



HEALTHY & POSITIVE AGEING INITIATIVE

**Respect and social inclusion: results from the
HaPAI survey**

2018

The Healthy and Positive Ageing Initiative (HaPAI) is a joint research programme led by the Department of Health with the Health Service Executive, the Age-friendly Ireland Programme, and The Atlantic Philanthropies.

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This report presents information collected by the HaPAI Age-friendly Cities and Counties Survey, a study involving adults aged 55 and older in 21 Local Authorities in Ireland.

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PREFACE

This report was completed by the Healthy and Positive Ageing Initiative (HaPAI) which is a research programme led by the Department of Health in association with the HSE, the Age-Friendly Ireland Programme, and The Atlantic Philanthropies. The HaPAI was established in order to achieve Goal 4 of the National Positive Ageing Strategy (1): *Support and use research about people as they age to better inform policy responses to population ageing in Ireland*. National Goal 4 involves two objectives:

- Continue to employ an evidence-informed approach to decision-making at all levels of planning; and
- Promote the development of a comprehensive framework for gathering data in relation to all aspects of ageing and older people to underpin evidence-informed policy making.

The HaPAI is also aligned with several goals and actions of Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025 (2), the national framework for the improvement of population health and wellbeing, and the WHO's Active Ageing: A Policy Framework (3) which provides key policy proposals for enabling active ageing in our societies. The HaPAI commenced in 2015 and is operational in a number of different areas of activity:

- The development of national indicators of older people's health and wellbeing, leading to the 2016 publication of a biennial report on the health and wellbeing of older people in Ireland;
- The establishment of a research fund to commission targeted additional research to fill identified data gaps required to cover all indicators, relevant to the design or configuration of future services and supports for older people; and,
- At a local level, the development of 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.

EXECUTIVE SUMMARY

At present, the majority of research and strategies aimed at understanding and addressing ageism has focused on paid employment and the labour market. Ageism as a barrier to community engagement has been largely overlooked. This study distinguishes between two aspects of ageism: 1) experience of ageism - experience of negative attitudes and behaviours towards you as an older person and 2) perceived ageism - the perception that people have negative attitudes towards older people taking part in activities.

Supporting evidence-informed strategies and programmes

The purpose of this study was to provide up-to-date evidence about experiences of ageism, perceptions of ageism and community participation. For the first time in Ireland this information is reported at local level in order to support positive and healthy ageing programmes and interventions in local areas. Data is from the HaPAI Age-friendly Cities and Counties Survey which involved 10,500 adults aged 55 and older in 21 Local Authority areas.

Key findings for adults aged 55+

- Over one in ten (11.1%) people aged 55+ experienced ageism and 8.2% perceived ageism within their community.
- Lower socio-economic status (lower education, being out of work, and material deprivation), poorer health and living in an urban location were associated with an increased likelihood of experiencing ageism.
- Women, those who are currently employed, materially deprived, in less than good health and urban dwellers were more likely to perceive ageism.
- People aged 55+ who perceived ageism were significantly less likely to participate in community activities, and this association remained significant when socio-demographic, socio-economic and health variables were accounted for.

Strategy pointer

Ageism is a barrier to community participation; however this barrier is potentially modifiable. Ensuring that ageing and the concerns of older adults are considered in national frameworks and policies could play an important role in modifying negative perceptions of ageing.

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CHAPTER ONE

INTRODUCTION

Positive ageing and age-friendly cities and counties

1. INTRODUCTION

IRELAND'S AGEING POPULATION

Demographic change has the potential to create opportunities and challenges for communities of the future. The demographics of Ireland are changing rapidly and according to a 2017 report from the Economic and Social Research Institute (ESRI) between 2016 and 2030 the population share of people aged 65 and over will increase from 13% to between 17% and 19 % and the number of people aged 65 and over is projected to increase by between 58% and 63% during this time (4).

Demographic ageing represents a triumph in development, as people are living longer lives due to better food, health care, sanitation, education and economic wellbeing (5). However, demographic ageing also has implications for public policies and strategies, service provision, long-term planning, and society as a whole in areas as diverse as housing, transport, education, employment, tourism, business development, and civic and social engagement.

Older adults contribute to both their extended families and the wider community in a variety of ways including financial support, family care or other supports and through active citizenship in their communities. Importantly, these relationships are often reciprocal, with older adults benefitting in terms of improved quality of life and psychological wellbeing. Far from being reliant on familial and social support, older members of society are in many instances net contributors to their extended family and communities. As such, it is important that we continue to move away from a predominantly health and medical focus on the ageing population towards a more holistic approach that also includes broader social and economic characteristics (6).

POSITIVE AGEING

Strategies and plans such as the National Positive Ageing Strategy (NPAS) (1) and Healthy Ireland – *A Framework for Improved Health and Wellbeing 2013-2025* (2), have recognised this new reality and have sought to take a different approach to planning for this new Ireland. There has been a shift in the perception of ageing towards the more positive perspective, conceptualising later life as a period of continued growth and development for older people. This view is central to the vision set out in the NPAS and is consistent with international developments in relation to ageing, and in particular the WHO's *Active Ageing: A Policy Framework* (3).

The NPAS set 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".

This vision translated into four 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

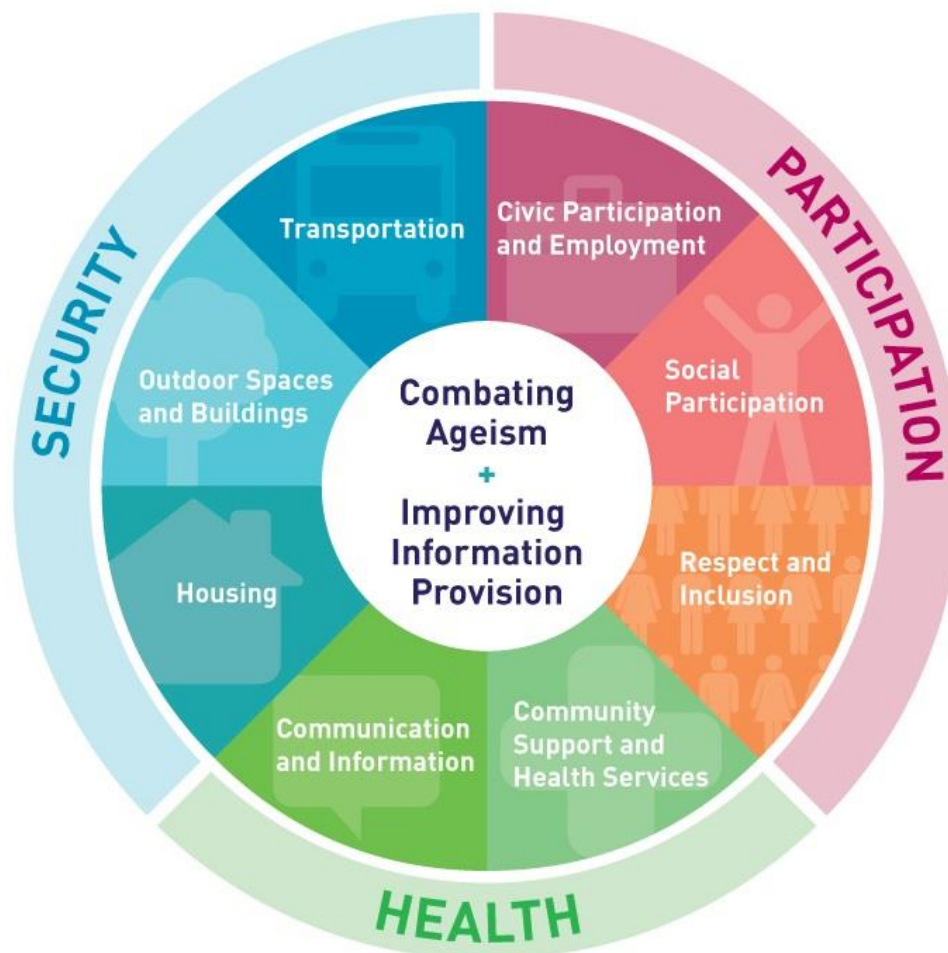
From the outset it was intended that implementation of the NPAS would require a 'whole of government' response, and be framed within the implementation of Healthy Ireland (2). At local level, the WHO Age Friendly Cities and Counties (AFCC) programme was identified in the National Positive Ageing Strategy (1) as being an important approach to improving the lives of older people throughout the country.

The concept of 'age-friendliness' is linked to an initiative started by the WHO in 2007 called the WHO Global Age-Friendly Cities project (7) . In an age-friendly community, policies, services and structures related to the physical and social environment are designed to support and enable older people to "age actively" – that is, to live in security, enjoy good health and continue to participate fully in society. Public and commercial settings and services are made accessible to accommodate varying levels of ability, to recognise the great diversity among older persons and to promote their inclusion and contribution in all areas of community life.

