

Older Women's Network



Bantracht na Sinsear

vibrant visible vocal
support opportunities celebration
wisdom fun connection laughter
choice fulfilment friendship

The way we are: Facts about older women in Ireland in **2008**

Marie Crawley

The way we are: Facts about Older Women in Ireland in 2008

Older Women's Network



Written by Marie Crawley

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Executive Summary

This purpose of this document, produced by the Older Women's Network Ireland (OWN) with funding from the pilot grant scheme of Age and Opportunity is to identify up-to-date gender specific policy data as it relates to older women. The main themes covered in this report are Health, Income, Employment and Risk of Poverty, Housing and Access to Transport and Information. The information in the document, in the main, addresses women as whole. Therefore, particular issues faced by Traveller women, other ethnic minority women, lesbian women or women in other categories where dual disadvantage is experienced are not covered in this report. The main findings are as follows:

General

- In 2006 there were 584,900 women aged over 50 and 260,831 women aged over 65 (12.4% of female population). Population projections point to a 134% increase in the population of women over the age of 65 to 609,200 (21.4% of the female population) by 2036 – that is, in just over 27 years time.

Health

- Cardiovascular disease (CVD) is the biggest cause of death in women, with the majority of deaths in women over 65. In 2005, 2,225 women died from ischaemic heart disease, approximately twice as many than from all cancers combined. A significant proportion of these deaths are preventable. Older women are just as much at risk of heart attack as men, in some cases more so, and the proportion of women at risk is rising. The recognition of symptoms and risk among the public and medical staff needs to be improved, coupled with an investment in research on CVD in women.
- More than half (54%) of all cancers in women occur over the age of 65. Breast cancer is the most common cause of cancer death (663 deaths in 2005), followed by lung cancer (624 deaths). A significant proportion of cancers in older women is preventable, by reducing the risk factors of getting a particular form of cancer in the first place, and through early diagnosis, reducing the chance of dying from cancer.

- There are significant treatment differences between young and older women suffering from cancer. Research is required to establish non-discriminatory guidelines for cancer treatment in older women.
- Three quarters of women diagnosed with breast cancer are over 50 years of age and 85% of deaths due to breast cancer occur in women over the age of 50. Early diagnosis and catching the cancer in its early stages is essential for reducing death or disability. BreastCheck, the national breast screening programme, is not sufficiently resourced or implemented to provide adequate screening facilities for the older women of Ireland, especially in parts of the West.
- Cancer of the cervix is the 9th most frequently diagnosed cancer in women in Ireland and the 12th most common cause of cancer-related death. 40% of the women diagnosed with cervical cancer are over 50 and 63% of those women who die from cervical cancer are over 50. The average age at death is 56 years. Mortality rates from cervical cancer increase with age, with the highest number of deaths occurring in the 75-79 age group. Regular cervical screening could prevent around 75% of potential cervical cancers from developing. The provision of a nationwide cervical screening programme (CervicalCheck) which began operating on 1st September 2008, may assist early diagnosis if it is fully available to older women, adequately resourced, and properly monitored.
- Women over 70 years of age suffer an increasing risk of a single or multiple types of disability, with over 62% of women over 85 reporting disability, more than twice the rate for men of the same age. The biggest cause of disability is loss of mobility.
- Two thirds of long-stay patients are women, mostly women over 65. Women over 75 have the highest rates of mental illness, both organic disorders such as Alzheimer's, dementia and others such as depression and anxiety.

Employment, Income and Risk of Poverty

- Women are employed less compared to men in all the older age groups. This employment gap is 26.5% for women aged between 55 and 64, and 46.6% for women aged over 65.
- Spending on pensions and disability is much lower in Ireland than the EU average. The majority of older women are dependent on a non-contributory state pension, and the level of

this pension will be the principal determinant of the quality of life for many Irish women over 65.

- Over 1 in 7 women over the age of 65 (13.7%) were at risk of poverty in 2006 which amounted to 35,734 Irish women over the age of 65 at risk of poverty. Of these, fewer than 2% were living in consistent poverty.
- Women are the principal care-givers in Ireland. In 2006, there were 28,237 women carers over 55 which is 28% of all women carers or 18% of the total number of carers. One third of women carers are 45-54 years of age and half of the women carers over 65 devote more than 43 hours per week to care. Providing care for others is often at the expense of the carers' own physical and mental health and quality of life.

Housing

- Although the level of home ownership is known to be high in Ireland, recent data on the level of home ownership by older women is not available. The proportion of older women living alone increases with age, from 34.3% for women over 65 to 44.3% for women over 75. Grants are available to support older women in their own homes, but knowledge of and access to these grants may be problematic for some older women. Gender disaggregated research is required to clarify the uptake of grants, the provision of supportive housing and the proportion of older women living communally and in nursing homes.

Access to transport and information

- Access to independent transport is a problem for many older women. About 55% of women aged between 60 and 69 hold a full drivers licence, around 35% of those between 70 and 79, but only 13% of women over 80 hold a full drivers licence. Adequate public transport is unevenly distributed throughout Ireland and lack of this poses a problem for many older women. The Rural Transport Initiative is a significant benefit where it is available, but research is required to establish the extent of its availability for older women most in need of it, i.e. those women without a full driving licence or access to a car. Lack of transport undermines the potential for older women to fully participate in the community and maintain a good quality of life.

- Older women's access to information via the Internet is limited by a variety of factors including a lack of understanding of computers, cost, and a certain level of technophobia. Resources are required to address this with the purpose of ensuring older women are enabled to fully participate in a society in which information dissemination is becoming increasingly provided by the Internet.

Introduction

The Older Women's Network Ireland (OWN) is a national organisation that links older women and older women's organisations. One of its main objectives is to encourage, facilitate and resource older women to have a voice on issues of concern and to participate in policy and decision making processes.

In 2008 OWN received a grant from the pilot grant scheme of Age and Opportunity to identify gender specific policy data as it relates to older women. It therefore commissioned the production of a document, the purpose of which was to outline the issues facing older women in contemporary Irish society. A secondary purpose of the research was to identify gaps in existing information and specifically to identify particular questions which would benefit from further dedicated research. All research for this particular document was to be desk-based and the resultant document primarily to be comprised of statistics and factual information. The primary audience for the document is the membership of the Older Women's Network. Its contents are to be used by the Network in its lobbying work as evidence of the issues facing older women.

The particular objectives of the research were to;

- Outline factual information on older women in Irish society,
- Carry out a policy overview in order to identify areas in which older women may be treated differently and
- Identify gaps in existing information on the situation of older women and make specific recommendations on where future research is required.

The main issues covered in the report namely; Health, Income, Employment and Risk of Poverty, Housing and Access to Transport and Information were those agreed with OWN at the outset. As such the contents of this document are limited as they do not cover the entirety of issues faced by older women. These were agreed as the primary areas from which other research proprieties could be identified. Research was conducted in October and November 2008 using the most up-to-date statistical information available. The document, in the main, addresses women as whole. Although issues facing women with disabilities and mental health problems are examined, the particular issues faced by Traveller women, other ethnic minority women, lesbian women or women in other categories where dual disadvantage is experienced

are not covered in this report. It should be noted that there would undoubtedly be variance in some statistics if these separate categories were taken into account.

One of the main challenges in researching this document was the variance with which age is classified and grouped within and between government departments and in the community and voluntary sector. So, for example, one band of age statistics published in Ireland by the CSO is 50-64 while its own database uses the grouping 45-54. There is the added factor that often older people are categorised as over 65, over 75, over 80, etc. This makes it difficult to correlate and compare statistics. The Older Women's Network works with women over 50.

Section 1 of this report provides a broad overview of older women in Ireland in 2008. It presents broad statistical information on women themselves and on also on the primary government documents and policy instruments which pertain to all the report research areas. Section 2 focuses on the medical dimension of health. It examines some of the key medical concerns pertaining to older women and outlines government services and programmes in response to same. Comparisons with the UK and broader EU statistics are provided where appropriate. Section 3 addresses income, employment and poverty and in particular examines the risk of poverty and factors which contribute to this. Section 4 examines access to transport and information as two issues of access which can greatly affect the quality of life of older women. Section 5 looks at housing and accommodation in general. Finally, section 6 outlines conclusions and recommendations for further research.

Warning, by Jenny Joseph

When I am an old woman I shall wear purple
With a red hat which doesn't go, and doesn't suit me.
And I shall spend my pension on brandy and summer gloves
And satin sandals, and say we've no money for butter.
I shall sit down on the pavement when I'm tired
And gobble up samples in shops and press alarm bells
And run my stick along the public railings
And make up for the sobriety of my youth.
I shall go out in my slippers in the rain
And pick flowers in other people's gardens
And learn to spit.

You can wear terrible shirts and grow more fat
And eat three pounds of sausages at a go
Or only bread and pickle for a week
And hoard pens and pencils and beer mats and things in boxes.

But now we must have clothes that keep us dry
And pay our rent and not swear in the street
And set a good example for the children.
We must have friends to dinner and read the papers.

But maybe I ought to practice a little now?
So people who know me are not too shocked and surprised
When suddenly I am old, and start to wear purple.

1 Context

'The term 'older people' encompasses a vast range of individuals, each shaped by a unique set of life experiences, each with aspirations and needs just like other members of society. The growth of older people as a proportion of the population represents both challenges and opportunities. As we age we must all be enabled to live with dignity. The challenge to provide adequate incomes for vulnerable older people must be met and adequate care must be provided where it is needed. All older people – whether living independently in the community or living in care settings – must be enabled, to the maximum extent possible, to participate in the decisions that affect them and in all the facets of life that contribute to their well-being.'

Ivor Callely TD, Minister of State for Services for Older People (2004)¹

1.1 Policy and strategy initiatives relevant to older women

There is a large number of recent key policy and strategy initiatives from government and the community and voluntary sector that bear on the theme of older women and many of them have been drawn on in the production of this document. An overview of three of these - the National Development Plan (NDP), The National Women's Strategy (NWS) and the Strategy for Older People in Ireland as the primary and most relevant policy documents are outlined below.

1.1.1 The National Development Plan 2007-2013 (NDP)

The NDP, set within the context of the Social Partnership Towards 2016, planned to invest €9.7 billion on the Older People Programme, which consists of two main strands – Living at Home and Residential Care. Under the former, the objective is to provide support and services to:

*'enable older people to maintain their health and well-being, as well as live active and full lives, in an independent way in their own homes and communities for as long as possible.'*²

¹ Opening address to Meeting the Health, Social Care and Welfare Services: Information Needs of Older People in Ireland (2004)

² NDP 2007-2013 p 256

Schemes to assist with essential repairs and maintenance of older people's homes and increased social housing are part of the overall objective (NDP Social Infrastructure). This strand, the Living at Home sub-programme, provides measures such as Home Care packages, Home Help, a Meals on Wheels service, Respite and Day Care, and the support of Community Intervention Teams to help older people stay in their own homes as long as they want.

The second strand of this programme, The Residential Care sub-programme, is aimed at improving the health and wellbeing of older people who need care that cannot be provided in their own home and intends to restructure nursing care and nursing home provision.

There have been no systematic qualitative evaluations of the Older People's Programme to date. Some aspects of the Programme will be looked at in sections of this document.

1.1.2 The National Women's Strategy (NWS)

The vision of the National Women's Strategy is of:

An Ireland where all women enjoy equality with men and can achieve their full potential, while enjoying a safe and fulfilling life.³

The NWS contains twenty key objectives and over two hundred planned actions under three key themes:

- Equalising socio-economic opportunity for women;
- Ensuring the wellbeing of women; and
- Engaging as equal and active citizens.

The actions include a wide range of measures including, for example,

- increasing the participation of women in the labour force and decreasing the gender pay gap;
- reducing the numbers of women experiencing poverty;
- improving physical and mental health status of women
- promoting healthy lifestyles and
- increasing the number of women in decision making.

³ National Women's Strategy 2007 – 2016: Introduction

1.2.3 Towards a National Positive Ageing Strategy

A report from the Older & Bolder Campaign in 2006, put forward a Strategy for Older People in general, based on the UN Principles for Older Persons (1991) that provides the basic tenets for equality for older people. These tenets are that older people have endowed by right the assurance of the means to secure their:

- Independence;
- Participation in society;
- Care provision;
- Self-fulfillment opportunities and
- Dignity

The Older and Bolder Campaign's document outlined some of the basic elements required in Ireland:

- Citizenship: All older people must be treated the same as other citizens. Legislation must ensure equality and remove explicit and implicit discrimination.
- Wealth and Income: Older people require an adequate state pension. This should be set at 50% of pre-retirement income or 40% gross average industrial earnings.
- Work and retirement: Mandatory retirement at 65 should be abolished and replaced by a more flexible system, so long as people are not *required* to work over the age of 65.
- Healthy ageing: Promote an increase in life expectancy and promote early diagnosis of mental and physical illness where possible.
- Independent living: Ensure that older people live in their own communities for as long as possible.
- Identity and self-image: Examine the process of ageing and develop policies that promote positive self-image and identity over the life course.⁴

⁴ Towards a Strategy for Older People in Ireland, 2006

In October 2008, the Older and Bolder Campaign, in its Baseline Statement, set out its call for a National Positive Ageing Strategy (NPAS) that will provide ‘a coherent framework that will guide policy-making, enable cross-sectoral planning and rational resource allocation, and facilitate public input into public policy’. Although progress on the NPAS has only just begun, the Office for Older People will lead the process with an inter-departmental group structure. This will facilitate all relevant government departments to contribute and allow for an extensive public consultation process. The vision for the NPAS is of:

‘an Ireland that affirms ageing and the rights of older people, including those with disability, enabling all of us to live with confidence and dignity as equal, respected and involved members of society as we age.’

1.2 Political representation of women

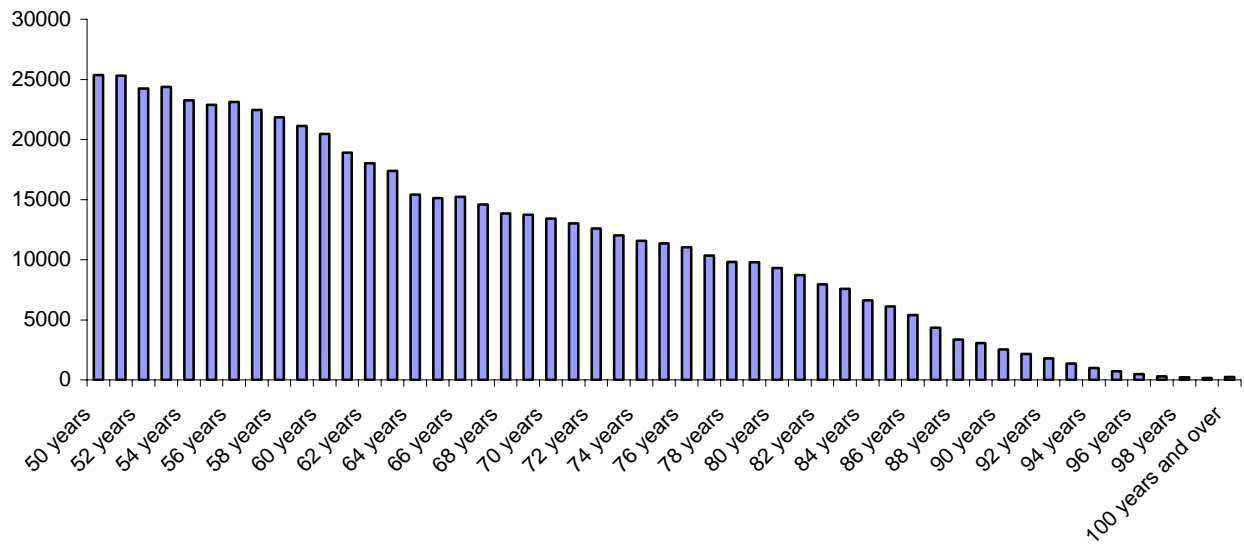
Women are seriously under-represented in political life at all levels. In 2007, only 5.9% of Ministers of State, 21.4% of government ministers, 20% of the Seanad, and 13.3% of the Dail were women. The proportion of women in any of these categories has not exceeded 21.4% over the last ten years.⁵ It is widely accepted that a critical mass of between 30-40% is required before any meaningful change can be affected.

1.3 The population of older women in Ireland

In the last census (2006) there were over 4.2 million people in the Republic of Ireland. In the age groups relevant for the purpose of this document there were 460,831 women aged between 45 and 64, and 260,831 women aged over 65 (CSO). Unfortunately age group categories set by the CSO do not cleave at 50, so most of the statistics in this report will be subject to the CSO’s rather broad definitions of age group, which can vary from table to table. However, an analysis of population by year shows that in 2006 there were 584,900 women aged over 50 (Figure 1.1). Figure 1.2 shows the population of women by age group. These age group categories are similar to some, but not all, of those used by the CSO. The pie chart (Figure 1.3) shows the distribution of older women across the age groups.

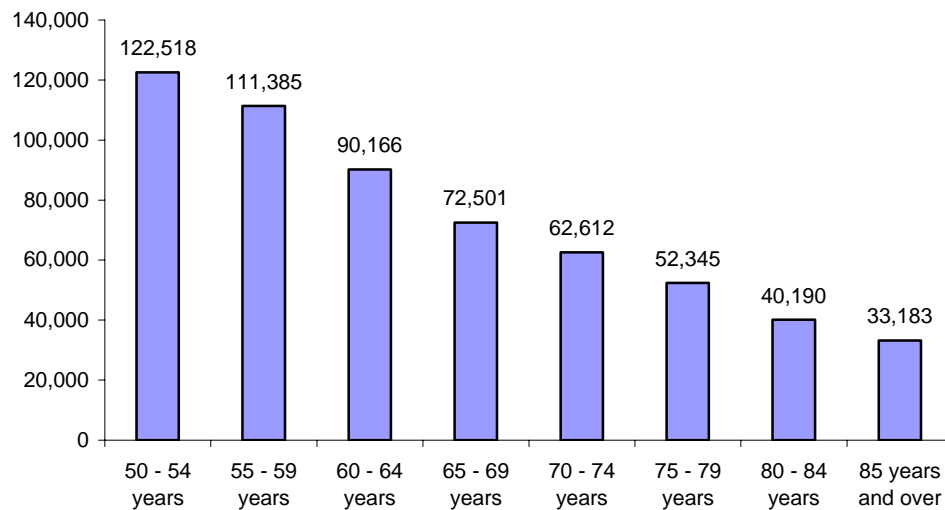
⁵ Equality in Ireland 2007

Figure 1.1 Population profile of women aged 50 to 100 and over by single year



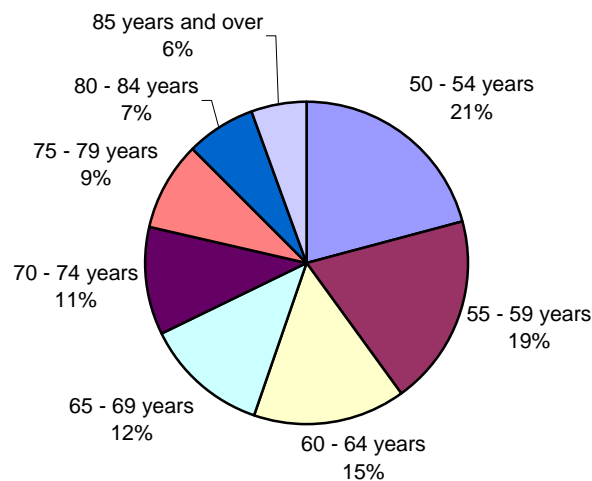
Source CSO Database

Figure 1.2 Population of women over 50 by age group



Source CSO Database

Figure 1.3 Distribution of women over 50 by age group



Source CSO Database

1.4 Population projections for older women to 2036

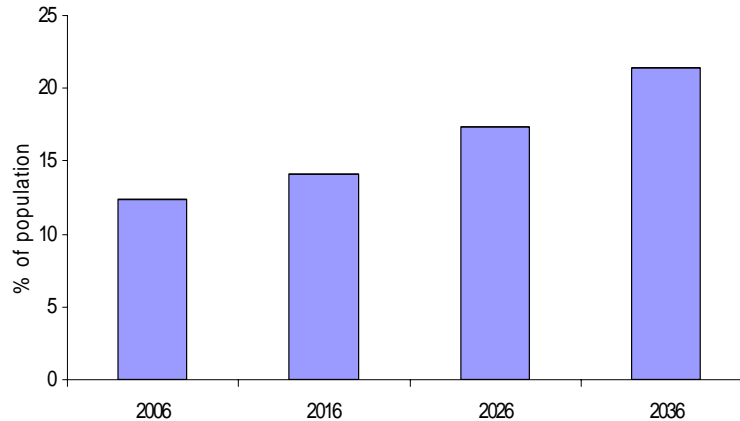
Population projections by the CSO in 2004 indicate that the numbers of older women will increase by 134 percent from 260,831 in 2006 to around 609,200 in 2036. The largest percentage increase will be among women aged over 85, where the numbers are expected to increase by 200% from around 33,000 in 2006 to over 99,000 in 2036.⁶

In terms of the proportion of older women in the whole female population, the percentage of older women is projected to increase from 12.4% in 2006 to 17.4% in 2026 and 21.4% in 2036 (see Figure 1.4).⁷ What this means in human terms is that at least 1 in 5 of the women on the streets, shopping, engaging in social activities and **voting** in 2036 will be a woman over 65.

