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HeSSOP Health and Social Services for Older People : Survey of service use, evaluation and preceived need by older people in two health board areas. INTERM REPORT II

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HeSSOP

Health and Social Services for Older People

Survey of service use, evaluation and perceived need by older people in two health board areas

INTERIM REPORT II

Eastern Regional Health Authority

June 2000

HeSSOP

Health and Social Services for Older People

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INTERIM REPORT II

Eastern Regional Health Authority

Report completed on behalf of:

The Eastern Regional Health Authority
and
The National Council on Ageing and Older People

By:

Health Services Research Centre
Department of Psychology, Royal College of Surgeons in Ireland

June 2000

PREFACE

The (HeSSOP) project study was jointly commissioned by the National Council on Ageing and Older People, the Eastern Health Board (now the Eastern Regional Health Authority, which incorporates the Northern, East Coast and South Western Area Health Boards) and the Western Health Board. The Health Services Research Centre at the Department of Psychology, Royal College of Surgeons in Ireland conducted the study. The study team was Ms. Rebecca Garavan (study coordinator), Ms. Rachel Winder, Professor Hannah McGee and Professor Ciaran O'Boyle. The overall study covers the two health board areas involved. The information gained will be used to compare service need, use and evaluation across boards and thus to promote equity and to examine, in the largest such study ever conducted in Ireland, the challenges to service delivery for older people.

This report is the second of two interim reports, on the separate population profiles for the two boards – it outlines the major findings from the Eastern Regional Health Authority survey. We acknowledge the support and assistance of many individuals in completing the Eastern Regional Health Authority review and particularly note the coordinating role of Mr Edward Matthews in the consultation process.

Following wide consultation with health and social service professionals, and with small numbers of older people in each of the counties – Wicklow, Kildare and Dublin, a survey questionnaire reflecting service issues of most relevance for older people was developed. This was used as the basis for over 400 interviews with older people living in the community in the Eastern Regional Health Authority. We acknowledge the assistance of Mr. James Williams and the Survey Unit of the Economic and Social Research Institute in completing the community interviews. We trust that this second report will be of benefit in current planning for quality services for older people in the east of Ireland.

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SECTION ONE

INTRODUCTION

BACKGROUND

The commitment to consumer participation and consultation regarding planning and evaluation in the health services, as outlined in the Government's policy document "Shaping a Healthier Future" has remained mostly aspirational across the 1994 -1998 timeframe of the document and beyond. Consultation with older people as major consumers of health care is now imperative as a core component of the evidence base from which policies and service plans for this group are developed across the Irish health boards. Such consultation is important not just to reflect the views of older people in their own right, but also because the majority of structural, process and attitudinal challenges experienced by older people in availing of services are also challenges for other more marginal subgroups, for instance, disabled groups in the population. Moreover, while average health status decreases somewhat in older age, there is a larger variability in health care needs than at any other time in the lifecycle.

Fahey (1995, 1998) outlines an anticipated relative stability in the proportion of older people in Ireland at least in the next 25 years. He proposes that influences on health spending internationally relate more to macroeconomic matters and to actual demands on services from various interests than to changes in demography *per se*. Services are seen as 'supply' rather than 'demand' led with professionals acting as agents in informing patients of their needs and entitlements. In a rapidly developing Irish society, where traditional expectations and attitudes (e.g. regarding what can be expected from health and social services or from old age itself) combine with a range of health problems for older people (problems often distressing, frightening or embarrassing for individuals), there is a real challenge to health service providers to balance views of older people about service need and acceptability with benchmarks about best quality care.

High quality health care is 'care that is desired by the *informed* patient or client (and family); is based on sound judgement of the professionals involved, from scientific study and/or experience; and is agreed upon and carried out in a relationship of mutual trust and respect' (Williams, 1996). One of the main challenges in developing some form of consultation with

older people is to directly consult representatives of the largest constituency of older Irish people, i.e. those living in the community. This large group is typically under-researched because of the practical difficulty and costs associated with evaluation of adequate samples in their own homes. The aim of this project is to commence this consultation process.

THE HEALTH AND SOCIAL SERVICES FOR OLDER PEOPLE (HeSSOP) PROJECT

HeSSOP is a collaboration across the National Council on Ageing and Older People and two health boards: the Eastern Regional Health Authority and the Western Health Board. Information on service use, service evaluation and perceptions of service need of a large community-dwelling group will be reported separately for each board in the first instance; this is to assist service planning for 2000. A combined report will allow further analysis of patterns of use etc., including comparisons across boards to identify common and location-specific challenges to service delivery. While the project will cover only two of the country's health boards as constituted at the time of the work, the particular boards involved represent the most urban and one of the most rural of the boards. Thus findings are expected to have value for other health boards. The wider issue of consultation strategies to involve older people will be addressed and will be included in the combined survey report.

OVERALL AIM OF PROJECT

The aim is to provide a systematic evaluation of health and social service provision from the perspective of community-dwelling older people needing and/or using these services.

SPECIFIC OBJECTIVES:

a) To document experiences with health and social services recently received or required by population-based groups of older individuals in two health boards.
b) To include specific assessment of issues for those recently discharged from secondary care services, users of domicilary (e.g. public health nursing) services, users of 'social' services (e.g. home helps/meals-on-wheels); and providers of informal care of older people at home.
c) To assess preferences to key care issues (home vs institutional care; home services by care professionals; and other concerns for future health needs).
d) To establish recommendations for service improvements based on the above.
e) To compare information across the two health boards to identify common and specific concerns; and to consider issues of equity and access across the boards.
f) To develop research protocols for the above issues which can be used by other agencies when examining these issues for other locations.
g) To make recommendations about promoting consumer consultation for the future such that older and more marginalised groups can be consulted and views incorporated into health and social service policy development.

THIS REPORT

This is the second of two reports on the main and separate findings from the health boards. The Western Health Board survey was reported on in May 2000; the Eastern Regional Health Authority survey is outlined here.

SECTION TWO

METHODOLOGY

DESIGN

The main study strategy for this part of the HeSSOP project was to conduct a large randomised survey of community dwelling older people in the Eastern Regional Health Authority (ERHA) area. The survey instrument was developed on the basis of three types of consultation. Firstly, an extensive literature review of research on health and social service use and needs of older people, and on service user satisfaction more generally, was completed. Then consultation was completed with two groups: local health and social service professionals and older people, selected to represent various health and social service experiences. Professionals and older persons in the three ERHA counties were included. The survey was then completed over a four month period (March - June, 2000). Further details of the methodology are outlined next.

SAMPLE

The survey targeted those living in the three ERHA counties (Dublin, Kildare and Wicklow). They were randomly selected through the electoral register, aged 65 years and over and living in private households. Where the individual selected to take part in the survey was unable (due to serious illness or cognitive impairment, for example), a primary carer or next of kin living in the same household was invited to participate as a proxy. While there are weaknesses with proxy responding, it was felt very important to have some representations of service use and needs of those most incapacitated in the community.

PROCEDURE

CONSULTATION PROCESS

Key service providers/ Older persons' interest groups

A wide range of key health and social service providers were consulted. These were primarily identified through the Director of Services for Older People on the Board (Mr Edward Matthews) and others as suggested through the conduct of the consultation exercise. (Information from a similar process in the Western Health Board was combined to develop a

common research instrument). The aim was to prioritise topics of interest to professionals and/or older people to discuss initially in the organisation of focus groups with older people and later in the questionnaire. Views, experiences and perceived barriers in being the recipient of services were solicited. Service providers were consulted either in the form of focus groups, or they were interviewed individually. They included professional, administrative and older people's interest group representatives; across the two boards the following were consulted: older people's service co-ordinators, administrators, geriatricians, area medical officers, general practitioners, directors of nursing and psychiatric nursing services, public health nurse superintendents, matrons from community nursing unit, nursing and care attendant staff from day hospitals, day centres and day care units, acute services ward sister, long stay hospital nursing staff, carers' association member, occupational therapists and physiotherapists, social worker, community welfare officers, home help managers, head of ambulance service and housing welfare officer. A total of 36 personnel were interviewed in three focus groups, and many others were individually interviewed or contacted by phone.

Focus groups with older people

Participants for focus groups were contacted through community services managers and other key service providers (e.g. public health nurses, day centre managers, medical officers for elderly services etc.) working in the health boards. Endeavours were made to obtain the experiences, views and needs from a broad range of participants from different backgrounds; thus they were representative of those living in rural, village and city locations, of those with assorted degrees of ability and of those with varying levels of health and social care needs; from those with little or no experience of health and social services, to those who required or received services on a regular basis. Some were members of active retirement groups, attended day centres, day care units or day hospitals; others had experience of community or hospital care. A total of six focus groups (3 in each health board) comprising 62 people aged 65 years and older (23 men, 39 women) were conducted. Each group consisted of between 8 and 14 older people, and lasted approximately 2 hours. Sessions were recorded with participant consent. The aim was to hear the views, experiences and preferences of older people themselves. Topic areas were kept broad, so that information on a wide variety of topics could be covered. An honorarium of fifty pounds was given to each participant, in appreciation of their contribution and to cover travel expenses.

SURVEY

Preparatory work

A pilot survey comprising six interviewers and 31 participants was conducted and the interview schedule amended as necessary over a period of 10 days prior to commencing the full survey. The survey received ethical approval from the Research Ethics Committee of the Royal College of Surgeons in Ireland. Key service providers were made aware of the upcoming project by letter; leaflets, explaining the study's purpose, were left as reminders with participating individuals. The leaflet provided contact telephone numbers to confirm the interviewer's identity if necessary, or to discuss subsequent queries they had about the research itself or about services they had used.

Selection and interview process

The Economic and Social Research Institute's (ESRI) Survey Unit was engaged to conduct the interviews through local experienced survey researchers. Names and addresses were randomly drawn from the Register of Electors for the health board counties. Interviewers called on the identified household, and if a person of 65 years of age or older lived there, they were asked to take part in a study on health and social services for older people. Where there was more than one person of 65 years or over in the household, then the person whose birthday was nearest to the interview date was asked to take part.

The survey contact outcomes are outlined in Table 2.1. Of 4175 addresses identified; nine per cent (374 / 4175) of addresses selected could not be included, due to a variety of reasons (e.g. household had been vacated or there was no reply following four separate house calls, complete refusal, etc).Twenty nine addresses were excluded as they were of institutions rather than private households. Where contact was made, there was at least one person over 65 in 749 (18%) of households. Seven per cent (42 people) were either too ill or impaired to participate in a survey with 18 (43%) of these having no suitable proxy respondent. Of the others, all did have a consenting proxy respondent. Of those contactable and without serious illness/impairment (707), twenty per cent directly declined. Combining potential proxy and direct respondents, a total of 19% refused participation. A further 26% of those able to participate directly, did not participate because of unavailability, continuous non-contact with the individual concerned or other reasons. Of those consenting to interview (404), all but 3 people completed interviews.

Table 2.1 : Response rates: outcomes of household survey invitation attempts

Response Outcome	Number of households
Total interviews completed and usable for analysis:	**401**
Of which:	
- person(s) aged 65+ and completed in person	377
- person(s) aged 65+ and completed on a proxy basis	24
Interviews incomplete: insufficient data for inclusion in analysis	**3**
Household with person aged 65+ but who did not participate	**345**
Of which:	
- person (s) aged 65+ and too ill or senile and no proxy available	18
- person (s)age 65+ and refused to participate	145
- person (s) 65+and permanently unavailable	123
- other reason for non-participation	59
No-one in household aged 65+	**3052**
Complete refusal/household composition unknown	**50**
'Household' was institution (i.e. not a private residence)	**29**
Household vacated	**17**
Could not locate address	**76**
Other	**202**
TOTAL TARGET SAMPLE:	**4175**

MEASURES

The finalised interview schedule was a 152-item questionnaire. Questions were broadly focused on the respondent's health status and health and social service experiences over the past 12 months, satisfaction with current health and social services, level of demand for services not currently being used, and preferences for services that may be required in the future. Where appropriate, questions were drawn from previously used and standardised tools, such as the measure of psychological distress, Hospital Anxiety and Depression Scale, in order that useful comparisons could be made from the overall study. Many questions included were, however, constructed for this study on the basis of the consultation process with older people and service providers. The topics are outlined in brief next.

Demographic characteristics

Data on age, gender, household composition, occupation, education, type of geographic location and living arrangements were collected.

Finances

Information on household income, level of health cover through medical card, insurance, or benefit schemes and degree of payment for services used were investigated.

Housing

Questions concerned the presence of a set of basic home facilities (such as hot water supply), whether these were fully functional, and if they could be used without assistance. Accommodation status (owner-occupied or rented) was evaluated.

General health and functional independence

Occurrence of any physical or mental conditions within the last 12 months was recorded as was the extent to which they had caused disruption to their life over the past month (from 'extremely' to 'not at all disrupted'). Further questions focused on experience of pain in the past week. Functional capacity was measured using the validated Health Assessment Questionnaire (HAQ) (Fries, Spitz & Young, 1982). The instrument was augmented to incorporate items that reflected activities with which older people may have difficulty. Respondents were asked about ability, taking into account the use of a device or aid if one

was usually used, across a range of activities of daily living ranging from dressing oneself through doing the shopping.