The Age Friendly Cities and Counties programme was built on the understanding that the wide-ranging change and planning required to prepare for demographic ageing called for a collaborative approach. In each local authority, the Age Friendly Cities and Counties programme provides a mechanism for the relevant local agencies and stakeholders, working under the aegis of the Local Authorities, to ensure that their combined resources are used optimally, delivering necessary services to older people within their own local communities. These stakeholders include agencies from local governments, non-profit organisations, advocacy groups, older people themselves and the broader community.

Each Local Authority in Ireland has committed to developing an Age Friendly Programme based on the World Health Organisation (WHO) Age-Friendly Cities Framework and Guidelines (7). An age-friendly environment fosters health and wellbeing by focusing on and nurturing eight domains which are closely aligned with the goals of the NPAS as illustrated in Figure 1.

FIGURE 1 NATIONAL POSITIVE AGEING STRATEGY GOALS ALIGNED WITH WHO AGE-FRIENDLY CORE DOMAINS



This report focuses on the WHO Age-friendly core domain of '*Respect and Social Inclusion*' which is NPAS cross-cutting objective of '*Combating Ageism*'. This report has three aims:

- Aim 1: To profile the characteristics of adults aged 55+ who had experienced ageism and who perceive ageism in their community.
- Aim 2: To explore the factors associated with experiences and perceptions of ageism.
- Aim 3: To investigate the association between experiences and perceptions of ageism and the likelihood of participating in community activities.

This report is organised as follows: Chapter 2 presents relevant literature on ageism and social inclusion, and describes existing strategies surrounding ageism. Chapter 3 outlines the methods used in this study. Chapter 4 presents the results of this study

by describing the distribution of experiences of ageism, perceptions of ageism and community participation by socio-demographic, socio-economic, health and location characteristics, and by geographical area. Chapter 4 also investigates the factors associated with experiences of ageism, perceptions of ageism, and the association between ageism and participation in community activities. Chapter 5 presents a discussion of the findings and also concludes the report.



CHAPTER TWO

BACKGROUND

Ageism and Social Inclusion

2. BACKGROUND

In this section we consider attitudes to age and ageing and discuss current research evidence surrounding the effects of ageism on the health and well-being of older adults. We also describe social inclusion and its relationship with ageing. We conclude this section by looking at current trends and existing strategies surrounding ageism in Ireland.

RESPECT: ATTITUDES TO AGE AND AGEING

Terms such as ‘healthy ageing’, ‘positive ageing’ and ‘successful ageing’ have emerged which aim to dispel an image of older adults as dependent and unproductive and instead focus on maintaining a positive attitude towards ageing and engaging fully throughout the life course (8). Nevertheless, negative images, attitudes, and perceptions of age and ageing still persist (9). Ageism is often characterised by negative stereotyping, animosity or negative behaviours and attitudes towards people because of their age. Ageism can manifest itself in multiple ways including discriminatory practices, prejudicial attitudes and institutional policies which promote and sustain negative stereotypical beliefs (10).

Previous studies have shown that negative attitudes towards older persons have the propensity to reduce their quality of life (9,11), lead to poorer quality of healthcare and health outcomes, lower self-esteem (12) and have a negative impact on a range of social and economic opportunities, including community participation. Conversely, it has been suggested that an active and engaged lifestyle can provide a source of immunity to negative perceptions of ageism (13).

During consultations for the development of the WHO’s (2007) Age-friendly Cities Guide, older adults reported experiencing conflicting types of attitudes and behaviours from others. Although, many older adults feel they are respected and included, many others feel that they are not well recognised within their communities. In addition, factors such as culture, gender, health status and economic status influence older adults’ experiences of respect and social inclusion. The degree to which older adults participate in the social, civic and economic aspects of their community is closely associated with this *inter-sectionality* between age and other socio-economic and socio-cultural factors and identities (7).

Societal-level attitudes about age and ageing form an important part of the social and cultural environment within which people construct their own beliefs and attitudes towards ageing. Societal attitudes towards age and ageing affect people of all ages, by confounding understanding of the ageing process, reinforcing structural inequalities, and influencing the behaviour patterns of older persons in particular, in a manner which may be antagonistic with their own interests (8,14). Consequently, as people age there is an increased risk of internalising negative age-related stereotypes. Negative self-perceptions of ageing have been linked to a range of

adverse consequences such as cognitive decline, physical frailty and cardiovascular responses to stress (15,16) and are therefore a major threat to healthy ageing.

SOCIAL INCLUSION

Social inclusion has been described as an individual's capacity to participate sufficiently within mainstream society and reflects the quality and quantity of their social ties (17). In contrast, social exclusion describes the separation of persons and groups from conventional society (18,19) through various processes across the life course and into old age. In a recent review, Walsh, Scharf & Keating (31) refined Levitas et al.'s (21) definition of social exclusion in later life to:

"...a multidimensional, dynamic construct that varies in form and degree across the older adult life course. It involves the interchange between multi-level processes and outcomes leading to diminished access to the activities, resources and relationships, and rights and choices available to the majority of people across the interconnected domains of: neighbourhood and community; services, amenities and mobility; material and financial resources; social relations; cultural aspects; and civic participation."(p.16).

As such, social inclusion cannot simply be described as a set of individual characteristics and it is necessary to consider both neighbourhood and community factors. Social exclusion not only encompasses economic disadvantage and disabling environments but also negative societal attitudes and norms surrounding ageing which have the propensity to exclude individuals and groups over time.

CURRENT TRENDS

In a 2011 European network of equality bodies (Equinet) report on active ageing and solidarity between generations there was considerable variation in complaints and inquiries surrounding ageism in Europe: 20% in Austria, 17% in the Netherlands, Germany, and Lithuania; 16% in France; 11% in Hungary; 10% in Denmark; 8% in the Czech Republic; 7% in Luxemburg; 5% in Belgium, and, approximately 3% in the U.K, Ireland and Bulgaria (22). Even though, Ireland is amongst the countries with the lowest rates of reports of age-related discrimination, indicators based on reported complaints and inquiries and are likely to underestimate the day-to-day experience of negative attitude and behaviours. For example, in Ireland data from the Quarterly National Household Survey (QNHS) data showed an upward trend in experiences of ageism among adults aged 50 and older from 34% in 2004 to 45% in 2014. Among the contexts surveyed, two were particularly problematic: 'looking for work' which increased from 82% in 2004 to 87% in 2014; and, 'in shops, pubs and restaurants' which increased from 27% in 2004 to 37% in 2014 (23).

CURRENT POLICY AND STRATEGIES

At an international level, the World Report on Ageing and Health published by the WHO (24) made an explicit call for a new framework for global action that will have the capacity to transform dated ways of viewing ageing, encourage a significant shift in the understanding of ageing, as well as inspiring the development of multi-sectoral approaches. Key steps to combating ageism outlined in the WHO report

included: government policy developments should be created which allow for the enhancement of solidarity between generations; intergeneration initiatives at local, regional and national level; the inclusion of older people in policy and service development; and, age-balanced representations of society in the media (24).

At a national level, the NPAS (1) positioned Combating Ageism as a cross-cutting objective on the basis that it is relevant to all Pillars of the Strategy (health, participation, and security) and highlighted the need to eliminate ageism in all its forms to create a society characterised by equality. The specific objectives for Combating Ageism including:

1. The promotion of activities which will help to combat ageism and to debunk age related stereotypes;
2. Combating ageism by means of awareness campaigns and by encouraging the media to provide an age balanced image of society;
3. Ensuring older people's needs are considered in the development of any policies that might actually affect them;
4. Promoting a better understanding of the importance of intergenerational solidarity and ensuring that policy developments enhance solidarity between generations;
5. Encouraging the development of intergenerational initiatives at local, regional and national level; and,
6. Creating a better awareness of the needs and preferences of people as they age during policy and service development by adopting more comprehensive and inclusive approaches consultation.

To date, the majority of Irish laws regarding ageism relates to employment and the labour market such as The Employment Equality Act (1998) (25). Under the Equal Status Act (2000) (26) ageism is also prohibited in relation to the provision of goods, services and facilities, accommodation and education.

Another concern surrounding the respect and social inclusion of older adults relates to the development of strategies themselves (27). The guidelines set out by the Irish Human Rights and Equality Commission (28) in relation to consulting with older people in the development of national strategies are an important resource in addressing this issue. These guidelines advocate for the use of a range of good consultation practices including information provision that is clear and user friendly and inclusive of older adults.

One of the core structures developed as part of the Age Friendly Cities and Counties programme is the Older People's Council. These councils provide older adults with the opportunity to identify areas of need within their local area, to raise important issues and concerns and to inform and influence the decision making process of the City or County Age Friendly Alliance (29). There are currently Older People's Councils in all 31 Local Authority areas in Ireland and they ensure that each local Age-friendly Alliance is accountable to older people at local level (30). In terms of social inclusion, Older People's Councils provide a mechanism to represent the diversity of older adults in each area and to support the civic and social participation of those who may be marginalised (29).

