Older People in Northern Ireland: Report 3: Health and social wellbeing

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Introduction

In this, our third report on older people in Northern Ireland, we present data on health and social wellbeing and allied issues. As we indicated in previous publications (Evason et al, October 2004; Evason et al, December 2004) our intention is not to undertake new research but to explore what existing datasets can tell us about the lives and circumstances of older people in this part of the United Kingdom (UK). Our analysis of the data for this part of the project leads us to two main conclusions. Firstly, there is clearly a significant degree of disability and need for help amongst older persons in Northern Ireland. Nevertheless, the picture to emerge is more positive than would be expected from the alarmist and negative discourse on ageing which we discussed in detail in our first report. Secondly, in our earlier reports, we referred to the extent of reliance in Northern Ireland on certain disability benefits and the fact that, on a proportionate basis, people in Northern Ireland are more likely to be receiving these benefits than in any other UK region. The data presented below suggest that this may be a consequence of greater success in delivering these benefits to those entitled to them.

Aspects of the health of older people in Northern Ireland

Table 1 presents a fairly positive picture inasmuch as, with a predictable variation by age, the majority of older persons in Northern Ireland report their health to be "good" or "fairly good". Notwithstanding this, the majority (64.6%) of older persons report some longstanding illness or disability. The proportion of older people with a longstanding illness which limits activity is somewhat lower, however, at 50.1%.

Table 1: Reported health status by age

	%		
	65-74	75 and over	Total
Good	30.6	23.0	27.2
Fairly good	38.1	42.5	40.0
Not good	31.3	34.4	32.7
Total	100.0	100.0	100.0
Has longstanding illness/disability	62.4	67.3	64.6
Has illness/disability which limits activities	46.4	54.6	50.1

Source: Continuous Household Survey, 2002/03

Table 2 provides data on the most common health problems experienced by older people. Significant numbers have disorders such as arthritis, high blood pressure and respiratory problems. Difficulties with hearing and sight are less widespread than might be expected and the most serious forms of illness affect relatively small numbers.

Table 2: Type of health problem by age

	%		
	65-74	75 and over	Total
Disability/problem with joints etc including arthritis/rheumatism	44.2	48.9	46.2
Heart/ blood pressure/circulation problems	39.2	49.1	43.4
Chest/breathing problems	16.5	18.9	20.7
Stomach/liver/kidney problems	11.0	16.6	13.4
Hearing problems	15.9	27.2	20.9
Sight problems	5.5	17.1	10.4

Note - excludes conditions reported by under 10% of respondents e.g. diabetes 8.9%, cancer 2.8% and stroke 2.0%
Source: Northern Ireland Household Panel Survey, Wave 2, 2002

People may, of course, have multiple health difficulties but Table 3 underlines the need to avoid simplistic generalisations about the need for health care amongst older people in general. One quarter of those aged under 75 report no health problems at all and, as would be expected, those most likely to report the most health problems are aged 75 and over.

Table 3: Number of health problems by age

	%		
	65-74	75 and over	Total
None reported	24.6	14.0	20.1
One/two problems reported	51.1	52.2	51.6
Three/four problems	18.1	24.6	20.8
Five or more problems	6.2	9.2	7.5
Total	100	100	100

Source: Northern Ireland Household Panel Survey, Wave 2, 2002

The significance of age is evident again in Table 4 which indicates that ill health is more likely to be accompanied by impaired functional capacity amongst the over 75's. It also needs to be stressed that the majority of older people in the community can cope with the tasks listed.