⁶ Source Long-stay Activity Statistics 2006 Table A10

⁷ Source Long-stay Activity Statistics 2006 Table A10

Figure 1.4 The proportion of women over 65 as a percentage of the population 2006-2036

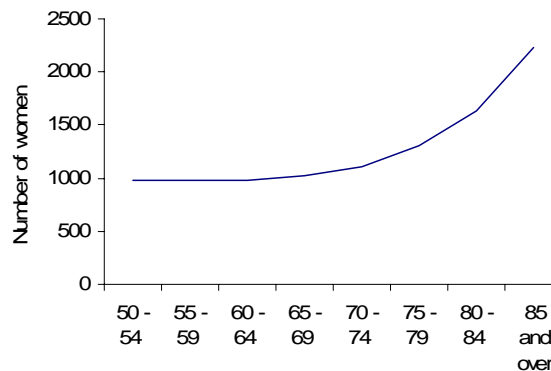


Source Long Stay 2006 Based on 2004 projections.

1.5 The ratio of older women to older men in different age groups

The ratio of men to women changes across the older age groups. Up until around 65 the ratio is similar to the population as a whole with slightly more men than women, but for people aged over 65: 55.7% are women. If we break this down by age group, between 65 and 84 the ratio drops to 84 men per 100 women, and after 85 it is dramatically reduced to 45 men per 100 women.⁸ It is worth bearing these ratios in mind when considering statistics relating to older people where gender is not disaggregated, so for example, when figures are given for 'people over 85', more than 2/3 will be women.

Figure 1.5 The number of women per 1000 men in the older age groups 2006



⁸ Equality in Ireland 2007

2 Health

The first wealth is health.

Ralph Waldo Emerson

2.1 Introduction

This section will examine the health status and associated services for older women. While it is widely understood that health and well being have wider determinants than simply not being ill, this section will focus on the medical dimension of health and well being.

This section on health will be organised as follows:

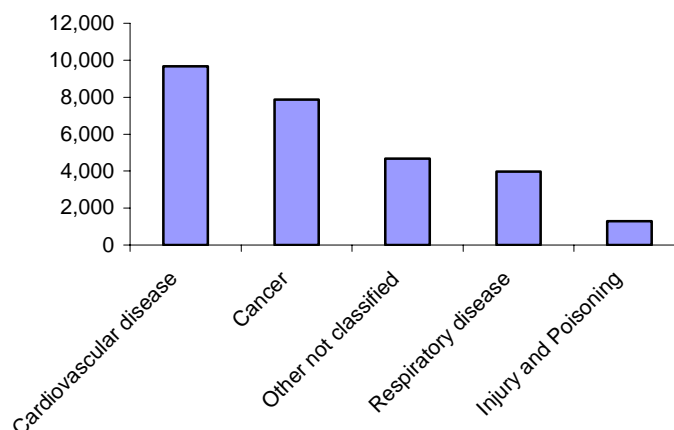
Section 2.2 sets the context and provides a short overview of the prevalent diseases and causes of death in the Irish population as a whole. Sections 2.3 to 2.7 look at the factors affecting incidence and mortality in cardiovascular disease, breast and cervical cancer for older women. Sections 2.8 and 2.9 investigate accidental injury and disability suffered by older women and sections 2.10 and 2.11 outline the provision of general and mental health care.

2.2 Principal causes of death in Ireland

Over the whole population, a higher proportion of men than women die from all circulatory diseases, cancer, accidents and suicide. Circulatory diseases remain the biggest cause of death for both men and women, followed by cancer and respiratory disease⁹.

⁹ Deaths from Principal Causes 1998 to 2006: CSO

Figure 2.1 The principal causes of death for the whole population of Ireland 2006



2.2.1 Cardiovascular disease

Cardiovascular disease (CVD) including coronary heart disease (CHD), stroke, and other circulatory diseases is the principal cause of death in Ireland. Around 10,000 people die each year from CVD, accounting for 36% of all deaths. About half of CVD deaths (5000) are from CHD, mainly heart attack. Over one fifth (22%) of premature deaths (people dying under the age of 65) are from CVD.

About 10,000 people suffer a stroke each year and 2,500 die from stroke. Strokes account for more deaths than breast cancer, prostate cancer and bowel cancer combined. There are an estimated 30,000 people in the community with residual disability from stroke.¹⁰

Around twice as many women die each year from CVD than from all cancers combined. To put this in perspective, 2,225 women died from ischaemic heart disease in 2005, compared to 678 from breast cancer. The rate of ischaemic heart disease amongst Irish women (90 per 100,000 women) is high compared to the EU 15 average (62.2 per 100,000).¹¹

¹⁰ The Irish Heart Foundation

¹¹ Cardiovascular Disease In Women (2007)

Deaths from diseases of the circulatory and respiratory systems decreased substantially between 1998 and 2006.¹² In contrast, death from cancer has increased. The death rate for all three categories of disease is consistently higher in Ireland than in the EU15.¹³

A Cardiovascular Health Strategy was initiated in 1999 requiring over €220m for full implementation, but to date only €60m has been made available by the government (mostly in the early years of that strategy). Very little government funding has been made available in the last few years, one result of which is that Ireland suffers a severe shortage of cardiologists, less than 1/3 the EU average (11 per million compared to 35 per million in the EU. The rising rate of obesity in the Irish population is likely to result in an increase in CVD¹⁴.

2.2.2 Cancer

- One Irish person in three will develop invasive cancer and one in three of these will die from it.
- Around 20,000 Irish people develop cancer and 7,500 die of the disease each year.
- About 60% of cancer patients die of the disease within five years of diagnosis.
- There are approximately 120,000 cancer survivors in Ireland at present.
- A substantial proportion of these cases are preventable.¹⁵

According to the Strategy for Cancer Control Report (2006), there is inequity in the provision, availability and performance of cancer services when examined by region, social class, age and sex. There is an urgent need for significant expansion in all aspects of cancer service capacity in order to meet the cancer needs of the Irish population.

By 2020 (approx 11 years time), the average number of the most serious cancers for both women and men is projected to more than double¹⁶ to nearly 29,000 per year¹⁷. For all cancers, non-melanoma skin cancer (NMSC), 13,328 per year of these will be women¹⁸ of which 54% will be women over the age of 65.

¹² Deaths from Principal Causes 1998 to 2006: CSO

¹³ WHO European Mortality Database 2007

¹⁴ The Irish Heart Foundation

¹⁵ Cancer Strategy Report (2006)

¹⁶ Excluding non-melanoma skin cancer (NMSC)

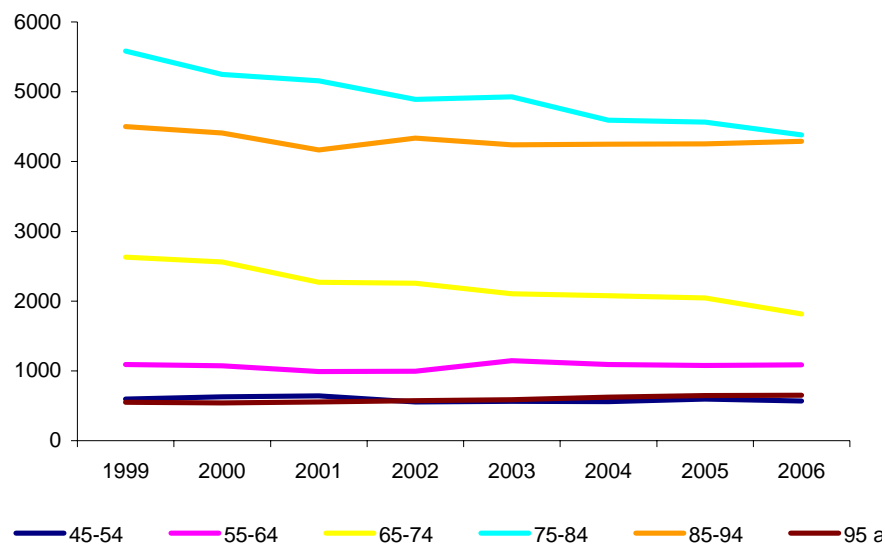
¹⁷ Trends in Irish cancer incidence 1994-2002 with projections to 2020 (2006)

¹⁸ Trends in Irish cancer incidence 1994-2002 with projections to 2020 (2006)

2.2.3 Causes of death among older women

There has been a 61% fall in the overall death rate for all women since 1996. This is attributable mainly to a fall in the death rate of women aged 65-74 and 75-84 since 1999. The death rates for older women in age groups older and younger than this have not differed significantly over this period.

Figure 2.1 Death rates by age group for older women



Source: CSO Vital Statistics

2.3 Cardiovascular Disease (CVD) in older women

The pattern of CVD incidence in older women has been changing over the last decade or so. The old stereotype of stressed overweight middle-aged men being most at risk from heart attacks and strokes is no longer plausible and needs to be re-considered. The rate of heart disease in women is similar to that of men, but onset in women is about 10 years later and the incidence of heart attack in women can lag behind that of men by almost 20 years.

Older women are just as much at risk of heart attack as men, in some cases more so, and the proportion of women at risk is rising.

The vast majority of deaths from a CVD were among the over 65 population, and although slightly more men died in total, more older women than men died of stroke in 2005. Ireland has

the second highest rate of ischaemic heart disease among women in the EU, with 125.8 compared to 74.2 per 10,000 women.¹⁹

There are two areas of particular concern for older women; first that most of the research on CVD has been undertaken on men. Secondly, there is a poorer recognition of the risk and symptoms of CVD due to lack of knowledge coupled with misconceptions among older women and many health professionals^{20 21}.

2.3.1 A research bias towards men

It has been assumed until very recently that the enormous body of research on CVD in men would transfer easily and apply equally well to older women. However, it is becoming clear that this is not the case. Differences in cholesterol levels, the interaction between female hormone levels and cholesterol need a considerable degree of further research. In particular, the effects of different HRT medications require further research. Differences in older women's lifestyle, metabolism in general and how this might affect the appropriate type and level of prescription for blood pressure medication all need further research.

2.3.2 Poorer recognition of symptoms and risk

Warning signs of an imminent problem seem to be different in women. Instead of the sudden acute chest and arm pain thought to be the typical precursor to a heart attack in men, women may have neck or shoulder discomfort, abdominal pains, shortness of breath, sudden fatigue, nausea or vomiting. Possibly because these are often less acute and unrecognised, women tend to wait longer before consulting medical services. In cases of angina, the symptoms of chest pain may be the same, but angina is more likely in women than in men to occur at rest, during sleep, or when mentally stressed.²²

Some of the factors that increase the risk of CVD are also different between older women and men. Although the three principal risk factors of smoking, high cholesterol and high blood pressure (hypertension) are the same for both, there are gender differences in the latter two. In women, low-density lipoprotein cholesterol and total cholesterol levels increase after the age of

¹⁹ Eurostat, 2002.

²⁰ Women and cardiovascular health (2003)

²¹ Cardiovascular Disease In Women (2007)

²² Women and cardiovascular health (2003)

55 years and peak between 55 and 65 years of age, about 10 years after men. High-density lipoprotein cholesterol has been found to be a stronger predictor of coronary heart disease among women than men. Hypertension substantially increases the risk of CHD in women, and as more women than men suffer hypertension over the age of 45, this is a particular risk for older women. A high consumption of alcohol, a sedentary lifestyle and obesity each increase the risk of a CVD on their own, but in addition they are associated with a higher risk of diabetes, which in conjunction with CVD, is more likely to be fatal in women.

The socio-economic differences in risk factors, incidence and mortality add to the gender differences in complicated ways that need to be better understood. For example, quite recent studies show that risk is substantially higher in disadvantaged groups and rates of disease virtually trebled from 90 to 279 per 100,000 between the professional and semi/unskilled socio-economic groups²³.

The Women's Health Council identifies three areas in urgent need of research and policy development:

1. Addressing the inequalities – the particular need of women, especially those from less well-off groups, need to be recognised and targeted.
2. Lifestyle factors – smoking reduction, dietary improvement, increased physical activity, awareness of CVD risk factors and knowledge of symptoms need to be promoted.
3. Health Services – the appropriate services need to be identified, funded and put in place urgently, particularly given the increasing numbers of at risk older women.²⁴

2.4 Cancer in older women

More than half (54%) of all cancers in women occur over the age of 65. The number of women over 65 in the population is predicted to double from 260,831 in 2006 to 521,000 in 2030²⁵, and the percentage of women who are over 65 is predicted to increase from 13% to 19% of all

²³ Women and cardiovascular health (2003)

²⁴ Women and cardiovascular health (2003)

²⁵ Trends in Irish cancer incidence 1994-2002 with projections to 2020 (2006)

women. This significant upward trend in the relative size of the population of older women will bring with it an increase in cancer incidence.

A recent National Cancer Registry of Ireland (NCRI) report (2006) estimates that around 65% of the projected increase in cancer rates can be attributed to demographic changes by 2020, i.e. that there will be a significantly higher proportion of women in the 65+ age group than there was in the baseline years 1998-2002. This leaves around 35% of the increase attributable to 'other factors'. Exactly what these 'other factors' are is crucial but they have not all been identified. The demographic predictions up to 2020 (which account for roughly 2/3 of the increase in cancer) are based on known population forecast algorithms and are likely to be reasonably accurate within a given margin of error. The other risk factors need to be quantified in the same way, requiring substantial investment in new research. Why is it, for example, that for many cancers there is a trend of slowly increasing risk, which, according to the report, is likely to continue? Action is urgently required and particularly for older women who are the biggest sufferers of the most prevalent cancers. Breast cancer, for example, is the most common cause of cancer in the UK, and disproportionately affects women over 50. The NCRI report concludes:

*'If the future cancer burden is to be reduced, action needs to be taken now, both to deal with known risk factors and to identify others, as cancer risk in 2020 will be largely determined by current exposures ... The increase in cancer numbers will place a major additional burden on cancer diagnostic and treatment services and must be considered in current planning for staffing and capital investment. The improvements in cancer survival that are currently being seen, taken with the increasing number of elderly patients, will also generate a much greater need for cancer aftercare services and will require a more active approach to the management of cancer in the elderly.'*²⁶

2.4.1 Types of cancer

According to the NCRI report, some cancers in women as a whole are projected to increase disproportionately. Among the biggest projected increase are cancers of the liver (309%), kidney (166%), breast (146%), lung (136%), and gallbladder. However, if we look at the projected numbers of women who will be affected, then breast cancer will be the most prevalent cancer

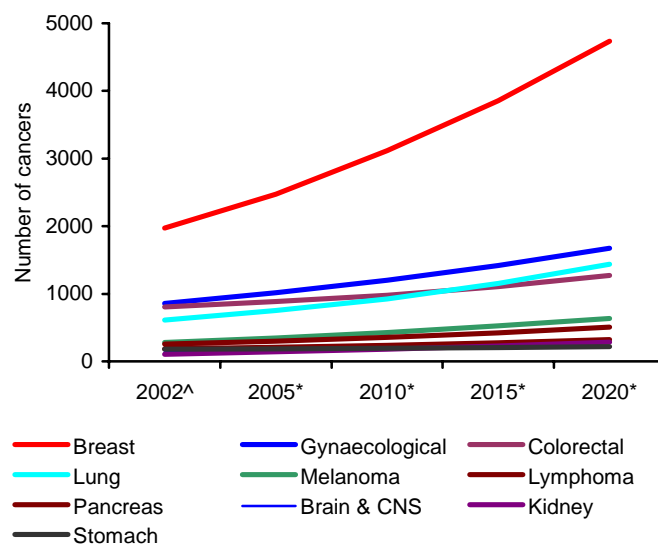
²⁶ Trends in Irish cancer incidence 1994-2002 with projections to 2020 (2006). P4

(4,734 women), followed by 'gynaecological' cancers (vagina, cervix, uterus, ovary, etc.) and lung cancer (see Table A.1 in Appendix and Figure 2.2).

2.4.2 Current and projected incidence of cancers in Irish women 2002-2020

The projected figures compare reasonably with the actual incidence in 2005, based on the number of cancers registered. What stands out most significantly from Figure 2.2 is the high level of breast cancer to date increasing at a much faster rate than the other cancers. Gynaecological cancers, in second place, show lower levels of incidence and a slower rate of increase, as does lung cancer in women. (Further details are available in Table A.1 in Appendix)

Figure 2.2 Cancer incidence by type 2002 – 2020



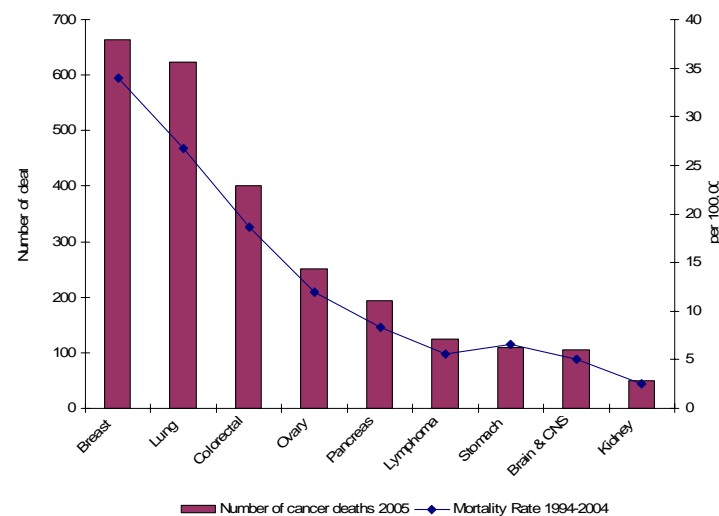
2.4.3 Number of deaths from cancer in Irish women

- The average age at diagnosis of breast cancer is 59
- The average age at death from breast cancer is 66
- The chance of developing breast cancer;
 - by age 65 = 5.4%
 - by age 75 = 7.9%²⁷

²⁷ Women and Cancer in Ireland 2006

In 2005, 663 women died from breast cancer in the Republic²⁸ (Figure 2.3) and 301 in Northern Ireland.²⁹ Breast cancer is the most common cause of cancer death with a mortality rate of 34 per 100,000. Lung cancer is the second highest with 624 deaths, but a substantially lower rate of mortality (26.7) and cancer of the colon and rectum produce another 400 deaths, though the mortality rate is much lower, tending towards half that of breast cancer. Around 250 women died from ovarian cancer in 2005, and again with a significantly lower mortality rate, getting on for a third of that for breast cancer. Table A.2 in the Appendix gives further details on other causes of death.

Figure 2.3: The number of deaths and mortality rate per 100,000 by type of cancer for Irish women of all age groups in 2005



Many estimates suggest that a significant proportion of cancers in women are preventable, perhaps as much as 30%,³⁰ by reducing the risk factors of getting a particular form of cancer in the first place, and through early diagnosis, reducing the chance of dying from cancer. The principal method of reducing the risk of lung cancer – giving up smoking – must be well enough known by now, as are the risks of being passively in a carcinogenic environment such as cigarette smoke and asbestos dust. In the next sections those cancers that affect women specifically and especially older women, cancer of the breast and cervix will be dealt with in more detail.

²⁸ Cancer in Ireland 1994-2005, NRCI (2006)

²⁹ The Northern Ireland Cancer Registry

³⁰ Cancer Control Strategy (2006)

2.4.4 Treatment differences between young and older women suffering from cancer

One very striking finding from the Women and Cancer 2006 report is that:

'Older women are much less likely to receive treatment for cancer than women in younger age groups'³¹

The report suggests that this might be because older women may have more complications and contraindications to treatment than younger women and / or that clinicians believe that treatments on offer will be less effective, and /or that older women will be more adversely affected by the toxicity of cancer treatments like radiation or chemotherapy. But not only is there no research evidence to support these differences in treatments, older women may actually be excluded by virtue of their age from clinical trials, and where they are included, older women are usually severely under-represented.

According to the Women and Cancer report, older women suffering breast cancer were more likely than younger women to receive hormone therapy, but less likely to have surgery, chemotherapy or radiation therapy. Disease progression tends to be more advanced in older women. One quarter of women over 75 had localised cancer, approximately another quarter had regional cancer and half had a more distant spread of the disease. The spread of cancer may be one reason why hormone therapy would be used as a treatment in this case. Older women may not receive chemotherapy because the treatment efficacy is in doubt (Women and Cancer);

'Whatever the explanation, the lower rate of treatment among women in older age groups is a serious concern given the ageing of the population, and the fact that women constitute a greater proportion of the older population. This means that there will be a concomitant increase in the numbers of older women suffering with cancer in Ireland, so it is vital that care is taken to ensure their treatment needs are appropriately addressed.

³²,

Decisions on type of treatment and duration may appropriately include considerations of age and gender and even discriminate on that basis, but only where the scientific and medical evidence supports the discrimination in terms of effective treatment outcome. Judgments based

³¹ Women and Cancer in Ireland 2006 p162

³² Women and Cancer in Ireland 2006 p163

solely on belief or common practice may turn out to be discriminatory and counter to medical good practice.

Research is clearly required to establish non-discriminatory guidelines for cancer treatment in older women.

