An Roinn Sláinte
DEPARTMENT OF HEALTH

Tús Áite do Shábháilteacht Othar
Patient Safety First

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HEALTHY & POSITIVE AGEING INITIATIVE

Preliminary Report
May 2015

Abbreviations

ADL	Activities of Daily Living
AAI	Active Ageing Index 2012
AgeWatch Index	Global index of the wellbeing of older people 2014
AITHS	All Ireland Traveller Health Study
APQ	Ageing Perceptions Questionnaire
ARK	Access Research Knowledge Northern Ireland
BMI	Body Mass Index
CARDI	Centre for Ageing Research and Development in Ireland
CDG	Cross-departmental Group
CES-D	Centre for Epidemiological Studies - Depression
CSO	Central Statistics Office
DCYA	Department of Children and Youth Affairs
DOH	Department of Health
EC	European Commission
ED	Emergency Department
EQLS	European Quality of Life Survey
EU	European Union
EU-SILC	European Survey of Income and Living Conditions
EU27	European Union Member States: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden and the United Kingdom.
EU28	European Union Member States: EU27 plus Croatia.
Eurofound	European Foundation for the Improvement of Living and Working Conditions
EY2012	European Year for Active Ageing and Solidarity between Generations
GP	General Practitioner
HADS-A	Hospital Anxiety and Depression Scale - Anxiety
HaPAI	Healthy and Positive Ageing Initiative
HDI	Human Development Index
HLS-EU	European Health Literacy Survey
HSE	Health Service Executive
IADL	Instrumental Activities of Daily Living
ICT	Information and Communication Technologies
IPAQ	International Physical Activity Questionnaire
LFS	Labour Force Survey
MIPAA	Madrid International Plan of Action on Ageing
MMSE	Mini-Mental State Examination
NALA	National Adult Literacy Agency
NPAS	National Positive Ageing Strategy
OECD	Organisation for Economic Co-operation and Development
ONS	Office of National Statistics, the United Kingdom
PIAAC	Programme for the International Assessment of Adult Competencies
QNHS	Quarterly National Household Survey
RIS	UNECE Regional Implementation Strategy of MIPAA
SHARE	Survey of Health, Ageing and Retirement in Europe
TILDA	The Irish Longitudinal Study on Ageing
UNDP	United Nations Development Programme
UNECE	United Nations Economic Commission for Europe
WHO	World Health Organisation

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Design: Source Design

CONTENTS

KEY: Males only | Females only | Males & Females | 52 YEARS Age range

Foreword

Positive and healthy ageing are in everyone's interest.

In the past, policy relating to older people tended to deal almost exclusively with health and social care issues, focusing on burden and costs. With the launch of the National Positive Ageing Strategy, this Government sought to change that view of ageing, to highlight the positives and to create the conditions to allow all older people to flourish.

Over the next 30 years, the number of people in Ireland over the age of 65 will double and the number over 80 will quadruple. This population ageing poses challenges for our health, care and pension systems as well as our capacity to create environments which will allow us lead healthy, active and engaged lives.

The National Positive Ageing Strategy sets out a vision for an age-friendly society and includes four National Goals around participation, health, security, and research to provide direction on the issues that need to be addressed to promote positive ageing. The Strategy is to be implemented under the broader Healthy Ireland framework, which sets out a vision to improve the health and wellbeing of the entire population of Ireland. Both the Minister for Health and I have reiterated our commitment to implementing the National Positive Ageing Strategy in our statement of health priorities for 2015.

To be successful, implementation of this Strategy must be the responsibility of all sectors of society: government, health service providers, local authorities, businesses, voluntary groups, families and we as individuals all have our part to play. Many of the factors that contribute to a good quality of life for older people and to the creation of communities in which ageing can be a positive experience are influenced at local level. The local authority led, multi-agency Age Friendly Cities and Counties programme provides an excellent example of cooperation for positive ageing by bringing together all the key players in local service provision to improve the lives of older people. The establishment of Older People's Councils in each participating local authority area also gives older people a strong voice to influence local development.

We know that in order to plan for an ageing population, policy makers have to be able to make projections of future need across all policy areas. We also need access to valid, reliable and timely evidence about the determinants of health, wellbeing and quality of life and the relationships between them. The Healthy and Positive Ageing Initiative (HaPAI) aims to provide this evidence. It is a national three-year programme of research, data translation, health promotion and dissemination led by the Department of Health with the HSE and Age Friendly Ireland as key partners. It has benefited, like so many other initiatives in the ageing field, from a significant financial contribution from the Atlantic Philanthropies, as well as the Department of Health and the HSE.

This report, the first for the Healthy and Positive Ageing Initiative, provides an overview of current evidence on the lives of older people. It will establish a baseline against which we can measure progress on positive ageing and allow us to identify areas of potential need.

Kathleen Lynch TD
Minister of State at the Department of Health

Tables and Figures

Definitions

To provide clarity and consistency, it is useful to define some of the main terms used throughout this report.

Health is described in Healthy Ireland as meaning "…everyone achieving his or her potential to enjoy complete physical, mental and social wellbeing". As per the WHO definition, the concept is broadly defined as being "more than an absence of disease or disability…"(Department of Health 2013. p.9).

Wellbeing is seen as an integral part of this definition of and "…reflects the quality of life and the various factors which can influence it over the course of a person's life". [p.9] Healthy Ireland also sees wellbeing as an aspect of "positive mental health, in which a person can realise his or her own abilities, cope with the normal stresses of life, work productively and fruitfully, and be able to make a contribution to his or her community" (WHO 2001).

Indicators - Many definitions of indicators have been found in literature and in use internationally, varying slightly depending on their intended use. For example, Rogers et al (2011) define an outcome indicator as… "Specific, observable, and measurable characteristics or change that will represent achievement of the outcome" (Rogers et al 2011).

HIQA focused on performance indicators in the healthcare system and defined indicators as "…quantitative measures of structures, processes or outcomes that may be correlated with the quality of care delivered by the healthcare system (HIQA, 2013), while the EU used…"a quantitative or qualitative measure of how close we are to achieving a set goal (policy outcome)" (http://ec.europa.eu/health/indicators/policy/index_en.htm).

For the purposes of this report we have chosen to use the following, (adapted from the WHO definition); An Indicator is "A variable with characteristics of quality, quantity and time used to measure, directly or indirectly, changes in a situation… to appreciate the progress made in addressing it…and to assess the extent to which the objectives and targets of a programme are being attained" (WHO 2000).

Methodology

DATA SOURCES

This report presents data relating to the three pillars of the NPAS: Participation, Healthy Ageing and Security. It uses information which is currently available from survey and administrative data sources. Nationally representative surveys from which data was extracted, analysed and presented include:

- The Census, collected by the Central Statistics Office (CSO)
- European Quality of Life Survey (EQLS)
- National Disability Survey (NDS)
- Northern Ireland Life and Times Survey
- Programme for the International Assessment of Adult Competencies (PIAAC)
- Quarterly National Household Survey(s) (QNHS) including special modules on Sports, Retirement Planning, Voter Participation, Caring, and Crime and Victimisation
- European Union Survey of Income and Living Conditions (EU-SILC)
- Survey of Health, Ageing and Retirement in Europe (SHARE)
- The European Health Literacy Survey (HLS-EU)
- The Irish Longitudinal Study of Ageing (TILDA)
- Eurostat

Published reports and strategy documents containing administrative data from which information has been extracted and presented include:

- All Ireland Traveller Health Study (All Ireland Traveller Health Study Team, 2010)
- Irish National Dementia Strategy (Department of Health, 2014)
- Long-stay Activity Statistics (Department of Health, 2013)
- Statistical Information on Social Welfare Services (Department of Social Protection, 2011)
- Open Your Eyes, HSE Elder Abuse Services Report (Health Service Executive Elder Abuse Services, 2013)
- Health Service Management Data Report (Health Service Executive, 2014)
- BreastCheck – Programme Report (Health Service Executive National Screening Service 2014)

A detailed summary of the survey datasets used to compile this report is provided in the Appendix. Key information includes the reference period(s), the frequency with which the data are collected (e.g. annually), the sample size and population coverage that the survey data provides, methods of data collection, the content of the data, relevant policy area(s), and references to further information on each survey dataset.

PRESENTATION OF THE RESULTS

Throughout the report, data are reported as percentages (%), meaning the proportion of older people of a specific age with a specific characteristic. In several instances the number of persons is reported, rather than percentages, on the basis that this information is particularly relevant for current and future health and social service provision (e.g. current estimates and projected growth in the number of people with dementia). Unless otherwise indicated, data are un-weighted. Confidence intervals (CI) are not reported.

A number of data sources include data at a European level (e.g. EQLS, SHARE). However, in this report only data related to Ireland is presented, unless otherwise specified.

Comparisons

Indicators for the general population are presented alongside those for older people in several areas in order to illustrate key differences between persons aged (minimum) 50 and older and the general population. These include: income, intergenerational solidarity and health status. In order to illustrate similarities and differences between the population of Ireland and the European Union, comparative EU27 and EU28 data are presented for the following indicators: Active Ageing Index (AAI); percentage of the total population in older age groups (50 plus); and participation in formal education and training.

Disaggregation

Throughout the report information is disaggregated in several ways in order to demonstrate trends over time, differences between men and women, geographical and spatial differences (particularly between rural and various urban areas) and differences between older age groups. Disaggregation varies depending on the available data and the relevance of the comparison for the specific indicator.

Age

Indicators are, in the main, reported for three separate age groups (50 to 64, 65 to 74, and 75 and older). Where it was not possible to disaggregate available data by age group, specific age cut points are presented (50 plus, 55 plus and 65 plus). Where there was no difference observed between the three age groups combined data are presented. For selected indicators, five year age groups are presented in order to illustrate age-related trends. However, caution is advised when interpreting the data for the older age groups (80 and over) in isolation due to small numbers.

For longitudinal datasets, the age ranges presented may vary depending on the survey wave that the data relates to. For example, TILDA wave 1 includes adults aged 50 and over, while participants in TILDA wave 2 are aged 52 and over.

Trends over time

Key trends over time which are presented in the report illustrate changes in the age composition of the population, employment rates and participation in formal education and training among older age groups, life expectancy and healthy life years at age 65 and fuel poverty among older people. Throughout the report, data from both Wave 1 (2009-2011) and Wave 2 (2012-2013) of TILDA data are presented in selected graphs where results differ between these two time points. Similarly, data from the Northern Ireland Life and Times Survey on ageism and discrimination is presented from 2003 and 2008.

INTRODUCTION

to the Healthy and Positive Ageing Initiative (HaPAI)

BACKGROUND

The National Positive Ageing Strategy (NPAS[1]) was published in 2013, setting out a vision for Ireland as

"…a society for all ages that celebrates and prepares properly for individual and population ageing. It will enable and support all ages and older people to enjoy physical and mental health and wellbeing to their full potential. It will promote and respect older people's engagement in economic, social, cultural, community and family life, and foster better solidarity between generations. It will be a society in which the equality, independence, participation, care, self-fulfilment and dignity of older people are pursued at all times".

This vision suggests that a range of interconnected social, economic and environmental factors can have an impact on the health and wellbeing of older people.

The NPAS was developed following extensive consultation with older people and their representatives about what was needed to enable them to age positively. Strategy development also involved a Cross-Departmental Group (CDG) made up of representatives of several government departments as well as the Central Statistics Office and An Garda Síochána and was overseen by the Cabinet Committee on Social Policy.

The NPAS takes the WHO's *Active Ageing – A Policy Framework* (2002)[2] as a 'theoretical underpinning' for the Strategy. The key feature of the WHO's framework is that it recognises the broad range of factors that affect how people and populations age. It sees ageing from the life-course perspective and seeks to promote intergenerational solidarity in the policy response to population ageing.

The WHO's *Active Ageing* Framework calls for action on three fronts by defining active ageing as "a process of optimising opportunities for participation, health and security" (NPAS 2013). These three pillars will form the basis on which indicators for Positive Ageing will be developed by the Healthy and Positive Ageing Initiative (HaPAI).

To achieve the vision outlined by the NPAS, a number of goals, objectives and actions have been identified, aimed at improving the lives of older people. The Strategy identifies four national goals:

1. Remove barriers to participation and provide more opportunities for the continued involvement of people as they age in all aspects of cultural, economic and social life in their communities according to their needs, preferences and capacities;
2. Support people as they age to maintain, improve or manage their physical and mental health and wellbeing;
3. Enable people to age with confidence, security and dignity in their own homes and communities for as long as possible;
4. Support and use research about people as they age to better inform policy responses to population ageing in Ireland.

Similarly Healthy Ireland, the national framework to improve the health and wellbeing of the population, has identified four high level goals and details 64 actions grouped under six broad themes. To achieve the vision of these strategies, the implementation of the NPAS must be framed within the implementation of Healthy Ireland, in recognition of the fact that "health and wellbeing is a multi-dimensional concept... determined by a range of interconnecting social, economic and environmental factors" (NPAS 2013). Implementation of the NPAS is an essential part of the vision for creating a society in which…"every individual and sector of society can play their part in achieving a healthy Ireland" (Healthy Ireland Goal 4).

These two interlinked Government strategies have committed to the development of indicators to monitor and evaluate progress. Indicators are regarded as playing a vital role in the identification of trends and issues while contributing to the process of priority setting, policy formulation and the evaluation and monitoring of progress. The full set of indicators will be used to assess the level of progress being made through the implementation of the Strategy to improve the lives of older people over time, ideally benchmarked against other countries.

The Department of Health is leading a joint national programme with the HSE and Age Friendly Ireland (AFI) to develop these indicators. Hosted by Dublin City Council, Age Friendly Ireland provides technical and programme related support to each of the 31 local authority led, multi-agency Age Friendly programmes. Through the Age Friendly Cities and Counties programme, local authorities bring together diverse organisations, groups, services and businesses (An Garda Síochána, HSE, Education and Training Boards/Universities, key NGO's, transport and service providers) to streamline their work, with the interests and needs of older people at their heart.

In its role as an intermediary organisation Age Friendly Ireland promotes and supports the application of the World Health Organisation (WHO) approach to age-related planning and service provision. Age Friendly Ireland is tasked with

[1] http://health.gov.ie/wp-content/uploads/2014/03/National_Positive_Ageing_Strategy_English.pdf

[2] http://whqlibdoc.who.int/hq/2002/who_nmh_nph_02.8.pdf

[3] http://www.hse.ie/eng/services/publications/corporate/hieng.pdf

supporting the development of effective local multi-agency planning structures, the promotion of relevant partnerships and collaborations, and the development and implementation of integrated city and county plans which promote and advance older people's health and wellbeing across Ireland. The Healthy and Positive Ageing Initiative is led by Age Friendly Ireland's Research Manager.

Nationally, funding has been granted from Atlantic Philanthropies with a co-funding commitment from the Department of Health and the HSE over the three year duration of the project, with a commitment from the Department of Health to continuation of its contribution for a further two years. The Healthy and Positive Ageing Initiative (HaPAI) has a number of strands and operates on a national and local level. The project involves a number of key activities:

- Formulation of key national indicators of Older People's Health and Wellbeing, using research and data already developed especially from The Irish Longitudinal Study of Ageing (TILDA), as well as the Central Statistics Office, and the HSE's Health & Wellbeing Directorate (H&W);
- The establishment of a research fund to commission targeted additional once-off research to fill identified gaps in existing data required to cover all indicators, relevant to the design or configuration of future services and supports for older people;
- Publication of a biennial Report on the Health and Wellbeing of Older People in Ireland (to be continued on a permanent basis after the term of this Programme);
- At a local level, developing indicators using either national data broken down to the county level where possible, or additional data collected locally and published in a series of County Reports in selected counties.

POSITIVE AGEING FRAMEWORK

It is useful at the outset to identify the components and parameters of 'Positive Ageing' and to present these in a framework to provide a structured way of thinking about the issue. In relation to the HaPAI project, this conceptual framework will help to ensure that the indicators selected are relevant to the NPAS and support an evaluation of progress towards the goal of ensuring that older people in Ireland can age positively. The framework will also provide a way of organising and communicating the indicators in a meaningful way.

The framework (presented below) is structured around the three Goal areas of Participation, Health and Security. Within each goal area a number of objectives have been identified, each of which are associated with an indicator or indicators, where possible. The NPAS also identifies two cross-cutting objectives relating to ageism and information provision. This report sets out the data that is currently available on the lives of older people under each of the three pillar areas and policy action areas.

National Goals 1-3

Goal 1 Remove barriers to participation and provide more opportunities for the continued involvement of people as they age in all aspects of cultural, economic and social life in their communities according to their needs, preferences and capacities

Goal 2 Support people as they age to maintain, improve or manage their physical and mental health and wellbeing

Goal 3 Enable people to age with confidence, security and dignity in their own homes and communities for as long as possible

National Goal 4

As stated previously, the conceptual framework sets out key policy areas under the three goals which have been identified as priorities, in order to enhance opportunities for health, participation and security. The fourth goal recognises the importance of …"timely and regular access to comprehensive information about all the determinants of health, wellbeing and quality of life" in the development of policy. It commits to the use of evidence to inform policy responses to population ageing and to the development of a research framework.

The development of the Healthy and Positive Ageing Initiative will fulfil the two main objectives of this goal. Through the analysis and presentation of data on all aspects of the lives of older people, it will make evidence available to support policy and decision-making within planning for population ageing. Through the development of a Research and Data Plan, it will also develop a comprehensive framework for gathering and disseminating data on all aspects of ageing and older people.

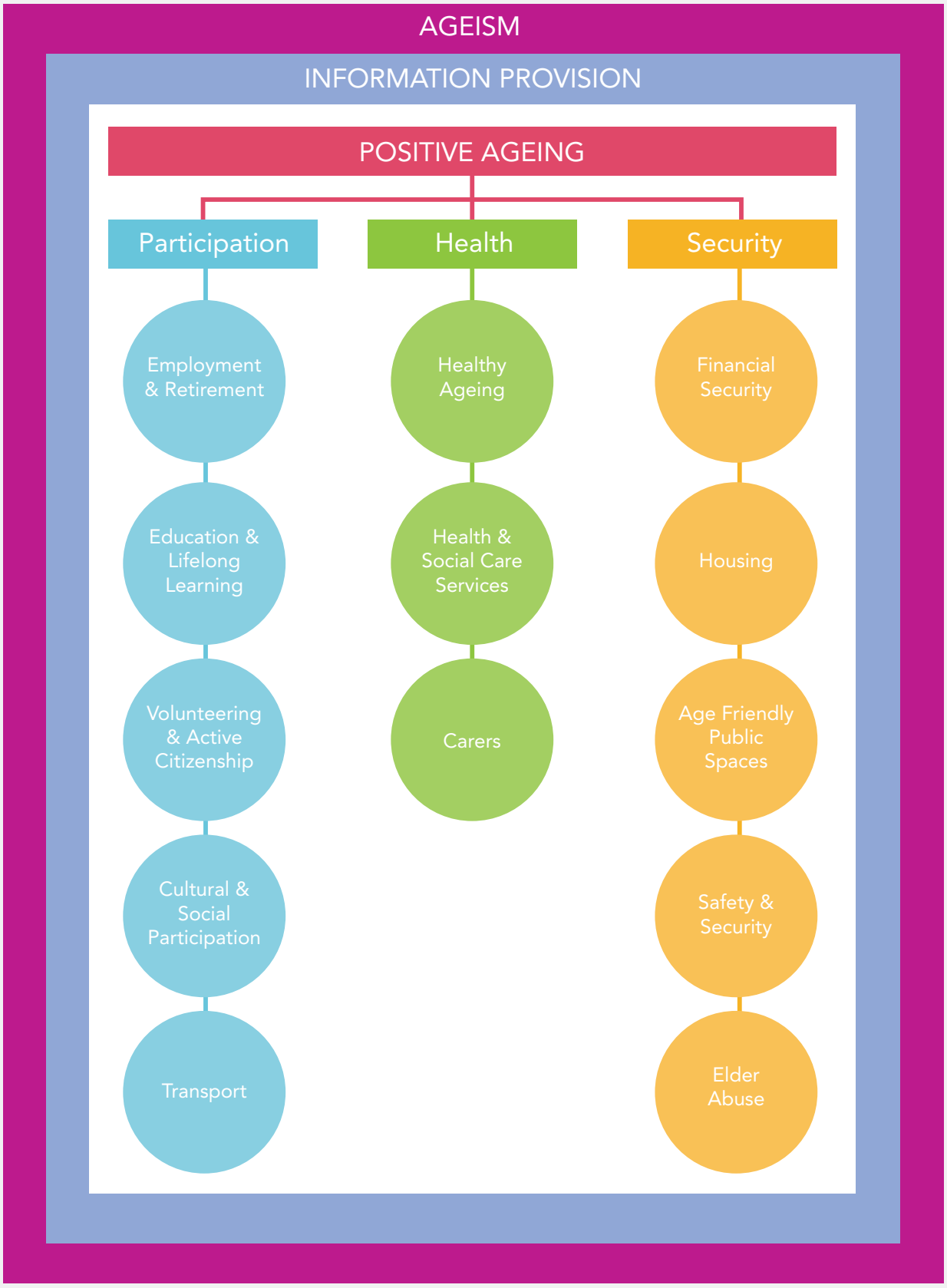
This preliminary report, using data from TILDA as well as data from national sources such as CSO and international sources such as Eurostat, is the first step in the fulfilment of these objectives. It is intended to act as a baseline against which future progress will be measured.

This document sets out the proposed process to develop a set of national indicators of Healthy and Positive Ageing. The process is being overseen by a Steering Group convened by the Services for Older People unit in the Department of Health.

Section 1 outlines the background and the rationale for this initiative and summarises the approach to be taken to develop national indicators of Healthy and Positive Ageing. It also sets out the conceptual framework, based on the goals and objectives of the NPAS.

Section 2 presents the data currently available from a range of existing sources identifying what we know about the lives of older people. This preliminary report is intended to inform a wider consultation process with older people and other stakeholders in the area of ageing, to identify the set of indicators that will be used to monitor the implementation of the NPAS.

POSITIVE AGEING FRAMEWORK



NEXT STEPS

To inform the 'next steps', an international review of different approaches to the development of indicator sets was carried out. This section will outline the actions to be taken in the next phase of this process, based on the findings of the international review.