Regarding mental health, the Hospital Anxiety and Depression Scale (HADS) (Zigmond and Snaith, 1983), a well-validated 14 item self-report measure, was completed to assess the prevalence of anxiety and depression requiring professional attention in this group of older people.

Health behaviours and health promotion activities

Exercise and smoking were selected as important health promotion targets for older people – levels of inactivity, smoking and barriers to more healthy behaviours were investigated, including professionals' encouragement regarding smoking cessation. With regards to possible preventive and screening strategies recommended for use with older individuals, levels of use of the influenza vaccination ('flu' injection'), blood pressure measurement and general health check-ups were investigated.

Social contact and social support

Issues assessed included perceived emotional support, time spent alone in a typical day and interest in availing of services/groups.

Utilisation of services

Service use, need, access and satisfaction was assessed across a wide spectrum of locations and professionals: GP and locum GP, A&E, hospital in-patient and out-patient experiences, day care/day hospitals, day centres/clubs, respite care, public health nurse, care attendant, home help, social worker, meals-on-wheels, chiropody, occupational, speech, physiotherapy, dietician, optician, dental, hearing, psychological and rehabilitation.

Factors influencing service access and acceptability

Views on the embarrassment (stigma) associated with a variety of services were assessed, e.g. meals-on-wheels, continence aids, chiropody services. The role of transport in service access, cost and the level of access to information were also queried. Views on care preferences for long-term or high-intensity care, if required, were investigated. This involved comparisons among various combinations of home (family) and health service-provided assistance.

SECTION THREE

RESULTS

DEMOGRAPHIC PROFILE OF GROUP

AGE DISTRIBUTION

A total of 401 respondents (47% male, 53% female) were interviewed, and ranged in age from 65 years to 99 years (female, mean: 74.1, SD: 7.0; male, mean, 71.8, SD: 5.9). (Percentages in Table 3.1 and all subsequent tables are rounded to nearest whole number). Seventeen percent were aged eighty years or older; twice as many women (22%) as men (11%) are in this 'old-old' category.

Table 3.1 : Age and gender profile of respondents

	Gender		
	Male %*(N)*	Female %*(N)*	**TOTAL** % *(N)*
Age group (years):			
65-69	45 (84)	32 (68)	38 (152)
70-74	27 (52)	29 (62)	28 (114)
75-79	17 (32)	17 (37)	17 (69)
80-84	7 (13)	11 (24)	9 (37)
85-89	3 (5)	7 (14)	5 (19)
90-94	1 (2)	3 (7)	2 (9)
95+	0 (0)	1 (1)	<0.5 (1)
TOTAL % (N)	100 (188)	100 (213)	100 (401)

PROXIES FOR RESPONDENTS

Twenty-four people (6%) out of the total sample acted as proxies for the respondent, either due to the respondent being permanently (39%) or temporarily (17%) ill, or other reasons (44%). Seventy eight per cent of those acting as proxies were either the son or daughter (in 11 cases) or the spouse (in four cases) of the respondent. Grandchildren, and non-relatives made up the remaining of those interviewed. Most proxies (74%) lived with the respondent,

the mean age of proxies was 51.1 years, with ages ranging from 20 to 63 years. (Data was not gathered for those proxies who did not live with the respondent). Proxy interviewees were asked to answer survey questions from the view of the respondent, rather than putting forward their own ideas.

MARITAL STATUS

Out of the total sample, 34 (or 9%) said they were single, (i.e. never married), and 36% were widowed, while the largest proportion were married (53%). Very few reported they were separated or divorced (2%) (Table 3.2).

Table 3.2 : Marital status by gender

	Gender		
	Male	Female	**TOTAL**
	% (N)	% (N)	**% (N)**
Marital status:			
Single	9 (17)	8 (17)	9 (34)
Widowed	14 (26)	56 (119)	36 (145)
Separated/divorced	2 (4)	2 (4)	2 (8)
Married	75 (139)	34 (73)	53 (212)
TOTAL	47 (186)	53 (213)	100 (399)

Out of all those who were widowed (i.e., 145 respondents), 64% had been so for 10 years or more. The percentage of married men (75%) was more than twice that of married women (34%), and widowed female respondents (56%) were exactly four times more prevalent than male widowers (14%). This may in some part be due to the higher longevity of the female compared to male respondents.

SOCIO-ECONOMIC STATUS

EDUCATION AND EMPLOYMENT

One hundred and seventy four respondents (i.e, 44%) had completed primary education only, and a further 23% had reached Group or Junior Certificate level. Around a fifth of respondents had completed Leaving Certificate or equivalent, and somewhat less (13%) had gone on to third level education (e.g. university, regional college or equivalent), although some of the respondents (2%) had not finished the course.

The majority of older people reported being retired (67%) or were involved in home duties (29%). With the exception of one, all those reporting being involved in home duties were women. Paid or self-employed respondents made up a further four per cent of the sample (mean age 69.5 years), and were mainly men (76%).

Given the changing climate of employment in Ireland and an interest by employees and others in attracting back or retaining older workers, those not currently employed were asked whether they would like to return to work full or part-time, if there was a job that interested them. Of those not currently working (379 respondents), 16% (forty men, twenty women; mean age 70.2 years) said that they would like to work part-time. One woman said that she would like to work full time.

HOUSEHOLD INCOME

Household income was measured in broad terms, in that respondents were asked about the approximate level of net household income (i.e. total income, after tax, PRSI and other statutory deductions, of all members of the household) (Table 3.3). In this form, the findings are of limited value, due to the variation in household size and type.

Twenty percent of households reported an income of less than IR£130 per week, inclusive of all types of income (employment, social welfare payments, rents, interest, pensions, etc.), while most households had an income in the category of either IR£130 to £219 per week (35%), or between £220 to £359 per week (26%).

Table 3.3 : Weekly income per household †

	Income per household, per week			
	Under IR£130 % (N)	IR£130-£219 % (N)	IR£220-£359 % (N)	> IR£IR350 % (N)
Number of households (N=364):	20 (75)	35 (127)	26 (94)	19 (68)

† Thirty seven respondents unclassifiable

To have a more useful guide to estimated income per person, however, it is necessary to 'equivalize' income across different sizes and types of households. For example, a net household income of £200 per week may be quite large if that person is living alone. However, if there are three adults in the same household, plus one child, £200 may be quite inadequate. Thus various equivalence scales are used in Ireland which try to accomplish a more comparative measure by assigning a 'weight' to each household member, which takes into account the age (e.g. adult or child) and the number of people within the household. The equivalence scale used here has been used in previous socio-economic studies, and was suggested by the ESRI as one that best reflects the rates of financial assistance for older people. The scale gives the first person in the household a weight of one, with a weight of 0.66 attached to each subsequent adult, and 0.33 to each child (up to the age of 14). However, only one item addressed income in this study and thus it should be emphasised that unless a comparatively detailed study of socio-economic status is undertaken, such values

Table 3.4: Estimated equivalent income per person

		Estimated equivalent income (IR£) per person				
		£17-£49	£50-£99	£100-£199	£200-£400	**TOTAL**
		% (N)	% (N)	% (N)	% (N)	% (N)
Age group (years):	65–69	4(6)	21 (28)	66 (89)	9 (12)	100 (135)
	70–74	3 (3)	28 (30)	59 (63)	10 (11)	100 (107)
	75-79	11 (7)	31 (20)	46 (30)	12 (8)	100 (65)
	80+	5 (3)	32 (18)	51 (29)	12 (7)	100 (57)
	TOTAL % (N)	5 (19)	26 (96)	58 (211)	11 (38)	100 (364)

provide only a broad estimate of income. Table 3.4 illustrates the sample profile using this scale.

Using the equivalence scale as described above, the mean net weekly income per person within the household was an estimated IR£130.16 (SD: 63.92, range: £17.86 to £400.00). Nineteen older people (i.e., 5%) had an estimated income of between £17 to £49 per week, and two to three times as many 75-80 year old respondents (11%) fell into the latter category compared to any other age group (Table 3.4). Twenty six per cent of respondents had a weekly income of between £50 to £99 per week, while most respondents, from all age groups, fell into the £100 to £199 category (58%), although more of those aged 65-75 years (63%) were in this group than those aged 75 years or over (48%). Few (11% of all respondents) had an estimated income of more than £200 per week. Women tended to have a lower average income than men (Mean: £124.96, SD: 66.57 vs Mean: £136.10, SD: 60.40).

SOCIO-ECONOMIC CLASS

The sample was also classified in terms of socio-economic status (Table 3.5). About a quarter (26%) were classified as professional with almost half (49%) having worked or working in skilled to unskilled manual occupations.

Table 3.5 : Socio-economic groups (CSO classification)

	Sex of respondent:		
	Male % (N)	Female % (N)	TOTAL % (N)

Irish CSO Socio-economic group:				
0	**Unclassified**	3 (6)	4 (8)	4 (14)
1	**Higher professional** (and managers and farmers with more than 200 acres)	17 (32)	8 (17)	12 (49)
2	**Lower professional** (and proprietors and farmers with 100-199 acres)	15 (28)	13 (27)	14 (55)
3	**Other non-manual** (and farmers with 50-99 acres)	19 (35)	24 (51)	21 (86)
4	**Skilled manual** (and farmers with 30-49 acres)	26 (49)	13 (28)	19 (77)
5	**Semi-skilled manual** (and farmers with <30 acres)	12 (23)	22 (48)	18 (71)
6	**Unskilled manual**	8 (15)	16 (34)	12 (49)
	TOTAL % (N)	100 (188)	100 (213)	100 (401)

HOUSING

HOUSEHOLD COMPOSITION

One quarter of all the respondents (i.e. one hundred people) lived alone and of these, 73% were widowed, while most of the remaining (19%) were single. In addition, almost three quarters of those living alone were female and just under a quarter (23%) were aged eighty years or over. Of the 212 respondents who reported being married, the majority (63%) lived with their spouse only, and 31% lived with their children either with or without their spouse (Table 3.6). Just over half (51%) of all the respondents who were widowed, separated, divorced, or single lived alone, while about a third (35%) of this latter group lived with a second generation (e.g. their children) and/or third generation (e.g. their grandchildren). Of all those interviewed, only two per cent lived solely with other relatives, or non-relatives.

Of those who lived with one or more others, the mean number of persons per household was 2.8 (Range: 2-8, SD: 1.2).

HOME OWNERSHIP

Generally, respondents (81%) lived in property that they owned. Nine per cent of homes were rented by respondents themselves, while ten per cent lived in property that was owned or rented by someone else. Nearly two thirds (61%) of these properties were owned or rented by their own son or daughter, while others lived in the homes owned or rented specifically by their spouse (three per cent), siblings (ten per cent), other relatives (three per cent) or non-relatives (23%). Most (seventy per cent) of those relatives or non-relatives renting or owning the property lived in the home alongside the respondent.

In an attempt to establish who was seen as 'the head of the household', respondents were asked who they saw as 'making most of the important decisions in the household.' Seventy two per cent named themselves (male: 43%; female: 57%, mean age: 72.9 years, SD: 6.0) while 18% named their spouse, and a further nine per cent put forward their son or daughter as the 'head of the household.' One per cent of those designated as head of household comprised siblings or non-relatives. Some of those respondents who named themselves (23%), also commented that they and another household member made joint decisions

Table 3.6 : Household type by gender, marital status and age group

	Household type. Respondent lives								
	Alone % (N)	With spouse only % (N)	With family: 2 generations % (N)	With family: 3 generations % (N)	With siblings only % (N)	With other relatives % (N)	With non-relatives % (N)	Unclassified % (N)	**TOTAL** % (N)
Gender:									
Male	14 (27)	44 (82)	31 (59)	3 (5)	3 (5)	<1 (1)	1 (2)	4 (7)	47 (188)
Female	34 (73)	24 (51)	23 (49)	9 (19)	4 (8)	1 (3)	1 (3)	3 (7)	53 (213)
TOTAL SAMPLE %(N)	25 (100)	33 (133)	27 (108)	6 (24)	3 (13)	1 (4)	1 (5)	4 (14)	100 (401)
Marital status:									
Single	56 (19)	0 (0)	0 (0)	0 (0)	26 (9)	3 (1)	15 (5)	0 (0)	9 (34)
Widowed	50 (73)	0 (0)	28 (40)	16 (23)	2 (3)	2 (3)	0 (0)	2 (3)	36 (145)
Separated/divorced	50 (4)	0 (0)	38 (3)	0 (0)	12 (1)	0 (0)	0 (0)	0 (0)	2 (8)
Married	1 (2)	63 (133)	31 (65)	<1 (1)	0 (0)	0 (0)	0 (0)	5 (11)	53 (212)
Age group (years):									
65-69	12 (19)	44 (67)	31 (47)	3 (4)	4 (6)	<1 (1)	<1 (1)	5 (7)	38 (152)
70-79	31 (58)	31 (57)	25 (46)	5 (9)	2 (3)	1 (2)	2 (3)	3 (5)	46 (183)
80 +	35 (23)	13 (9)	22 (15)	17 (11)	6 (4)	2 (1)	2 (1)	3 (2)	16 (66)

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concerning household matters. Where joint decisions were made, spouses were reported most commonly, although children, siblings and non-relatives were also put forward. Altogether, those identified as the head of household, other than the respondent, made up 112 people (28%), with a mean age of 60.0 years (range: 26 to 87 years; male: 34%, female: 66%).