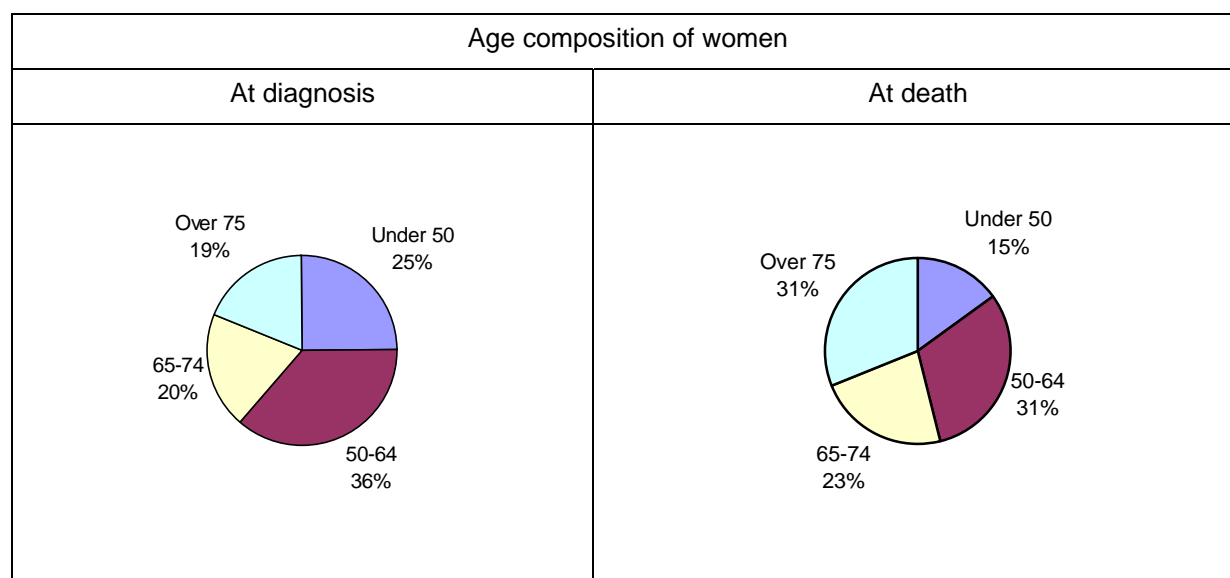
2.5 Breast cancer in older women

2.5.1 Incidence of breast cancer and mortality in Irish women³³

Three quarters of women diagnosed with breast cancer are over 50 years of age (Figure 2.4), and the majority of diagnoses lie in the 50-64 age group, thus women are often considered to be at greatest risk in the years following menopause. Thereafter the incidence reduces, but is still significant at around 20% (1 in 5 women). Younger women, under the age of 50 are still at considerable risk (25%) and need to be aware of the need to reduce risk factors (Section 2.5.2).

The mortality figures show that 85% of deaths due to breast cancer occur in women over the age of 50, with over 30% each in the 50-64 and over 75 age groups (Figure 2.4). Only a relatively small proportion of younger women die from the disease.

Figure 2.4: Breast cancer: Age composition of women at diagnosis and death



³³ Women and Cancer in Ireland 2006

2.5.2 Incidence and deaths from breast cancer in older women in the UK

Up to date statistics on the incidence of breast cancer and deaths from breast cancer in the UK are given here for comparative purposes. The situation for older women is much the same as it is in Ireland.³⁴

The bad news:

- Breast cancer is now the most common cancer.
- Breast cancer incidence rates have increased by more than 50% over the last twenty-five years.
- In the last ten years, female breast cancer incidence rates in have increased by 13%.
- Breast cancer is now the second most common cause of death from cancer in women.
- 8 in 10 breast cancers are diagnosed in women aged 50 and over.
- More than half of breast cancer deaths are women aged over 70.
- Around 9 out of 10 of women diagnosed with stage I breast cancer survives beyond five years. This drops to around 1 out of 10 diagnosed with stage IV.

The encouraging news:

- Breast cancer survival rates have been improving for more than twenty years.
- Breast cancer survival rates are significantly higher among women from the most affluent areas compared to women living in the most deprived areas.
- Breast cancer survival rates are better the earlier the cancer is diagnosed.
- 8 out of 10 breast cancer patients survive beyond five years.

2.5.3 Reducing breast cancer incidence and mortality in older women

We have established that breast cancer is the most prevalent form of cancer for older women and is the greatest cause of cancer mortality over 50. In this section we will examine the efforts being made to reduce the incidence of breast cancer in Ireland. More than 30% of all cancers are preventable so prevention must remain a central focus of cancer policy.

³⁴ <http://info.cancerresearchuk.org/cancerstats/types/breast/incidence/>

Early diagnosis and catching the cancer in its early stages is essential for reducing death or disability. The earlier the diagnosis, for most cancers, and the earlier appropriate treatment is available, the more likely it is that a person will survive the disease and lead a normal and productive life.

Early diagnosis can be massively enhanced if someone visits her GP regularly, is informed of the risk factors, leads a healthy lifestyle, and has access to screening.

Factors leading to an increased risk of breast cancer:

- Women with a mother, sister or daughter diagnosed with breast cancer have an 80% higher risk of being diagnosed with breast cancer themselves.
- Risk increases with the number of first-degree relatives diagnosed with breast cancer, but even so, eight out of nine breast cancers occur in women without a family history of breast cancer.
- Obesity increases risk of postmenopausal breast cancer by up to 30%.
- Women using hormone replacement therapy (HRT) for five years or longer have a 35% increased risk of breast cancer.
- Use of hormone replacement therapy (HRT) causes approximately 2,000 cases of breast cancer in the UK each year.
- The risk of breast cancer in current users of oral contraceptives is increased by around a quarter.
- Drinking as little as one pint of beer or one large glass of wine a day increases risk of breast cancer by more than 7%.
- A more active lifestyle reduces breast cancer risk.

2.5.4 The Irish government's response to breast cancer

The National Cancer Screening Service was established by the Minister for Health and Children in January 2007 and included the already existing BreastCheck Screening Programme.

BreastCheck, 'The National Breast Screening Programme', aims to reduce the number of deaths from breast cancer in Ireland amongst women aged 50 – 64. It started operating in February 2000 in Dublin and plans to offer, by personal invitation, free breast screening to all women aged 50 to 64 every two years.

BreastCheck currently provides four clinical screening units (one per 70,000 women) each supported by four to seven mobile units. The service, which commenced in Dublin in February 2000, covered the North East, East, Midlands and South East of the country. Screening commenced in Wexford in March 2004, was extended to Carlow in 2005 and then Kilkenny in May 2006. Screening was eventually extended to cover the South and West from December 2007. The Annual Report for 2006 states that there is a 'Planned extension to extend the upper age limit to 69 once screening has been 'rolled out' nationally.'³⁵

The CEO of BreastCheck recently reaffirmed its objective and development:

*"Every woman aged 50 to 65 living in Ireland has an equal need and equal right to the BreastCheck service ... there is no evidence that any geographical area has a greater population health need in respect of this service than any other and accordingly no particular area is deserving of a higher priority than any other area."*³⁶

No reference was made to the fact that 54% of the women who die from cancer (generally) are aged over 65.

There has been considerable dissatisfaction with the speed and way in which the Breast Check programme has been implemented, or 'rolled out' geographically on an area by area basis, resulting in a large number of women suffering geographical disadvantage. For example, although women in Dublin were invited for free screening from February 2000 and have been offered further screenings, eight years later women in counties Sligo and Donegal and other parts of the South and West have yet to be given the opportunity of screening.

Table 2.1 shows that in 2005, even given the considerable efforts of the BreastCheck programme, 255,197 women, or more than 80% of the 50-64 age group, did not receive screening under the programme, for whatever reason. Breast Check's own estimate of breast cancer incidence suggest 7-9 per 1000 women will suffer the disease. This means that in 2005 between 1,786 and 2,293 Irish women who were not screened may have had breast cancer.

³⁵ Annual Report 2006 p8

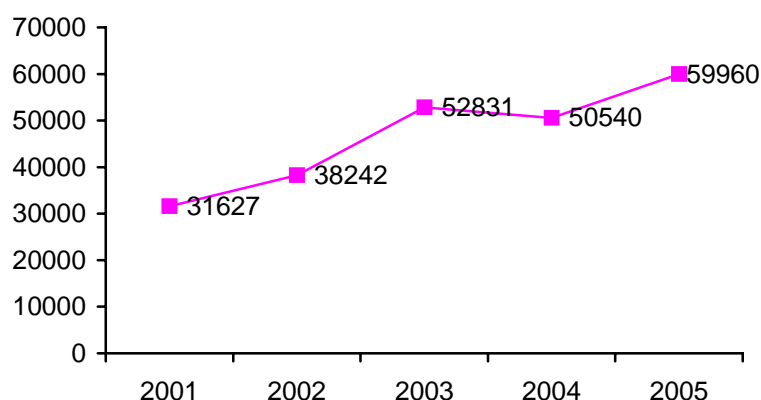
³⁶ BreastCheck 7 Oct 2008

Table 2.1 Number of BreastCheck screenings 2001 to 2005

	2001	2002	2003	2004	2005	2006
Attended screenings	31627	38242	52831	50540	59960	n/a
Total number of women in Ireland aged 50-64	279863	288418*	297331	306244	315157	324069*
% Women screened	11.3	13.3	17.8	16.5	19	?

**Source CSO Census Statistics*

Figure 2.5 Number of BreastCheck screenings 2001 to 2005



2.6 Cervical cancer

2.6.1 Cervical cancer in all Irish women

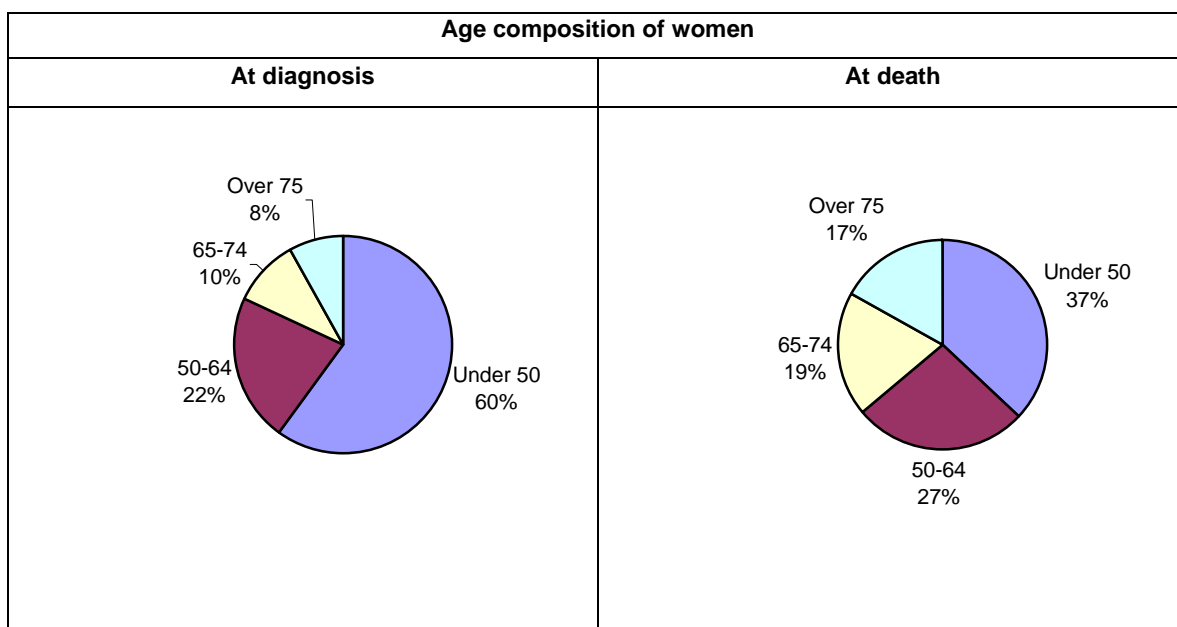
- Cancer of the cervix is the 9th most frequently diagnosed cancer in women in Ireland.
- Cervical cancer is the 12th most common cause of cancer-related death.
- The average age at death is 56 years.³⁷
- Mortality rates from cervical cancer have been found to increase with age, with the highest number of deaths occurring in the 75-79 age group.
- There is a strong trend of increasing risk of cervical cancer with increasing deprivation. Women resident in the most deprived areas had incidence 2-6 times higher than those in the least deprived areas.

³⁷ Women and Cancer in Ireland 2006

2.6.2 Cervical cancer in older women

Cervical cancer is, in popular opinion, a disease predominantly affecting younger women, and the statistics bear that out in so far as 60% of women diagnosed with cervical cancer are under 50 years old. But, as Figure 2.6 shows, 40% of the women diagnosed with cervical cancer are over 50 and 63% of those women who die from cervical cancer are over 50 with a cluster of incidence and mortality in the 50-64 age group. So it is not, in fact, a disease even predominantly affecting only younger women if we take the two sets of figures – incidence and mortality, into account. Diagnosis of cervical cancer tails off with age, as does mortality, but even so, 18% of women over 65 are diagnosed and 36% of these women die from the disease.

Figure 2.6 Cervical cancer: Age composition of women at diagnosis and death



Cervical cancer is one of the most preventable types of cancer. The number of cervical cancer cases has dropped over the past twenty years largely due to the Pap (Human Papilloma Virus) smear test that picks up pre cancerous changes which can be treated surgically with a relatively simple and safe procedure. Vaccines have been developed against most variants of the Human Papilloma Virus (HPV) and are the subject of a mass vaccination campaign in the UK. From September 2008, all 12-13 year-old girls in the UK will routinely be offered HPV vaccination. Starting in the autumn of 2009, there will also be a 'catch-up' programme to vaccinate girls under 18. A plan for a similar campaign in Ireland was deferred in November

2008. In the future it is anticipated that substantially fewer older women will suffer or die from the disease as a result of this campaign.

In the meantime, cervical cancer smear tests for older Irish women offer the best option for prevention.

2.6.3 Screening for cervical cancer

“Cervical cancer mortality in the Irish Republic, which, unlike the UK, does not have comprehensive population-based screening, has been increasing by an average of 1.5% per year since 1978. The mortality rate, which was half of that in the UK in the late 1970s, now exceeds that in any of the region of the UK. The absence of population-based screening for cervical cancer in the Republic of Ireland is the most plausible explanation for these differences in trend.”³⁸

The National Cancer Registry of Ireland estimates that there are approximately 1,000 new cases of cervical pre-cancer where abnormalities in the cervix have been detected, 200 new cases of cervical cancer and 70 deaths from cervical cancer every year - which is one of the highest rates in Western Europe.³⁹ Up until very recently, Ireland has had no free nationwide cervical screening programme unlike many of its European counterparts.⁴⁰ So the incidence of pre-cancerous cervical abnormalities may be far greater than the figures above indicate.

Regular cervical screening could prevent around 75% of potential cervical cancers from developing⁴¹. The Irish Cervical Screening Programme was officially launched in October 2000, covering the Mid-Western Health Board area. This provides a cervical smear test service women between the ages of 25 and 60 living in counties Limerick, Clare and Tipperary North. In a 2004 review it emerged that just over 70% of women in the target area had been screened (primarily through their GP). A Woman's Health Council review, also in 2004, found that the women who had taken part were largely favourable in their response to the programme, appreciated the free screening service, but were concerned about delays involved and felt that the 5 year period for re-test was too long.

³⁸ Comber H and Gavin A 'Recent trends in cervical cancer mortality in Britain and Ireland: the case for population-based cervical cancer screening' British Journal of Cancer (2004) 91, 1902–1904

³⁹ WHO European Database 2008

⁴⁰ Irish Cancer Society, Nov 2006

⁴¹ Cervical screening: the facts 2002

CervicalCheck, Ireland's first free nationwide cervical screening programme took over where the Irish Cervical Screening Programme left off. It began operating on 1st September 2008. Women aged between 45 and 60 are eligible for a free smear test every five years, but at present it is up to individual women to request the test from a registered smearer. Under this programme, women aged over 60 years who are not eligible and have never had a smear test can apply to a CervicalCheck registered smearer for possible screening. This is of course dependent on them being aware of the programme.

Information on CervicalCheck is provided on its website <http://www.cervicalcheck.ie> which currently gives contact details for 2,363 registered Smearters. The level of dissemination of information on CervicalCheck is hard to quantify (November 2008) but women who do not have access to the internet may be significantly disadvantaged.

No information is currently available on the number of women applying for or receiving cervical screening under this programme (November 2008).

2.7 Cancer screening - comparison with other EU countries

The National Cancer Screening Service mission statement is that:

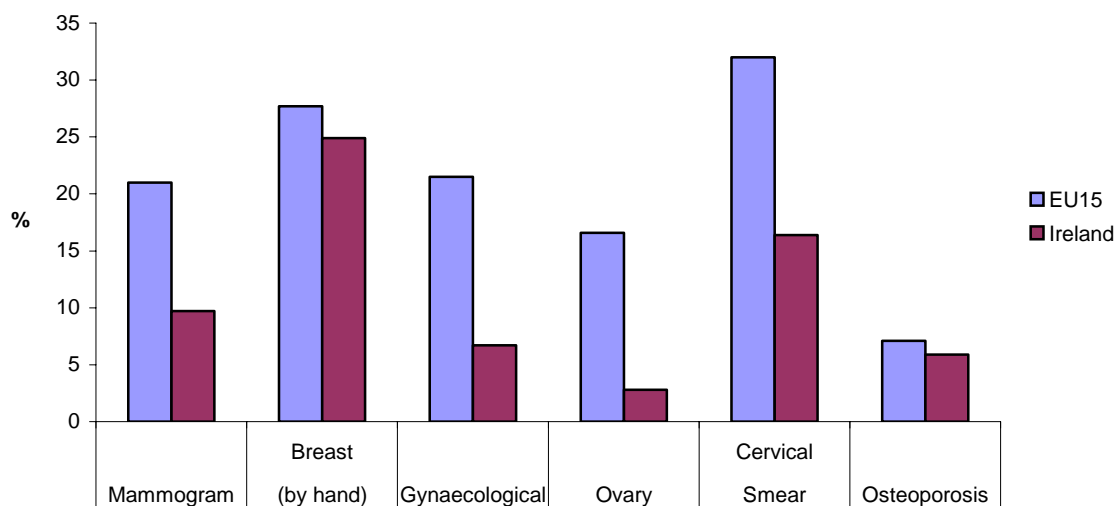
*'Ireland will have a system of cancer control which will reduce our cancer incidence, morbidity and mortality rates relative to other EU15 countries by 2015. Irish people will know and practice health promoting and cancer-preventing behaviours and will have increased awareness of, and access to, early cancer detection and screening. Ireland will have a network of equitably accessible state-of-the-art cancer treatment facilities and we will become an internationally recognised location for education and research into all aspects of cancer.'*⁴²

However, compared to other countries in the EU, it has a long way to catch up, and does not appear to be investing sufficiently to do so.

⁴² A Strategy for Cancer Control in Ireland (2006)

Preventative examinations for women were considerably lower in Ireland than in the EU for all types of treatment (Table 2.3). Only 16.4% of Irish women over 15 underwent the cervical smear test compared to the EU average of 32% and only 2.8% underwent an ovarian examination compared to the EU average of 16.6%.⁴³

Figure 2.7 Preventative examinations by type, EU and Ireland



Comparison of Ireland with Luxembourg, where provision is the highest in the EU, puts the Irish programme in perspective. (Table 2.3)

Table 2.3 Preventative examinations by type, Luxembourg and Ireland

% of women aged over 15

	Examination type					
	Mammogram	Breast (by hand)	Gynaecological	Ovary	Cervical Smear	Osteoporosis
Luxembourg	30.4	54.4	43.7	38.0	57.9	9.5
EU15	21.0	27.7	21.5	16.6	32.0	7.1
Ireland	9.7	24.9	6.7	2.8	16.4	5.9

Source: Women and Men in Ireland 2006

⁴³ Women and Men in Ireland 2006 p48

2.8 Accidental injury in older women

Older women had more recorded accidents than older men. In the case of the 70+ years group, this may be due to the presence of a higher number of older women than older men in the general population.

Every year, 10% of all older people need treatment following an injury. Falls cause 75% of these injuries. In Ireland, three-quarters of all fall related deaths occur in older people. Death rates have been increasing. If current trends continue, deaths and injuries due to falls in older people could double over the next 20 years.

Women over 65 years have the highest incidence and rate of fall related deaths and these increase with age.

Many causes of falls may be due to osteoporosis, a common metabolic bone disease in Ireland. One in three women and one in five men in Ireland over the age of 50 years of age may have osteoporosis. Many people do not know they have this condition until the first fracture occurs. This means that up to 300,000 Irish people aged 50 years and over may have osteoporosis. The prevalence is rising as the population ages.⁴⁴

The issue here is not that older people are prone to osteoporosis and therefore falls are inevitable. The point is that osteoporosis which is one of the main causes of falls in older people can both be prevented and treated.

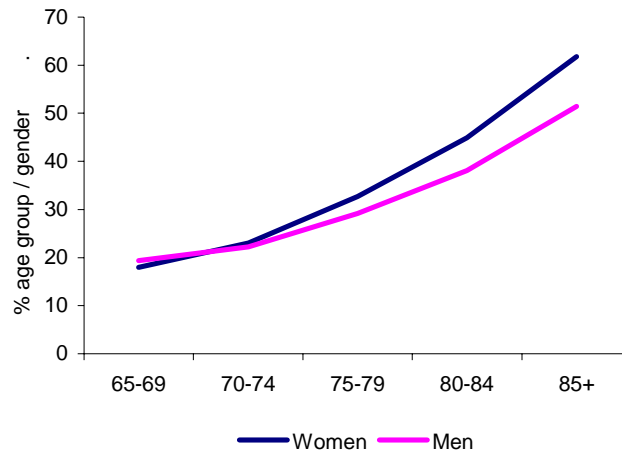
2.9 Disability in older women

As a general rule, acquired disability tends to increase with age. Although the prevalence of disability is higher for men than women in the 65-69 age group, thereafter (70+) the proportion of women suffering disability increases markedly and disproportionately. So, for example, 18% of women in the 65-69 age group suffer disability, which rises to nearly 62% in the 85+ age group, approx 10% greater than for men⁴⁵ (Table A.3 in Appendix).