In summary, the concept of social inclusion is exceptionally broad, encompassing a wide range of domains and processes including neighbourhood and community relations, social relations, services, amenities and mobility and material and financial resources. Furthermore, ageism is conceptually inherent within a modern day understanding of social inclusion and within the WHO Age-friendly Cities –A Guide, respect and social inclusion are presented as being co-dependent.



CHAPTER THREE

METHODS

Data, fieldwork, study measures, analysis,
and study sample overview

3. METHODS

DATA AND SAMPLE

Data is from the Healthy and Positive Ageing Initiative (HaPAI) survey. This was a random-sample, population representative survey of people aged 55 and older, living in 20 Local Authority areas in 2015-2016. The following Local Authorities participated in the survey: Dublin City; South Dublin; Fingal; Dun Laoghaire-Rathdown; Galway City; Galway County; Clare; Limerick City and County; Kildare; Kilkenny; Laois; Louth; Meath; Wexford; Wicklow; Cavan; Cork City; Cork County; Mayo; and Tipperary. Approximately 500 interviews were completed in each local authority area with the exception of Limerick where both the city and county were surveyed separately and 500 interviews were carried out for each area. The results for Limerick City and County are presented separately in the tables below. Data was collected between 2015 and 2016.

The target population for this survey includes all community-dwelling members of the population aged 55 and older in each Local Authority. This sample did not include people aged 55 and older who were in long-term care or living in an institution at the time of survey.

A multi-stage random-route sampling strategy was used to generate a sample of this population. This sampling approach involved several steps. Firstly, a random sample of 50 District Electoral Divisions (DED) in each Local Authority was selected as the primary sampling units (PSUs). Within each selected DED a starting address was selected at random. Beginning with this address a total of 10 interviews were to be completed in each of the 50 areas.

Detailed information on the approach that interviewers took to identify eligible households within each area for the survey is described below. In summary, from their starting address, interviewers called to every fifth house. The interviewer asked to speak to a person aged 55 years or older in the household. One person aged 55 or older per household was invited to complete the interview. If there were two or more older people in the household the interviewer applied the 'next birthday' rule to select one participant.

FIELDWORK AND DATA COLLECTION

A total of 10,540 interviews were conducted in Ireland between 2015 and 2016. Each participant completed a structured Computer-Assisted Personal Interview (CAPI) in their own home with a trained interviewer from Amárach Research. Participants were also invited to complete an additional, separate, paper-based survey which included subjective wellbeing (depressive mood and quality of life) and experience of elder abuse.

RESPONSE RATES AND SAMPLE WEIGHTS

The response rate is the proportion of selected households that included an eligible participant who completed an interview.

The overall response rate was 56%, and this ranged from 51% to 63% across the areas. This includes an estimate of the households who are likely to contain an eligible household member, but for which eligibility was not determined. The response rate and number of respondents within each Local Authority area are reported in Table 1 below.

Response rates typically vary among different groups within a given population such as different age groups or levels of education. This variation can lead to biased estimates when reporting results. In order to adjust for this, sample weights have been applied to the survey data. The sample weights corresponded to the number of people, with a given set of characteristics, in the population that were represented by each survey participant. Weights which were applied to the survey sample were estimated using the Census (2011). The characteristics compared were age, gender, educational attainment (primary/secondary/third level) and marital status (married/not married).

TABLE 1 NUMBER OF PARTICIPANTS AND RESPONSE RATE IN EACH LOCAL AUTHORITY

Area	Sample (n value)	Response Rate (%)
Clare	500	59
Cork County	501	58
Cork City	501	56
Cavan	500	56
Dublin City	502	57
Dublin Fingal	502	50
Dun Laoghaire-Rathdown	502	51
South Dublin	501	57
Galway County	518	55
Galway City	504	63
Kildare	500	62
Kilkenny	500	55
Laois	501	60
Limerick City	501	59
Limerick County	502	59
Louth	500	53
Meath	500	56
Mayo	502	51

Area	Sample (n value)	Response Rate (%)
Tipperary	502	54
Wicklow	500	57
Wexford	501	51
Total	10,540	56

MEASURES

The HaPAI survey contained a number of questions that asked respondents about their experiences of ageism, perceptions of ageism and community participation. The survey questions and the response categories are shown in Table 2.

TABLE 2 EXPERIENCE OF AGEISM, PERCEPTION OF AGEISM AND COMMUNITY PARTICIPATION MEASURES

Measures	Description
Experience of Ageism	<p>A derived measure based on responses to a series of questions asking respondents whether they had experienced negative attitudes or behaviour towards them as an older person from the following sources or settings: 1) Their family; 2) People in their community; 3) Young people; 4) Health professionals providing services; 5) Those providing services in the financial sector; 6) Social care providers; 7) Other older people; 8) In places like shops, pubs; and, 9) Using leisure facilities such as gyms or clubs.</p> <p>Response categories: Yes or No.</p>
Perceptions of Ageism:	<p>Thinking about your local area, would you agree or disagree with the following statement about involvement in these types of activity in the community?</p> <p>Statement: People have negative attitudes about older people being involved in the activities.</p> <p>Response categories: Did Agree (agree); Did not agree (disagree and don't know).</p>

Measures	Description
Participation in Community Activities:	How often do you participate in any groups such as a sports or social club, a church connected group, a self-help or charitable body or other community group or a day centre? Response categories: Weekly; Monthly (but not weekly); or, Never.

A list of the indicators included in the analysis in this report is provided in Table 3 below. As shown we have included a wide range of important demographic characteristics, socio-economic status, and health status indicators.

TABLE 3 DEMOGRAPHIC, SOCIO-ECONOMIC, SOCIAL AND HEALTH MEASURES

Measures	Description
Gender	Male or female
Age	Age group categories used in this study: 55+, 55-64, 55-69, 65+, 65-74, 70+ and 75+
Marital status	Married/living with a partner as married, single (never married), divorced/separated, or widowed
Household composition	Living alone, living with spouse/partner, or living with family/non-family (with or without spouse/partner)
Material Deprivation	Responding 'no' to two or more items from a list of 11 items about the household E.g. Does the household replace any worn out furniture.
Income	Income bands: €501 up to €1,000; €1,001 up to €1,500; €1,501 up to €2,500; €2,501 or more. A missing category is also included due to missing information (32.4%).
Location of home	Rural (open countryside or village) or urban (town, city or city suburb)
Education	Primary or none, secondary, or third level
Health	How is your health in general? Very good, good, fair, bad, very bad
Long-standing illness/condition that limits everyday activities	No long-standing illness/condition; yes, not limiting; yes, limiting; yes, severely limiting.

ANALYSIS

All descriptive statistics were computed using Stata (Version 14) and percentages are reported with 95% confidence intervals (95% CI).

In Section 4 we report the results of a series of mixed effects logistic regression analyses that examine the association between ageism and demographic, socio-economic and health characteristics factor and the likelihood of experiencing and perceiving ageism. A second model investigated the association between experiences of ageism and perceptions of ageism and the likelihood of participating in community activities, controlling for demographic, socio-economic and health characteristics. A multilevel approach was taken to account for the two-stage sampling strategy employed that involved respondents (level 2) being sampled from within Local Authority regions (level 1). An important advantage of this technique is that it enables us to statistically control for the effect of a number of factors simultaneously. Stata (Version 14) computer software was used to analyse the data (32).

The results are reported in Odds Ratios (OR) which represents the odds that a predefined outcome (i.e. experiencing ageism) will occur given a particular exposure, compared to the odds of the outcome occurring in the absence of that exposure. An OR of >1 indicates that the odds of the predefined outcome occurring in the presence of an exposure relative to the predefined outcome occurring in the absence of the same exposure increases as the predictor changes. For the purpose of interpretation, this means that a particular predefined outcome is more likely. An OR <1 indicates that the odds of the predefined outcome occurring decreases as a variable changes.

For each Odds Ratio present in the tables 95% confidence intervals are also reported which provide an estimate of the accuracy of the parameter estimate, that is, the odds ratio. Also, if a value of 1.00 does not fall between the confidence interval we can say that there is a statistically significant difference between the groups being compared.

SAMPLE CHARACTERISTICS

Sample characteristics are presented in Table 4. Just over half were female (52.7%) and almost half were aged less than 65 years (46.5%). Two-thirds (65.0%) were married and 10.1% were single/never married. Almost one-in-five (17.9%) had a third level education. Half of the sample was retired (50.9%) and a further 25.0% were in paid employment. Almost one-in-ten respondents were considered to be materially deprived. As is typical in surveys like this one, there was a lot of missing information on household income: respondents either refused to answer the question about their income or could not do so. Of those who did respond, the distribution of household income was quite even across the sample.