BASIC HOME FACILITIES

Whilst conducting focus groups with older people, one of the areas which was identified as causing great concern for a small, but needy group, was the lack, or indeed the lack of functioning, of facilities seen as basic to the larger population. In this survey, basic facilities were defined as having a hot water supply, an indoor flush toilet, a bath or shower, adequate lighting and cooking facilities and the continuous use of a telephone.

In reality, very few respondents were found to be lacking these home facilities (Table 3.7). Twelve respondents (i.e., three per cent of the sample) reported one or more basic facilities lacking in their home. A telephone (two per cent), was the most common facility missing, whilst only four people (one per cent) in total reported not having other facilities; three of these respondents had neither a hot water supply, an indoor flush toilet, nor a bath nor shower and the fourth person lacked both an indoor flush toilet and a bath or shower (although all four respondents said that they had the continuous use of a telephone). No one reported lacking adequate lighting or cooking facilities. All of those with facilities reported them to be fully functional, whereas the percentage of respondents needing assistance in order to use their facilities tended to be in the region of one to two per cent per facility.

Of the twelve people reporting the absence of one or more basic facilities, four lived alone, four were aged 75 years or older, and three had some minor to major reduction in independence when carrying out activities necessary for daily living. Six of those lacking facilities reported that their net weekly income was under £130 for the entire household, with nine people having an estimated total net income of less than £100 per person per week within that household. Ten out of the twelve were living in urban locations. Six of those lacking facilities felt they ‘definitely’, or ‘possibly’ needed changes or adaptations made to their home to aid independent living.

Out of the total sample, 14% said they ‘definitely’ or ‘possibly’ needed adaptations made to their home, while a further eight people (i.e., 2%) were unsure whether they needed any changes made, but would have liked to have an assessment.

Table 3.7 : Respondents with facilities which were lacking, non-functional or could not be used without assistance.

	Lacking % (N)	Facility not fully functional % (N)	Unable to use without assistance % (N)
Facility:			
Hot water supply	1 (3)	0 (0)	2 (6)
Indoor flush toilet	1 (4)	0 (0)	1 (3)
Bath or shower	1 (4)	0 (0)	2 (9)
Adequate lighting	0 (0)	0 (0)	<1 (2)
Adequate cooking facilities	0 (0)	0 (0)	2 (8)
Use of a telephone	2 (8)	.	.

SAFETY

One question addressed the issue of fear of crime, and asked 'how safe do you feel alone in your home at night?' A total of 7% reported that they felt 'unsafe' or 'very unsafe', and the majority feeling unsafe were those living alone (32%) or living with just one other person (32%). Eighty three people (21%) owned a fully functioning personal alarm, although this seemed to have little bearing on how safe they felt; almost equal percentages of respondents felt unsafe or very unsafe, whether or not they possessed a personal alarm system.

HEALTH CARE ACCESS

FUNDING FOR MEDICAL CARE

In total, 198 respondents (50%) said that they were not covered by a medical card (Table 3.8). Of all the respondents aged 75 or over, 33% did not have a card. Fifty two per cent of the whole sample, regardless of age, were covered by private health insurance, either in their own name, or through someone else. However, fifty respondents (13%) (with over a third of these aged 75 years or over) had use of a medical card as well as private insurance. Eleven per cent of the total sample had neither medical card nor private health insurance. The vast majority of those not covered were under 75 years old (84%), while all but two respondents aged over 84 years were covered either by medical card (83%) and/or private insurance (32%).

Of those who had neither medical card, nor private health care insurance (44 respondents), 14% were receiving an estimated net income of less than £100 per week per person, within their household (based on an equivalised income scale). A further third of this group were receiving an income estimated at less than £50 per week. Many of those without medical card or private cover (39%) did, however, report using either the long term illness scheme, or a drug cost refund scheme. Of the total sample, twenty three people (six per cent) reported using the long-term illness scheme, while almost a third (32%) made use of a drug cost refund scheme.

Table 3.8 : Medical expense cover by age group

	Age group (years)			
	65 – 74	75 –84	>84	**TOTAL**
	% (N)	% (N)	% (N))	**% (N)**
Medical card:				
Covered	42 (110)	63 (67)	83 (24)	50 (201)
Not covered	58 (154)	37 (39)	17 (5)	50 (198)
TOTAL:	100 (264)	100 (106)	100 (29)	100 (399)
Private health insurance:				
Own name	48 (125)	40 (43)	32(9)	45 (177)
Family member's name	9 (25)	4 (4)	0 (0)	7 (29)
Not medically insured	43 (113)	56 (59)	68 (19)	48 (191)
TOTAL:	100 (263)	100 (106)	100 (28)	100 (397)
Neither private nor medical card cover:	84 (37)	11 (5)	5 (2)	11 (44)
Both private and medical card cover	62 (31)	26 (13)	12 (6)	13 (50)
Long-term illness scheme:	61 (14)	35 (8)	4 (1)	6 (23)
Drug cost/drug refund scheme:	68 (85)	28 (35)	4 (6)	32 (126)
Other schemes:	55 (5)	44 (4)	0 (0)	2 (9)

PROFILE OF HEALTH AND FUNCTIONAL ABILITY

ACTIVITIES OF DAILY LIVING

Functional ability was measured using the Health Assessment Questionnaire (HAQ). The HAQ is normally used to measure levels of physical ability within the general population, in terms of the activities that are performed on a daily basis. Respondents are asked to rate their ability in the past week for seventeen daily tasks within eight activity categories, on a four point scale ('without any difficulty', 'with some difficulty', 'with much difficulty' or 'unable to do'). For each category of two to five activities, respondents are also asked 'Do you usually need help from another person in carrying out any of these tasks?.' An overall measure of independence can be calculated from the eight categories, yielding four levels of ability to maintain independence in activities of daily living.

For the purposes of this study however, some amendments were made to the tool to include activities that older people have at times found difficult. Additions were made to the questionnaire to incorporate eight items that reflected activities that some older people may have difficulty with, such as those requiring fine finger movement and sensation, and physical flexibility, (e.g. 'taking care of feet and toenails' or 'making a cup of tea'). An extra category was added to address difficulties with concentration, memory and reasoning skills (e.g. 'managing your own affairs'). Respondents self-reported their abilities, taking into account the use of a device or aid if one was usually used. Thus the measure provided a guide to which activities required extra help to overcome barriers to independence, as well as providing a measure of physical ability itself. While the amended areas were useful additions for this particular sample, it was felt that the original tool (with amended items omitted) would be more valid and appropriate to use when comparing physical ability with other variables or across studies.

Across all nine daily activity categories, on average, 10% reported that they usually needed help with one or more of the tasks in each category. Three categories emerged as the main areas where help was usually needed (Tables 3.9 and 3.10). These areas were mobility for activities (e.g. shopping, getting into and out of the car, or doing housework), where 18% of the sample normally required help for one or more of these activities; cognitive ability, (e.g. managing one's own affairs or remembering daily plans), tasks for whom 14% normally

required help; and personal grooming, (e.g. dressing, shampooing hair, or care for feet and toenails), where 13% tended to need help with one or more of the tasks. Less people (9%) reported requiring help with mobility in reaching (i.e. reaching to get a 5 pound object or bending to pick up clothing from the floor), eating and drinking (e.g. preparing meals or a cup of tea, cutting meat, etc) (9%), walking mobility (such as walking on flat ground outside or climbing stairs), where help was usually required for 7% of respondents and intimate personal care (i.e. bathing, washing and drying, or getting on and off the toilet) also for which 7% of the respondents reported needing help for one or more of the tasks.

For individual tasks, the activity for which the highest number of respondents reported being unable to perform, was caring for their feet and toenails (11%) followed by housework and shopping (9% and 7% respectively). Taking a bath, shampooing hair and preparing meals (each at 6%), were also individual tasks for which moderately high numbers were unable to perform unaided.

When level of independence is assessed by age group, older people reported higher levels of difficulty carrying out these tasks. Intimate personal care, for example, is an area where age group differences are relatively high. Twenty-nine (44%) of those aged eighty and over had 'much difficulty' or were 'unable to' take care of feet and toenails, compared to just 6% of those aged under eighty. Housework was a task reported by 38% of respondents aged eighty or older as very difficult or impossible without help, compared to only eight per cent of those under eighty years. Other tasks which showed large age differences included shopping (30% of those over eighty vs 3% of those under eighty), shampooing hair (30% vs 4% respectively) taking a bath (29% vs 4%), and preparing meals (26% vs 3%). The preceding areas were those where the highest differences occurred, although a similar pattern was seen throughout all tasks when comparing younger with older age groups. In fact, on average, those aged 80 and over reported having 'much difficulty' or 'unable to do' around nine times more frequently than those under eighty years old, over all individual tasks.

When examining gender differences, on average, women reported having 'much difficulty' or being 'unable to' to carry out tasks between two and three times as often as men; this finding was consistent throughout, on all but one of the tasks. These differences were particularly

Table 3.9 : Functional ability (rated with device or aid if usually used)

		Functional ability				
In the past week were you able to:		No difficulty % (N)	Some difficulty % (N)	Much difficulty % (N)	Unable to do % (N)	Usually need help for one or more tasks % (N)
Personal care: Intimate	Wash and dry entire body	90 (362)	6 (23)	1 (5)	3 (10)	7 (27)
	Take a bath	86 (342)	6 (24)	2 (7)	6 (25)	
	Get on/off toilet	94 (376)	4 (14)	1 (6)	1 (3)	
Personal care: Dressing and grooming	Dress, including tying shoelaces and buttons	90 (360)	6 (27)	3 (11)	1 (3)	13 (53)
	Shampoo hair	87 (348)	5 (21)	2 (9)	6 (23)	
	Care of your feet and toe nails	80 (322)	8 (31)	2 (9)	10 (39)	
Mobility: Arising	Stand up from an armless chair	89 (357)	7 (26)	2 (9)	2 (9)	5 (19)
	Get in and out of bed	92 (369)	6 (22)	2 (9)	<1 (1)	
Eating and drinking	Prepare meals – including dinner	89 (358)	4 (15)	1 (5)	6 (23)	9 (37)
	Make a cup of tea	95 (381)	2 (8)	1 (2)	2 (9)	
	Cut meat	94 (377)	2 (8)	1 (4)	3 (11)	
	Lift a full cup or glass to mouth	97 (385)	2 (9)	0 (0)	1 (3)	
	Open a new milk carton	86 (342)	6 (25)	4 (16)	4 (16)	

Table 3.10 : Functional ability (rated with device or aid if usually used) (c

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In the past week were you able to:		No difficulty % (N)	Some difficulty % (N)	Much difficulty % (N)	Unable to do % (N)	Usually need help for one or more tasks % (N)
Mobility: Walking	Walk outdoors on flat ground	90 (359)	5 (23)	3 (12)	2 (7)	7 (27)
	Climb up 5 stairs	86 (341)	8 (33)	4 (17)	2 (9)	
Mobility: Reaching	Reach up and get down a 5 pound object	83 (331)	8 (33)	4 (14)	5 (21)	9 (33)
	Bend down and pick up clothing from floor	84 (336)	9 (36)	2 (8)	5 (19)	
Grip	Open car doors	92 (367)	5 (20)	1 (5)	2 (7)	6 (24)
	Open jars previously opened	90 (360)	6 (26)	1 (3)	3 (11)	
	Turn taps on/off	93 (373)	4 (17)	2 (7)	1 (4)	
Mobility: Activities	Do messages, shopping, etc	86 (347)	6 (23)	1 (4)	7 (27)	18 (73)
	Get into/out of car	88 (354)	7 (26)	4 (16)	1 (4)	
	Do housework e.g. vacuuming, cleaning.	78 (312)	9 (36)	4 (16)	9 (36)	
Cognitive ability	Manage own affairs (e.g. pay bills)	89 (355)	5 (22)	1 (4)	5 (19)	14 (56)
	Remember daily tasks (e.g. appointments)	89 (357)	6 (23)	2 (7)	3 (12)	

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evident in individual tasks, such as 'shampoo your hair' (men: three per cent, women: twelve per cent); 'manage your own affairs' (men: two per cent, women: nine per cent); 'remembering important daily plans' (men: two per cent, women: eight per cent); 'turn on and off taps' (men: one per cent, women: four per cent) and 'care for your feet and toenails' (men: seven per cent, women: 16%). These figures may in part reflect the higher proportion of women who are older; however, they are of particular concern since a much greater proportion of women than men lived alone (34% vs 14% respectively).

USE AND NEED OF DEVICES

Respondents were asked whether they currently used, or if not using, were in need of a range of aids or devices (i.e. walking stick or frame, crutches, wheelchair, raised toilet seat, bath seat or handrail, or other device) to help maintain their independence. The most commonly reported devices were to aid mobility. Forty nine respondents (12%) said that they usually used a walking stick, and three per cent normally used a Zimmer frame. Three per cent used a wheelchair, while only one person reported using crutches. In terms of unmet needs thirteen respondents (four per cent) currently not using a walking device said they needed either a walking stick, frame, a wheelchair or crutches.