The OECD has suggested that the following steps are essential to the development of a reliable and sustainable set of indicators:

1. Define the issue: the choice of indicator needs to be located within a framework identifying the scope of what is being measured. A good framework should identify the dimensions of progress that one is seeking to measure and describe the ways in which they relate to one another.
2. Identify partners and establish a core group of stakeholders: an organisation seeking to measure progress should engage a wide range of stakeholders.
3. Produce an initial set of indicators: the process to define the key dimensions of what is being measured (health, material wellbeing, etc.), and to select the most relevant indicators takes time. The OECD report suggests that the legitimacy of the final result will depend on the extent to which key stakeholders have been involved in the process.
4. Dissemination: getting the information 'out there' using a variety of different approaches. While dissemination is a key step for indicator producers, it is also important to build knowledge around the issue. Knowledge comes about when information has been absorbed by users, allowing them to understand and relate the information to an appropriate context.
5. Ensuring continuity and relevance: Indicators of progress, when published regularly over time, allow people to judge what is being done well and where action is needed to change course. To have any kind of meaningful impact, the exercise must be repeated regularly over time with possible adjustments to the indicators and the communications approach over time.

In keeping with international best practice, the development of indicators for the Positive Ageing Strategy will seek to follow this advice by

1. ***Defining the issue:*** This report sets out the key areas that impact Positive Ageing.

2. ***Identifying the potential data sources and indicators:*** A Steering group made up of experts in the area of Irish data sources, statistics and older people has been established and will review the data from both international and national sources.

3. ***Publication of an initial report:*** This report sets out the existing data within the framework identified. The indicators presented in this report are based on internationally agreed definitions for which data are available, collected regularly and reported internationally.

4. ***Developing a consensus process:*** With the publication of this report the HaPAI project enters its second phase which will involve a detailed process aimed at developing consensus around the indicators that most accurately suit the goals and objectives of the National Positive Ageing Strategy. The process for developing consensus is likely to follow the approach adopted by the Department of Children and Youth Affairs (DCYA) in the development of the first set of Child Health and Wellbeing indicators using the Delphi technique.

Consensus development

The Delphi 'technique' is a research approach used to develop consensus among participants in a panel of experts through a series of rounds of questionnaire surveys, usually two or three, where information and results are fed back to panel members between each round. Five phases of the process have been identified in literature (Vázquez–Ramos, Leahy, and Estrada Hernández 2007):

1. Expert panel selection;
2. Exploration;
3. Evaluation;
4. Re-evaluation; and
5. Final consensus.

In the Department of Children and Youth Affairs the Delphi process was used to structure thinking around key areas of child wellbeing so that consensus could be achieved around a national set of child wellbeing indicators. Before deciding on this approach, the Department of Children and Youth Affairs considered other group approaches to reaching consensus. These included, for example, nominal groups (Carney et al., 1996), brain-storming (Hasson et al., 2000), focus groups (Morgan, 1997), analytic hierarchy process (AHP) technique (Lai et al., 2002) as well as the establishment of working groups.

Following a thorough examination of these different approaches the DCYA decided that these approaches were less appropriate to the development of a set of national child wellbeing indicators due to their potential for taking account only of the perceptions of the most outspoken or opinionated members of that group, or of only focusing on interesting or controversial elements (Fein et al., 1997).

Delphi panel members do not meet face to face, but rather through controlled feedback where they are encouraged to express and react to ideas free of pressure or rebuke from other panellists of higher standing within an expert community (Hakim & Weinblatt, 1993; Rowe & Wright, 1999; Hasson et al., 2000).The key features of this approach are therefore anonymity, iteration with controlled feedback, statistical group response and expert input.

The Healthy and Positive Ageing Initiative, with the publication of this report, has now completed the first three steps in the process and is now commencing step 4 - consensus-building. Stakeholders will be invited to participate in this Delphi process during 2015 and to contribute to decisions on the most appropriate indicators to measure progress towards achieving the vision set out in the National Positive Ageing Strategy.

Preparation of this report has allowed the Initiative identify areas in which good quality, timely and reliable data are available. However, the process has also identified areas in which data are not available or has not been updated in several years. Plans for the filling of those gaps will be outlined in the Research and Data plan which will be completed by mid 2015.

CHAPTER 2

Demographic Trends

This section presents data on the changing age structure of Ireland's population.

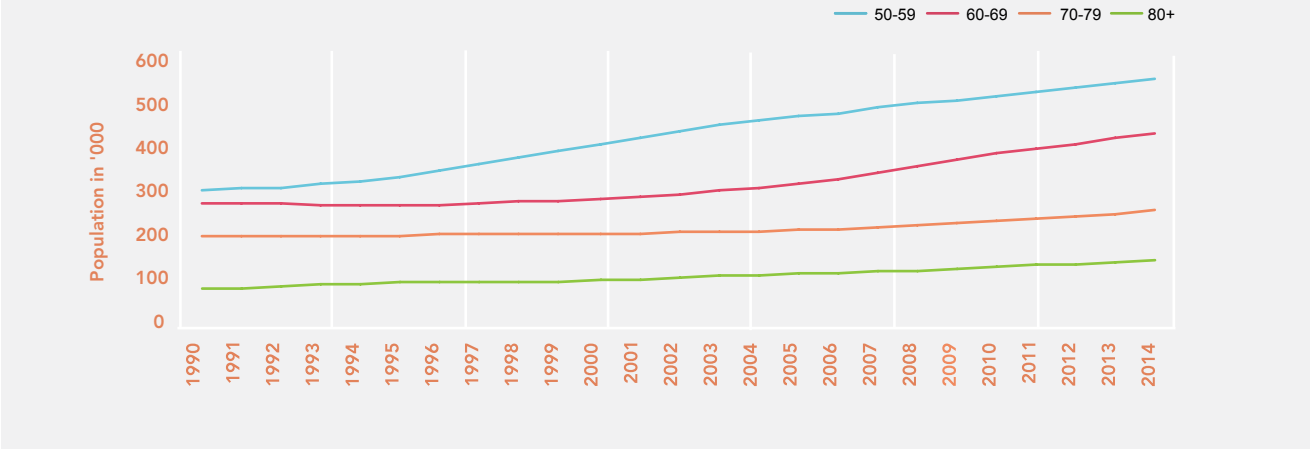
DEMOGRAPHIC TRENDS

The growth of the population aged 65 and over, affects many aspects of future planning for society by healthcare providers, policymakers and others. In order to plan for and meet the needs of a larger older population it is important to have an accurate picture of recent trends and future predictions. This section sets out demographic information on the current population as well as predictions of population ageing developed by the Central Statistics Office.

Ireland's current demographic profile is very different from that of the EU 27. This is explained by a number of factors such as a higher birth rate than other EU countries during the 70s; an increase in immigration the late 1990s and early 2000s, mainly from younger age groups; and high levels of emigration from the 1930s to the 1950s – a period during which up to half of the working age group emigrated, many of whom never returned (CSO, 2007).

Historically, Ireland's population has grown steadily since 1960 with an average growth rate of 1.35% per year between 1991 and 2006 and a high average annual increase of 1.6% between 2006 and 2011. Since 1990, the population aged 65 and over has grown by 46.7% (CSO, 2013).

Figure 1: Total population of Ireland aged 50 and over, by age group, 1990-2014

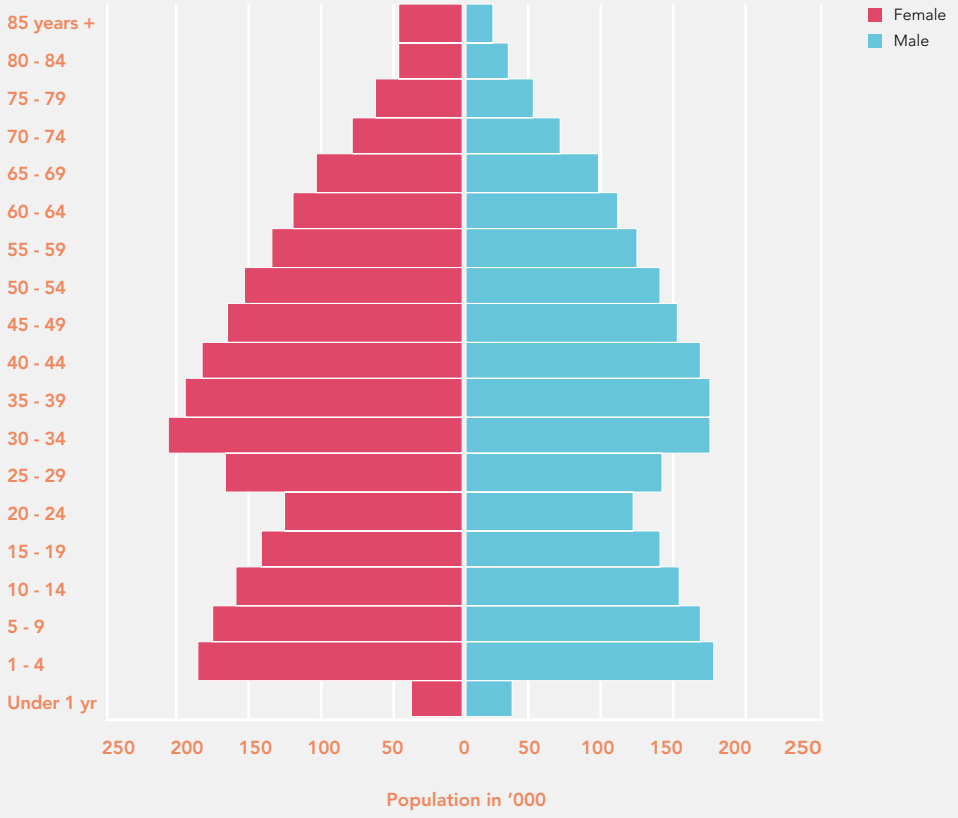


Source: CSO (2014). Figures for inter-censal years are estimated

The 2011 Census found there was a total of 535,393 people aged 65 and over in Ireland, representing 11.7% of the population (CSO, 2012). This proportion is lower than the EU average of 18.2% (Eurostat 2013).

There is great variation within Ireland, however. Only 3.3% of the Traveller Community, 9.5% of UK nationals, 1.1% of 'other' EU nationals and 1.8% of 'other non-Irish nationals' are aged 65 and over (Census, 2006).

Figure 2: Population estimates in thousands by age group and gender (2014)



Source: CSO

Table 1. Percentage of the total population in the older age groups with EU comparisons (2006, 2011, and 2014)

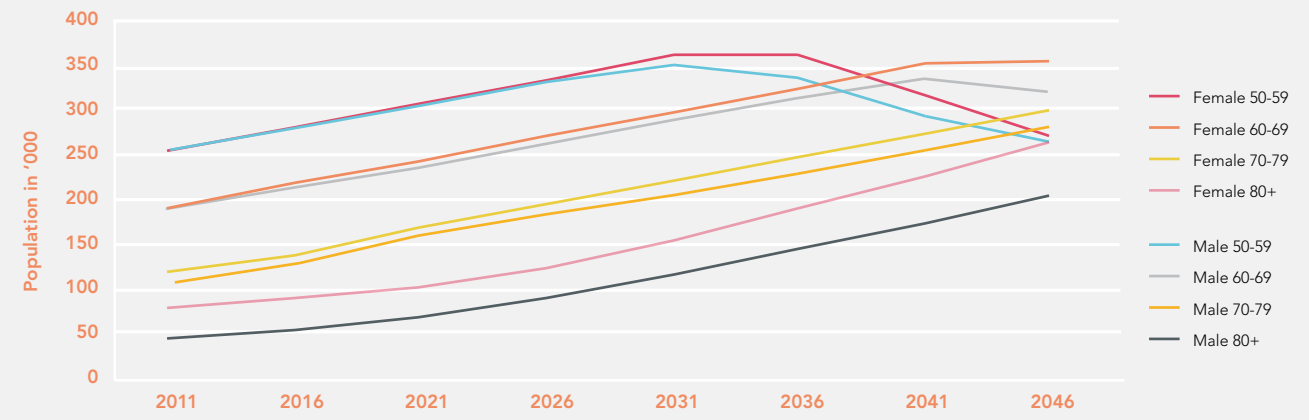
	2006		2011		2014	
	Ireland (%)	EU27 (%)	Ireland (%)	EU27 (%)	Ireland (%)	EU27 (%)
55 to 59	5.3	6.4	5.3	6.4	5.5	6.6
60 to 64	4.2	5.1	4.7	6.0	4.9	6.1
65 to 69	3.4	4.9	3.7	4.7	4.2	5.3
70 to 74	2.8	4.2	2.8	4.4	3.1	4.4
75 to 70	2.2	3.5	2.2	3.6	2.3	3.7
80 and older	2.6	4.1	2.8	4.8	3.0	5.1

Source: Eurostat

FUTURE PREDICTIONS

By 2041, there will be 1.4 million people in the Republic of Ireland aged 65 and over, three times more than the older population now. This older group will make up 22% of the total population, compared to 11.6% in 2011. The total population aged 70 and over is set to treble from approximately 359,000 to over 1 million (1,064,694) by 2046. (CSO, 2013)

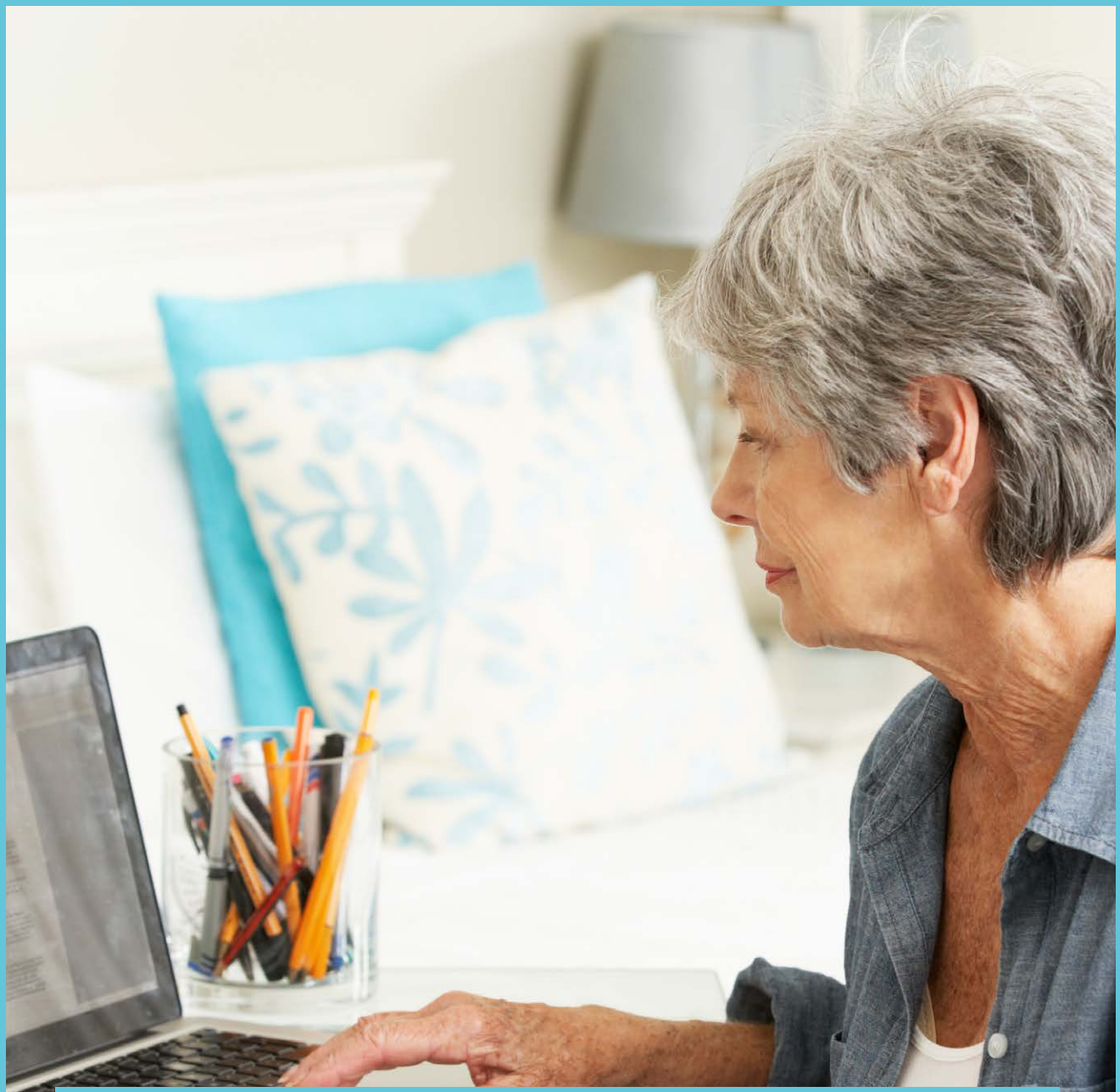
Figure 3: Population Projections ('000s) 2012, 2026 and 2046 by gender and by older age group



Source: CSO (2013). Projections are based on the M2F2[4] projections which assume moderate migration based on recent patterns, and declining fertility.

The old-age dependency ratio indicates the total population aged 65+ as a percentage of the population aged 15-64 (the working age population). In 2002, this was 16.4%. By 2011 it had risen to 19.5%, and it is projected to rise to 30.0% by 2031 (CSO, 2013).

[4] CSO makes population predictions based on assumptions on migration and fertility. Their three migration and two fertility assumptions gives six different scenarios: M1F1- high migration, high fertility, M1F2 – high migration, low fertility, M2F2 – moderate migration, high fertility, M2F1 – moderate migration, low fertility, M0F1 – zero net migration, high fertility and M0F2 - zero net migration, low fertility.



PARTICIPATION

Remove barriers to participation and provide more opportunities for the continued involvement of people as they age in all aspects of cultural, economic and social life in their communities according to their needs, preferences and capacities.

Under this goal, the National Positive Ageing Strategy has identified the following objectives:

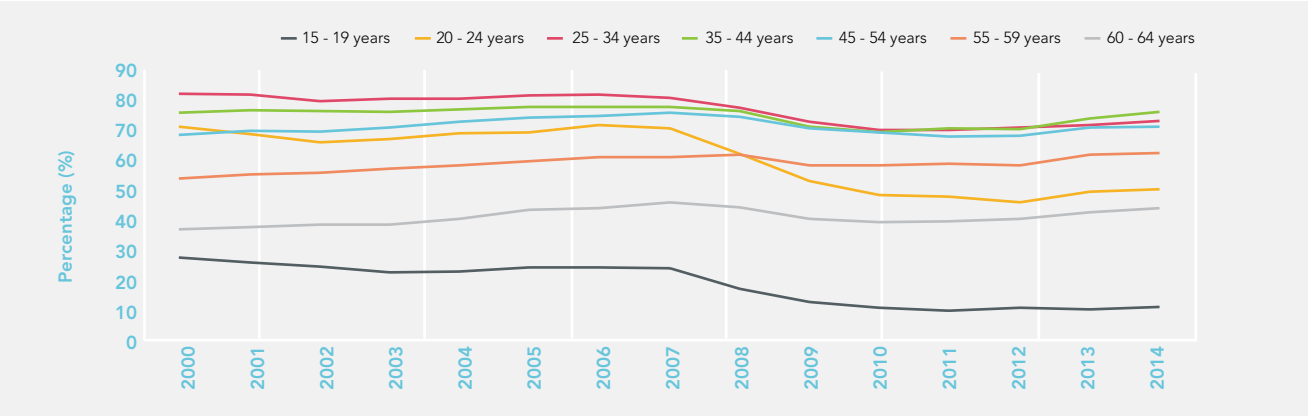
- Increase employment options;
- Identify and tackle barriers (legislative, attitudinal, custom and practice) to continued employment and training;
- Promote access to continued learning and education;
- Promote active citizenship and volunteering;
- Increase opportunities for participation in arts, cultural, spiritual, leisure, learning and physical activities;
- Enable people as they age 'to get out and about' through the provision of accessible, affordable and flexible transport systems in both rural and urban areas.

EMPLOYMENT AND RETIREMENT

Working in later life has a significant influence on income levels and can be an indicator of better health and wellbeing (Clark et al 2007). For some, particularly those on lower incomes, remaining in the workplace may be an economic necessity while for others it is an important way of remaining engaged and maintaining social contacts. While many retire by choice, forced retirement can have an impact on levels of physical and emotional health and lower life satisfaction (Van Solinge & Henkens 2005; Van Solinge, 2007).

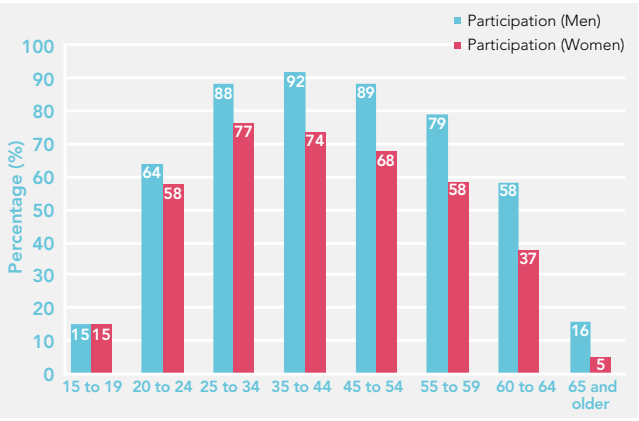
- The proportion of people in the labour force aged 55-64 increased gradually from 2000 to 2008 when all age groups experienced a fall in employment. Levels remained stable between 2010 and 2012 after which they began to rise again gradually. The level of employment of those aged 55-59 has risen steadily to return to the 2008 level in that age group.
- Among those aged 50 to 64, a greater proportion of men (61.6%) were employed compared with 49.31% of women (TILDA, 2012).

Figure 4: Employment rates (%) for adults aged 15 to 64 (Quarter 4, 2000-2014)



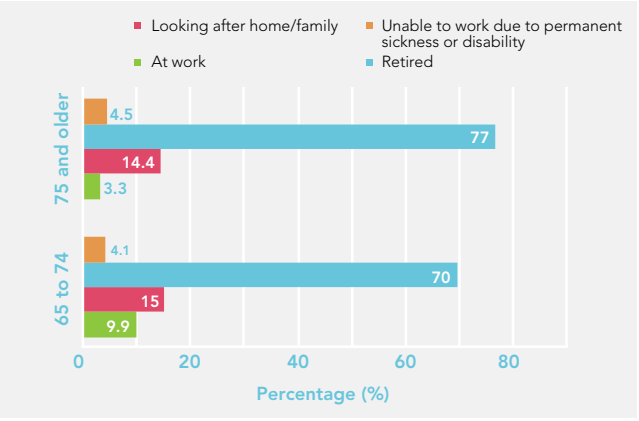
Source: CSO (2014)

Figure 5: Percentage of people in the labour force by age group



Source: QHNS (2014)

Figure 6: Principle economic status (65 and older)



Source: CSO (2011)

- A total of 9.9% of people aged 65 to 74 and 3.3% of people aged 75 and older are classified as 'at work' (CSO, 2011).
- A small proportion of people aged 65 and older were classified as unemployed (0.7%), student (0.1%) or other (including not stated) (0.9%) (CSO, 2011).