TABLE 4 RESPONDENT CHARACTERISTICS

Characteristics		%	(95% CI)
Gender	Male	47.3	(46.0-48.5)
	Female	52.7	(51.5-54.0)
Age	55-64	46.5	(44.9-48.1)
	65-74	31.5	(30.3-32.7)
	75+	22.0	(20.7-23.3)
Marital status	Married/living with a partner	65.0	(63.5-66.5)
	Single (never married)	10.1	(9.3-11.0)
	Separated/divorced	6.2	(5.5-6.9)
	Widowed	18.7	(17.8-19.8)
Education	Primary or less	34.4	(32.3-36.4)
	Secondary	47.8	(46.1-49.5)
	Third Level	17.9	(16.6-19.2)
Employment Status	Retired	50.9	(49.2-52.6)
	Employed/self-employed	25.0	(23.7-26.4)
	Looking after home/family	14.2	(13.1-15.4)
	Other	9.9	(9.0-10.8)
Material deprivation	No	92.1	(91.2-93.0)
	Yes	7.9	(7.0-8.8)
Income	€501 up to €1,000	15.1	(13.6,16.6)
	€1,001 up to €1,500	14.3	(13.0,15.6)
	€1,501 up to €2,500	20.8	(19.3,22.5)
	€2,501 or more	17.4	(15.7,19.3)
	Missing	32.4	(29.8,35.1)
	Very Good	25.3	(23.9,26.7)
Health Status	Good	45.3	(43.8,46.9)
	Less than Good	29.4	(28.0,30.8)
	No Illness	57.0	(55.2,58.7)
Limiting illness	Not limited by illness	14.0	(13.0,15.2)
	Limited by illness	29.0	(27.5,30.5)



CHAPTER FOUR

RESULTS

Experiences of ageism, perceptions of ageism and community participation

4. RESULTS: RESPECT

EXPERIENCE AND PERCEPTION OF AGEISM

Table 5 shows the total number and percentage of adults aged 55+ who experienced ageism and perceived ageism. Just over one in ten adults aged 55+ (11.1%) had experienced ageism. A smaller proportion perceived ageism (8.2%).

TABLE 5 EXPERIENCED AND PERCEIVED AGEISM AMONG ADULTS AGED 55+

	N	%	95% CI
Experienced Ageism	1,125	11.1	(10.1,12.2)
Perceived Ageism	811	8.2	(7.0,12.2)

Table 6 shows the distribution of experiences of ageism and perceptions of ageism by the socio-demographic characteristics of adults aged 55+.

Adults aged 55+ who were separated or divorced reported more experiences of ageism (16.6%) and perceptions of ageism (11.7%) than any other marital status.

TABLE 6 EXPERIENCES AND PERCEPTIONS OF AGEISM BY SOCIO-DEMOGRAPHIC CHARACTERISTICS

		Experienced Ageism		Perceived Ageism	
		%	95% CI	%	95% CI
Age	55-64	10.7	(9.4,12.3)	8.3	(6.8,10.1)
	65-74	11.3	(9.8,13.0)	8.3	(6.8,9.9)
	75+	11.5	(9.9,13.4)	7.7	(6.2,9.6)
Gender	Male	11.1	(9.9,12.5)	8.5	(7.2,10.2)
	Female	11.1	(9.9,12.4)	7.8	(6.6,9.3)
Marital Status	Married	9.4	(8.4,10.6)	7.5	(6.2,9.1)
	Single/ never married	14.4	(11.5,17.8)	10.1	(7.8,13.0)
	Separated/ divorced	16.6	(13.1,20.8)	11.7	(8.7,15.6)
	Widowed	13.4	(11.4,15.7)	8.2	(6.6,10.2)
Household Composition	Living Alone	14.6	(12.7,16.7)	10.1	(8.4,12.3)
	Living with spouse	9.3	(8.2,10.6)	7.4	(6.1,9.0)
	Living with spouse /others	11.2	(9.2,13.5)	7.5	(5.4,10.4)

As shown in Table 7, respondents who had a primary education were the most likely to report having experienced ageism (11.8%) and to perceive ageism (9.1%). Almost one-in-five adults who were out of work reported experiencing ageism, compared with 10.4% of adults who were retired. Perceptions of ageism were also higher among those who were out of work (12.7%) Experience of ageism was also more prevalent among those who were materially deprived (32.8%) compared with those who were not (9.2%). Those who were materially deprived also reported more perceptions of ageism (22.0%). Experience of ageism was also higher among those on lower net monthly household incomes (e.g. €500 and €1,000 a month) (16.8%), and this was also the case for perceived ageism (11.1%)

TABLE 7 EXPERIENCES AND PERCEPTIONS OF AGEISM BY SOCIO-ECONOMIC CHARACTERISTICS

		Experienced Ageism		Perceived Ageism	
		%	95% CI	%	95% CI
Education	Primary	11.8	(10.1,13.8)	9.1	(7.5,11.2)
	Secondary	10.9	(9.7,12.3)	7.9	(6.4,9.6)
	Third Level	10.2	(8.7,12.0)	7.1	(5.5,9.1)
Occupation	Retired	10.4	(9.2,11.7)	7.3	(6.2,8.6)
	Employed	8.5	(7.0,10.2)	7.3	(5.6,9.4)
	Out of work	19.9	(16.5,23.9)	12.7	(9.7,16.4)
	Homemaker	12.1	(9.8,14.9)	9.6	(7.3,12.4)
Material Deprivation	No	9.2	(8.3,10.2)	6.9	(5.8,8.1)
	Yes	32.8	(28.0,37.9)	22.0	(18.2,27.2)
Income (bands)	€501 up to €1,000	16.8	(14.1,19.8)	11.1	(8.7,14.0)
	€1,001 up to €1,500	14.8	(12.4,17.7)	8.0	(6.1,10.4)
	€1,501 up to €2,500	9.9	(8.4,11.7)	5.8	(4.4,7.6)
	€2,501 or more	8.7	(6.8,10.9)	6.6	(4.5,9.5)
	Missing	9.0	(7.4,10.8)	9.3	(7.1,12.0)

As seen in Table 8, a considerably higher proportion of respondents who had less than good health had experienced ageism (18.4%) compared to those who had very good health (7.7%). Experience of ageism was also higher among those who had an illness that limits their everyday activity (18.4%) compared with those who had no limiting illness (8.0%).

TABLE 8 EXPERIENCES AND PERCEPTIONS OF AGEISM BY HEALTH CHARACTERISTICS

		Experienced Ageism		Perceived Ageism	
		%	95% CI	%	95% CI
Health Status	Very Good	7.7	(6.3,9.5)	4.9	(3.8,6.4)
	Good	8.3	(7.2,9.5)	8.3	(6.7,10.2)
	Less than Good	18.4	(16.4,20.7)	10.7	(9.1,12.7)
Limiting illness	No Illness	8.0	(6.9,9.2)	8.0	(6.5,9.8)
	Not limited by illness	8.4	(6.6,10.6)	3.7	(2.6,5.4)
	Limited by illness	18.4	(16.4,20.6)	10.7	(8.9,12.8)

As demonstrated in Table 9, in terms of location, a higher proportion of those living in urban areas reported experiencing ageism (12.3%) and perceiving ageism (9.1%) than those living in rural areas.

TABLE 9 EXPERIENCES AND PERCEPTIONS OF AGEISM BY LOCATION

		Experienced Ageism		Perceived Ageism	
		%	95% CI	%	95% CI
Location	Rural	9.4	(8.0,11.0)	6.9	(5.4,8.7)
	Urban	12.3	(10.9,13.8)	9.1	(7.5,11.0)

AGEISM IN EACH LOCAL AUTHORITY AREA

Figure 2 shows the percentage of respondents who reported experiencing ageism in each Local Authority area. Experiences of ageism ranged from 4.3% to 26%.

