b>	<b>9</b>	<b>11</b>	<b>9</b>	<b>11</b>
<b>Out-patient services</b>							
Optician services	16 (84)	14	20	15	17	16	15
Dental services	6 (33)	5	9	6	7	6	6
Hearing services	3 (16)	2 *	6 *	3	2	3 *	0 *
Dietician services	3 (14)	3	2	3	1	2	6
<b>% receiving at least 1 out-patient service</b>	<b>20 (106)</b>	<b>18</b>	<b>25</b>	<b>20</b>	<b>20</b>	<b>20</b>	<b>18</b>
<b>Respite services</b>							
Respite care as receiver of care	1 (3)	1 *	4 *	1	1	1	0
Respite care as a carer	1 (2)	0	2	1	0	1	0
<b>% receiving at least 1 service</b>	<b>2 (10)</b>	<b>1 *</b>	<b>4 *</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>0</b>

Note: <sup>a</sup> Low HAQ = mild/no impairment (grading 0 or 1), High HAQ = grading of some/substantial impairment (grading 2 + 3); \* significant group difference (p<.01).

**Table 5.20: Current use of primary care services by selected vulnerable HeSSOP I groups in the ERHA (n = 401)**

Received in past 12 months	Yes % (n)	Age group %		Living alone %		HAQ %	
		≤ 79 years	80+ years	No	Yes	Low <sup>a</sup>	High
<b>Home services</b>							
Public health/district nurse	15 (59)	12 *	29	12 *	23 *	12 *	44 *
Home help	6 (25)	4 *	20	4 *	14 *	3 *	34 *
Meals-on-wheels	2 (9)	2	2	1 *	4 *	1 *	11 *
Personal care attendant	1(4)	1 *	3	1	1	1 *	7 *
<b>% receiving at least 1 home service</b>	<b>18 (72)</b>	<b>15 *</b>	<b>37 *</b>	<b>13 *</b>	<b>31 *</b>	<b>14 *</b>	<b>56 *</b>
<b>Therapies</b>							
Chiropody services	29 (120)	18 *	56 *	22	31	20 *	62 *
Physiotherapy services	12 (48)	4	6	4	3	3	9
Counselling services	1 (1)	1	0	1	0	0	3
Social worker	2 (8)	1 *	7 *	1 *	5 *	1 *	14 *
Occupational therapy	1 (5)	1	5	1	3	1 *	11 *
<b>% receiving at least 1 therapy</b>	<b>26 (104)</b>	<b>21 *</b>	<b>56 *</b>	<b>26</b>	<b>31</b>	<b>22 *</b>	<b>69 *</b>
<b>Out-patient services</b>							
Optician services	17 (69)	18	19	17	19	15 *	42 *
Dental services	11 (46)	11	10	11	11	10	17
Hearing services	6 (22)	4 *	14 *	6	6	4 *	18 *
Dietician services	3 (13)	3	5	3	4	3	8
<b>% receiving at least 1 out-patient service</b>	<b>27 (107)</b>	<b>26</b>	<b>32</b>	<b>27</b>	<b>27</b>	<b>24 *</b>	<b>53 *</b>
<b>Respite services</b>							
Respite care as receiver of care	1 (2)	1	1	1	1	0 *	4 *
Respite care as a carer	1 (3)	1	0	1	0	1	0
<b>% receiving at least 1 service</b>	<b>3 (12)</b>	<b>2 *</b>	<b>8 *</b>	<b>2</b>	<b>5</b>	<b>2 *</b>	<b>16 *</b>

Note: <sup>a</sup> Low HAQ = mild/no impairment (grading 0 or 1), High HAQ = grading of some/substantial impairment (grading 2 + 3); \* significant group difference (p<.01).

**Table 5.21: Current use of primary care services by selected vulnerable HeSSOP I groups in the WHB (n = 536)**

Received in past 12 months	Yes % (n)	Age group %		Living alone %		HAQ %	
		≤ 79 years	80+ years	No	Yes	Low <sup>a</sup>	High
<b>Home services</b>							
Public health/district nurse	14 (84)	10 *	29 *	12 *	20 *	9 *	46 *
Home help	4 (22)	2 *	9 *	2 *	8 *	2 *	16 *
Meals-on-wheels	1 (3)	1 *	2 *	1	1	1	1
Personal care attendant	1 (3)	0 *	2 *	1	0	0 *	3 *
<b>% receiving at least 1 home service</b>	<b>17 (92)</b>	<b>10 *</b>	<b>33 *</b>	<b>13 *</b>	<b>22 *</b>	<b>10 *</b>	<b>50 *</b>
<b>Therapies</b>							
Chiropody services	16 (83)	7 *	14 *	8	11	7 *	23 *
Physiotherapy services	5 (28)	2	5	3	2	1 *	11 *
Counselling services	1 (2)	1	0	1	0	1 *	0 *
Social worker	1 (2)	1	0	1	0	1	0
Occupational therapy	1 (2)	1	1	1	1	1 *	2 *
<b>% receiving at least 1 therapy</b>	<b>12 (64)</b>	<b>9 *</b>	<b>17 *</b>	<b>11</b>	<b>12</b>	<b>8 *</b>	<b>28 *</b>
<b>Out-patient services</b>							
Optician services	15 (81)	14	14	13	16	13	19
Dental services	5 (31)	5	5	4	8	5	6
Hearing services	3 (18)	2 *	7 *	4	2	3	5
Dietician services	1 (4)	1	1	1	2	1 *	4 *
<b>% receiving at least 1 out-patient service</b>	<b>21 (115)</b>	<b>19</b>	<b>21</b>	<b>18</b>	<b>24</b>	<b>19</b>	<b>24</b>
<b>Respite services</b>							
Respite care as receiver of care	1 (7)	1 *	3 *	1	1	1 *	5 *
Respite care as a carer	1 (5)	1	0	1	1	1	2
<b>% receiving at least 1 service</b>	<b>2 (13)</b>	<b>2</b>	<b>3</b>	<b>3</b>	<b>1</b>	<b>2 *</b>	<b>7 *</b>

Note: <sup>a</sup> Low HAQ = mild/no impairment (grading 0 or 1), High HAQ = grading of some/substantial impairment (grading 2 + 3); \* significant group difference (p<.01).

The percentage of participants availing of at least one service within each category (home services, therapies, out-patient services and respite services) was calculated. In this way, information across services could be condensed and it was possible to examine whether many people were receiving just one service or whether people who availed of one service also tended to avail of other services. In the ERHA in 2004, a greater proportion of those aged eighty years and over received some type of home service, therapy, out-patient or respite care service. Similar results were found for participants in the WHB, in which adults aged eighty years or over were significantly more likely to receive a greater range of home and respite care services (but not therapies or out-patient services) in comparison with those aged 79 years or under.

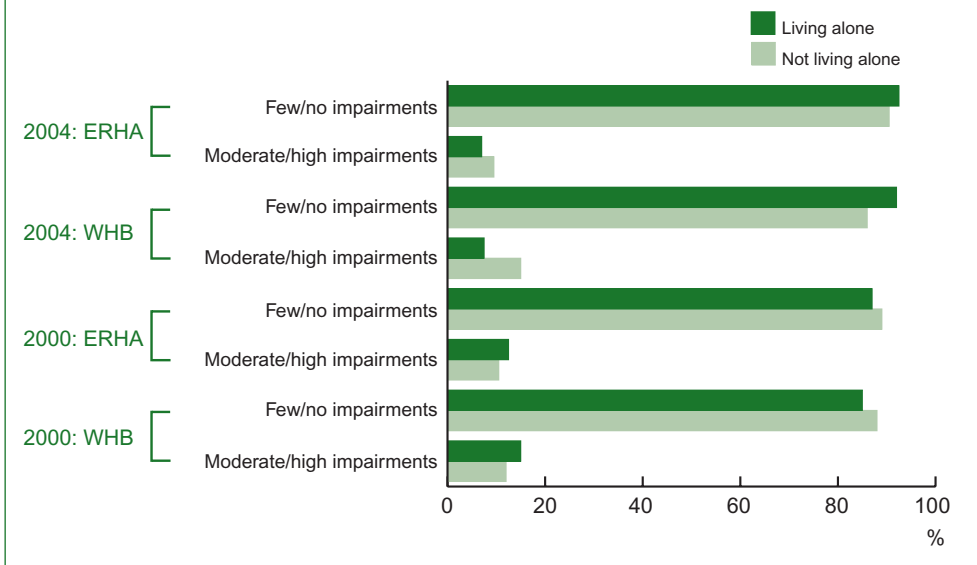
Thus, overall, ERHA adults aged eighty years or over tended to be more likely to avail of a range of home-based and respite services. Fewer age group differences, however, were found in the WHB, with adults aged eighty years or over not any more likely to avail of most therapies or out-patient services.

#### 5.5.4.2 Household composition: Comparing those living alone with others

Adults living alone in the ERHA were more likely than others to have availed of Home Helps and meals-on-wheels (see Tables 5.18 and 5.19). However, adults living alone were not any more likely than others to have availed of any remaining home services, most of the therapies, or out-patient or respite services. There were two exceptions: in the ERHA, adults living alone were more likely than others to have availed of chiropody (32 per cent v. 22 per cent) and optician services (41 per cent v. 30 per cent). The finding that mostly there was no difference in use of services between those who lived alone and others was similar in *HeSSOP I* (see Tables 5.20 and 5.21).

While many studies show that adults who live alone are more vulnerable than others, the current study indicated that participants living alone were relatively healthy. For instance, adults living alone in this study were not any more likely to be at risk of psychological problems (see Chapter 4 on depression and morale), nor were they any more likely to be at risk of functional impairments (see Figure 5.1).

**Figure 5.1: Functional impairment (HAQ scores) among adults living alone v. with others in the ERHA and WHB (*HeSSOP 1* and *HeSSOP II*)**



#### 5.5.4.3 Functional capacity: Comparing those with few or major functional impairments

In *HeSSOP II*, adults with higher levels of functional impairment did not typically make more use of services. For example, 13 per cent of those in the ERHA with mild or no functional impairments availed of public health or direct nursing services in contrast to 20 per cent of those with moderate to high impairments (HAQ grading of 2 or 3, Tables 5.18 and 5.19). Similarly, 39 per cent of those with low impairments availed of Home Helps in contrast to 8 per cent of those with moderate to high levels of functional impairment. (Further analyses in Chapter 4 examined whether those with greater levels of impairments were also those more likely to avail of devices, but this was not the case.) There were non-significant trends showing that those with higher levels of impairment were more likely to avail of chiropody services ( $p=.06$ ), physiotherapy services ( $p=.07$ ) and counselling services ( $p=.08$ ). Nevertheless, these results suggest that the most physically vulnerable are not availing of services (or devices) which could improve their independence and quality of life in their own homes. Understanding why people are not availing of services warrants further research (see also later section on stigma).

One further analysis conducted when considering vulnerability factors was one based on health conditions reported. As seen in Tables 5.22 and 5.23, musculoskeletal conditions were the most common conditions (present in 19 per cent of the sample) in both boards. The three other most common conditions were

cardiovascular, endocrine-metabolic (including disorders such as diabetes) and respiratory conditions. The pattern reflects morbidity data as collected based on hospital discharges in Ireland. The conditions were more prevalent in older people and in those with high HAQ scores. However, living alone was not significantly related to the profile of health conditions reported by the group.

**Table 5.22: Health conditions reported by age, household status (living alone) and functional impairment (HAQ) for HeSSOP II participants in the ERHA**

Health condition	Yes %	Age group %		Living alone %		HAQ %	
		< 74 years	75+ years	No	Yes	Low <sup>a</sup>	High
Musculo-skeletal	19	17	23	19	19	14	38
Cardiovascular	16	16	15	17	12	15	21
Endocrine-metabolic	8	9	8	9	8	9	7
Respiratory	5	6	3	5	5	3	11
Neurological	4	2	5	4	4	2	11
EENT	3	3	3	3	4	3	3
Oncological	2	3	0	2	1	2	1
Gastrointestinal	1	0	1	1	1	1	1
Psychiatric/Behavioural	1	1	1	1	1	1	0
Genitourinary	1	0	1	1	0	1	1
Hepatic	0	0	0	0	1	0	0
Renal	0	0	0	0	0	0	1

Note: <sup>a</sup> Low HAQ = mild/no impairment (grading 0 or 1), High HAQ = grading of some/substantial impairment (grading 2 + 3).

**Table 5.23: Health conditions reported by age, household status (living alone) and functional impairment (HAQ) for HeSSOP II participants in the WHB**

Health condition	Yes %	Age group %		Living alone %		HAQ %	
		< 74 years	75+ years	No	Yes	Low <sup>a</sup>	High
		Musculo-skeletal	20	13	30	18	26
Cardiovascular	15	14	18	14	15	14	18
Endocrine-Metabolic	6	6	6	7	4	6	4
Respiratory	5	10	5	4	7	5	3
Neurological	3	4	2	4	2	2	8
EENT	5	3	7	6	3	4	9
Oncological	1	2	1	2	0	1	3
Gastrointestinal	3	2	4	2	0	3	2
Psychiatric/Behavioural	1	0	1	1	0	0	3
Genitourinary	1	0	1	0	3	1	2
Hepatic	0	0	0	0	0	0	0
Renal	0	0	0	0	0	0	0

Note: <sup>a</sup> Low HAQ = mild/no impairment (grading 0 or 1), High HAQ = grading of some/substantial impairment (grading 2 + 3).

## 5.6 Summary

### 5.6.1 GP services

- GP services were used by almost all of the population in the previous year with high levels of satisfaction and a high level of continuity of care as evidenced by patients having a long-established relationship with a particular GP.
- GP visits averaged six in the WHB and 4.5 in the ERHA; a significantly higher level of use in the WHB.
- There was also evidence of higher use of GP services in those aged seventy and over in 2004 compared with 2000, i.e. following the national introduction of free access to GP care for this group in 2001.

## 5.6.2 Hospital and related services

- There was no significant board difference in the use of A&E services in either *HeSSOP I* or *HeSSOP II* (10-13 per cent across groups over time).
- Hospital in-patient service use was similar across boards and time (with 15-18 per cent attending across health board and time).
- Out-patient hospital services were used by significantly more ERHA than WHB participants at both times (36 per cent v. 13 per cent in 2000 and 25 per cent v. 14 per cent in 2004).
- The frequency of out-patient appointments per person treated increased in 2004 in the ERHA only. Rural dwellers were less likely to have used out-patient services in the previous year.
- Day hospital use was similar across boards in 2000 (6 per cent in the ERHA and 4 per cent in the WHB) but reduced significantly in coverage in 2004 for the WHB (5 per cent in the ERHA v. 1 per cent in the WHB).
- Day care centres were used by a small and similar proportion across time with services used by fewer WHB than ERHA participants. Over 70 per cent of ERHA service users availed of two or more weekly visits while all WHB attendees had one visit per week.
- Waiting lists for in-patient services were the same across time and boards (4-5 per cent in 2004). Out-patient waiting lists were also similar across boards but with a greater proportion of the sample waiting in 2004 (7-8 per cent) than in 2000 (2-3 per cent). Day hospital waiting lists followed the same pattern as out-patient lists but with very few waiting (<2 per cent).
- Proportions waiting for any service were similar across boards but had increased almost twofold in 2004 (to 11-13 per cent waiting).

## 5.6.3 Home support services

- A greater proportion of those in the ERHA availed of home help at both time points. The proportion availing of this service did not differ within boards over time. Those who used Home Helps were more likely to be older and to live in urban settings.

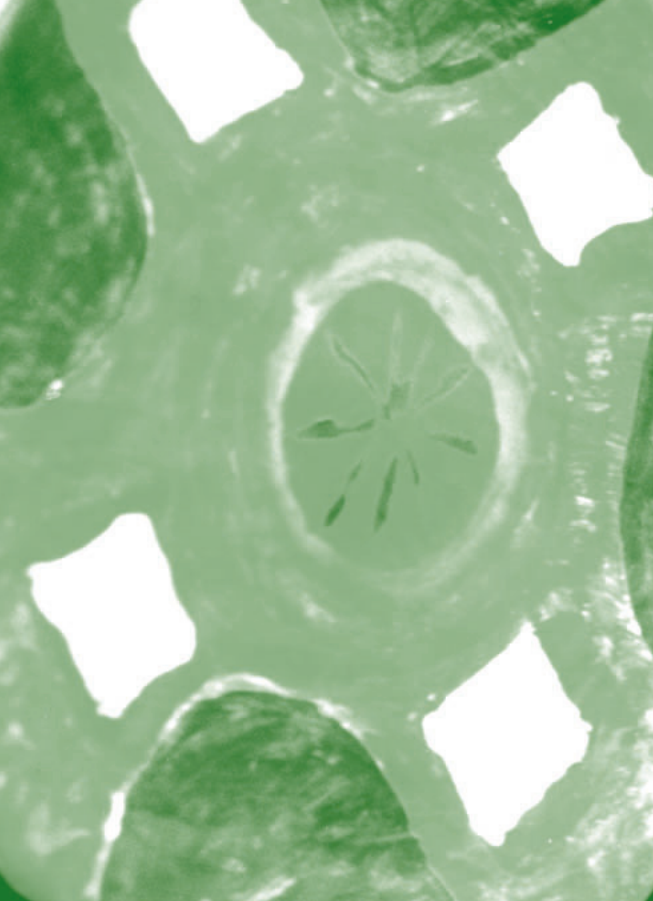


- A greater proportion of those in the ERHA availed of meals-on-wheels at both time points. The meals-on-wheels service was used more by urban dwellers and those in higher income brackets.

#### 5.6.4 Therapies

- There was a low uptake of services such as physiotherapy, occupational therapy, speech therapy, and psychological therapy or counselling.





# 6

## Chapter 6

Needs and barriers  
to health and  
social services:  
Repeat study

# Chapter 6

## Needs and barriers to health and social services: Repeat study

### 6.1 Barriers to health and social services

A range of factors can impede access to health and social services. As discussed in the sections to follow, these barriers can include difficulties in transportation, stigma associated with issues concerning later life and cost.

#### 6.1.1 Transportation

##### 6.1.1.1 Driving

As well as having practical benefits, being able to drive a car can be an important part of identity, and compulsory or voluntary surrender of one's car can have meaningful psychological consequences. Quotes from the focus groups illustrate this:

*My husband had to give his car away; he gave the keys to my daughter because of his eyes and I saw him crying. That was the end of his independence.*

*My husband ... it felt like the world fell in on him literally. I didn't feel much better. I had to give up driving because I've got double vision in my eyes so I've missed it tremendously.*

*Felt dreadful, you lose your independence.*

*You feel lost without your car.*

*I think loss of independence is the worst thing. Yes, yes I think that is, yes it is the worst. Until October when this hit me I was driving everywhere giving*

people lifts. Now I have to depend on people to pick me up. I find it awful but they say 'but you've given people lifts all these years, what's wrong with it' (but) ... it doesn't work like that.

#### Health board differences

Participants were asked if they drove a car. As can be seen in Table 6.1, just under half of the sample in each of the health boards responded affirmatively; health board differences were significant for *HeSSOP I* only ( $p < .01$ ). This difference remained even when controlling for known health board differences in demographic factors.

#### Wave differences

There were no differences between time points for either the ERHA or the WHB. Analysis was undertaken to determine which groups of participants were most likely to drive. Age, gender, education, household composition (living alone, living in multigenerational homes), income, social class and geography (living in urban v. rural areas) were considered. Of the demographic variables, significant effects were found for age ( $p < .001$ ), gender ( $p < .001$ ) and education ( $p < .01$ ); men were more likely to drive than women, as were those with a post-primary level of education. Increasing age was also associated with a lower probability of driving: 66 per cent of those in the 65-69 years group were drivers, as were 52 per cent of the 70-74 years group, 29 per cent of the 75-84 years group, and 13 per cent of those aged 85 years and over.

**Table 6.1: Car drivers by board (ERHA and WHB) and wave (2000 and 2004)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Whole sample</b>	49*	46*	47	48
<b>Gender</b>				
Men	77	68	72	66
Women	30	26	29	31
<b>Education</b>				
Primary only	31	36	25	39
Post-primary	65	66	61	66

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); \* health board difference where  $p < .01$ .

### 6.1.1.2 Walking/cycling

#### *Health board differences*

Walking and cycling can have significant health benefits. Participants were asked if they had walked or cycled in the previous six months. As can be seen in Table 6.2, participants in the ERHA were more likely to walk/cycle by comparison with those in the WHB ( $p < .001$  for *HeSSOP II*,  $p < .001$  for *HeSSOP I*); these significant differences remained even when controlling for known health board differences in demographic factors.

#### *Wave differences*

A significant wave effect was found for participants in the ERHA ( $p < .001$ ) but not for those in the WHB; *HeSSOP II* participants in the ERHA were less likely than those in *HeSSOP I* to walk or cycle. Analysis was undertaken to determine which groups of participants were most likely to walk/cycle; age ( $p < .001$ ), gender ( $p < .01$ ), education ( $p < .001$ ) and social class ( $p < .01$ ) all emerged as significant predictors. Men were more likely than women to walk or cycle (63 per cent of men v. 53 per cent of women). Similarly, while 66 per cent of those aged 65-69 walked or cycled, 60 per cent of those aged 70-74 did so, 55 per cent of those aged 75-84 did so, and just 32 per cent of those aged 85 years or over did so. Higher social class groups and having a post-primary level of education were both associated with a higher probability of walking/cycling.

### 6.1.1.3 Getting lifts with family and friends

Family and friends can be a vital support to many older people living in the community, enabling them to avail of health and social services. Often this support can be given freely and willingly as the following quote shows:

*My family ... live fairly near now and they are very good. ... One thing I've learned ... is how good people really are and it's no effort to them (to pick you up). They seem to enjoy helping you and I never realised that before until I got older how good everybody is. I never met anybody who wasn't willing to do something so that is something I have learned since I have gotten older.*

**Table 6.2: Types of transportation used in the last six months by board (ERHA and WHB) and wave (2000 and 2004)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Walking/cycling	76*Δ	50*	66*Δ	52*
Getting lifts with family or friends	44Δ	42Δ	58Δ	58Δ
Public transport such as bus or train	69*	32*	65*	20*

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); \* health board difference where  $p < .01$ , Δ wave difference where  $p < .01$ .

#### *Health board differences*

Participants were asked if they had availed of lifts with family and friends in the previous six months. As can be seen in Table 6.2, 58 per cent of the *HeSSOP II* sample in each of the health boards had made use of this type of transport; there was no significant health board difference for *HeSSOP II* or *HeSSOP I*.

#### *Wave differences*

Wave effects were found for the ERHA ( $p < .001$ ) and the WHB ( $p < .001$ ); in both boards, *HeSSOP II* participants were more likely to avail of lifts from family and friends than those in *HeSSOP I*. These significant results remained even when controlling for other known demographic differences between the samples. Analysis was carried out to determine which groups of participants were most likely to avail of lifts from family and friends; gender ( $p < .01$ ), living in intergenerational homes ( $p < .001$ ) and living circumstances ( $p < .001$ ) emerged as significant predictors. While 64 per cent of women availed of lifts from friends and family, just 34 per cent of men did so. People living in intergenerational families were more likely than others to avail of lifts from family and friends (67 per cent v. 53 per cent) presumably because more opportunities exist. Perhaps for this same reason, people living alone were less likely than others to avail of lifts from family and friends (56 per cent v. 61 per cent).

#### 6.1.1.4 Public transport

Public transport can be a vital link to wider community activities including access to health and social services. In addition to delays while waiting for services, public transport can create other health difficulties for older people, as noted in the focus groups:

*Buses are not the easiest things to use because if you're not very accurate the steps are very high and very dangerous. You need only get one little fall, you need only do that and you're gone.*

#### *Health board differences*

Participants were asked if they had used public transport in the previous six months. As can be seen in Table 6.2, 65 per cent of participants in the ERHA and just 20 per cent of those in the WHB responded affirmatively; this difference was significant ( $p < .001$ ). When this analysis was repeated for the *HeSSOP I* sample, a significant effect was also found ( $p < .001$ ). These data indicate that people in the ERHA are more likely to avail of public transport by comparison with their counterparts in the WHB.