Nineteen people (five per cent) reported normally using a raised toilet seat, and a further two per cent said they needed the appliance. Similarly, bath appliances (i.e. bath seat or handrail) were used by ten per cent of the respondents and a further four per cent felt in need of the appliance. Two per cent in total used 'other' devices, which they specified as commodes, a chairlift for the stairs, a long shoehorn, a handgripper for picking up objects and a side rail for a bed. Very few (one per cent) said they needed other appliances, but those which were mentioned tended to be home adaptations such as needing a bath or a stair rail.

The majority of respondents who reported the need for mobility aids also reported at least some degree of difficulty with many of the activities that require a certain level of mobility, such as walking on flat ground, climbing steps, getting into and out of bed, standing up from an armless chair, housework or shopping. Similarly, most of those interested in obtaining bath appliances were people reporting at least some difficulty with bathing, and half of those reporting the need for a raised toilet seat were those also indicating that they had some difficulty getting on or off the toilet.

INFORMAL CARE

Many respondents reported receiving help from informal carers, on a regular basis, to maintain their independence (Table 3.11). Spouses or partners, and other relatives living in the household provided a great deal of help: 27% and 21% (respectively) of respondents who lived with spouses or other relatives were provided with the care necessary to maintain independence. Again, many of those helpers gave continuous, (twenty-four hour) support: 51% and 35% respectively of spouses and residing relatives gave twenty-four hour help, although it was not possible to examine in detail the type of help or care provided. Help was also reportedly provided by relatives who lived elsewhere (twenty per cent of respondents) and neighbours (11% of respondents), while there was little help availed of from voluntary organisations (two per cent) or 'other' means (one per cent).

CARERS

Some of those interviewed (35 respondents, or nine per cent of the sample) reported being the main person providing the necessary care for someone else in the past twelve months: nineteen (or around two thirds) of these respondents were women, and four were over eighty years old themselves. Most carers (83%) had no difficulties maintaining their independence, nevertheless four respondents had some difficulties and two people reported many difficulties in carrying out daily tasks due to their limited independence. In addition, seven respondents (or twenty per cent of those who reported being carers) felt they currently 'definitely' or 'possibly' needed adaptations to their home to maintain their independence.

PREVALENCE AND IMPACT OF HEALTH CONDITIONS

In order to gain an understanding of the types of illnesses and medical conditions which affect the lives of older people, respondents were asked to indicate if they had suffered from any of 30 chronic illnesses or other health conditions in the past 12 months. Only 15% of the entire

Table 3.11 : Percentage of respondents receiving regular help by informal provider and frequency of help

Help provided regularly to maintain independence % (N)		Frequency of help provided				
		Continuous, (including night) % (N)	Most of the day % (N)	1-2 times per day % (N)	A few times a week % (N)	Once weekly or less % (N)
Informal provider:						
- Spouse/partner (where applicable, N=245)	27 (66)	51 (34)	23 (15)	11 (7)	15 (10)	0 (0)
- Other relative in your household (where applicable, N=304)	21 (63)	35 (22)	14 (9)	18 (11)	19 (12)	14 (9)
- Other relative living elsewhere (N=398)	20 (79)	5 (4)	5 (4)	12 (10)	45 (38)	27 (23)
- Neighbour (N=398)	11 (44)	5 (2)	7 (3)	23 (10)	29 (13)	36 (16)
- Voluntary organisation (N=396)	2 (6)	33 (2)	0 (0)	17 (1)	0 (0)	50 (3)
- Other (N=316)	1 (2)	0 (0)	0 (0)	50 (1)	50 (1)	0 (0)

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sample reported that they were free from any underlying illness or condition in the past year. A further 21% reported only one condition, while twenty per cent reported two illnesses. The total number of illnesses per respondent ranged from 0 to 14 (mean, 2.9 SD: 2.6).

For each condition that a respondent reported, they were then asked to rate the extent to which it had disrupted their life over the last month. Table 3.12 shows the prevalence of the conditions in the whole sample and the comparative level of disruption for those reporting that specific illness. For example, high blood pressure was reported by 35% of respondents, but only one per cent of those with high blood pressure said that it had caused extreme disruption in the past month. The most commonly reported conditions were as follows: bone or joint conditions (45%), hypertension (35%), eye or vision problems (19%), heart conditions (19%), hearing or ear problems and sleep problems (17% each) and memory or concentration problems (16%). 'Other illnesses' not listed, but specified by respondents were hiatus hernias, gall stones, circulatory disorders, pancreatic cyst, gout, muscular dystrophy, pressure sores, and shingles (each reported by only one to two respondents).

Looking across all illness conditions, sixty four respondents (16%) had at least one condition that they described as causing extreme disruption. In terms of all 401 respondents, the conditions most commonly reported as causing extreme life disruptions were: bone or joint conditions (seven per cent of the whole sample), foot problems (three per cent) and sleep, back, eye or vision problems, heart conditions, ear or hearing problems (each causing extreme disruption to two per cent of the total sample).

Pain had been experienced in the past week by over a third of the respondents interviewed (35%). Twenty six (19%) of those experiencing pain reported mild pain for between four and seven days in the past week, and twenty per cent reported moderate pain over the same duration. A further 13% had experienced severe pain for at least four days in the past week.

Table 3.12: Prevalence of health conditions over past year and level of disruption caused in past month† *

		Level of disruption % (N)			
Condition:	Prevalence	Extremely disruptive	Moderately disruptive	A little disruptive	Not at all disruptive
Bone or joint condition	45 (181)	14 (26)	**30** (53)	37 (66)	19 (35)
High blood pressure	35 (138)	1 (1)	20 (27)	25 (35)	54 (74)
Eye or vision problem	19 (76)	11 (8)	22 (17)	33 (25)	34 (26)
Heart condition	19 (75)	9 (7)	27 (20)	27 (20)	37 (27)
Ear or hearing problem	17 (68)	11 (7)	**31** (21)	42 (28)	16 (11)
Sleep problems	17 (68)	15 (10)	23 (16)	50 (34)	12 (8)
Memory/concentration problem	16 (64)	6 (4)	29 (18)	43 (27)	22 (14)
Back problems or slipped disc	15 (60)	17 (10)	26 (15)	40 (23)	17 (10)
Foot problems	13 (53)	**25** (13)	19 (10)	41 (22)	15 (8)
Lung condition	12 (48)	9 (4)	24 (11)	31 (14)	36 (16)
Depression /anxiety	12 (46)	9 (4)	24 (11)	52 (24)	15 (7)
Prostate/bladder problem	11 (43)	9 (4)	**37** (16)	35 (15)	19 (8)
Diabetes mellitus	8 (32)	6 (2)	**31** (10)	38 (12)	25 (8)
Dental/gum problem	8 (31)	0 (0)	22 (7)	39 (12)	39 (12)
Bowel disorder	7 (27)	12 (3)	**31** (8)	38 (10)	19 (5)
Migraine/chronic headache	6 (25)	4 (1)	**38** (9)	29 (7)	29 (7)
Stomach or peptic ulcer	5 (19)	10 (2)	**32** (6)	26 (5)	32 (6)
Serious skin disorder	5 (19)	0 (0)	21 (4)	53 (10)	26 (5)
Leg ulcer	3 (13)	15 (2)	23 (3)	54 (7)	8 (1)
Blood disorder	3 (13)	0 (0)	**38** (5)	38 (5)	23 (3)
Cancer	2 (10)	10 (1)	**30** (3)	20 (2)	40 (4)
Thyroid gland disorder	2 (10)	0 (0)	20 (2)	40 (4)	40 (4)
Other consequences of stroke	2 (9)	**37** (3)	0 (0)	37 (3)	25 (2)
Kidney disease	2 (7)	**33** (2)	17 (1)	50 (3)	0 (0)
Parkinson's disease	1 (4)	0 (0)	**50** (2)	50 (2)	0 (0)
Speech difficulty	1 (4)	0 (0)	0 (0)	100 (4)	0 (0)
Epilepsy	1 (3)	**33** (1)	**33** (1)	33 (1)	0 (0)
Liver disorder	<1 (2)	0 (0)	0 (0)	0 (0)	100 (2)

† Condition prevalence ranked from most to least. Bold figures highlight most disruptive conditions, regardless of prevalence.

MENTAL HEALTH

The Hospital Anxiety and Depression Scale (HADS) was implemented to gain some insight into the mental well-being of all the respondents, and measured levels of anxiety and depression in this population. The HADS is particularly useful in differentiating between anxiety and depression, and yields scores which indicate the levels (normal, borderline or clinical) of each.

Scores of eight to ten on either the anxiety or depression scale indicate borderline depression or anxiety, while a score above ten (up to the maximum of 21) indicates levels of clinical depression or anxiety, and suggests the person may be requiring a professional level of intervention. It should be noted here that all respondents for whom a proxy was interviewed on their behalf have been analysed separately in this section, since in many cases, proxies would have had difficulty answering these questions from the point of view of the respondent.

ANXIETY

A total of seventeen respondents (five per cent) had scores denoting clinical levels for anxiety and eight per cent scored at borderline levels (Tables 3.13 and 3.14). When comparing women with men, women had twice the prevalence of both borderline and clinical scores combined, (16% of women versus eight per cent of men in these categories). A fifth of those with borderline or clinical levels of anxiety also scored highly for depression, and indeed, three respondents had clinical levels of both.

DEPRESSION

Only five respondents (one per cent) scored at levels suggesting clinical depression and a further twelve (three per cent) produced borderline scores for depression. Both borderline and clinical scores tended to be more prevalent at aged eighty years and above; however, the numbers involved are extremely small. Because of the small numbers of clinical and borderline scores, further exploration of the associates of anxiety and depression could not be not undertaken.

Table 3.13 : Prevalence of anxiety and depression by gender, using Hospital Anxiety and Depression Scale (HADS)

		Gender		
		Male (N=177)	Female (N=191)	**TOTAL** (N=368)
		% (N)	% (N)	% (N)
ANXIETY:				
	Borderline	5 (8)	11 (20)	8 (28)

	Clinical disorder	3 (6)	6 (11)	5 (17)
DEPRESSION:				
	Borderline	2 (3)	5 (9)	3 (12)
	Clinical disorder	1 (2)	2 (3)	1 (5)

Table 3.14 : Prevalence of anxiety and depression by age group, using HADS

		Age group				
		65 – 69 (N=143) % (N)	70 – 74 (N=111) % (N)	75-79 (N=62) % (N)	80+ (N=52) % (N)	TOTAL (N=368) % (N)
ANXIETY:						
	Borderline	8 (11)	5 (6)	8 (5)	12 (6)	8 (28)
	Clinical disorder	4 (6)	5 (6)	5 (3)	4 (2)	5 (17)
DEPRESSION:						
	Borderline	3 (4)	3 (3)	3 (2)	6 (3)	3 (12)
	Clinical disorder	1 (2)	0 (0)	0 (0)	10 (3)	1 (5)

Three of the proxies (13%) who answered this section on behalf of the respondent reported levels of clinical depression, and another three reported borderline levels in the respondent. The picture was similar for numbers reporting clinical and borderline anxiety levels (three and two of the proxies, respectively).

SOCIAL CONTACT AND SUPPORT

Many respondents reported life situations that could indicate risk of problems of isolation or lack of social support. Although the majority lived in urban or town settings, (89%), the remainder were from rural, possibly isolated, areas (11%), lived alone (25%), or were widowed (36%). Some had limited independence in every day activities (21%), while others had extremely disrupted lifestyles through illness (16%). Of course, a combination of these latter factors os also possible. A number of questions addressed the issues of loneliness and level of morale for this group.

TIME SPENT ALONE

Spending time alone was seen as an important marker of social contact. In examining loneliness, a set of three questions were constructed to establish the average number of hours the respondent would usually spend alone on an average weekday, Saturday and Sunday, from 8 o'clock in the morning, to 10 o'clock at night (i.e. a 14 hour period). Although the overall mean number of hours for respondents was relatively low (weekday: 3.7; Saturday 2.8; Sunday: 2.4), these figures may be somewhat misleading, as the number of hours spent alone deviated considerably across respondents (SD: 4.0, 3.8, and 3.6, respectively) (Table 3.15). On further investigation, it appears that almost a third of respondents (32%) spent on average, no time at all alone during the day. The majority of those, unsurprisingly, were married or living with others.

The mean number of hours alone per day of those respondents who reported spending any time at all alone, was somewhat higher at 5.0 (SD 3.5) hours throughout the whole week. This perhaps provides a more realistic view of those who live alone. Indeed, exactly a third of all those living alone, reported being alone for an average of 10 - 14 hours during the day, and over another third (36%) between five and nine hours per day, throughout the week. Thirty-nine per cent of those spending between 10 –14 hours alone had limited independence when performing at least some activities of daily living without help. Another question attempted to ascertain just how lonely respondents felt and they were asked 'How often in the last 12 months have you been bothered by loneliness?' indicating their answer on a four point scale from 'very often, to 'never.' Out of the whole sample, only eight per cent said that they were bothered by loneliness either 'very often' or 'fairly often.' However, of those thirty five respondents who spent an average of 10-14 hours per day alone, just over a quarter reported being bothered by loneliness either 'very often' or 'fairly often.'