FIGURE 2 EXPERIENCES OF AGEISM BY LOCAL AUTHORITY AREA

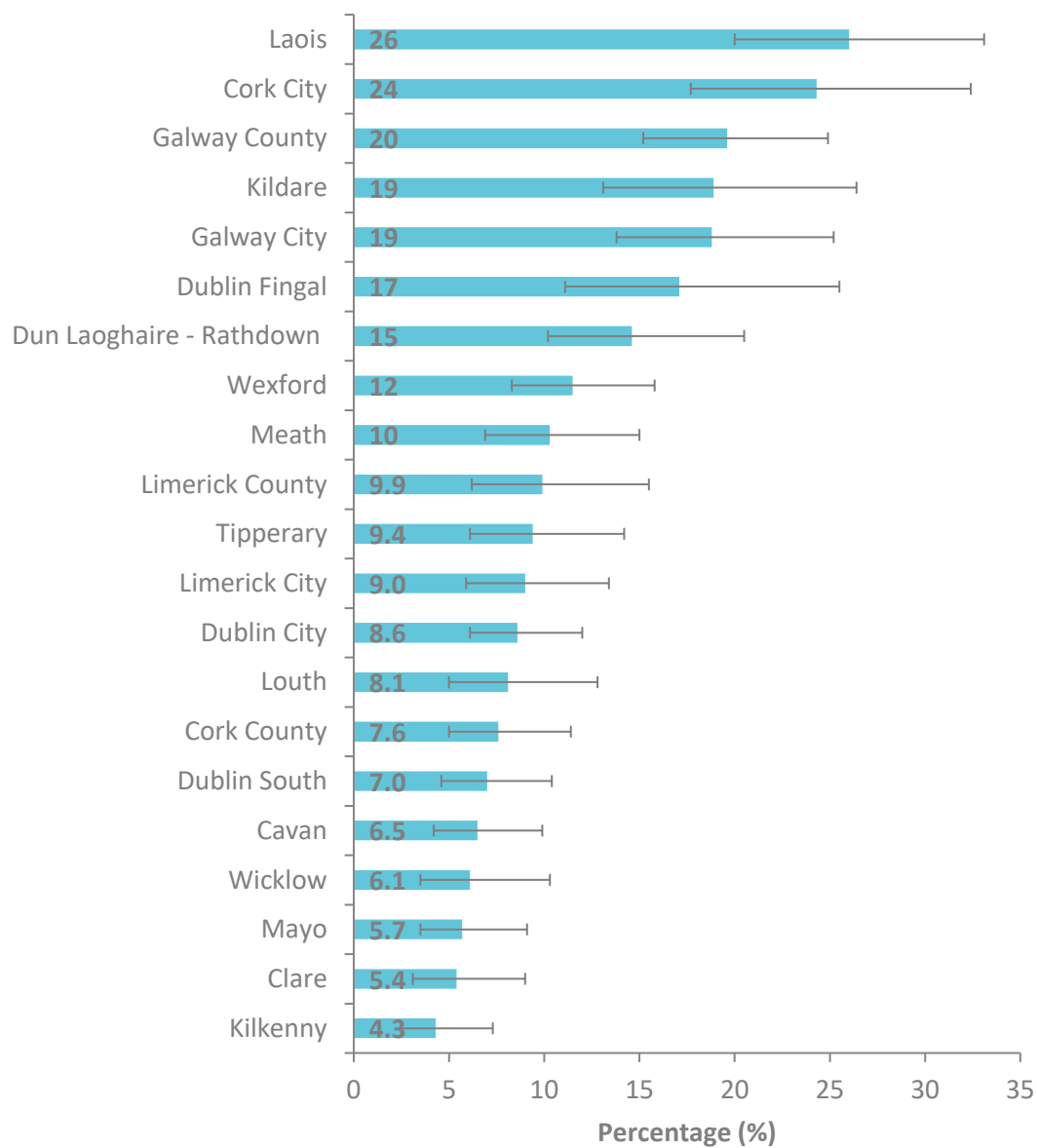
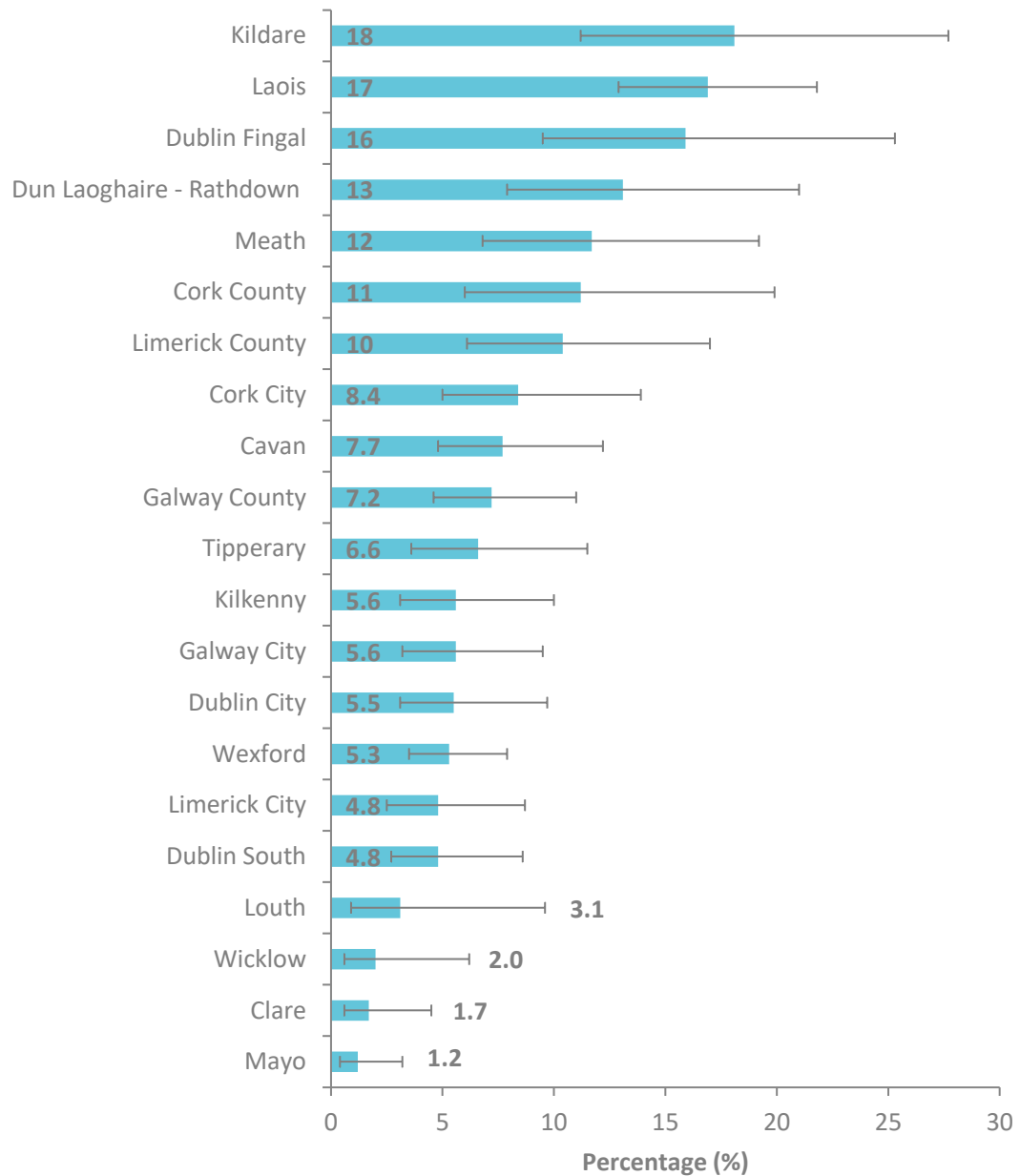


Figure 3 shows the percentage of respondents who perceived ageism in their community, in each Local Authority area. This ranged between 1.2% and 18%

FIGURE 3 PERCEPTIONS OF AGEISM BY LOCAL AUTHORITY AREA



FACTORS ASSOCIATED WITH EXPERIENCE AND PERCEPTIONS OF AGEISM

In this section we investigate whether a range of socio-demographic, socio-economic, health and location factors are associated with an increased likelihood of 1) experiencing ageism, and 2) perceiving ageism. The full results of the mixed-effects logistic regression models are presented in Table 10 and Table 11.

Experience of ageism

To begin it is important to note that none of the demographic factors of age, gender, marital status or household composition were significantly associated with the likelihood of experiencing ageism.

In terms of socio-economic status, respondents who had a secondary school education were 24% more likely than those with a primary education to have experienced ageism, as shown in Table 10 below. With an odds ratio of 3.45(95% CI 2.83-4.21), respondents who reported material deprivation were almost three and half times more likely than those who did not report material deprivation to have experienced ageism. Also, respondents who earned a disposable monthly income between €1,501 and €2,500 and between €1,001 and €1,500 were 31% and 60% more likely to have experienced ageism than those who earned €2,500 or above. Additionally, respondents who were out of work were 54% more likely than those who were retired to have experienced ageism.

Self-reported health status was significantly associated with experiences of ageism: those with less than good health were 60% more likely than those with very good health to report experiencing ageism. Additionally, those who were limited by a chronic illness were 81% more likely than those without an illness to report experiencing ageism. Finally, in comparison to living in a rural area, living in an urban area was associated with a 28% increase in the likelihood of experiencing ageism.