#### *Wave differences*

No significant wave effect was found for the ERHA but there was a significant wave effect for the WHB ( $p < .001$ ); *HeSSOP II* participants in the WHB were less likely than those in *HeSSOP I* to avail of public transport. Further analysis was carried out to determine which groups of participants were most likely to avail of public transport. Higher levels of education ( $p < .01$ ) were associated with a reduced probability of using public transport.

## 6.1.2 Stigma

Embarrassment and perceived stigma may mean that some older adults do not avail of services that could facilitate their greater independence and autonomy. *HeSSOP I* participants had been asked how acceptable or embarrassed they would be if they needed to use a particular service; acceptability was rated on a five-point scale. This same question was posed again in *HeSSOP II* for the following services: meals-on-wheels; home help, and personal care assistants coming into the participant's home. Table 6.3 shows the percentage of participants rating each of these services as highly embarrassing (would not accept/accept only with difficulty groups).

### 6.1.2.1 Meals-on-wheels

#### *Health board differences*

Ten per cent of *HeSSOP II* participants in each of the health boards viewed the prospect of using meals-on-wheels as very embarrassing. A further 19 per cent in the ERHA and 22 per cent in the WHB viewed this service with some embarrassment. There was no significant difference between the health boards. When this analysis was repeated for *HeSSOP I*, however, a significant health board difference was found ( $p < .001$ ); in *HeSSOP I*, participants in the WHB viewed meals-on-wheels with greater embarrassment than did those in the ERHA.



**Table 6.3: Stigma ratings by board (ERHA and WHB) and wave (2000 and 2004)**

Living situations	ERHA			WHB		
	Fairly/very embarrassed %	Somewhat embarrassed %	Not at all embarrassed %	Fairly/very embarrassed %	Somewhat embarrassed %	Not at all embarrassed %
<b>HeSSOP I</b>						
Meals-on-wheels	15 * $\Delta$	21	63	37 * $\Delta$	16	46
Home help	12 *	10	77	23 * $\Delta$	19	56
Personal care assistant coming into home	11 *	20	69	17 * $\Delta$	24	53
<b>HeSSOP II</b>						
Meals-on-wheels	10 $\Delta$	19	71	10 $\Delta$	22	68
Home help	8	18	73	7 $\Delta$	21	71
Personal care assistant coming into home	11	20	68	8 $\Delta$	22	70

Note: HeSSOP I n = 937 (ERHA n = 401, WHB n = 536); HeSSOP II n = 1,053 (ERHA n = 518, WHB n = 535); \* health board difference where p < .01,  $\Delta$  wave difference where p < .01.

### *Wave differences*

Significant wave differences were also found for the ERHA ( $p < .01$ ) and the WHB ( $p < .001$ ); in both instances, *HeSSOP II* participants were less embarrassed about meals-on-wheels than were their counterparts in each board in *HeSSOP I*.

Analysis was carried out to determine which groups of participants were most likely to perceive meals-on-wheels with embarrassment. None of the variables that were considered emerged as significant in predicting perceptions of embarrassment with regard to using meals-on-wheels.

### 6.1.2.2 Home help

#### *Health board differences*

Eleven per cent of *HeSSOP II* participants in the ERHA and 8 per cent in the WHB were very embarrassed about the prospect of Home Helps coming into their homes to the extent that they would not accept this support. A further 18 per cent of the *HeSSOP II* sample in the ERHA and 21 per cent in the WHB viewed the prospect of Home Helps with some embarrassment. There was no significant health board difference in levels of embarrassment for *HeSSOP II*, but a significant health board difference was found for *HeSSOP I* ( $p < .001$ ); ERHA participants in *HeSSOP I* viewed the prospect of home help support less negatively than did those in the WHB.

#### *Wave differences*

No significant wave effect was found for the ERHA. There was, however, a significant wave effect for the WHB ( $p < .001$ ) with WHB participants in *HeSSOP II* being less embarrassed about the prospect of home help support than in *HeSSOP I*.

Analysis was carried out to determine which groups of participants were most likely to perceive home help as embarrassing. None of the predictors considered were significantly related to perceptions of home help as embarrassing.

### 6.1.2.3 Personal care assistant coming into home

#### *Health board differences*

Eight to eleven per cent of *HeSSOP II* participants in each of the health boards viewed the prospect of personal care assistants with embarrassment. In contrast, 11-17 per cent of participants in *HeSSOP I* viewed the prospect of personal care assistants with embarrassment. No health board difference was found for *HeSSOP II*, but the health board difference found in *HeSSOP I* was significant ( $p < .001$ ).

#### *Wave differences*

There were no wave effects found for the ERHA; however, a significant effect was found for the WHB ( $p < .001$ ). WHB participants in *HeSSOP II* viewed the prospect of

personal care assistants less negatively than did WHB participants in *HeSSOP I*. Analysis was carried out to determine which groups of participants were most likely to perceive support from personal care assistants as embarrassing. None of the predictor variables were significant.

### 6.1.3 Funding for medical care

Funding can be a barrier to health and social services. *HeSSOP* participants were asked if they were covered for healthcare by a medical card either in their own name or through some one else's card. Participants were also asked if they were covered by private health insurance either in their own names or through other family members (Table 6.4).

#### 6.1.3.1 Medical card holders

##### *Health board differences*

Seventy-five per cent of *HeSSOP II* participants in the ERHA and 89 per cent in the WHB were holders of medical cards; a further 22 per cent in the ERHA and 10 per cent in the WHB were covered for healthcare on someone else's medical card. This difference between the health boards was significant ( $p < .001$ ). When this analysis was carried out for the *HeSSOP I* sample, a significant effect was also found ( $p < .001$ ) with participants in the WHB being more likely than those in the ERHA to hold medical cards.

##### *Wave differences*

Wave differences were also found for the ERHA ( $p < .001$ ) and the WHB ( $p < .001$ ); *HeSSOP II* participants in each health board were more likely to hold medical cards than those in *HeSSOP I* (75 per cent v. 52 per cent in the ERHA, and 89 per cent v. 75 per cent in the WHB). These differences remained even when known demographic differences between the samples were controlled. The increase in medical card ownership is likely to reflect changes in Government policy to extend non-means-tested eligibility for medical cards to all adults aged seventy years and over in late 2001. Analysis was carried out to determine which groups of participants were most likely to hold medical cards. Of the variables considered, significant effects were found for age ( $p < .001$ ); while 48 per cent of those aged 65-69 years were medical card holders, this figure rose to 97 per cent for those aged seventy years and over. Medical card holders were also more likely to be widowed ( $p < .01$ ), to have a primary level of education only ( $p < .001$ ) and to be residing in rural areas ( $p < .01$ ).

### 6.1.3.2 Private health insurance

#### Health board differences

More participants in the ERHA than in the WHB had private health insurance: 52 per cent and 30 per cent respectively in *HeSSOP II* (Table 6.4). Similar results were found in *HeSSOP I*, with participants in the WHB less likely to have private health insurance. Even when controlling for known health board differences in demographic factors (age, marital status, education and income), these health board differences were significant ( $p < .001$  for *HeSSOP I*;  $p < .001$  for *HeSSOP II*).

#### Wave differences

Wave differences were not found for the ERHA or the WHB, i.e. *HeSSOP II* participants were not any more or any less likely to have private health insurance than those individuals who took part in *HeSSOP I*.

**Table 6.4: Funding for medical services by board (ERHA and WHB) and wave (2000 and 2004)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Covered by a medical card?</b>				
Yes: in own name	52* $\Delta$	75 * $\Delta$	75* $\Delta$	89* $\Delta$
Yes: on someone else's card	1	0	3	1
<b>Private health insurance?</b>				
Yes: in own name	43*	23 *	41*	25*
Yes: through family member	8	4	11	5

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535); \* health board difference where  $p < .01$ ,  $\Delta$  wave difference where  $p < .01$ .

Analysis was carried out to determine which groups of *HeSSOP II* participants were most likely to hold private health insurance. A significant effect was found for geography ( $p < .001$ ) with people in urban areas more likely to have private health insurance than their more rural counterparts; of *HeSSOP II* participants holding private health insurance, 63 per cent of those living in urban areas had insurance while 24 per cent residing in rural areas had insurance. Participants having private health insurance were also significantly more likely to hold a post-primary level of education ( $p < .001$ ) and be in higher income categories ( $p < .001$ ). While 75 per cent of those holding private health insurance had a post-primary level of education, the

corresponding figure for those with a primary level of education only was just 25 per cent. Similarly, while 48 per cent of those in the highest income brackets had private health insurance, the corresponding figure for those in the lowest income brackets was just 24 per cent.

Further analysis was carried out to determine whether people with health insurance were more likely to rate services positively or to have availed of different types of care services (see Chapter 5). In this instance, predictor variables were GP satisfaction and receipt of care services (respite care, public health nurse, personal care attendants, home help, social workers, chiropody, occupational therapy, dietician services, optician services, dental services, hearing services and psychological or counselling services). Private health insurance holders were not any more likely to rate GP visits more positively. They were less likely than others to have availed of public health nurses ( $p < .001$ ); 1 per cent of private health insurance holders had availed of public health nurses by comparison to 16 per cent of others. However, private health insurance holders were more likely to have availed of physiotherapy services ( $p < .01$ ); 8 per cent of those with private health insurance received physiotherapy services, while just 4 per cent of others did the same. Similarly, 19 per cent of those with private health insurance availed of dental services while just 10 per cent of others did so ( $p < .001$ ).

#### 6.1.4 Payment for services

Cost can be a barrier to health and social services. Participants were asked if they had personally paid directly for any health or social service used. This information was only asked of some services in *HESSOP I*. Table 6.5 shows that a considerable proportion of older people paid for some of the services received in the past year, in particular in the ERHA and in *HeSSOP II*. Home help services were paid for by more participants in the ERHA (4 v. 1 per cent). Many paid for chiropody services (over one in ten or 11 per cent in the ERHA, and one in twenty or 5 per cent in the WHB). Regarding out-patient services, many participants paid for optician and dental services.

Comparing Table 6.5 with tables reporting on service uptake overall in *HeSSOP II* (i.e. Tables 5.18 and 5.19), it can be seen that up to half of those from both boards who used the most commonly availed of primary care services (home help, meals-on-wheels, chiropody, physiotherapy, optical, dental and hearing services) reported paying directly for some or all of those services. Since the ERHA participants were much more likely to receive services, this means that a much larger

percentage/number from the ERHA paid for services. The most commonly used primary care services (optician services and chiropody) were paid for by 84 out of 164 ERHA participants and 33 out of 84 WHB participants (for optician services), and by 56 out of 123 ERHA participants and 26 out of 45 WHB participants (for chiropody services) in *HeSSOP II*. Thus, a significant proportion of the excess in service use per equivalent older person in the ERHA (in comparison to the WHB) was a consequence of use of personally funded services. What was also clear in both boards was a trend of increasing numbers of people paying for community-based health and social care services from the year 2000 to 2004.

**Table 6.5: Paying for services by board (ERHA and WHB) and wave (2000 and 2004)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	% (n)	% (n)	% (n)	% (n)
<b>Home services</b>				
Public health nurse/district nurse	-	-	1 (4)	1 (3)
Home help	1 (3) Δ	1 (2)	4 (23) *	1 (6) *
Meals-on-wheels	-	-	2 (11)	.1 (1)
Personal care attendant	0 (0)	1 (1)	.3 (2)	.4 (2)
<b>Therapies</b>				
Physiotherapy services	8 (29)	2(10)	5(25)	1 (6)
Occupational therapy	-	-	5 (2)	3 (3)
Chiropody services	13 (50)	7 (36)	11 (56)	5 (26)
Social work services	-	-	3(14)	1 (3)
Psychological/counselling services	-	-	.5 (2)	2 (1)
<b>Out-patient services</b>				
Optician services	-	-	16 (84)	6 (33)
Dental services	-	-	12 (60)	3 (15)
Hearing services	-	-	4 (20)	1 (5)
Dietician services	-	-	2 (8)	1 (3)
<b>Respite services</b>				
Respite care as a receiver of care	-	-	1 (3)	.1 (1)
Respite care as a carer	-	-	.1 (1)	.4 (2)

### 6.1.5 Summary

Barriers to health and social services were discussed. Services are available to support older people and to help them live independently at home; barriers such as transportation or stigma, however, can prevent people from availing of those services. Further research is needed to determine why some services are stigmatised more than others and the consequences of such stigmatisation for older people and professionals.

## 6.2 Needs and preferences for long-term care

As people get older, there may be an increasing need for long-term care options. *HeSSOP* participants were asked about their preferences for care across situations where they would continue to live at home and situations where they would move to another residence.

### 6.2.1 Care at home

Participants were asked to rate the acceptability of two situations if needed: living at home with family taking care of needs, and living at home with health board involvement to meet needs. In evaluating the acceptability of these situations, participants were asked to assume that cost was not a factor and that adaptations to their homes could be made.

#### *Health board differences*

Eighty-nine per cent of *HeSSOP II* participants in the ERHA and 97 per cent in the WHB favoured living at home with family taking care of their needs (see Table 6.6); this difference was significant ( $p < .01$ ). A significant health board difference was also found for the *HeSSOP I* sample ( $p < .01$ ) with 74 per cent of ERHA and 83 per cent of those in the WHB favouring this option for care if needed. A slightly less favoured option for *HeSSOP II* participants was to live at home with health board staff to meet care needs. Sixty-seven per cent of *HeSSOP II* participants from the ERHA, and 83 per cent from the WHB found this option to be acceptable; this health board difference was significant ( $p < .01$ ). There were no significant health board differences for *HeSSOP I* participants.

**Table 6.6: Preferences for home living situations if long-term care is needed by board (ERHA and WHB) and wave (2000 and 2004)**

Living situations	ERHA		WHB	
	Acceptable %	Would not accept with reservations %	Acceptable %	Would not accept with reservations %
<b>HeSSOP I</b>				
Current home: family only to care for needs	74Δ	11	83Δ	7
Current home: health board staff to care for needs	63*Δ	22	43*Δ	22
<b>HeSSOP II</b>				
Current home: family only to care for needs	89*Δ	8	97*Δ	3
Current home: health board staff to care for needs	67*Δ	26	83*Δ	15

Note: HeSSOP-I n = 937 (ERHA n = 401, WHB n = 536); HeSSOP-II n = 1,053 (ERHA n = 518, WHB n = 535); \* health board difference where p<.01, Δ wave difference where p<.01.



### *Wave differences*

Wave differences were found when looking at the acceptability of living at home with family taking care of needs. In both the ERHA ( $p < .001$ ) and the WHB ( $p < .001$ ), a greater percentage of participants in *HeSSOP II* favoured care at home with families.

When looking at the acceptability of living at home with health board involvement to meet needs, wave differences were also seen both for participants in the ERHA ( $p < .001$ ) and the WHB ( $p < .001$ ); *HeSSOP II* participants in both boards were more likely than in *HeSSOP I* to have support for this care option if needed.

### *Wave 2*

Analysis was undertaken to determine which groups of adults were most likely to favour care at home with family only taking care of their needs. None of the variables considered were significant in predicting care preferences though there was a trend for increasing age, being male and only having a primary level of education to be associated with a preference for care at home with only family looking after needs.

Analysis was also undertaken to determine which groups of adults were most likely to favour care at home with health board professionals taking care of their needs. The only significant predictor variable was geography ( $p < .01$ ); 80 per cent of those living in rural areas indicated this option to be acceptable, compared to 74 per cent of those in urban areas.

## 6.2.2 Care in the community

Participants were also asked for their views and preferences on moving residence if need be. Care options included moving permanently to the home of a child or other family member with only that family member caring for needs, living in sheltered/group accommodation (i.e. purpose-built with a caretaker on site), or living in a nursing home.

### 6.2.2.1 Permanent move to home of child/other family member with only family to care for needs

#### *Health board differences*

In *HeSSOP II*, participants in the WHB were more willing than those in the ERHA to move to the homes of adult children and to have those family members take care of their needs ( $p < .001$ ) (see Table 6.7). There were no significant differences in *HeSSOP I*.

### *Wave differences*

There was no significant wave effect for participants in the ERHA, but there was a wave effect for participants in the WHB ( $p < .001$ ); *HeSSOP II* participants in the WHB were more favourable towards moving to the homes of adult children. Analysis was undertaken to determine which other groups of adults were likely to favour moving permanently, if needed, to the homes of adult children with only those family members taking care of their needs. Only geography was a significant predictor ( $p < .001$ ); while 30 per cent of those living in rural areas were favourably disposed to moving to the homes of adult children, just 22 per cent of those in urban areas expressed the same view.

### 6.2.2.2 Sheltered/group accommodation

#### *Health board differences*

Participants were asked for their views on moving to sheltered or group accommodation. In the ERHA, 24 per cent of *HeSSOP II* participants thought this was acceptable and a further 45 per cent would accept such a move with reservations; 30 per cent would not accept such a move. In the WHB, the corresponding percentages are 18 per cent, 52 per cent and 29 per cent respectively. There was no significant health board difference for either *HeSSOP II* or *HeSSOP I*.

#### *Wave differences*

Wave differences were found, however ( $p < .001$  for the ERHA,  $p < .001$  for the WHB); *HeSSOP II* participants in both boards were more likely to accept sheltered accommodation by comparison with those in *HeSSOP I*. Analysis was undertaken to determine which groups of adults were likely to favour moving permanently, if needed, to sheltered accommodation. There were no significant differences between predictor variables and acceptability of this care option.



### 6.2.2.3 Move to nursing home

#### *Health board differences*

The least favoured option for care, if needed, was moving to a nursing home. As can be seen in Table 6.7, only 11 per cent of *HeSSOP II* participants in the ERHA and 15 per cent in the WHB found this option to be acceptable. However, in each area a further 41 per cent and 50 per cent respectively would accept this option, albeit with reservations. Forty-seven per cent of those in the ERHA and 34 per cent in the WHB would not accept moving to a nursing home; the corresponding percentages for *HeSSOP I* were 54 per cent and 65 per cent. Significant health board differences for this care option were found ( $p < .001$  for *HeSSOP II*,  $p < .01$  for *HeSSOP I*); in *HeSSOP II*, participants in the ERHA were more negative about this option, while in *HeSSOP I*, participants in the WHB were more negative.

#### *Wave differences*

No significant wave differences were found for participants in the ERHA. A significant wave effect was found in the WHB ( $p < .001$ ) with attitudes being more favourable in *HeSSOP II* than *HeSSOP I*. Analysis was undertaken to determine which groups of adults were likely to find living in a nursing home acceptable, if needed. Geography ( $p < .001$ ) emerged as a significant predictor; 18 per cent of those living in rural areas found this option acceptable, while the corresponding percentage for those in urban areas was just 9 per cent.

## 6.2.3 Expectations of care preferences

### 6.2.3.1 Discussion of care preferences

#### *Health board differences*

Participants were asked whether they had discussed their long-term care preferences with others. As can be seen in Table 6.8, 71 per cent of *HeSSOP II* participants in the ERHA and 76 per cent in the WHB had not discussed their long-term care preferences with others. Differences at *HeSSOP II* and *HeSSOP I* were not significant.

#### *Wave differences*

No wave differences were found for either the ERHA or the WHB. Analysis was undertaken to determine which groups of adults were likely to discuss their preferences with others. None of the predictor variables were significant.

**Table 6.8: Expectations on care preferences by board (ERHA and WHB) and wave (2000 and 2004)**

	<i>HeSSOP I</i>		<i>HeSSOP II</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Discussed care preferences?</b>				
No	72	77	71	76
<b>Feel wishes would be honoured?</b>				
Yes	89	82	80	78

Note: *HeSSOP I* n = 937 (ERHA n = 401, WHB n = 536); *HeSSOP II* n = 1,053 (ERHA n = 518, WHB n = 535).

### 6.2.3.2 Honouring of wishes

#### *Health board differences*

Participants were then asked if they thought their long-term care preferences would be honoured. The majority of participants in both health boards believed their views would be honoured (see Table 6.8). There was no significant health board difference either for *HeSSOP II* or *HeSSOP I*.

#### *Wave differences*

There were no significant wave differences for the ERHA or the WHB. Analysis was undertaken to explain variance in responses to this question. No significant effects were found.

### 6.2.4 Summary

Like *HeSSOP I*, the majority of *HeSSOP II* participants wished to remain in their own homes even if unable to care for themselves in the long term. Perceptions of other care options however, such as sheltered accommodation and residential care, were viewed more favourably in *HeSSOP II*. Further research is needed to examine care choices in more detail. It is not clear, for instance, whether greater favourability towards other care options reflects higher standards of expected care from a growing group of more critical and informed consumers of care. Alternatively, participants may simply be more open to the possibility of other care options given greater pessimism about the reality of staying in their own homes. It is of concern that the majority of older people do not discuss their care preferences with their families and others and this has not changed over the four years.

### 6.3.1 Long-term care preferences

- Almost all participants chose living at home with family support as their care preference if they needed long-term care. This preference increased from 2000 to 2004.
- The least preferred mainstream option if needing long-term care was a nursing home. About half of the ERHA group would not accept a nursing home option at both study times. While resistance was higher in the year 2000 for the WHB, this was halved in 2004 (65 per cent v. 34 per cent not accepting a nursing home as an option in 2000 and 2004 respectively).
- About one in four participants had discussed their long-term care preferences with others with marginally fewer WHB participants doing so. Nonetheless, over 95 per cent consistently across boards and time believed their wishes in this regard would be honoured.

### 6.3.2 Transport

- About half of the participants were car drivers with no board or time differences. More ERHA than WHB participants walked or cycled (about half the WHB participants did so) but there was a significant ERHA-only reduction over four years (76 per cent to 66 per cent). The number of people availing of lifts from others was similar across boards and increased by about a quarter over time such that half of the samples accepted lifts in 2004. Public transport was used much more by ERHA participants (about two thirds at both times) than by those in the WHB – WHB uptake decreased from 32 per cent to 20 per cent over four years.

### 6.3.3 Stigma

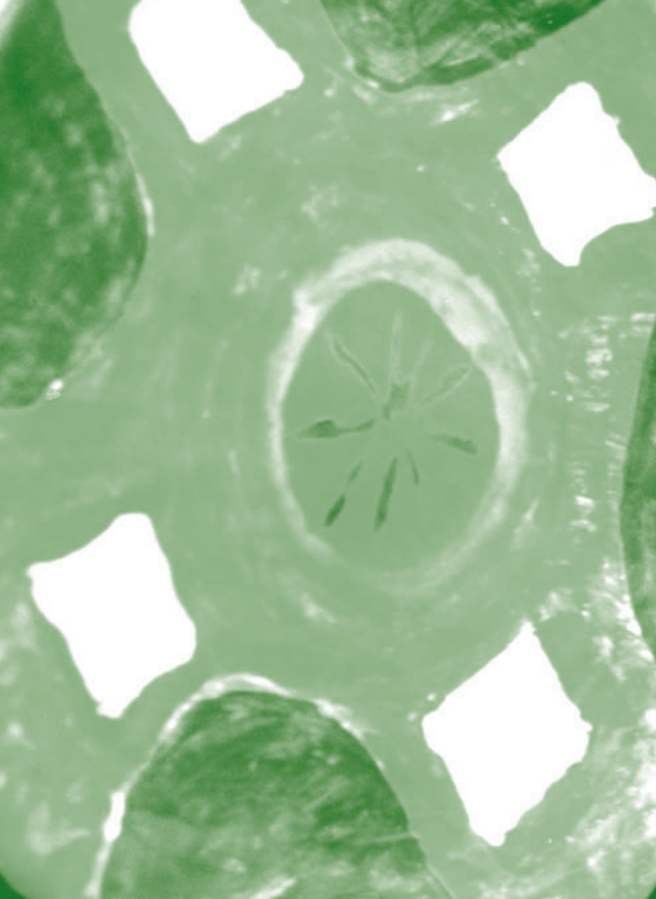
- Up to 10 per cent of participants would feel stigmatised and would, therefore, not use meals-on-wheels, home help or personal care assistants even if needed. In general, those in the ERHA felt less stigmatised than WHB respondents in 2000 with WHB respondents becoming less stigmatised over time such that there were no board differences in 2004.