Data from TILDA (2013) showed:

- Of the 11.8% of people aged 66 and older who do paid work, 2.8% are employed as their principal economic status, 5.9% are self-employed (including farming) and 3.2% are not employed but nevertheless do some work.
- Among those aged 65 to 74, 80.75% of men and 57.12% of women are classified as retired. The lower figure for women is in recognition of the fact that many women who have not been active in the labour force do not see themselves as 'retired'.
- A greater proportion of women are classified as 'looking after home/family': 28.47% aged 65-74 and 33.61% aged 75 and older compared with 0.51% of men aged 65 and older.

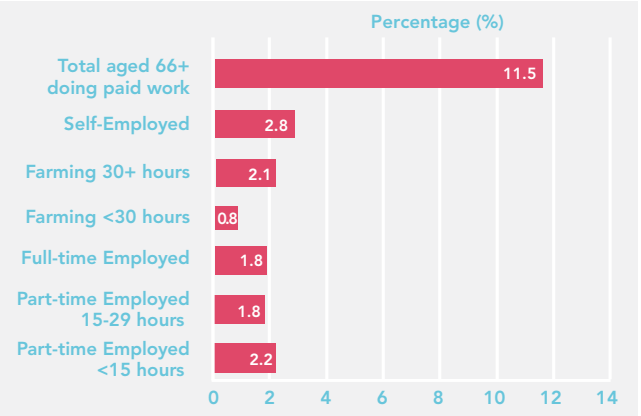
Quarterly National Household Survey (QNHS) Quarter 2, 2012

- A total of 89% of people aged 50 to 65 and 62% of people aged 66 to 69 who are currently not working (and are in receipt of a pension) retired early.
- Among people aged 50 to 69 who are not currently working (and are in receipt of a pension), a higher proportion of persons with upper secondary (81%) and third level (85%) education retired early, compared with 63% of those with primary education or below.

Gradual Retirement

Many people wish to phase in their retirement (Fahey & Russell, 2000) so the proportion of older people working on a part-time basis can be an indicator of how flexible the workplace is and whether there are additional options available

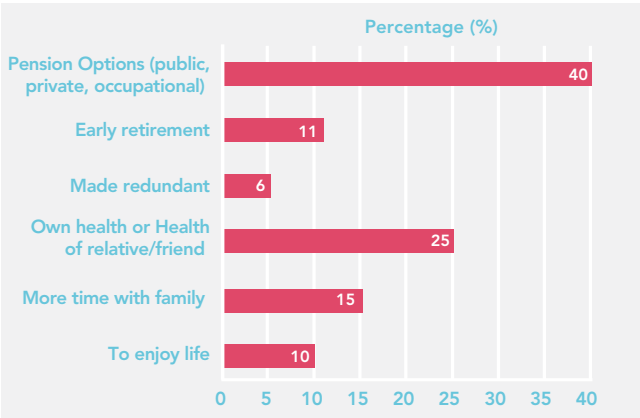
Figure 7: Percentage of people aged 66 and older who do paid work, by the hours worked and employment type



Source: TILDA (2013)

- One third of men (33%) and just over one quarter of women (28%) would have preferred to remain in work at the time of their retirement (QNHS, Quarter 2, 2012).

Figure 8: Main reason for early retirement among people aged 50 and older



Source: SHARE (2008)

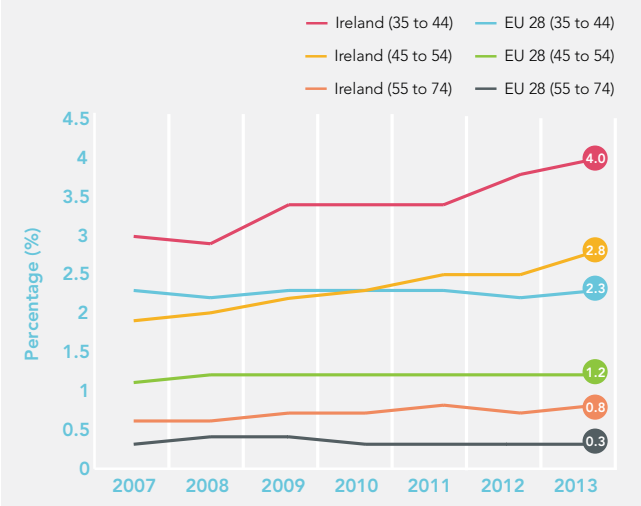
Data from the QNHS (2012) showed the following differences in early retirement:

- A higher proportion of people aged 50 to 69 with primary education or lower only (42%) would have preferred to remain at work, at the time of their retirement, compared with 35% of those with lower secondary education and 27% of those with upper secondary education.
- A larger proportion of women (31%) compared with men (20%) did not stay in work longer due to family and health reasons combined (family, care-related reasons or their own health or disability).
- 20% of men compared with 15% of women did not stay longer due to 'favourable financial arrangements' (excluding pension eligibility).
- Among persons aged 50 to 69 who retired early, a higher proportion of those with upper secondary (26%) and tertiary education (23%) retired due to favourable financial arrangements compared with 12% of those with lower secondary (12%) and primary education or lower (10%).
- A higher proportion of persons with primary education or lower (30%) retired early due to family or health reasons (family, care-related reasons or their own health or disability) compared with 18% of those with upper secondary education and 16% of those with tertiary education.
- More recent data available from TILDA (2011) indicates that the percentage of adults taking early retirement because they were made redundant or could not find another job increased to 10.1%. The percentage offered an early retirement option increased to 16.8%. This may reflect the changing labour market between 2008 and 2011 as a result of the economic crisis.

EDUCATION AND LIFELONG LEARNING

Continued mental stimulation in later life has been found to have strong links with the maintenance of good physical health (Wilson et al 2002). Participating in learning also provides many intrinsic rewards for older people. In addition to increasing knowledge, successful completion of an educational course can enhance quality of life, increase motivation and coping skills, maintain independence and increase social connections (Simone & Scuilli, 2006).

Figure 9: Participation rate in formal education and training in Ireland and EU 28



Source: Eurostat

- Although higher than the EU 28 average, participation in formal education and training in Ireland by persons aged 55 to 74 is low, at 0.8% compared with 1.2% (45 to 54 years) and 4% (35 to 44 years).
- A total of 34% of people aged 60 and older completed their full-time education before age 16 (CSO, 2011).

Figure 10: Percentage of men and women aged 50 and older enrolled over a calendar year in formal tertiary education

Source: TILDA (2013)

Note: Formal tertiary education includes enrolment in a third level institution or in a course leading to a formal qualification.

Literacy

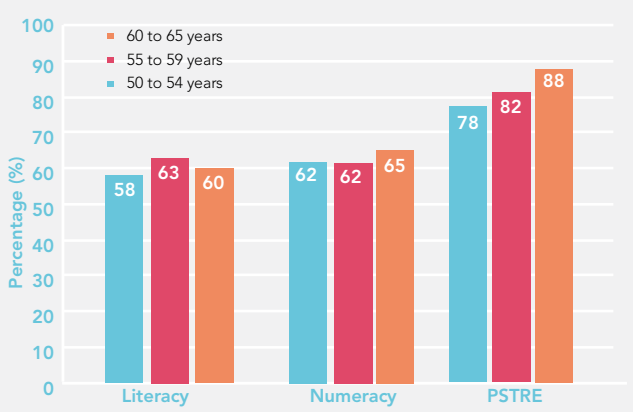
Literacy levels and level of completed education can impact on the ability of older people to be informed and to fully engage with society. Research carried out by National Adult Literacy Agency (NALA) (2009) found that literacy difficulties impacted across all areas of life: the home, the workplace and social life. Many older learners were reluctant to engage in community activities, or to associate with nearby neighbours.

The Programme for the International Assessment of Adult Competencies (PIAAC) provides information on adults' proficiency in literacy, numeracy and problem-solving in technology rich environments (ICT skills):

- Literacy – the ability to understand and respond appropriately to written texts
- Numeracy – the ability to use numerical and mathematical concepts
- Problem solving in technology rich environments (PSTRE) – the capacity to access, interpret and analyse information found, transformed and communicated in digital environments

Scores at or below level 1 are considered to indicate "low proficiency".

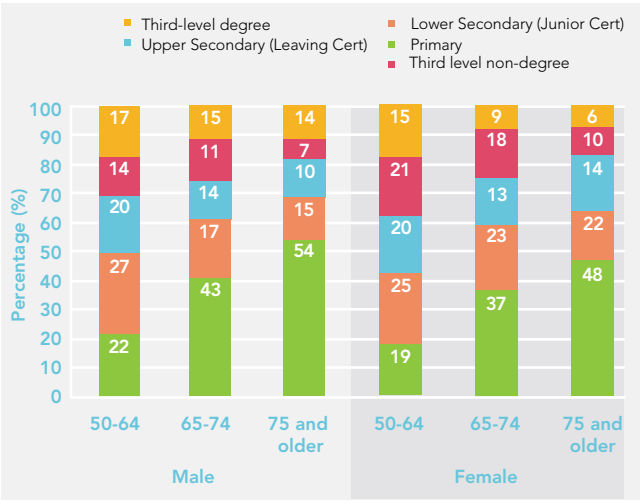
Figure 11: Percentage of adults aged 50 to 65 with "low proficiency" in literacy, numeracy and ICT skills



Source: OECD (2012)

Among people aged 50 to 65 in Ireland, 60% have low literacy (OECD average 57%), 63% have low numeracy (OECD average 55%) and 83% have low PSTRE (OECD average 76%).

Figure 12: Highest level of completed education, by age group and gender



Source: TILDA (2011)

Note: The primary school category includes a small number of participants who did not complete primary school (3.4% of total).

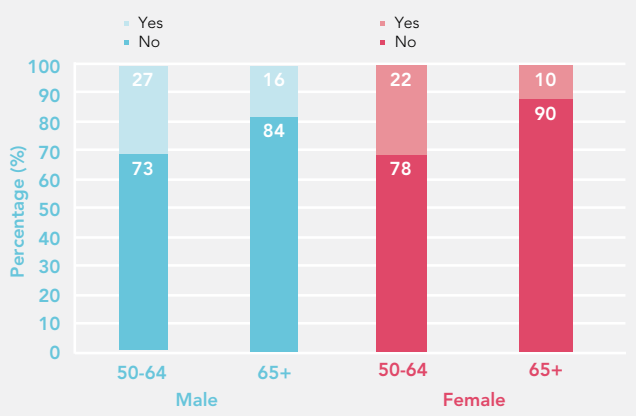
- Among the TILDA sample, 50.8% of adults aged 75 and over had completed only primary school education or less, compared with 40% of those aged 65-74, and 20.4% of those aged 50-64.
- Similarly, only 18.1% of adults aged 75 and over had completed some third level education, compared with 26.3% of those aged 65-74, and 34.2% of adults aged 50-64.

ACTIVE CITIZENSHIP AND VOLUNTEERING

The Taskforce on Active Citizenship (2007) states in its report that being an Active Citizen means "being aware of, and caring about, the welfare of fellow citizens, recognising that we live as members of communities and therefore depend on others in our daily lives" (p.2). In practice, this covers involvement in different types of voluntary and community activities, respect for difference and having a role in decisions on issues that affect themselves and others, in particular by participating in the democratic process.

Among people aged 55 and older, the main reasons given for not voting in the 2011 General Election were "Difficulty in getting to the polling station" (27%); "Not interested/ Disillusioned with politics" (24%) and "Away from home on polling day" (23%) (Quarterly National Household Survey, Voter Participation, Quarter 2, 2011).

Figure 13: Percentage of people aged 50 and older who engaged in political activities in the past 12 months



Source: EQLS (2011)

Activities include: attended a meeting of a trade union, political party or political action; attended a protest or demonstration; signed a petition including Email or online petitions; or contacted a political or public official.

Table 2: Percentage of persons aged 55 and older who voted in the 2011 general election

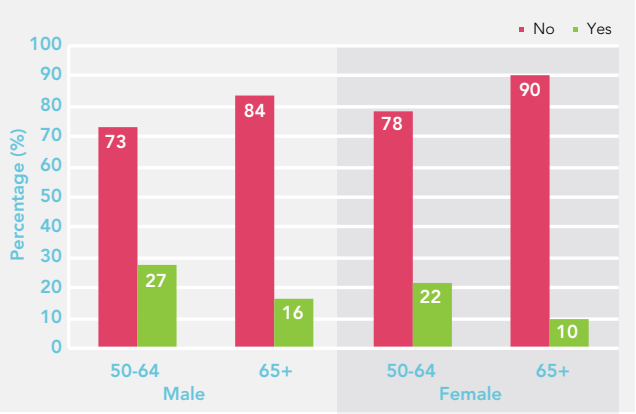
	Voted in the general election (%)		Unweighted sample (number of persons aged 18 years and over eligible to vote in 2011)
	Yes	No	
55-64 years	92	8	1,455
65 years and older	88	12	1,960
All persons (18 years and older)	82	18	8,810

Source: QNHS, Voter Participation, Quarter 2 (2011)

Volunteering

Volunteering activity can have important psychological and other health benefits for the volunteers themselves. Research has found positive effects on the wellbeing, quality of life, health and longevity of older people as a result of their volunteer activity (Onyx & Warburton, 2003; Warburton, 2006).

Figure 14: Participation in or unpaid voluntary work for civic, charitable or political organisation (in the past 12 months)



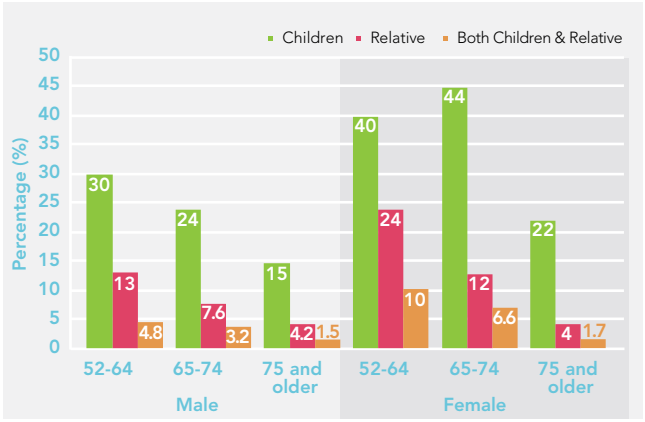
Source: EQLS (2011)

Note: This includes participation in any of the following: the social activities of a club, society or an association; community and social services; education, cultural, sports or professional associations; social movements or charities; political parties or trade unions.

Participation in Family life

In addition to formal volunteering, many older people make substantial unpaid contributions within the family in both caring for grandchildren and providing long term care to their spouse. Just under half (45%) of all women aged 65-74 provide care to children or grandchildren while 35% of those aged 52-64 provide such care.

Figure 15: Percentage of men and women aged 52 and older who (1) provide care to children and/or grandchildren and (2) who provide care to an older relative and/or disabled relative (at least once a week)



Source: TILDA (2013)

- Among participants aged 52-64, 10.4% of women and 4.8% of men reported caring for both children and an older or disabled relative.

Financial Transfers

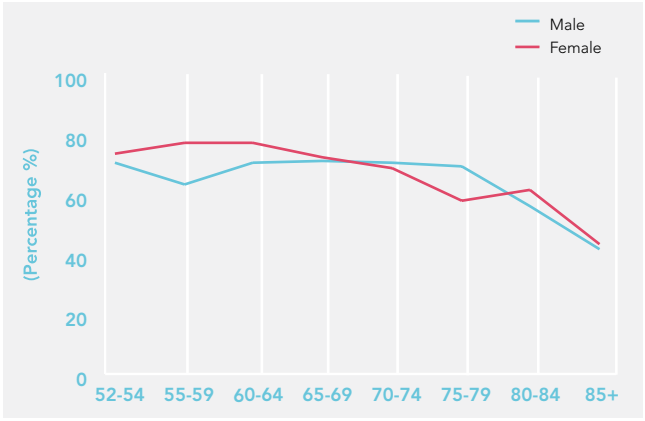
Not all older people are in need of financial support from the State and many have accumulated wealth or assets throughout their lives through their contribution to their own pensions, their investments or their mortgage which they pass on to the next generation on their death. Many also contribute financially during their lifetimes to their families through transfers of money or other assets.

Data from TILDA (2013) showed that just under a quarter (23.0%) gave financial help worth €5,000 or more in the previous two years. This assistance could include help paying bills, or covering costs such as education, healthcare or rent. A similar proportion (24.9%) reported a transfer of assets (such as a property or business) or other financial help worth at least 5,000 in the previous ten years.

SOCIAL AND CULTURAL PARTICIPATION

Engagement in the arts, culture and sports at any age pays dividends for both mental wellbeing and physical health (Cohen 2009). The benefits of engagement in these activities can include a sense of wellbeing, friendship, development of creativity, increased social interaction, and increased physical and cognitive health benefits (Greaves & Farbus, 2006).

Figure16: Percentage of men and women aged 52+ engaging in active social activities, by age group and gender

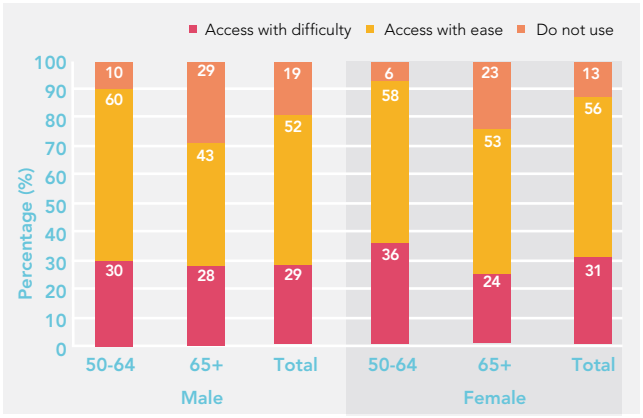


Source: TILDA (2013)

Note: Active social leisure includes 'goes out to films, plays or concerts'; 'attends classes and lectures'; 'plays cards, bingo or games in general'; 'eat out of the house'; 'participates in sports or exercise' and 'does voluntary work'.

- Almost all (99.4%) adults aged 52+ engage in solitary or passive activities at least once a week. These activities include watching television; working in the home, car or garden; reading books or magazines for pleasure; listening to music or radio; spending time on hobbies or creative activities.
- Two thirds of women (66.4%) and 61.31% of men aged 50 and older report attending religious services (apart from weddings, funerals or christenings), daily or at least once a week; this proportion is highest among women aged 65 and older (80%) (EQLS, 2011).

Figure 17: Percentage who experience difficulty with accessing a cinema, theatre or cultural centre (in your area)

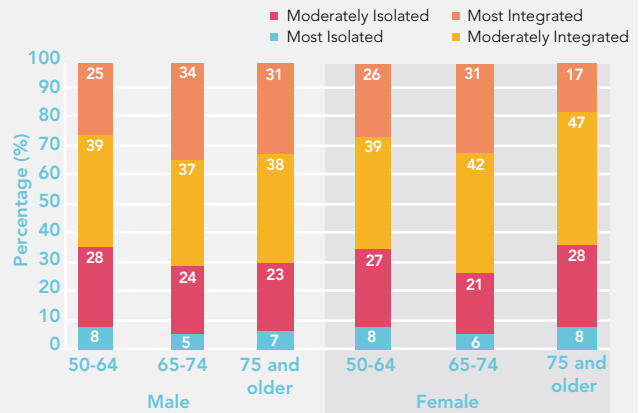


Source: EQLS (2011) (Question: "How would you describe your access to….")

At all ages from 50 years and older, a minimum of 95.5% of men and women have at least two close friends or relatives (TILDA, 2011).

In TILDA a modified version of the UCLA Loneliness Scale was used (5 items), with a scale of 0 to 10: not lonely to extremely lonely. Average levels of loneliness are higher for women than men and increase between age 50 and 85. Mean scores for women ranged from 2.2 (aged 50 to 54) to 2.4 (aged 80 and older). Mean scores ranged from 1.9 for men aged 50 to 54 to 2.0 for men aged 85 and older.

Figure 18: Social connectedness (Berkman-Syme Social Network Index), by age and gender



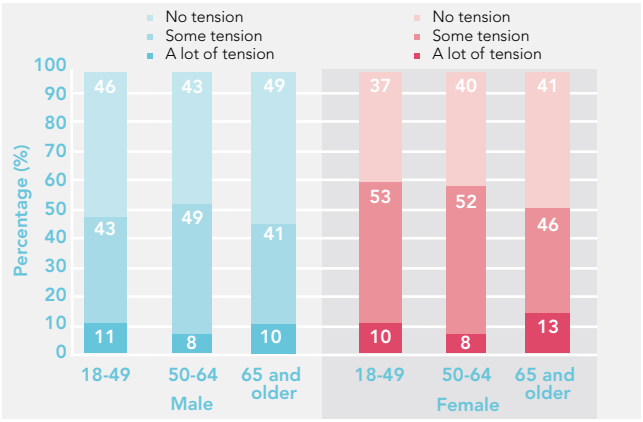
Source: TILDA (2013)

- This measure of social connectedness (or isolation) includes ties with a spouse or partner, contact with close friends and relatives and membership in social and community groups.
- While the proportion of people who can be described as 'most isolated' is low, more than one third of people aged 75 and older are described as either 'most' or 'moderately' isolated (30.2% of men and 36.5% of women).

Intergenerational Contact

As the proportion of older people in society grows over the coming decades, development of positive attitudes and mutual understanding between young and old will become increasingly important. A number of factors have the potential to increase social distance and tension between generations. There is a growing tendency for the generations to associate with and value their contemporaries to the exclusion of other age groups (Kupetz 1993). An increased emphasis on self-sufficiency also contributes to intergenerational 'distance' and as families become more geographically dispersed, intergenerational contact within the family has reduced. (Chudnovskaya & Kolk, 2014; Wellard, 2012).

Figure 19: Perceived tension between older and younger people in society



Source: EQLS (2011)

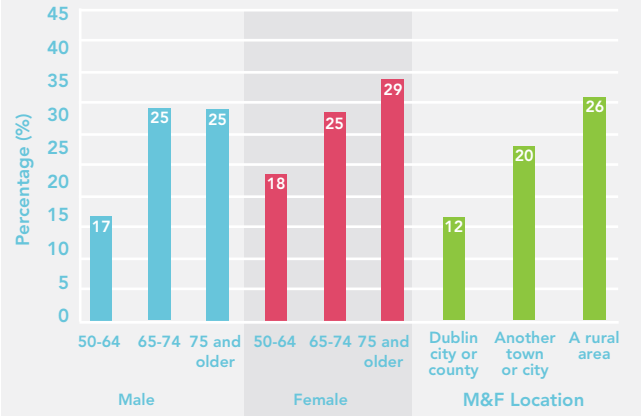
A high proportion of people aged 65 and older feel close to the people in the area they live in (90.91% of men and 88.89% of women) (EQLS, 2011).