⁴⁴ Strategy to Prevent Falls and Fractures in Ireland's Ageing Population (2008)

⁴⁵ Ageing in Ireland (2007)

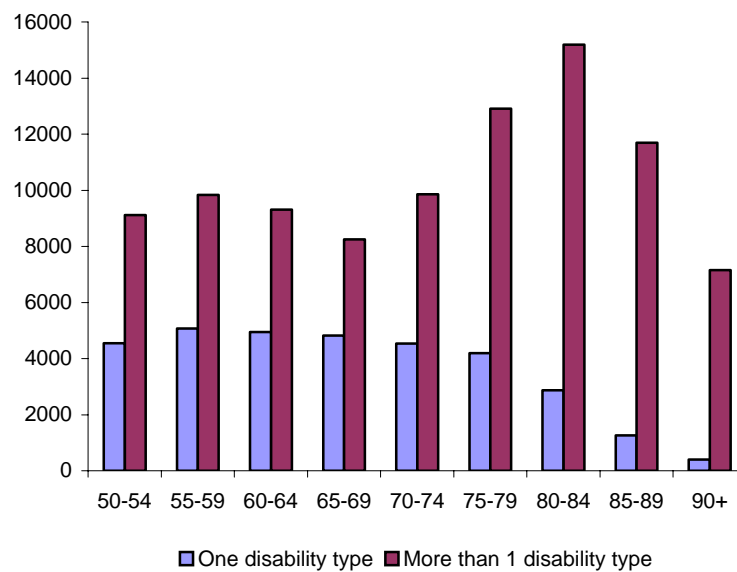
Figure 2.8 Prevalence of disability by gender and age-group 2006



Source CSO Census of Population 2006

However these bare figures mask the fact that the level of disability suffered, indicated by the number of activity-limiting disabilities, also increases with age, and given these two facts, there will be more women than men in the 85+ age group who will suffer considerable activity limitation.

Figure 2.9 Number of disability types - women and men over 65



Source CSO Database

2.9.1 Controversy over the disability rate

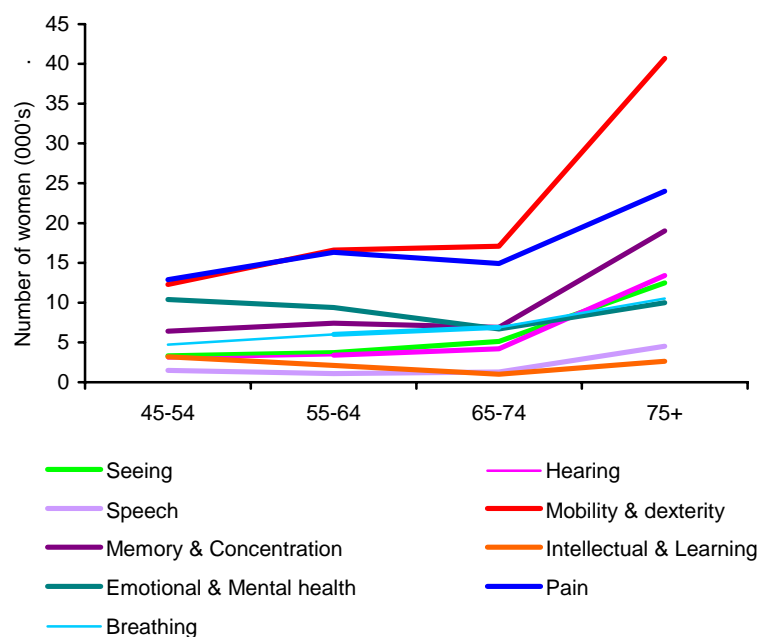
In the 2006 Census of Population, 9.3% of the population or 393,800 people reported a disability. The National Disability Survey 2008 (NDS), undertook a further, smaller sample study of people either reporting a disability in the Census or claiming no disability and from this study they reassessed the level of disability in Ireland. There was a very substantial difference in the two estimates. The NDS estimate more than double the numbers of people with a disability (749,100 compared to 325,800) that, if accepted, raises the proportion to 18.5% disability (as opposed to 9.3%). The NDS estimate, unlike the Census estimate, is comparable to that of England and Wales (18.2% in 2001), Northern Ireland (18% in 2006), Canada (16% in 2001) and Australia (19.8% in 2001). The NDS results also offer a much more fine-grained understanding of the nature of the disability.

Clearly, if the NDS is considered to be a better estimate of disability in Ireland, then changes in government policy and funding should follow the 9.2% increase in the number of people considered to have a disability.

If we use the NDS estimate to look at gender differences in older people then the pattern remains much the same in that more men up to the 65-74 age group have a disability. Thereafter the proportion of women with a disability increases markedly so that after the age of 75 more than twice as many women as men have a disability.

Results from the NDS provide an assessment of the nature of the impairment suffered by older disabled women. As we can see from Figure 2.10 the most striking changes are after the age of 75. A much higher number of women suffer impairment in mobility in particular, rising from around 16,000 -17,000 between 55 and 74 to over 40,000 after 75. Similarly the number of women disabled by pain rises from 15,000 to 16,000 to 24,000, and for disability through impaired memory and concentration raised from around 7,000 to 19,000, after the age of 75.

Figure 2.10 Type of disability suffered by older women in 2006 (NDS survey)



2.10 General Health Care

In 2006 the Irish Medical Organisation (IMO) launched a Position Paper on Care of the Elderly describing a crisis in medical care that appears to be continuing in 2008:

“Older Irish people are one of the groups most affected by the crisis in access to emergency services in the Irish health services. Not only do they represent about 40% of such admissions, but they present with complex care needs and are particularly ill-equipped for care in settings such as trolleys in corridors”⁴⁶

The Report pointed to the number of older people needing Long Stay Care and the inadequate provision in many services, including acute hospital beds and mental health provision. It pointed to the fact that in 2003, 4.8% of older people were in Long Stay Care. Reasons for admission included a wide variety of medical conditions often requiring specialised care that was not always appropriately available. These included: Chronic Illness (33%); Mental Infirmary (23.9%); Physical Disability (12.3%); Social Reasons (11%) and other non-designated (19%). Unfortunately, these figures are not readily available on a gender disaggregated basis.

⁴⁶ IMO Position Paper: Care of the Elderly (2006)

2.10.1 Residential Care

In all types of residential facility, more older women were present than men. In the country as a whole, approximately two-thirds of those in extended care facilities were women, though this must be understood in light of the presence of a higher number of older women than older men in the population.

2.10.2 Long Stay Hospital Accommodation

In 2006, the HSE commissioned the Long Stay Bed Survey.⁴⁷ This provided details of long and limited stay accommodation for older people up to the end of 2006. The survey showed that for all categories there were more women in this type of care by a considerable margin, and the difference between male and female long stay increased with age.

Table 2.4 shows the percentage of men and women in long and limited stay beds in December 2006. The survey (80% response) showed 21,768 long-stay beds and 2,485 limited-stay beds (24,253 total).

Two thirds of all long-stay patients, mostly older people, are women. A majority of those occupying limited-stay beds are women (Table 2.4 and Figure 2.11).

Table 2.4 Percentage of patients resident in different type of long-stay care 2006

Care Provision*	%	
	Women	Men
Long Stay	66.8	33
Limited Stay in limited stay beds	59.1	40.9
Limited stay in all beds	66.2	33.7

Source: Long-Stay Activity Statistics for 2006 (2008)

⁴⁷ Long-Stay Activity Statistics for 2006 (2008)

Figure 2.11 Percentage of patients in limited and long-stay beds December 2006

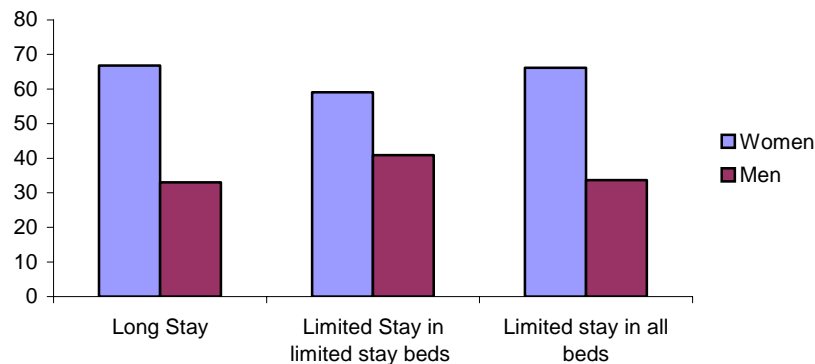
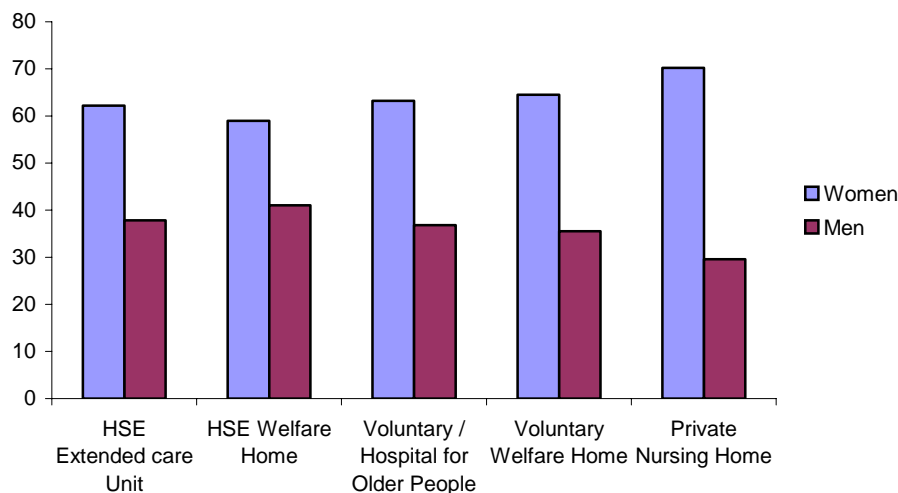


Figure 2.12 Percentage of patients resident in different type of long-stay care 2006



Source: Long-Stay Activity Statistics for 2006 (2008)

2.11 Mental Health Care

Mental health care has been substantially under-funded for decades^{48 49} which adversely affects all those in need of adequate mental health care in Ireland. Mental health expenditure has fallen from 13% of the total health budget in 1984 to around 7% from 2004 to 2006 and was below 6% in 2007.⁵⁰ The Report of the Inspector of Mental Health Services in 2004 stated that, while also noting that “Mental health services today are unsatisfactorily financed, receiving less

⁴⁸ Manifesto on current needs and issues of concern in Mental Health Service Delivery (2008)

⁴⁹ Report of the Inspector of Mental Health Services (2004, 2007)

⁵⁰ Manifesto on current needs and issues of concern in Mental Health Service Delivery (2008)

than 7% of the health care budget” pointed to the fact that geriatric psychiatry was one of the areas least developed.

Older people in general are most vulnerable to the consequences of underfunding and older women in particular. The mental health needs of older people require specific skills for assessment, treatment and care. Five percent of those over 65 suffer from some degree of dementia and over age 80 this figure rises to 20%.⁵¹ Within this overall figure there are significant gender differences in the type of mental illness suffered and the type of treatment offered. Women over 75 have the highest rates of mental illness, both organic disorders such as Alzheimer’s, dementia, and others such as depression and anxiety. Women are also more likely than men to be prescribed psychotropic drugs rather than other forms of treatment such as counselling.⁵²

2.11.1 Psychiatric Hospitals

The overall number of psychiatric hospital inpatient admissions has fallen steadily over recent year from nearly 26,000 in 1997 to 21,250 in 2005, reflecting a change in mental health care policy towards care in the community.

The number of women as a proportion of men admitted as inpatients to psychiatric hospitals has been increasing since 1997 and is now approximately equal.⁵³

Substantially more women than men admitted to psychiatric hospitals were diagnosed with depressive disorders, mania and personality disorders.

These figures are not available on an age-disaggregated basis.

2.11.2 Mental illness in nursing homes

The Women’s Health Council Submission on Care for Older Women⁵⁴ points to research showing that women over 75 have the highest rates of mental illness in the population, and that among residents of nursing homes (predominantly women) the rate of mental illness is 65%.

⁵¹ Vision for Change: Report of the expert group on Mental Health Policy (2006)

⁵² Women’s Mental Health: Promoting a Gendered Approach to Policy and Service Provision (2005)

⁵³ Department of Health and Children

2.11.3 The Vision for Change report (2006)

The Vision for Change report gives somewhat higher figures for the rate of mental illness in nursing homes, estimating that the prevalence of dementia in residential and nursing homes is between 60% and 75% and, in addition, 31% of older people in acute hospital beds have cognitive impairment that requires specialist intervention. A significant proportion of older people with dementia will also suffer from behavioural or psychological disorders⁵⁵. Looking to the future, the number of older people suffering depression and dementia, and it must be stressed that this is predominantly older women, is predicted to increase substantially. For example, for people over 85 (2.1 women to 1 man), the number of older people suffering depression will increase from 47,300 in 2001 to 122,540 in 2036; the number of over 85 year olds suffering from mental illness will increase from 40,000 to 159,000 over the same time period.

Table 2.5 Current and projected populations for selected years and age groups with estimated depressive syndrome and dementia numbers

	2001		2016		2026		2036	
	Number	% of population	Number	% of population	Number	% of population	Number	% of population
65 and over	430,000	11.1	629,000	13.3	866,000	16	1,114,000	19.7
75 and over	187,000	4.9	254,000	5.2	382,000	7.1	551,000	9.5
85 and over	40,000	1.1	64,000	1.1	91,000	1.6	159,000	2.7
Depression	47,300		69,190		95,260		122,540	
Dementia	21,500		31,450		43,300		55,750	

Source Vision for Change (2006)

Given the current under funding and poor provision in the area, plus a significantly increasing problem for older women over time, the Vision for Change report recommended a plan for restructured mental health services for older people providing; local Community Mental Health Teams (1 per 100,000 total population); eight in-patient beds in the local general acute in-patient unit; and one unit with 30 beds per 300,000 population for continuing care/challenging behaviour. It is difficult to assess at present how far these recommendations have been implemented. The report recommended 8% of the total health budget but less than 6% was allocated in 2007,⁵⁶ however, the situation seems to be worse than this according to the

⁵⁴ Submission on Care for Older Women (2005)

⁵⁵ Vision for Change: Report of the expert group on Mental Health policy (2006)

⁵⁶ The Economics of Mental health Care in Ireland (2008)

independent Vision for Change Monitoring Group. Their Second Report on Implementation⁵⁷ listed a catalogue of problems including the lack of clear identifiable leadership and lack of a coordinated implementation policy by the HSE, together with concerns over the 'reassignment' of €24m of the €51.2m development fund allocated in 2007 for Vision for Change.

A high quality mental health service provision for older women is essential if the promises of the Social Partnership are to be kept. Implementation of Vision for Change will go part of the way to ensuring such a provision. It is unfortunate that, even though a large number of people over 65 suffer mental health problems, there are very few up-to-date gender disaggregated statistics to aid policy development and monitoring.⁵⁸

The great secret that all old people share is that you really haven't changed in seventy or eighty years. Your body changes, but you don't change at all. And that, of course, causes great confusion. Doris Lessing

⁵⁷ Second Report of the Independent Monitoring Group on A Vision For Change (2008)

⁵⁸ Women's Mental Health: Promoting a Gendered Approach to Policy and Service Provision (2005)

3 Income / Employment / Risk of Poverty

‘We believe that initiatives included within the National Women’s Strategy will benefit very many women and will enable us to achieve the vision of:

*“an Ireland where all women enjoy **equality** with men and can achieve their full potential, while enjoying a safe and fulfilling life.”⁵⁹*

Bertie Ahern TD; Michael McDowell TD; Frank Fahey TD

This quote was taken from The National Women's Strategy, which as stated in section 1.1.2 addresses the key themes of equalising socio-economic opportunity for women; ensuring the wellbeing of women and engaging women as equal and active citizens. Progress on achieving these objectives with regard to older women will be examined in this section.

3.1 Employment

For both women and men aged over 65, overall employment rates remained fairly stable between 1997 and 2005, with men’s employment staying at around the 14% to 15% level, well above women’s participation rates of around 3%. In 2006 women’s employment rate rose a little to 4.2%.

3.1.1 Employment Gap: Working age women 55-64 years

The employment rate for women in the workforce as a whole (15-64) was 58.7% compared to 77.4% for men, producing an 18.7% gender difference.

In 2006, the employment figures for ages 55-64 show a very substantial difference in the employment rates between women and men. Only 40% of women aged from 55 to 64 were employed in 2006 (the most recently available figures). This compares with 66.5% of men in

⁵⁹ National Women’s Strategy 2007-2016 (2007)

the same age bracket, a difference of 26.5%. In other words, 2/3 of men were employed, or nearly 7 out of 10, compared with only 4 out of 10 women⁶⁰.

In comparison with the EU, the percentage of women in employment in that age group (40%) is above the EU 27 average (34.9%). Ireland has the 10th highest proportion of women employed, but compares poorly with countries like Sweden (66.9%) and Denmark (54.3%).⁶¹

Table 3.1 & Figure 3.1 Employment rate of workers aged 55–64 by gender, 2006

Country	Women	Men
Sweden	66.9	72.3
UK	49.1	66
Ireland	40	66.5
EU27	34.9	52.7



Source: Measuring Ireland's Progress 2007

Although employment rates for all working women are higher on average than those of older women, the employment gender difference for all women (18.7%) is lower than that for older women (26.5%).

3.1.2 Employment Gap: Women 45-54, 55-64 and over 65 years

As might be expected, the number of women employed in all the older women's age groups declined with age - dropping from almost 170,000 employed between the ages of 45 and 54, to just under 84,000 for the 55-64 age group. This is a very substantial fall in employment, with

⁶⁰ Measuring Ireland's Progress 2007 (2008) p.34

⁶¹ Measuring Ireland's Progress 2007 (2008) p.39

only around half the women (49%) employed in the 55-64 age group. The reasons for this drop are not entirely clear, and one might surmise at length, but it is an area that warrants further information. If we compare this decrease with that of men in the two age groups, the decrease in employment is about 38% over the same period (approx. 235,000 to approx.145,000, Table 3.1). In other words, the number of older men employed in the 55-64 age group is 61.5% of the 45-54 group – over 12% more than the comparison for older women (49%)⁶².

A similar pattern of unequal proportionate reduction in employment is apparent if we compare the numbers for the over 65 age group, and the decrease in employment compared with the 55-64 age group. The number of older women employed in the over 65 age group is only 11% of the 55-64 age group, whereas for men it is 17%.