### 6.3.4 Health service funding

- More WHB than ERHA participants had medical cards at both time points (e.g. 89 per cent v. 75 per cent in 2004). Almost all participants aged seventy years or over in 2004 (i.e. 97 per cent) reported having the medical card to which they had become entitled.
- Private health insurance was held by about 40 per cent of ERHA and 25 per cent of WHB participants at both time points.
- There were no major increases in the use of primary care services such as physiotherapy, chiropody or home help over time. About half of those using physiotherapy and chiropody services paid for them with no significant change over time. Those paying for home help increased fourfold in the ERHA over time (11 per cent to 44 per cent) with a much less notable increase in the WHB (13 per cent to 19 per cent).







## Chapter 7

Changes in health and mortality for *HeSSOP I* participants over four years:  
Longitudinal study

# Chapter 7

## Changes in health and mortality for *HeSSOP I* participants over four years: Longitudinal study

### 7.1 Chapter overview

One of the goals of this report was to provide a longitudinal follow-up of older adults first interviewed four years previously as part of *HeSSOP I*. In Ireland, there is a dearth of longitudinal data on older people and few opportunities to study older people's experiences and changes over time. Longitudinal studies not only facilitate a greater understanding about the nature of ageing and health over time, but they can also shed light on the role of health and social services in facilitating better health and well-being for older adults. These insights in turn offer the potential for more focused interventions to facilitate optimal development and quality of life for more people. By examining changes over time, health professionals in the field of ageing also have unique opportunities to challenge boundaries and stereotypes, and extend what is known about the nature of ageing, older people and later life.

*HeSSOP I* took place in 2000 and involved 937 participants. Although not originally set up as a longitudinal study, 873 participants (92 per cent) were traced four years later in *HeSSOP II* (Wave 2). As can be seen in Appendix 1, 325 members of this group were re-interviewed (41 per cent of the *HeSSOP I* ERHA group and 29 per cent of the WHB group) and 306 were not able or unwilling to be interviewed (108 declined to take part in the research, 57 were too ill to take part, 83 were willing to complete only a four-page questionnaire, and no suitable time could be found to interview 58 participants). The remainder could not be interviewed: 160 had died by the four-year follow-up, 13 had moved to institutional care and 34 had changed address. The status of 64 participants was unknown at the follow-up, e.g. there was no one home despite

repeated call-backs. Information was obtained by interview or short questionnaire completion from those known to be alive in 2004. Re-interviewing 40 per cent of those known to be alive from the original sample poses challenges to the generalisability and interpretability of the data. Nevertheless, as already noted, useful information can still be gained from following participants longitudinally.

The chapter to follow is in two sections. The first section gives summary information on participants not interviewed (see also Appendix 3) including:

- participants whose status was unknown (n = 64)
- participants who were unavailable for interview in *HeSSOP II* because they had moved to institutional care (n = 13)
- participants who were available for interview but not interviewed (e.g. because they were too ill or because they had declined involvement in the study)
- participants who had died by *HeSSOP II* (n = 160).

The second and main section of this chapter examines data from participants who participated fully in the four-year follow-up interviews (n = 314; of these, 164 were based in the ERHA and 150 in the WHB). For each of a range of health and social service type variables, three key issues are examined:

- similarities and differences between longitudinal participants and all others (since having information about the longitudinal sample provides a context for interpreting subsequent data)
- the nature of change over time (since understanding the degree and extent of change over time can enable health professionals and others to manage change and offer targeted support where needed)
- explanations for *HeSSOP II* outcomes using *HeSSOP I* measures (since understanding why changes occur is useful to health and social service providers and policy analysts interested in facilitating optimal health and well-being among adults into advanced old age).

## 7.2 Participants not interviewed

Basic descriptive information is given in Table 7.1 on participants who did and did

not take part in the longitudinal study.

A series of statistical analyses were conducted comparing demographic profile, health status and health service use between participants who took part in the longitudinal study and other sample groups. There were few or no features distinguishing 'not interviewed' groups from those interviewed in *HeSSOP II* with the exception of participants who had died; these were more likely to be older and less likely to have been educated to above primary level. Full details of these analyses are provided in Appendix 3. From a research perspective, their similarity to others in *HeSSOP I* is reassuring since it increases the generalisability of later findings.

**Table 7.1: Wave 2 status of *HeSSOP I* participants as contacted for the longitudinal study**

Wave 2 status	Demographic variables							
	Men		65-74 years		75+ years		Primary education only	
	ERHA	WHB	ERHA	WHB	ERHA	WHB	ERHA	WHB
	%	%	%	%	%	%	%	%
Interview complete (n = 314 <sup>1</sup> )	46	50	46	42	55	58	37	68
Status unknown (n = 64)	45	42	46	25	52	75	64	68
Unknown at address (n = 69)	46	35	61	20	39	80	23	76
Moved to residential care (n = 13)	25	38	0	11	100	90	50	63
Deceased (n = 160)	54	56	23*	4*	77*	96*	60*	68*
No suitable time for interview (n = 58)	57	50	37	36	63	64	31	61
Too ill to take part (n = 57)	32	47	28	44	74	56	24	31
Willing to do shorter questionnaire (n = 83)	43	49	37	38	63	62	43	66
Declined involvement (n = 108)	49	43	38	33	62	67	49	70

Note: <sup>1</sup> incomplete interview data from a further 11 participants (n = 325), \* significant difference between any group and others in *HeSSOP I*.

### 7.3 Longitudinal participants

Of the original *HeSSOP I* sample, 325 took part in the *HeSSOP II* longitudinal study

with 314 completed interviews. In the three sections to follow, the following are discussed (using  $n = 314$  dataset): demographic profiles of longitudinal participants including similarities and differences to others in the original *HeSSOP I* study; health at both time points for longitudinal participants; and use of health and social services, including the factors that can explain variation in service use.

### 7.3.1 Demographic profile of longitudinal study participants

In *HeSSOP I*, in the ERHA ( $n = 160$ ), 46 per cent of longitudinal participants were men, 56 per cent were married and 10 per cent were aged 85 years or over (see Table 7.2). Sixty-three per cent were educated above primary level, 24 per cent lived alone and 34 per cent lived with spouses only. The majority lived in urban areas (86 per cent) and 76 per cent were in higher (i.e. skilled, non-manual or professional) social classes. Comparing demographic differences between ERHA *HeSSOP I* participants who took part in the longitudinal study and all other ERHA participants in *HeSSOP I*, significant differences were found only for age ( $p < .01$ ) and social class ( $p < .001$ ), i.e. participants in the longitudinal study were younger and in higher social class groups.

**Table 7.2: Demographic profile of HeSSOP I participants who completed and who did not complete follow-up interviews at HeSSOP II**

Demographic profile	Longitudinal sample (n = 314)		All others in HeSSOP I (n = 623)	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Gender</b>				
Men	46	50	47	43
Women	53	50	53	57
<b>Age at HeSSOP I†</b>				
65-74 years	46	42	35	24
75-84 years	45	41	46	47
85+ years	10	17	20	29
<b>Education</b>				
≤ Primary	37	68	49	67
> Primary	63	32	51	33
<b>Marital status</b>				
Married	56	48	51	40
Widowed	34	38	38	47
Never married/single	9	13	9	13
<b>Household composition</b>				
Living alone	24	26	26	33
With spouse only	34	31	35	28
With spouse and children	20	17	14	13
With children and/or grandchildren	20	26	23	26
Other (e.g. non-relatives)	2	1	2	1
<b>Social Class († in east only)</b>				
Professional/high farmer	32	20	21	24
Skilled or non-manual	44	50	38	44
Semi-skilled or manual	19	24	37	26
Unclassified	4	6	3	6
<b>Geographical location</b>				
Open country or village	10	88	11	79
Small town	4	6	3	10
Large town or city (10,000+ people)	86	7	86	11

Note: † indicates that difference within same boards is significant ( $p < .01$ ).

In *HeSSOP I*, in the WHB ( $n = 150$ ), 50 per cent of longitudinal participants were men, 48 per cent were married and 17 per cent were aged 85 years or over (see Table 7.2). Of this group, 32 per cent were educated above primary education, 26 per cent lived alone, and 31 per cent lived with spouses only. Eighty-eight per cent of this group lived in open country or small villages and 70 per cent were in higher (i.e. skilled, non-manual or professional) social classes. Comparing demographic differences between WHB *HeSSOP I* participants who took part in the longitudinal study and all other WHB participants, significant differences were found only for age ( $p < .001$ ), i.e. participants in the longitudinal study were younger than others in the *HeSSOP I* study.

### Summary

*HeSSOP I* participants who took part in the longitudinal study were younger but otherwise comparable to others in *HeSSOP I* who were not interviewed four years later.

## 7.3.2 Examining and explaining changes in functional health

Functional health was measured by the HAQ which measures levels of physical ability in terms of the activities that are performed on a daily basis. Three components of functional health are examined in the section to follow: differences in functional health at *HeSSOP I* between longitudinal participants and all others; changes over time in functional health for longitudinal participants; and factors explaining changes over time in functional health for longitudinal participants.

### 7.3.2.1 Health at *HeSSOP I*: Comparisons of longitudinal participants and all others

Participants who took part in the longitudinal study had difficulties in some key activities of daily living but they had significantly fewer difficulties than did others from *HeSSOP I*, e.g. in dressing (see Table 7.3). This longitudinal study is particularly informative regarding the four-year health and psychosocial outcomes for adults in relatively good health.

**Table 7.3: Percentage rating activities of daily living tasks as being very difficult or impossible to do in *HeSSOP I***

Functional health (ADLs)	Ratings in 2000			
	Longitudinal sample only (n = 314)		All others in <i>HeSSOP I</i> , (n = 623)	
	ERHA %	WHB %	ERHA %	WHB %
Dressing	9 †	13 †	19 †	20 †
Personal care, e.g. washing	12 †	10 †	17 †	22 †
Arising, e.g. getting out of bed	4	5	8	12
Eating /drinking	8 †	5 †	14 †	14 †
Walking	11 †	18 †	21 †	31 †
Reaching	8	10 †	15	23 †
Gripping	4	1	4	12
Complex activities, e.g. shopping	13 †	14 †	24 †	26 †

Note: † within health board difference where  $p < .01$ .

### 7.3.2.2 Changes over time in health for *HeSSOP II* longitudinal participants

Over time there was an increase in the percentage of participants experiencing difficulties in some but not all key activities of daily living (ADLs). As can be seen in Table 7.4, there was a significant increase over time in the percentage of participants finding activities such as personal care and hygiene difficult, as well as more complex activities such as shopping. However, there were no significant changes over time in the percentage of participants finding other activities difficult, such as dressing, arising and gripping. Furthermore, there was a reduction over time in the percentage of people who found walking difficult.



**Table 7.4: Percentage rating activities of daily living tasks as very difficult or impossible to do in *HeSSOP I* and *HeSSOP II* (n = 314)**

Functional health (ADLs)	Ratings in 2000		Ratings in 2004	
	Longitudinal participants		Longitudinal participants	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Dressing	9	13	7	10
Personal care, e.g. washing	12 <sup>†</sup>	10 <sup>†</sup>	13 <sup>†</sup>	12 <sup>†</sup>
Arising, e.g. getting out of bed	4	5	8	9
Eating/drinking	8	5	5	8
Walking	11 <sup>†</sup>	18 <sup>†</sup>	9 <sup>†</sup>	14 <sup>†</sup>
Reaching	8 <sup>†</sup>	11	16 <sup>†</sup>	18
Gripping	4	5	7	9
Complex activities, e.g. shopping	13 <sup>†</sup>	14 <sup>†</sup>	16 <sup>†</sup>	19 <sup>†</sup>

Note: † within health board difference where  $p < .01$ .

Examining differences in the mean level of difficulty associated with key activities over time offers additional information about possible change for this longitudinal group. For instance, while the proportion of adults experiencing moderate to high levels of difficulty in some activities may not change, mean ratings for the group as a whole can become higher (more negative). Increases over time in some activities were found (see Table 7.5). This data can indicate that more support is needed in these areas.

**Table 7.5: Mean ratings of functional health at two time points for longitudinal participants (n = 314)**

Functional health (ADLs)	Mean Ratings in 2000 <sup>1</sup> Mean Ratings in 2004 <sup>1</sup>			
	Longitudinal participants		Longitudinal participants	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
Dressing	.27	.32	.29	.34
Personal care, e.g. washing	.30	.26Δ	.39	.44Δ
Arising, e.g. getting out of bed	.15	.18Δ	.28	.36Δ
Eating/drinking	.25	.14Δ	.20	.30Δ
Walking ability	.26	.44	.36	.53
Reaching ability	.31	.41	.46	.58
Grip ability, e.g. jars	.14	.15Δ	.27	.29Δ
Complex activities, e.g. shopping	.34Δ	.37Δ	.59Δ	.66Δ

Note: Higher mean scores = higher disability; <sup>1</sup> standard deviations for all measures ranged from .50 to 1.1; Δ wave difference where p<.01.

In summary, over the four-year period, there was an increase in the percentage of participants experiencing difficulties in some key ADLs. Although most participants continued to remain independent, an increasing number found key activities such as shopping difficult. Health board differences were found, with participants in the WHB being more likely to experience difficulties in activities involving personal care and eating or drinking.

### 7.3.2.3 Explaining functional health changes over time for longitudinal participants

Of interest in this analysis were the *HeSSOP I* factors that would explain functional health in *HeSSOP II*. Functional health in *HeSSOP II* was measured by ADL mean scores on the HAQ. Possible *HeSSOP I* demographic explanations included age, gender, marital status and household composition (living alone, living with spouse only, or living in intergenerational families; while the former may put people at risk, the latter support may have protective value). Also considered were socioeconomic status and the available resources for healthcare; these measures included social class, education and financial cover for healthcare by a medical card. Other *HeSSOP I* measures used to explain functional health in *HeSSOP II* included: ADL, depression and anxiety scores, loneliness, boredom ('I often find I am bored or have time on my hands I do not know how to fill') and the experience of ageism ('Generally people treat me with less respect due to my age').

In the first regression analysis, the sample was combined in order to identify general factors that explain *HeSSOP II* ADL scores, and in order to include health board as a possible explanation. The outcome and predictor variables were as above. When all variables were entered, the regression was significant ( $R^2 = .45$ ,  $F(18, 246) = 11.44$ ,  $p < .001$ ). *HeSSOP I* HAQ scores predicted HAQ scores in *HeSSOP II* which is expected ( $p < .001$ ). Age at *HeSSOP I* also predicted *HeSSOP II* HAQ scores ( $p < .001$ ) with older participants at *HeSSOP I* more likely to have greater functional impairment by *HeSSOP II*. Social class and education were unrelated to *HeSSOP II* HAQ scores but a significant effect was found for having a medical card at *HeSSOP I* ( $p < .01$ ). Depression (but not anxiety) at *HeSSOP I* was also significantly related to HAQ scores at *HeSSOP II* (both  $ps < .01$ ). Health board, household composition and loneliness were all unrelated to *HeSSOP II* HAQ scores; however, perception of ageism at *HeSSOP I* was approaching significance, i.e. even when controlling for other explanations (e.g. HAQ scores at *HeSSOP I*, social class), there was a trend for perceptions of ageism to be related to greater functional impairment four years later.

The above analysis was repeated separately for participants from each health board in order to examine possible regional variations in the *HeSSOP I* factors that might explain *HeSSOP II* HAQ scores. The outcome and predictor variables were as above with the exception that health board as a predictor variable was removed. As described next, the regressions were significant in both the ERHA ( $R^2 = .50$ ,  $F(18, 119) = 6.6$ ,  $p < .001$ ) and the WHB ( $R^2 = .49$ ,  $F(18, 108) = 6.6$ ,  $p < .001$ ).

In the ERHA, participants who had most functional impairment at *HeSSOP II* were those who at *HeSSOP I* were older and already had at least some physical impairments ( $p < .001$ ); the latter results highlight the ongoing problems adults with functional impairments can have and the need for health professionals to support efforts by older adults to be as independent as possible. Participants who were depressed and bored at *HeSSOP I* with time on their hands were also most likely to have greater functional impairments at *HeSSOP II* ( $p < .01$  and  $.01$  respectively). Again, these results highlight a role for health professionals and others in facilitating optimal health and functional ability for more people for longer into advanced years.

In the WHB, older age and greater functional health problems at *HeSSOP I* both significantly predicted functional impairment at *HeSSOP II* ( $p < .001$  for both). Having a medical card at *HeSSOP I* was also related to greater functional impairment at *HeSSOP II* ( $p < .01$ ).

### 7.3.2.4 Summary

Although participants taking part in the longitudinal study had better functional health at *HeSSOP I* than did others at that time, there was some increase in the percentage of participants experiencing problems in at least some activities of daily living over the intervening four years. Activities which were the most problematic included complex activities such as shopping and also activities concerned with personal care, washing and gripping. Nevertheless, most participants continued to retain independence and good functional health over the four-year period. Older age and pre-existing functional impairments were both significant predictors of later functional impairments. Even when controlling for these variables, however, *HeSSOP I* depression also predicted variance in *HeSSOP II* functional health. Boredom and perceptions of ageism were also related to greater functional impairments four years later.

## 7.4.3 Examining and explaining changes in self-rated health

Self-rated health was measured by asking participants about their general health in the present relative to a year ago, and their expectations for their health one year from now. Three components of self-rated health are examined in the section to follow: differences in self-rated health at *HeSSOP I* between longitudinal participants and all others; changes over time in self-rated health among longitudinal participants; and factors explaining changes over time in self-ratings of health.

### 7.4.3.1 Self-rated health at *HeSSOP I*: Comparison of longitudinal participants and all others

General physical health was measured by three self-ratings scales (see Table 7.6). The majority of *HeSSOP I* participants (56-78 per cent of each health board) rated their health as being fair to good. In examining mean scores, however (see Table 7.7), *HeSSOP I* participants who took part in the longitudinal study rated their current general health more positively than did other *HeSSOP I* participants. There were no significant differences between these two groups in terms of ratings of current health relative to a year ago or in expectations for health a year from now. These results indicate that participants who took part in the longitudinal study had better current health perceptions but similar 'anchors' in terms of optimism about their current and future health relative to others in *HeSSOP I*.

**Table 7.6: Self-ratings of health among HeSSOP I participants**

Self-ratings of general physical health	Ratings in 2000			
	Longitudinal sample only (n = 314)		All others in HeSSOP I (n = 623)	
	ERHA %	WHB %	ERHA %	WHB %
<b>Current health</b>				
Good/excellent	78	65	74	56
Fair	18	32	18	31
Poor/very poor	7	3	6	11
<b>Health compared to year ago</b>				
Much/somewhat better	5	16	8	10
About the same as now	81	62	76	66
Worse/much worse	14	22	15	24
<b>Expected health year ahead</b>				
Much/somewhat better	6	9	11	9
About the same as now	88	81	81	78
Worse/much worse	6	9	7	13

**Table 7.7: Mean ratings of self-rated health by HeSSOP I participants who took part in longitudinal study and all others in HeSSOP I**

Self-ratings of general physical health	Ratings in 2000			
	Longitudinal sample only (n = 314)		All others in HeSSOP I (n = 623)	
	ERHA Mean <sup>1</sup>	WHB Mean <sup>1</sup>	ERHA Mean <sup>1</sup>	WHB Mean <sup>1</sup>
Current health	1.9	2.2	2.1	2.4
Health compared to one year ago	3.0	3.0	3.0	3.1
Expectations for health one year from now	2.9	2.9	2.9	3.0

Note: Higher mean scores refer to more poor health, <sup>1</sup>standard deviations for all measures ranged from .37 to .91.

### 7.4.3.2 Changes over time in self-rated health among longitudinal participants

Between waves 1 and 2, self-ratings of general health did not change greatly (see Table 7.8). Over the four-year period there was no significant difference in mean ratings of general health for participants in either board (see Table 7.9).

There were no significant changes over the four-year period for participants in either health board in ratings of health relative to a year ago. In terms of health expectations one year ahead, a significant effect was found for participants in the ERHA only. They had more negative expectations about their future health in *HeSSOP II* by comparison with *HeSSOP I* ( $p < .001$ ).

**Table 7.8: Self-ratings of health among longitudinal sample (n = 314)**

Self-ratings of general physical health	Ratings in 2000 Longitudinal participants		Ratings in 2004 Longitudinal participants	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Current health</b>				
Good/excellent	78	65	74	66
Fair	18	32	21	28
Poor/very poor	7	3	4	6
<b>Health compared to year ago</b>				
Much/somewhat better	5	16	11	7
About the same as now	81	62	67	77
Worse/much worse	14	22	21	17
<b>Expected health year ahead</b>				
Much/somewhat better	6	9	3	5
About the same as now	88	81	85	85
Worse/much worse	6	9	12	10

**Table 7.9: Mean ratings of health at two time points by longitudinal participants (n = 314)**

Self-ratings of general physical health	Ratings in 2000		Ratings in 2004	
	Longitudinal sample only		Longitudinal sample only	
	ERHA Mean <sup>1</sup>	WHB Mean <sup>1</sup>	ERHA Mean <sup>1</sup>	WHB Mean <sup>1</sup>
Current health	1.9	2.2	2.0	2.3
Health compared to one year ago	3.0	3.0	3.1	3.1
Expectations for health one year from now	2.9 $\Delta$	2.9	3.1 $\Delta$	3.1

Note: Higher mean scores refer to more poor health,  $\Delta$  = wave difference where  $p < .01$ ; <sup>1</sup> standard deviations for all measures ranged from .37 to .81.

#### 7.4.3.3 Explaining *HeSSOP II* self-ratings of health from *HeSSOP I* measures

The first analysis focused on *HeSSOP I* measures that would explain self-ratings of general health at *HeSSOP II*. Possible *HeSSOP I* demographic explanations included age, gender, marital status and household composition (living alone, living with spouse only, or living in intergenerational families; while the former may put people at risk, the latter support may have protective value). Also considered were socioeconomic status and the available resources for healthcare; these measures included social class, education and financial cover for healthcare by a medical card. Other *HeSSOP I* measures used to explain self-ratings of health in *HeSSOP II* included: ADL, depression and anxiety scores, loneliness, boredom and the experience of ageism.

When these variables were entered, 40 per cent of the variance in the ERHA was explained ( $R^2 = .40$ ,  $F(19, 118) = 4.2$ ,  $p < .001$ ) as was 34 per cent of the variance in the WHB ( $R^2 = .34$ ,  $F(19, 108) = 2.9$ ,  $p < .001$ ). In the ERHA, the only variable to explain *HeSSOP II* general health self-ratings was *HeSSOP I* general health self-ratings ( $p < .001$ ). In the WHB, the only *HeSSOP I* variables to explain *HeSSOP II* general health self-ratings were: *HeSSOP I* health ratings ( $p < .001$ ), marital status ( $p < .01$ ) and HADS depression scores ( $p < .01$ ). Participants in *HeSSOP II* were more likely to rate their general health negatively if, at *HeSSOP I*, they had rated their general health negatively, had never married, and if they had higher scores on measures of depression.

The above predictor variables were used to explain how participants rated their health relative to a year ago. These variables were only significant for the ERHA (ERHA  $R^2 = .28$ ,  $F(19, 118) = 2.4$ ,  $p < .001$ ; WHB  $R^2 = .21$ ,  $F(19, 108) = 1.5$ ,  $p = .08$ ). In the ERHA, the specific *HeSSOP I* variables to carry this effect were levels of functional disability as measured by the HAQ ( $p < .001$ ) and levels of *HeSSOP I* depression ( $p < .01$ ).

When the above predictor variables were used a third time to explain adults expectations for future health, significant effects at  $p < .01$  were found for the ERHA only. The above variables explained 40 per cent of the variance in the ERHA ( $R^2 = .40$ ,  $F(19, 115) = 4.0$ ,  $p < .001$ ) and 23 per cent of the variance in the WHB ( $R^2 = .23$ ,  $F(19, 106) = 1.7$ ,  $p < .01$ ). Even when controlling for health expectations at *HeSSOP I*, the specific variable to carry this effect in the ERHA was depression ( $p < .01$ ). Level of functional ability as measured by the HAQ also approached significance.