Neighbourhood capital is a composite indicator of seven items when older people are asked how they feel about their local area). Sample items include:

- I really feel part of this area/I feel that I don't belong in this area;
- I often feel lonely living in this area/ I have never felt lonely living in this area;
- Most people in this area can be trusted/Most people in this area can't be trusted.

The graph below shows that greater numbers of older females (aged 75 and over) are in the highest quartile of the neighbourhood social capital index and feel more positively about their local area. It also shows that those living in rural areas have more positive views about their neighbourhood than those living in Dublin or another urban area.

Figure 20: Percentage of people aged 50 and older in the highest quartile of the neighbourhood social capital index

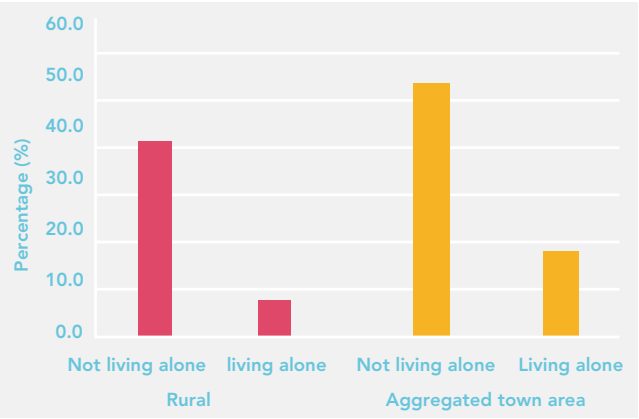


Source: TILDA (2013)

TRANSPORT

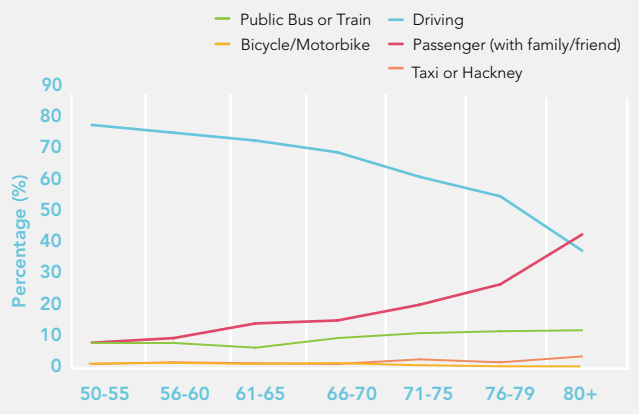
Transport is closely linked to independence, autonomy, and quality of life. For older people who can no longer drive, particularly those living far from public transport routes, lack of access to public or other forms of transport can influence their ability to participate in social activities and to feel secure and independent (Liddle & McKenna, 2003). It can also have an impact on the overall health and wellbeing of older people. Driving in particular has been associated with higher levels of life satisfaction, higher adjustment, less loneliness and better perceived control (Liddle et al 2004).

Figure 21: Housing units (aged 65 and older living alone) with no motor car



Source: CSO (2011)

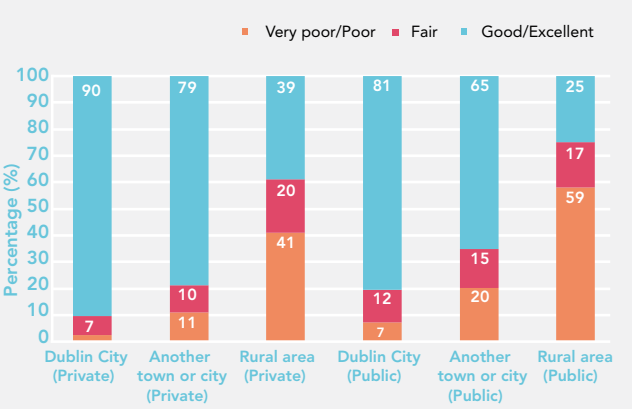
Figure 22: Main mode of transport for people aged 50 and older



Source: TILDA (2011)

- A consistently high proportion of older people in Ireland continue to drive, although this proportion reduces by half between people aged 50 to 55 and people aged 80 and older.
- The proportion of older people who travelled by a car, driven by a family member or friend increases across all age groups, and is the main form of transport for people aged 80 and older.
- A small proportion of people aged 50 plus reported that not driving or reduced driving had an impact "most or all of the time" on the following aspects of their lives:
  - Socialising with others (e.g. visiting family and friends) (4.3%)
  - Ability to go about your business (such as doing the shopping, going to the post-office, visiting the bank, attending the church etc.) (3.1%)
  - Ability to attend health and social care appointments (such as out-patient clinics at the hospital) (2.3%)
- Older people living in Dublin and other urban areas expressed a high level of satisfaction with both private and public transport. However the majority of those living in rural areas stated that public transport was 'poor or very poor'.

Figure 23: Rating of public and private transport services by area type (50 and older)



Source: TILDA (2011)

HEALTH

Support people as they age to maintain, improve or manage their physical and mental health and wellbeing

Under this goal, the National Positive Ageing Strategy has identified the following objectives:

- Prevent and reduce disability, chronic disease and premature mortality caused by lifestyle factors;
- Deliver a continuum of high quality care responsive services and supports;
- Implement the National Carers' Strategy (2012).

HEALTHY AGEING

Health is a key determinant of quality of life and wellbeing for older people, impacting significantly the extent to which they can enjoy life and participate in the economic, social and cultural life of their community. Many chronic conditions can be prevented, deferred or mitigated through good health promotion, screening and preventative measures. A number of behavioural factors can play a significant role in promoting healthy ageing: non-smoking, being physically active, maintaining weight within moderate ranges and using alcohol in moderation.

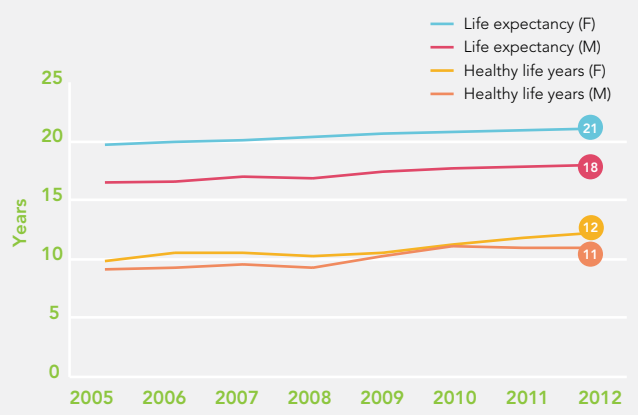
Life Expectancy

Life expectancy is perhaps the most important measure of health.

In Ireland, life expectancy for both men and women has been increasing steadily since 1926 when it stood at 57.4 years for men and 57.9 for women. By 2010 this had increased to 77.9 years for men, a gain of 20.5 years over the eighty-four year period. Women have seen a larger increase from 57.9 to 82.7 - a gain of 24.8 years by 2010. The gap between male and female life expectancy was only 0.5 years back in 1926. By 2010 that gap had grown to 4.7 years (CSO 2013).

In contrast to life expectancy, healthy life years measure the number of years that a person is expected to live free from disability, defined as having at least one activity limitation. This provides an indication of the quality of remaining life years in addition to the quantity.

Figure 24: Life expectancy and healthy life years at age 65 by gender



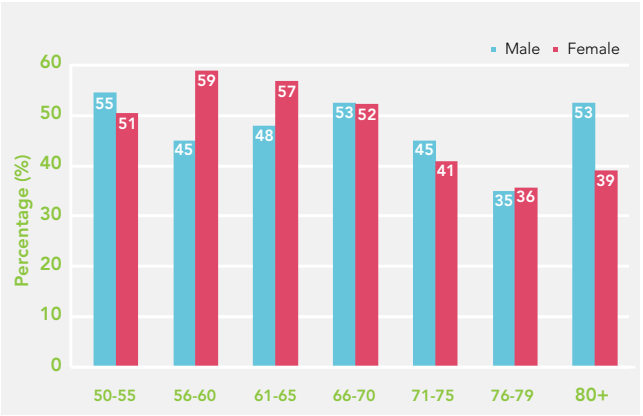
Source: Eurostat. Note: F: female, M: male.

- Both life expectancy and healthy life years at age 65 increased steadily increasing between 2005 and 2012.
- Life expectancy at age 65 is consistently higher for women, however a smaller difference in healthy life years is observed.
- Compared with the EU 27 average in 2012, women and men in Ireland had a similar life expectancy at age 65 to their European counterparts (Eurostat).
- Eurostat data for 2010 shows that men in Ireland had an expected additional 2.4 healthy life years above the EU 27 average of 8.7 years. Women had an expected additional 2.3 healthy life years compared with the EU 27 average of 8.9 years.

Self-rated health

Self-rated health has been identified as a key predictor of both mortality and health service utilisation (Desalvo et al., 2005).

Figure 25: Percentage of men and women aged 50 and older with good health



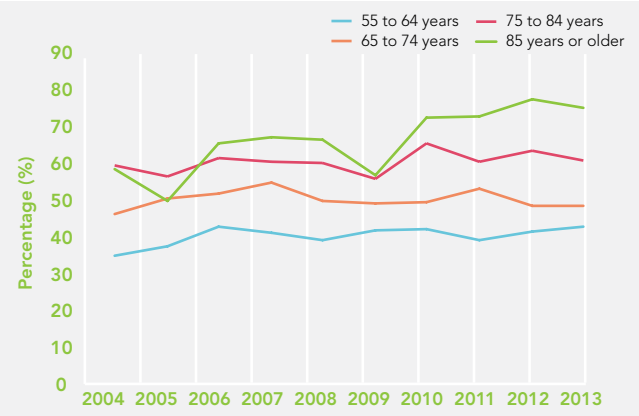
Source: EQLS (2011) Note: "Very good or good" health is compared with "Fair, Bad or Very Bad Health"

- The proportion of women who reported being in good health declines from 59% of those aged 56-60 to 39.2% for women aged 80 and older.
- The proportion of men who report being in good health is lower than women up to age 65. A larger percentage of men, compared with women, in their 70s and 80s reported being in good health.

General health limitations

In 2013, over half of men (52.4 %) and women (55.5%) aged 65 and older had a longstanding illness or health problem (EU-SILC, 2013).

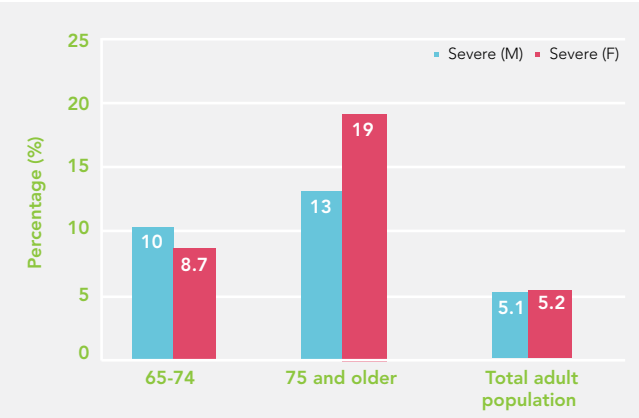
Figure 26: Percentage of persons aged 55 and older with a longstanding illness or health problem (2004 to 2013)



Source: SILC (2004-2013)

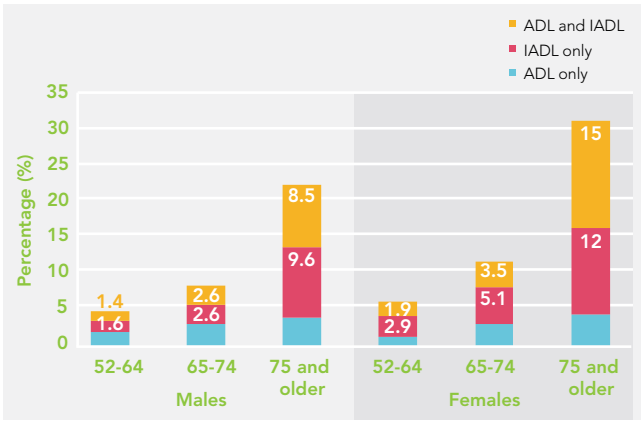
As shown in Figure 26 above, the percentage of people aged 85 and older with a longstanding illness or health problem has increased the most, from 57.5% in 2004 to 74.6% in 2013.

Figure 27: Percentage of people aged 65 and older with a severe limitation in daily activities, due to health problems



Source: EU-SILC (2011)

Figure 28: ADL and IADL disability, by age group and gender



Source: TILDA (2013)

Note: Limitations in ADLs (activities of daily living) relate to difficulties doing basic self-care tasks such as dressing or washing oneself. Limitations in IADLs (instrumental activities of daily living) relate to difficulties doing more complex tasks such as shopping or cooking.

The proportion of both men and women experiencing one or more ADL or IADL limitations increases across each age group. At all ages, a greater proportion of men experience one or more ADL limitations compared with women. The proportions of women aged 75 and older with either an IADL limitation or both ADL and IADL limitations are almost double compared with the proportion of men in the same age group.

Table 3: Number and percentage of men and women aged 50 and older with a disability, by age group

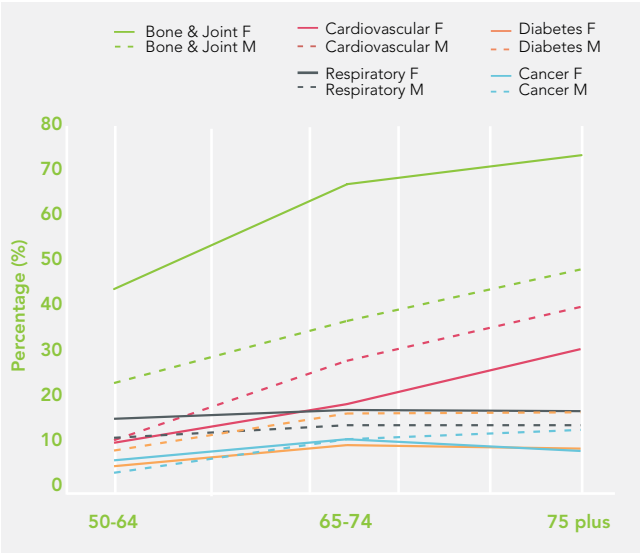
	Number of people			Percentage (%) of relevant age group		
Age Group	All	Male	Female	All	Male	Female
50-54 years	13,561	7,410	6,151	7.5	7.6	7.4
55-59 years	12,320	7,135	5,185	8.9	9.2	8.5
60-64 years	9,235	5,593	3,642	10.5	10.6	10.3
65 years and over	7,039	4,914	2,125	15.5	15.5	15.7
Total (18 years+)	112,502	60,855	51,647	6.2	6.4	6.1

Source: CSO (2011)

Chronic Conditions

Internationally, research evidence suggests that there is some uncertainty about the extent to which increased longevity will be matched by an increased number of healthy and active years (Fries et al 2011; Crimmins and Sanchez 2011). However, there is evidence that an increase in some specific chronic health conditions and problems can be expected as people live longer (Robine and Jagger 2005; Robine & Michel, 2004).

Figure 29: Percentage of adults aged 52+ with a self-reported doctor diagnosed chronic condition

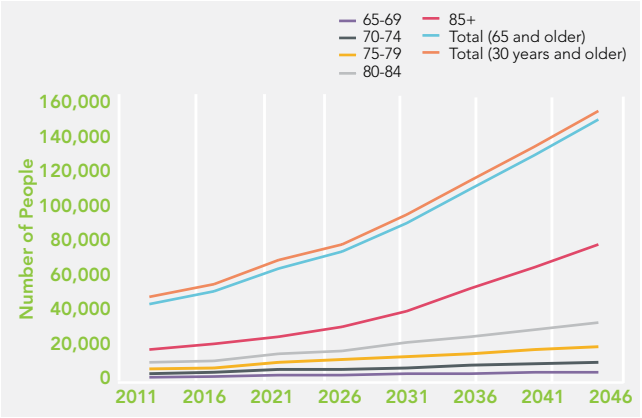


Source: TILDA (2013)

Note: M = Male; F = Female;
Bone & Joint = arthritis, osteoporosis;
Cardiovascular = angina, heart rhythm, heart murmur, heart attack, heart failure, stroke, TIA;
Respiratory = chronic lung disease or asthma

Dementia

Figure 30: Estimated number and projected growth in the number of people with dementia in Ireland (selected age groups) (2011-2046)



Source: The Irish National Dementia Strategy, DOH (2014).

Note: Estimates for 2011 based on Census of Population 2011. Projections for 2016 to 2041 based on CSO (2013) Population and Labour Force Projections, 2016-2014, Stationery Office, Dublin, Table 3, page 40 and EuroCoDe (2009) Age and gender specific dementia prevalence rates. (Source: Pierce, M. et al. (forthcoming). Prevalence and Projections of Dementia in Ireland, 2011. Genio Ltd., Mullingar)

Mild cognitive impairment

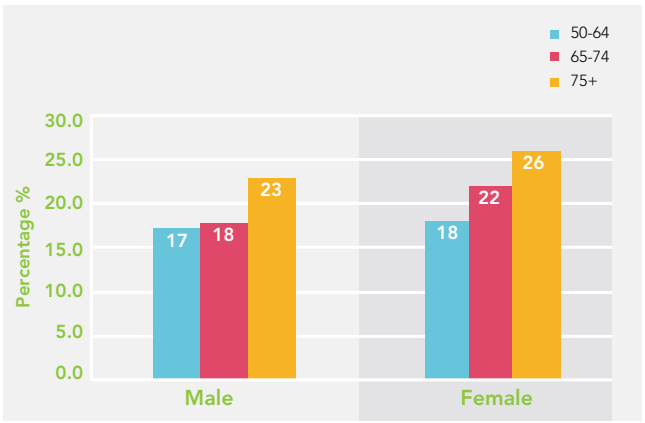
Mild cognitive impairment occurs where an individual displays measurable deficits in cognitive function (e.g. attention, memory, language), but does not meet the criteria for a diagnosis of dementia. It is often considered as a transitional stage between the cognitive changes associated with normal ageing and a clinical diagnosis of dementia (Portet et al, 2006). While TILDA did not include any individuals with dementia or severe cognitive impairment, the survey included the Mini Mental State Examination (MMSE) as a test of global cognitive function. This test is commonly used as a screening tool for cognitive impairment and dementia.

Of TILDA wave 2 participants aged 52 and over, 7.5% met the criteria for mild cognitive impairment (MMSE score 20-25). Less than 1% had a score of less than 20, which indicates a more moderate or severe level of cognitive impairment (TILDA, 2013).

Falls and Injuries from Falls

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

Figure 31: Percentage of adults aged 50 and older reporting a fall in the previous year by age and gender



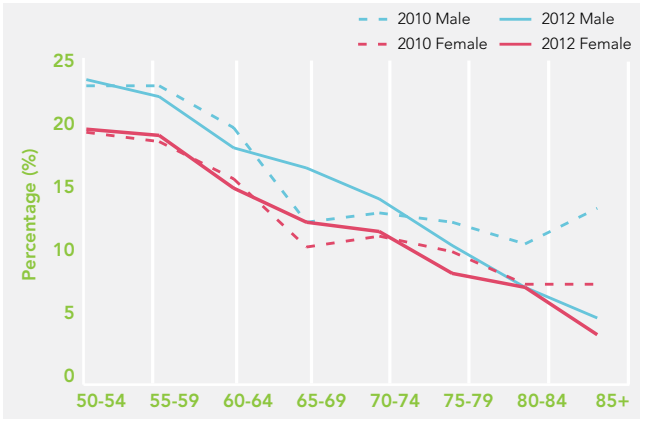
Source: TILDA (2011)

- Overall, 19.4% of adults aged 50 and over reported a fall in the previous year. 7.2% reported two or more falls, and 7.0% had a fall that resulted in serious injury.
- Between wave 1 (2009-2011) and wave 2 (2012) of TILDA, 22.6% of adults aged 50 and over reported a fall. The length of time between wave 1 and wave 2 varied across participants (1.5-3 years), so that it is not possible to compare this with the figure recorded at wave 1, which related to the previous year only.

Health Behaviours

Increased longevity is largely an outcome of improvements in health care, life-styles and diet. Controlling health risk behaviours (e.g. smoking, physical inactivity, poor diet, and excessive drinking) and using preventive health-care services (e.g. cancer, hypertension, and cholesterol screenings) has been shown to reduce morbidity and mortality from chronic diseases (WHO 2009; Peel et al 2005).

Figure 32: Percentage of adults aged 50+ who report current smoking by age, gender and year



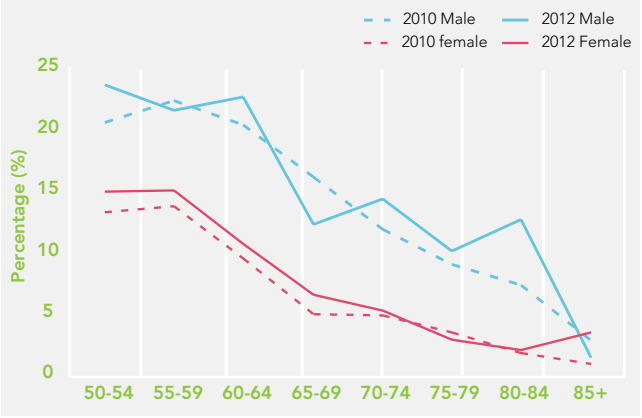
Source: TILDA. Wave 1 (W1) collected 2009-2011; wave 2 (W2) in 2012.

- Smoking rates are higher in men compared to women and tend to decline with age. Rates of smoking in all age groups have declined between 2010 and 2012.
- Smoking rates also vary by social class. 24.1% of adults aged 50 and over classified as unskilled are current smokers, compared with 10.6% of adults classified as professional. However, smoking rates decreased between 2010 and 2012 across social classes.

The CAGE measure captures whether a person has ever felt they should cut down on drinking (C), have been annoyed by others criticising their drinking (A), have felt guilty about their drinking (G), or taken a drink first thing in the morning to cure a hangover (eye-opener) (E). A point is assigned for each yes answer, with >= 2 points indicating problematic alcohol use.

Problematic alcohol use declines with age, is higher in men, and appears to have increased between 2010 and 2012.

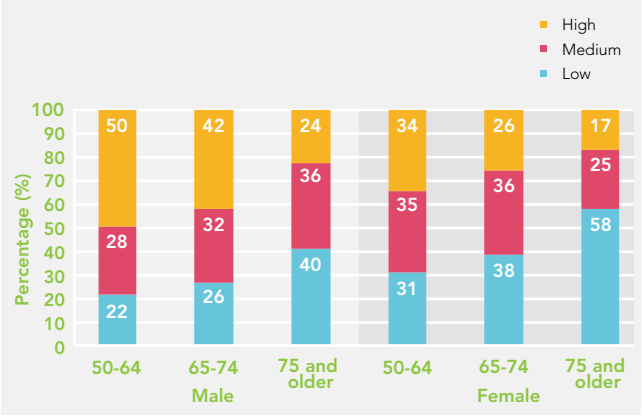
Figure 33: Percentage of adults aged 50 and over who report problematic alcohol use by age, gender and year



Source: TILDA. Wave 1 (W1) collected 2009-2011; wave 2 (W2) in 2012.