Table 3.15 : Mean number of hours spent alone during waking hours

	Average number of hours spent alone from 0800 to 2200 hrs, per day				
	0 % (N)	1-4 % (N)	5-9 % (N)	10-14 % (N)	**TOTAL** **% (N)**

Age group (years):					
65-74	33 (86)	43 (112)	18 (48)	6 (16)	100 (262)
75-84	28 (29)	33 (34)	24 (24)	15 (15)	100 (102)
85+	35 (10)	31 (9)	17 (5)	17 (5)	100 (29)
TOTAL % (N)	32 (125)	39 (155)	20 (77)	9 (36)	100 (393)

MORALE

Morale was measured using a selection of four statements, from which the scores were averaged for each person and re-categorised into low, moderate and high morale (Table 3.16). Only fourteen respondents (four per cent) had overall scores that were suggestive of low morale. When the statements were looked at individually, 18% of the sample agreed or strongly agreed that they had 'fears of becoming a burden to society.' A further 18% disagreed with the statement 'I feel I still contribute to my community and society as much as I would like to.' Less respondents (eight per cent) disagreed with the statement 'generally people treat me with less respect due to my age.' This broad morale categorisation indicates a relatively high level of morale in this group.

Table 3.16 : Level of morale amongst older people

	Level of agreement/disagreement				
	Strongly agree % (N)	Agree % (N)	Neither agree nor disagree % (N)	Disagree % (N)	Strongly disagree % (N)
Statement:					
'I am often bored and have time that I don't know how to fill'	6 (23)	13 (52)	8 (33)	27 (108)	46 (185)
'Generally, people treat me with less respect due to my age'	2 (7)	6 (25)	5 (19)	42 (169)	45 (179)
'I feel I still contribute to my community and society as much as I would like to'	27 (110)	41 (163)	14 (54)	11 (45)	7 (29)
'I worry a great deal that I am becoming a burden to other people'	5 (19)	13 (51)	11 (45)	32 (127)	39 (158)
Overall mean level of morale:	**High:** 79 (318)		**Moderate:** 17 (69)		**Low:** 4 (14)

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SOCIAL SUPPORT

Three statements addressed the respondents' level of social contact from a practical and emotional support viewpoint. Again, the scores from all three items were averaged for each person and re-categorised into low, moderate and high levels of social support. Overall, support appeared very high for the sample. Respondents who said that they had someone who made them 'feel loved and appreciated', or someone they could 'confide in and would give advice and support', either 'none of the time', or 'a little of the time', were very few (four and five per cent, respectively). Slightly more respondents (ten per cent) agreed that they very seldom had someone to 'help with practical tasks, such as preparing meals, household chores or shopping.' Social support was also examined alongside the number of hours respondents spent alone per day. Despite the number spending many hours alone (36 respondents in all), almost half (47%) of this group indicated they had frequent social support, and around 31% indicated they had support some of the time. However, eight (22%) of those alone for very long periods indicated that they had social and emotional support only 'a little' or 'none of the time' (Table 3.17).

Another set of items explored the level of interest respondents had in a selection of social support or contact options (Table 3.18). Various levels of interest were evident: respondents appeared most interested in an informal visit from a friend or relative (62% replied that they would be 'interested' or 'very interested'). Eighteen per cent were interested in 'a person whose job it is to visit older people', while 17% were interested in a 'volunteer who visits people', 15% in 'a phone number to use for a chat' and only six per cent in 'a person whose job it is to accompany you outside the home.' Almost a third (31%) were interested in 'becoming an active member of a group.'

Table 3.17 : Social contact and support

	Frequency of reporting				
	None of the time % (N)	A little of the time % (N)	Some of the time % (N)	Most of the time % (N)	All of the time % (N)
Do you have someone who:					
- makes you feel loved and appreciated?	3 (13)	2 (7)	7 (28)	16 (63)	72 (287)
- you can confide in and will give you advice and information?	2 (7)	2 (7)	6 (24)	17 (67)	73 (292)
- will help you with practical tasks (e.g. preparing meals, household chores or shopping)?	7 (29)	3 (14)	4 (16)	14 (53)	72 (282)
Overall mean level of social support:	**High: 347** (87)		**Moderate: 8** (31)		**Low: 5** (20)

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Table 3.18 : Level of personal interest in strategies to provide formal and informal social contact.

	Level of interest:					
	Very interested	Interested	Unsure	Not very interested	Not at all interested	TOTAL
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)
Interest in the following:						
An informal visitor (friend or relative)	35 (142)	27 (109)	5 (19)	12 (47)	21 (83)	100 (400)
A person whose job it is to visit older people	4 (17)	14 (55)	8 (32)	32 (127)	42 (169)	100 (400)
A volunteer who visits older people	5 (19)	12 (47)	8 (34)	31 (122)	44 (177)	100 (399)
A phone number to use for a chat or reassurance	4 (15)	11 (44)	9 (36)	30 (121)	46 (183)	100 (399)
A person whose job it is to accompany you outside	1 (4)	5 (18)	5 (18)	29 (117)	60 (241)	100 (398)
Becoming an active member of a group	10 (39)	21 (83)	6 (26)	25 (99)	38 (154)	100 (401)

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ATTENDANCE AT SOCIAL EVENTS

Two final items were designed to look at whether respondents were able to get out to social events if they so desired. Respondents were asked 'over the last month were you able to attend events outside your home (e.g. a community or social event)' and were you able to 'visit friends or family in their own home', on a four point scale from 'without difficulty' to 'unable to do.' Although relatively small numbers are involved, nevertheless, five per cent said that they were unable to attend events outside their home, and a further two per cent could attend, but only with great difficulty. Four per cent said that they were unable to visit friends or family in their own homes, and three per cent found 'much difficulty' in visiting family and friends' in the last month.

HEALTH BEHAVIOURS AND PROMOTION

A selected range of activities were evaluated; two areas concerned people's own health-related behaviours (smoking and exercise), and three represented possible preventive and screening activities of health professionals for this group (the flu' injection, blood pressure monitoring and general health check-ups).

EXERCISE

Respondents were asked one question about exercise: 'All things considered do you think you exercise enough at present?' If they said they did not, respondents were given a range of reasons why they thought this was so, from which they could tick as many they liked. Twenty three per cent of respondents reported that they felt they did not exercise enough. The majority of this group (63%), and especially of those aged eighty or more, said it was because of health reasons, although only eight per cent also said they were 'afraid of overdoing it.' Fifteen per cent said they were not interested while 11% did not have the time (Table 3.19).

Table 3.19 : Reasons given for being unable to take enough exercise

	Age group		
	65-79	**80+**	**TOTAL**
	% (N=68)	% (N=24)	% (N=92)
Health reasons	53 (36)	92 (22)	63 (58)
Areas for walking not safe/accessible/easy	4 (3)	8 (2)	5 (5)
Afraid of 'overdoing it'	9 (6)	4 (1)	8 (7)
Not interested	19 (13)	4 (1)	15 (14)
No time	15 (10)	0 (0)	11 (10)

SMOKING

Current smoking was a habit reported by almost a fifth of respondents (19%), with slightly more women than men women smoking (22% vs 16%) (Table 3.20). Just over two thirds of these respondents said they smoked over 10 cigarettes daily (mean per day: 16.3, SD: 9.0). The vast majority had been smoking for over forty years (mean: 48 years; SD: 13). Forty-five per cent of those who smoked had been spoken to about smoking by a medical doctor in the past year. Only 13 respondents (17%) wanted help from their GP to stop smoking.

Of past smokers, most (47%) had given up between age fifty and 65 years. The single most important reason given for giving up, from a choice of six reasons was their own decision (71%).

THE 'FLU' INJECTION' AS PRIMARY PREVENTION

Just over a third of the group (35%) said that they had received the flu' vaccine last winter. The idea had most often been suggested by a doctor (51%), although in over a third (37%) of cases, the respondent themselves suggested it to the doctor. For some respondents (seven per cent), a friend or relative put forward the idea. Four per cent gave an 'other' response regarding whose suggestion it was, and in all but one case, they specified media sources ('advertised on TV'; 'newspaper advert', etc).

For those who did not receive a flu' injection last year (261 respondents in all, or 65%), many reasons were put forward. From a list of six reasons (from which they could tick as many reasons as applied), 23% of those who did not have it, did not believe that it would reduce the risk of flu'; 13% were concerned about the side effects; seven per cent each of respondents said that they did not know they were entitled to it, or that they had had a previous negative experience with flu' injections and six per cent reported that their doctor said they did not need one.

Forty four per cent of the respondents who did not have the injection specified 'other' comments too: 16% of those who did not have the injection said either they had not bothered, it was not important to them, or that they had forgotten. A further five per cent said that

Table 3.20 : Levels of smoking and related medical advice

	Number of respondents % (N)	Duration of smoking (years) Mean (SD)
Smoking status:		

Never smoked	45 (182)	NA
Ex-smoker	35 (142)	28 (14)
Current smoker	19 (77)	48 (13)
Current smokers:		
Medical advice given in previous year?		
by GP only	35 (27)	
by hospital doctor only	5 (4)	
by both	5 (4)	
Total	**45 (35)**	
Would like GP assistance to quit	17 (13)	
Actively trying to quit	16 (12)	
Actively planning to quit	5 (4)	
Considering quitting	15 (11)	
Not considering quitting	64 (49)	
Ex-smokers:		
Age at quitting?		
< 50 years	44 (61)	
50-65 years	47 (66)	
66-74 years	9 (13)	
Most important reason for quitting?		
Own decision	71 (101)	
Specific medical advice	13 (18)	
General medical advice	9 (12)	
Other, professional advice	<1 (1)	
Advice from family/friends	4 (6)	
Media	3 (4)	

they themselves thought they did not need it. Other comments included those saying that they did not usually get flu', or that they were not normally sick (five per cent), or conversely that they were already unwell (two per cent), that they had not had the injection due to the cost (four per cent), or that either they were afraid or they did not like injections (three per cent).

This level of uptake was largely established in winter 1999, before a major flu' epidemic developed in Ireland along with other European countries. Extensive media discussion took place shortly after Christmas (and in advance of these interviews) regarding the desirability of high levels of flu' vaccination for Winter 2000, in particular for older people. Intention to

avail of these injections for the coming winter was of interest in this context. Out of the overall study sample, 53% intended to get the flu' injection next year, 24% were not sure, and 23% said they did not intend to.

BLOOD PRESSURE MANAGEMENT

Three questions were aimed at blood pressure. Nearly two thirds of respondents (63%) said that they had had their blood pressure checked within the past three months and a further 24% had had it checked within the last year. Only three per cent had not had it checked in the last 5 years. All but five per cent reported they knew whether their blood pressure was high (17%), normal (75%), or low (four per cent). Interestingly, 37% per cent said they were on regular medication for their blood pressure (i.e. those with high pressure and those reporting normal pressure because of treatment).

GENERAL HEALTH CHECK-UP

Two thirds of respondents said that they had had a general check up with a GP within the last 12 months. Of those who had not had a check up in the last year, men (36%) were more likely than women (26%) to be in this group.

UTILISATION AND PERCEPTION OF SERVICES

GENERAL PRACTIONER SERVICES

Respondents were asked a variety of questions regarding their contact and experiences with GPs. These experiences included those with a regular GP, a doctor on call, a locum, and/or some other doctor in a group practice. Although it is more common in recent years for people not to have a single, identified GP, the vast majority of respondents (98%) did identify having their 'own' GP. Of those who did have their own GP, most reported having a long association with that doctor. Thirty eight per cent have been seeing their GP for 20 or more years, while 27% have been seeing their GP for between 10 and 19 years. Only 3% of the respondents had been with their current GP less than five years. In terms of satisfaction, respondents were asked how satisfied they were with different aspects of their care; including whether or not their concerns were taken seriously, the availability of their GP to get an appointment, and the information they received about their health. The majority of respondents (94%) were either 'satisfied' or 'very satisfied' with all of these aspects, while less than three per cent were either 'dissatisfied' or 'very dissatisfied.'

Respondents were also asked if they had been seen by GPs other than their own. In the last 12 months, approximately four per cent had been seen by a doctor on call, 8% had seen a locum, and 9% had been seen by another doctor in a group practice. Although satisfaction with these other doctors was also quite high, for those who had seen both their own GP and another GP, differences were found on ratings for all three aspects of care. Respondents were more satisfied that their concerns were taken seriously, with the availability to get an appointment and with the information that they received from their own GP than they were with another doctor. Indeed, when respondents were asked directly to compare the level of care they received from this other doctor to the care they received from their own, approximately nine per cent rated it as 'somewhat worse' or 'much worse.'

Utilization of GP services over the past 12 months varied considerably and ranged from zero to 30 visits. Nine per cent of the respondents had not been to the GP at all in the past 12 months, while 58% had seen a GP from one to five times. The average number of visits reported by respondents was 4.5 visits. Although the majority of respondents (88%) reported that 'nothing' prevents them from seeing a GP as much as they would like, some barriers

were reported. A total of 31 respondents (eight per cent) reported that 'cost' was a factor for them, while another 11 respondents (3 per cent) reported that transportation prevented them from seeing the GP.

HOSPITAL SERVICES (A&E, INPATIENT, OUTPATIENT, REHABILITATION)

Respondents were asked about their use of hospital services over the past 12 months, including visits to accident and emergency (A&E), scheduled inpatient admissions, hospital outpatient appointments and rehabilitation. Those who used a particular service were then asked to indicate the number of times or separate episodes that they visited each of the services, and to rate their satisfaction with the service overall.