These results indicate that ERHA participants who rated their future health more negatively also scored more highly on measures of depression, had never married and had some current functional impairment. In the WHB, the explanatory variable was parental status ( $p < .01$ ), i.e. more negative evaluations of future health were associated with having no children.

#### 7.4.3.4 Summary

Participants were asked at two time points about their general health in the present, relative to a year ago and their expectations for their health one year from now. Results indicated that *HeSSOP I* participants who took part in the longitudinal study had health ratings similar to remaining *HeSSOP I* participants. Over the four-year period, ratings about general health tended to decrease, but not dramatically. Specifically, WHB participants rated current health as poorer but did not anticipate more deterioration in the coming year than they did in *HeSSOP I*. On the other hand, ERHA participants rated current health as equivalent to that in *HeSSOP I* but anticipated more disimprovement in the coming year. These results may reflect known biases in information processing, identified by gerontologists, whereby older people can evaluate their current health or circumstances positively, even in the context of abject problems and constraints (e.g. see Thompson *et al.*, 1990). A number of objective and subjective *HeSSOP I* measures were found to explain variance in self-ratings of health; these included demographic variables such as education and marital status, and psychosocial variables such as depression and the experience of ageism.



## 7.4.4 Examining and explaining changes in psychosocial health

Psychosocial health was measured by the HADS depression scale and questions on emotional, informational and practical support. Three components of psychosocial health are examined in the section to follow: differences in psychosocial health at *HeSSOP I* between longitudinal participants and all others; changes over time in psychosocial health among longitudinal participants; and factors explaining changes over time in psychosocial health.

### 7.4.4.1 Psychosocial health at *HeSSOP I*: Comparison of longitudinal participants and all others

Psychosocial health was measured in terms of depression and support. The majority of participants were in the non-clinical range of depression and rated their levels of social support as being very high; between 75 and 90 per cent of all participants reported that they had emotional, practical and informational type support most of the time when they needed it (see Table 7.10).

**Table 7.10: Psychosocial health ratings at *HeSSOP I***

Psychosocial health measures	Ratings in 2000			
	Longitudinal sample only (n = 314)		All others in <i>HeSSOP I</i> (n = 623)	
	ERHA %	WHB %	ERHA %	WHB %
<b>Depression</b>				
Non-clinical	94	94	94	85
Borderline	5	4	3	7
Clinical	1	2	2	7
<b>Support:</b>				
<b>Emotional support</b>				
None/little of time	4	10	6	6
Some of time	11	7	4	7
Most of time	85	82	90	90
<b>Informational support</b>				
None/little of time	4	9	3	6
Some of time	7	7	5	6
Most of time	88	85	92	89
<b>Practical support</b>				
None/little of time	12	18	10	12
Some of time	6	7	3	5
Most of time	81	75	87	83

*HeSSOP I* participants who took part in the longitudinal study scored similarly to others from *HeSSOP I* on psychosocial health measures with few exceptions (see Table 7.11). In the WHB, longitudinal participants scored less negatively on the HADS (depression scale) than others ( $p < .01$ ).

**Table 7.11: Mean psychosocial health ratings at *HeSSOP I***

Psychosocial health measures	Ratings in 2000			
	Longitudinal sample only (n = 314)		All others in <i>HeSSOP I</i> (n = 623)	
	ERHA Mean <sup>1</sup>	WHB Mean <sup>1</sup>	ERHA Mean <sup>1</sup>	WHB Mean <sup>1</sup>
Depression	2.6	2.8 <sup>†</sup>	2.7	3.8 <sup>†</sup>
Emotional support	4.5	4.3	4.5	4.5
Informational support	4.6	4.3	4.6	4.6
Practical support	4.3	4.1	4.6	4.3

Note: <sup>†</sup> within health board difference where  $p < .01$ , <sup>1</sup> standard deviations for all measures ranged from .78 to 3.8.

#### 7.4.4.2 Changes over time in psychosocial health among longitudinal participants

Over the four years, the percentage of participants having borderline or clinical levels of depression did not change significantly (see Table 7.12). Nevertheless, there was an increase in mean levels of depression over this timeframe among participants which was significant for both health boards (ERHA  $p < .001$ , WHB  $p < .001$ ).

For participants in the ERHA, there were no significant changes over the four-year period in terms of the perceived availability of support when needed (see Tables 7.12 and 7.13). In the WHB, the perceptions of emotional support ( $p < .001$ ) and practical support ( $p < .001$ ) increased over the four-year period.

**Table 7.12: Psychosocial health at two time points among longitudinal participants (n = 314)**

Psychosocial health measures	Ratings in 2000			
	Longitudinal sample only (n = 314)		All others in <i>HeSSOP I</i> (n = 623)	
	ERHA %	WHB %	ERHA %	WHB %
<b>Depression</b>				
Non-clinical	94	94	94	89
Borderline	5	4	4	6
Clinical	1	2	2	5
<b>Support:</b>				
<b>Emotional support</b>				
None/little of time	4	10	9	3
Some of time	11	7	7	4
Most of time	85	82	84	93
<b>Informational support</b>				
None/little of time	4	9	5	7
Some of time	7	7	9	2
Most of time	88	85	85	91
<b>Practical support</b>				
None/little of time	12	18	13	10
Some of time	6	7	9	3
Most of time	81	75	80	87

**Table 7.13: Mean ratings of health at two time points for longitudinal participants (n = 314)**

Psychosocial health measures	Ratings in 2000			
	ERHA	WHB	ERHA	WHB
	Mean <sup>1</sup>	Mean <sup>1</sup>	Mean <sup>1</sup>	Mean <sup>1</sup>
Emotional support	4.5	4.3 Δ	4.4	4.6 Δ
Informational support	4.6	4.3	4.4	4.5
Practical support	4.3	4.1 Δ	4.2	4.4 Δ

Note: Δ = wave difference where  $p < .01$ ; <sup>1</sup> standard deviations for all measures ranged from .37 to 1.2.

#### 7.4.4.3 Explaining changes over time in psychosocial health

The first analysis focused on *HeSSOP I* measures that would explain psychosocial health at *HeSSOP II*. Possible *HeSSOP I* demographic explanations included age, gender, marital status and household composition (living alone, living with spouse only, or living in intergenerational families). Also considered were socioeconomic status and the available resources for healthcare; these measures included social class, education and financial cover for healthcare by a medical card. Psychosocial health measures from *HeSSOP I* included in this were loneliness, boredom and the experience of ageism.

Being depressed and pessimistic about one's health and being in a lower social class in *HeSSOP I* predicted depression in both health boards four years later in *HeSSOP II*. The above measures explained 30 per cent of the variance of depression scores in the ERHA ( $R^2 = .30$ ,  $F(21, 114) = 2.3$ ,  $p < .01$ ) and 43 per cent of the variance of depression scores in the WHB ( $R^2 = .34$ ,  $F(21, 103) = 3.8$ ,  $p < .001$ ). In the ERHA, the *HeSSOP I* factors which carried a significant effect four years later were depression ( $p < .01$ ) and future health expectations ( $p < .01$ ). In the WHB, age ( $p < .001$ ) was a significant predictor of depression in *HeSSOP II*.

The above *HeSSOP I* predictor measures were also used to try to explain psychosocial health at *HeSSOP II*. No significant effect was found for either board in terms of emotional or informational support (all  $ps > .01$ ). When these predictor variables were used again to explain levels of practical support at *HeSSOP II*, no significant effect was found in the WHB ( $R^2 = .29$ ,  $F(24, 102) = 1.7$ ,  $p = .05$ ) or the ERHA ( $R^2 = .14$ ,  $F(24, 109) = .73$ ,  $p = .81$ ).

#### 7.4.4.4 Summary

Participants were asked at two time points about their psychosocial health as measured by levels of depression and perceptions of emotional, informational and practical support. Those who took part in the longitudinal study did not generally differ greatly from other *HeSSOP I* participants on these measures. While the majority of participants remained non-depressed over the four years, mean ratings of depression were higher in *HeSSOP II*. Perceived support generally remained stable for participants in the ERHA, while perceptions of support became more favourable over time for WHB participants. Results indicate that objective factors (such as social class) and subjective factors (such as perceptions of own health in *HeSSOP I*) were related to psychosocial health four years later.

## 7.4.5 Examining and explaining changes in use of GP services

Although a range of GP service measures were used, this analysis will focus on measures of GP contact and levels of satisfaction. As with other sections, three questions are addressed: similarities in GP use at *HeSSOP I* between longitudinal participants and all others; changes over time in GP service use; and *HeSSOP I* factors that explain *HeSSOP II* use of GP services.

### 7.4.5.1 Use of GP services in *HeSSOP I*: Comparison of longitudinal participants and all others

Longitudinal participants did not differ from others in *HeSSOP I* on measures of GP service use and acceptability (see Table 7.14). Over two thirds were registered with the same GP for over ten years (67 per cent in the ERHA and 70 per cent in the WHB). Approximately half would definitely change GP if dissatisfied and few had difficulties with getting to their GPs due to transport). Numbers of visits averaged four to five per year. There were very high levels of satisfaction with all aspects of the GP service assessed.

**Table 7.14: GP service use and acceptability for HeSSOP I participants**

GP-related profile	Ratings in 2000			
	Longitudinal sample only (n = 314)		All others in HeSSOP I (n = 623)	
	ERHA	WHB	ERHA	WHB
<b>Visited GP in past year</b>				
Yes (%)	90	97	89	93
<b>Willing to change GP if dissatisfied</b>				
Yes definitely (%)	53	49	56	48
Yes possibly (%)	26	26	20	26
No (%)	21	25	15	26
<b>Difficulties with transport to GP</b>				
Yes (%)	3	2	4	6
Number of GP visits in past year (mean; SD)	4.3 (3.7)	5.6 (4.6)	4.6 (4.5)	5.4 (4.5)
Median (range)	4.0 (0-25)	4.0 (0-25)	3.0 (0-20)	4.0 (0-30)
<b>Satisfaction Satisfied/very satisfied:</b>				
that concerns taken seriously (%)	91	91	89	85
with quality of information (%)	93	91	87	80
with availability of appointments (%)	90	91	90	87
<b>Satisfaction (mean<sup>1</sup>, <sup>2</sup>)</b>				
that concerns taken seriously	4.5 (.7)	4.5 (.5)	4.5 (.6)	4.6 (.5)
with quality of information	4.5 (.7)	4.5 (.4)	4.4 (.6)	4.6 (.6)
with availability of appointments	4.4 (.8)	4.5 (.5)	4.5 (.6)	4.6 (.6)

Note: <sup>1</sup>lower mean scores = less satisfaction, <sup>2</sup>standard deviations for all measures ranged from .46-.80.

There were no differences between the follow-up sample and all others in *HeSSOP I* in terms of the proportion of participants who had had the flu injection, those who smoked or those who had had advice from their GPs about smoking (see Table 7.15). Similarly, there were no group differences between those at different stages of quitting smoking, including thinking about quitting v. actively planning quitting.

**Table 7.15: Health services from GPs for *HeSSOP I* participants**

GP-related profile	Ratings in 2000			
	Longitudinal sample only (n = 314)		All others in <i>HeSSOP I</i> (n = 623)	
	ERHA %	WHB %	ERHA %	WHB %
<b>Received a flu injection last year</b>				
Yes	35	46	35	48
<b>Current smoker</b>				
Yes	15	19	22	20
<b>Has GP spoken to you in past year about smoking?</b>				
Yes	5	9	9	10
<b>Are you at present</b>				
trying to quit smoking	24	7	12	1
actively planning to quit smoking	8	14	4	4
thinking about quitting but not planning to	4	11	20	15
not thinking about quitting	64	66	64	80

#### 7.4.5.2 Examining changes over time in GP service use and experience

Changes over the four-year period were examined both for objective factors (e.g. availing of services) and subjective evaluations concerning the GP (i.e. satisfaction with care received).

##### *Availing of GP services*

Participants in the ERHA were more likely in *HeSSOP II* than in *HeSSOP I* ( $p < .001$ ) to have attended their GPs within the past year. Over the two time points, similar proportions of participants stated that they would change GPs if dissatisfied with

care (see Table 7.16). Very few participants had difficulties relating to transport in getting to their GPs. When comparing mean number of visits to GPs in 2000 and 2004, no significant differences were found in either health board (both  $p>.05$ ). Differences, however, were found between health boards; in both studies, WHB participants had more visits to their GPs than those in the ERHA ( $p<.01$ ).

**Table 7.16: Use of GP services by participants at two time points (n = 314)**

GP-related profile	Ratings in 2000			
	Longitudinal participants			
	ERHA	WHB	ERHA	WHB
<b>Visited GP in past year</b> Yes (%)	90 $\Delta$	98	98 $\Delta$	98
<b>Willing to change GP if dissatisfied</b>				
Yes definitely (%)	53	49	51	47
Yes possibly (%)	26	26	24	28
No (%)	21	25	25	24
<b>Difficulties with transport to GP</b>				
Yes (%)	3	2	3	2
Number of GP visits in past year (mean; SD)	4.3 (3.7)*	5.6 (4.6)*	4.8 (3.9)*	6.0 (5.6)*
Median (range)	4.0 (0-25)	4.0 (0-25)	4.0 (0-30)	4.0 (0-50)
<b>Satisfaction:</b>				
<b>Satisfied/very satisfied:</b>				
that concerns taken seriously (%)	91	91	92	96
with availability of appointments (%)	93	91	94	95
with quality of information (%)	90	91	90	96
<b>Satisfaction (mean<sup>1</sup>; SD<sup>2</sup>):</b>				
that concerns taken seriously (%)	4.5 (.7) $\Delta$	4.5 (.5) $\Delta$	4.2 (.7) $\Delta$	4.3 (.5) $\Delta$
with availability of appointments (%)	4.5 (.7) $\Delta$	4.5 (.4) $\Delta$	4.2(.7) $\Delta$	4.2(.6) $\Delta$
with quality of information (%)	4.4 (.8) $\Delta$	4.5 (.5) $\Delta$	4.3(.8) $\Delta$	4.3(.5) $\Delta$

Note: <sup>1</sup>Lower mean scores = less satisfaction, <sup>2</sup>standard deviations for all measures ranged from .46-.83,  $\Delta$  = wave difference where  $p<.01$ , \* between health board difference where  $p<.01$ .



*Evaluations of GP visits: Satisfaction ratings at two time points*

Although the majority of participants were satisfied that GPs took their concerns very seriously, mean satisfaction ratings in *HeSSOP II* were significantly lower than in *HeSSOP I* (both  $ps < .005$ ). Satisfaction with access to GPs was high in *HeSSOP I* but satisfaction ratings were lower in *HeSSOP II* in each of the health boards (both  $ps < .005$ ). Similarly, most participants in each health board were satisfied with the quality of information given to them, but mean satisfaction ratings were significantly lower in *HeSSOP II* than *HeSSOP I* (both  $ps < .005$ ). In the section to follow, possible explanations for GP satisfaction ratings are examined, including objective factors such as social class and more subjective factors such as psychosocial health.

Since access to GP care is the most common primary health service differentiated by fee payment v. medical card coverage, this analysis was repeated to consider whether medical card status in *HeSSOP I* influenced satisfaction ratings in either *HeSSOP I* or *HeSSOP II* (see Table 7.17). Of the 314 participants being followed up, 137 did not have medical card coverage for healthcare in *HeSSOP I*. There were no differences, however, by medical card status in the three satisfaction criteria evaluated and, although still high, satisfaction ratings were lower in *HeSSOP II* than in *HeSSOP I* for both groups.

**Table 7.17: *HeSSOP II* ratings of satisfaction with GP over time for longitudinal participants with and without medical card cover in *HeSSOP I***

GP-related profile	Ratings in 2000			
	ERHA	WHB	ERHA	WHB
<b>Participants with medical card in <i>HeSSOP I</i></b>				
Satisfaction (mean <sup>1</sup> )				
that concerns taken seriously	4.6Δ	4.7Δ	4.2Δ	4.3Δ
with availability of appointments	4.6Δ	4.7Δ	4.2Δ	4.2Δ
with quality of information	4.6Δ	4.6Δ	4.3Δ	4.3Δ
<b>Participants without medical card in <i>HeSSOP I</i></b>				
Satisfaction (mean <sup>1</sup> )				
that concerns taken seriously	4.6Δ	4.8Δ	4.3Δ	4.3Δ
with availability of appointments	4.7Δ	4.8Δ	4.2Δ	4.1Δ
with quality of information	4.6Δ	4.7Δ	4.3Δ	4.4Δ

Note: <sup>1</sup>standard deviations for all measures ranged from .49-.79; lower mean scores = less satisfaction, Δ wave difference where  $p < .01$ .

*GP health promotion: Smoking and flu injection*

As in the repeat study, more WHB than ERHA participants received flu injections in 2000. There were significant increases in the proportion of participants in each health board who had had the flu injection in 2004 with no differences across boards at this time (see Table 7.18). There were significant differences over time in terms of the proportion of participants who were smoking but not in those who had had advice from their GPs about smoking. In *HeSSOP II*, more participants were thinking about giving up but these differences were not significant in either board.

**Table 7.18: GP health promotion (flu injection and smoking) for longitudinal participants at two time points (n = 314)**

GP-related profile	Ratings in 2000		Ratings in 2004	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Received a flu injection last year</b>				
Yes	35 Δ*	46 Δ*	78 Δ	81 Δ
<b>Current smoker</b>				
Yes	15 Δ	19 Δ	1 *Δ	6 *Δ
<b>Has GP spoken to you in past year about smoking?</b>				
Yes	5	9	6	9
<b>Are you at present</b>				
trying to quit smoking	24	7	17	9
actively planning to quit smoking	8	14	6	5
thinking about quitting but not planning to	4	11	28	14
not thinking about quitting	64	66	50	72

Note: Δ wave difference where  $p < .01$ , \* = between health board difference where  $p < .01$ .

**7.4.5.3 Explaining changes in GP service use and experience**

*Explaining HeSSOP II GP attendance from HeSSOP I variables*

Of interest were the *HeSSOP I* measures that could explain frequency of visits to GP in *HeSSOP II*. The outcome variable was the number of times a GP had been seen in the previous year. Possible *HeSSOP I* factors that might explain this variance

included demographic factors (age, gender and marital status), socioeconomic factors (social class, education, cover for healthcare by a medical card) and both physical and psychosocial health (functional disability, anxiety and depression). When these variables were entered, 25 per cent of the variance in the ERHA was significantly explained ( $R^2 = .26$ ,  $F(8, 116) = 2.3$ ,  $p = .004$ ). Age and gender, however, did not explain frequency in GP attendance. Instead, GP attendance was explained by *HeSSOP I* HAQ scores ( $p = .004$ ) and anxiety ratings as measured by the anxiety subscale of the HADS ( $p = .01$ ), i.e. higher levels of anxiety and functional impairment at *HeSSOP I* explained higher levels of GP attendance at *HeSSOP II*. When the same predictor variables were used to explain frequency of GP attendance in the WHB, the results were not significant ( $R^2 = .16$ ,  $F(8, 107) = 1.1$ ,  $p = .31$ ).

#### *Explaining HeSSOP II GP satisfaction ratings from HeSSOP I variables*

The same predictor variables were used to explain GP satisfaction ratings in *HeSSOP II*. The results were not significant for either the ERHA ( $R^2 = .13$ ,  $F(8, 110) = 2.3$ ,  $p = .16$ ) or the WHB ( $R^2 = .14$ ,  $F(10, 102) = 0.7$ ,  $p = .77$ ).

#### 7.4.5.4 Summary

*HeSSOP I* participants taking part in the longitudinal study did not differ from others in *HeSSOP I* on a range of GP service measures. Although ratings of satisfaction were lower in *HeSSOP II*, they still remained very high, i.e. participants continued to be satisfied on a range of dimensions with the quality of care being received from GPs. *HeSSOP I* measures that explained *HeSSOP II* attendance at GP services included higher levels of anxiety and functional disability.

### 7.4.6 Examining and explaining changes in use of hospital services

A range of hospital service measures were used. Of interest in this section are frequency and type of hospital visits, changes in use of these services over time and possible explanations for these changes.

#### 7.4.6.1 Use of hospital services in *HeSSOP II*: Comparison of longitudinal participants and all others

Participants who took part in the longitudinal study did not differ from others in *HeSSOP I* on a range of hospital-based measures (see Table 7.19).

**Table 7.19: Use of hospital services by *HeSSOP I* participants who took part in the longitudinal study, and all others from *HeSSOP I***

Hospital use profile	Ratings in 2000			
	Longitudinal sample only (n = 314)		All others in <i>HeSSOP I</i> (n = 623)	
	ERHA %	WHB %	ERHA %	WHB %
<b>Attended in past year</b>				
A&E	15	12	14	10
In-patient	11	17	30	18
Out-patient	34†*	14*	37†	16
<b>Frequency of out-patient appointments</b>				
Not enough	6	0	6	2
About right	92	94	94	96
Too many	2	6	0	2
<b>On hospital waiting list for</b>				
In-patient treatment	3	7	3	6
Out-patient treatment	1	1	2	3

Note: † within health board difference where  $p < .01$ , \* between health board difference where  $p < .01$ .

#### 7.4.6.2 Examining changes over time in hospital service use and experience

The proportion of participants using hospital services at both time points can be seen in Table 7.20. There was a statistically significant increase over time in the numbers of ERHA participants availing of both in-patient and out-patient services (all  $ps < .001$ ) but not A&E services. In the WHB, there was a significant increase over time in the use of A&E ( $p = .003$ ), in-patient services ( $p < .001$ ) and out-patient services ( $p < .001$ ).

**Table 7.20: Use of hospital services by *HeSSOP I* longitudinal participants at two time points (n = 314)**

Hospital profile	Ratings in 2000		Ratings in 2004	
	Longitudinal participants		Longitudinal participants	
	ERHA %	WHB %	ERHA %	WHB %
<b>Attended in past year</b>				
A&E	15	12 Δ	23	31 Δ
In-patient	11 Δ	17 Δ	30 Δ*	51 Δ*
Out-patient	34 Δ*	14 Δ*	64 Δ*	39 Δ*
<b>Frequency of out-patient appointments</b>				
Not enough	6	0	8	12
About right	92	94	92	88
Too many	2	6	–	–
<b>On hospital waiting list for</b>				
In-patient treatment	3	7	3	5
Out-patient treatment	1	1	1	2

Note: Δ wave difference where  $p < .01$ , \* between health board difference where  $p < .01$ .

The differing pattern of in-patient and out-patient service use seen across boards in *HeSSOP I* (i.e. ERHA participants have less in-patient and more out-patient use than WHB participants) was repeated and enlarged in 2004 with, for example, 30 per cent v. 51 per cent of ERHA and WHB participants using in-patient services, and 64 per cent and 39 per cent of those in the ERHA and WHB using out-patient services.

Attitudes towards out-patient appointments were examined over time. In both health boards, the majority of participants believed that the frequency of visits was appropriate and no significant differences over time were found (ERHA  $p = .55$ , WHB  $p = .22$ ). There were no significant changes over the four years in terms of the percentages of participants waiting for either in-patient or out-patient services (all  $ps > .05$ ) although these results need to be treated with caution given the low numbers of participants on waiting lists.

#### 7.4.6.3 Explaining changes in hospital service use and experience

##### *Explaining HeSSOP II use of hospital services from HeSSOP I variables*

Of interest were *HeSSOP I* measures that could explain use of A&E hospital services in *HeSSOP II*. Possible *HeSSOP I* measures included demographic factors (age and gender), socioeconomic factors (education and cover for health by medical card) and both physical and psychosocial health (functional disability, anxiety and depression). Firstly, the relationship between A&E attendance and each of these variables was examined individually, in order to keep sample size high and to examine the variance explained by the most relevant variables. These variables, however, were not significantly related to A&E attendance in either board ( $p > .05$ ).

Of interest were *HeSSOP I* measures that could explain use of both in-patient and out-patient hospital services in *HeSSOP II*. For both these analyses, possible *HeSSOP I* predictor variables were as above. However, in neither board were these predictor variables related to either in-patient or out-patient use of hospital services (all  $p > .05$ ).

#### 7.4.6.4 Summary

*HeSSOP I* participants taking part in the longitudinal study did not differ from all others on measures of hospital use. Results indicated an increase over time in the use of A&E, in-patient services and out-patient hospital-based services. Satisfaction with the number of hospital out-patient services over time remained high and stable. There were no changes in the proportion of participants on waiting lists for hospital treatment.