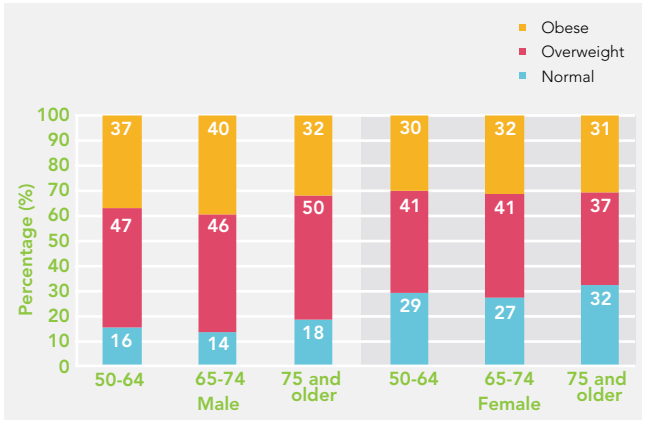
The short form International Physical Activity Questionnaire (IPAQ) captures time spent performing physical activities (moderate to vigorous). The proportion of men and women aged 50 and older who have either high, moderate or low levels of physical activity are presented below in Figure 34.

Figure 34: Physical activity levels (IPAQ categories), by age and gender



Source: TILDA (2013)

Figure 35: WHO weight classifications (based on Body Mass Index (BMI) for people aged 50 and older, by gender



Source: TILDA (2011)

In the total population aged 50 and over in Ireland, approximately 37.1% of men and 30.3% of women are obese.

Health Literacy

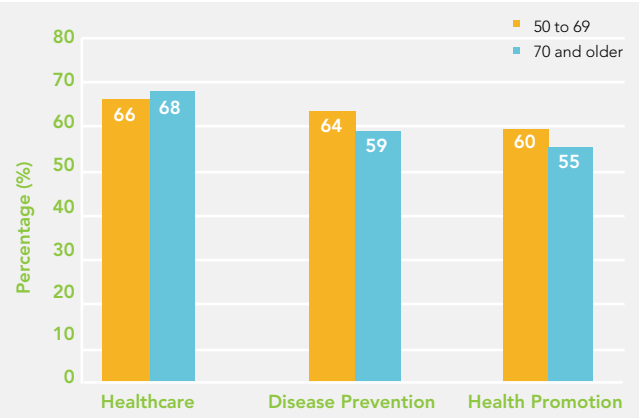
The ability to make judgements and decisions about health can be strongly determined by one's level of health literacy. Health literacy was measured in Ireland in 2011 as part of the European Health Literacy Survey and was defined as being

"…linked to literacy and entails people's knowledge, motivation and competences to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course."[5]

Health literacy index scores ranged from 0 to 50, with the following thresholds: 0 to 25 "inadequate health literacy"; more than 25 but less than 33 "problematic health literacy"; more than 33 but less than 42 "sufficient health literacy"; and more than 42 "excellent health literacy". The proportion of persons aged 50-69 and aged 70 and older who have either "sufficient" or "excellent" health literacy in the areas of healthcare, disease prevention and health promotion is illustrated in Figure 36.

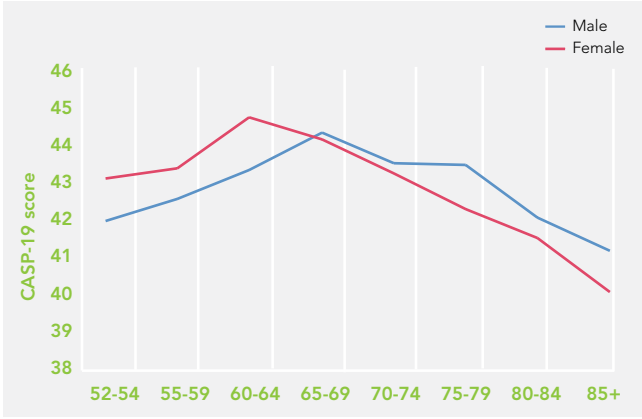
[5] Sorensen, K. 2012: Health literacy and public health: A systematic review and integration of definitions and models, BMC Public Health, 12(80).

Figure 36: Sufficient or excellent health literacy among persons aged 50 and older



Source: HLS-EU Consortium (2012)

Figure 37: Self-reported quality of life (CASP-19 score), by age and gender



Source: TILDA (2013) Note: Scores range from 0 to 57; low to high.

The percentage of persons with excellent or sufficient health literacy is highest in the area of healthcare and lowest in relation to health promotion.

Subjective Wellbeing

Subjective wellbeing has been defined as "an umbrella term for different valuations that people make regarding their lives, the events happening to them, their bodies and minds and the circumstances in which they live" (Diener, 2006 p400). Research has found strong links between being happy and various other positive physical and psychological outcomes. For example, happy people were reported to be psychologically and physically healthier than their less happy counterparts, having stronger immune systems and higher resistance to pain.

Quality of life or wellbeing is measured in TILDA using CASP-19 which assesses four domains of wellbeing: control; autonomy; self-realisation; and pleasure. The scale includes 19 items. The total score ranges from 0, representing a complete absence of quality of life, to 57, representing total satisfaction. The mean (average) score for men and women aged 50 and older is presented in Figure 37.

Adults aged 52 and older report a high level of meaning and enjoyment in life (over 70% across age groups). Items in the CASP-19 which captured meaning (self-realisation) and enjoyment (pleasure) in life had high levels of agreement: 76% of TILDA participants said that they often felt "my life has meaning" while 80% agreed that they often "look forward to each day". Both meaning and enjoyment in life appear to be highest just after retirement age (age 65-69).

Levels of control and autonomy were slightly lower: just over half (54%) said that they often felt free to plan for the future (control), while 64% felt that they could do as they pleased in life (autonomy). The percentage who felt free to plan for the future peaked after retirement age, followed by a decline in older age groups. Participants in the older age groups, on the other hand, were more likely to feel that they could do as they pleased (68% of age 80-84 compared with 45% of age 50-54).

Life Satisfaction and Happiness

- On a scale of 0 to 7, 42% of men and 43% of women rated their satisfaction with life as 7, with life satisfaction peaking at age 65-74, (TILDA, 2013).
- People aged 50 and older in Ireland report a high level of happiness, with an average score of 7.9 on a scale of 1(very unhappy) to 10 (happy) (EQLS, 2011).

Measures of quality of life and life satisfaction capture how people evaluate their lives overall. In contrast, measures of affective wellbeing capture people's mood, or how they feel on a day to day basis. Depressive mood is measured in TILDA using the Centre for Epidemiologic Studies Depression Scale (CES-D) scale. Three categories of depressive mood are derived from the scores: severe, moderate and non/mild.

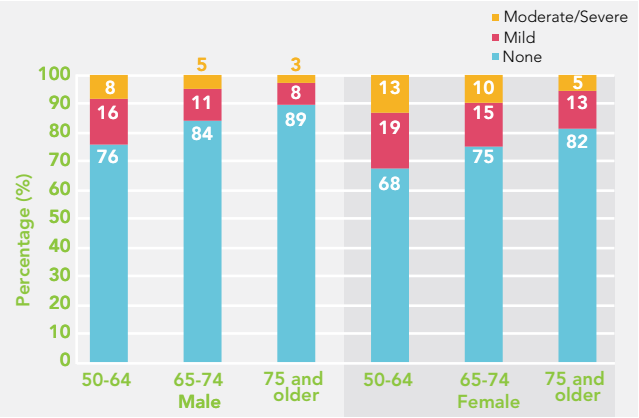
Figure 38: Self-reported depressive mood symptoms (CES-D categories), by age group and gender

Source: TILDA (2013)

Anxiety was measured in TILDA using the Hospital Anxiety and Depression Scale – Anxiety subscale (HADS-A). Regardless of age, women tended to have higher levels of anxiety than men. Females aged 50-64 were found to have the highest levels of anxiety with 13% reporting moderate or severe levels. Almost 10% of females age 65-74 reported moderate or severe levels.

The following score ranges are recommended for the purpose of interpreting results: 0–7 for normal or no anxiety; 8–10 for mild anxiety; 11–14 for moderate anxiety; and 12–21 for severe anxiety.

Figure 39: Percentage of adults aged 50+ reporting mild or moderate/severe levels of anxiety (HADS-A) by age and gender



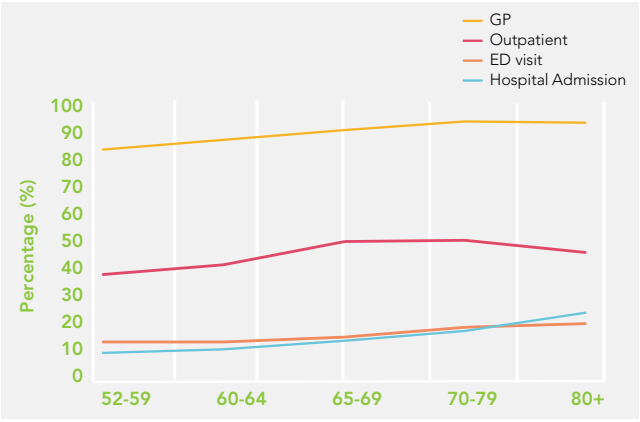
Source: TILDA (2011)

HEALTH AND SOCIAL CARE SERVICES

Although many older people live healthy and active lives, as they grow older they become vulnerable to a more diverse set of health issues, and so the care they require is marked by increasing complexity. As a result providing healthcare for older people requires the collaboration of a number of different healthcare professionals (Johansson et al 2010).

Most adults aged 50 and over (89.6%) visit their GP at least once year. The proportion using acute hospital services (emergency department or inpatient admission) rises with age.

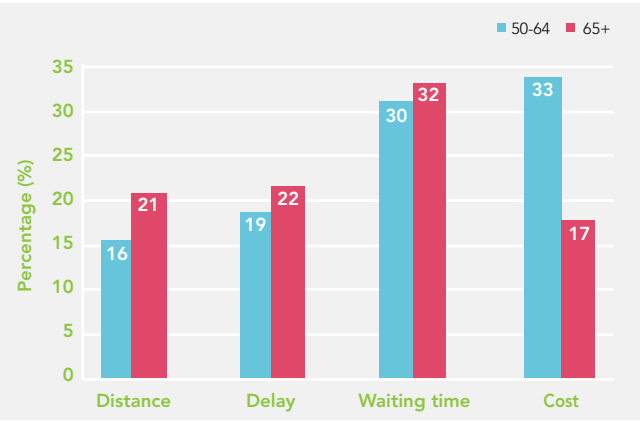
Figure 40: Percentage of people aged 52 and older who accessed healthcare services in the past 12 months



Source: TILDA (2013) Note: GP (General Practitioner), ED (Emergency Department)

The European Quality of Life Survey provides several indicators related to difficulty in seeing a doctor in the past 12 months. Four reasons are presented: distance to doctors' office/ hospital/medical centre; delay in getting an appointment; waiting time to see the doctor on the day of appointment; and cost of seeing the doctor.

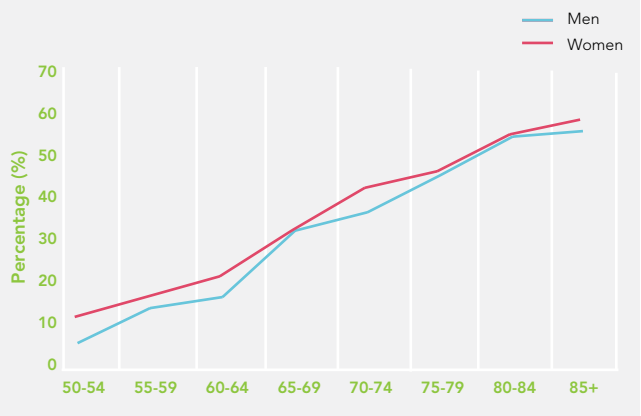
Figure 41: Percentage of people aged 50 and older who experienced any difficulty in seeing the doctor



Source: EQLS (2011)

The percentage of adults who are taking five or more medications increases with age, rising from less than 20% in the age 50-60 age group to more than 50% in those aged 80 and over.

Figure 42: Polypharmacy (five or more medications, excluding supplements), by age group and gender

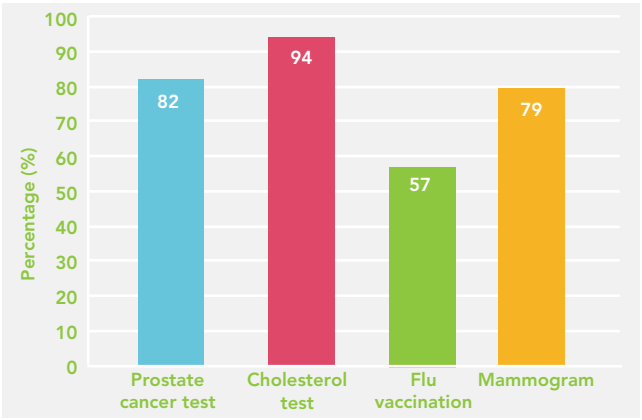


Source: TILDA (2013)

Preventative Services

Preventative services are playing an increasing part in care for older people, as it is recognised that such services along with rehabilitative care can help to avoid costly and inappropriate forms of institutional care. Many common conditions although not life-threatening, if left untreated can lead to disability and can negatively impact on older people's quality of life. (Stuki et al 2005)

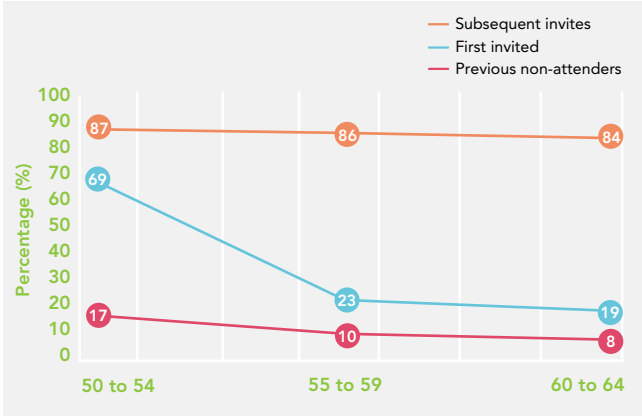
Figure 43: Percentage of people aged 50 and older who have ever accessed preventive healthcare services



Source: TILDA (2013)

Use of flu vaccination was more common in older age groups (82% in age 70-79, compared with 32.8% in the 50-59 age group).

Figure 44: Uptake rate of breast cancer screening by population type and age group (2013)



Source: HSE National Screening Service (2014)

- Figure 44 illustrates the consistently higher uptake rate among adults aged less than 60 compared with those aged 60 to 64. The difference in uptake between age groups is most apparent in the first invites.

Table 4: Percentage distribution of long stay residents by level of dependency (31 December 2013)

Category	Low Dependency	Medium Dependency	High Dependency	Maximum Dependency
	Percentage (%)			
HSE Extended Care Unit	14.3	23.7	27.8	34.2
HSE Welfare Home	4.3	11.9	24.4	59.3
Voluntary Home/Hospital for Older People	15.3	18.4	17.8	48.6
Voluntary Welfare Home	13.3	21.1	26	39.6
Private Nursing Home	49.7	17.5	13.1	19.7
Total Long Stay	12.8	21.3	26.7	39.2

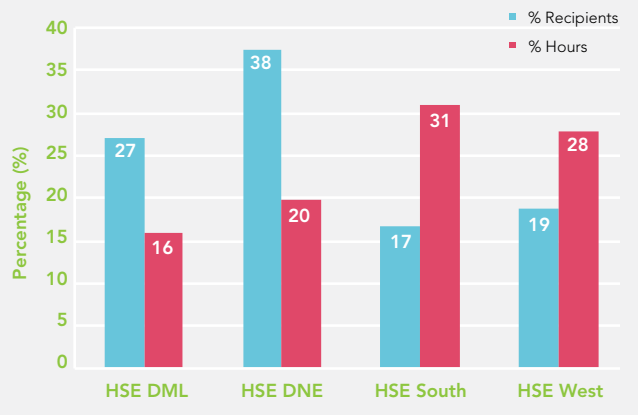
Source: Department of Health (2012)

Social Care

- Among community dwelling adults aged 70+, 11.3% use a home care service such as home help, personal care attendant or meals on wheels, while 2.8% attend a day centre service.
- Just over one in 25 (4.2%) adults aged 70+ and living in the community have spent time in residential services (a nursing home, convalescent care or respite care) in the previous 12 months.

Source: TILDA (2013)

Figure 45: Percentage distribution of recipients of home care packages, by HSE region



Source: HSE (2014)

Note: DML = Dublin Mid-Leinster; DNE = Dublin North-East.

Table 5: Number of recipients and hours of home care packages, by HSE region

	Number of recipients	Number of hours
HSE DML	3,559	1,636,331
HSE DNE	4,951	2,052,188
HSE South	2,218	3,198,158
HSE West	2,471	2,865,239
Total	13,199	10,298,481

Source: HSE (2014)

Note: DML =Dublin Mid-Leinster; DNE = Dublin North-East.

The proportion of patients resident in long stay units and their level of dependency is outlined below. The four categories of dependency are defined as follows:

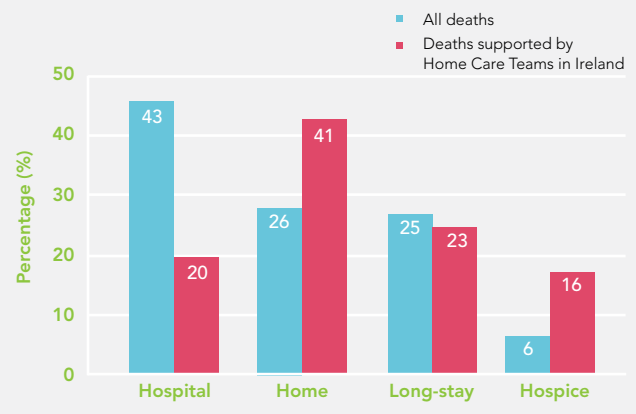
- **Low Dependency:** Persons who need some support in the community and the more independent residents in residential accommodation who require little nursing care. They are usually independently mobile but may use a walking stick and have difficulty managing stairs.
- **Medium Dependency:** Person whose independence is impaired to the extent that he or she requires residential care because the appropriate support and nursing care required by the person cannot be provided by the community. Mobility is impaired to the extent that the person requires supervision or a walking aid.
- **High Dependency:** Independence is impaired to the extent that the person requires residential care but is not bed bound. The person may have a combination of physical and mental disabilities, may be confused at times and be incontinent. He/she may require a walking aid and physical assistance to walk.
- **Maximum Dependency:** People whose independence is impaired to the extent that he/she requires nursing care. The person is likely to be bed bound, requires assistance with all aspects of physical care and may be ambulant but confused, disturbed and incontinent

Palliative care and end of life care

In 2011, 74% of deaths in Ireland took place at home and 26% took place in hospitals and institutions (CSO, 2011).

According to the Joint Committee on Health and Children (2014), the majority of people in Ireland (67%) express a preference to die at home, however only 26% of people in Ireland actually die at home. According to the Irish Hospice Foundation, one in four deaths that occurred in acute hospitals could have taken place at home if the necessary supports were in place (Irish Hospice Foundation, 2013).

Figure 46: Place of death for all deaths and specialist palliative care deaths supported by home care teams



Source: Irish Hospice Foundation (2014)

Traveller Health

Information regarding the health status of the Traveller population in Ireland is provided by the All Ireland Traveller Health Study (AITHS) (2010).

- Among those aged 65 and older, 19.9% of Travellers rate their health as "Excellent or Very Good", whereas 49.2% rated their health as "Fair or Poor".
- A total of 40.7% of Travellers aged 65 and older reported a limiting long-term illness.
- Among those aged 65 and older, 46.1% of Travellers in Ireland and Northern Ireland report having high cholesterol and 54.1% reported having high blood pressure (AITHS, 2010).

According to the AITHS (2010), regarding the incidence of specific illnesses, the Traveller group in Ireland appear to have a greater burden of chronic diseases than the general population (as measured by the Survey of Lifestyle, Attitudes and Nutrition (SLÁN) 2007).

Figure 47: Chronic illness among Travellers and the general population (all adults)

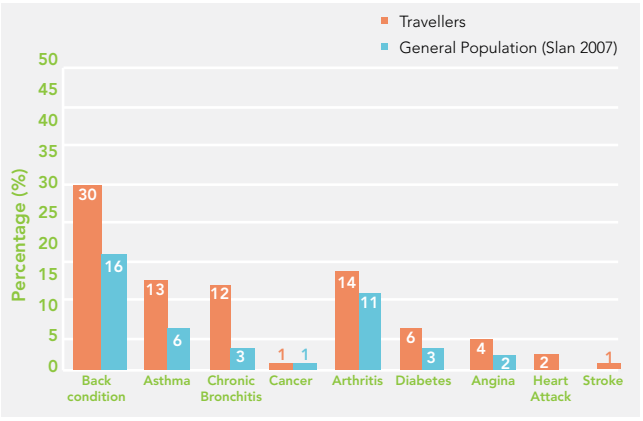
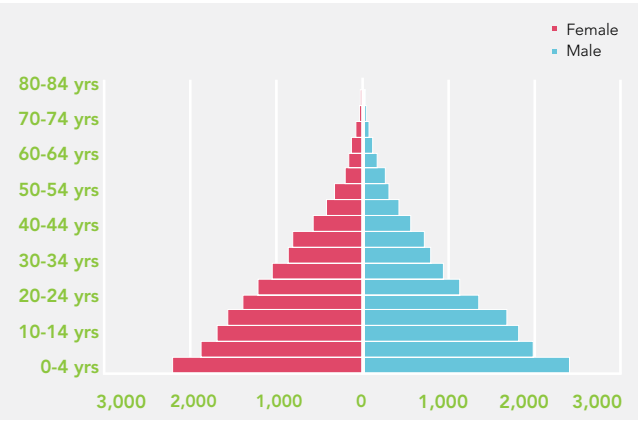


Figure 48: The age distribution of the population of Irish Travellers



According to the All-Ireland Traveller Health Study (2010), Travellers experience considerably higher mortality at all ages in both males and females, compared with the general population.

In 2008, life expectancy at age 65 for male Travellers was 10.6 compared with the 16.6 for the general population of males. Among female Travellers life expectancy at age 65 was 12.3 compared with 19.8 for the general population of females.