Table 3.2 Number of women and men employed by age group

	45-54	55-64	Over 65
All	405029	228664	33813
Men	235458	144847	24797
Women	169571	83817	9016

Source CSO

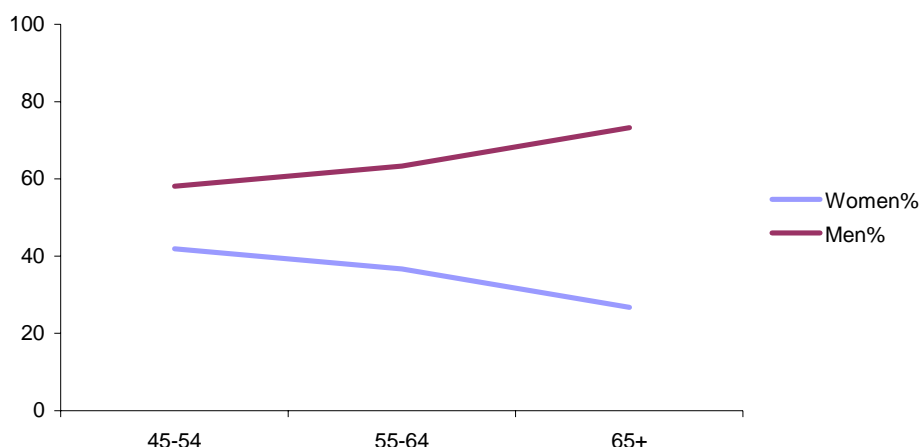
Table 3.3 Women and men's rates of employment for the three age groups 2006

Age Group	Women	Men
45-54	41.9	58.1
55-64	36.7	63.3
65+	26.7	73.3

Source CSO

⁶² CSO Database

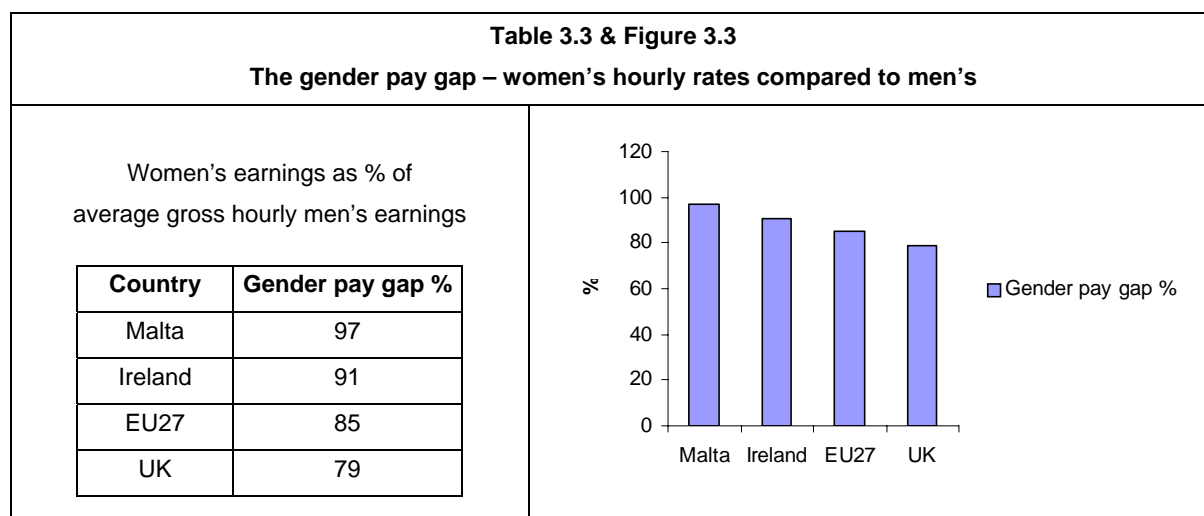
Figure 3.2 Women and men's rates of employment for the three age groups 2006



Source CSO

3.1.3 Pay discrimination: all women

Government statistics do not separate women's and men's comparative hourly pay by age-group, but there is no reason to believe that the situation is different for women in the age group 55-64 or for those over 65. Across all age ranges, women are paid less than men, earning only 91% of men's gross hourly rate on average. This pay inequality between women and men has improved only slightly over the last three years and has remained static since 2005 (2006 figures, see Table 3.3). There is no evidence to suggest whether it is higher or lower in the older women's age group.⁶³



Source: Measuring Ireland's Progress 2007, Eurostat, EU-SILC

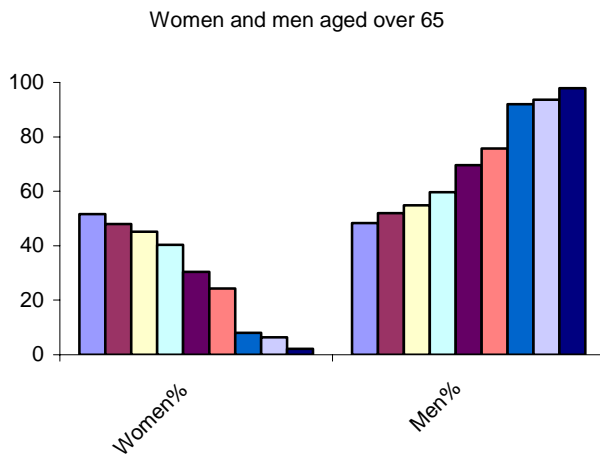
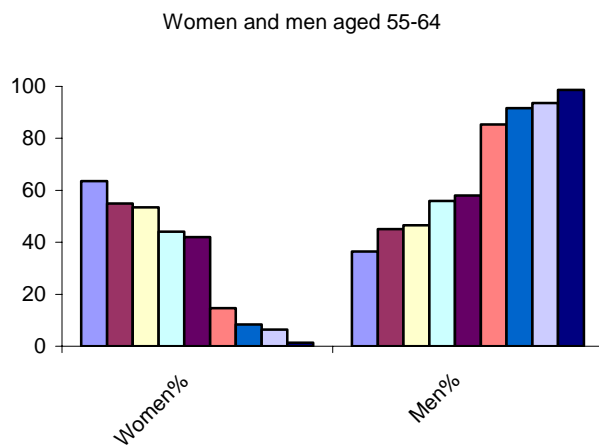
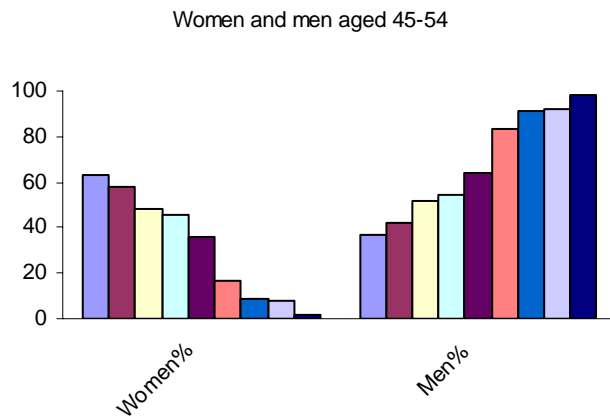
⁶³ Measuring Ireland's Progress 2007 (2008) p.44

3.1.4 Occupational category of employment

The occupational groups that the Central Statistics Office use are very broad and provide only category of occupation, not type of work or hierarchical level, so for example, 'Clerical, managing and government' implies a very wide range of possible job descriptions, all the way from the lowliest to the most exalted job in government. Be that as it may, the largest numbers of older women in the 45-54 age group are employed in 'clerical, managing and government occupations', about 48,800 all told. This is followed by 'professional, technical and health workers' with over 40,000 older women, and 28,000 older women working in service occupations. The number of women in all occupational categories decreases significantly over the three age groups, but the percentage of women employed decreases much more slowly with the exception of clerical, managing and government occupations where the proportion of women rises substantially between the 45-54 and 55-64 age groups and still remains relatively high after 65.

The other category with an unexpected rise in rate of employment is in manufacturing where the proportion of older women working is higher in the over 65 age group by about a third compared with the 45-54 group (see Table A.5 in Appendix and Figure 3.4 for details)

Figure 3.4 % of older people by age and occupational group



Occupational Group	
Services	
Professional, technical and health	
Sales and commerce	
Other workers (incl. not stated)	
Clerical, managing and government	
Manufacturing	
Farming, fishing and forestry	
Communication and transport	
Building and construction	

Source CSO Database

3.1.5 Nature of employment - full-time and part-time employment over 60

A different perspective on employment for older women is provided in the CSO Factsheet 'Ageing in Ireland' published in 2007. Part-time and full-time figures are provided using a different set of age-group categories; 60-64, 65-69 and over 70.

Overall, labour participation rates consist of full-time and part-time working but the gender differences in these two modes of employment is quite striking.

It is clear from Table 3.5 and the Figure 3.5 that:

- Men had a far higher full-time employment rate than women, and the difference in the full-time employment rate rose dramatically with increasing age.
- In the 60-64 age group, more than three times the number of men than women were employed, with a gender difference of 35.8%
- In the 65-69 age group, more than six times the number of men were employed, with a gender difference of 15.8%
- In the over 70 age group, although significantly fewer people overall were employed, more than nine times the number of men were employed, with a gender difference of 5.1%
- Older women's rates of part-time employment were higher than men's from 60 –70.
- In the over 70 age group, men had a much higher rate of part-time AND full-time employment.
- Older women's part-time employment fell substantially from 16.3% for the 60-64 age group to 1.3% for the over 70's – a decrease to 1/12 of the original, whereas men's part-time employment only halved over the same age-groups.⁶⁴

⁶⁴ Ageing in Ireland 2007

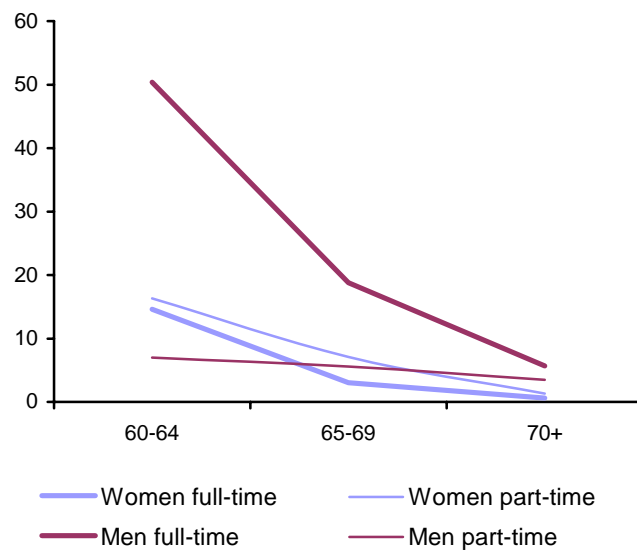
Table 3.5 Percentage of older women and men in full-time and part-time employment

% of sex/age group

	<i>Over 65 total</i>	60-64	65-69	<i>Over 70</i>
Women full-time	1.3	14.6	3	0.6
Men full-time	10.1	50.4	18.8	5.7
Women part-time	2.9	16.3	7.1	1.3
Men part-time	4.3	7	5.6	3.5

Source: Ageing in Ireland 2007

Figure 3.5 Percentage of older women and men in full-time and part-time employment



Overall, for both men and women aged over 65, Ireland's employment rate was virtually twice the EU27 average (4.4%), but less than half that of Portugal (18.3%).

The importance of the contribution of women of all ages to the economy through part-time work is emphasised by the fact that most of the employment growth in 2007 was made up of part time work or self employment. Over two thirds was accounted for by females.⁶⁵

3.1.6 Older women's employment by economic sector

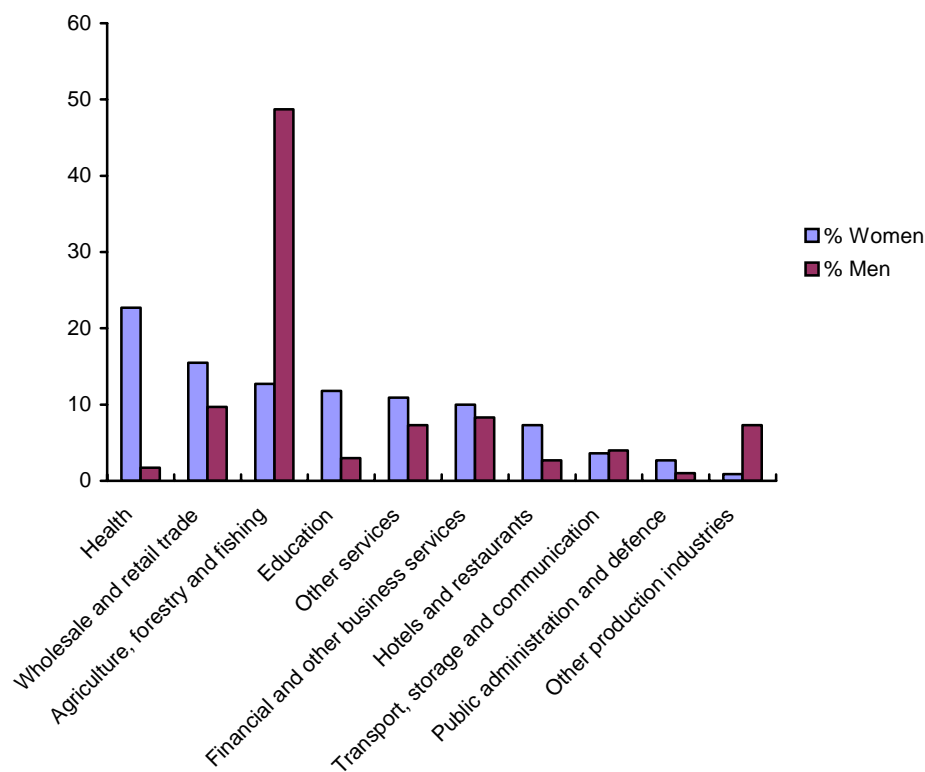
The factsheet 'Ageing in Ireland' published in 2007 (also by the CSO) provides a breakdown of employment by economic sector as distinct from the 'occupational groupings' in section 3.1.4 above. Unfortunately there is very limited breakdown by age group, the figures given are for women and men over 65 only, which makes comparison with the occupational categories (Section 3.4) a little tricky.

There are very marked differences in the proportion of women and men employed in different economic sectors (Figure 3.6). The biggest area of employment for women aged over 65 was in the health services with more than 1 in 5 working women employed (22.5%), which was more than 13 times that of men (1.7%). No information is provided on the nature of this employment, whether it was in medical, nursing, medical support and so on. 15.5% of women worked in the wholesale/retail trade, about 1/3 more than men (9.7%). The other notable area where women over 65 were employed was in education - just under 12%, and nearly quadruple that of men (3%). As might be expected in Ireland the majority of employed men over 65 were in agriculture forestry and fishing, (see Table A.6 in Appendix for details).

Unfortunately, the way in which these statistics are gathered gives little scope for analysis. We do not know where women and men in these age groups are placed in terms of levels and grades within these categories of employment. Consequently, we do not have information on comparative income levels, access to decision making positions in employment or an indication of whether women progressed upwards in terms of grades of employment. We do not know for instance if there is a glass ceiling in age terms and we do not know if older women are more or less likely to either seek promotion, or be promoted, as they grow older.

⁶⁵ Socin2008

Figure 3.6 Percentage of older women's employment by economic sector



Source: Ageing in Ireland 2007 (2008)

3.2 The risk of poverty amongst older women

The Office of Social Inclusion defines poverty as existing where:

'People are living in poverty if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living which is regarded as acceptable by Irish society generally. As a result of inadequate income and resources people may be excluded and marginalised from participating in activities which are considered the norm for other people in society.'

This definition of poverty underpins the Government's strategic response to tackling poverty and social exclusion as set out in the National Action Plan for Social Inclusion 2007 – 2016 (Office of Social Inclusion 2008).

3.2.1 Income poverty

Risk of poverty is defined as *'anyone with an income of less than 60% of the national median income is considered to be at-risk-of-poverty'*⁶⁶.

The risk of poverty in 2006, according to this definition, is 13.7% for women and 13.6% for men. These income poverty figures are significantly improved on those in 2005 (19.9% and 20.3% respectively).⁶⁷

This is high compared to the EU averages, and if a comparison is made of poverty risk after the effect of social transfers (e.g. social security benefits) and pensions are taken into account, Ireland ranks as *second highest risk of poverty* in the EU for people aged more than 65 (2005 figures).

According to the CSO Principal Statistics, there were 260,831 women aged over 65 resident in Ireland in 2006. So:

- 13.7% of women over the age of 65 are at risk of poverty, which is the same as:
- Just over 1 in 7 women over the age of 65 at risk of poverty, which in numbers is
- 35,734 women over the age of 65 who are at risk of poverty (13.7% of 260,831).⁶⁸

3.2.2 Consistent poverty

The Irish government's target on consistent poverty is:

*'To reduce the number of those experiencing consistent poverty to between 2% and 4% by 2012, with the aim of eliminating consistent poverty by 2016.'*⁶⁹

For those people who are considered to be 'at risk of poverty' because they have an income below 60% of national median income, there is a further set of indicators that assess the extent

⁶⁶ Ageing in Ireland 2007

⁶⁷ Measuring Ireland's Progress 2007.

⁶⁸ Note that these figures are dependent on social transfers. Risk of poverty is over 40% without them.

⁶⁹ Office of Social Inclusion 2008

to which poverty prevents people from living a physically and socially normal lifestyle.⁷⁰ This is known as consistent poverty.

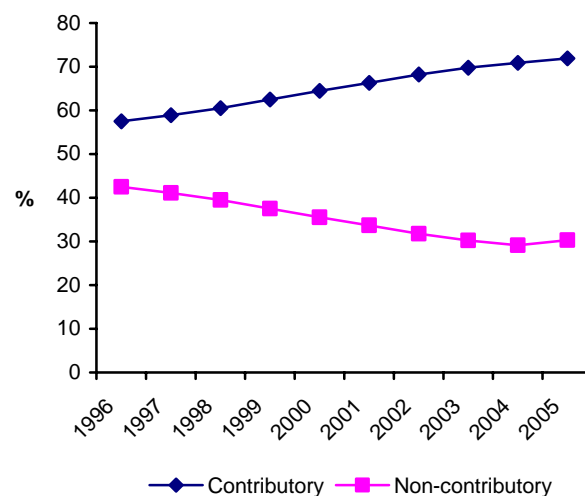
The percentage of women aged over 65 in 'consistent poverty' at 60% level using basic life-style deprivation indicators is 1.9%.⁷¹

It is 2.4% for men in the same age group, giving an overall rate of 2.2% which falls within the governments *Towards 2016* targets.⁷²

3.2.3 Pensions

The number of people receiving a State pension has risen by more than 60,000 since 1996, a rise of 25.4%, from 239,400 in 1996 to 300,100 in 2005. A greater proportion of people now receive a State contributory pension (around 72%), than was the case in 1996 (around 58%).

Figure 3.7 Contributory and non-contributory state pensions 1996 - 2006



Source: *Ageing in Ireland 2007*

The majority of older women are dependent on a non-contributory state pension, and the level of this pension will be the principal determinant of the quality of life for many Irish women over 65. In essence they are dependent on the vagaries of government policy and with that being

⁷⁰ Office of Social Inclusion 2008

⁷¹ Measuring Ireland's Progress 2007

⁷² National Action Plan for Social Inclusion 2007 – 2016

kept in line by the social partnership agreement. It is important to note however that these agreements are subject to negotiation between the social partners and Government and from a government perspective are dependent on a whole gambit of financial considerations and competing priorities.

3.2.4 Pension spend – comparison with other EU countries

Welfare spending (also known as social protection expenditure) in relation to national income, i.e. the percentage of GDP, is used by the ESRI to establish the relative welfare spending for the EU as a whole and for comparison amongst its member states.

The Irish government prefers to use Gross National Income instead (GNI) instead of Gross Domestic Product (GDP) which is the EU standard for comparison. Using GNI makes Ireland's performance look better in comparisons with the rest of the EU, but whichever measure is used, Ireland's social welfare payments, especially pensions, are substantially low compared to many other EU countries, and particularly so if compared to the EU15 states.

Table 3.6 illustrates Ireland's social welfare expenditure compared with that of the rest of the EU (only those countries spending more than Ireland have been included). Overall, total expenditure at 18.2% GDP is comparatively very low – the 8th lowest in the EU. Expenditure on pensions and survivors benefits at 4.5% is much less than half the EU mean (12%) and expenditure on sickness and disability also considerably lower (7.8% compared to 9.6%). Ireland spends the same percentage as the EU mean (0.9%) on housing and social exclusion, and performs slightly better on only one measure, expenditure on family and children (2.5% compared to 2.1%)⁷³.

⁷³ Measuring Ireland's Progress 2007

Table 3.6 Social welfare expenditure by type in the EU

% of GDP

Country	Family/ Children	Unemployment	Sickness and disability	Old age and survivors	Housing & social exclusion	Total expenditure
Sweden	3.0	1.9	12.3	12.5	1.2	32.0
France	2.5	2.2	10.6	13.0	1.3	31.5
Denmark	3.8	2.5	10.3	11.0	1.7	30.1
Belgium	2.0	3.5	9.6	12.7	0.5	29.7
Germany	3.2	2.1	10.0	12.4	0.8	29.4
Austria	3.0	1.6	9.3	13.5	0.4	28.8
Netherlands	1.3	1.5	10.7	11.1	1.6	28.2
EU 27	2.1	1.6	9.6	12.0	0.9	27.2
United Kingdom	1.7	0.7	10.5	11.8	1.7	26.8
Finland	3.0	2.4	10.0	9.6	0.8	26.7
Italy	1.1	0.5	8.3	15.5	0.1	26.4
Greece	1.5	1.2	7.7	12.0	1.1	24.2
Slovenia	2.0	0.7	9.4	10.2	0.7	23.4
Luxembourg	3.6	1.1	8.3	7.9	0.6	21.9
Hungary	2.5	0.6	8.5	9.1	0.7	21.9
Spain	1.1	2.5	7.9	8.4	0.4	20.8
Poland	0.8	0.6	5.8	11.5	0.5	19.6
Czech Republic	1.4	0.7	8.0	7.9	0.6	19.1
Malta	0.9	1.3	6.0	9.5	0.4	18.3
Ireland (% of GDP)	2.5	1.3	7.8	4.5	0.9	18.2

Adapted from Measuring Ireland's Progress 2007

The relative social expenditure on sickness and disability, and pensions and survivors, compared to the EU, might prompt us to ask ‘why is Ireland’s performance so poor?’ and furthermore, ‘do these lower levels of social expenditure lead to increased poverty or loss of wellbeing in older women?’

Table 3.7 gives the risk of poverty rates for selected EU countries before pensions and social transfers, and then maps across illustrating how the risk of poverty decreases after pensions only, and then after pensions together with other social transfers, providing a figure for risk reduction. The figures of most interest are the figures showing the risk of poverty after pensions and transfers.

We can see that in 2006, the percentage of the population at risk of poverty in Ireland, before pensions and social transfers, was 40% compared with 43% in the EU 25. The effect of pensions and social transfers (“risk reduction”) was less in Ireland than in most other EU countries. As a result, the risk of poverty rate in Ireland after pensions and social transfers, at 18%, was greater than the EU 25 figure of 16%, i.e. there was a greater risk of poverty⁷⁴.