### 7.4.7 Examining and explaining changes in use of social services

Participants were asked about their possible use of a wide range of social services. In this analysis, data is examined for use of public health nurses, Home Helps and meals-on-wheels, i.e. use and perceptions of key services designed to help people live independently in their own homes.

#### 7.4.7.1 Use of social services at *HeSSOP I*: Comparison of longitudinal participants and all others

##### *Use of social services*

Participants who took part in the longitudinal study did not generally differ from others in *HeSSOP I* on a range of social service measures (see Table 7.21). However, longitudinal participants in the ERHA were less likely than all others in *HeSSOP I* to have availed of services from a public health nurse. Longitudinal participants in the WHB were less likely than others to have availed of home help services. Health board differences were found for meals-on-wheels among all others in *HeSSOP II*, i.e. for this sub-sample, participants in the ERHA were more likely to have received this service than were others.

**Table 7.21: Use of health and social services by *HeSSOP I* participants who took part in the longitudinal study, and all others from *HeSSOP I***

Service use	Ratings in 2000			
	Longitudinal sample only (n = 314)		All others in <i>HeSSOP I</i> (n = 623)	
	ERHA %	WHB %	ERHA %	WHB %
<b>Availed of services from</b>				
Public health nurse	8 †	11	19 †	17
Personal care attendant	1	1	1	1
Home Help	4	1 *	8	5 *
Meals-on-wheels	1	0	3 *	1 *

Note: † within health board difference where  $p < .01$ , \* between health board difference where  $p < .01$ .

*Perceptions of health and social services: Stigma*

Levels of stigma or embarrassment associated with different social services can be seen in Table 7.22. There were no differences in these perceptions among participants who took part in follow-up and all others from *HeSSOP I*.

**Table 7.22: Stigma associated with key social services by *HeSSOP I* participants who took part in the longitudinal study, and all others from *HeSSOP I***

Service use	Ratings in 2000			
	Longitudinal sample only (n = 314)		All others in <i>HeSSOP I</i> (n = 623)	
	ERHA %	WHB %	ERHA %	WHB %
<b>Meals-on-wheels</b>				
Not embarrassed/very acceptable	69	53	68	46
Slightly/somewhat embarrassed, but acceptable	14	13	15	9
Fairly embarrassed, acceptable with difficulty	5	8	5	12
Very embarrassed, and not acceptable	12	26	12	32
<b>Home help</b>				
Not embarrassed/very acceptable	79	62	81	62
Slightly/somewhat embarrassed, but acceptable	7	16	7	10
Fairly embarrassed, acceptable with difficulty	6	8	4	10
Very embarrassed, and not acceptable	8	14	8	18
<b>Personal care attendant</b>				
Not embarrassed/very acceptable	76	61	72	57
Slightly/somewhat embarrassed, but acceptable	13	16	15	17
Fairly embarrassed, acceptable with difficulty	5	12	6	15
Very embarrassed, and not acceptable	6	11	7	11

#### 7.4.7.2 Examining change over time in use and perceptions of health and social services

##### *Use of social services*

For participants in the ERHA there were significant increases over time in the proportion availing of services from public health nurses, home helps and meals-on-



wheels (see Table 7.23). For participants in the WHB there were increases over time in the proportion availing of services from public health nurses, but not other services (see Table 7.23).

**Table 7.23: Use of health and social services by HeSSOP I longitudinal participants at two time points (n = 314)**

Service Use	Ratings in 2000		Ratings in 2004	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Availed of services from</b>				
Public health nurse	8 Δ	11 Δ	18 Δ	19 Δ
Personal care attendant	1	1	2	2
Home help	4 Δ	1	9 Δ	5
Meals-on-wheels	1 Δ	0	4 Δ*	1 *

Note: Δ wave difference where  $p < .01$ , \* between health board difference where  $p < .01$ .

*Perceptions of social services: Stigma*

As can be seen in Table 7.24, there was a reduction over time in the proportion of participants in each health board who would find it embarrassing to avail of meals-on-wheels and Home Helps. In the ERHA only, however, there was an increase in the proportion of participants who would find it difficult to avail of services from a personal care assistant.

**Table 7.24: Stigma associated with key social services at two time points (n = 314)**

Service Use	Ratings in 2000		Ratings in 2004	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Meals-on-wheels</b>				
Not embarrassed/very acceptable	69	53	70	66
Slightly/somewhat embarrassed, but acceptable	14	13	18	24
Fairly embarrassed, acceptable with difficulty	5	8	4	2
Very embarrassed, and not acceptable	12	26	7	8
<b>Home help</b>				
Not embarrassed/very acceptable	79	62	73	67
Slightly/somewhat embarrassed, but acceptable	7	16	12	24
Fairly embarrassed, acceptable with difficulty	6	8	3	2
Very embarrassed, and not acceptable	8	14	6	7
<b>Personal care attendant †</b>				
Not embarrassed/very acceptable	76	61	67	67
Slightly/somewhat embarrassed, but acceptable	13	16	21	24
Fairly embarrassed, acceptable with difficulty	5	12	4	3
Very embarrassed, and not acceptable	6	11	8	6

Note: † within health board difference where  $p < .01$  for ERHA only.

When examining mean differences in embarrassment ratings at the two time points, no differences were found for participants in the ERHA (see Table 7.25, all  $ps > .01$ ). However, for participants in the WHB, ratings towards the use of these social services became significantly more positive.

**Table 7.25: Mean stigma ratings for key social services at two time points (n = 314)**

Service Use	Ratings in 2000		Ratings in 2004	
	ERHA	WHB	ERHA	WHB
	Mean <sup>1</sup>	Mean <sup>1</sup>	Mean <sup>1</sup>	Mean <sup>1</sup>
Meals-on-wheels	1.7	2.4Δ	1.6	1.6Δ
Home help	1.5	1.9Δ	1.5	1.6Δ
Personal care attendant	1.5	1.9Δ	1.6	1.6Δ

Note: Higher scores refer to greater stigma (range 1-5; SDs ranged from 1.1 to 1.4).

### 7.4.7.3 Explaining changes in use of health and social services

#### *Explaining HeSSOP II use of public health nurses from HeSSOP I variables*

Of interest were the *HeSSOP I* measures that could explain use of public health nurses in *HeSSOP II*. Possible *HeSSOP I* explanations included demographic factors (age, gender, marital status and household composition), socioeconomic factors (education and cover for health by medical card) and both physical and psychosocial health (functional disability, anxiety and depression). A significant effect was found in the ERHA ( $p < .001$ ) and the WHB ( $p < .001$ ). In the ERHA, the specific variables to explain variance were functional ability ( $p = .01$ ) and education ( $p = .008$ ), i.e. people who were availing of services from a public health nurse were those who were least functionally able and those less likely to have a post-primary level of education. In the WHB, the specific variables to explain variance in use of services from public health nurses were marital status ( $p = .01$ ) and age ( $p = .02$ ), i.e. when all variables were entered, not having a partner and increasing age were factors associated with use of services from a public health nurse.

The *HeSSOP I* predictor variables above were used to explain *HeSSOP II* use of home help services. These variables were significant in the ERHA ( $p < .01$ ) but not for participants in the WHB ( $p = .53$ ). In the ERHA, education was significant ( $p < .01$ ) and owning a medical card was approaching significance level ( $p = .057$ ), i.e. not having a post-primary level of education was associated with use of home help services in *HeSSOP II*. There was also a trend for ownership of a medical card at *HeSSOP I* to be associated with use of home help services in *HeSSOP II*.

The above *HeSSOP I* predictor variables were also used to explain *HeSSOP II* use of meals-on-wheels. These variables were significant in the ERHA ( $p < .01$ ) but not the WHB ( $p = .22$ ). In the ERHA, there was a trend for ownership of a medical card in *HeSSOP I* to be associated with use of meals-on-wheels in *HeSSOP II* ( $p = .09$ ).

#### 7.4.7.4 Summary

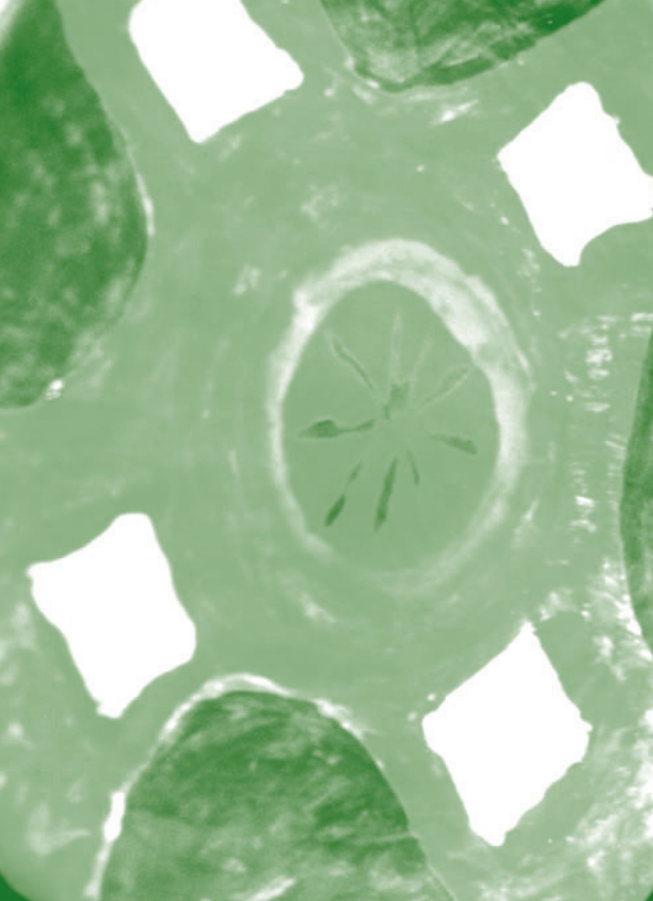
Longitudinal participants did not generally differ from others in *HeSSOP I* in their use of health and social services. Over time there was an increase in the use of social services, particularly for participants in the ERHA.

### 7.5 Chapter summary

- *HeSSOP* provides the opportunity to consider quality of life and quality of healthcare issues for the broad population of older Irish people.
- The repeat and longitudinal studies of 2000 and 2004 provide indicators of positive ageing such as low levels of functional impairment, high morale, reduction in smoking and increases over time in preventive health strategies like flu injections.
- *HeSSOP I* participants who took part in the longitudinal study were younger but otherwise comparable to others in *HeSSOP I* who were not interviewed four years later.
- Most participants continued to retain independence and good functional health over the four-year period but there was an increase in difficulties in some activities of daily living. Even when controlling for age and functional health in *HeSSOP I*, depression, anxiety, boredom and perceptions of ageism predicted variance in functional health.
- Over the four-year period, ratings about general health tended to decrease, but not dramatically.
- The majority of participants remained non-depressed over the four years but mean ratings of depression were higher in *HeSSOP II*.
- There were increases in use of A&E, in-patient services and out-patient hospital services over time.
- Ratings of satisfaction remained very high over the four years and few barriers to care were identified in both studies.
- Over time there was an increase in the use of social services, particularly for participants in the ERHA.

- About one in ten older people could be classified as vulnerable on a range of physical, mental and social health indices.
- The studies provide valuable lessons for planned longitudinal study initiatives in the future.
- Evaluation of quality of life and quality of healthcare indices for older people is important as much because of the similarities, as of the differences, between older people and other groupings in society.





# 8

## Chapter 8

### Discussion and conclusions

# Chapter 8

## Discussion and conclusions

### 8.1 Conclusions

This project capitalises on a previous project, funded by the NCAOP with health board support, undertaken in 2000. The project aimed to revisit the group of almost 1,000 older people to establish their current status. It also aimed to select a new cohort of older people in 2004. There is an overlap of about one third of the 2000 and 2004 cohorts in the comparison across the four years. This was necessary due to funding constraints. Identifying older people in community settings is very costly since there are no *a priori* methods of randomly sampling individual households by age. However, statistical comparisons compensated for the repeat participants in across year comparisons. The project also, again because of funding constraints, focused on two health board areas – those that represent the most urban area of Ireland (ERHA) and one of the most rural areas (WHB). The two are contrasted as exemplars of differing services in predominantly urban/eastern and rural/western settings. The value of this approach is to identify where there is uniformity of attitudes, experiences and service use across parts of Ireland and where there are differences. Analyses comparing the two boards were controlled for basic demographic variables which differed between the groups (age, marital status and income). This allows for an identification of differences in attitudes, experiences or service uptake by board which are attributable to aspects of location (i.e. board) rather than background characteristics of the specific population. Thus for instance, differences in service uptake where identified are not attributable to basic sample differences across boards.

The project response rate was lower than desired. Findings are thus tempered by a caution that those not included are more likely to be those in more difficult health or social circumstances. However, while there are caveats because of project constraints, the dataset provides a unique opportunity to examine many aspects of ageing in contemporary Ireland. Although the structure of the health service management regions changed in January 2005, with the abolition of the health board structure and



the implementation of a new HSE plan, the lessons here of differences across geographic regions which can be attributed to either the characteristics of the individual or the geographic region (in terms of health service delivery) remain the most relevant and up-to-date available to health service planners in 2005 and beyond.

The project aimed to consider change and continuity over a four-year period in Ireland. Perhaps unsurprisingly, there was little difference in the background (demographic and related) characteristics of the samples over time. There was also little difference in psychological and social variables – morale, levels of depression, loneliness and social support remained largely similar across the four years. Of concern is the fact that one in ten older adults living at home reported finding it very difficult or impossible to visit others or attend social events outside their homes. This was mainly due to limitations in physical capacity and rates were similar across the boards. It is unclear if and how environmental constraints including lack of access to suitable transport contributes to the social isolation and invisibility of these people. However, considering use of public transport as a marker of independence for older people, use was three times lower in the WHB than the ERHA in 2004 (20 per cent vs. 65 per cent). Even more notably, the east/west gap had disimproved since 2000, when rates were 32 per cent (WHB) and 65 per cent (ERHA). Since one in two older people did not drive cars, being able to access transport without dependence on others may be an important part of a person's sense of independence and control with significant implications for their social participation.

In terms of markers of a more health-promoting 'world', there were some positive signs. In terms of individual health behaviour, there was a clear shift in smoking status over the four-year period with fewer participants smoking and a relative increase in those seriously intending to give up. It is to be expected that the smoking ban, enacted in April 2004 (two months before the start of the 2004 survey), would have helped in this shift although interim evidence from the second SLÁN survey (Friel *et al.*, 2002) indicates that the rates decreased steadily from 1998 to 2002. In terms of other behaviour which could be either individual or health service initiated, take-up of the flu injection increased substantially over the time of the study with about 70 per cent in each board receiving the flu injection in 2003. These two activities highlighted differences across boards alongside notable successes in improving these health indicators. The ERHA area appeared to be a stronger anti-smoking environment in 2004 whereas the WHB started with a better flu injection take-up in 2000 with the ERHA improving more to achieve similar and higher targets in 2004. This figure compares well with Northern Ireland where rates were 65 per cent for 2000 (O'Reilly *et al.*, 2002). However, the proportion of older people availing of this simple preventive service is still far from ideal.

The project studied many aspects of health service use, including both primary and secondary care. A significant proportion of the older population had come into contact with hospital services during the previous year. At least one in ten attended an A&E department (13 per cent ERHA v.10 per cent WHB). This appears high and raises questions about the adequacy of primary care and elective secondary care services. Percentages on waiting lists, while appearing low in absolute terms, represent a large number of people. Percentages on waiting lists for in-patient procedures had not reduced significantly from 2000 to 2004. Moreover, the overall number of people waiting for services (including in-patient, out-patient, day hospital and day centre care) had increased significantly – from 3 per cent (ERHA) and 7 per cent (WHB) in 2000, to 11 per cent (ERHA) and 13 per cent (WHB) in 2004. Numbers on waiting lists for long periods were also significant. Making general calculations from the percentages on in-patient waiting lists in the two health board areas for longer than nine months, some 10,000 older people nationally were on such lists for over nine months in 2004<sup>8</sup>. While the treatments needed were not specified in the survey, and a more sophisticated analysis of the operation of waiting list criteria and access are needed to make definitive statements, such numbers represent a significant challenge for the National Treatment Purchase Fund (NTPF), and service providers generally, in terms of addressing service needs of older people.

Community-based services, with the exception of GP services, were used by a minority. This was paralleled by low levels of use of appliances such as mobility aids. One of the challenges in considering these findings is the fact that older people have been found to be relatively undemanding in terms of services. It may be difficult for older people themselves to gauge service need, particularly for services with which they are unfamiliar such as physiotherapy or occupational therapy. Walker (1999) argues that the dominant biomedical view of ageing, as a sequence of decline and infirmity, has left older people disempowered and relatively passive in terms of their approach to healthcare needs and services. Thus many older people themselves may consider health problems to be inevitable and immutable. A structured assessment of the healthcare needs of older Irish people is urgently needed if service needs are to be quantified and the ability of services to match these needs ensured. There is currently no 'gold standard' against which to gauge service coverage and to plan to meet shortfalls. In this context, it is inevitable that the specialist services needed, e.g physiotherapy and chiropody, will be in short supply as there are gaps in staff numbers across the whole spectrum of the health services. For instance, an additional 1,300 physiotherapists were identified as

<sup>8</sup> A rate of 2.35 per cent of older people waiting 33+ weeks for in-patient procedures was estimated (Table 5.15). Given a population of 436,001 people aged 65 years and over in the last census, 10,246 older people waiting 33+ weeks for inpatient services would be estimated based on scaling up the WHB and ERHA figures.

needed for the health service overall in a 2001 staffing needs report (Bacon, 2001). While it is not possible to assess shortfall in Irish service provision to older people without a comprehensive assessment of service need, some comparisons are enlightening. For instance, home help service provision in Ireland is very low by international standards. While take-up of this service has increased from about 3.5 per cent nationally in the early 1990s, to 6 per cent of WHB participants and 9 per cent of ERHA participants in 2004, this is still less than half the rate of countries such as Sweden (19 per cent) and Northern Ireland (14 per cent). Take-up rates in Northern Ireland now stand at 19 per cent as assessed in *One Island – Two Systems* (McGee *et al.*, 2005).

Health board comparisons suggest significant inequities exist. Where there were health board differences, participants in the ERHA were almost always more likely to have received a service and/or to have received it more frequently. For instance, in 2004, hospital out-patient care was almost twice as high in the ERHA as in the WHB (25 per cent v. 14 per cent, from 36 per cent ERHA and 13 per cent WHB in 2000). In terms of community and primary care service use, of the 15 services listed, eight were provided to a greater proportion of ERHA than WHB participants with none provided more frequently in the WHB area. In terms of changes over the four-year period, provision of three services increased from 2000 to 2004 in the ERHA (i.e. physiotherapy, optician and dental services) but none increased in the WHB. Board differences found are of great concern since the statistical analyses specifically controlled for factors such as demographic differences across boards which might have accounted for differences. The number of service providers per head of population is one likely explanation of differences. However, it was beyond the scope of this study to compare numbers of service providers in professional groups across health boards. The study did evaluate private health insurance take-up and the number of services that were paid for by participants. Those in the ERHA area were much more likely to have private health insurance with little change in cover availed of by board over the four years (52 per cent in the ERHA and 30 per cent in the WHB in *HESSOP II*). Up to half of the participants from both board areas who used the most commonly availed of primary care services (home help, meals on wheels, chiropody, physiotherapy, optical, dental and hearing services) reported paying directly for some or all of them. Since the ERHA participants were much more likely to receive services, this means that a much larger percentage of ERHA participants paid for services. For instance, 23 of the 46 people availing of home help services in the ERHA area paid, while 6 of the 34 using these services in the WHB paid. The most commonly used primary care services (optician services and chiropody) were paid for by 84 of 164 (ERHA) and 33 of 84 (WHB) in the case of optician services, and by 56 of 123 (ERHA) and 26 of 45 (WHB) in the case of chiropody services. Thus a significant proportion of the excess in service

use per equivalent older person in the ERHA (in comparison to the WHB) was a consequence of use of personally-funded services. What was also clear in both board areas was a trend of increasing numbers of people paying for community-based health and social care services for the four-year period from 2000 to 2004. Furthermore, many of the services identified as being paid for would not be reimbursed by private health insurance. Thus the figures reported here signal significant personal investment in health services by older people, i.e. direct payment for community services and indirect (insurance) payment in anticipation of hospital service need. If direct payments in particular are driven by unmet need, then implications for those unable to afford such services or unable to access them (because of geographic location, transport or knowledge about service availability) would be significant. The professional regulation and qualifications of those providing private services also need to be assured so that older people are receiving care from appropriately qualified staff.

Overall, the emerging pattern of personal payment for health services to which older people are entitled requires further examination. In parallel, older people's perspectives on potential healthcare needs and associated costs/service availability need consideration. It is likely, in the current climate of discussion of charges for nursing home care etc., that many older people have significant concerns about their care should they need long-term and/or intensive service provision. Fear of loss of independence and of social or healthcare needs which cannot be met could be a significant burden. The experiences and views of older Irish people on these matters should be investigated.

Analysis of GP service usage indicated differences, with the WHB having a higher attendance rate. The very high level of satisfaction with GP services was also notable. Introduction of free access to GP care for those aged over 70 years in the period between study points was associated with increased levels of service use. The value of this increased use is unknown. It is clear, however, that GP charges had acted to some, albeit small, extent as a deterrent to service use in the earlier survey. It is interesting to speculate on the increased personal spending on some community services over the two studies. This was most notable for optical, dental, chiropody, physiotherapy and home help services with 4-16 per cent paying personally for services. In 2004, more than one in ten participants in the ERHA paid for chiropody, optical or dental services. These services were also the ones most likely to be paid for by WHB participants, albeit at a lower take-up level than the ERHA.

The finding that older people wish to remain in their own homes even when in need of long-term care remains to the fore in 2004. Highly publicised events concerning very poor standards in a particular nursing home since the completion of the

interviews are likely to have made many older people wary or fearful of the option of nursing home care<sup>9</sup>. Despite the enormous costs to individuals, their families and the State of nursing home care as an option, there appears to be inadequate effort to build up services that could minimise the need for such care, including home helps, meals on wheels, physiotherapy and occupational therapy. In fact, current embargos on recruitment of additional public service staff actively prevent such service development. A recent Government announcement focusing on building the State's health and social services capacity, to match the unparalleled growth in its economic capacity, is welcome in this regard if it can deliver improved services in a manner that supports the independence of older people at whatever level appropriate to their healthcare needs. The impact of recent initiatives such as the Home Care Grant Scheme need to be monitored in future studies.

A major concern, however, is that the current focus on the costs of delivering nursing home care, and on legislative changes to make older people pay for an increasing portion of these costs through deductions from their weekly pension, will divert attention away from other models of supporting people in need of care in their old age. This point has been made repeatedly since the publication of *The Years Ahead: A Policy for the Elderly* (DoH, 1988), which became official Government policy in 1993 with progress on its implementation being reviewed by the NCAOP four years later (Ruddle *et al.*, 1997). At this point a re-energising of the State's commitment to older people is needed. While strategy is the start rather than the conclusion of improved service delivery, recent examples of successful strategies such as the National Cardiovascular Strategy (DoHC, 1999) highlight the value of a clear contemporary review of services, an accompanying timed plan of action and a series of progress reports. It is against this reference point that the relevant annual business plan of the DoHC (currently on services for older people and palliative care) can be most usefully determined. Ireland now has national cardiovascular and cancer strategies. In the UK, similar disease-specific national service plans were followed by the *National Service Framework for Older People* (DoH UK, 2001). In 2003, a national progress report was published. These activities ensure that services focus continually on service development and delivery, as well as highlighting progress and areas for further attention. In essence they provide medium-term guidance in terms of service delivery. An up-to-date national strategy for older people is needed; to be developed using the framework of the current National Health Strategy (DoHC, 2001) and incorporating important aspects of other relevant publications including *Adding Years to Life and Life to Years: A Health*

<sup>9</sup> A television programme in summer 2005 highlighted serious deficits in care in one centre, Leas Cross in Dublin. Public outrage and Government actions to address this particular problem and to ensure standards in other centres raised the profile of nursing home care in an unprecedented manner in the public awareness.