Table 6: Age specific mortality rates per 1,000 Traveller and general population

Age Group	Male Traveller Population	Male General Population	Female Traveller Population	Male Traveller Population
45 to 54	16.75	3.28	4.26	2.41
55 to 64	23.59	8.75	20.51	5.54
65 to 74	69.43	24.4	42.57	13.67
75 to 84	184.62	69.2	124.08	46.35
85 and older	808.82	192.32	606.61	158.58

Source: All-Ireland Traveller Health Study (2010)

CARERS

As people age, many develop chronic conditions which require higher levels of care and they may become dependent on others for help in carrying out the activities of daily life. Many family members provide unpaid care for a spouse, parent or other family member with a disability, mental illness or chronic condition. This can place heavy demands on the carers who may often have to balance the responsibilities of caring with work and family commitments. They may find themselves undertaking the role following very little consultation, education or preparation for the task (Moen et al,1994; Pinquart & Sorensen 2011).

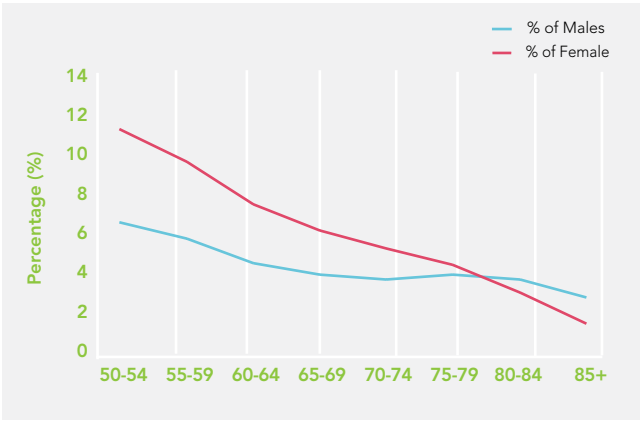
The National Carers Strategy[6], published by the Department of Health in 2010, sets out the priority areas that have been identified by carers and the organisations that represent them. It identifies four key goals for carers:

1. To recognise the value and contribution of carers and promote their inclusion in decisions relating to the person that they are caring for;
2. To support carers to manage their physical, mental and emotional health and wellbeing;
3. To support carers to care with confidence through the provision of adequate information, training, services and supports;
4. To empower carers to participate as fully as possible in economic and social life.

The range of support services that can be offered to carers include: 1) information about available services; 2) assistance in getting access to support services; 3) individual counselling, support groups, and training to help with problem solving related to their roles; and 4) respite care.

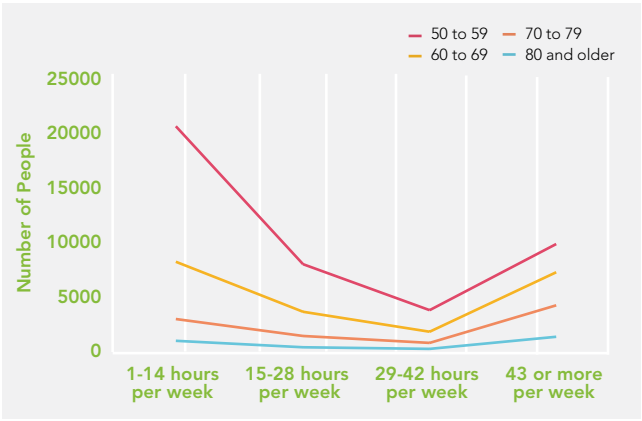
- The average age of care recipients on the island of Ireland is 76 years. The average age of care givers for an older person is 73 years (CARDI, 2009).
- The peak age for caring amongst women was 45-49 with more than 1 in 10 (11.2%) of all women in this age group providing unpaid care, amounting to 572,680 hours every week. Of these carers 114,113 (61%) were women and 72,999 (39%) men.
- A total of 6,287,510 hours of care were provided by carers each week, giving an average of 33.6 hours of unpaid help and assistance each. Females provided almost two-thirds (66.1%) of all care hours.
- In the Irish census, care is defined as providing unpaid care to a friend or family member with a long term illness, health problem or disability. In the 2011 census there are 187,000 carers, and 13% of these are 65 years of age or over (CSO, 2012a). Substantial amounts of care were provided by older people (aged 70+) who were providing almost 800,000 hours (795,916) of unpaid care a week in April 2011.
- Between 2006 and 2011 the number of carers aged 50 and older increased by 39.6% among men and 29.7% among women.
- The largest increase was for men aged 75 and older, with a 58.6% increase among men aged 80 years and older.

Figure 49: Percentage of people aged 50 and older who are carers (male and female), by age group



Source: CSO (2011)

Figure 50: Number of people aged 50 and older providing care, by hours per week and age



Source: CSO (2011)

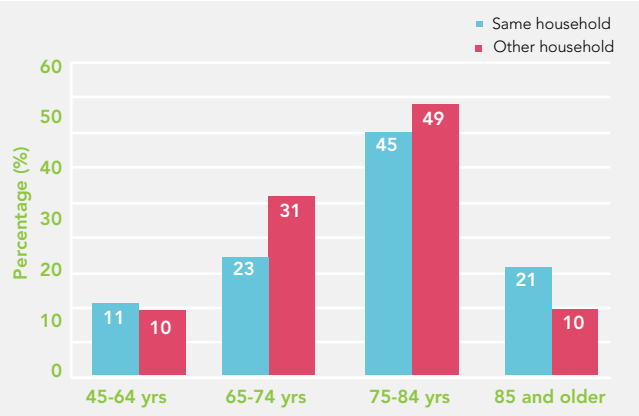
Indicators relating to carers were also collected in a special module of the Quarterly National Household Survey (2009). The definition of carers adopted by the QNHS:

Some people have extra responsibilities because they look after someone who has long-term physical or mental ill health or disability, or problems related to age. May I just check, is there anyone living with you/not living with you who is sick, disabled or elderly whom you look after or give special help to, other than in a professional or paid capacity (for example, a sick or disabled (or elderly) relative/husband/wife/child/friend/parent etc?).

[6] http://health.gov.ie/wp-content/uploads/2014/03/National_Carers_Strategy_en.pdf

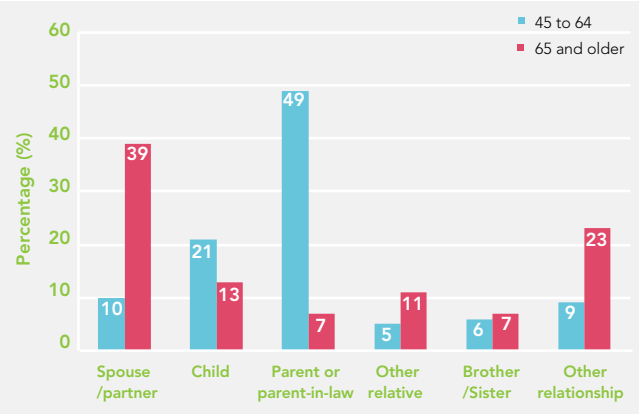
This includes help provided to others either living with the respondent or living in another private household. The definition excluded help in a paid capacity or where the support provided is financial only. The definition included all types of caring tasks self-defined by the respondent. By this definition, 8% of persons aged 65 and older were classified as carers.

Figure 51: Location of person being cared for, by age group of carer



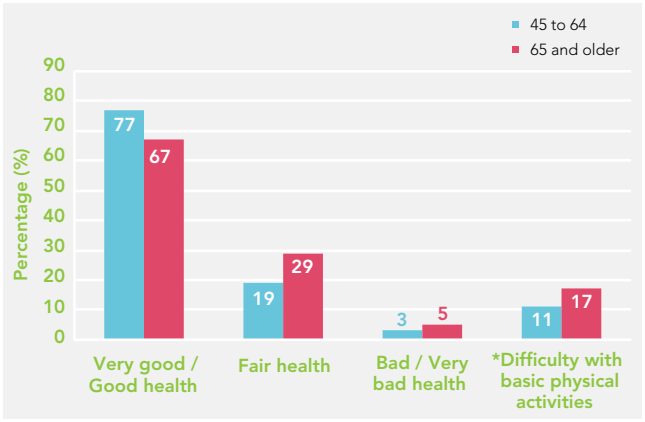
Source: QNHS (2009)

Figure 52: Relationship of the person being cared for to the carer, by age group of carer



Source: QNHS (2009)

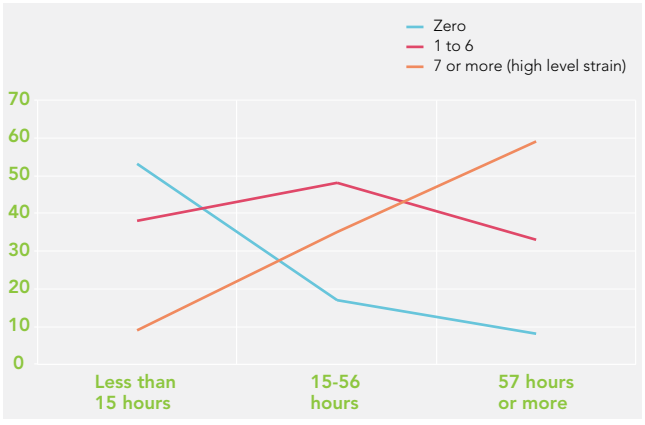
Table 53: Self-reported health status of carers, by age group



Source: QNHS (2009)

- The QNHS (2009) included the Caregiver Strain Index as a measure of strain related to care provision for carers of all ages.
- This 13 item measure includes the following domains: employment, financial, physical, social and time.
- A score of seven or more items on the index indicates a greater level of strain.

Figure 54: Percentage of carers in each Caregiver Strain Index Score range, by number of hours spent caring



Source: QNHS (2009)

- Almost 60% of people providing 57 hours of care or more indicate having a high level of caregiver strain.
- Over one quarter of carers (27%) have a Caregiver Strain Index score of 7 or more, indicating a high level of strain.
- The average score ranges from 1.9 for people providing less than 15 hours, compared to 5.1 for 15-65 hours and 7.2 for 57 hours or more.

SECURITY

Enable people to age with confidence and dignity in their own homes and communities for as long as possible

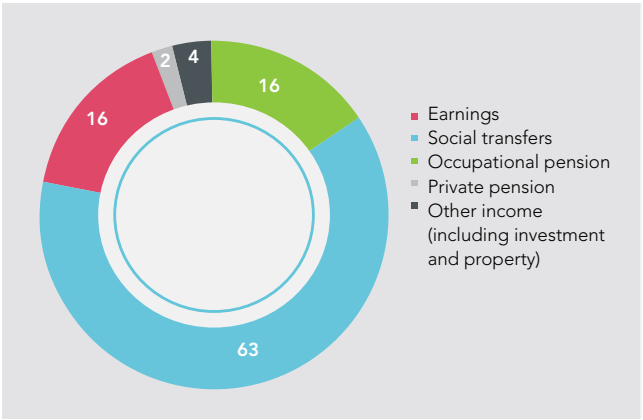
Under this goal, the National Positive Ageing Strategy has identified the following objectives:

- Ensure an acceptable standard of living;
- Well-maintained, affordable, safe and secure homes, suited to physical and social needs;
- Develop age-friendly public spaces, transport and buildings;
- Implement the Garda Older People Strategy and empower people as they age to live free from fear in their own homes, to feel safe and confident outside in their own communities, and support an environment where this sense of security is enhanced;
- Continue to address the problem of elder abuse at all levels of society through raising awareness, improving reporting rates and developing services.

FINANCIAL SECURITY

Having an adequate income provides older people with security and stability in retirement. Research findings suggest that while there is a positive relationship between income and wellbeing, the connection between income and happiness tends to be influenced by comparison with others (social comparison) or to oneself in the past (habituation) (Clark et al 2008). The numbers living in poverty or experiencing deprivation is an indicator of wellbeing and their ability to participate fully in society, exercising choice about how to live their lives.

Figure 55: Sources of gross income for people aged 65 and older (percentage, %)



Source: SILC (2011)
Note: Average equivalised weekly income

Income for older people in Ireland is derived from three main sources: pensions; employment; and other sources such as savings and investments. The Irish pension system, in common with the pension systems of much of the developed world, is made up of three components: the state pension, which is available to most retirees; additional income gained from supplementary pensions (such as public service schemes, funded occupational pension schemes set up by private employers or personal pensions); and personal savings or investments.

- Social transfers make up the majority of weekly incomes for people aged 65 and older (62.7%).
- Earnings and occupational pensions make up a similar proportion of incomes, 16.1% and 15.6% respectively. Private pensions only make up 2% of weekly incomes.
- According to the Global AgeWatch, in 2014 pension coverage in Ireland, expressed as the percentage of people aged 65 and older receiving a pension, was 90.5%.
- In 2013, of the 437,962 people aged 65 and older, 21.8% (n=95,801) were in receipt of a Non-contributory State Pension, 75.2% (n=329,531) were in receipt of a Contributory State Pension and 2.8% (n=12,630) were in receipt of a Transition Pension (Department of Social Protection, 2013).

In relation to income, three indicators of poverty are presented: at-risk-of-poverty; material deprivation; and consistent poverty. Data are from the European Survey on Income and Living Conditions (EU-SILC). This income and spending data are collected annually in Ireland by the Central Statistics Office (CSO).

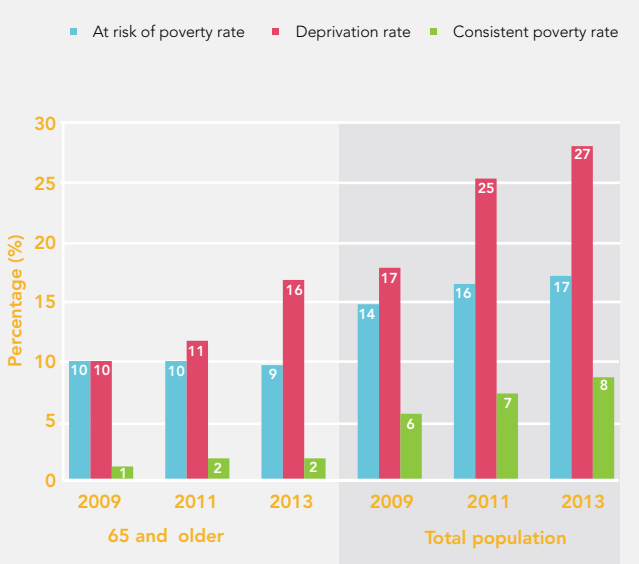
At-risk-of-poverty is estimated by comparing an individual's or household's income with the average income. In Ireland, this is measured using the median income (the mid-point on the scale of all incomes in the State from highest to lowest) and reported as the proportion of individuals or households who are at or below 60% of the median income.

Material deprivation measures lack of access to resources and activities, which are considered normal for daily life, due to lack of income rather than personal choice. In Ireland, individual level material deprivation is measured by an index which is based on 11 items. Sample items include:

- Unable to afford new (not second-hand) clothes
- Unable to afford to keep the home adequately warm
- Unable to afford to have family or friends for a drink or meal once a month

Consistent poverty is a measure of poverty which combines both income and deprivation. Consistent poverty is defined using the national definition of being at risk of poverty at 60% of the median income and experiencing two or more forms of deprivation from the list of 11 individual level deprivation indicators.

Figure 56: At risk of poverty rate, deprivation rate and consistent poverty rate for all persons aged 65 and older and the total population (2009 to 2013)



Source: SILC (2013)

- The at-risk-of-poverty, deprivation and consistent poverty rates are lower for people aged 65 and older compared with the total population.
- The at-risk-of poverty rate has remained similar for people aged 65 and older between 2009 and 2013, however deprivation has increased from 11.3% to 16.1% between 2011 and 2013.

As in previous years data from 2013 and early data from 2014 show that severe material deprivation rates are determined mainly by changes in the ability to afford: unexpected financial expenses; a meal with meat, chicken or fish (or vegetarian equivalent) every second day; and one week's holiday away from home (Eurostat). These items are covered largely by monetary income for household expenditure rather than durable (investment) items.

- Data from SILC (2011) showed the following differences in relation to age, gender and household composition:
  - Two older age groups had a higher risk of poverty compared with all those aged 65 and older: people aged 65 to 69 (10.1%) and people aged 80 and older (12.5%).
  - The risk of poverty was similar for men and women aged 65 and older but the deprivation rate was higher for women (13%) compared with men (9.2%).
  - The deprivation rate was higher for people living alone compared with two older people living together (14.2% versus 8%).
- Relative welfare is defined as the average income/consumption of a specific group or cohort expressed as a percentage of the average income/consumption of the rest of the population. According to the Global AgeWatch Index, in 2014, the relative welfare of people aged 60 and older in Ireland was 89%.

Income Support for Carers

- According to the CSO, there were 85,034 people aged 50 and older providing unpaid care to a friend or family member with a long term illness, health problem or disability.
- Based on figures from the Department of Social Welfare (2011), the proportion of carers in receipt of each allowance was:
  - Carer's Allowance 31.6% (n = 26,824)
  - Based on figures from the Department of Social Welfare, in 2011, 31.6% (n=26,842) of carers received the Carer's Allowance and 0.6% (n = 531) of carer's received the Carer's Benefit.

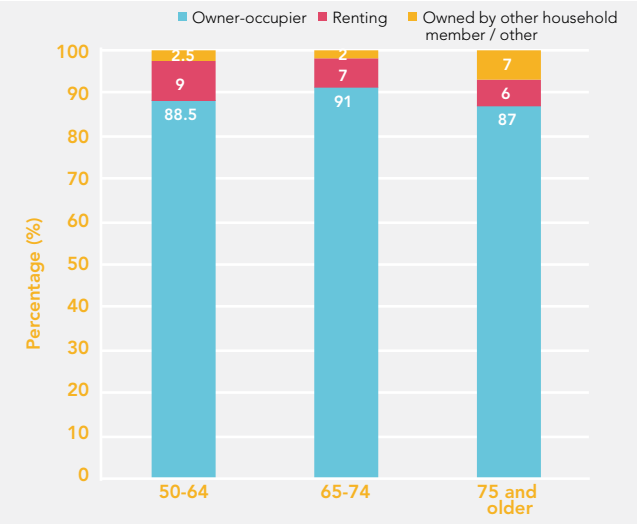
Just under 5% of people of those in receipt of a benefit received the Respite Carer's Grant (n = 4,166) However, this number includes only those who are not in receipt of any other Carer's payment. There are approximately a further 65,000 Respite Care Grant recipients who qualify for payment automatically under the terms of the relevant scheme.

HOUSING

As people age they spend relatively more time in their homes. The physical comfort, security and appropriateness of the home environment can therefore have a big impact on their quality of life and health. Older people are especially vulnerable to inadequate heating, and cold has been found to be a predictor of poorer overall health status among older people. The condition and quality of the home can impact on physical and mental health and substandard housing conditions can lead to restrictions in activity (Thompson, et al 2002; Windle, Burholt & Edwards, 2006).

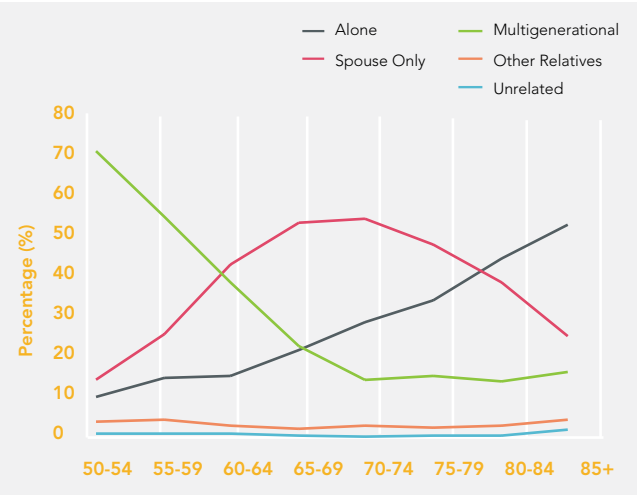
Data from TILDA (2013) shows that the vast majority of older people aged 50+ live in a house owned by themselves or their spouse (89.2%). This figure reduces slightly with increasing age, along with a corresponding increase in the level of housing 'owned by other household member' – most likely accounted for by older people who move in with another family member. Compared with older age groups, more adults aged 50-64 rent their home (8.7%).

Figure 57: Housing tenure by age group in Ireland (community-dwelling adults aged 50 and older)



Source: TILDA (2013)

Figure 58: Living arrangements by age group in Ireland (community-dwelling adults aged 50+)

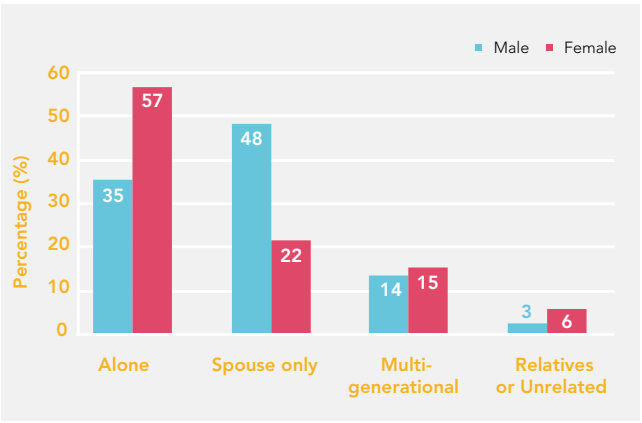


Source: TILDA (2013)

- The proportion of older people living in a multigenerational household declines from age 50, stabilising from age 70 onwards. From age 70 the proportion living with a spouse only declines.
- The proportion of people who live alone increases across the age groups, with an increase of over 18 percentage points between the age group 75-79 (34.0%) and 85 plus (52.5%).
- A small proportion of older people live with a relative other than close family, or someone they are not related to.

Among those aged 80 and older in Ireland, women make up a higher proportion of those who live alone (56.9%) whereas a higher proportion of those who live with a spouse are men (48.3%).