Table 3.7: At-risk-of-poverty rates, before and after social transfers in the EU, 2006

% of population

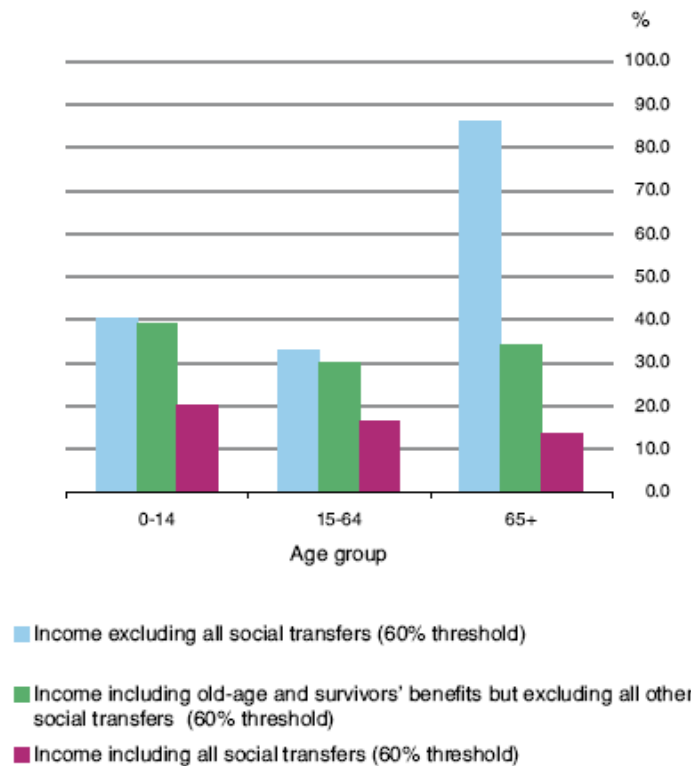
Country	Before pensions and social transfers	After pensions only	After pensions and social transfers	Risk reduction
Czech Republic	39	22	10	29
Netherlands	36	21	10	26
Denmark	37	28	12	25
Slovenia	41	24	12	29
Slovakia	39	20	12	27
Sweden	42	29	12	30
Germany	46	26	13	33
France	44	25	13	31
Austria	43	25	13	30
Finland	41	29	13	28
Bulgaria	41	17	14	27
Luxembourg	40	24	14	26
Malta	34	22	14	20
Belgium	41	27	15	26
Cyprus	29	22	16	13
Hungary	49	30	16	33
EU 25	43	26	16	27
Estonia	38	25	18	20
Ireland	40	33	18	22
Portugal	40	25	18	22
Poland	49	29	19	30
Romania	42	24	19	23
United Kingdom	42	30	19	23

Adapted from Measuring Ireland's Progress 2007

⁷⁴ Measuring Ireland's Progress 2007

The dependence of the over 65 age group on social transfer payments, including pensions, and the dramatic effects on government pension policy on reducing the 'at risk of poverty' rate for older people is shown in Table 3.7 and Figure 3.8.

Figure 3.8 At-risk-of-poverty-rates (60% threshold) classified by age group



EU-SILC 2006

3.3 Carers

Women are the principal care-givers in Ireland and Irish women are three times more likely than men to provide child care and care for ill or elderly adults.⁷⁵

Carers are 'dedicated people at all levels of society who care in the home for older people, people with physical or learning disability and those with long term illness. Their role may involve 24 hours a day, 7 days a week commitment without respite and often very little financial help or emotional support.'⁷⁶ Carers fill a need amongst older people, those who are disabled and ill. A NCAOP report in 2001 found that 12% of older people living in the community need

⁷⁵ Submission to the Department of Social and Family Affairs: National Carer's Strategy (2008)

⁷⁶ Support for Carers in Ireland (2008)

some help with daily tasks such as shopping, transport, personal grooming, and for those people over 80, 43% reported that they had 'much difficulty' or were 'unable' to do housework without help⁷⁷.

In 2006 there were 29,121 people receiving carers payments, a three-fold increase in a little over ten years. Of these, approximately 81% (23,560) were women which included 8,701 women aged between 50 and 64, and 3,436 aged over 65, i.e. 12,137 women aged over 50.⁷⁸ In other words, 42 % of people in receipt of carers allowance in Ireland are women over the age of 50.

However, if we examine the 2006 Census of Population statistics, 160,917 people were described as carers providing unpaid caring help, of whom 100,214 (62%) were women. In the 45-54 age group there were 29,374 women acting as unpaid carers, 17,228 women aged between 55 and 64, and just over 11,000 women over 65 (Table 3.8 and Figure 3.9)⁷⁹.

In total there were 57,611 women carers over 45 which amounts to 58% of all women carers or 36% of the total number of (male and female) carers, and 28,237 women carers over 55 which is 28% of all women carers or 18% of the total number of carers. Women over 65 represent 11% of all women carers and 7% of all carers.

The proportion of older women carers who devoted more than 43 hours per week to care increases with age group, even though the number of carers in the older age groups decline. For example, around 23% of the 29,374 women carers aged 45-54 spent more than 43 hours on care work, about 33%, (one third) of women aged 55-64, and 50%, (half) of women over 65.

Table 3.8 Number of women carers and number of hours of unpaid help per week.

Age Group	No. of Carers	1-14	15-28	29-42	43 or more
45-54 years	29374	17507	3503	1567	6797
55-64 years	17228	8754	1913	953	5608
65 years and over	11009	3945	888	669	5507
Total	57611	30206	6304	3189	17912

Source: CSO 2006 Census Database

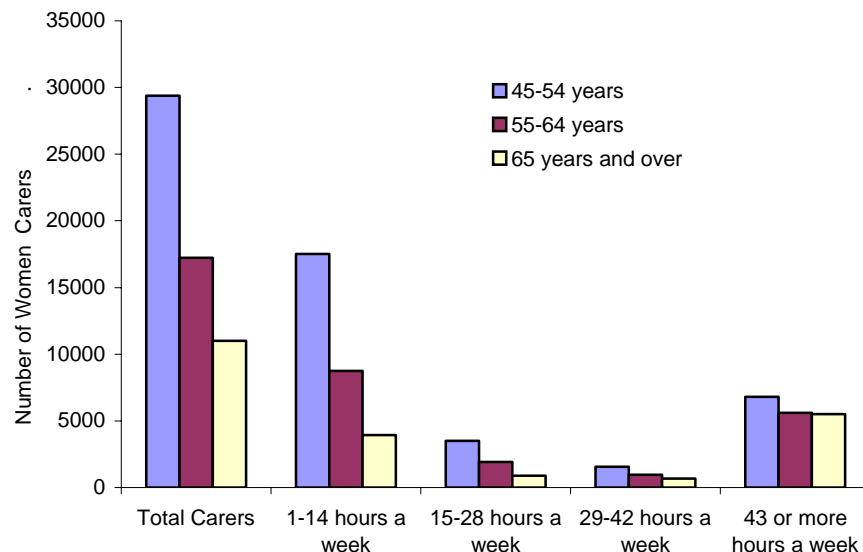
⁷⁷ Carers: Ageing in Ireland Factfile (2001)

⁷⁸ Women and Men in Ireland (2007)

⁷⁹ CSO 2006 Census Database

The contribution to Irish social and economic wealth provided by older women carers (whether or not they are in receipt of a carers allowance) is clearly substantial given the figures above. However, the actual provision of care may be considerably understated given that there is reason to believe that the Census figures underestimate care provision.⁸⁰

Figure 3.9 Number of women carers and number of hours of unpaid help per week.



Providing care for others is often at the expense of the carers' physical and mental health and quality of life. A research report by Care Alliance Ireland⁸¹ on the Health and Well-being of Family Carers in Ireland (October 2008) found that in comparison to the general public, carers suffered from high levels of stress, headaches, lower back pain, anxiety, depression, and tiredness from being constantly on call. 30% of carers reported that caring affected their health and carers overall were less likely to say they were in 'very good' or 'excellent' health. This recent Irish research confirms research on care-givers in UK and internationally.

There is growing concern that carers in Ireland are undervalued, their contribution is unappreciated, and that the personal cost of caring - economically, physically, mentally and emotionally - is very high. As the Carers Strategy Consultation Group points out:

⁸⁰ Carers' Strategy Consultation Group : Submission to the National Carers' Strategy Process (2008)

⁸¹ Health and Well-being of Family Carers in Ireland (2008).

The Family Carer takes on double duty, i.e., additionally being responsible for maintaining the life and quality of life of another. Doing so takes time that is unavailable to the Family Carer for his/her own concerns/interests. By considering opportunity cost only in the context of the paid work environment, we unjustly deny Family Carers their basic right to use their precious, finite, time on this earth for their own purposes.⁸² These concerns have led to a call for legislation to recognise carers. The proposed Carers Act would provide recognition for carers, provide for assessment of the needs of carers and provide resources to meet those needs⁸³.

In an address to the Carers Association National Conference for Family Carers on 13th November 2008, the Minister for Older People said:

“I am very much aware of the invaluable role played by carers and indeed of the many sacrifices they make. The Government is committed to supporting carers, and to ensuring they receive a comprehensive range of services to enable them to continue to care.”

The Minister stated that a National Carers Strategy is being developed by various government departments. It is also receiving submissions from NGO and other public agencies. The outcome of this Strategy and its provisions will be of considerable interest to upwards of 57,000 older women providing care.

Time and trouble will tame an advanced young woman, but an advanced old woman is uncontrollable by any earthly force. Dorothy L. Sayers

⁸² Carers' Strategy Consultation Group : Submission to the National Carers' Strategy Process (2008) p. 3

⁸³ Carers' Strategy Consultation Group : Submission to the National Carers' Strategy Process (2008)

4 Housing

'the core objective of housing policy is to enable every household to have available an affordable dwelling of good quality, suited to its needs, in a good environment and, as far as possible, at the tenure of its choice (Social Partnership Towards 2016 Section 13).'

In order to meet this Social Partnership objective, the National Economic and Social Council (NESC) concluded in its 2004 Housing Report⁸⁴ that an additional 73,000 social housing units would need to be provided in the period 2004 to 2012 in order to bring the overall proportion of social housing up to 12% of the total housing stock. The government planned to increase the total number of social housing units via a variety of means, by 27,000 between 2007 and 2009.

4.1 Housing objectives for older people

One target group for this increase in social affordable housing was to provide for older people. Another target outlined in Towards 2016, specifically directed towards the needs of older people, was to provide resources so that older people would be helped to stay in their own homes if they wished:

*'Every older person would have adequate support to enable them to remain living independently in their own homes for as long as possible. This will involve access to good quality services in the community, including: health, education, transport, housing and security.'*⁸⁵

4.2 Types of Accommodation

Three quarters (74.7%) of all Irish people own their own home⁸⁶ but it is difficult to find disaggregated up to date data to show what proportion of older women own their own home.

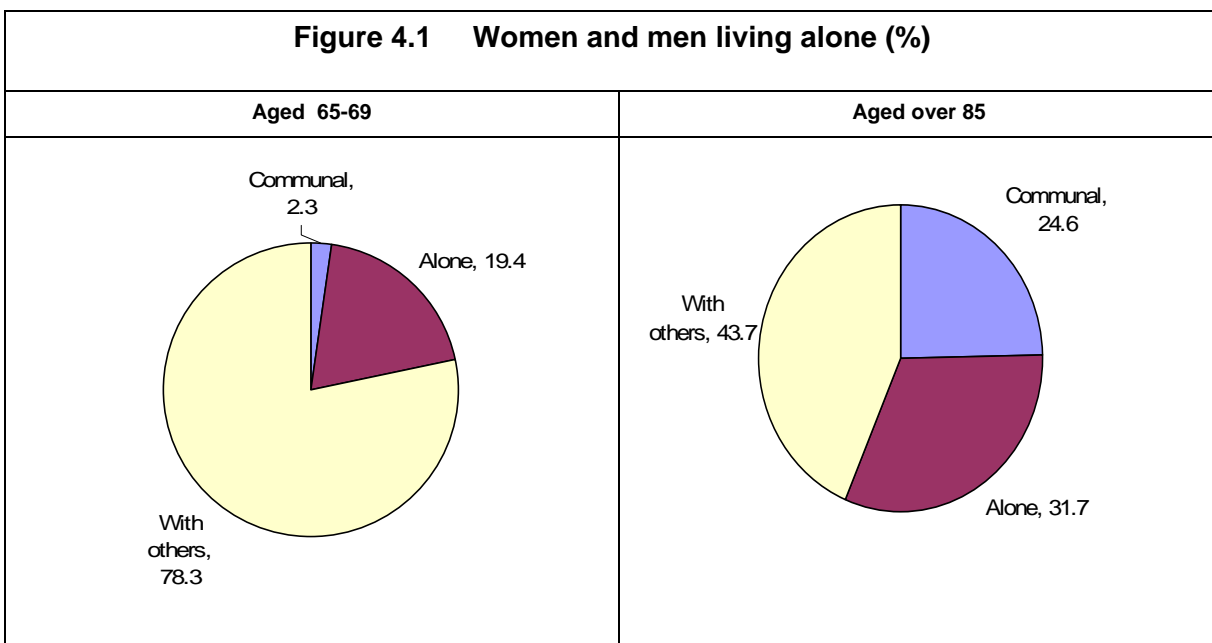
⁸⁴ Housing in Ireland: Performance and Policy (2004)

⁸⁵ Towards 2016, Ten-Year Framework Social Partnership Agreement 2006-2015 (2006) p.61

⁸⁶ CSO Census 2006

Some reports suggest that over 87% of older people own their own homes⁸⁷ but again it is difficult to find recent data which provides an accurate breakdown of the proportion of older women who own their own home.

The 2006 CSO Census indicates that of the nearly 453,000 women and men over the age of 65, two thirds were living with other people, approximately 27% were living alone, and around 7% were living in a communal establishment of some sort.

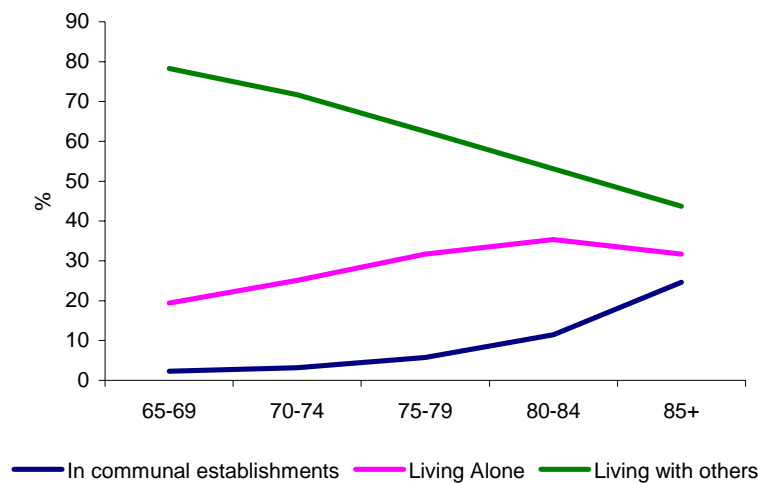


Source CSO Database

A closer look at Figure 4.1 (see also Table A.7 in Appendix) shows that the type of accommodation people in the 65+ age group choose changes as they get older. For example, in the age group 65-69 only 2.3% were living in a communal establishment, but this had increased to nearly a quarter (24.6%) for those people aged 85 and more, and for this 85+ age group almost 1 in 3 (31.7%) were living alone.

⁸⁷ Stratton, 2004

Figure 4.2 The living arrangements of people over 65



Of the 26.7% of people over 65 live who live alone, substantially more of these are women. The difference in the proportion between women and men increases across the age groups, from 12.4% more women living alone in the 65 and over group, to 17.3% in the over 75 age group.

Table 4.1 The proportion of women and men over 65 living on the own

Age Group	% age /group		
	Aged 65 years and over	Aged 70 years and over	Aged 75 years and over
Women	34.3	39.6	44.3
Men	21.9	24.2	27
Difference	12.4	15.4	17.3

4.3 Home ownership

Given the extraordinary rise in house prices since the millennium, it would not be easy for most older women to buy a house outright, and mortgages are difficult to come by for someone over 50. It is likely that most women who do own their own house have had it for a fair number of years and even if the house is relatively new, the owner may not necessarily have the means for adequate maintenance. There is also a tendency for older people's house to be older than the

general housing stock, to suffer from damp, poor insulation and ventilation have structural problems and lack some of the basic facilities normally found in newer stock.⁸⁸

The house must be a healthy environment to live in. There is an incontrovertible link between housing and health so improvements to older people's housing should bring with it an improvement in health and quality of life, with an attendant reduction in the costs of illness to both the person and the state. In addition, ageing brings with it a progressively higher risk of disability, the most pronounced of which is reduced mobility, so the habitation either has to be suitable to accommodate the disability or be adapted to those needs.

We can see from Table 4.1 that there is a steady increase in the proportion of older women living on their own up until about 75 years of age. Figure 4.2 shows a substantial increase in the proportion of both men and women living in communal establishments between 80 and 84 years, and during the same period a marked reduction in people living alone. We also know from Section 2 that around this age in life many women are suffering increasing disability, especially a reduction in mobility. It may well be that these years mark a difficult decision point for women living on their own and considering a variety of possibilities – whether to try to adapt their own home, or move to communal accommodation. This would be a difficult decision for anyone at any time of life and a time at which professional expert advice would be useful. Help the Aged make a similar point on these issues:

'Unsuitable housing can effectively disable older people. Unfit housing can lead to ill-health and depression. Lack of information about housing options can also leave many older people in unsuitable accommodation. Improving access to a range of appropriate housing for older people is therefore a key concern for older people'.⁸⁹

However, most older women want to stay in their own homes for as long as possible, and the policy under Toward 2016 attempts to facilitate them to do this by providing grants and assistance for essential repairs and maintenance, with some provision for upgrading. HSE home care packages are available, targeted at people aged over 65, which include services provided by Public health nurses, Home care attendants, Home helps, Physiotherapists and Occupational therapists.

⁸⁸ Stratton, D (2004) The Housing Needs of Older People.

⁸⁹ Help the Aged Website (2008)

Allowances are available towards offsetting the running cost of living in one's own home for women over 70, and older women on a state pension or receiving a carers allowance. These include electricity, gas, phone (including mobile), television licence, fuel allowance and an additional allowance for those living alone.

4.3.1 Availability of grant schemes⁹⁰

As a result of a recent reshuffle of government departments, two schemes to assist older people to remain in their own homes, the Special Aid for the Elderly and the Special Housing Aid for the Elderly Scheme were combined into the Housing Aid for Older Persons Scheme in November 2007. Means-tested grants for essential repairs are available for older home-owners for:

- structural repairs or improvements
- re-wiring, repair or replacement of windows and doors
- the provision of water, sanitary services and heating
- cleaning and painting
- radon remediation
- re-wiring and any other repair or improvement work considered necessary.

However, the maximum grant available is €10,500 which is unlikely to entirely cover the costs of substantial repairs or improvements.

If an older woman becomes disabled she can also apply to her local authority for a Housing Adaptation Grant or a Mobility Aids Scheme. These grants have also been 'restructured' since 2007 and are means-tested.

If major alterations or improvements are necessary which are not covered by grants and other assistance, there is always the possibility of raising money by releasing equity on the house. This is not a simple process and one that is fraught with the risk of financial exploitation or even abuse. There are many considerations to balance in undertaking this type of venture, concerning life assurance, tax, possible eventual nursing or nursing home costs, and the desire to leave the house unencumbered as a family inheritance.

⁹⁰ Material in this sections from www.hse.ie & www.citizensinformation.ie

While we have information on the grants available for older people and for what, we lack the qualitative information which would tell us the extent to which older people feel informed about these grants, how accessible the grant making procedure is or whether there is support available for people with low levels of education to assist them through the grant giving process. For older women, there may well be the added consideration of how confident they feel about seeking tenders from and recruiting tradespeople (a task which for women of that generation would in the main, have been performed by a male member of the household). Finally, for women and men alike, particularly those living alone, there is the question of whether they feel it is safe to permit a stranger to their home to carry out essential repairs and maintenance and whether they may instead opt to leave the work undone.

Essentially, the availability of the grant programme is only half the story. Further information is required to assess whether that programme is actually improving the quality of the housing stock of older women, particularly that of older women living alone.

For those older women who can get to a Citizens Advice Centre, access the Internet, or find an advocate to assist them by phone or in person the process of applying for a grant can be made easier, but many older women living in more isolated circumstances who do not have this support will be severely disadvantaged. The Housing With Care report suggests that 10% of older people's homes may need repairs or upgrading to allow a good quality of life and maintain independence.

David Stratton comes to the same conclusions in his summing up on the housing needs of older people;

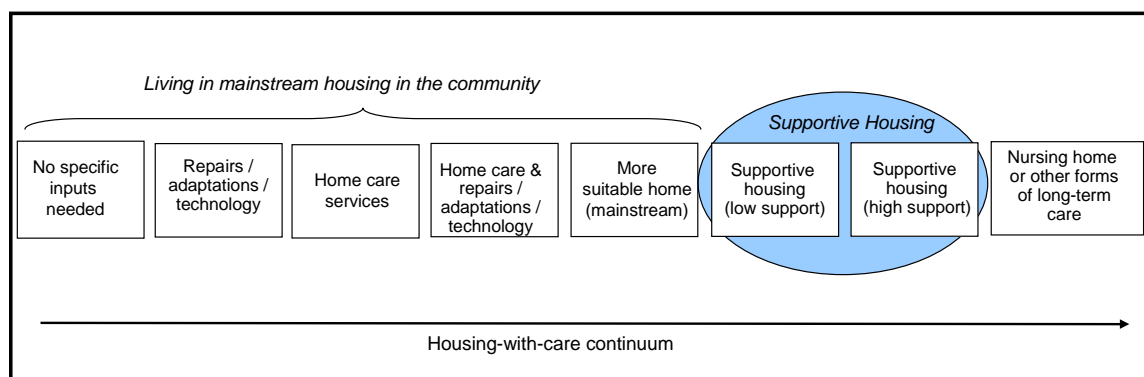
*'without proper provision being made to equip older people with independent advice and information and the skills that they may need to make their voices heard, it will be difficult for them to make informed choices. Support therefore needs to be given for an independent advisory service that will deal with the housing issues of older people.'*⁹¹

There is a wealth of information available on the Internet that would be helpful, particularly through the government's websites www.welfare.ie or www.CitizensInformation.ie, but that raises the problem of lack of access to these resources by many older women. How much of

⁹¹ Stratton, D (2004) p.43

the same information is easily available through other means for older women is unknown. In the UK the organisation 'Elderly Accommodation Counsel' (<http://www.eac.org.uk>) provides a very useful service covering most of the issues outlined above through telephone advice lines or through their advisory website (<http://www.housingcare.org>). The provision of similar services covering the needs of older women and older men in the Republic of Ireland may be required.