TABLE 10 RESULTS FROM A MIXED-EFFECTS LOGISTIC REGRESSION FOR EXPERIENCE OF AGEISM

Reference: Did not experience ageism		Experienced Ageism	
		OR	(95% CI)
Age	55-64	Reference	
	65-74	0.99	(0.82-1.20)
	75+	0.96	(0.76-1.21)
Gender	Male	Reference	
	Female	0.94	(0.81-1.09)
Marital Status	Married	Reference	
	Never married	1.25	(0.87-1.78)
	Separated/ divorced	1.30	(0.90-1.88)
	Widowed	1.26	(0.90-1.77)
Household Composition	Living Alone	Reference	
	Living with spouse	1.08	(0.77-1.52)
	Living with spouse / others	0.95	(0.74-1.23)
Educational Attainment	Primary	Reference	
	Secondary	1.24	(1.04-1.48)
	Third Level	1.18	(0.95-1.46)
Occupational Status	Retired	Reference	
	Employed	1.16	(0.93-1.44)
	Out of work	1.54	(1.20-1.98)
	Homemaker	1.24	(0.99-1.54)
Income (in bands)	>€2,500	Reference	
	€1,501 up to €2,500	1.31	(1.03-1.66)
	€1,001 up to €1,500	1.60	(1.23-2.08)
	€501 up to €1,000	1.11	(0.84-1.48)
	Refusal	0.89	(0.71-1.13)
Material Deprivation	No	Reference	
	Yes	3.45	(2.83-4.21)
Health Status	Very good	Reference	
	Good	1.03	(0.85-1.25)
	Less than good	1.60	(1.27-2.03)
Limiting Illness	No Illness	Reference	
	Not limited by illness	1.06	(0.84-1.34)
	Limited by illness	1.81	(1.50-2.19)
Location	Rural	Reference	
	Urban	1.28	(1.08-1.53)

Perceptions of ageism

Similar to experiences of ageism, none of the socio-demographic factors of age, gender, marital status or household composition were significantly associated with the likelihood of perceiving ageism.

With an odds ratio of 3.41 (95% CI 2.74-4.26) respondents who were materially deprived were almost three and a half times more likely as those who were not materially deprived to perceive ageism. Education was not significantly associated with the likelihood of perceiving ageism. In terms of occupational status, respondents who were employed were 38% more likely than their retired counterparts to perceive ageism.

With an odds ratio of 2.28 (95% CI 1.72-3.02), respondents who rated their health as being 'less than good' were more than twice as likely as those who rated their health as 'very good' to perceive ageism. In addition those who rated their health as being 'good' were 86% more likely than those who rated their health as being 'very good' to perceive ageism. Those who had a chronic illness or condition but were not limited by it were 51% less likely than those without any limiting illness or condition to perceive ageism.

Finally, in comparison to living in a rural area, living in an urban area was associated with a 49% increase in the likelihood of perceiving ageism.

TABLE 11 RESULTS FROM A MIXED-EFFECTS LOGISTIC REGRESSION FOR PERCEPTIONS OF AGEISM

Reference: Did not perceive ageism		Perceived Ageism	
		OR	(95% CI)
Age	55-64		Reference
	65-74	1.04	(0.85-1.30)
	75+	1.04	(0.80-1.36)
Gender	Male		Reference
	Female	1.11	(0.94-1.31)
Marital Status	Married		Reference
	Never married	1.16	(0.77-1.76)
	Separated/ divorced	1.02	(0.66- 1.58)
	Widowed	0.91	(0.61-1.35)
Household Composition	Living Alone		Reference
	Living with spouse	0.91	(0.62-1.35)
	Living with spouse /others	0.75	(0.54-1.02)
Educational Attainment	Primary		Reference
	Secondary	0.86	(0.71-1.05)
	Third Level	0.83	(0.65-1.06)
Occupational Status	Retired		Reference
	Employed	1.38	(1.09-1.75)
	Out of work	1.15	(0.85-1.56)
	Homemaker	1.22	(0.95-1.57)
Income (in bands)	>€2,500		Reference
	€1,501 up to €2,500	0.87	(0.66-1.15)
	€1,001 up to €1,500	1.20	(0.89-1.61)
	€501 up to €1,000	1.04	(0.77-1.43)
	Refusal	1.04	(0.81-1.33)
Material Deprivation	No		Reference
	Yes	3.41	(2.74-4.26)
Health Status	Very good		Reference
	Good	1.86	(1.48-2.33)
	Less than good	2.28	(1.72-3.02)
Limiting Illness	No Illness		Reference
	Not limited by illness	0.49	(0.36-0.66)
	Limited by illness	0.88	(0.71-1.09)
Location	Rural		Reference
	Urban	1.49	(1.23-1.81)

5. RESULTS: SOCIAL INCLUSION

AGEISM AND COMMUNITY PARTICIPATION

In this section we explore whether experiences of ageism and perceptions of ageism are associated with the likelihood of not participating in community activities. In terms of community participation the majority of respondents reported that they never participate (44.7%) while 31.5% reported participating at least once a week as demonstrated in Table 12 below.

TABLE 12 COMMUNITY PARTICIPATION AMONG ADULTS AGED 55+

Participation	N=	%	95% CI
Weekly	3,142	31.5	(29.0,33.1)
Less than weekly	2,660	23.8	(21.9,25.7)
Never	4,606	44.7	(42.7,46.8)

As shown in Table 13, adults aged 75+ reported the largest proportion of never participating in community events (51.7%). A higher proportion of adults aged 55+ who were separated or divorced reported never participating in community events (62.4%) than any other marital status. In relation to household composition, those living alone reported the largest proportion of never participating in community events (52.8%)

TABLE 13 COMMUNITY PARTICIPATION BY SOCIO-DEMOGRAPHIC CHARACTERISTICS

		Weekly Participation		Less than weekly		Never Participates	
		%	95% CI	%	95% CI	%	95% CI
Age	55-64	29.3	(26.9,31.9)	28.0	(25.4,30.6)	42.8	(40.1,45.5)
	65-74	34.1	(31.6,36.7)	23.1	(20.9,25.4)	42.8	(40.4,45.4)
	75+	32.3	(29.2,35.6)	16.0	(13.9,18.4)	51.7	(48.5,54.8)
Gender	Male	32.0	(29.6,34.5)	26.0	(23.7,28.4)	42.0	(39.7,44.4)
	Female	31.0	(28.7,33.5)	21.8	(19.8,23.9)	47.2	(44.7,49.7)
Marital Status	Married	32.4	(30.2,34.6)	27.6	(25.4,30.0)	40.0	(37.8,42.3)
	Single (never married)	29.1	(24.9,33.7)	19.5	(16.5,22.9)	51.4	(47.2,55.6)
	Separated or divorced	23.5	(19.3,28.3)	14.1	(11.0,18.0)	62.4	(57.2,67.3)
	Widowed	32.3	(28.9,35.8)	15.9	(13.4,18.8)	51.8	(48.3,55.3)
Household Composition	Living Alone	30.4	(27.6,33.5)	16.8	(14.7,19.2)	52.8	(49.7,55.8)
	Living with spouse	32.1	(29.8,34.5)	27.8	(25.5,30.3)	40.1	(37.6,42.5)

		Weekly Participation		Less than weekly		Never Participates	
	Living with spouse /others	31.1	(27.4,35.0)	22.2	(19.3,25.4)	46.7	(42.9,50.6)

As shown in Table 14 there is an education gradient in terms of community participation. Participants who had a primary education were the most likely to report never participating in community activities (55.5%). Participants who were out of work reported never participating in community activities (56.5%), more than any other occupational status. Those who were materially deprived reported the highest proportion of never participating in community events (66.9%). Those who earned €2,501 or more reported the highest levels of weekly participation (41.0%).

TABLE 14 COMMUNITY PARTICIPATION BY SOCIO-ECONOMIC CHARACTERISTICS

		Weekly Participation		Less than weekly		Never Participates	
		%	95% CI	%	95% CI	%	95% CI
Education	Primary	25.6	(22.4,29.0)	18.9	(16.4,21.6)	55.5	(52.2,58.8)
	Secondary	32.6	(30.4,34.9)	23.4	(21.3,25.7)	44.0	(41.5,46.4)
	Third Level	39.6	(36.3,42.9)	33.9	(30.4,37.7)	26.5	(23.7,29.4)
Occupation	Retired	35.0	(32.7,37.4)	20.2	(18.3,22.2)	44.8	(42.6,47.1)
	Employed	30.3	(27.3,33.4)	34.3	(31.1,37.6)	35.5	(32.4,38.6)
	Out of work	21.1	(17.4,25.4)	22.4	(18.2,27.1)	56.5	(51.4,61.6)
	Homemaker	28.1	(24.4,32.1)	19.1	(16.2,22.5)	52.8	(48.6,57.0)
Material Deprivation	No	32.5	(30.4,34.6)	24.7	(22.8,26.8)	42.8	(40.7,44.9)
	Yes	21.3	(17.0,26.3)	11.8	(9.0,15.3)	66.9	(61.4,72.0)
Income (bands)	€501 to €1,000	23.6	(20.5,27.1)	15.2	(12.6,18.3)	61.2	(57.2,65.1)
	€1,001 to €1,500	28.1	(24.7,31.7)	17.8	(15.1,20.9)	54.2	(50.4,57.9)
	€1,501 to €2,500	37.8	(34.1,41.7)	24.8	(21.7,28.2)	37.3	(34.0,40.7)
	€2,501 or more	41.0	(36.5,45.6)	34.3	(29.8,39.0)	24.8	(21.7,28.2)
	Missing	27.4	(24.5,30.5)	24.1	(21.5,27.0)	48.5	(45.3,51.6)

As shown in Table 15, those who had very good health were more likely to report participating in community activities weekly (38.9%) than those who had less than good health (21.8%). Those who had a limiting illness reported the highest proportion of never participating in community events (55.1%).