*Promotion Strategy for Older People* (Brenner and Shelley, 1998), *An Action Plan for Dementia* (O'Shea and O'Reilly, 1999) and the Ombudsman's report on nursing home subventions (Office of the Ombudsman, 2001). Such a strategy would give philosophical direction to what is acknowledged to be a high level of activity and investment in the area. It should also be a much more integrated one than previously, incorporating the work of the Interdepartmental Group on Older People (IDGOP) established in 2002, with a focus on integration of activities across sectors and agencies including housing, home improvements, security and equality, and health and social service provision.

While there were many positive signs regarding contemporary ageing in both *HeSSOP* studies, there must be a particular focus on those who have difficulties. As a very general rule, at least one in ten of the older people interviewed reported major difficulties in areas such as functional capacity, depression, loneliness and lack of social supports. Evidence suggested no significant shift in these figures over the four-year period studied. These figures can be considered in terms of the experience of other countries. Taking loneliness as an example, a recent UK study is useful as a comparison. This study examined loneliness in a nationally representative cohort of 999 older people (Victor *et al.*, 2005). Of the respondents, 37 per cent lived alone (in comparison with 28 per cent of *HeSSOP II* participants) and 7 per cent reported being always or often lonely (3 per cent of *HeSSOP II* participants).<sup>10</sup> Proportions reporting they were sometimes lonely were 31 per cent in the Victor *et al.* study, while this study found that 34 per cent of participants reported being lonely 'quite often' and 41 per cent reported being lonely 'not very often'. For those participants living alone, loneliness was an issue for 17 per cent in the Victor *et al.* study and 7 per cent in *HeSSOP II*. The overall profile of loneliness thus appears broadly similar across the two countries. This information mitigates against concerns that older age in Ireland is a very lonely experience but also provides little evidence for a complacent view of Ireland as a particularly sociable country where loneliness is not a feature in the lives of older people. In the UK context, Victor *et al.* argue for a more sophisticated analysis of patterns of loneliness if the information is to be useful to policy-makers and those working with older people, e.g. those who are temperamentally lonely as opposed to those who become lonely through life events. A similar analysis would be valuable in Ireland to determine the role of services as diverse as meals on wheels, day care centres and postal deliveries in alleviating loneliness. The analysis by Victor *et al.* reveals varying contexts of the experience of loneliness and the need for sophisticated solutions, informed by and acceptable to older people.

<sup>10</sup> Wording in the two surveys was somewhat different but similar enough to allow broad comparisons.

When services consider ageing in relation to health and social care, there may be some merit in fostering a specific focus on a clearly identified marginal group (the composition of this group may shift depending on the health or social outcome under consideration but factors such as gender, older age, rural residence, single person households and low income may provide a constellation of those likely to be at more risk). In this study for instance, older age proved to be the clearest differentiator of use of primary care services. This analysis does not of course describe the most vulnerable group – rather the group availing of most services. Assessment of vulnerability will be very important in determining if services are targeted at those with most need. A concerted effort to improve the status of those who are most vulnerable, while acknowledging and promoting the good health and quality of life enjoyed by most older people, can be a strategically valuable means of moving the agenda of quality of life and quality in healthcare for older people. While beyond the scope of this report on health board comparisons, the HARP programme involves the piloting of a brief vulnerability measurement tool with potential for use by professionals such as GPs and public healthcare nurses, when assessing risk in older people. This will help to further clarify lessons to learn from health status and service use patterns in a parallel system (McGee *et al.*, 2005).

Alongside a focus on vulnerability, a greater understanding of how older people view ageing and how they experience their own ageing is also required. In this regard, HARP is testing a new method of assessing perceptions of ageing in the c. 2,053 older people surveyed in 2004. The method – a self-report instrument developed through focus group work with older people and using theoretical models of illness representations as a template – is called the Ageing Perceptions Questionnaire. This will allow the ageing perceptions of those of any age, and of those with or without health, social or other constraints, to be documented in a systematic manner. It will also allow for tracking of changes across time or location. This two-pronged approach, i.e. paying particular attention to identifying and assisting the most vulnerable older Irish people while also developing a greater understanding of the meaning of ageing to older people and all others in society, represents the twin challenges of advocating on behalf of all older people. As was the case in *HeSSOP I* this study demonstrated that older people provide significant support as primary carers for other people, mainly other older people. The message that older people contribute to society in this way, in addition to their activities in the voluntary sector and in terms of child-minding and grandparenting, is an important one to keep in focus. It challenges the negative perspective typified by economically-oriented articles such as 'The demographic deficit: how ageing will reduce global wealth' (Farrell, Ghai and Shavers, 2005) which focus on the problem for society of an increasing 'burden' of economically inactive older people.

The longitudinal aspect of this study provides some important lessons for the planning of future studies of older people in Ireland. *HeSSOP I* was not set up as a longitudinal study. Thus participants in the study did not expect to be contacted four years later. All of those contactable by telephone were called in order to advise them of the follow-up and give them the opportunity to participate. Nonetheless, follow-up rates were lower than desired. Others were informed about the follow-up and invited to participate in writing. In further studies where a longitudinal component is planned or is a possibility, a number of factors would increase tracing and participation rates. In terms of tracing or accounting for all participants, permission to check with the person's GP could facilitate establishing whether an older person had moved residence, moved into a care setting or was deceased. When the longitudinal aspect of *HeSSOP II* was planned, it was envisaged that tracing older people in rural areas would be easier because of lower levels of residential mobility and a network of neighbours who would be able to confirm changes of accommodation or status. This was not the case. Despite extensive efforts, retracing older people in more rural areas in the WHB proved much more difficult than in urban areas in the WHB or in the ERHA.

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Safety and security issues may be an important consideration in planning future studies with some means of pre-notifying older people of researcher visits to their homes being incorporated. This is likely to be a particular issue in rural areas with increasing focus on crime and wariness of strangers representing themselves in an official or professional capacity. Participation is also likely to increase if a sense of a unique and important activity is promoted. This can be achieved through means such as an easily recognisable title, feedback to participants between assessment points and media visibility; all of which highlight the importance of the findings and the value to public understanding and public policy of the contribution of the study participants. Many individuals take part in research for altruistic purposes and to support improvements in knowledge and service delivery (Cousins *et al.*, 2005). A sense that this is valued may be particularly important in longitudinal studies. Information from proxy respondents (family members in particular) may also be more forthcoming where necessary if the study has had greater visibility for, and perceived commitment to, the older person concerned.

Quality of life and quality of healthcare are equally important criteria in assessing how life is and should be for older people. In this regard, it is necessary to focus on best health and quality of life for the whole population while ensuring a specific and appropriate focus on those who are most vulnerable and in need of care. In this way, the challenges of providing for older people in society are no different to those



for other groups. When focusing on older people, we can embrace the findings as equally relevant for other potentially vulnerable groups such as children and those with disabilities. This project provides a heretofore unavailable profile of the health and social status and related service use of a large group of older people in Ireland. The longitudinal aspect provided a first profile of older Irish people over time while the repeat study allowed for an examination of continuity and change over a four-year period where there were notable developments in service delivery such as increasing availability of GP service funding for older people. A comparison with the UK illustrates how far behind we are in terms of the study of the health and social status of older people. Over 50 longitudinal studies examining many facets of life for older people are underway in the UK (Medical Research Council, 1994). We need to address this situation if the evidence required to plan for and deliver high quality services to those older people who need them is to be available. In a related development, the Government has supported debate and consultation for a number of years on a national longitudinal children's study. This project is now designed and about to commence. As a society, we urgently need to begin the same dialogue regarding substantial longitudinal research to inform policy and practice on ageing in the coming decades in Ireland.

In summary, annual business plans provide immediate feedback on levels of service provision for older people. They should provide this feedback in the medium-term context of a national strategy for older people. In turn, these activities should be set against the back-drop of a national longitudinal study of older people such that the longer-term trends in numbers, health status, and health and social care needs of older people can be anticipated. Ironically, for many involved in policy development and immediate service delivery at present, taking steps to establish the longer-term perspective would provide for the type of information needed to best plan services they will experience in their own old age. Thus vision in planning for health and social services for older people in Ireland is something that the older people of today, i.e. the builders of our present economy, deserve. It is at the same time the legacy that the rest of Irish society will inherit, for better or worse, in the coming decades. It is in everyone's best interest that we provide the ageing services we ourselves aspire to receiving.

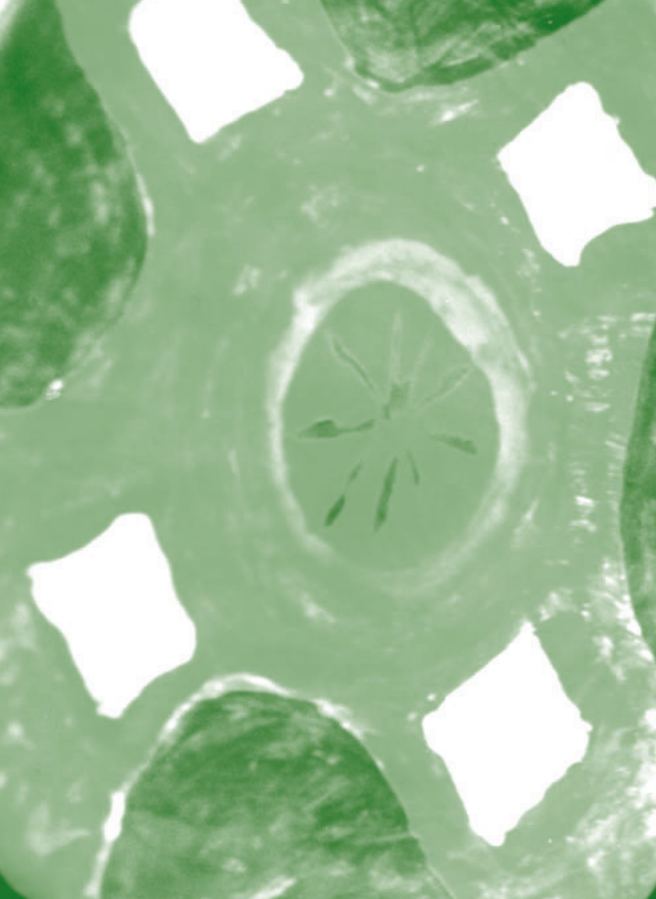
## 8.2 Summary findings

- The *HeSSOP* studies aimed to provide insights into the experience of ageing and use of health and social services as applied to community-based adults rather than those assessed in hospital or other care settings.
- In examining the health and well-being of participants, *HeSSOP II* findings challenge many prevalent negative stereotypes; the longitudinal aspect of the study found that there were few negative changes in health and psychosocial measures. Many adults continued to function at high levels without significant disabilities.
- About one in ten participants had major difficulties in physical and/or psychosocial health (e.g. physical impairment, depression, loneliness or lower levels of support). While promoting the message that the majority of older people are in good health, it is also important to provide the resources and care necessary to improve the status of the substantial minority who are most vulnerable.
- *HeSSOP II* offers insights about primary and secondary health service use. A substantial number of participants came into contact with hospital services during the previous year with at least one in ten attending an A&E department. Percentages on waiting lists for in-patient procedures had not reduced significantly from 2000 to 2004. Moreover, the overall number of people waiting for hospital and related services had increased significantly from 2000 to 2004. Thus there appears to have been little progress in increasing capacity to meet need in the past four years.
- Significant board differences were found even when controlling for demographic differences. For instance, hospital out-patient care was almost twice as high in the ERHA as in the WHB. Of 15 primary care services assessed, eight were provided to a greater proportion of ERHA than WHB participants with no service provided more frequently in the WHB. This suggests substantial inequity, with those in the ERHA more likely than in the WHB to have received a range of both primary and secondary (hospital) care services.
- Provision of many health and social services remained low in 2004, despite the capacity of these services to facilitate independent living at home which is the care preference of the majority of older adults. For instance, home help service provision was about half that of comparable European countries. There was also an increasing

pattern of direct payment by older people for community-based services. This was particularly notable in the ERHA. Coverage by private health insurance was also considerable (52 per cent in the ERHA and 30 per cent in the WHB).

- There is currently no 'gold standard' against which to gauge service coverage and to plan to meet service shortfalls for older people. If service planning for older Irish people is to be meaningful, some assessment of the level of health and social service need is urgently needed.
- *HeSSOP I* was not originally designed as a longitudinal study. Nonetheless, 93 per cent (n = 873) of the original sample was traced four years later and 71 per cent of those eligible participated in the second interview. While many useful points can be made from *HeSSOP* and similar occasional surveys, they cannot substitute regular updates on the status of older people in terms of health and social status, and related service provision. A longitudinal study, in combination with newly developing national information systems, is needed both to provide an analysis of the impact of service provision on the lives of older people and to anticipate future trends and their implications for service need in the community.





## References



# References

Bacon, P., 2001. *Current and Future Supply and Demand Conditions in the Labour Market for Certain Professional Therapists*. Dublin: Stationery Office.

Benyamini, Y., Leventhal, E.A. and Leventhal, H., 2003. 'Elderly people's ratings of the importance of health-related factors to their self-assessments of health.' *Social Science and Medicine*, 56 (8): 1661-1667.

Bernstein, D., Clark-Stewart, A., Roy, E., Srull, T., Wickens, C., 1994. *Psychology*. Boston: Houghton Mifflin.

Beyene, Y., Becker, G. and Mayen, N., 2002. 'Perceptions of aging and sense of well-being among Latino elderly.' *Journal of Cross-Cultural Gerontology*, 17: 155-172.

Blumenthal, H.T., 2003. 'The aging-disease dichotomy: true or false?' *Journals of Gerontology, Series A, Biological Sciences and Medical Sciences*, 58: M138-145

Birks Y., Roebuck A. and Thompson D.R., 2004. 'A validation study of the Cardiac Depression Scale (CDS) in a UK population.' *British Journal of Health Psychology*, 9: 15-24.

Bjelland, I., Dahl, A.A, Haug, T.T. and Neckelmann, D., 2002. 'The validity of the Hospital Anxiety and Depression Scale: an updated review.' *Journal of Psychiatric Research*, 52: 69-77.

Blazer, D.G., 2003. 'Depression in late life: review and commentary.' *The Journals of Gerontology, Series A, Biological Sciences and Medical Sciences*, 58: 249-265.

Brenner, H. and Shelley, E., 1998. *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People*. Dublin: NCAOP.

Bruce, B. and Fries, J.F., 2003. 'The Stanford Health Assessment Questionnaire (HAQ): a review of its history, issues, progress, and documentation.' *The Journal of Rheumatology*, 30: 167-78.

Charles, S.T., Reynolds, C.A. and Gatz, M., 2001. 'Age-related differences and change in positive and negative affect over twenty-three years.' *Journal of Personality and Social Psychology*, 80: 136-151.

Charlson, M.E., Pompei, P., Ales, K.L. and McKenzie, C.R., 1987. 'A new method of classifying prognostic comorbidity in longitudinal studies: development and validation.' *Journal of Chronic Diseases*, 40(5): 373-383.

Cleary, P.D. and Edgman-Levitan, S., 1997. 'Health care quality: incorporating consumer perspectives.' *Journal of the American Medical Association*, 278: 608-1621.

Coleman, P.G., Ivani-chalian, C. and Robinson, M., 1993. 'Self-esteem and its sources: stability and change in later life.' *Ageing and Society*, 13: 171-192.

Cousins, G., McGee, H., Ring, L., Conroy, R., Kay, E., Croke, D. and Tomkin, D., 2005. *Public Perception of Biomedical Research: A Survey of the General Population in Ireland*. Dublin: Health Research Board.

Dalsky, G.P., Stocke, K.S., Ehsani, A.A., Slatopolsky, E., Lee, W.C. and Birge, S.J., Jr., 1988. 'Weight-bearing exercise training and lumbar BMC in postmenopausal women.' *Annals of Internal Medicine*, 108: 824-828.

Davison, S. and Philp, I., 2003. 'Time to deliver with dignity.' *British Medical Journal*, 326: 1300.

Department of Health UK, 2001. *National Service Framework for Older People*. London: HM Stationery Office.

Department of Health and Children, 2001. *Quality and Fairness: A Health System for You*. Dublin: Stationery Office.

Department of Health and Children, 1999. *Building Healthier Hearts: The Report of the Cardiovascular Health Strategy Group*. Dublin: Stationery Office.

Donabedian, A., 1988. 'The quality of care, how can it be assessed.' *Journal of the American Medical Association*, 260: 1743-1748.

European Commission, 2000. *Survey on the Current Status of Research into 'Ageing' in Europe*. Brussels: Ad Hoc Advisory Committee on Coordination of RTD Policies.

Fahey, T. and Murray, P., 1994. *Health and Autonomy Among the Over-65s in Ireland*. Dublin: NCAOP.

Farrell, D., Ghai, S., Shavers, Y.T., 2005. 'The demographic deficit: how ageing will reduce global wealth.' *McKinsey Quarterly*, 2: 61-66. <http://www.mckinseyquarterly.com/>

Friel, S., NicGabhainn, S. and Kelleher, C., 2002. *The National Health and Lifestyle Surveys: Survey of Lifestyle. Attitudes and Nutrition (SLÁN)*. Dublin: Stationery Office.

Fries, J.F., Spitz, P. and Young, D.Y., 1982. 'The dimension of health outcomes: the Health Assessment Questionnaire, disability and pain scales.' *The Journal of Rheumatology*, 9: 789-93.

Garavan, R., Winder, R. and McGee, H., 2001. *Health and Social Services for Older People (HeSSOP)*. Dublin: NCAOP.

Hawkey, L.C., Burleson, M.H., Berntson, G.G., Cacioppo, J.T., 2003. 'Loneliness in everyday life: cardiovascular activity, psychosocial context, and health behaviors.' *Journal of Personality and Social Psychology*, 85: 105-120.

Heikkinen, R-L. and Kauppinen, M., 2004. 'Depressive symptoms in late life: a ten-year follow-up.' *Archives of Gerontology and Geriatrics*, 38: 239-250.

Hunt, D.A., Ramji, S. and Walker, P.B., 2005. 'Taking the risk out of retirement.' *McKinsey Quarterly*, 2: 72-81.

Institute of Medicine, 2001. *Crossing the Quality Chasm*. Washington, D.C: National Academy Press.

Kane, R.L., Maciejewski, M. and Finch, M., 1997. 'The relationship of patient satisfaction with care and clinical outcomes.' *Medical Care*, 35 (7): 714-730.

Kelleher, C., Friel, S., Nic Gabhainn, S. and Tay, J., 2003. 'Socio-demographic characteristics of self-rated health in the Republic of Ireland: findings from the National Survey of Lifestyle, Attitudes and Nutrition.' *Social Science and Medicine*, 57 (3): 477-486.

Kirkwood, T., 1999. *Time of Our Lives: The Science of Human Ageing*. London: Weidenfeld and Nicolson.

Kizer K.W., 2001. 'Establishing healthcare performance standards in an era of consumerism.' *Journal of the American Medical Association*, 286: 1213-1217.



Layte, R., Fahey, T. and Whelan, C., 1999. *Income, Deprivation and Well-Being Among Older Irish People*. Dublin: NCAOP.

Livingston, G., Manela, M. and Katona, C., 1996. 'Depression and other psychiatric morbidity in carers of elderly people living at home.' *British Medical Journal*, 312: 153-156.

Lund, R., Due, P., Modvig, J., Holstein, B., Damsgaard, M.T. and Andersen, P.K., 2002. 'Cohabitation and marital status as predictors of mortality: an eight year follow-up study.' *Social Science and Medicine*, 55: 673-9.

Madden, D., Nolan, A. and Nolan, B., 2004. *GP Reimbursement and Visiting Behaviour in Ireland*. Dublin: ESRI.

Manson, J.E., Rimm, E.B., Stampfer, M.J., Colditz, G.A., Willett, W.C., Krolewski, A.S., Rosner, B., Hennekens, C.H. and Speizer, F.E., 1991. 'A prospective study of physical activity and incidence of non-insulin-dependent diabetes mellitus in women.' *Lancet*, 338: 774-778.

McGee, H.M., O'Hanlon, A., Barker, M., Stout, R., O'Neill, D., Conroy, R., Hickey, A., Shelley, E. and Layte, R., 2005. *One Island – Two Systems. A Comparison of Health Status and Health and Social Service Use in the Republic and Northern Ireland*. Dublin: Institute for Public Health in Ireland.

Medical Research Council, 1994. *The Health of the UK's Elderly People*. London: Medical Research Council.

Morgan, K., Dallosso, H., Bassey, E.J., Ebrahim, S., Fentem, P.H. and Arie, T.H.D., 1991. 'Customary physical activity, psychological well-being and successful ageing.' *Ageing and Society*, 11: 399-415.

Nguyen Thi, P.L, Briançon, S., Empereur, F. and Guillemin, F., 2002. 'Factors determining inpatient satisfaction with care.' *Social Science and Medicine*, 54: 493-504.

Nolan, B., Gannon, B., Layte, R., Watson, D., Whelan, C.T. and Williams, J., 2002. *Monitoring Poverty Trends in Ireland: Results from the 2000 Living in Ireland Survey*. Dublin: ESRI.

Nolan, A. and Nolan, B., 2005. 'Ireland's health care system: some issues and challenges.' IN: Callan T., Doris A. and McCoy, D., eds. *Budget Perspectives 2005*. Dublin: ESRI.

Office of the Ombudsman, 2001. *Report on Nursing Home Subventions: An Investigation by the Ombudsman of Complaints Regarding Payment of Nursing Home Subventions By Health Boards*. Dublin: Office of the Ombudsman.

O'Neill, D. and Bacon, P. Associates., 2001. *Current and Future Supply and Demand Conditions in the Labour Market for Certain Professional Therapists*. Dublin: Department of Health and Children.

O'Reilly, D., Gormley, G., Gilliland, A., Cuene-Grandidier, H., Rafferty, C., Reilly, P., Steele, K., Stevenson, M. and Smyth B., 2002. 'Influenza vaccinations in Northern Ireland: are older patients missing out?' *Age & Ageing*, 31: 385-90.

O'Shea, E. and O'Reilly, S., 1999. *An Action Plan for Dementia*. Dublin: NCAOP.

Prochaska, J.O. and DiClemente, C.C., 1983. 'Stages and processes of self change of smoking: toward an integrative model of change.' *Journal of Consulting and Clinical Psychology*, 51: 390-395.

Romano, P.S., Roos, L.L. and Jollis, J., 1993. 'Adapting a clinical comorbidity index for use with ICD-9-CM administrative data: differing perspectives.' *Journal of Clinical Epidemiology*, 46:1075-1079.

Rowe, J.W. and Kahn, R.L., 1997. 'Successful aging.' *The Gerontologist*, 37: 433-440.

Ruddle, H., Donoghue, F., Mulvihill, R., 1997. *The Years Ahead Report: A Review of the Implementation of Its Recommendations*. Dublin: NCAOP.

Schoen, C., Blendon, R.J., desRoches, C.M. and Osborn, R., 2002. *Comparison of Health Care System Views and Experiences in Five Nations: Findings from the Commonwealth Fund 2001 International Health Policy Survey*. New York: The Commonwealth Fund.

Siegert, C.E.H., Vleming, L. and Van Den Broucke, J.P. *et al.*, 1984. 'Measurement of disability in Dutch rheumatoid arthritis patients.' *Clinical Rheumatology*, 3: 305-309.

Sprance, M., Kanouse, D.E. and Elliott, M. *et al.*, 2000. 'Do consumer reports on health plan quality affect health plan selection?' *Health Services Research*, 35: 933-947.

Thompson, P., Itzin, C. and Abendstern, M., 1990. *I Don't Feel Old: The Experience of Ageing*. Oxford: Oxford University Press.

Travers, A.F., 1996. 'Caring for older people: carers.' *British Medical Journal*, 313: 482-486.

Treharne, G., 1990. 'Attitudes towards the care of elderly people: are they getting better?' *Journal of Advanced Nursing*, 15: 777-781.

Victor, C.R., Scambler, S.J., Bond, J. and Bowling, A., 2004. 'Loneliness in later life.' IN: Walker A. and Hagan Hennessy, C., eds. *Growing Older: Quality of Life in Old Age*. Maidenhead: Open University Press.