Table 4: Impact of ill health on functional capacity by age

	%		
	65-74	75 and over	All
Ill health hinders			
- doing housework	21.0	20.6	20.8
- climbing stairs	20.0	27.2	23.0
- getting dressed	9.7	11.4	10.4
- walking more than 10 minutes	19.7	30.3	24.2
Cannot			
- get in/out of bed unaided	2.9	4.8	3.7
- bath/shower unaided	6.8	16.2	10.8

Source: Northern Ireland Household Panel Survey, Wave 2, 2002

Use of health and social care services

We noted in our first report that, amongst women, General Practitioner (GP) consultation rates for those aged 65 and over are similar to the rates for women aged 45-64. There is, however, a significant increase in the use of this service amongst men aged 65 and over. In effect, their rates come into line with those for women. Within this broader picture, Table 5 indicates fairly limited use of GP services by the under 75's; 48.4% had not seen their GP's at all or only once or twice in the year before the interview took place. The majority (64.6%) of those aged 75 or over had visited their GP's at least three times. As Table 6 shows, this group was also more likely to receive in-patient hospital care.

Table 5: Use of GP service by age

	%		
	65-74	75 and over	Total
Number of visits in year before interview:			
None	18.2	7.9	13.8
One or two	30.2	27.5	29.1
Three to five	23.4	27.9	25.3
Six or more	28.2	36.7	31.9
Total	100.0	100.0	100.0

Source: Northern Ireland Household Panel Survey, Wave 2, 2002

Table 6: Use of hospital services by age

	%		
	65-74	75 and over	Total
Number of visits to outpatients department in year before interview:			
None	47.7	46.9	47.4
One or two	30.8	28.9	30.0
Three or more	21.4	24.1	22.7
	100	100	100
Hospital inpatient in year before interview	13.9	18.9	16.0

Source: Northern Ireland Household Panel Survey, Wave 2, 2002

Table 7 demonstrates the extent to which community health and social care services are most heavily used by those aged 75 and over.

Table 7: Use of community health and social care services by age

	%		
Service used in year before interview	65-74	75 and over	Total
Health visitor/District nurse	6.5	20.2	12.3
Home help[1]	5.2	27.2	14.5
Social worker	3.6	6.6	4.8
Chiropodist[1]	25.9	52.6	37.2
Physiotherapist[2]	10.4	8.3	9.5

Note - excludes services quoted by under 2% of interviewees
[1] 25% private provision
[2]19% private provision
Source: Northern Ireland Household Panel Survey, Wave 2, 2002

Caring responsibilities

As we noted in our first report, it is important to remember that older people are givers, as well as receivers, of care. The data suggest that in Northern Ireland, 11.8% of people aged 65 or over - one in every eight - have caring responsibilities. They are assisting persons with ill health/disability in the same household, in another household or, in a small number of cases (9), both. Table 8 shows who is caring for whom in the 73 caring situations identified and demonstrates that informal care is largely about family members caring for other family members. The table also indicates that for nearly one third of these carers, helping others takes more than twenty hours a week.

Table 8: Direction and volume of informal care

Cares for:	%
Spouse	47.9
Children/siblings/other relatives	41.1
Friends/neighbours/unspecified	11.0
	100.0
Cares for:	
Under 10 hours per week	42.0
10-19 hours per week	12.3
20 hours a week and over	32.3
Varies	13.3
	100.0

Source: Northern Ireland Household Panel Survey, Wave 2, 2002

Mental wellbeing and social inclusion

Popular discourse on older people is peppered with assumptions about loneliness, isolation and family neglect all of which are likely to impact on mental health. Clearly older people may experience all of these problems but it is important that we look at the full picture.

Table 9 indicates that mental health/subjective wellbeing, as measured by the General Health Questionnaire (GHQ12), is slightly better amongst 65-74 year olds than younger age groups but mental health is poorer amongst the oldest age group. This divergence amongst older people is evident again in Table 10, with those over 75 reporting that age often inhibits their activities. Nevertheless, the majority of those both under and over the age of 75 are positive about many aspects of their lives; for example, they often look forward to every day and look back on their lives with happiness.