Once the decision is made to move out of one's own home, there is a range of options, depending on personal life-style choices, abilities and income. A recent report from the Work Research Centre⁹² provides a useful diagram for a housing-with-care continuum:



Source: *Housing-with-Care: A New Paradigm?*

4.4 Supportive housing – general provision

Supportive housing covers a range of housing types including sheltered housing and housing schemes where older people have independent accommodation often arranged in clusters or 'villages' and catering for different levels of support. The emphasis is on independent living within a social environment providing a range of facilities and amenities to promote a healthy, active and social lifestyle. Support is often provided by locally provided care facilities.

In the UK, many local authorities have provided a relatively high ratio (60 units per 1000 older people) of single-storey bungalows as groups of distinct clustered units within larger public 'council' housing schemes, but as the Housing With Care report notes, a high proportion of these were 'low support'.

⁹² Delaney S, Cullen K & Dolphin C. (2007)

The National Council for Ageing and Older People (NCAOP)⁹³, surveyed the level of supportive housing of this type in Ireland (providing older people with their own accommodation in a supported, affordable cluster). They found 9,232 supportive housing units across Ireland in 419 schemes, a ratio of just under 20 housing units per 1000 older people. 248 units were provided by housing associations within the voluntary sector, and 171 were provided by local authorities, a large proportion of which was in Dublin City (3,330 units). As the NCAOP points out, housing associations were the main or only providers of supportive housing in more than three quarters of the 34 city and county areas in Ireland. The level of provision varied widely throughout the country, many areas much lower than the 20/1000 ratio overall given the high proportion in Dublin City.

Compared with figures available for the rest of the EU (From Cullen et al: not an exhaustive list), Ireland's provision of supportive housing is less than half that of Finland and Norway, one third that of the UK and only a fraction of Sweden's.

Table 4.2 Number of Supportive Housing units per 1000 older people

Country	Units per 1,000 older people
Sweden	71.4
UK	60
Finland	50+
Norway	50
Ireland	20
Czech Republic	18
France	16-20
Germany	16

Adapted from Cullen et al 2007

Cullen et al's survey of the housing association schemes in Ireland showed that 71% had communal facilities, with about 2/3 (64%) having social facilities such as TV or living rooms and day centres. 37% had a dining room with communal meals, and 15% of schemes had communal laundry facilities. 60% provided alarm facilities, half of which were systems linked to resident staff, and half linked to an external centre. Overall, the level of care varied quite widely.

⁹³ Delaney S, Cullen K & Dolphin C. (2007)

4.4.1 Supportive housing and older women

The demand for supportive housing by older women is difficult to assess. Cullen et al assessed the demand for supportive housing at the time of the research to be 3000 older people but did not give the gender composition. We may assume that it would be at least 50% of this figure given the overall gender statistics for older people, that is, at least 1,500 older women looking for supportive housing. Further research on the extent of need/demand by older women is required as is research on particular requirements of older women. Are there greater or different needs in terms of safety or perceived safety, availability and support of active age or other types of community group (women comprise a high proportion of the membership of such groups)?

There is clearly also a need for integrated policy decisions on the provision of supportive housing and care in a general sense:

- There is no obvious government policy on the provision of supportive housing.
- There is no clear departmental responsibility for supportive housing.
- There is no 'yardstick' for the ratio of provision (e.g. 60 per 1000 older people).
- The roles of housing association, local authorities and care providers needs to be clarified.
- Supportive housing should be equitably provided across Ireland.

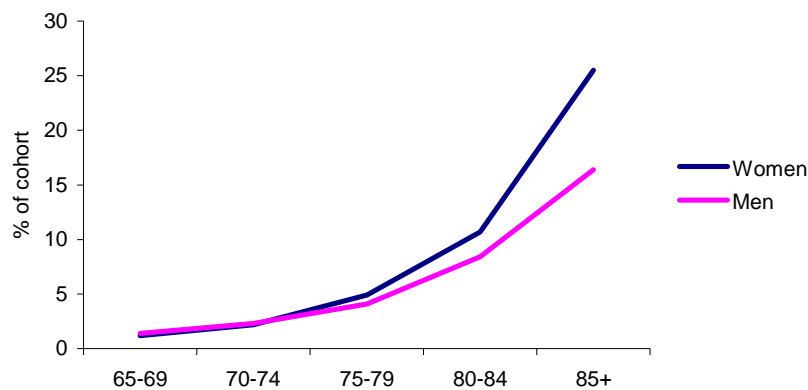
4.5 Communal living

The CSO definition of 'communal establishment' is surprisingly wide and defined as people living in 'a boarding house, hotel, guest house, hostel, barrack, hospital, nursing home, boarding school, religious institution, welfare institution, prison or ship'. The census data collapses these categories so it is very difficult to assess how many older women are living in different types of communal establishments, with the exception of nursing homes and hospitals where some data is available from the CSO and other sources.

4.6 Nursing Homes and hospitals

The proportion of women and of men in nursing homes and hospitals is roughly equal in the 65-69 age group, but by over 85 only 16.4% of men were in residential care compared with 26.5% of women⁹⁴. What this means is that more 1 in 4 women aged 85 and over were in residential care.

Figure 4.3: The percentage of women and men in nursing homes and hospitals



Source: CSO Database

I have enjoyed greatly the second blooming that comes when you finish the life of the emotions and of personal relations; and suddenly find - at the age of fifty, say - that a whole new life has opened before you, filled with things you can think about, study, or read about...It is as if a fresh sap of ideas and thoughts was rising in you.

Agatha Christie

⁹⁴ CSO Database

5 Access to Transport and Information

‘Accessibility of transport for older people is vital in terms of accessing health and other services, social networks and remaining active.’

Towards 2016⁹⁵

5.1 Transport provision – getting around

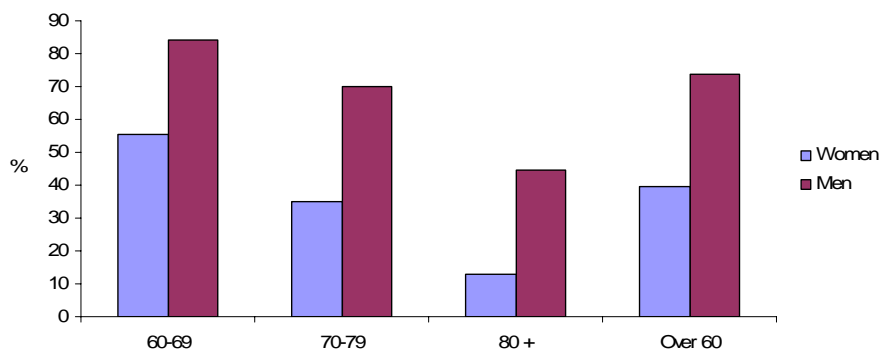
The provision of adequate transport for older people was made a priority under the Social Partnership Agreement and reaffirmed as a priority in 2007. Having some way of getting around is accepted as being essential for having a good quality of life, for shopping, socialising, meeting family and friends, taking part in community and voluntary activities, personal development and for many other reasons. In this section we will assess what means of transport older women might have at their disposal, and then look at some of the activities for which transport is essential, in particular, participating in family and community life - in voluntary work and as carers, personal development and to participation in further education.

5.1.1 Older women and personal transport

For most adults, access to independent transport is important to a perceived good quality of life. Although having a driving licence is a fairly necessary prerequisite, fewer than 40% of women over 60 own one. Only about 55% of women aged between 60 and 69 hold a full drivers licence, around 35% of those between 70 and 79, but for the over 80's age group, only 13% of women are licenced to drive a car. More than three times the number (45%) of men in this age group hold a driving licence and a far greater proportion of men in all age groups hold one. There was a small but steady increase in the percentage of older women in all age groups holding a driving licence between 2004 and 2006 (Figure 5.1 and Table A.8 in Appendix).

⁹⁵ Towards 2016, Section 4: Ensuring Mobility for Older People p.64

Figure 5.1 Percentage of people aged 60 and over holding a full driver's licence 2006



Source: Ageing in Ireland 2007

It is clear that women are significantly disadvantaged when it comes to driving a car because of the low ownership of a licence to drive one. The nature and extent of this disadvantage should be considered in light of the facts that:

- 31.7% of women aged 65 and over live alone⁹⁶ and
- 22% of women aged 55-64, 21.4% of women aged 65-69 live alone
- 14.5% of women aged over 65 are engaged in voluntary work
- 4.2% of women aged 65 and over are still at work full-time⁹⁷

Owning and running a car, however, is a very costly business and likely to be progressively and disproportionately more so in the future. For many older women the costs may be prohibitively expensive regardless of the availability of a driving licence.

In June 2008, the Automobile Association of Ireland estimated that a new small car would cost around €11,800 with operating costs of about 17c per kilometre (based on 130c per litre of petrol). Standing charges, (depreciation, garaging, interest on capital, insurance and so on) were estimated at around €7,000 per annum.⁹⁸

⁹⁶ Ageing in Ireland 2007

⁹⁷ Ageing in Ireland 2007

⁹⁸ http://www.aaireland.ie/infodesk/cost_of_motoring.asp

5.1.2 Older women travelling by public transport

Because older women are significantly disadvantaged when it comes to driving a car to get where they want, they are much more likely to be dependent on public transport. The provision of a good quality, affordable, and frequent public transport service is therefore essential for older women, and particularly rural older women, to get to work (paid or voluntary), meet friends and family, have a reasonable social life and avail themselves of all the opportunities life offers. A public transport system of this description is very rare, and exists only in some cities in Ireland, if at all. So, what does the public transport system offer to older women?

National bus, train and ferry services

Women and men aged 66 and over qualify for a free travel pass for most CIE bus and train services on local and national routes, air services for inhabitants of some islands, and free bus travel with some private operators. The free travel pass is also available to partner or spouse, companion or carer with some restrictions, and under some conditions for women under 66.⁹⁹

For most rural women, transport services offered by CIE and others are often not 'local' enough. City-to-city and (large) town-to-town services are available with some intermediate stops, but for rural women who do not have the means to either drive or afford a car, one big problem is how to get to the bus stop which can often involve a distance of many miles.

Local bus services

Bus Éireann Local Bus Services cover many of the towns and large villages, but many routes are 'summer only' leaving many rural women bereft of transport during the winter months. Unfortunately, some services essential for older rural women (and others) have been withdrawn because they are not commercially viable and government subsidy has not been available.

The Rural Transport Plan (RTP)

The RTP (formerly The Rural Transport Initiative) arose from a commitment under the National Development Plan 2000-2006 to: *'encourage innovative community based initiatives to provide public transport services in rural areas with a view to addressing social exclusion in rural Ireland caused by lack of access to transport'*.

⁹⁹ Department of Social and Family Affairs: <http://www.welfare.ie/publications/sw40.html>

The objective of the RTP is 'To provide a quality nationwide community based public transport system in rural Ireland which responds to local needs'. There are currently (November 2008) 34 RTP projects, fairly evenly distributed across the 26 counties, using four different models of operation.

Each project differs in what it provides but each is aimed at benefiting the community at large. Women holding a travel pass travel free of charge on RTP services, and the cost for others is reasonable. For example, Waterford Deise Link Community Transport is aimed at '*assisting people with the highest unmet transport needs particularly older people, people with disabilities, people on home duties (and young people).*' Door-to-door transport with a semi-flexible transport service is available where the bus can divert off route if necessary to accommodate passengers' needs is available. Adult fares for those who have to pay is €5 return (November 2008)¹⁰⁰.

No gender or age disaggregated data has been located to describe the use and / or problems with use of the RTI.

5.2 Transport to participate in the community

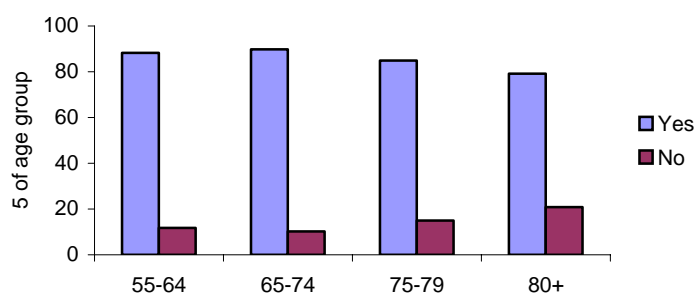
5.2.1 Transport and voting

In the May 2002 general election, 86.3% of persons aged 65 & over who were eligible to vote actually voted. The highest proportion of the older age groups that voted was the 65-74 (89.8%) and the lowest, at 79.2%, was persons aged 80 and over. This was in all cases significantly higher than the turnout of people aged 18-64.¹⁰¹ Among the main reasons given as to why people aged 65 & over did not vote was due to illness and disability (43.4%) and lack of transport (9.4%).

¹⁰⁰ <http://www.deiselink.ie/>

¹⁰¹ Ageing in Ireland 2007

Figure 5.2 Percentage of older people voting in the General Election



Source: Ageing in Ireland 2007

This information is not gender disaggregated, so we cannot tell what proportion were women. However, it would be reasonable to assume that at least half were, which gives us a sizeable proportion of older women who didn't vote, and were unable to do so because of lack of transport. Further research is needed to ascertain what proportion of the ill/disabled older women were disenfranchised through means that could have been prevented – by lack of transport or lack of assistance with postal voting. There are important issues here for equality of access to participate in one of the most important features of a democracy – voting in elections and referenda.

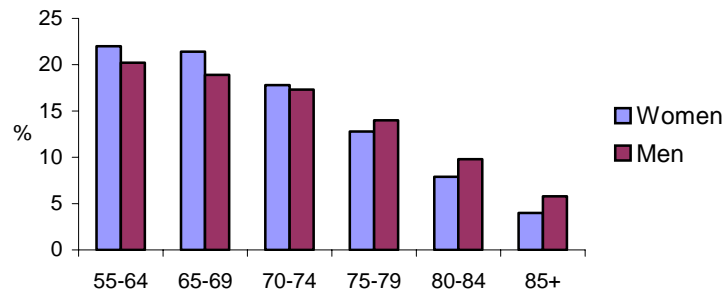
5.2.2 Transport and voluntary work

Around 15% of older women took part in voluntary work in 2006. More than 1 in 5 (22%) of 55-64 year olds did voluntary work and this dropped only fractionally for women aged 65-69 (21.4%). More than 1 in 6 (17.8%) older women between 70 and 74 were involved in voluntary activities, decreasing to about 1 in 8 (12.8%) of women aged 80 to 84 and at this time there was still 4% of women aged over 85 involved in voluntary work.¹⁰² We have no way of knowing if the proportions would have been greater with better provision of transport.

Broadly speaking, about the same proportion of older men took part, fewer up to 75 and more thereafter, but the type of voluntary work differed in some respects between women and men.

¹⁰² Ageing in Ireland 2007

Figure 5.3 Women and men aged 65 and over involved in voluntary work (%), 2006



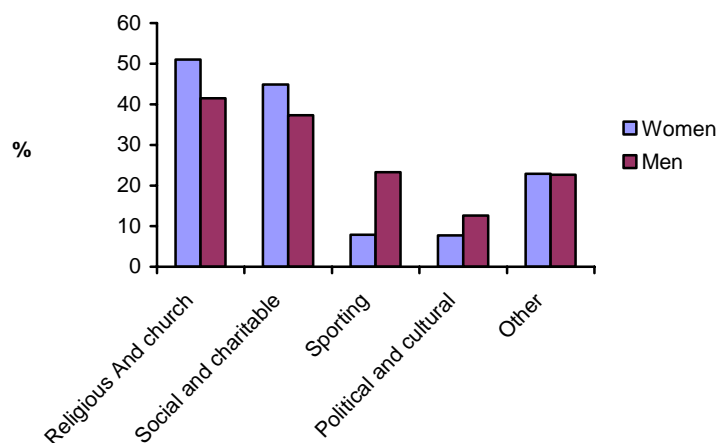
Source: Ageing in Ireland 2007

The above are percentages of women and men engaged in voluntary work, however the types of voluntary work pursued by women and men were different (Figure 5.3). More than half of older women over 65 were engaged in voluntary work associated with a church or religious group, and about 45% were doing social and charitable voluntary work (see Table A.9 in Appendix). A much smaller proportion were engaged in sporting (7.9%) or political and cultural (7.7%) voluntary work, however more than 1 in 5 were involved in 'other' work for which we don't have any further information.

The two big gender differences were that over 23% of older men were involved in sporting voluntary work compared to about 8% of women and 12.6% in political and cultural work compared with 7.7% of older women¹⁰³. Unfortunately the figures are not disaggregated by gender and age group so we are unable to determine what proportions of women in each age group were involved in the different areas of voluntary activity.

¹⁰³ Ageing in Ireland 2007

Figure 5.4 Women and men aged 65 by type of voluntary work (%), 2006



Source: Ageing in Ireland 2007

5.3 Transport and personal development for older women

5.3.1 Education level of people over 65

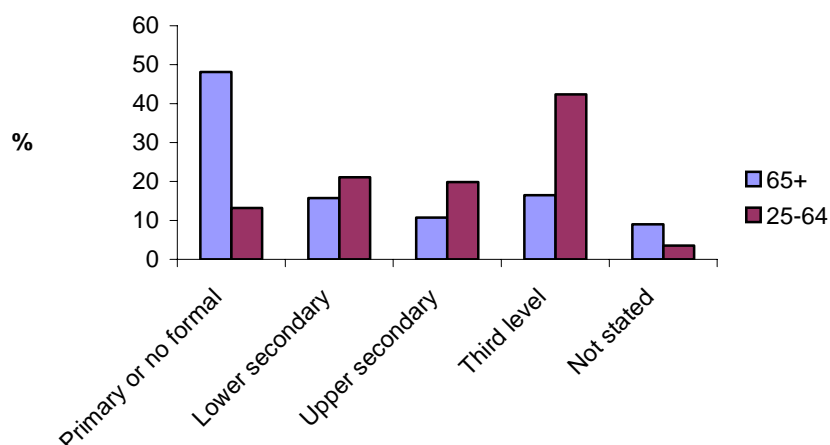
In 2007, nearly half of the men and women over 65 have had relatively little formal education compared with younger age groups (Table 5.1 and Figure 5.5). Over 48% of people over 65 only received formal education to primary level, over 50% of people aged over 75. This data is not gender disaggregated so it is difficult to assess what the proportion of older women might be.

Table 5.1 People aged 65 and over by level of educational attainment, 2006

Age group	% age group				
	Primary or no formal	Lower secondary	Upper secondary	Third level	Not stated
65-69	43.1	17.8	11.7	20.5	6.9
70-74	47.5	16.3	11	17.4	7.9
75-79	51	15	10.1	14.6	9.3
80-84	52.8	13.7	9.8	12.8	10.9
85+	52.7	12.1	8.9	11.4	15
65+	48.1	15.7	10.7	16.5	9
25-64	13.2	21.1	19.8	42.4	3.5

Source: Ageing in Ireland 2007

Figure 5.5 Level of education for people aged over 65 with those aged 25-64



5.3.2 Lifelong learning and continuing education

The Irish government's commitments, included in the social partnership agreement is to provide equal access education for all. One central strand of this is the ability to participate in the social fabric and to do this older women have to cope with the increasing plethora of information, bureaucracy, enquiries, forms to be filled in and so on. Having a relatively low level of education is a serious disadvantage in this 'information age'.

For those older women who wish to continue their education, want to undertake other forms of self-improvement, or to develop new skills for enhancing their employment prospects, there is a range of courses offered by the state, local government and voluntary organisations in community centres and colleges.

One such opportunity is provided under the Back To Education Initiative (BTEI)¹⁰⁴ The overall objectives of the BTEI are:

- To increase the participation of young people and adults with less than upper secondary education in a range of flexible learning opportunities, and to do this through learner

¹⁰⁴ Back to Education Initiative (BTEI) www.education.ie

centeredness, equality, accessibility and inclusiveness, recognising and accommodating diversity, innovation, local consultation and quality assurance.

- A priority to target the individuals and groups that experience particular and acute barriers to participation in education and are more difficult to engage in the formal learning process.

These objectives dovetail well into the needs and wants of many older women. The courses are generally free for women over 65, or older women with a medical card or receiving social welfare payments. In 2005, 22,000 participants took part in BTEI courses, of which 75% were women, reflecting a steady increase in the numbers of women participating. Age disaggregated data to provide us with the number of older women taking part is not available.

However, there are several barriers to participation in the BTEI and other vocational, educational or personal development courses:

- Lack of transport and
- Awareness that such opportunities are available.

Access to information is vital for full participation in modern Ireland, and the means of information delivery for a very large proportion of information sources is becoming more and more concentrated on the Internet.

The next section outlines some factors which bear on older women's access to information through the Internet and looks at the way older women may be disadvantaged with respect to information access. It also suggests possible solutions.

5.4 Older women and information access: confronting the 'digital divide'

'The European Commission has identified that Information and Communications Technology (ICT) is an important means of fostering inclusion, better public services and improved quality of life for European citizens (European Commission 2005b). In particular, its focus has been on ICT use and access for people who are disadvantaged due to age, gender, disability and limited resources or education, as well as those living in less favoured areas (European Commission 2005b). This development, known as 'e-inclusion', aims to give these social groupings, which are most at risk of exclusion from

*ICT, the opportunity to use the Internet to improve their quality of life and employment opportunities, and to contribute to a knowledge-based society.'*¹⁰⁵

There are key times when older people need greater than normal access to information - when they are placed under great stress and need help and assistance. These are times of transition when significant factors in a person's life change dramatically. A 2004 paper from the National Council on Ageing and Older People¹⁰⁶ looked specifically at the information needs of older people during the four 'transition' times that many older people are likely to face during:

- retirement or reaching pension age
- onset of illness or disability
- moving from home for increased care or
- bereavement.