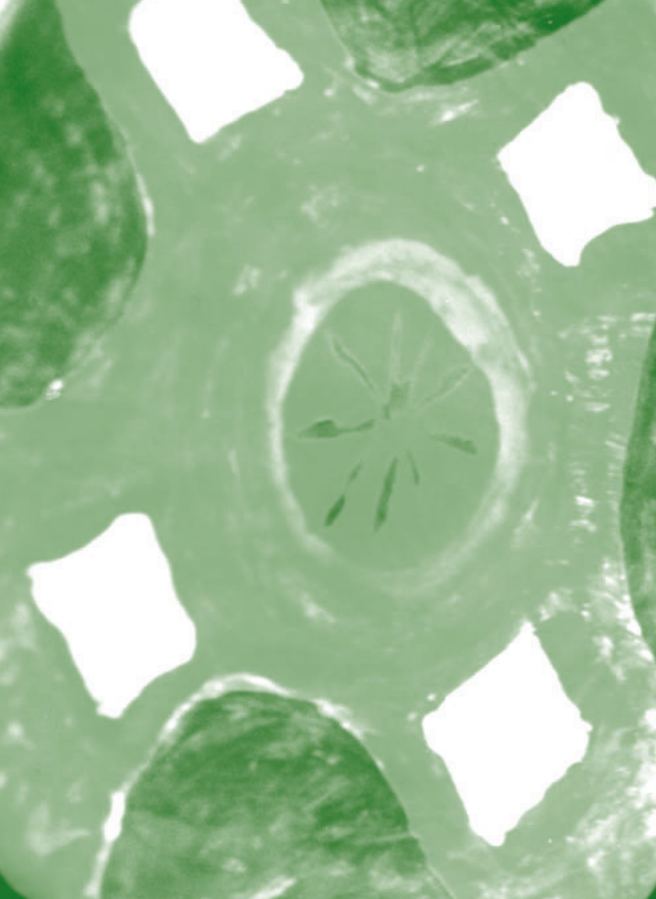
Victor, R., Scambler, S., Bowling, A. and Bond, J., 2005. 'The Prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain', *Ageing and Society*, 25: 1-19.

Walker, A., 1999. 'Older people and health services: the challenge of empowerment.' IN: Purdy, M. and Banks, D., eds. *Health and Exclusion: Policy and Practice in Health Provision*. London: Routledge.

Wannamethee, S.G., Shaper, A.G., Walker, M. and Ebrahim, S., 1998. 'Lifestyle and 15-year survival free of heart attack, stroke and diabetes in middle-aged British men.' *Archives of Internal Medicine*, 158 (22): 2433-2440 (B3).

Zigmond, A.S. and Snaith, R.P., 1983. 'The Hospital Anxiety and Depression Scale.' *Acta Psychiatrica Scandinavica*, 67: 361-70.



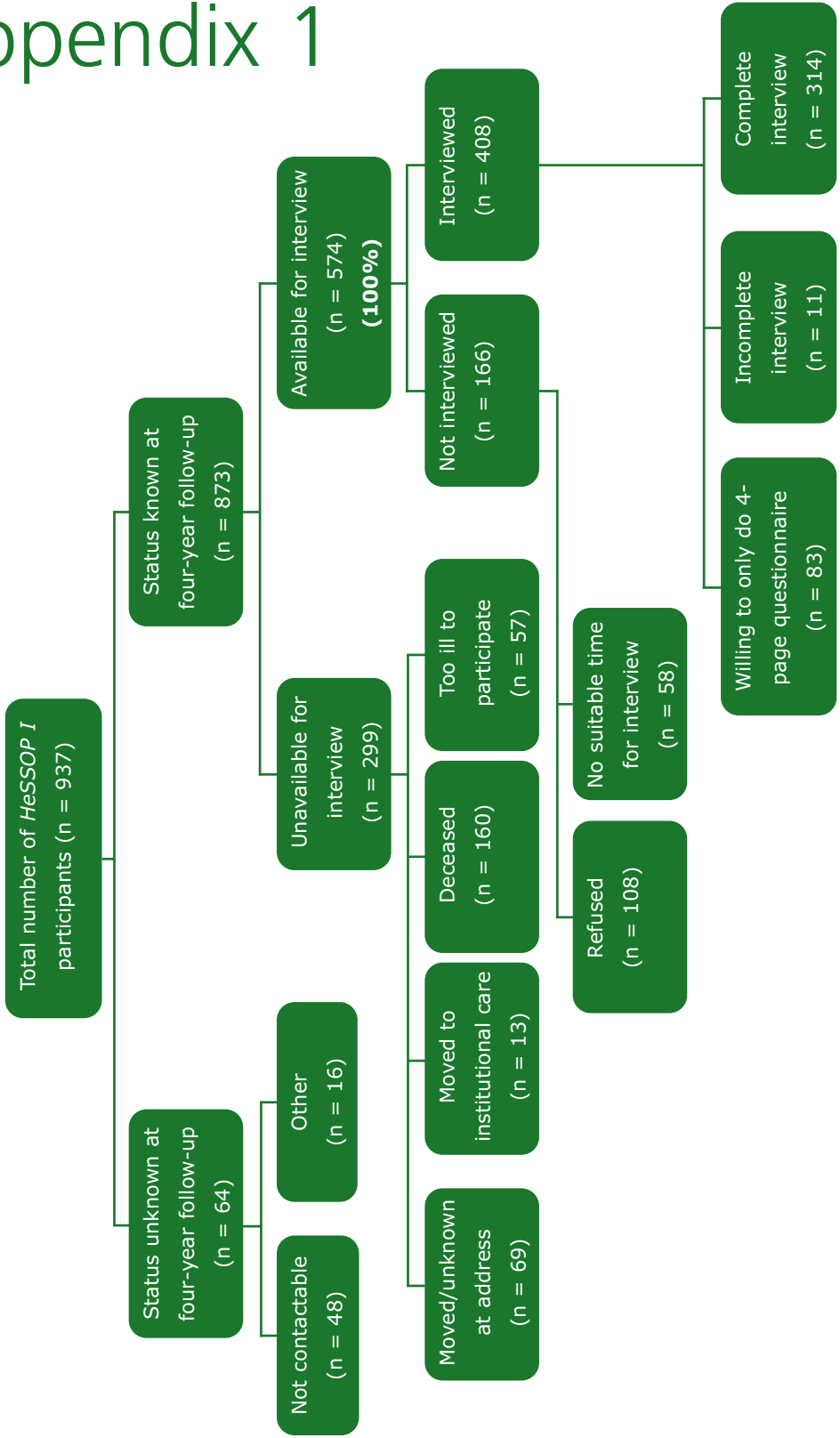


## Appendices



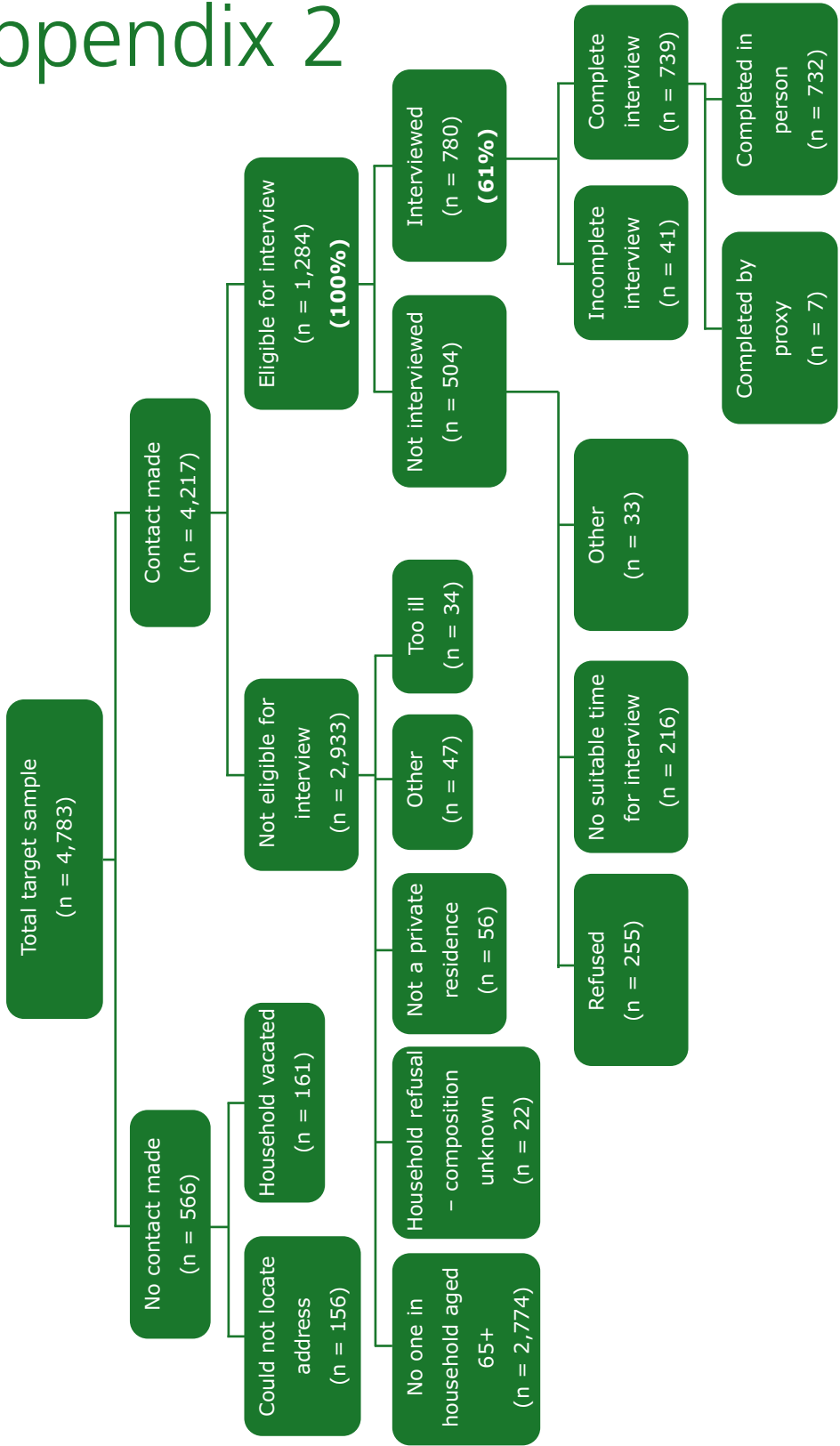
# Appendix 1

**Figure A1: Recruitment profile of HeSSOP II longitudinal sample (participants originally interviewed for HeSSOP I in 2000)**



# Appendix 2

Figure A2: Recruitment profile of HeSSOP II repeat sample ('new' participants in 2004)



# Appendix 3

## Tables: Additional Data

**Table A1: HeSSOP I longitudinal sample - Response rates.**

	ERHA		WHB		Total	
	%	(n)	%	(n)	%	(n)
<b>HeSSOP I participants</b>	<b>100</b>	<b>(401)</b>	<b>100</b>	<b>(536)</b>	<b>100</b>	<b>(937)</b>
<b>Unknown status</b>	<b>3</b>	<b>(11)</b>	<b>10</b>	<b>(53)</b>	<b>(7)</b>	<b>64</b>
Not contactable	1	(4)	8	(44)	5	(48)
Other	2	(7)	2	(9)	2	(16)
<b>Status known</b>	<b>97</b>	<b>(390)</b>	<b>90</b>	<b>(483)</b>	<b>93</b>	<b>(873)</b>
<i>Unavailable for interview</i>	28	(115)	34	(184)	32	(299)
Deceased	14	(56)	19	(104)	17	(160)
Moved to institutional care	1	(4)	2	(9)	1	(13)
Moved address	3	(13)	4	(21)	4	(34)
Unknown at address	4	(17)	3	(18)	4	(35)
Too ill to participate	6	(25)	6	(32)	6	(57)
<b>Available for interview</b>	<b>69</b>	<b>(275)</b>	<b>56</b>	<b>(299)</b>	<b>61</b>	<b>(574)</b>
<i>Non-respondents</i>	19	(75)	17	(91)	18	(166)
Refused	11	(45)	12	(63)	11	(108)
No suitable time for interview	8	(30)	5	(28)	6	(58)
<i>Respondents</i>	<b>50</b>	<b>(200)</b>	<b>39</b>	<b>(208)</b>	<b>43</b>	<b>(408)</b>
Willing to do 4-page questionnaire	7	(30)	10	(53)	9	(83)
Interviewed – incomplete	2	(6)	1	(5)	1	(11)
Interviewed – complete	41	(164)	28	(150)	33	(314)
<b>Vital status ascertained</b>	<b>97</b>		<b>90</b>		<b>93</b>	
	(390/401)		(483/536)		(873/937)	
<b>No longer in sample frame</b>	<b>49</b>		<b>61</b>		<b>56</b>	
	(11+114+75/401)		(53+184+91/53)		(64+299+166/937)	
<b>Response rate</b>	<b>72</b>		<b>70</b>		<b>71</b>	
	(200/275)		(208/299)		(408/574)	
<b>Complete follow-up rate</b>	<b>60</b>		<b>50</b>		<b>55</b>	
	(164/275)		(150/331)		(314/574)	



**Table A2: Outcome of recruitment attempts for repeat sample in 2004 by board**

<b>New sample recruitment</b>	<b>ERHA</b>	<b>WHB</b>	<b>Total (N)</b>
<b>TOTAL TARGET SAMPLE</b>	<b>2827</b>	<b>1956</b>	<b>4783</b>
<b>Non contacts</b>	<b>333</b>	<b>233</b>	<b>566</b>
Household vacated	58	103	161
Could not locate address/no contact despite repeated call-backs	275	130	405
<b>Total contact addresses</b>	<b>2494</b>	<b>1723</b>	<b>4217</b>
<b>Not eligible for participation</b>	<b>1791</b>	<b>1142</b>	<b>2933</b>
No one in household aged 65+	1688	1086	2774
Complete refusal: Household composition unknown	13	9	22
'Household' was institution (i.e. not private residence)	31	25	56
Other	40	7	47
Over 65 but too ill/cognitively impaired and no proxy available	19	15	34
<b>Eligible households</b>	<b>703</b>	<b>581</b>	<b>1284</b>
<i>Non-respondents</i>			504
Refused to participate/permanently unavailable	302	169	471
Other reason for non-participation	20	13	33
<i>Respondents</i>	381	399	780
Interviews incomplete: Insufficient data for inclusion in analysis	27	14	41
Total interviews completed and usable for analysis	354	385	739
Completed in person	353	379	732
Completed on a proxy basis	1	6	7
<b>Response rate</b>	<b>54%</b>	<b>69%</b>	<b>61%</b>
	(381/703)	(399/581)	(780/1284)
Completed interview rate	<b>50%</b>	<b>66%</b>	<b>58%</b>
	(354/703)	(385/581)	(739/1284)

**Table A3: Age profile by wave (2000 and 2004), board (ERHA and WHB) and gender**

Age group (years)	<i>HeSSOP I</i>				<i>HeSSOP II</i>			
	ERHA		WHB		ERHA		WHB	
	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%
65-69	40	31	33	27	38	31	33	27
70-75	31	31	32	30	33	31	32	30
76-84	25	29	28	32	26	30	29	32
85+	4	9	7	11	4	8	6	11
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

**Table A4: Marital status by wave (2000 and 2004), board (ERHA and WHB) and gender**

Marital status	<i>HeSSOP I</i>				<i>HeSSOP II</i>			
	ERHA		WHB		ERHA		WHB	
	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%
Single	10	8	19	6	5	8	13	7
Widowed	15	56	16	65	16	44	16	64
Separated/ divorced	2	2	2	0	2	1	0	0
Married	73	34	63	29	77	47	71	29
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

**Table A5: Level of difficulty for HAQ tasks in the ERHA in 2004**

Task	HAQ score (difficulty rating)			
	0	1	2	3
	None	Some	Major	Severe
	%	%	%	%
Dressing	85	11	2	2
Personal care, e.g. washing entire body	82	10	4	4
Arising, e.g. getting in and out of bed	84	11	4	1
Eating and drinking	90	6	3	1
Walking ability	79	14	5	3
Reaching ability	70	17	5	8
Grip ability, e.g. jars	86	10	3	2
Complex activities, e.g. shopping	69	18	5	9

0 = HAQ score of 0-0.5 indicating self-sufficiency; 1 = HAQ score of 0.51-1.25 indicating mostly minor difficulties with ADL; 2 = HAQ score of 1.26-2.0 indicating major difficulties with ADL; 3 = HAQ score of 2.01-3.0 indicating severe impairment.

**Table A6: Level of difficulty for HAQ tasks in the WHB in 2004**

Task	HAQ score (difficulty rating)			
	0	1	2	3
	None	Some	Major	Severe
	%	%	%	%
Dressing	82	8	3	7
Personal care, e.g. washing entire body	75	12	5	8
Arising, e.g. getting in and out of bed	79	13	2	4
Eating and drinking	85	8	2	5
Walking ability	71	16	4	9
Reaching ability	65	16	7	12
Grip ability, e.g. jars	85	6	3	6
Complex activities, e.g. shopping	65	17	5	13

0 = HAQ score of 0-0.5 indicating self-sufficiency; 1 = HAQ score of 0.51-1.25 indicating mostly minor difficulties with ADL; 2 = HAQ score of 1.26-2.0 indicating major difficulties with ADL; 3 = HAQ score of 2.01-3.0 indicating severe impairment.

**Table A7: Level of difficulty for HAQ tasks in the ERHA in 2000**

Task	HAQ score (difficulty rating)			
	0	1	2	3
	None	Some	Major	Severe
	%	%	%	%
Dressing	81	3	10	6
Personal care, e.g. washing entire body	80	4	10	6
Arising, e.g. getting in and out of bed	87	7	4	2
Eating and drinking	83	5	7	5
Walking ability	78	5	14	3
Reaching ability	78	10	6	6
Grip ability, e.g. jars	87	7	3	3
Complex activities, e.g. shopping	75	4	11	10

0 = HAQ score of 0-0.5 indicating self-sufficiency; 1 = HAQ score of 0.51-1.25 indicating mostly minor difficulties with ADL; 2 = HAQ score of 1.26-2.0 indicating major difficulties with ADL; 3 = HAQ score of 2.01-3.0 indicating severe impairment.

**Table A8: Level of difficulty for HAQ tasks in the WHB in 2000**

Task	HAQ score (difficulty rating)			
	0	1	2	3
	None	Some	Major	Severe
	%	%	%	%
Dressing	80	4	8	8
Personal care, e.g. washing entire body	81	2	8	9
Arising, e.g. getting in and out of bed	86	6	4	4
Eating and drinking	88	2	5	5
Walking ability	71	3	19	7
Reaching ability	75	8	7	10
Grip ability, e.g. jars	88	3	4	5
Complex activities, e.g. shopping	74	5	8	13

0 = HAQ score of 0-0.5 indicating self-sufficiency; 1 = HAQ score of 0.51-1.25 indicating mostly minor difficulties with ADL; 2 = HAQ score of 1.26-2.0 indicating major difficulties with ADL; 3 = HAQ score of 2.01-3.0 indicating severe impairment.

# Appendix 4

## Comparing longitudinal participants to other *HeSSOP* / groups not interviewed

### Overview

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In this appendix, information is given on the participant groups not interviewed. These include participants whose *HeSSOP II* status is unknown ( $n = 133$ ), those who moved to institutional care ( $n = 13$ ) and others ( $n = 306$ ) including those who declined involvement in the research or who reported being too ill to participate. For these groups, demographic and health status information (such as physical functional health and psychological well-being) is given at *HeSSOP I*.

### Status unknown group

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Of the original *HeSSOP I* sample, the status of 64 participants was unknown at follow-up; of this group, 11 were in the ERHA and 53 in the WHB.

### Demographic profile of status unknown group

In the ERHA, 45 per cent of participants whose status was unknown at follow-up were men, 54 per cent were aged 75 years or over in 2000 and only 36 per cent were educated above primary level. In 2000, 36 per cent of this group were married, 27 per cent were widowed and 27 per cent had never married or were single. Furthermore, while 18 per cent lived alone in 2000, 45 per cent lived in intergenerational households, i.e. with children or grandchildren. When examining similarities and differences on the above variable between this group and all others at *HeSSOP I*, significant differences were only found for marital status ( $p < .05$ ), i.e. ERHA participants in the unknown group were more likely than others to be with a partner in the year 2000 (53 per cent v. 36 per cent) (see Table A9).

In the WHB, 42 per cent of follow-up participants were men, 75 per cent were aged 75 years or over in 2000 and only 32 per cent were educated above primary level. In 2000, 30 per cent of this group were married, 59 per cent were widowed and 9 per cent had never married or were single. Furthermore, while 40 per cent lived alone in 2000, 30 per cent lived in intergenerational households. Comparing the above demographic differences between this group and all others at *HeSSOP I*, no significant effects were found, i.e. participants whose status was unknown at four-year follow-up were not any different to others in the same region from *HeSSOP I* on demographic variables (see Table A9).

**Table A9: Demographic profile of *HeSSOP I* participants (status known and status unknown) at the four-year follow-up interviews**

Demographic profile	Status unknown group (n = 64)		Status known group (all other <i>HeSSOP I</i> participants)	
	ERHA (n = 11)	WHB (n = 53)	ERHA (n = 390)	WHB (n = 483)
	%	%	%	%
<b>Men</b>	45	42	47	45
<b>Age at <i>HeSSOP I</i></b>				
65-74 years	46	25	39	30
75-84 years	27	47	46	45
85+ years	27	28	15	25
Primary level of education only	64	68	44	67
Lives alone	18	40	27	32

### Health profile of status unknown group: Comparison with all others from *HeSSOP I*

In the ERHA, 17 per cent of *HeSSOP I* participants whose status was unknown at follow-up were in the medium to high disability group; this proportion is not statistically different to the 11 per cent of remaining *HeSSOP I* participants reporting medium to high levels of disability (see Table A10). In the status unknown group, 9 per cent reported their general health as being poor or very poor, and none were in the clinical depression group. There were no significant differences on self-rated and psychological health between this group and all others at *HeSSOP I*. In the WHB, 9 per cent of *HeSSOP I* participants whose status was unknown at follow-up were in the medium to high disability group as measured by HAQ scores; this

proportion is not statistically different to the 15 per cent of remaining *HeSSOP I* participants reporting similar levels of disability (see Table A10). In the status unknown group, 11 per cent reported their general health as being poor or very poor, and 6 per cent were in the clinical depression group. There were no significant differences on self-rated and psychological health between this group and all others at *HeSSOP I*.

**Table A10: Health profile of *HeSSOP I* participants (status known and status unknown)**

Health profile	Status unknown group (n = 64)		Status known group (all other <i>HeSSOP I</i> participants)	
	ERHA %	WHB %	ERHA %	WHB %
<b>Functional disability (HAQ)</b>				
Medium-high disability	9	17	11	15
<b>Self-ratings of general health</b>				
Fair	0	25	19	32
Poor/very poor	9	11	5	9
<b>Depression (HADS)</b>				
Borderline	0	8	4	6
Clinical	0	6	2	6

### Health and social service profile of status unknown group: Comparison with all others from *HeSSOP I*

In the ERHA, a similar proportion of *HeSSOP I* participants in the status known group and the status unknown group at follow-up would definitely consider changing GPs if dissatisfied with care (54 and 57 per cent respectively, see Table A11). There were no statistical differences between *HeSSOP I* participants whose status in 2004 was unknown and all others, on the proportions accessing hospital A&E or in-patient services (all  $ps > .05$ ). When examining similarities and differences on social service measures (e.g. public health nurse and chiropody), again no significant differences were found (all  $ps > .05$ ). Similarly, in the WHB none of these variables differed between participants whose status was known or unknown at follow-up.