Figure 59: Household composition of people aged 80 and older, by gender

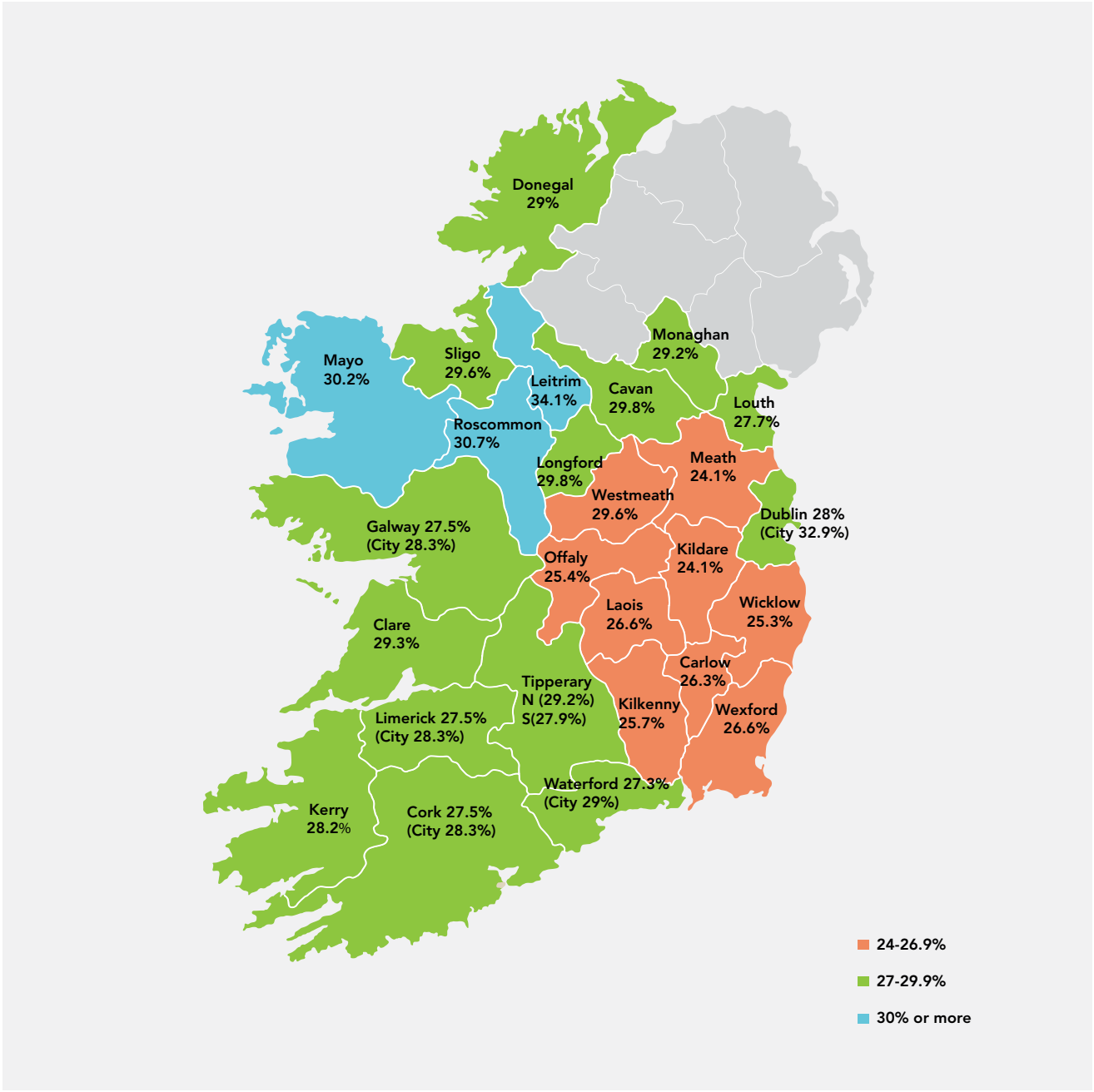


Source: TILDA (2013)

The proportion (%) of the population who are aged 65 and older and live alone in private households is illustrated for each county in Figure 60.

- There is higher proportion of people aged 65 and older who live alone located in cities across Ireland: Dublin City 32.9%; Galway City 28.8%; Limerick City 29.7%; Cork City 29.8%; and Waterford City 29%.

Figure 60: Percentage of adults aged 65+ in private households living alone, by county

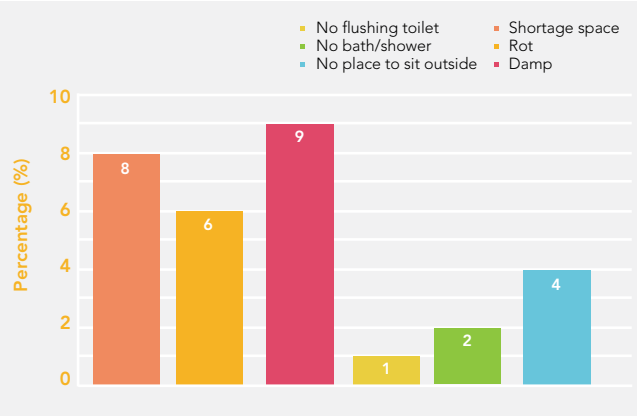


Source: CSO (2011)

Housing Conditions

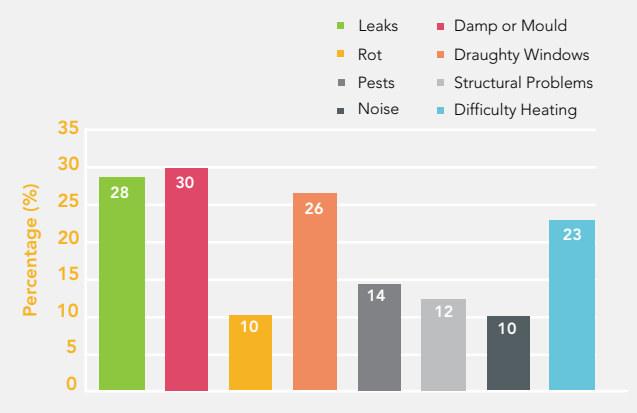
People in Ireland aged 50 and older report being satisfied with their accommodation; with an average score of 8.31 on a scale from 1 (very dissatisfied) to 10 (very satisfied) (EQLS, 2011). The proportion of respondents who reported problems with their accommodation is displayed below, including problems with facilities (Figure 61) and with housing conditions (Figure 62).

Figure 61: Housing facilities problems among adults aged 50 and older



Source: EQLS (2011)

Figure 62: Housing condition problems among adults aged 50 and older



Source: TILDA (2013)

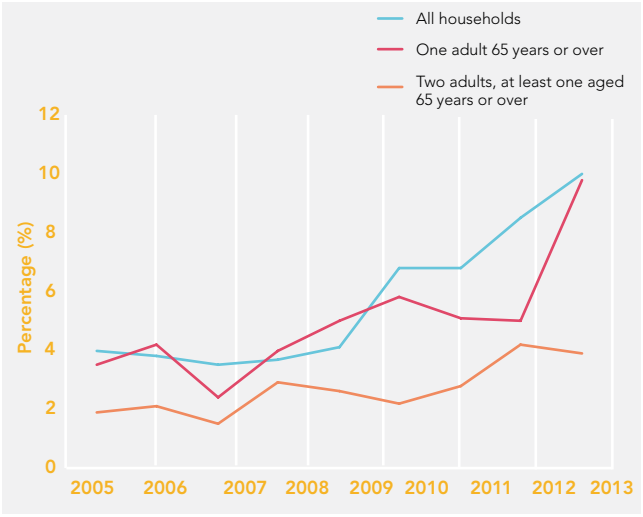
- A high proportion of people aged 65 and older reported having no problems with their accommodation (63.7%), 12.9% reported having 1 or 2 problems and 23.5% reported having 3 problems or more (EQLS, 2011).
- Reported problems with noise varied considerably by geographical location, ranging from 17.8% in Dublin, 13.9% in a town or city other than Dublin, to 4.5% in rural areas (TILDA, 2013).

Fuel Poverty

According to CARDI (2011), those who are most at risk of fuel poverty in the older population are those living alone, those with chronic illness and/or disability, those on low incomes, and those with no central heating or living in poorly insulated homes. Subjective measures of fuel poverty are available from EU-SILC and include, 1) going without heating in the last year because you could not afford it and 2) being unable to keep the house adequately warm. Goodman et al. (2011) note that the EU-SILC indicator of whether a householder has gone without heating in the last year may under-represent the extent of fuel poverty. An objective measure of fuel poverty derived from the household budget survey is whether the household spends 10% or more of disposable income on heat and light. Using this expenditure data, 22% of people aged 65 and older spend more than 10% of their disposable income on light and heat in 2005 (CSO, 2006).

The percentage of households who could not keep their home adequately warm between 2005 and 2013 is illustrated below.

Figure 63: Inability to keep home adequately warm, by household type

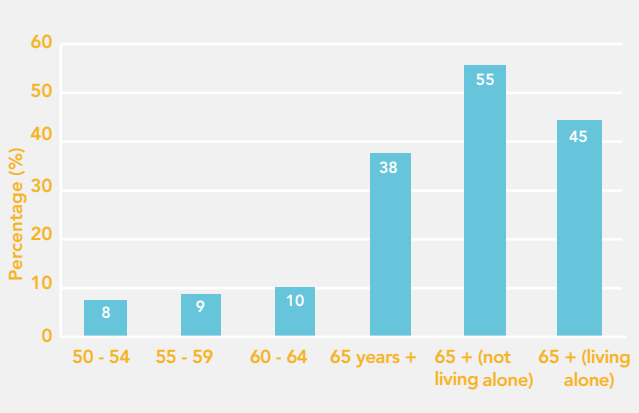


Source: EU-SILC (2005-2013)

In 2013, 10.0% of households in Ireland were unable to keep their homes adequately warm. Among those aged 65 and older who lived alone, this proportion increased from 5.0% to 9.8% between 2012 and 2013.

In 2011, a total of 26,952 households in Ireland had no central heating (CSO, 2011). The age profile of these households is illustrated in Figure 64.

Figure 64: Age profile of households with no central heating



Source: CSO (2011)

A greater proportion of households with no central heating are headed by person aged 65 and older (38%).

Assistive Technology

Assistive technology (AT) - defined as 'any device or system that allows an individual to perform a task that they would otherwise be unable to do, or increases the ease and safety with which the task can be performed' (Cowan and Turner-Smith 1999) - has the potential to facilitate people of varying levels of dependence to remain in their own homes, merging different services within the same home setting.

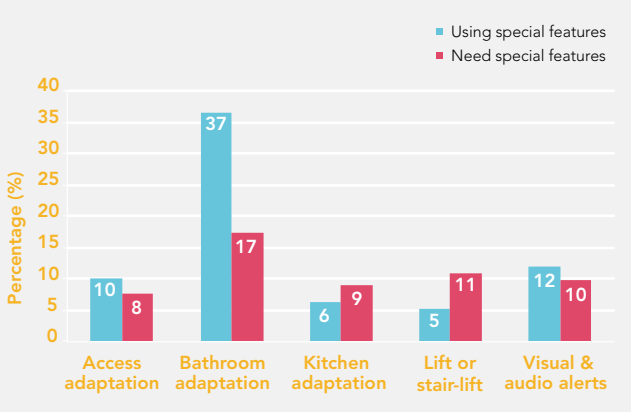
The potential uses of assistive technologies to support older people to receive care in their homes are varied. Technologies have advanced in many fields and in combination with advances in sensor development, miniaturisation of electronics and extended battery life, offer enormous opportunities in healthcare, especially for older people.

Health providers at both national and European levels now appreciate the need to introduce new approaches to healthcare delivery to meet the challenges of the changing demographics. Technological solutions such as remote monitoring are being viewed by many as one of the most promising solutions to this challenge, facilitating improved quality of life and community care.

Data in relation to assistive technologies are available from the National Physical and Sensory Disability Database (NPSDD) managed by the Health Research Board (HRB) and from the National Disability Survey (NDS) conducted by the Central Statistics Office (CSO) in 2006. The following data are from the NDS (2006).

- A total of 62.8% people aged 65 to 74 and 18.5% people aged 75 and older with disability were limited or affected by their disability before the age of 65.
- A total of 44.7% of people with a disability aged 65 and older living in private households use specialised features in and around the home.
- Almost one third of people aged 65 and older who have a disability (32.3%) need special features in and around the home but do not currently have them.

Figure 65: People aged 65 and older with a disability currently using / needing special features and aids in and around the home



Among this age group, the reasons given for not having specialised features in and around the home were as follows: not eligible (18.1%); don't have the money (40.45%); feature not approved (14.25%); and currently being on a waiting list (18.25%).

- Almost half of people with a disability who are aged 65 and older (49.7%) experience accessibility difficulties outside the home. These include difficulty with footpaths (34.2%), street-crossing (42%), signs (20.15%), access to recreational space (30.8%) and car parks (30.05%).
- In order to access educational facilitates, the following modified features were reported as needed by people age 65 to 74 with a disability: accessible transport (7.6%); accessible buildings (5.7%); accessible/adapted classroom or equipment (6.7%) and accessible toilets (4.3%).
- People aged 55 to 64 with a disability who worked or were willing to work identified the following features as necessary for participation: modified work stations (10.9%); communication aids (2.8%); technical aids (2.7%).
- Larger proportions of people aged 55 to 65 with a disability who work or are willing to work identified that access to transport (20%), buildings (15.3%), appropriate parking (19.2%), lifts (17%) and handrails/ramps (12.8%) was required for participation.

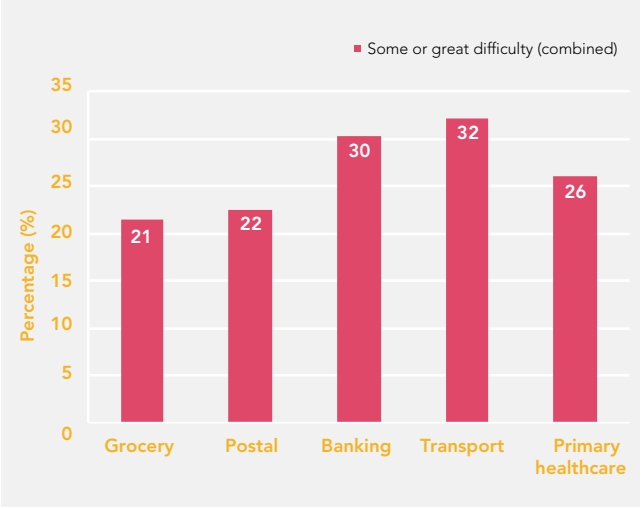
AGE FRIENDLY PUBLIC SPACES

The health and wellbeing of older people is enhanced by having access to public spaces or outdoor venues that have natural elements where people can congregate. Environments that promote increased levels of physical activity support active ageing and provide opportunities for social engagement (Sugiyama & Thompson, 2007b; Sugiyama et al 2009).

Information on the area immediately surrounding the accommodation in which older people live was captured in the Survey of Health, Ageing and Retirement in Europe (2007). Figure 66 illustrates the proportion (%) of older people in Ireland who responded 'Yes' to the following questions:

- How about the area immediately surrounding your accommodation – would you say it has sufficient supply of facilities such as pharmacy medical care or grocery? (Facilities)
- Would you say it has sufficient possibilities for public transport? (Transport)
- Would you say it has pollution, noise or other environmental problems? (Pollution)

Figure 66: Local area facilities and problems, by age group

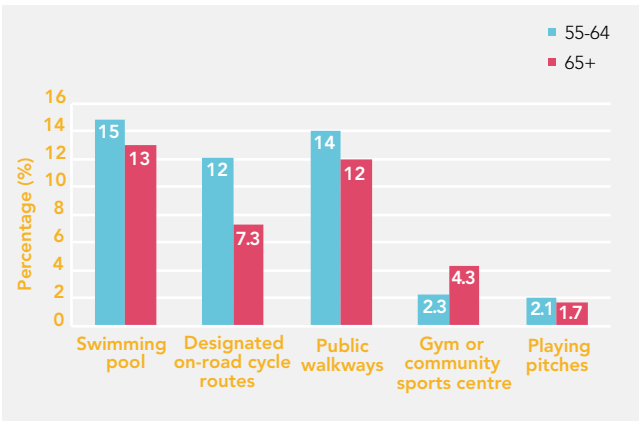


Source: SHARE (2007)

Green Areas

A total of 9.2% of people aged 50 and older in Ireland reported difficulty in accessing a recreational or green area and 6.25% report not using green spaces or recreational areas (EQLS, 2011).

Figure 67: Main additional facilities persons would like to see in their local area



Source: QNHS (2013)

Note: Excludes persons who do not participate in sport or other physical activity

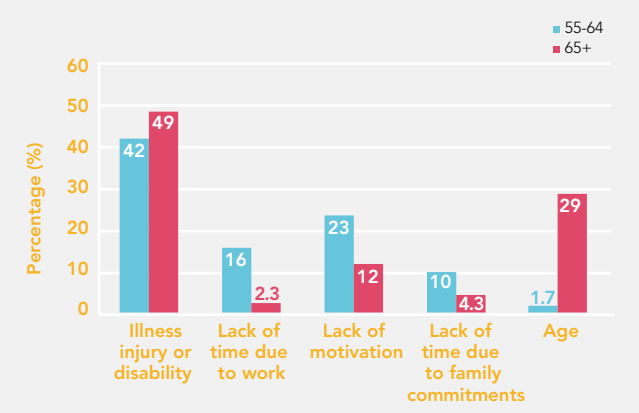
Walkability

Walking is a low-cost, low-impact means of transport which provides the added benefit of promoting good health and social connectivity for older people.

The design of a community's built environment can often make the difference between a healthy and active lifestyle or one characterised by limited mobility and high levels of social isolation. Physical changes that often accompany ageing, such as poorer eye sight, hearing and reduced mobility can pose risks for older people when they are out and about in their community (Michael, Green & Farquhar, 2006). Communities with accessible and 'walkable' facilities and services are ones in which older people can make more regular use of the public spaces, services and facilities provided (Michael, Green & Farquhar, 2006).

However, a significant number of older people have difficulty walking as much as 15 minutes. If essential services such as shops, church, park, bus stops etc are outside the maximum walking range of an older person, they become very limited in independently moving about their community.

Figure 68: Persons who do not participate in walking or any other form of sport or physical activity by main reason for non-participation



Source: QNHS (2013)

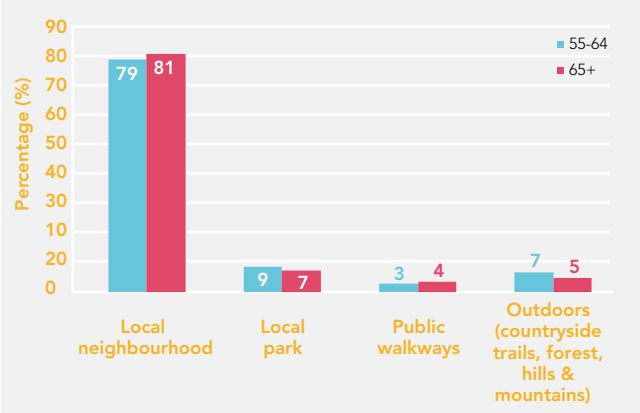
Walkability Audit Tool

The Age Friendly Town (AFT) Programme, which is part of the national Age Friendly Cities and Counties programme (AFCC), developed a walkability audit tool which was piloted in the eight Irish towns and urban centres which were part of the AFT programme in 2014. This project was carried out in partnership with the Centre of Excellence in Universal Design (CEUD) at the National Disability Authority and it aimed to improve the walkability audit tool and to reflect the experiences of people of different ages, sizes and abilities.

The CEUD intends to use the data collected and experience gained from the process to inform the development of a national audit tool for roads and streets, using a universal design approach. The Age Friendly Towns programme will use the data collected in each of the towns to make targeted improvements in each of the individual areas.

The walkability audits found that people were for the most part happy with the structures of their towns. On the whole respondents were happy with the accessibility and walkability of their local area. This is borne out by findings from the QNHS study (2013) which found that high proportions of older people walked for recreational purposes in their local neighbourhood.

Figure 69: Persons who walked for recreational purposes, classified by the areas they walk in



Source: QNHS (2013)

The areas covered by the tool included: safety and comfort; footpaths; crossing points; parking; aesthetics; accessibility of public spaces and buildings. Key findings included the following:

- Over 75% of those participating in the audits said they would feel safe walking the route they took on their own.
- The available footpaths were not in good repair (68%) and some respondents said they were not ramped or easy to negotiate (53%).
- Only 33% of people agreed that crossing points were safe and easy to use.
- Over 60% of people were happy that there were accessible parking spaces available close to amenities in the towns audited.
- Over 70% of participants agreed that the streets provided a pleasant environment. More than 60% were happy with the signage available in the towns, though even more signs could be provided for public buildings and local amenities.
- However, 85% of people stated that there were problems with obstacles on the paths they walked, e.g. utility poles, bins, signs or shrubbery.
- Over 75% of people found facilities, such as shops, post offices, churches and libraries accessible.
- A majority (77%) found parks accessible though some would welcome the provision of exercise equipment.

SAFETY AND SECURITY

A feeling of safety when out and about or at home is a very important factor in sustaining independence and engagement (Clarke and Lewis 1982). While all age-groups need to feel safe in their own homes and neighbourhoods, there is some evidence that older people are more fearful for their own safety – a fear which is linked to the potential vulnerability of older people both within their own homes and in the surrounding environment (Ziegler and Mitchell 2003). Good lighting, well-kept, clean streets and a police presence all contribute to a feeling of safety in the community and promote more physical activity and social interaction within the local area (Bennett et al 2007).

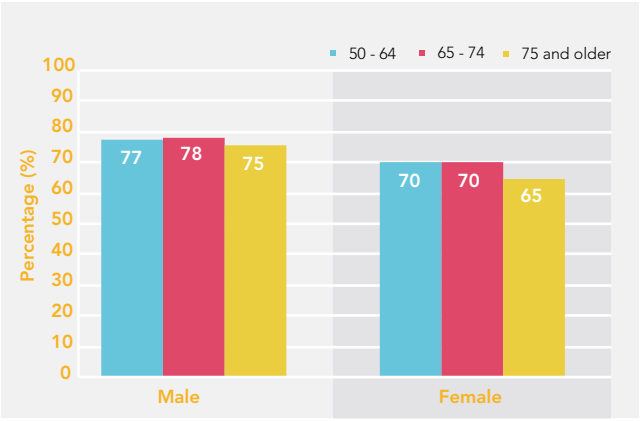
Information collected in the Crime and Victimisation survey (2006) as part of the QNHS illustrated the extent to which adults: perceived crime as a serious problem in Ireland; worried about being the victim of crime and feelings of safety.

Table 7: Percentage (%) of population who...

perceive crime as a serious problem in Ireland (classified by age group)		
	65+	All persons (18 and older)
Very serious problem	63.0	45.9
Serious/Fairly serious problem	36.3	51.1
Not a serious problem/ Not a problem	0.6	3
Total	100.0	100.0
are worried about becoming a victim of crime (classified by age group)		
Yes, personal injury only	14.6	14.9
Yes, property theft, damage only	2.8	3.7
Yes, both personal and property	36.5	34.3
No	46.1	47.1
Total	100.0	100.0

Source: QNHS (2006)

Figure 70: Percentage of adults aged 50+ who feel safe walking alone after dark in their local area



Source: TILDA (2013)

- The percentage who agreed that it was safe to walk alone in their area varied by geographical area, with residents of rural areas more likely to agree (76.1%) relative to Dublin residents (71.5%) or residents of a town or city other than Dublin (68.9%).

Elder Abuse

The problem of elder abuse continues to be addressed at all levels of society through raising awareness, improving reporting rates and developing services.