Table 3.21 : Frequency of utilization and satisfaction with hospital services

Service:	Used service in past year % (N)	Number of times service availed Mean (SD)	Satisfied with service %
Accident & Emergency	14 (57)	1.6 (1.2)	82
Scheduled hospital inpatient	15 (59)	1.4 (1.3)	93
Hospital outpatient	37 (146)	3.3 (3.4)	93
Rehabilitation	< 1 (1)	1.0 (-)	100

Table 3.21 above shows the percentage of respondents who reported having visited each of these hospital services in the past twelve months. Fourteen per cent of the respondents reported having been seen in accident and emergency, and of those who had utilized A&E, they had gone on average between one and two times. Almost 15% of respondents had been in the hospital for a scheduled inpatient admission. Of these respondents, there was a range of one to ten admissions during the last year. Hospital outpatient appointments were reported by the greatest number of respondents, 146 (37%), with the total number of visits over the past 12 months ranging from one to twenty for this group. The percentage of respondents who rated a service as 'satisfied' or 'very satisfied' are shown in the previous table. All three services were rated quite highly. Accident and emergency was rated somewhat lower than the other services, due to almost 15% of respondents indicating that they were 'dissatisfied' or 'very dissatisfied' with that service. This is compared to only seven and four per cent of respondents indicating dissatisfaction with inpatient or outpatient hospital visits, respectively. Rehabilitation services were utilized by only one respondent

(less than one per cent of the sample), and consisted of one stay lasting 21 days in length. The single respondent who used rehabilitation services was satisfied with them.

Respondents who had indicated that they had a scheduled inpatient admission in the past 12 months (N=59) were asked a series of questions about that experience. The mean number of weeks that respondents reported having waited between referral and admission to the hospital on their most recent admission was 6.0 weeks. However, while half of the respondents (50%) waited up to one week, a few respondents waited significant periods of time and up to 52 weeks for their inpatient admission. Respondents also rated their satisfaction with various aspects of the transition at discharge from inpatient hospitalization to their home. When asked how satisfied they were with the amount of notice that they received in advance from the hospital before discharge, 66% of respondents were 'very satisfied', 27% were 'satisfied', and less than seven per cent were either 'dissatisfied' or 'very dissatisfied.' Satisfaction with the preparations made for their return home, and amount of information given for their recovery at home were rated similarly; the majority of the respondents were satisfied, and less than four percent were either 'dissatisfied' or 'very dissatisfied.'

DAY SERVICES (DAY HOSPITAL, DAY CARE UNIT, DAY CENTRE/CLUB)

In addition to hospital services, respondents were asked about a range of daytime services, including day hospital services, day care unit services, day centres and day clubs. Due to the fact that many of these day services were set up by various organizations, there is some amount of inconsistency in terms of how these services are defined and what particular services are provided. In this study, we have tried to make a distinction between services which provide some form of medical service with those whose primary purpose is more social in nature. Day hospitals and day care units were viewed as the more 'medical' services, where recipients may receive physiotherapy, chiropody, get their blood pressure checked, etc. Alternatively, day centres and day clubs were viewed as places with a 'social' emphasis, providing a range of social activities which may include a meal or bath, but are not medically focused. Even though we attempted to make this distinction with the survey respondents, it appears that a distinction was difficult to make. This is most likely due to the fact that the names of many day services can be very misleading in terms of what is really offered to the recipients. For example, there are several services called 'day centres' which may be classified as 'day care units' due to the medical services offered there, while several other 'day centres' offer purely social activities. In order to more accurately describe the

types of services that respondents received, we asked them to name the day service they attended, and services were re-categorized if necessary after data collection. (Due to re-categorization, some respondent data is missing because slightly different questions were asked of each of the services.)

A total of twenty respondents (five per cent) reported that they had utilized a day hospital or day care unit. The mean number of times that these respondents used the service was 57 visits in the last 12 months. Among this group of users, there was considerable variation in how often they used these services, ranging from just one time in the last year to five times a week for the whole year. Satisfaction with these more medically-based day services was high, with only one respondent dissatisfied with the number of services offered. When asked if they were getting to use the day hospital or day care unit as much as they would have liked, 11% felt that they were not. The only barrier reported for these respondents was having been allocated only a limited number of visits.

Fewer respondents, (slightly less than two per cent), reported using the more socially-based services (day centres or clubs) in the last 12 months. The mean number of times that these respondents utilized the services was also 57 visits. Usage ranged from one time a week, every week, to two times a week for forty weeks in the last year. Most respondents (83%) were either 'satisfied' or 'very satisfied' with these types of services. Of those respondents who were not using these services, a total of nine (just over two per cent) reported that they would like to avail of this service. When asked what was preventing them from getting to use a day centre or club service, three out of the nine respondents reported that the service was not available to them, while another three were unaware of the service. One person stated that transportation was a barrier for them and another admitted that they had not tried to access the service.

WAITING LISTS

All respondents were asked if they were currently on any waiting lists for the following services: hospital inpatient, hospital outpatient, day hospital, day care unit, day centres or rehabilitation. A total of 13 respondents (or three per cent) were waiting for one or more

services. Seven respondents were waiting for an inpatient hospital service. Waiting times ranged from four weeks to 52 weeks at the time of the interview. A similar number of respondents (i.e., six) were waiting for outpatient services, with waiting times ranging from one to 24 weeks. No respondents reported waiting either for day hospital, day care, day centre, or rehabilitation services. The mean length of waiting time across both of the above services (inpatient and outpatient) was 15 weeks (SD 14).

USE OF OTHER HEALTH AND SOCIAL SERVICES

Respondents were asked about their utilization of a number of other health and social services that are provided by the health board. Some services were available to the respondents in their own home, while others would have been accessed through outpatient clinics, day hospitals, day care units, or private clinics. Table 3.22 summarizes the services that were included in the survey. Respondents who utilized a service in the past year were asked how often they availed of the service, and then asked to rate their satisfaction with that service on a five point scale. The table below shows the percentage of respondents who were either 'very satisfied,' or 'satisfied' with each service. Therefore, greater percentages indicate greater satisfaction with the service.

Of the home-based services, the public health nurse service was used by more respondents in the last 12 months (15% of the sample) than any other home-based service. The mean number of times a public health nurse was seen in a year by the users of the service was almost eight times. In interpreting this mean, however, one should note that there are a number of distinctive visiting patterns in the data. Almost 18% of users saw the nurse at regular intervals, such as once a month or once a week. However, the majority, 65% saw the public health nurse only once or twice in the last 12 months. Satisfaction with this service was high, with 88% of respondents indicating that they were satisfied with it. Of the other services which are based in the home, home help was the service used next most often, with six per cent of respondents reporting use of it. Respondents reported using this service approximately two to three times a week, and satisfaction was also high (88% satisfied with the service.) Meals-on-wheels and personal care attendants were used by two and one percent of the respondents, respectively. Meals-on-wheels was provided on average three times a week, while personal care attendants were used less than once per week. Satisfaction with meals-on-wheels was rated similar to home help (88%) while satisfaction with care attendants

was much lower (67%), although it must be noted here, that reported usage of this service was extremely low.

Table 3.22 : Frequency of utilization and satisfaction with other health and social services

	Used service % (N)	Number of times service used Mean (SD)	Satisfied with service %
Home services:			
Home help	6 (25)	2.4 (1.7)[a]	88 (21)
Meals-on-wheels	2 (9)	3.3 (2.6) [a]	88 (7)
Public health nurse	15 (59)	5.7 (10.7)	88 (50)
Personal care attendant	1 (4)	>1 (1.0)[a]	67 (2)
Therapies:			
Physiotherapy	4 (17)	36.6 (64.8)	100 (17)
Occupational therapy	1 (5)	13.4 (22.1)	100 (5)
Chiropody	23 (94)	3.6 (2.6)	98 (90)
Speech therapy	0.5 (2)	26.5 (36.1)	100 (2)
Psychological/ counselling	<0.5 (1)	20 (-)	100 (1)
Outpatient services:			
Dietician	3 (13)	17.0 (43.9)	100 (13)
Optician	17 (69)	1.3 (0.6)	97 (65)
Hearing services	5 (22)	1.5 (0.7)	86 (19)
Dental services	11 (46)	2.2 (3.7)	96 (44)
Others:			
Respite care	1 (5)	32.6 (37.5)[b]	100 (5)
Social worker	2 (8)	3.9 (4.1)	62 (5)

a -- Use per week, otherwise assume yearly use
b -- Number of days used respite care

Of the specific services or therapies that could have been provided in a number of different settings, and indeed, of all the above services, chiropody services were utilized by the largest number of respondents (23%). If respondents had seen a chiropodist, they received this service approximately three to four times in the last year. Satisfaction with this service was quite high (98% of respondents were satisfied). Physiotherapy was used by four per cent of respondents, and satisfaction with this service was also rated very highly (100%). The frequency of use of physiotherapy is again, as with public health nursing, perhaps misleading. A closer look at the data revealed that seven of the 10 respondents (71%) saw a physiotherapist 10 times or less in the last year. The remaining four respondents had physiotherapy regularly one to three times per week. Again, it is more likely that this

frequency of visits was maintained for only a few weeks or months, but not the whole year. Occupational therapy, speech therapy and psychological or counselling services were all used by one or less than one per cent of respondents, but were rated very highly in terms of satisfaction.

Optician and dental services were the third and fourth most utilized services among respondents (17% and 11%, respectively), but were obviously used less frequently (1.3 and 2.2 times a year) than public health nurses, for example. Of those that used these services, 97% were satisfied with them. Hearing and dietician services were reportedly used by five and three per cent of respondents, respectively. Of interest is the fact that hearing services were rated somewhat lower than other outpatient services in terms of satisfaction (86% of respondents were satisfied). Hearing services were utilized on average 1.5 times a year, while dietician services were utilized more often with an average of 17 times a year. Respite services were used by one per cent of the sample. Of the five people who used this service, three were caregivers and two were recipients of care (i.e. respite was provided to their caregivers.) The mean number of days respondents used respite care in the last year was almost 33 days, ranging from eight days to 84 days. Satisfaction for respite care services was high among all the recipients. Only two per cent of respondents used social work services. Among the few that did use these services, ratings of satisfaction were among the lowest of all the services (63% satisfied).

REPORTED NEEDS FOR HEALTH AND SOCIAL SERVICES

Respondents were also asked about their unmet needs for services. If they reported that they had received a particular service in the last 12 months, they were asked if they received or availed of that service as much as they would like. If they hadn't received the service at all, they were asked if they would have liked to receive or avail of that service. In both cases, the respondents were then asked what was preventing them from receiving or availing of the service (or availing of it more often). Table 3.23 presents the percentage of respondents in

Table 3.23 : The percentage of respondents who reported service needs

	Used service % (N)	Used service, but would have liked to receive more[a] % (N)	Did not use service, but would have liked to[a] % (N)
Home services:			
Home help	6 (25)	9 (2)	2 (8)
Meals-on-wheels	2 (9)	22 (2)	2 (8)
Public health nurse	15 (59)	19 (11)	5 (15)
Personal care attendant	1 (4)	33 (1)	3 (10)
Therapies:			
Physiotherapy	4 (17)	0 (0)	5 (18)
Occupational therapy	1 (5)	20 (1)	2 (6)
Chiropody	23 (94)	14 (13)	9 (25)
Speech therapy	0.5 (2)	0 (0)	1 (4)
Psychological/ counselling	<0.5 (1)	0 (0)	2 (6)
Outpatient services:			
Dietician	3 (13)	0 (0)	2 (6)
Optician	17 (69)	3 (2)	7 (21)
Hearing services	5 (22)	5 (1)	5 (18)
Dental services	11 (46)	0 (0)	5 (15)
Others:			
Respite care	1 (5)	33 (1)	1 (4)
Social worker	2 (8)	12 (1)	2 (7)

[a]– Percentage calculated from the total number of people who answered these sections

each of these cases, alongside the total numbers of people who did receive the service in the last 12 months (column 1).

The middle column depicts the percentage of respondents who reported receiving a particular service, but would have liked to receive or avail of the service more than they had. Although the overall numbers of respondents who indicated that they would like more of a service were small, it is interesting to note that for some services, a large percentage of those who received it would have liked to receive it more. For example, 11 out of 59 respondents, or 19% would have liked to receive the services of a public health nurse more than they did, and similarly, 13 out of 94 chiropody users, or 14%, would have liked to avail more of the service. At least ten per cent of respondents who used meals-on-wheels, personal care attendants, occupational therapy, respite care or social work services would have liked to avail of the service more, as well.

Of the people who did not receive the service in the last 12 months, the far right column depicts the percentage who would have liked to receive the service. For a third of the services provided, there are more people who did not receive a service, but would have liked to, than the number of people who did receive the service. Services such as personal attendant care, speech therapy and psychological or counselling services, had at least twice as many people reporting that they would have liked to receive the service as those who had received it. For example, one person received psychological or counselling services, but six others indicated that they would have liked to receive this service. Chiropody services stand out as the service most indicated by respondents (9%) as one they had not used, but would like to.