**Table A11: Health and social service profile of *HeSSOP I* participants (status known and status unknown) at the four-year follow-up interviews**

Health and social service profile	Status unknown group (n = 64)		Status known group (all other <i>HeSSOP I</i> participants)	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Consider changing GPs if dissatisfied with care</b>				
Yes	54	51	57	49
<b>Hospital attendance</b>				
A&E attendance	0	9	15	11
In-patient	0	17	18	18
<b>Received social services</b>				
Public health nurse	27	15	14	16
Home help	9	2	6	4
Meals-on-wheels	0	2	2	1

## Summary

Of the original *HeSSOP I* sample, the status of 64 participants was unknown at follow-up. This group, however, did not differ from the rest of the remaining *HeSSOP I* sample on a range of demographic, health, and health and social service use variables. From a research perspective, their similarity to others in *HeSSOP I* is reassuring since it increases the generalisability of findings.

## Participants who moved to residential care

Thirteen participants from *HeSSOP I* were reported to have moved to care institutions by 2004; of this group, four were from the ERHA and nine were from the WHB. Since the numbers are so small, subsequent analyses are not reported separately by health board.<sup>11</sup>

<sup>11</sup> In some instances, differences seem large but are not statistically different because of small sample size in residential care. All significant differences are noted.



## Demographic profile for 'moved to residential care' group and comparison with all others from HeSSOP I

Of those who had moved to residential care, 62 per cent (n = 8) were women, 46 per cent (n = 6) were widowed, 39 per cent (n = 5) were aged over 85 years in 2000, and 77 per cent (n = 10) had completed education at primary level (see Table A12). There were no significant differences on these demographic variables, although there was a trend for participants who had moved to residential care to be older than others in *HeSSOP I*.

**Table A12: Demographic profile of *HeSSOP I* participants who moved to residential care and others from *HeSSOP I***

Demographic profile	Residential care group (n = 13) %	All others in <i>HeSSOP I</i> (n = 924) %
<b>Men</b>	38	45
<b>Age at <i>HeSSOP I</i></b>		
65-74 years	8	34
75-84 years	54	45
85+ years	39	21
Primary level of education only	77	57
Lives alone	38	30
Has medical card	83	65

## Health profile of residential care group and comparison with all others from HeSSOP I

There were few differences in the year 2000 health profile of those who had moved to residential care v. others in 2004 (see Table A13). A greater proportion of participants who moved to residential care in *HeSSOP II* had been in the clinically depressed group in 2000 (17 per cent v. 4 per cent of all others); however, this difference was not significant.

**Table A13: Health profile of *HeSSOP I* participants who moved to residential care and others from *HeSSOP I***

Health profile	Residential care group (n = 13) %	All others in <i>HeSSOP I</i> (n = 924) %
<b>Functional disability (HAQ)</b>		
Medium-high disability	23	13
<b>Self-ratings of general health</b>		
Fair	39	25
Poor/very poor	15	7
<b>Depression</b>		
Borderline	8	5
Clinical	17	4

### Health and social service profile of residential care group and comparison with all others from *HeSSOP I*

There was no significant difference between the two groups in terms of the percentage who would be highly likely to change their GPs if dissatisfied with aspects of their care or those who used services at A&E (all  $ps > .05$ , see Table A14). A significant difference between the two groups, however, was found for hospital in-patient services; while 38 per cent of those who moved to care had availed of hospital in-patient services in the previous year (1999), the figure for others in *HeSSOP I* was 16 per cent. There were no significant differences between the groups in terms of the percentages who used other health or social services.

**Table A14: Health and social service profile of *HeSSOP I* participants who moved to residential care and others from *HeSSOP I***

Health and social service profile	Residential care group (n = 13) %	All others in <i>HeSSOP I</i> (n = 924) %
<b>Consider changing GPs if dissatisfied with care</b>		
Yes	46	53
<b>Hospital attendance</b>		
A&E attendance	13	8
In-patient	38*	16*
<b>Received social services</b>		
Public health nurse	23	15
Home help	8	5
Meals-on-wheels	0	2

Note: \* indicates that difference within boards is significant ( $p < .05$ ).

## Summary

Thirteen participants from the original *HeSSOP I* study moved to residential care by the year 2004. Those who had moved to residential care were significantly more likely to have used in-hospital services in the year prior to *HeSSOP I*. However, the two samples did not otherwise differ on a range of basic demographic, health and health and social service use factors.

## Participants who declined involvement

Of the original *HeSSOP I* sample, 108 declined involvement in the four-year follow-up study (45 participants in the ERHA and 63 in the WHB) (see Table A15).

## Demographic profile of the declined involvement group and comparison with all others from *HeSSOP I*

In the ERHA, no significant differences between this group and all others were found, i.e. ERHA participants who declined involvement in the follow-up study were

not any different to others on basic demographic variables at *HeSSOP I*. Similarly, in the WHB, there were no demographic differences between this group and all others at *HeSSOP I* (see Table A15).

**Table A15: Demographic profile of *HeSSOP I* participants who declined follow up, and all others from *HeSSOP I***

Demographic profile	'Declined' group (n = 108)		All others in <i>HeSSOP I</i>	
	ERHA (n = 45)	WHB (n = 63)	ERHA (n = 356)	WHB (n = 473)
Men	49	43	47	45
<b>Age at <i>HeSSOP I</i></b>				
65-74 years	38	33	39	29
75-84 years	42	46	45	45
85+ years	20	21	15	26
Primary level of education only	49	70	44	67
Lives alone	31	30	26	33
Has medical card	51	80	50	76

### Health profile of the declined involvement group and comparison with all others from *HeSSOP I*

The health profile of the two groups is outlined in Table A16. There were no differences in either the ERHA or the WHB in the health profiles of *HeSSOP I* participants who later declined involvement in the follow-up *HeSSOP II* study and all others in *HeSSOP I*.

**Table A16: Health profile of *HeSSOP I* participants who declined follow-up, and all others from *HeSSOP I***

Health profile	'Declined' group		All others in <i>HeSSOP I</i>	
	ERHA (n = 45)	WHB (n = 63)	ERHA (n = 356)	WHB (n = 473)
	%	%	%	%
<b>Functional disability (HAQ)</b>				
Medium-high disability	4	13	12	15
<b>Self-ratings of general health</b>				
Fair	20	27	18	32
Poor/very poor	2	5	6	9
<b>Depression (HADS)</b>				
Borderline	0	9	4	6
Clinical	2	3	2	6

### Health and social service profile of the declined involvement group and all others in *HeSSOP I*

The health and social service profile of the two groups is outlined in Table A17. There were no differences in either the ERHA or the WHB in the health and social service profiles of participants who later declined involvement in the longitudinal study and others from *HeSSOP I*.

**Table A17: Health and social service profile of *HeSSOP I* participants who declined follow-up, and all others from *HeSSOP I***

Health and social service Profile	'Declined' group		All others in <i>HeSSOP I</i>	
	ERHA (n = 45)	WHB (n = 63)	ERHA (n = 356)	WHB (n = 473)
	%	%	%	%
<b>Consider changing if dissatisfied with GP</b>				
Yes	60	52	57	49
<b>Hospital attendance</b>				
A&E attendance	18	5	14	12
In-patient	86	84	85	82
<b>Received social services</b>				
Public health nurse	9	9	15	16
Home help	11	3	6	4
Meals-on-wheels	2	0	2	1

## Summary

Participants who declined involvement in the *HeSSOP II* study did not differ from remaining *HeSSOP I* participants in a range of demographic, health, and health and social service use variables.

## Participants where no suitable time could be found for interviewing

No suitable time could be found to interview 58 participants in *HeSSOP I* (see Table A18); in these instances, researchers called back to houses on a number of occasions but could not schedule appointments (with participants known to live at the address contacted).

## Demographic profile of the 'no-suitable time' group and comparison with all others from *HeSSOP I*

No significant differences were found between this group and all others, i.e. ERHA participants who could not be interviewed due to time difficulties were not significantly different from other ERHA participants in *HeSSOP I* on a range of basic

demographic variables. Similarly, in the WHB, there were no demographic differences between this group and all others at *HeSSOP I*, with one exception; those for whom interviews could not be scheduled at follow-up differed from others in *HeSSOP I* in that they were significantly more likely to live alone ( $p < .01$ , see Table A18).

**Table A18: Demographic profile of *HeSSOP I* participants having no time for follow-up, and all others from *HeSSOP I***

Demographic profile	'No time' group (n = 58)		All others in <i>HeSSOP I</i>	
	ERHA (n = 30)	WHB (n = 28)	ERHA (n = 371)	WHB (n = 508)
	%	%	%	%
<b>Men</b>	57	50	46	44
<b>Age at <i>HeSSOP I</i></b>				
65-74 years	37	36	39	29
75-84 years	40	46	46	45
85+ years	23	18	15	26
Primary level of education only	31	61	45	67
Lives alone	17	54 *	27	31 *
Has medical card	57	79	50	76

Note: \* indicates that difference within boards is significant ( $p < .05$ ).

### Health profile of the 'no suitable time' group and others in *HeSSOP I*

The health profile of the two groups is outlined in Table A19. There were no differences in either the ERHA or the WHB in the health profiles of participants for whom no suitable time could be found for the interviews.

**Table A19: Health profile of *HeSSOP I* participants for whom no suitable time could be found for interviews and all others from *HeSSOP I***

Health profile	'No time' group (n = 58)		All others in <i>HeSSOP I</i>	
	ERHA	WHB	ERHA	WHB
	%	%	%	%
<b>Functional disability (HAQ)</b>				
Medium-high disability	9	17	11	15
<b>Self-ratings of general health</b>				
Fair	0	25	19	32
Poor/very poor	9	11	5	9
<b>Depression (HADS)</b>				
Borderline	0	8	4	6
Clinical	0	6	2	6

### Health and social service profiles of the 'no suitable time' group and comparison with all others from *HeSSOP I*

The health and social service profile of the two groups is outlined in Table A20. There were no differences in either the ERHA or the WHB in the profiles of participants for whom no suitable time could be found for the interviews.



**Table A20: Health and social service profile of *HeSSOP I* participants having no time for follow-up, and all others from *HeSSOP I***

Health and social service profile	'No time' group (n = 58)		All others in <i>HeSSOP I</i>	
	ERHA (n = 30)	WHB (n = 28)	ERHA (n = 371)	WHB (n = 508)
	%	%	%	%
<b>Consider changing if dissatisfied with GP</b>				
Yes	46	54	58	49
<b>Hospital attendance</b>				
A&E attendance	23	7	14	11
In-patient	73	93	86	82
<b>Received social services</b>				
Public health nurse	23	7	14	16
Home help	7	0	6	4
Meals-on-wheels	3	0	2	1

## Summary

No suitable time could be found to interview 58 participants from *HeSSOP I*. This group did not differ, however, from others in *HeSSOP I* on almost all of a range of health, and health and social service measures.

## Participants who were too ill to take part

Fifty-seven participants indicated they were too ill to take part in the study; 25 were based in the ERHA and 32 in the WHB.

## Demographic profile of participants too ill to take part in *HeSSOP II*

In the ERHA, 32 per cent of participants who described themselves as too ill to take part in *HeSSOP II* were men, 72 per cent were aged 75 years or over at wave 1 and 40 per cent were educated above primary level. No significant difference was found on a range of basic demographic measures (see Table A21) in either health board in the year 2000 between the group describing themselves as too ill to participate in 2004 and all other *HeSSOP I* participants.

**Table A21: Demographic profile of *HeSSOP I* participants who were too ill for follow-up, and all others from *HeSSOP I***

Demographic profile	'Too ill' group (n = 57)		All others in <i>HeSSOP I</i>	
	ERHA (n = 25)	WHB (n = 32)	ERHA (n = 376)	WHB (n = 504)
	%	%	%	%
Men	32	47	48	45
<b>Age at <i>HeSSOP I</i></b>				
65-74 years	28	44	40	29
75-84 years	56	47	44	45
85+ years	16	9	16	26
Primary level of education only	60	59	43	68
Lives alone	24	31	27	33
Has medical card	56	75	50	77

### Health profile of participants too ill to take part in *HeSSOP II* and comparison with all others from *HeSSOP I*

Of those in the ERHA who described themselves as too ill to take part in *HeSSOP II*, 8 per cent were in the medium to high disability group in 2000, 4 per cent had described their health as poor or very poor and 4 per cent were in the clinically depressed group (see Table A22). These percentages, however, were not statistically different to others in *HeSSOP I*, i.e. although this group may have had poorer health in 2004, there was no difference between their health and the health of others in *HeSSOP I* in 2000.

Of those in the WHB who described themselves as being too ill to take part in *HeSSOP II*, none were in the medium to high disability group in 2000; this rate contrasts with 16 per cent in the remaining sample ( $p < .01$ ), i.e. participants who described themselves as being too ill in 2004, had better functional health than did others from *HeSSOP I* in the same region. There were no significant differences, however, between the groups on measures of self-rated health or depression.

**Table A14: Health profile of *HeSSOP I* participants who were too ill for follow-up, and all others from *HeSSOP I***

Health profiles	'Too ill' group (n = 57)		All others in <i>HeSSOP I</i>	
	ERHA (n = 25)	WHB (n = 32)	ERHA (n = 376)	WHB (n = 504)
	%	%	%	%
<b>Functional disability (HAQ) Δ</b>				
Medium-high disability	8	0	11	16
<b>Self-ratings of general health</b>				
Fair	24	34	18	31
Poor/very poor	4	3	5	9
<b>Depression (HADS)</b>				
Borderline	0	3	4	7
Clinical	4	0	2	6

### Health and social service profile of participants too ill to take part in *HeSSOP II* and comparison with all others from *HeSSOP I*

Basic information on the health and social service profiles of participants reporting themselves to be too ill to take part in 2004 and all others from *HeSSOP I* can be seen in Table A22. There were no significant differences on these measures for participants in the ERHA with one exception; participants who reported themselves as being too ill in 2004 were more likely than others in 2000 to have availed of the services of a public health nurse (28 per cent v. 14 per cent,  $p < .05$ ).

For participants in the WHB, participants describing themselves as too ill to take part in research in 2004, did not differ in health and social service use from others four years earlier.

**Table A23: Health and social service profile of *HeSSOP I* participants who were too ill for follow-up, and all others from *HeSSOP I***

Health and social service profile	'Too ill' group (n = 57)		All others in <i>HeSSOP I</i>	
	ERHA	WHB	ERHA	WHB
	(n = 25)	(n = 32)	(n = 376)	(n = 504)
	%	%	%	%
<b>Consider changing if dissatisfied with GP</b>				
Yes	61	61	57	48
<b>Hospital attendance</b>				
A&E attendance	4	7	15	11
In-patient	88	87	85	82
<b>Received social services</b>				
Public health nurse	28 *	9	14 *	16
Home help	0	0	6	4
Meals-on-wheels	0	0	2	1

Note: \* indicates that difference within boards is significant ( $p < .05$ ).

## Summary

Fifty-seven *HeSSOP I* participants described themselves as being too ill to take part in the four-year follow-up research. Four years earlier, however, these participants did not generally differ from others on a range of demographic, health and health services measures.

## Participants who had died by 2004

Of the original *HeSSOP I* sample, 160 could not be interviewed as they had died within the four-year interval.

### Demographic profile of participants who had died by 2004: Similarities and differences with others in 2000

In the ERHA, 54 per cent of participants who had died by 2004 were men, 77 per cent were aged 75 years or over in 2000 and 40 per cent had some education above

primary level. In 2000, 47 per cent of this group were married, 47 per cent were widowed and 4 per cent had never married or were single. Furthermore, while 30 per cent of this group lived alone in 2000, 48 per cent lived in intergenerational households, i.e. with children or grandchildren. When examining differences on the above variable between this group and all others in the ERHA at *HeSSOP I*, significant differences were found for age ( $p = .004$ ), education ( $p = .01$ ) and medical card coverage ( $p = .02$ ), i.e. participants in the ERHA who had died by follow-up were more likely to be older, have had primary level education only and have had a medical card (indicative of lower levels of economic resources in *HeSSOP I*, see Table A24).

In the WHB, 56 per cent of follow-up participants were men, 96 per cent were aged 75 years or over in 2000 and only 32 per cent had some education above primary level. In 2000, 30 per cent of this group were married, 61 per cent were widowed and 9 per cent had never married or were single. When examining similarities and differences on the above variable between this group and all others in the WHB at *HeSSOP I*, significant differences were found for gender ( $p = .03$ ), age ( $p < .001$ ), and medical card coverage ( $p = .03$ ), i.e. participants who had died by follow-up were more likely to be women, older and with medical cards in 2000 (84 per cent of this group had medical cards in 2000 v. 75 per cent of all others in *HeSSOP I*).

**Table A24: Demographic profile of *HeSSOP I* participants who were deceased at follow-up, and all others from *HeSSOP I***

Demographic profile	'Deceased' group (n = 160)		All others in <i>HeSSOP I</i>	
	ERHA (n = 56) %	WHB (n = 104) %	ERHA (n = 345) %	WHB (n = 432) %
<b>Men</b>	54	56	46	47
<b>Age at <i>HeSSOP I</i></b>				
65-74 years	23	4	42	36
75-84 years	48	44	45	46
85+ years	29	52	14	19
Primary level of education only	60	68	42	67
Lives alone	30	69	26	33
Has medical card	64	84	48	75

## Health profile of participants who had died by 2004: Similarities and differences with others in 2000

In the ERHA, 30 per cent of *HeSSOP I* participants who had died by follow-up were in the medium to high disability group, while the corresponding figure for all others was just 8 per cent; this difference was statistically significant ( $p < .001$ , see Table A25). Participants who had died at follow-up were also more likely to have rated their health negatively by comparison to others in 2001 ( $p < .001$ ), and to have had more negative future expectations for their health ( $p = .001$ ); for example, while 18 per cent of those who later died thought their health one year ahead would be somewhat or much worse, just 5 per cent of all others thought this way. Participants who had died at follow-up were also significantly more likely to have had higher rates of depression in comparison with others in *HeSSOP I* ( $p = .01$ ).

In the WHB, 35 per cent of *HeSSOP I* participants who had died by the 2004 follow-up were in the medium to high disability group; among remaining *HeSSOP I* participants in the WHB, just 10 per cent were in this group ( $p < .001$ , see Table A25). Participants who had died at follow-up were also significantly more likely than others in the WHB to have rated their current general health more negatively ( $p < .001$ ), to have had more negative expectations for their future health ( $p < .001$ ) and to be depressed ( $p = .002$ ).

**Table A25: Health profile of *HeSSOP I* participants who were deceased at follow-up, and all others from *HeSSOP I***

Health profiles	Deceased group (n = 160)		All others in <i>HeSSOP I</i>	
	ERHA (n = 56)	WHB (n = 104)	ERHA (n = 56)	WHB (n = 104)
	%	%	%	%
<b>Functional disability (HAQ)</b>				
Medium-high disability	30	35	8	10
<b>Self-ratings of general health</b>				
Fair	20	32	18	31
Poor/very poor	16	20	3	6
<b>Depression (HADS)</b>				
Borderline	4	10	4	6
Clinical	7	13	1	4

## Health and social service profile of participants who had died by 2004: Similarities and differences with others in 2000

In the ERHA, 53 per cent of *HeSSOP I* participants who had died by follow-up would definitely consider changing GPs if dissatisfied with care, while 58 per cent of remaining *HeSSOP I* participants would do the same (see Table A26). This difference was not statistically different, nor were there any significant differences in 2000 between these groups in the proportion availing of A&E services, hospital in-patient services, Home Helps or meals-on-wheels. Participants who had died by follow-up, however, were statistically more likely to have availed of the services of a public health nurse ( $p = .053$ ).

**Table A26: Health and social service profile of *HeSSOP I* participants who were deceased at follow-up, and all others from *HeSSOP I***

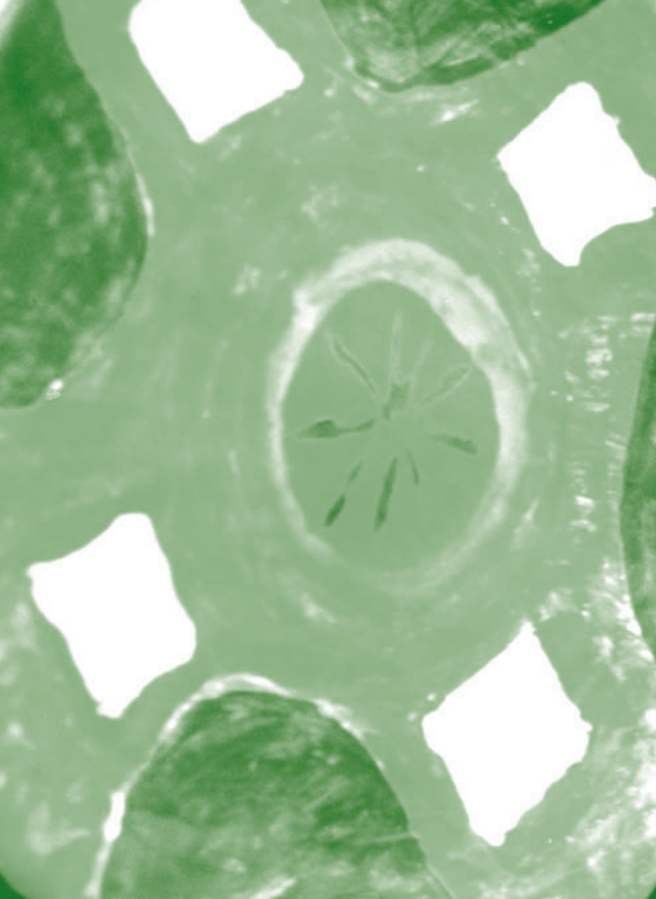
Health and social service profiles	Deceased group (n = 160)		All others in <i>HeSSOP I</i>	
	ERHA (n = 56)	WHB (n = 104)	ERHA (n = 56)	WHB (n = 104)
	%	%	%	%
<b>Consider changing if dissatisfied with GP</b>				
Yes	53	42	58	51
<b>Hospital attendance</b>				
A&E attendance	18	17	14	9
In-patient	20	18	14	17
<b>Received social services</b>				
Public health nurse	23	32	13	12
Home help	11	11	5	2
Meals-on-wheels	4	1	2	1

In the WHB, there were no significant differences between those who had died by follow-up and all *HeSSOP* others in terms of the proportion who would definitely change GPs if dissatisfied with quality of their care. However, WHB participants who had died by follow-up were more likely than others to have accessed A&E services ( $p = .02$ ). They were also more likely to have availed of the services of a public health nurse ( $p < .001$ ) and Home Helps ( $p = .001$ ).

## Summary

Of the original *HeSSOP I* sample, 160 had died within four years. This group differed from others in *HeSSOP I* (conducted in 2000) on a range of demographic, health, and health and social service usage measures.





## Terms of Reference



# Terms of Reference

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

## **The functions of the Council are as follows:**

1. To advise the Minister for Health on all aspects of ageing and the welfare of older people, either at its own initiative or at the request of the Minister and in particular on:
  - a) measures to promote the health of older people;
  - b) measures to promote the social inclusion of older people;
  - c) the implementation of the recommendations contained in policy reports commissioned by the Minister for Health;
  - d) methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for older people;
  - e) methods of encouraging greater partnership between statutory and voluntary bodies in providing services for older people;
  - f) meeting the needs of the most vulnerable older people;
  - g) means of encouraging positive attitudes to life after 65 years and the process of ageing;
  - h) means of encouraging greater participation by older people;
  - i) whatever action, based on research, is required to plan and develop services for older people.

2. To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:
  - a) undertaking research on the lifestyle and the needs of older people in Ireland;
  - b) identifying and promoting models of good practice in the care of older people and service delivery to them;
  - c) providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health, well-being and autonomy of older people;
  - d) liaising with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for older people.
3. To promote the health, welfare and autonomy of older people.
4. To promote a better understanding of ageing and older people in Ireland.
5. To liaise with international bodies which have functions similar to the functions of the Council.

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

# Membership

Chairperson: Cllr Éibhlin Byrne

Mr Bernard Thompson	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	Mr John Brady
Mr Noel Byrne	Ms Kit Carolan
Dr Davida de la Harpe	Mr John Grant
Dr Ruth Loane	Ms Sylvia Meehan
Mr Paddy O'Brien	Ms Martina Queally
Mr Oliver R Cleary	Ms Annette Kelly
Ms Eileen O'Dolan	Mr Paul O'Donoghue
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