TABLE 15 COMMUNITY PARTICIPATION BY HEALTH CHARACTERISTICS

		Weekly Participation		Less than weekly		Never Participates	
		%	95% CI	%	95% CI	%	95% CI
Health Status	Very Good	38.9	(35.7,42.1)	21.4	(18.9,24.2)	39.7	(36.6,42.9)
	Good	33.7	(31.1,36.3)	26.1	(23.7,28.8)	40.2	(37.7,42.7)
	Less than Good	21.8	(19.4,24.4)	22.0	(19.3,24.9)	56.2	(53.0,59.4)
Limiting illness	No Illness	30.8	(28.6,33.1)	28.5	(26.1,31.1)	40.7	(38.3,43.1)
	Not limited by illness	42.8	(38.7,47.0)	16.7	(14.0,19.8)	40.5	(36.7,44.4)
	Limited by illness	28.3	(25.2,31.6)	16.6	(14.7,18.7)	55.1	(51.8,58.3)

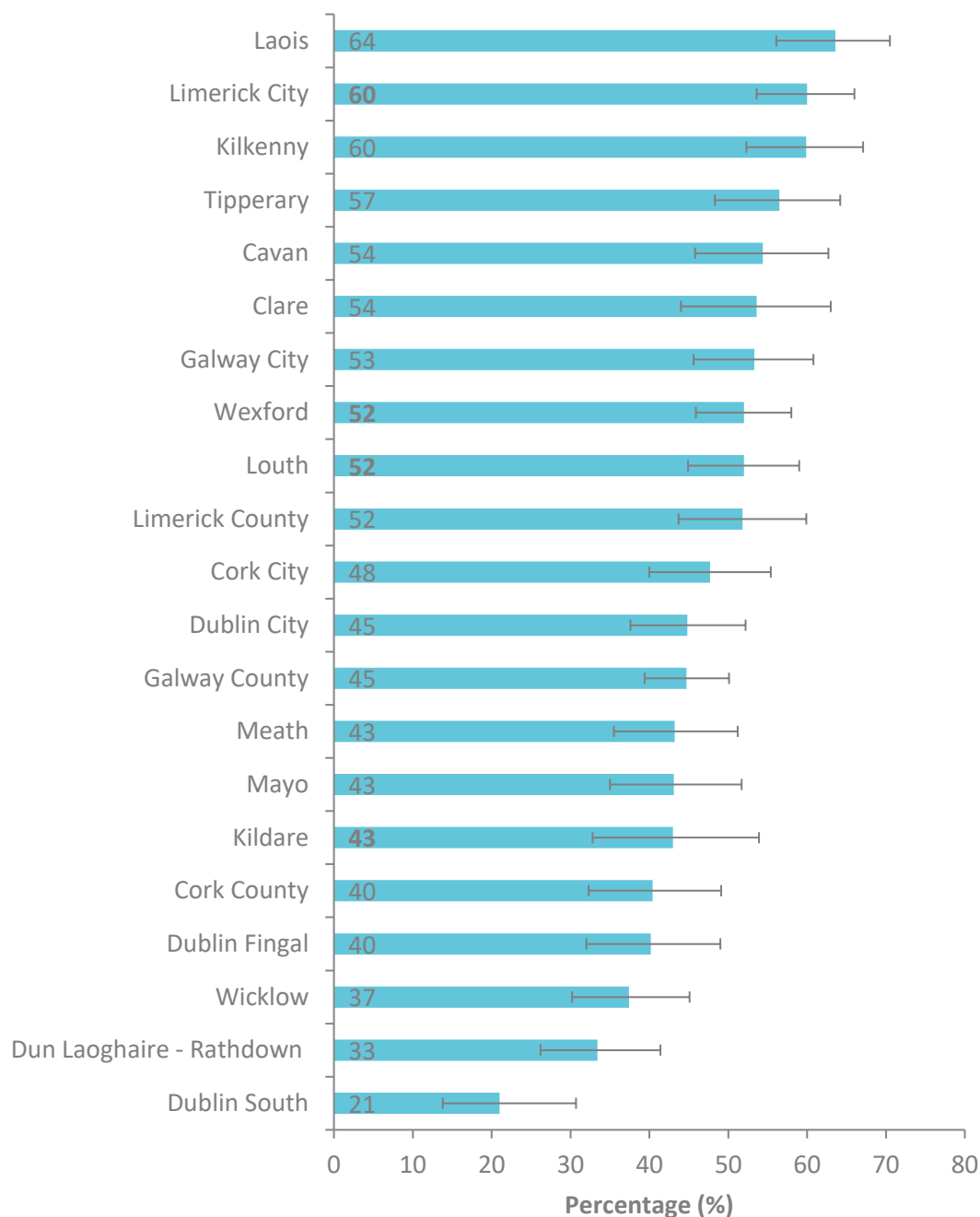
As can be seen in Table 16 there was very little variation in community participation between urban and rural dwellers.

TABLE 16 COMMUNITY PARTICIPATION BY LOCATION

		Weekly Participation		Less than weekly		Never Participates	
		%	95% CI	%	95% CI	%	95% CI
Location	Rural	30.0	(27.0,33.2)	24.5	(22.0,27.1)	45.5	(42.4,48.7)
	Urban	32.6	(30.0,35.2)	23.3	(20.8,25.9)	44.2	(41.6,46.8)

Figure 4 shows the percentage of respondents in each Local Authority area that engage in community activities at least once a week. This ranged from 16% in Laois to 44% in Cork County. There are a substantial number of adults who never take part in community activities (45%) and this varies from 21% to 64% across the Local Authority areas (Figure 4 below).

FIGURE 4 NEVER PARTICIPATES IN COMMUNITY ACTIVITIES IN EACH LOCAL AUTHORITY AREA



Note: community activities include sports or social clubs, a church group, or charitable body etc.

Exploring the role of ageism as a barrier to community participation

In this section we explore whether experiences of ageism and perceptions of ageism are associated with the likelihood of not participating in community activities. The majority of respondents fall into one of two groups: those who participate at least

monthly (48%) or those who never participate (45%). Therefore, we explore the likelihood of never participating in community activity. The full results of the regression analysis are presented in Tables 17 and are summarised below.

Once all other factors were controlled for, respondents who perceived ageism in their communities are 30% more likely to never participate in community activities. The independent association observed between experiences of ageism and non-participation was no longer apparent once other factors were considered.

There were a range of demographic and socio-economic characteristics that were associated with reporting never participating in community activities. Women were 12% more likely than men to report never participating in community activities. Respondents who were single were 34% more likely, and respondents who were separated or divorced were 64% more likely than married respondents to report never participating in community activities. Those who lived with a spouse and/or other family members were 32% more likely than those who lived alone to never participate.

Adults with higher levels of education were less likely to never participate in community activities. Those who had secondary education were 29% less likely and respondents who had had third level education 63% less likely to report never participating in community activities, compared to those with primary education or less. Compared with respondents who were retired from work, respondents who were out of work (unemployed or permanently sick or disabled) were 31% more likely and respondents who were responsible for looking after the home were 26% more likely to report never participating. Those who were materially deprived were 52% more likely not to participate in community activities. Respondents with lower incomes were more likely to never participate. For example, with an odds ratio of 2.21, those who had a monthly disposable income between €500 and €1,000 were more than twice as likely, as those who had a monthly disposable income of €2,500 and over, to report never participating in community activities.

Finally, those who had less than good health were 33% more likely than those who had very good health to never participate. The analyses did not find a significant association between locality and never participating in community activities.