To understand what the barriers were to receiving these services, respondents were asked what prevented them from receiving or availing of the service (if they hadn't received it), or availing of it more often (if they had received it). Table 3.24 presents the barriers reported by respondents across all the services. The percentage shown reflects the number of respondents out of the whole sample.

The table below shows the percentage of respondents who endorsed a particular barrier at least once. 'Didn't know the service was available' was the barrier that was reported most often by respondents. Almost six per cent of respondents indicated that they would have

Table 3.24 : Barriers to utilization of health and social services across all services

Barrier:	Respondents identifying barrier % (N)

Did not know service was available	6 (24)
Cost	5 (19)
Lack of time/Reluctance to use service	4 (15)
Had never heard of service	2 (8)
Transportation	<0.5 (1)

liked a service but were not aware of its availability. In examining the particular services that were associated with this barrier, chiropody and public health nurse services were identified by eleven respondents as services they were not aware of. Other services that were identified by at least one per cent of respondents as a service they didn't know was available were home help, personal care attendant, physiotherapy and hearing services. It should be noted that several respondents reported this barrier more than once. For example, five respondents reported that they didn't know about two of the services listed, while another five respondents were not aware of between three and five of the services listed.

Cost was the second most reported barrier. Slightly less than five per cent of the respondents endorsed this barrier, which seemed to be associated with some services more than others: fifteen respondents (four per cent) reported that the cost was a barrier to either availing of, or availing more of a chiropody service. Three per cent saw the cost as a barrier to visiting the optician, and a further two per cent said that cost prevented them from availing of dental, hearing and physiotherapy services. 'Lack of time/ reluctant to use the service' was reported by four per cent of respondents, although respondents did not report this barrier for one service more than another. 'Had never heard of the service' was reported by only eight respondents (two per cent) and one to two respondents reported this type of barrier for home help, public health nurse, physiotherapy, and chiropody services. Transportation was identified as a barrier by one person only, and was in relation to hearing services.

BARRIERS TO CARE

TRANSPORTATION

Respondents were also asked a series of questions about potential barriers to care outside of the context of their use of specific services. Transportation was one area that was targeted since difficulties with transportation can lead to a denial of access to various aspects of community life (e.g., community events, doing shopping, getting messages, religious services), that could both directly and indirectly affect a person's health and well-being. Having independence in transportation seemed to be a key issue, so respondents were first asked if they could drive a car. A total of 214 respondents (54%) reported that they could drive. Considering that some people might be able to drive, but may not have continuous access to a car (especially those who may share a vehicle with other household members), those who responded positively to the first question were then asked about access to a car. Of those who could drive, most of them (84%) had continuous access to a car.

In order to get a broad picture of the various modes of transportation that respondents utilized, respondents were also asked what types of transportation they had used in the last six months. The data collected did not, however, describe the frequency or situations in which each type of transportation was used. It was determined that the level of detail needed to gather that type of information was beyond the scope of this report. The following table (3.25) depicts the various modes reportedly utilized in the last six months.

Table 3.25 : Types of transportation used in the last six months

Mode of transport	Respondents used % (N)	Mode of transport	Respondents used % (N)
Walking	77 (308)	Bus	65 (259)
Driven by family/neighbour	50 (199)	Train/DART	32 (127)
Driving myself	44 (178)	Ambulance	4 (15)
Bicycling	6 (23)	Minibus	1 (4)
Hitching a lift	1 (5)	Taxi	0 (0)

As shown in the above table, the greatest number of respondents (77%) reported walking while half (50%) reported being driven by another family member, relative, friend or

neighbour. In addition to walking, respondents also reported using other forms of transportation that did not rely on others, such as driving themselves (44%), or cycling (6%). It should be noted that the number of people who have driven themselves in the last six months (i.e., 178) is more or less the same as the number of people who reported having continuous access to a car (i.e., 179), thus indicating that all those who had access to a car were able and chose to use it.

Public transportation was used by 83% of the population, with 65% and 32% of respondents having used either a bus and/or train, respectively, in the last six months. When asked specifically about their difficulties when using public transportation, almost two thirds reported that they had no problems with the services. Nevertheless, respondents who did have difficulties reported that crowding or the conditions of a service was the most common problem (46 respondents, or 12%), The next most common difficulties included getting on or off the bus or train (ten per cent), getting to the stop or station, or negotiating the gap between the end of a route and their destination (both at seven per cent each), time restrictions with free use (six per cent) and availability of the service (three per cent). Cost, safety, and unfamiliarity with the service were each reported as difficulties by just one per cent of the respondents.

Also, notable in the above table is the fact that no respondents indicated that they had used a taxi in the past six months. Respondents were also able to specify any other forms of transportation that they used: two people mentioned a 'plane' as a type of transport that they had used in the past 6 months.

Eighteen people also specified 'other' difficulties, the majority of whom commented that they did not, or could not use the service. It should also be noted that a further 8% of respondents did not answer this question at all, which may also be because they do not use, or were unable to use public transport. Nevertheless, no one specifically reported being unable to leave their home, although, as suggested earlier in the report, some respondents had found difficulty, or were unable to attend social events or visit their family.

Lastly, respondents were asked a general question relating to how much of a problem they considered transportation to be, using a five point scale ranging from 'rarely a problem' to 'almost always a problem.' The majority reported that it was 'rarely a problem' (73%) or

‘usually not a problem’ (13%), whilst 6% in total replied that it was ‘often a problem’ or ‘almost always a problem.’

STIGMA

Due to attitudes expressed while conducting focus groups, a series of questions were constructed that explored the possibility that some form of stigma or embarrassment posed a barrier to service use. Respondents were asked how acceptable or embarrassed they would be ‘if’ they needed to use a particular service. The following table (3.26) depicts the percentage of respondents who rated a variety of services or devices as either ‘very embarrassing, and would be unacceptable,’ or ‘fairly embarrassing, but would be acceptable with difficulty.’ Higher percentages indicate more stigma associated with the service.

Table 3.26 : Percentage of respondents who rated using particular services as embarrassing

Service:	Rated as highly embarrassing % (N)	Service:	Rated as highly embarrassing % (N)
Hearing specialist	2 (7)	Continence Aid	10 (39)
Chiropodist	3 (11)	Personal Care Attendant	11 (42)
Hearing Aid	3 (12)	Social worker	11 (44)
Ambulance service	3 (12)	Counselling/Psychological	12 (48)
Public Health Nurse	4 (15)	Home Help	12 (49)
Walking Aid	4 (17)	Meals-on-wheels	16 (62)

Overall, most services were rated as not being embarrassing, with only ‘slight’ or medium embarrassment associated with service use. However, as shown in the above table, some services were more unacceptable or stigmatizing than others. Respondents indicated that the most stigmatizing service was meals-on-wheels, with 62 respondents (16%) believing they would be either 'very embarrassed and unacceptable’ or ‘fairly embarrassed, and accept with difficulty’ to avail of this service. A home help calling to the home and psychological or counselling services were also fairly unacceptable, with 12% expecting to feel embarrassment. Social workers, personal care attendants, were all rated similarly, with 11% per cent of respondents finding those services 'unacceptable' or only acceptable with difficulty. Of the various medical devices or aids that were asked about, continence aids were

rated as less acceptable than the hearing aids or walking aids. A hearing specialist was rated the least embarrassing to respondents, with almost 93% rating this service as 'not at all embarrassing.' Ambulance services and public health nurses coming to respondents' homes were also among the least embarrassing, yet three to four per cent, respectively, of the respondents still found them to be 'fairly' to 'very' embarrassing.

ACCESS TO INFORMATION

Lack of information was also considered to be a potential barrier to services. When respondents were asked simply, 'how easy or difficult do you think it would be to get the information you need on how to get a particular health or social service,' 65% felt that it would be either 'easy' or ' very easy.' Another 19% of respondents reported that it was 'neither easy nor difficult', while 16% rated obtaining information as 'difficult' or 'very difficult.' These results were somewhat higher than the findings reported earlier which showed that when respondents were asked about what prevents them from using a particular service, six per cent indicated that they were not even aware of the service and a further two per cent had 'never heard of' the service.

In order to generate some possible solutions to the challenge of disseminating information, respondents were also asked about their preferences for receiving information about services provided by the health board (Table 3.27). GPs were preferred by the majority of the respondents (73%) as a source for that type of information. The Citizen's Information Bureau was also seen as a useful authority for information for 33% of respondents, whilst various forms of the media or telephone help lines were each seen by 18% of respondents as viable sources for information. A similar number (17%) saw other health care providers, such as useful sources, and some respondents specified particular health care providers as 'health centres' or 'clinics' (7% of the whole sample), 'nurse', 'district' or 'public health nurse' (6%), the 'Eastern Health Board' (3%). Hospitals, day centres, social workers, community welfare officers and doctors other than GPs were each specified by two or three respondents. Fifteen per cent also rated word of mouth from current or previous users of a service as a preferred method for gaining information. A less preferred option for obtaining information was for 'a speaker to come to a group' (7%), and 'posters in public places' was not rated by anyone as a preferred method. 'Other' sources to obtain information on health matters put forward by respondents (other than health related options) included family or friends, groups

and associations and the telephone directory. Some of the more unusual preferences put forward were 'the department of agriculture', 'labour exchange', 'post office', and 'local bingo hall.'

Table 3.27 : Preferences for obtaining information about health board services

Source of information:	Preferred by respondents % (N)	Source of information:	Preferred by respondents % (N)
General Practitioner	73 (294)	Other health care provider	17 (68)
Citizen's Information Bureau	33 (134)	Current or previous service user	15 (61)
Telephone help line	18 (74)	Speaker coming to group	7 (29)
TV/radio/other media	18 (72)	Posters in public places	0 (0)

PAYMENT FOR SERVICES

Cost was also considered as a barrier to services, especially for respondents who were not medical card holders. Table 3.28 is provided to compare usage of particular goods and services by medical card status. The first column shows the percentage of people who used a service out of the total number of people who were medical card holders. The second column shows the percentage of users out of the total number who did not have a medical card.

As shown in the table below, there are a number of goods and services which were utilized by a greater percentage of medical card holders than non-medical card holders. Among these include chiropody (34% vs. 24%), transportation (25% vs. 19%), and home help (8% vs. 3%). Only two services were utilized more often by those without a medical card, and they were physiotherapy and GP services. Seventeen per cent of non-medical card holders compared to only six per cent of card holders utilised physiotherapy, while only slightly more non-medical card holders than card holders used GP services (96% vs 90%).

Table 3.28 : Percentage of respondents who used service by medical card status

Service:	Medical card holders using service % (N)	Non-medical card holders using service % (N)
General Practitioner	90 (181)	96 (191)

Accident and Emergency	20 (40)	17 (34)
Physiotherapy	6 (12)	17 (34)
Chiropody	34 (68)	24 (48)
Medical devices/supplies	12 (25)	10 (19)
Medicines	71 (142)	69 (137)
Transportation	25 (51)	19 (37)
Home Help	8 (17)	3 (6)
Care attendant	<1 (1)	<1 (1)

Although medical card status can give some indication of whether or not cost may be involved in utilizing services, it does not reliably indicate whether respondents paid for various services. Therefore, if respondents had used a service in the past year, they were asked to indicate whether they paid in full for the service or paid partially for the service. The following table (3.29) depicts the percentage of respondents who paid (either fully or partially) for services by their medical card status.

In comparing those who held medical cards to those who did not, a much greater percentage of the non-card holders paid for services, as would be expected. Of particular interest is the number of respondents who indicated that they had paid at least partially, if not fully, for a service that should have been covered on their medical card. For example, six per cent of card holders paid for general practitioner services, and two per cent paid for medicines. A number of other services are usually or sometimes free for medical card holders, depending on various

Table 3.29 : Payment for health and social services by medical card holder status

Service:	Medical card holders (N = 201)			No medical card (N =198)		
	Partial or full payment % (N)	No payment % (N)	Total who used service % (N)	Partial or full payment % (N)	No payment % (N)	Total who used service % (N)
General practitioner	6 (11)	94 (170)	90 (181)	96 (183)	4 (8)	96 (191)
Accident and emergency	5 (2)	95 (38)	20 (40)	62 (21)	38 (13)	17 (34)
Physiotherapy	25 (3)	75 (9)	6 (12)	82 (28)	18 (6)	17 (34)
Chiropody	12 (8)	88 (60)	34 (68)	87 (42)	13 (6)	24 (48)
Medical devices/supplies	20 (5)	80 (20)	12 (25)	95 (18)	5 (1)	10 (19)
Medicines	2 (3)	98 (139)	71 (142)	92 (126)	8 (11)	69 (137)
Transportation	22 (11)	78 (40)	25 (51)	89 (17)	54 (20)	19 (37)
Home help	47 (8)	53 (9)	8 (17)	67 (4)	33 (2)	3 (6)
Care attendant	0 (0)	100 (1)	<1 (1)	0 (0)	100 (1)	<1 (1)
Family/friends/neighbours who provide care	16 (7)	84 (37)	22 (44)	23 (3)	77 (10)	7 (13)

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factors, including the availability of the service in the area. The fact that there were significant percentages of medical card holders who paid for services seems to indicate that many card holders needed to 'top up' or use their own resources to get the services (or enough of the services) that they required. For example, home help and care attendants were paid, at least partially, by 47% of card holders, and medical devices and supplies were paid by 20%. Although not covered by a medical card, a significant number of respondents (16%) are paying for informal types of care, such as that provided by family, friends, and neighbours.