Table 9: Mean scores for subjective wellbeing by age

	Mean GHQ12 score
Under 65	11.10
65-74	10.55
75 and over	11.41
All respondents	11.07

Source: Northern Ireland Household Panel Survey, Wave 2, 2002

Table 10: Indicators of subjective wellbeing by age

	%		
	65-74	75 and over	Total
Age often inhibits activities	21.8	42.4	30.8
Often looks forward to every day	74.6	72.6	73.7
Often looks back on life with sense of happiness	75.6	77.8	76.6
Often feels satisfied with the way things have turned out	51.6	62.0	56.1

Source: Northern Ireland Household Panel Survey, Wave 1, 2001

Table 11 shows that a minority of older people do feel left out of things. At the same time, however, clear majorities feel their families and friends include them in their lives and give them support and encouragement.

Table 11: Indicators of social inclusion by age

	%		
	65-74	75 and over	Total
Feel left out of things[1]	5.9	10.0	7.7
Family and friends make me feel an important part of their lives[2]	84.4	85.6	84.9
Family and friends make me feel loved[2]	86.5	85.8	86.2
Family and friends support and encourage me[2]	87.6	87.4	87.5

Sources:
[1]Northern Ireland Household Panel Survey, Wave 1, 2001 - percentage of respondents saying 'often'
[2]Health and Social Wellbeing Survey, 2001 – percentages of respondents saying statement is 'certainly true'. Note - other possible answers were "partly true" or "not true". For all three statements under 3% selected the "not true" answer.

A key element in a sense of wellbeing is security in the knowledge that someone will listen and help in a crisis. Here again, as Table 12 indicates, the data are more positive than might be expected and we are dealing with concerning minorities rather than older people in general.

Table 12: Indicators of social support

	%		
	65-74	75 and over	Total
Has someone outside household who can help if depressed[1]	68.5	76.3	72.0
Has at least one person they can count on to listen when need to talk[1]	90.2	92.7	91.6
Has at least one person who can help in a crisis[1]	87.0	92.3	89.3
Feels family and friends can be relied on[2]	88.3	89.0	88.6

Sources:
[1]Northern Ireland Household Panel Survey, Wave 1, 2001 - percentage of respondents saying 'yes'
[2]Health and Social Wellbeing Survey, 2001 - percentage of respondents saying statement is 'certainly true'

Table 13 suggests that a minority of older people are socially isolated but the majority talk to their neighbours, meet people and have contact with friends and relatives on a regular basis. Social isolation is also mitigated by attendance at church services and membership of various organisations.

Table 13: Social contact and social isolation by age

	%		
	65-74	75 and over	Total
Talks to neighbours[1] - most days	48.2	46.1	47.2
-1 to 2 days a week	35.1	38.2	36.6
Meets people[1] - most days	44.9	40.3	42.8
-1 to 2 days a week	46.5	44.8	45.7
Over previous two weeks[2]			
- visited/been visited by relatives	83.6	81.5	82.7
- spoke to relatives on phone	87.9	84.5	86.5
Regularly speaks to/sees close friend[2]	92.5	90.4	91.6
Attends religious services at least once a week[1]	69.5	56.5	60.6
Member of one of listed organisations[1]	51.3	44.8	48.3

Sources:
[1]Northern Ireland Household Panel Survey, Wave 1, 2001
[2]Health and Social Wellbeing Survey, 2001

Receipt of key disability benefits

Attendance Allowance (AA) and Disability Living Allowance (DLA) are non means-tested benefits which are intended to cover the extra costs of disability. AA is payable to persons aged 66 or over at the time of the claim and consists of a higher and lower rate depending on the volume of

care/supervision the person with disability requires. DLA is payable to those under 66 at the time of the claim and consists of a care component and a mobility component. The care component is payable at three rates depending on the volume of care supervision required. The mobility component is payable at two rates depending on the level and type of mobility impairment. It can be seen from these brief descriptions that AA and DLA give most help - but are not confined - to the most severely disabled.