Elder abuse has been defined by the Health Service Executive Working Group on Elder Abuse as: "A single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human and civil rights." [7]

The different types of abuse, which may result from deliberate intent, neglect, thoughtlessness or ignorance, were categorised by the Working Group on Elder Abuse (2002) in their first report as follows:

Physical abuse, including slapping, pushing, hitting, kicking, misuse of medication, inappropriate restraint (including physical and chemical restraint) or sanctions.

Sexual abuse, including rape and sexual assault or sexual acts to which the older adult has not consented, or could not consent, or into which he or she was compelled to consent.

Psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

Financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance, or financial transactions; or the misuse or misappropriation of property, possessions or benefits.

Neglect and acts of omission, including ignoring medical or physical care needs, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

Discriminatory abuse, including ageism, racism, sexism, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

[7] Working Group on Elder Abuse (2002, p.25)

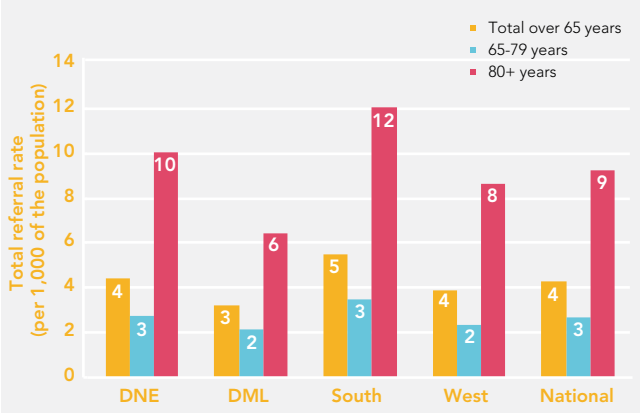
The first report of the Working Group did not include a definition of self-neglect. Self-neglect was subsequently defined as "the inability or unwillingness to provide for oneself the goods and services needed to live safely and independently." [8]

The actual level of elder abuse is difficult to determine as often victims themselves are reluctant to report or acknowledge the problem. In some cases this may be because the abuser is a family member or sole caregiver on whom the victim depends for fulfilment of their basic needs. Many older adults are also reluctant to report abuse because of fear of losing the close personal ties with the family member. When the abuser is a member of the family, there can also be a tendency for other family members to cover up the situation.

The HSE Elder Abuse Services was established in 2005 and systematic collection and analysis of data relating to elder abuse referrals/allegations was initiated in 2007, in the context of new health service staffing structures and reporting procedures. This has led to the establishment of a comprehensive database to capture and analyse referrals to the service.

The following Figure provides an overview of referral rates in 2013, by age and HSE area. Information on type of referral and change in referral rates since 2008 is also presented. The four HSE administrative areas are as follows: Dublin North East (DNE); Dublin Mid Leinster (DML); South; and West.

Figure 71: Elder abuse referral rate (per 1,000 of the population) by age and HSE area, 2013



Source: HSE Elder Abuse Services (2013)

- In 2013 there were a total of 2,437 referrals made to the HSE. These were distributed across the HSE areas as follows: 21% in HSE DNE; 20% in HSE DML; 36% in HSE South; and 23% in HSE West.
- Between 2008 and 2013 the number of referrals has increased by 29% nationally.
- In 1,013 substantiated cases were classified as follows: 47% (n=528) Psychological; 23% (n=255) Financial; 13% (n=147) Physical; and 15% (n=168) Neglect.
- Between 2008 and 2013 the HSE noted that a clear pattern emerged whereby alleged psychological abuse, financial abuse and self-neglect have dominated referrals.
- Across all types of substantiated cases, sons and daughters were the most commonly reported perpetrators, between 44% and 60%.
- The majority of perpetrators of substantiated cases were living with the victim, with the exception of financial abuse. In cases of financial abuse, 30% of perpetrators were living with the victim, 44% were sons or daughters of the victim and 22% were 'Other' relatives, i.e. not a spouse or child.

[8] Policy and Procedures for Responding to Allegations of Extreme Self-Neglect (HSE, 2012) .

CROSS CUTTING OBJECTIVES

Ageing and Age Discrimination Information

Many of the factors limiting the participation and engagement of older people in society are linked to ageism or age discrimination. Age discrimination (Harbison,1999) is an unjustifiable difference in treatment based solely on age and can result in exclusion of older people from employment or the purchase of goods and services.

Ageism is essentially an attitude of mind towards older people, seeing them as weaker, less capable or a potential drain on society's resources. Ageism is a form of discrimination that, according to some, is widespread, overlooked and accepted in western cultures.

Accessing advice and information is also an important part of healthy and positive ageing. Age-related impairments in sensory and cognitive function can act as a barrier to accessing information. Good quality accessible information can help older people become aware of key services and opportunities for social and leisure activities. It also plays a key role in the management of transitions associated with later life, such as securing access to more suitable housing, or other supports that will allow older people to remain in their own homes.

AGEISM AND AGE DISCRIMINATION

Attitudes to age and ageing were investigated in the Northern Ireland Life and Times Survey in 2003 and 2008. These modules were conducted in both Northern Ireland and the Republic of Ireland. Key figures from 2008 in relation to attitudes to age and ageing and discrimination against older people (in the areas of employment, healthcare and financial services) are summarised here.

Question: *Thinking about older people in Ireland, that is people in their 50's and over…Do you think that older people are, on the whole, treated better or worse than people in the general population in this country because of their age?*

Table 8: Treatment of older people

	Percentage of respondents (%)			
	2003		2008	
	Under 65	65+	Under 65	65+
Better	16	35	19	26
Worse	38	25	36	35
The same	42	38	39	35
Don't know	4	3	6	4

Gray and Dowds (2010) based on data from ARK (2009) Northern Ireland Life and Times Survey 2008.

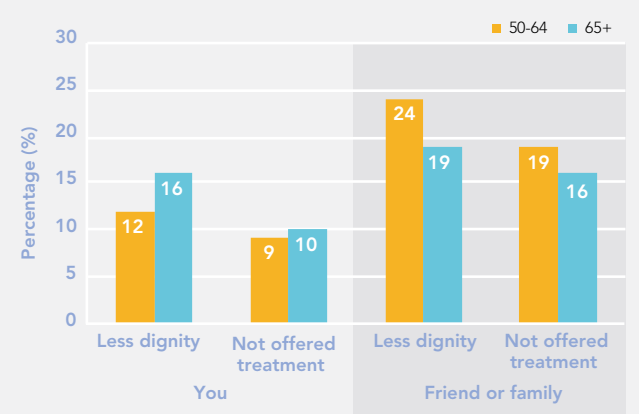
Employment

- In 2008, 11% of people aged 50 and older felt that they were not treated as well as the might have been by an employer because of their age.
- In relation to the workplace, the proportion of people aged 50 and older who felt that older workers were discriminated against in the following areas were: 69% job recruitment; 59% job promotion; 59% job training and 47% status or position in their organisation.

Health and Social Care

Question: Have you ever felt that you or a friend or family member were treated with less dignity and respect by people in the health and social care profession and not offered medical treatment that might have helped because of their age.

Figure 72: Treatment by health and social care staff because of age



Source: Gray and Dowds (2010) based on data from ARK (2009) Northern Ireland Life and Times Survey 2008.

- A larger proportion of people aged 65 and older (16%) felt that they had been treated with less dignity compared with 12% of people aged 50-64.
- A larger proportion of people aged 50-64 felt that a friend or family member had been treated with less dignity (24%) and not offered treatment (19%) because of their age.

Financial Sector

Question: Have you ever felt that you or a friend or family member was not treated as well as you might have been by people in the financial sector because of your age?

Figure 73: Treatment in the financial sector

Source: Gray and Dowds (2010) based on data from ARK (2009) Northern Ireland Life and Times Survey 2008.

- A larger proportion of people aged 65 and older (27%) felt that older people get as good a deal as anyone in the financial sector whereas more than half of all respondents felt that older people are treated less favourably in the financial sector.

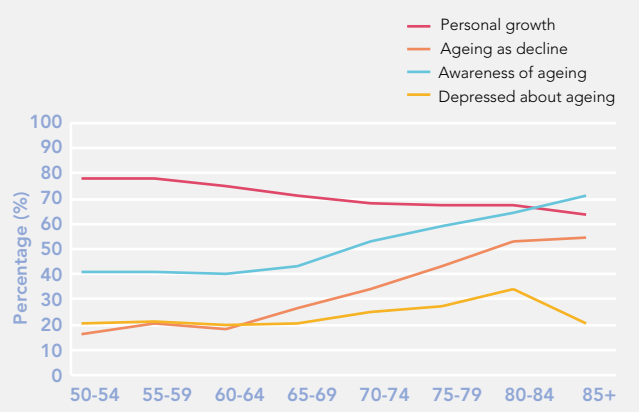
Personal views and experiences of getting older

TILDA captures self-perceptions of ageing among adults aged 50+, using the Ageing Perceptions Questionnaire (APQ). The questionnaire covers several domains of ageing perceptions, including awareness of ageing, ageing as having negative consequences (e.g. physical decline), ageing as having positive consequences (e.g. personal growth) and emotional representations of ageing.

Figure 74 shows the proportion of respondents who agree with the following statements, selected from each of these four domains.

- As I get older I do not cope as well with problems that arise (ageing as decline).
- As I get older I continue to grow as a person (personal growth).
- I am always aware of the fact that I am getting older (awareness of ageing).
- I get depressed when I think about how ageing might affect the things that I can do (depressed about ageing).

Figure 74: Percentage of adults aged 50 and older who agree with each ageing perception

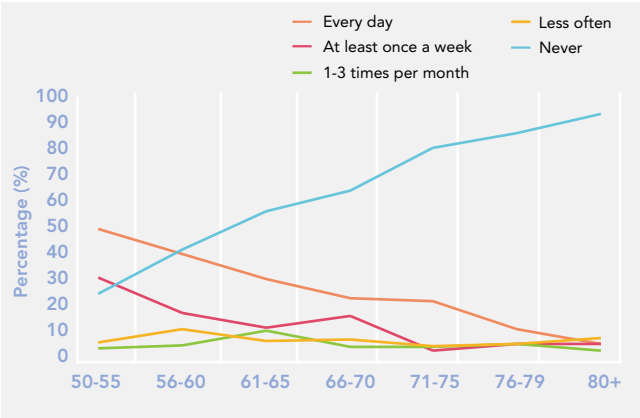


Source: TILDA (2011)

- Perceptions of ageing as having negative consequences increase with age, while positive views of ageing as a time of personal growth become less common. Positive perceptions are nevertheless more prevalent than negative perceptions at all ages.
- Perceptions of ageing as a time of growth and personal fulfilment was confirmed by data from the Northern Ireland Life and Times Survey. Only 3% of people aged 65+ and older considered 'boredom' to be one of the main problems faced by older people. This compared with 34% of adults aged <65.
- Just over one in five older adults (22.4%) report that they feel depressed about the negative effects of ageing.

INFORMATION

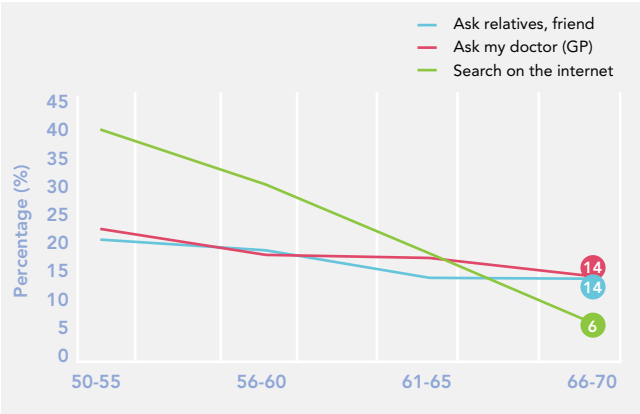
Figure 75: Percentage of people age 50 and older who use the internet



Source: EQLS (2011)

Participants in TILDA were asked to indicate the first step they would take to find information on State services if they, or a relative, need one of 17 different services listed. Services included social work, occupational therapy, meals-on-wheels, and home help. The most frequently stated sources of information were relative and friends, their doctor (GP) and searching the internet, though differences are seen across age groups.

Figure 76: Sources of information on State services



Source: TILDA (2011)

IRELAND IN THE ACTIVE AGEING INDEX

The Active Ageing Index is a tool developed for policy makers to support evidence-informed strategies in dealing with the challenges of population ageing and its impacts on society. It provides comparisons between European Union (EU) countries in each of the domains that contribute to an experience of Active Ageing: employment; social activity and participation; and independent, healthy and secure living. The AAI also includes a fourth domain which captures how EU countries differ with respect to the capacity and enabling environment for active ageing.

Table 9 displays the value recorded for Ireland for each indicator included in the Active Ageing Index (UNECE/ European Commission, 2015). The average value for the EU is displayed as a comparison, along with the maximum value achieved across EU countries, which represents a benchmark for potential achievement for each indicator. Ireland performs better than the EU average for almost all indicators; however, it also performs well below the maximum value for most indicators.

Table 9: How does Ireland measure up? The Active Ageing Index Indicators for Ireland and the European Union

Active Ageing Index Indicator		Ireland (%)	EU28 (%)	Max Value (%)
1. Employment				
1.1	Employment rate for the age group 55-59 (EU-LFS)	57.6	62.2	82
1.2	Employment rate for the age group 60-64 (EU-LFS)	39.8	31.6	64.2
1.3	Employment rate for the age group 65-69 (EU-LFS)	16.2	11.6	27
1.4	Employment rate for the age group 70-74 (EU-LFS)	8.6	6.1	20.4
2. Participation in society				
2.1	Voluntary activities: percentage of population aged 55+ providing unpaid voluntary work through the organisations (at least once a week) (EQLS)	20.1	8.9	20.6
2.2	Care to children and grandchildren: Percentage of population aged 55+ providing care to their children and/or grandchildren (at least once a week) (EQLS)	39.4	32.5	53.7
2.3	Care to older adults: Percentage of population aged 55+ providing care to elderly or disabled relatives (at least once a week) (EQLS)	16.5	12.9	17.1
2.4	Political participation: Percentage of population aged 55+ taking part in various forms of political activities (EQLS)	21.3	17.2	43.8
3. Independent, healthy and secure living				
3.1	Physical exercise: Percentage of people aged 55 years and older undertaking physical exercise or sport almost every day (EQLS)	25.4	15.6	48.9
3.2	Access to health and dental care: percentage of population aged 55+ who report no unmet need for medical and dental examination (SILC)	95.4	88.2	97.7
3.3	Independent living arrangements: percentage of persons aged 75 and older living in single or couple households (SILC)	87.2	84.2	99.5
3.4	Relative median income: ratio of the median equivalised disposable income of people aged 65+ to the median equivalised disposable income of those aged below 65 (SILC)	88.4	86.3	100.0
3.5	No poverty risk for older persons: percentage of people aged 65+ who are not at the risk of poverty using 50% of the national median equivalised disposable income as the poverty threshold (SILC)	92.3	93.0	98.6
3.6	No severe material deprivation for older persons: percentage of people aged 65+ not severely materially deprived (SILC)	97.7	90.0	100.0
3.7	Percentage of people aged 55 years and older who are feeling safe to walk after dark in their local area (ESS)	77.1	69.3	94.6
3.8	Lifelong learning: percentage of older persons aged 55-74 who received education or training in the 4 weeks preceding the survey (EU-LFS)	2.7	4.5	22.9
4. Capacity and enabling environment for active and healthy ageing				
4.1	Remaining life expectancy at age 55, as a share of the target of 50 years, using EHLEIS	56.3	53.8	59.4
4.2	Share of healthy life years in the remaining life expectancy at age 55, using EHLEIS	65.2	53.2	76.1
4.3	Mental wellbeing (for older population aged 55+, using EQLS and using WHOs ICD-10 measurement)	77.4	64.6	87.3
4.4	Use of ICT by older persons aged 55-74 at least once a week (including everyday), using Eurostat ICT Survey	43.0	40.8	78.0
4.5	Social connectedness: Percentage of older population aged 55+ who meet friends, relatives or colleagues at least once a month (ESS)	52.5	49.0	73.6
4.6	Educational attainment of older persons: Percentage of older persons aged 55-74 with upper secondary or tertiary educational attainment (EU-LFS)	49.0	59.7	84.3

EU-LFS = European Union Labour Force Survey; EQLS = European Quality of Life Survey; SILC = Survey of Income and Living Conditions;
ESS = European Social Survey; EHLEIS = European Health and Life Expectancy Information System

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APPENDIX: DATA SUMMARY

Data Source	Census
Reference Period(s)	2006, 2011
Data collection frequency	Five year intervals
Coverage	De facto population i.e. the population recorded for each area represents the total of all persons present within its boundaries on the night of the Census, together with all persons who arrived in that area on the morning of Monday, 11 April 2011, not having been enumerated elsewhere.
Method of data collection	Self-completed form
Data content	Demography
Relevant policy areas	Healthcare, health, carers education, employment, transport, housing and living arrangements
References	http://www.cso.ie/en/census/
Sample Size	4,581,269 (total population)

Data Source	European Quality of Life Survey (EQLS)
Reference Period(s)	2011-12
Data collection frequency	Every four years
Coverage	The target population is all residents aged 18 and older, and the target sample size ranges from 1,000 to 3,000. A multi-stage, stratified random sampling procedure is used.
Method of data collection	Face-to-face questionnaire
Data content	Employment, income, housing and environment, family, health, work-life balance, subjective wellbeing and social equality.
Relevant policy areas	Family life, housing, income, life satisfaction, subjective-wellbeing, trust and social solidarity, poverty and social inclusion.
References	http://www.eurofound.europa.eu/surveys/european-quality-of-life-surveys-eqls/european-quality-of-life-survey-2012
Sample Size	1051 (2011)

Data Source	Northern Ireland Life and Times Survey
Reference Period(s)	2008
Data collection frequency	Annual (Attitudes to Older People 2003 and 2008)
Coverage	A unique sample was selected from the Geo-directory using the Economic and Social Research Institute's random sampling system RANSAM and comprised a purposive selection of 84 wards / District Electoral Divisions nationally representative.
Method of data collection	Face-to-face paper based questionnaire in the respondents home
Data content	Attitudes to Older People, perception of and experience of age-related discrimination.
Relevant policy areas	Ageism, participation health and wellbeing and security.
References	1) 1)http://www.ark.ac.uk/nilt/ 2) http://www.ark.ac.uk/publications/occasional/sage10.pdf
Sample Size	1,234

Data Source	Programme for the International Assessment of Adult Competencies (PIAAC)
Reference Period(s)	2011-12
Data collection frequency	Longitudinal; Wave 2 TBC
Coverage	Adults aged 16 to 65 Three-stage sample, with areas, households and adults selected at random within each county. The sample of respondents was selected to be representative of the geographical distribution and socio-demographic characteristics of the population.
Method of data collection	Face-to-face in the homes of respondents using a combination of laptop computers and paper test booklets.
Data content	Adult skills in literacy, numeracy, problem-solving in technology rich environments, skills use in work and in everyday life (at home and in the community).
Relevant policy areas	Life-long learning, employment, participation in education, access to information.
References	http://www.oecd.org/site/piaac/
Sample Size	6,000

Data Source	Quarterly National Household Survey(s)
Reference Period(s)	1997-2014
Data collection frequency	Quarterly; The reference calendar quarters for survey results are: Q1-January to March, Q2- April to June, Q3- July to September and Q4- October to December.
Coverage	The sample is designed to be representative of on a quarterly basis and includes individuals living in private households where at least one individual is aged 15 years or older and for whom the household is the main residence. A two-stage sample design is used: 1) Probability Proportional to Size (PPS) in order to cluster the sample frame of households in to blocks and 2) Simple Random Sampling (SRS) of households from clusters of households.
Method of data collection	Face-to-face interviews using CAPI (Computer Assisted Personal Interviewing)
Data content	Labour market statistics: demographic variables; educational attainment; labour force classification; industrial activity; occupation and employment status. Special Modules referenced in this report include: Sports (Q2, 2013); Retirement Planning (Q2, 2012); Voter Participation (Q2, 2011); Caring (Q2, 2009); Crime and Victimisation (Q2, 2006).
Relevant policy areas	Participation in sport and physical activity, employment, educational attainment, political engagement, retirement planning and the health of carers, personal security and perceived safety.
References	http://www.cso.ie/en/qnhs/
Sample Size	The total quarterly sample is designed to be 26,000 households. The actual achieved sample varies over time depending on response rate.

Data Source	Survey of Health, Ageing and Retirement in Europe
Reference Period(s)	Wave 2, 2008
Data collection frequency	Longitudinal; Ireland participated in wave 2 (2008) and SHARELIFE (2010)
Coverage	Community dwelling adults aged 50 and older, and their partners (irrespective of age) selected at random within each county. The sample of respondents was selected to be representative of the geographical distribution and socio-demographic characteristics of the population.
Method of data collection	Face-to-face computer assisted personal interviews and a drop-off self-completion questionnaire.
Data content	Physical and mental health, health service utilisation, social support, behavioural risk, employment, pensions and retirement, housing, income and assets.
Relevant policy areas	Health, retirement, housing, income and assets, social support and participation.
References	www.share-project.org
Sample Size	Households: 836; Individuals: 1,119

Data Source	The Irish Longitudinal Study of Ageing (TILDA)
Reference Period(s)	Wave 1 (2009-2011); Wave 2 (2012-2013)
Data collection frequency	Every two years, wave 3 due to finish data collection in 2015
Coverage	Community-dwelling adults aged 50+ at wave 1 and 52+ at wave 2, living in the Republic of Ireland (ROI). A random, clustered, stratified sampling is used to ensure population representative sample.
Method of data collection	Face-to-face Interviews in participants homes; self-completion questionnaire; nurse-led health assessment
Data content	Health, economic and social data
Relevant policy areas	Employment, Education and Lifelong Learning, Active Citizenship, Engagement in Activities, Transport, Healthy Ageing, Support and Care Services, Income, Homes, Ageism
References	TILDA data available from http://www.ucd.ie/issda/data/tilda/
Sample Size	Wave 1: 8,175; Wave 2: 7,010

Data Source	European Survey of Income and Living Conditions (EU-SILC)
Reference Period(s)	2011, 2013 and Special Module on Housing (2012)
Data collection frequency	Annual
Coverage	A representative random sample of households based on two-stage stratified cluster sample (comparable to the QNHS)
Method of data collection	Face-to-face CAPI (Computer Assisted Personal Interviewing)
Data content	Direct income, social transfers, housing, income and deprivation.
Relevant policy areas	Poverty, deprivation, social inclusion, fuel poverty, accommodation and health.
References	http://www.cso.ie/en/silc/
Sample Size	In excess of 5,000 households since 2009

ADDITIONAL SOURCES OF DATA (PUBLISHED REPORTS):

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