LONG-TERM CARE PREFERENCES

Respondents were asked a series of questions about their long-term care preferences. These included things that they may or may not have ever needed to consider. In order to make the questions more concrete, respondents were asked about specific situations in which they might find themselves. For example, of interest was whether the respondents would prefer receiving care from professional forms of support, such as health board employees, or from informal sources of support, such as family, friends, or neighbours. However, it could be argued that it depends on the context, including what type of care is provided and where the service is provided. In terms of the former factor, respondents were first asked to consider two types of care that they may or may not need as they get older. One type of care was described as more similar to housekeeping, in which the person may need help with tasks like cleaning, cooking, shopping, or maintaining their home. The other type was described as more similar to personal care, in which the person may need help with bathing, dressing, going to the toilet, etc. Slightly over a third of the respondents (37%) reported that they would prefer family or friends for both types of care, while another 23% reported that they did not have a preference, with either informal or professional care being acceptable for both types of care (Table 3.30). Among those respondents who preferred professional care, however, 102 respondents (27%) preferred that source of care for personal care, while 117 (32%) preferred it for housekeeping care.

Table 3.30 : Preferences for care provider by type of care received

	Type of Care		
	Housekeeping Care	Personal Care	**Total**
Prefer to receive care from:	% (N)	% (N)	**% (N)**
Family, friends, or neighbours	45 (167)	41 (154)	37 (137)
Professionals	27 (102)	32 (117)	25 (94)
Either	27 (102)	27 (100)	23 (85)

Respondents were also asked to consider various living situations, in the event that they might need to adjust or change their home environment in order to remain fairly independent in the future. The acceptability of each option was rated on a five point scale, from 'very acceptable' to 'would not accept.' In an effort to control for other factors that respondents

may implicitly take into account on their ratings, we asked them to assume that cost was not a factor, and that adaptations to their home could be made. Three situations were presented to respondents in which they were living in their own, current home with various levels of health board involvement. The first level was described as having no health board involvement, with the respondent's own family to care for all their needs. The second level was the same as the first, with the exception that the health board provided respite for the family. The third level involved the health board providing for all of a respondent's needs, with no family involvement. This was a full range of health board services, including home help, meals-on-wheels, daily care attendants, public health nurse visits, and/or whatever else was needed. The ratings of acceptability for each of these situations is presented in Table 3.31. The first column depicts those who rated the situation as 'acceptable' or 'very acceptable.'

Table 3.31 : Acceptability of health board involvement in current home

Living Situation:	Acceptable % (N)	Would accept with reservations % (N)	Would not accept % (N)
Current home -- no health board involvement	74 (273)	11 (40)	15 (57)
Current home -- respite care	86 (317)	6 (22)	8 (29)
Current home -- full health board involvement	62 (245)	23 (89)	15 (60)

As shown in the table (3.31), the situation rated most acceptable of these three (rated acceptable by 86% of respondents) was remaining in one's current home with family members taking care of all needs and the health board providing respite services. The first situation, described as having no health board involvement, was rated a little lower, with 74% of respondents finding that acceptable. The last situation, in which full health board services would be provided, was rated as somewhat lower however, with 62% of respondents finding the option acceptable, although a further 23% said that they would accept the option with difficulty.

The next set of living situations presented to respondents involved a move from their current residence to another residence. Respondents were asked to rate the acceptability of moving permanently to the home of their child or other family member with only their family to care

for all their needs (i.e., no health board involvement). The next scenario was similar in that it involved moving to a family member's home, but included backup for the family in the form of respite care. The third situation presented involved moving permanently into a 'granny flat' or an accommodation attached to a relative's home. Respondents were also presented with a 'boarding' situation, in which they would take lodging with another person in the community who may provide meals, laundry, and other types of minimal help. The last

Table 3.32 : Acceptability of care in a residence other than the respondents' own home

Living Situation:	Acceptable % (N)	Would accept with reservations % (N)	Would not accept % (N)
Moving to family member's home -- no health board involvement	23 (81)	24 (84)	53 (182)
Moving to family member's home -- respite care	29 (102)	25 (86)	46 (161)
Granny flat	47 (169)	16 (56)	37 (133)
Boarding	8 (32)	19 (76)	73 (289)
Sheltered housing [a]	30 (50)	16 (26)	54 (90)

a -- NB: Because of an omission in the interview protocol, the total number of respondents who were asked this question (n=166) was a small subset of the whole sample (n=401). The percentages for this option were calculated from the number who were asked the question.

option in this category was sheltered housing, where the respondent would move to their own purpose-built residence with some back-up in the form of a warden and social contact with other residents. Table 3.32 shows the acceptability of these types of living arrangements.

Of these five types of living situations, respondents found a 'granny flat' living situation as more acceptable than any of the other four, with 47% rating it as 'acceptable' or 'very acceptable.' Alternatively, around half found either moving to sheltered accommodation (54%), to a family member's home with no health board involvement (53%), or indeed to a family member's home with only respite care (46%) as unacceptable. The boarding situation was viewed quite negatively by respondents, with eight per cent finding it an acceptable living arrangement, and 73% finding it unacceptable altogether.

The last group of living situations that were asked of respondents were more formal in nature, and included a state-run or public nursing home, a private nursing home, and a residential home. The residential home was described as somewhat like a private guest house catering to

the needs of older people only. The ratings of these options are presented in Table 3.33 below.

Table 3.33 : Acceptability of care in a managed type of residence

Living Situation:	Acceptable % (N)	Would accept with reservations % (N)	Would not accept % (N)
State-run (Public) nursing home	30 (120)	23 (92)	47 (184)
Private nursing home	46 (185)	20 (78)	34 (134)
Residential home	29 (108)	20 (79)	51 (242)

Living in a private nursing home was rated as more acceptable (46%) than a public nursing home (30%), or a residential home (29%), with around half of the all respondents accepting of neither a public nor a residential home. Overall, when comparing across the 11 long-term care living situations, the option rated the highest by respondents was remaining in one's current home with most care provided by family members, but with health board backup in the form of respite care. The situation least acceptable to respondents overall was boarding.

In order to distinguish between preferences and possible plans or expectations for care, respondents were then asked a follow-up question: 'If, for any reason, you could no longer live independently, which of the options listed above would you expect to be the most likely alternative in terms of what would actually happen?' Around a third (35%) reported that they would expect to stay in their current residence, with minimal involvement (i.e., respite care services). Another 16% each expected that they would remain in their current homes either with full health board involvement or no involvement from the health board. A further ten per cent each expected the most likely option would be that they moved to a granny flat or private nursing home, whilst only two per cent expected that they would go to a state-run nursing home or residential home. Perhaps more importantly, 82% of respondents had rated the option that they expected to happen as either 'acceptable' or 'very acceptable.' Conversely, five per cent 'would accept with considerable difficulty' or 'would not accept' the living arrangement that they nonetheless expected would happen.

Various other questions about long-term care preferences and plans were asked of respondents. Exactly a quarter of the respondents reported that the possible need for long-

term care was something that made them either 'quite concerned' or 'very concerned.' Yet, under half the respondents (44%) reported that they were ‘not concerned.’ Also of interest was the question of whether or not they had ever discussed their preferences for long-term care with their family or someone else they trusted. The vast majority of respondents, 73% reported that they had not. Even so, 89% of respondents felt that their wishes would be honoured. Finally, when respondents were asked if they felt their views were sufficiently taken into account when using health and social services by the people who provide these services, 78% reported that their views were taken into account ‘almost always’ or ‘most of the time.’ Only five per cent said their views were ‘seldom’ or ‘never’ taken into account by professionals.

SECTION FOUR

SUMMARY

- Under a fifth (19%) of private households in the Eastern Regional Health Area include at least one person aged 65 years or over.
- Seven per cent of those contacted were either seriously physically ill or cognitively impaired; 6% of completed interviews were with proxy respondents for these people.

- Eighty nine per cent are town or city dwellers.
- One quarter (25%) live alone.
- One third (33%) live with only their spouse or partner.
- Seventeen per cent are 'old old', i.e. aged 80 years or older; 22% of women and 11% of men are in this group.
- Over a third (36%) are widowed; again these are mainly women (56% vs 14%) while men are more likely to be married (75% vs 34%).

- Two per cent do not have access to a telephone. Only 1% are lacking other basic household facilities.
- Fourteen per cent felt they needed home adaptations to maintain their independence.

- Twelve per cent use a walking stick, 3% a Zimmer frame and 3% a wheelchair. Ten per cent used bath appliances and 5% a raised toilet seat.
- A small number reported needing appliances or aids (4% mobility aids, 2% raised toilet seat, 4% bath appliances). Those who did scored higher on the Disability Index suggesting validity in their evaluations.
- Ten per cent usually needed the help of someone else, on average, across nine areas of function. Those areas most problematic were household chores (shopping or housework) (18%), cognitive ability (14%), dressing and grooming, (13%), reaching and bending (9%) and preparing and eating meals (9%).
- Most common individual tasks that respondents reported unable to perform were caring for feet and toenails (11%), housework (9%), shopping (7%), bathing, shampooing hair and preparing meals (6% each).
- Those aged 80 or over on average, were nine times more likely than those under 80 to report that they had great difficulty or were unable perform these individual tasks.

- The most common health conditions presented were bone and joint problems (45% of the group), hypertension (35%), eye or vision problems (19%), heart conditions 19%), ear or hearing problems and sleep (17% each), and memory problems (16%).
- In terms of disruption, across the group the most disruptive conditions were bone and joint problems (causing considerable disruption to 7% of the whole group). Next were foot problems (3%), ear or hearing, back, eye or vision, sleep problems, and heart conditions (all at 2%).
- Pain had been experienced in over a third of respondents in the past week.
- Twenty per cent of spouses/partners and 10% of other household relatives provided help or care to the respondent most of the day or continuously, day and night.
- Nine per cent reported being the main caregiver for someone else over the past 12 months.

- One third of those living alone reported being alone for an average of 10-14 hours, every day of the week.
- Almost a third of respondents were interested in becoming an active member of a group.

- There was little evidence of clinical anxiety (5%) or depression (1%) in respondents.

- Almost one fifth (19%) are current smokers, with over 79% having little interest in quitting. Less than half (45%) had been spoken to by a doctor about their smoking in the previous year.
- About a third (35%) had received the flu' injection in Winter 1999; half (51%) of those vaccinated were advised to do so by their doctor.
- Around half (53%) definitely intend to have the injection next Winter while 24% definitely do not intend to do so.
- Sixty-three per cent of the group had their blood pressure checked in the previous three months and two thirds have had a general health check-up in the previous year.

- Ninety one per cent visited a GP in the past year.

- Almost all (98%) have their 'own' GP; many for a long time. Ninety four per cent were satisfied with their own GP.
- Some (8%) rated cost as a limiting factor for GP visits; 3% reported transport as a difficulty.

- Fifteen per cent had a scheduled inpatient hospital stay, 14% an A&E visit, and 37% an outpatient visit in the previous year.
- Satisfaction with hospital services used was high, with A&E being the only service with slightly lower satisfaction ratings.
- Very few (5%) used the medically-oriented day hospital/day unit services. Less than 2% used more socially-oriented services such as day centres, and a further 2% wanted to use these services.

- Professional services (other than GP) that were used by the highest number of respondents were chiropody (23%), optician (17%), and public health nurse (15%). Of those using services, the services where greatest numbers of respondents would have liked the service more were chiropody (N=13) and public health nurse (N=11), Of those not using a service, the most sought after service was chiropody (9%).

- Six per cent did not use services because they were unaware of their availability; this was most evident for chiropody and public health nurse services. In terms of preferences for information on health service availability, GPs were the most popular medium to access this information (73%).
- Sixteen per cent felt it would be difficult to obtain information on particular health or social services. Preferred methods for gaining information were: GP (73%), Citizen's Information Bureau (33%), telephone help line (18%), TV or radio (18%).

- Eighty-three per cent used public transport while 3% have poor access to such transport; 54% can drive with most having access to a car.

- Many would find it stigmatising to use services such as meals-on-wheels (16%), counselling (12%), home helps (12%), personal attendants (11%) and social workers

(11%). Little stigma was associated with aids such as for hearing; use of continence aids was the highest in this category at 10%.

- Over half are covered by private health insurance. Eleven per cent have neither private nor medical card cover, whilst 13% had both. A third (32%) made use of the drug cost refund scheme.
- Of those with medical cards (50%), 47% report paying for home help services, 25% for physiotherapy, 20% for medical devices and supplies, and 6% for GP services.
- Those with medical cards had higher use of chiropody services, transport and home help than those without, while those without had higher use of physiotherapy services.

- If people needed long-term care for health problems, around two fifths would prefer family to provide both intimate care and household services.
- Most (86%) would want to stay in their own home with some health board support if long-term care was needed; 82% expect that they would be cared for in an option that they indicated was acceptable to them. However, 5% envisage being in a setting they do not find acceptable.
- Under half (44%) were not currently concerned about long-term care issues and only 27% had discussed these issues with someone. Nonetheless, 89% believed that their wishes would be honoured if the situation arose.
- The majority (78%) felt their views were taken into account by health professionals.

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