Table 14 indicates the extent of receipt of these benefits amongst older people in Northern Ireland, and we noted in the introduction the relatively high rate of receipt of these benefits in Northern Ireland in comparison to other UK regions. One possible explanation for this would be a significant number of duplicitous claims and inadequate mechanisms to deal with these. Such explanations overlook the complexity of the claiming process, the range of information and evidence which may be required by decision makers in the Social Security Agency - decisions on awards do not rest with GP's as is commonly thought - and the mechanisms in place to monitor the quality of decision making. An alternative set of explanations, to which we referred in our second report, takes as its starting point the research in the 1990's (McCoy and Smith, 1992) which indicated that Northern Ireland had the highest rate of adult disability of any UK region. Additionally, account should be taken of the vibrancy of the voluntary benefits advice sector and the particular involvement of media such as radio and television in highlighting the availability of these benefits. Clearly more research is needed, but the data in Tables 15 and 16 do not suggest that AA and DLA are distributed capriciously or in a haphazard manner. There is, therefore, the possibility that other regions with lower levels of claims have simply done less well in getting these benefits - which can substantially improve the lives of those with disability - to those who need them.

Table 14: Receipt of AA/DLA by age group (numbers) and as % of age groups

	60/65-74	75 and over	Total
AA[1]	12,818	59,070	71,888
DLA[1]	44,626	3,850	48,476
Total	57,444	62,920	120,364
% of age group[2]	34	60	44

Sources:
[1] Department for Social Development, February 2004 (commissioned table, September 2004)
[2]NISRA, Mid-Year Population Estimates, 2003

Table 15 indicates that receipt of AA/DLA increases in line with the number of health problems reported. If there is error, it is at the margins. Table 16 shows a similar trend, with receipt increasing as the need for care rises and - given the proportion of people requiring a good deal of help who are not getting either benefit - suggests a need for further research to assess the extent of under-claiming of entitlement.

Table 15: Number of health problems reported by receipt of AA/DLA

	%				
	None	1	2	3 or more	Total
Not on AA/DLA	93.8	80.8	62.7	37.9	67.5
On AA/DLA	6.2	19.2	37.3	62.0	32.5
Total	100.0	100.0	100.0	100.0	100.0

Note - persons in residential/nursing home accommodation are not included
Source: Northern Ireland Household Panel Survey, Wave 2, 2002

Table 16: Receipt of AA/DLA by reported disability and need for help

	Not on AA/DLA	On AA/DLA	Total
No disability reported/has disability - no help required	95.0	5.0	100.0
Disability - some help required	65.1	34.9	100.0
Disability - a lot of help required	49.7	50.3	100.0

Note - scoring done on the basis of need for help with 14 functions
Source: Northern Ireland Life and Times survey, 1999

Conclusions

In this our third report on older people in Northern Ireland, we have reviewed data relating to health and wellbeing. Whilst a minority of older people in the community have significant levels of ill health and disability, it is important to note that the majority of older people (67.2%) report their health to be good or fairly good. It is also important to underline the fact that the majority of those with longstanding health problems are, nevertheless, able to undertake basic tasks such as doing the housework. Furthermore, ill health and a need for support are not synonymous with being an older person as such. Disability and the need for care are found more frequently amongst those aged 75 or over, and it is this age group which makes most use of health and community care services.

At the same time, although older people are typically depicted as care-receivers, there is a need to take account of the volume of care older people themselves provide. Around one in eight (11.8%) older people in Northern Ireland are helping and supporting someone else with disability. Our data also underlines the need to avoid negative stereotypes and generalisations about the views and lives of older people. Clearly, statutory and voluntary organisations must seek to ensure that older people are not socially excluded or isolated. It is, however, important to note that our data suggest the great majority of older people have very positive attitudes about their lives and their relationships with family and friends. The majority have someone who will help out in a crisis or listen to them if this is what is needed.

Finally, we have addressed the issue of the relatively heavy reliance on benefits to assist with the extra costs of disability. Further research is needed, but our data suggest a clear association between receipt of these benefits and levels of ill health and the need for help. These benefits can make a very considerable difference to the lives of older people. It may well be that in Northern Ireland we have been more successful in getting help to those for whom these benefits are intended.

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