TABLE 17 RESULTS FROM A MIXED-EFFECTS LOGISTIC REGRESSION FOR NEVER PARTICIPATING IN COMMUNITY ACTIVITIES

Reference: Participated to some extent		Never participated			
		Model 1		Model 2	
		OR	(95% CI)	OR	(95% CI)
Perceived Ageism	Did not perceive ageism	Reference			
	Perceived ageism	1.49	(1.27 -1.75)	1.30	(1.09-1.55)
Experienced Ageism	Have not experienced ageism	Reference			
	Has experienced ageism	1.33	(1.16-1.52)	1.02	(0.88-1.18)
Age	55-64	Reference			
	65-74			0.93	(0.82-1.05)
	75+			1.15	(0.99-1.33)
Gender	Male	Reference			
	Female			1.12	(1.02-1.23)
Marital Status	Married	Reference			
	Never married			1.34	(1.06-1.69)
	Separated/ divorced			1.64	(1.28-2.11)
	Widowed			1.10	(0.88-1.36)
Household Composition	Living Alone	Reference			
	Living with spouse			1.09	(0.87-1.35)
	Living with spouse / others			1.32	(1.11-1.57)
Educational Attainment	Primary	Reference			
	Secondary			0.71	(0.63-0.79)
	Third Level			0.37	(0.32-0.43)
Occupational Status	Retired	Reference			
	Employed			1.03	(0.90-1.19)
	Out of work			1.31	(1.08-1.58)
	Homemaker			1.26	(1.09-1.46)
Income (in bands)	>€2,500	Reference			
	€1,501 up to €2,500			1.31	(1.13-1.53)
	€1,001 up to €1,500			1.91	(1.60 -2.27)
	€501 up to €1,000			2.21	(1.84 -2.64)
	Refusal			1.97	(1.71 -2.27)
Material Deprivation	No	Reference			
	Yes			1.52	(1.26-1.83)
Health Status	Very good	Reference			
	Good			0.94	(0.84-1.05)
	Less than good			1.33	(1.15 -1.55)
Limiting Illness	No Illness	Reference			
	Not limited by illness			0.95	(0.83- 1.09)
	Limited by illness			1.11	(0.98 -1.26)
Location	Rural	Reference			
	Urban			0.97	(0.87 -1.08)



CHAPTER FIVE

DISCUSSION AND CONCLUSIONS

6. DISCUSSION AND CONCLUSIONS

According to Walsh, Scharf & Keating (31) social exclusion for older adults is a multidimensional construct involving *“interactions between multi-level processes and outcomes which can result in reduced access to activities, resources and relationships, choices and rights across various domains including: neighbourhood and community; services, amenities and mobility; material and financial resources; social relations; cultural aspects; and civic participation”*. (p.6) (20).

For older people, the WHO defines socially inclusive societies as those in which older adults are able to make important contributions to their communities and neighbourhoods if their needs, differences and involvement are respected. To date, international research evidence surrounding ageism has suggested that ageism is pervasive and has a negative impact on social and community life, including community participation (9,11). Therefore in this study we sought to profile experiences and perceptions of ageism and the association between both aspects of ageism and community participation, from a social inclusion perspective.

We consistently found that those who were in poorer health and lower socio-economic status and those living in urban areas were more likely to experience and perceive ageism. These factors were also associated with the likelihood of participating in community activities. Furthermore, experiences and perceptions of ageism are associated with high levels of participation (weekly), and never participating, but these relationships are different for each measure. Experience of ageism was associated with more frequent participation, while perception of ageism was associated with less frequent participation, and we will elaborate on these findings later in this section.

Factors associated with experiences and perceptions of ageism

In terms of socio-economic status, individuals who reported material deprivation and lower incomes were more likely to have experienced ageism and to perceive ageism, further highlighting the multi-dimensional nature of social exclusion. In relation to education, those who had a secondary school education were more likely to have experienced ageism than those who had a primary school education. This finding may be explained in terms of participation; those who had higher levels of education were significantly more likely to participate in community activities at least once a week and may consequently have had an increased risk of experiencing ageism due to having more social interactions with the wider community. It is important to note that although those with a secondary education were more likely to have actually experienced ageism they were not significantly more likely to perceive ageism.

In this study, those who had less than good health and were limited by an illness were more likely to have experienced ageism and to perceive ageism in their community. This is consistent with the findings reported in the WHO Age Friendly

Cities-A Guide whereby older adults who are ill or have disabilities are more likely to be viewed negatively (7) and previous research which showed that perceptions of older people are often typified by perceptions of poor physical health conditions (33), which can become self-internalised over time (12,16).

Living in an urban area was also associated with an increased likelihood of perceiving and experiencing ageism. This finding is in line with research conducted by McGuire, Klein & Chen (2008) which found that those living in urban areas were more likely to report experiencing ageism (34). The WHO has suggested that ageism in urban areas is linked to the impersonality of large and expanding cities and an increasing lack of intergenerational interaction (7). City and suburban areas are rapidly changing and often older adults feel like they are excluded from the planning process (35). Indeed, Scharf and colleagues interviewed older adults living in urban areas in the UK and found that older people felt 'excluded' from the organisations which influenced the quality of life in their neighbourhoods (36). Feeling excluded from the decision making process of one's community may lead to older adult's viewing themselves as having a diminished role within their community.

Ageism and Community Participation

Adults who perceive ageism in their communities were more likely to never participate in community activities. This finding is consistent with a Canadian study which linked senior's perceptions of ageing to an inactive lifestyle (13) and suggested that an active lifestyle could buffer against the negative impact of ageism.

Various other participant characteristics were associated with community participation and these are consistent with the social inclusion framework discussed previously. Socio-demographic factors such as gender, marital status and housing composition were all significantly associated with community participation. The current study found that respondents who were divorced or separated were more likely to never participate and marital disruption is known to generate emotional or financial stress and changes in social networks and social engagement (37).

Respondents with higher levels of education and income were more likely to participate in community activities and low socio-economic status is a known risk factor for social exclusion (38,39). Also, respondents who were in good health were more likely to participate in community activities and poor health may lead to a reduction in engagement in community activities as it affects individual resources, social life, and motivational factors. Changing health status is frequently cited as contributing to social exclusion (38,39).

Overall these findings on the association between participant characteristics and community participation highlight the multi-dimensional nature of social exclusion as we age insofar as several of these socio-economic factors such as income, education and health status are also associated with an increased likelihood of experiencing and perceiving ageism.

To conclude, it is evident from this study that individuals who perceive ageism are much less likely to participate in community activities. However, perceptions of ageism are modifiable. Experience of ageism and perceptions of ageism are linked, insofar as experiences of ageism over time can lead to internalised negative self-perceptions of ageing, and self-limiting behaviours. As such, both negative attitudes and behaviours towards older people, and negative perceptions of age and ageing more broadly, are a threat to healthy and positive ageing.

The WHO and the Madrid International Plan of Action on Ageing (MIPAA) proposes that a fundamental step in altering attitudes towards older people involves mainstreaming ageing and concerns of older people into national frameworks and strategies. The plan describes mainstreaming ageing as: “a strategy, process and multi-dimensional effort of integrating ageing issues into all policy fields and all policy levels.” (p.3) (40). The ultimate objective is to achieve a more equitable society to the benefit all social groups. Mainstreaming is considered as an important tool for achieving ‘a society for all ages’.

Echoing these international approaches, the National Positive Ageing Strategy in Ireland constituted a first and necessary step in mainstreaming the concerns of older people in all policy fields. The NPAS advocates for better consultations with older people as many stereotypes of ageing are a result of misinformation and misconceptions of the competencies, capabilities and beliefs of older people. The strategy posits that one of the most efficient methods of ensuring that the actualities of ageing are made salient in strategy and service development is to ensure that people as they age, are involved in decision making process at all levels. In order to allow older people to participate fully within their local communities and wider society alike, their rights and capacity to do so must be facilitated by suitable provisions which allow older people to be involved in consultations and decision making processes surrounding issues which concern them as a cohort.

Overall this research adds weight to existing literature surrounding respect and social inclusion amongst older people insofar as it highlights how ageism and more importantly, perceived ageism in the community can act as a barrier to community participation. The study also demonstrates how various other factors including level of education, income, material deprivation, health status, locality and employment directly affect community participation and as such, offers a valuable insight for stakeholders who are committed to promoting social inclusion and enhancing healthy and positive ageing in Ireland.

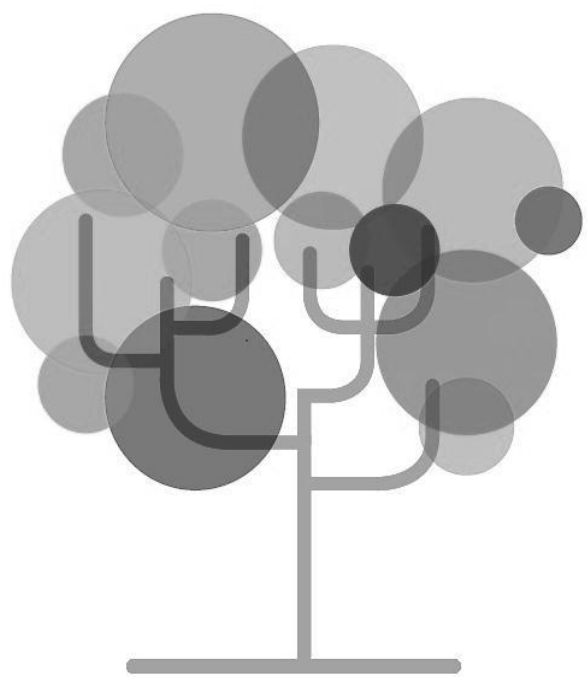
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