What older women need most at these times, apart from human comfort, is to know how to improve their situation, and to do this the most important factor is access to information. One of the themes that emerged from a recent conference was that although many older people prefer printed materials or face-to-face interviews with professionals to get their information (available through Citizens Information Centres and other sources) there was an increasing tendency for older people to use, or want to use, computers and the Internet to both access information and use email for communication. This raises further issues concerning teaching the necessary skills in a way tailored towards the specific needs of older people, and the provision of computers and Internet connection.

5.4.1 Accessing health information on the Internet

Most of the information in this section is not disaggregated in a way which enables us to identify the particular issues for older women. The information sources provide data either on older people or women in general. Therefore, the particular interests of older women can only be inferred.

¹⁰⁵ Internet use and seeking health information online in Ireland (2008)

¹⁰⁶ Meeting the Health, Social Care and Welfare Services Information Needs of Older People in Ireland (2004)

A Health Research Board study was produced in 2008 on demographic and other characteristics of Internet use. The report concludes that the findings:

'have important implications for the areas of e-inclusion and health services. The findings suggest that there is a need to develop community initiatives aimed at reducing the digital divide especially targeted at older people, those not in employment and those with physical or mental health problems'.

It further states:

*'The lack of access to or inability to use information technology will result in exclusion from the information society, which may have negative implications at both an individual and at a societal level. Furthermore, the use of the Internet as a source of health information has increased over the years with people now using the Internet to research health (e.g. treatment options, medical procedures, disease/wellness information) or as a means of self-care and information (e.g. health risk assessment, support groups, clinicians advice).'*¹⁰⁷

5.4.2 Accessing social welfare information and Irish government departments

The Citizens Information Board, which replaced Comhairle in 2007, was charged with responsibility to promote accessibility to, and disseminate information about, social services, and statutory and voluntary organisations.

In its Strategic Plan it states that although *'certain groups in society will always require access to information, advice and advocacy through phone and face-to face-contacts ... Public demand and eGovernment policies will continue to require that the organisation focus on the provision of information electronically.'*¹⁰⁸

What all this means in a nutshell is that the government body given responsibility to disseminate information on social welfare and services will do so primarily through the Internet via the Citizens Information website. This is an Irish eGovernment website provided by the Citizens Information Board. It can be read online in English, Irish, Polish, Romanian and French

¹⁰⁷ Internet use and seeking health information online in Ireland (2008)

¹⁰⁸ Citizens Information Strategic Plan 2006-2009 (2006)

(<http://www.citizensinformation.ie/categories>). The website also provides contact details for a drop-in network of 250 Citizen's Information Centres (CICs) spread throughout the country, many of which also provide on-line information via their individual websites. Each county has a large CIC, or key centre, that is usually open five days per week during normal office hours and many part-time or outreach centres to bring the service to people locally.

5.4.3 Home computer use and the Internet

For both women and men there has been a steady upward trend since the millennium in household computer ownership and connection to the Internet. Up until 2004 more men owned computers than women, but after 2004 this trend reversed with more women than men owning computers and having access to the Internet.

In 2007, two out of three (66%) households with a woman as the reference person owned a home computer and nearly 58% of households headed by a woman had Internet access¹⁰⁹.

For households where the reference person was in the 55-64 and 65-74 age groups, computer ownership and Internet access increased considerably in the years 2000-2007.

Table 5.2 Reference person of households with a home computer and access to the Internet

	% households	
	Home Computer	Internet Access
Men	64.7	55.8
Women	66.0	57.5
45-54	75.6	68.1
55-64	57.4	50.1
65-74	34.2	28.1

Source: Information Technology and Telecommunications 2007 (2008)

Note that these figures can only be taken as 'indicative' as they are based on the 'reference person' in the survey, which doesn't necessarily mean that the reference person is the person who uses the computer or has access to the Internet.

¹⁰⁹ Information Technology and Telecommunications 2007 (2008)

Table 5.3 Percentage of people who have used a computer or the Internet

	<i>% people using</i>	
	Computer	Internet
Men	58.6	54.0
Women	62.8	55.7
45-54	58.0	50.1
55-64	38.2	30.6
65-74	25.9	18.0

Source: Information Technology and Telecommunications 2007 (2008)

If we look at the figures for those people who say they have used a computer or the Internet, irrespective of whether they are the reference person in the household, then a different pattern of use emerges. Comparing the two tables, all the usage figures are lower, but this is particularly marked for the older age groups and increase with age, so although, for example, about 28% of households headed by someone 65-74 have Internet access, only 18% of this age group have actually used the computer for this purpose¹¹⁰. This suggests that the use of this technology for accessing information is not being fully utilized even where it is present in the house.

There is no gender / age group disaggregated data – it is not possible to determine from these figures the percentage of, for example ‘women 65-74 owning a computer with access to the internet’, but such figures would be useful to determine the proportion of older women who might be able to access government, social welfare or other information sources this way.

5.4.4 Technophobia

Women over the age of 65 tend to have had a lower level of formal education than younger women and men (5.3.1 above). At the time of primary education for many women over 65, computers hadn’t even been invented. In contrast, most of the younger age group (25-35) would have ‘grown up’ with computers as part of their educational and social milieu even if they didn’t own one.

¹¹⁰ Information Technology and Telecommunications 2007 (2008)

This lack of familiarity with, and lack of knowledge about, computers and the Internet, may dissuade some people, especially older women, from considering their use and create barriers to learning resulting in a form of ‘technophobia.’

A study by Hogan (2005)¹¹¹ examined the level of technophobia taking gender, computer experience, age and level of education attained into account. Women were found to have higher levels of technophobia than men. Negative thoughts and feelings towards computers led to higher levels of technophobia and older adults were found to have higher levels than students. Older women also had higher levels of anxiety than young female students.

5.4.5 Learning and Training

Clearly, learning a little about computers and how to use the Internet are an essential prerequisite to accessing information online. A report¹¹² on ‘Enhancing Older People’s Capacities to Access Information in the Computer Age’ provided a list of recommendations to promote older people’s use of the Internet:

- Free or affordable computer training is essential and should be made widely available through community groups, Vocational Education Committees (VEC’s), libraries and adult education centres.
- Most older people learn best when taught by a patient member of their own peer group.
- Older learners must feel at ease for basic IT skills training. Patience and empathy with the learner is essential to boost their confidence and encourage continued learning.
- The use of jargon must be avoided and training given in a language that is fully comprehensible to the older learner.
- One-to-one learning is most effective.
- People with disabilities should be specially catered for. Those who provide computer training for older people should be aware of their particular needs.
- The danger of social isolation through computer use should be countered by encouraging people to access computers through community groups, libraries or other centres where there is the possibility of interaction with others.

¹¹¹ Hogan M (2005). Technophobia Amongst Older Adults in Ireland.

¹¹² Carey P. & Gavin J. (2004)

- Considerable effort should be made to encourage older learners with initiatives at a local level such as those provided by public libraries or funded by CAIT.
- A mobile training facility for rural areas and communities in which there is low library usage, could raise awareness about information technology.
- Provision of reconditioned or recycled computers is vital in helping to make technology accessible and affordable for older users.

5.4.6 Trends in Use & Access

The 2007 Census data from the CSO showing the steady rise in home computer use and Internet connection suggests that there is a growing interest and investment in information technology by both older people and by women (we can therefore infer this includes a large proportion of older women).

There has been a similar rise in the uptake of Information and Communication Technology (ICT) courses by women. Through the BTEI, The Department of Education and Science provides funding for ICT courses for adult learners. Older people are a priority target group in BTEI. In 2007 over 5,000 participants on BTEI programmes were aged 55 years or over. This represented 20.6% of all BTEI participants. Of the 20.6%, 7.9% were aged over 65 years. The interest among older Irish learners in ICT could be attributed to the same factors motivating older learners in the UK to take up these technologies.

“It is no surprise that computer skills are so popular for older people. The physical distance they have from family and friends is critically important to overcome and getting to grips with ICT helps to reduce isolation, quite apart from satisfying a desire to keep an eye on the latest developments.”¹¹³

5.4.7 Older people using the Internet for political lobbying: The Medical Cards Crisis

Free Medical cards for the over 70's had been available by right in Ireland since July 2001, and available to others with various restrictions. However, in the 14th October Budget, 2008 (Budget 2009), a system of means-testing was proposed which would have resulted in a significant proportion (estimated at 125,000) of older women and men losing this right to free medical care.

¹¹³ Don't Stop Me Now (2008)

Outcry against this proposal was swift and angry from all quarters of Irish society and most political parties, not least from the people most affected by the proposal – the over 70's.

A protest rally was organised in Dublin on 22nd October by The Irish Senior Citizens' Parliament¹¹⁴ amongst others. An estimated 15,000 older women and men travelled from all over Ireland to attend the demonstration outside Leinster House and berated the Minister for Older People who addressed the meeting. This was one of the largest and angriest demonstrations in Dublin in recent times, but what most surprised Government Ministers was that so many older people could be organised and mobilised so quickly to be in a particular place at a particular time. The Irish Senior Citizens' Parliament led the way through its very state-of-the-art website containing RSS feeds, Blogs, Podcasts, an Epolling facility and well-organised information both on the Budget proposals and the rally itself. A wide range of other websites repeated the call (too many to list here), but including AgeAction Ireland, The Organisation of National Ex-Service Men and Women, The Friends of The Elderly, many Churches, Trades Unions and Voluntary Organisations.

This protest combined with intensive lobbying resulted in the Government overturning its initial decision.

The extent to which internet coverage informed people about the rally and the part played by internet resources in its success has yet to be researched. However, what is evident is that these resources were available and they have demonstrated that they offer an additional pathway which enables older women to collectively and individually lobby government and agencies.

To be seventy years young is sometimes for more cheerful and hopeful than to be forty years old. Oliver Wendell Holmes

¹¹⁴ <http://iscp.wordpress.com/over-70-medical-card-crisis/>

6 Conclusions and Recommendations

6.1 General

- The ability to advocate effectively on behalf of any sector in society is to a large extent dependent on the availability of accurate statistical information as evidence to support one's case. In the case of older women, this availability of statistical information is limited on two fronts. Firstly, in many cases statistics are not gender disaggregated so we only have information on older people as a generic category. Secondly, information which is gender disaggregated is frequently not broken down on an age basis so again the statistics are limited in value. In some instances, where age-specific information is available, broad categorisations such as over 65s, over 75s, over 80s, etc. are used. People within these categories are therefore assessed as one homogenous group. This implies that the needs and conditions of someone aged 76 for instance is the same as someone aged 99. This is highly unlikely to be the case. There is also an uncomfortable, implicit dismissal in people being categorised on this basis, as being 'over' a certain age and even though the age gap could be 20-30 years, it is not considered worthy of specific analysis.

This report recommends that all statistics are gathered, collated and stored in a way which permits analysis on the basis of age and gender. Furthermore, there is a need for consistency across all agencies, organisations and research bodies to work from agreed age bands in relation to older people. These need to be consistent with EU and UN measures. In the absence of this consistency, comparison is difficult if not impossible.

6.2 Health

- There are very high rates of cardio vascular disease (strokes and heart attacks) among older women. Older Irish women have the 2nd highest rate of ischaemic heart disease of all women in the EU. In response to this, there is considerable under-funding from the Government and a Government failure to live up to its promises under the Cardio-vascular Health Strategy (1999). This needs to be rectified. These commitments are in response to a very real need and a major cause of illness and death amongst older women. The commitments should be honoured. There is also a need for further research on two issues, namely older women and incidents of heart disease and stroke and secondly, risk recognition in both of these areas.

- Also in relation to cardio-vascular disease there is a need for investment in public awareness and education on the extent to which older women are at risk from both heart attack and stroke. The current mis-perception that middle aged men are most at risk needs to be altered.
- It has been assumed that the enormous body of research on CVD in men would transfer easily and apply equally well to older women. However, it is becoming clear that this is not the case. Factors such as differences in cholesterol levels, the interaction between female hormone levels and cholesterol, the effects of different HRT medication and the ways in which these might contribute to CVD need a considerable degree of further research. Other factors such as differences in older women's lifestyle, metabolism in general and how this might affect the appropriate type and level of prescription for blood pressure medication all need further research.
- 54% of cancers in all women in Ireland occur over the age of 65. The number of women over 65 in the Irish population will double between now and 2030. Of all cancers, breast cancer has both the highest rate of incidents and is the biggest all cancer killers amongst Irish women. It is the 2nd highest cause of death of women living in Ireland. The average age of diagnosis for breast cancer is 59. The average age of death is 66. There are recognisable treatment differences for cancer between younger and older women suffering from all forms of cancer. The Government run Breast-screening programme is inadequately funded. As it has been rolled out, it actively discriminates against women in some parts of the country, namely women in the north-west, parts of the south and parts of the west. Despite breast cancer being the 2nd highest cause of death of women in Ireland and being preventable if detected at a sufficiently early stage, women in some parts of Ireland have never been screened – 8 years after women were first screened in Dublin.
- Cervical cancer is the 9th most frequently diagnosed cancer among women in Ireland and the 12th most common cause of cancer related death amongst all women. The average age of death is 56 years and mortality increases with age. The highest number of deaths as a result of cervical cancer occur in the 75-79 age group. However, despite this, nationwide screening has only just been introduced (Sept 2008). It was initially launched in 2000 in the geographical area covered by the then Mid Western Health Board on a test basis. Given

the fact that it has just been launched, there is no information on its progress. However, it is critical for older women that this screening programme is implemented on a national basis and does not become a victim of Government health cuts.

- Both cervical and breast cancers are amongst the most preventable cancers in women and their highest incidence is in older women. Any removal or selective implementation of screening programmes in relation to either of these cancers will directly discriminate against older women.
- Preventative examinations for women in Ireland are considerably lower than in other countries in the EU for all types of treatment. This includes gynaecological examinations, osteoporosis, etc.
- Older women suffering breast cancer were more likely than younger women to receive hormone therapy, but less likely to have surgery, chemotherapy or radiation therapy. Disease progression tends to be more advanced in older women. Decisions on type of treatment and duration may appropriately include considerations of age and gender and even discriminate on that basis, but only where the scientific and medical evidence supports the discrimination in terms of effective treatment outcome. Judgments based solely on belief or common practice may turn out to be discriminatory and counter to medical good practice. Research is clearly required to establish whether discriminatory practice is taking place and if so, non-discriminatory guidelines for cancer treatment in older women should be developed.
- Older women experience a higher rate of accidental injury, especially falls, than older men. A high proportion of these may be due to osteoporosis, for which many countries in the world have programmes for early diagnosis. There is a need for further HSE investment in preventative treatment for osteoporosis.
- The proportion of women suffering disabilities increases substantially after the age of 70. This affects mobility in particular. A survey of need for mobility aids (and their subsequent provision) amongst older women would therefore be useful.

- A high quality mental health service provision for older women is essential if the promises of the Social Partnership are to be kept. Implementation of Vision for Change will go part of the way to ensuring such a provision. The lack of gender-disaggregated statistics referred to above and the consequences in terms of policy implementation is acutely noticed here: despite the fact that a large number of people over 65 suffer mental health problems, there are very few, if any gender disaggregated statistics, to aid policy development and monitoring.

6.3 Income / Employment / Risk of Poverty

- There is an employment gap between women and men for all older age bands (the rate of male employment as against the rate of female employment). This is 16.2% in the 45-54 age bracket, 26.6% between 55-64 and this rises to 46.6% in the over-65 age group. This obviously has consequences in terms of lower rates of income, a high financial dependency on spouses or state benefit and is likely to be a major factor contributing to the relatively high percentage of women at risk of poverty over 65 (1 in 7).
- The way in which the CSO has gathered statistics in relation to where women are placed in employment gives us insufficient information to ascertain comparative income levels between women and men, their access to decision making positions in employment or an indication of whether women progress upwards in terms of grades of employment as they grow older. We do not know for instance if there is a glass ceiling in age terms and we do not know if older women are more or less likely to either seek promotion or be promoted as they grow older. There is a need for further research in this area. This should examine the various categories of women and men's employment on an age disaggregated basis, provide detailed information on the levels and grades of employment and outline progression between these grades. This would provide us with a more accurate picture of older women's employment status. This information would usefully be supplemented by qualitative research both amongst older women and employers to ascertain attitudes to older women in the workplace and their expectations and potential for career progression.
- Nearly 14% of women (1 in 7) over the age of 65 in Ireland are at risk of income poverty. A high proportion of women over 65 are in receipt of a non-contributory (as opposed to a contributory) pension which provides them with a reduced income and a dependence on

state benefits. Ireland social welfare spend, especially that on old age pensions, is very low compared with the rest of the EU. Ireland's pension spend is 4.5% of GDP versus the EU27 average of 12%.

6.4 Housing

- Housing is one of those areas for which there is insufficient information on women and men to develop comprehensive analyses. There are for instance no significant statistics on the proportion of women living in communal living or supportive housing.
- There is significant provision (in the form of grants programmes) as a result of the social partnership agreement to assist women (and men) who own their own homes to remain there should they chose to do so. However, there is a lack of information on the level of need and consequent level of uptake on grants available. There is no research on 'need' in terms of housing conditions of older women, nor is there information on either the extent to which older women are aware of the grants available, have the confidence to apply for them, subsequently use them, or the extent to which existing grant programmes are effectively responding to housing needs. Given the projected increase of older women in the population and the centrality of good housing conditions to health and well-being, this general area would benefit from more dedicated research, both qualitative and quantitative.

6.5 Access to transport and information

- A substantial proportion of women aged over 65 do not possess a driving licence; approximately 55% of women aged 60-69, 35% between 70 and 79 and only 13% of over women over 80. More than 3 times the number of men than women over 80 hold a driving licence. Clearly, the lack of a driving licence presents older women with problems in terms of getting around and accessing services. This is particularly acute in rural communities. The Government has made a considerable investment in the Rural Transport Programme but it is unknown what proportion of older women without driving licences that programme actually reaches. Further research is needed to ascertain the extent to which older women are prevented from social activities, voluntary work, further education, personal development and very importantly voting, as a consequence of not having a driving licence and access to an alternative means of transport.

- Access to the internet is one of the most important means of accessing information in today's world. This may be problematic for older women. Even though the indications are that increasing numbers of older women are using the internet for accessing information, significant barriers to internet use in that category of women also exist. These include low levels of formal education, a degree of technophobia and a relatively high number of women at risk of poverty in the over 65 age bracket. Access to information for entertainment, communication with family and friends, services and general information and knowledge has the potential to contribute hugely to one's quality of life. Further research to ascertain what would be required in terms of education, training, support and actual provision of hardware to provide older women with home computer access would be useful. In future years, it is likely that ready access to a home computer will be viewed as essential as access to a telephone currently is. Given the projected increase in numbers of older people and older women in particular in the population, research on this needs to begin sooner rather than later.

November 2008

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8 Appendices

Table A.1 Projections for number of cancers in women 2002-2020

	2002*	2005^	2010*	2015*	2020*
Breast	1972	2472	3117	3856	4734
Gynaecological	855	1019	1202	1420	1676
Colorectal	802	883	979	1108	1273
Lung	609	752	923	1153	1437
Melanoma	280	346	426	523	633
Lymphoma	254	297	353	423	504
Pancreas	183	207	235	275	324
Brain & CNS	131	159	192	234	285
Kidney	106	143	179	226	282
Stomach	182	186	192	203	218

Source: National Cancer Registry of Ireland

Table A.2 Cancer deaths among women in Ireland 2005

Type of cancer	Number of cancer deaths 2005	Mortality Rate 1994-2004
Breast	663	34
Lung	624	26.7
Colorectal	400	18.6
Ovary	252	12
Pancreas	194	8.3
Lymphoma	124	5.6
Stomach	109	6.6
Brain & CNS	105	5
Kidney	49	2.5

Source: Women and Cancer in Ireland 2006

Table A.3 Prevalence of disability by gender and age-group 2006

	Women	Men
65-69	18	19.4
70-74	23	22.2
75-79	32.7	29.2
80-84	44.9	38.1
85+	61.8	51.4
65+	31.9	26.6

Source CSO Census of Population 2006

Table A.4 Type of disability suffered by older women in 2006 (NDS survey)

Disability	Numbers of women by Age Group (000's)			
	45-54	55-64	65-74	75+
Seeing	3.3	3.7	5.1	12.5
Hearing	3.0	3.4	4.2	13.4
Speech	1.5	1.1	1.3	4.5
Mobility & dexterity	12.3	16.6	17.1	40.7
Memory & Concentration	6.4	7.4	6.9	19.0
Intellectual & Learning	3.2	2.1	1.0	2.6
Emotional & Mental health	10.4	9.4	6.7	10.0
Pain	12.9	16.3	14.9	24.0
Breathing	4.7	6.0	6.9	10.5
Average number of disabilities per person	2.7	2.7	2.8	2.9

Source NDS survey

Table A.5 Percentage of women employed by age and occupational group 2006

(%)			
Occupational Group	45-54	55-64	Over 65
Services	63.4	63.5	51.6
Professional, technical and health	58.1	53.4	40.3
Sales and commerce	48.2	42	30.4
Other workers (incl. not stated)	45.2	44.1	45.2
Clerical, managing and government	35.6	54.9	48
Manufacturing	16.6	14.6	24.3
Farming, fishing and forestry	8.5	8.4	8
Communication and transport	8.3	6.4	6.4
Building and construction	1.8	1.4	2.1
All occupations	41.9	36.7	26.7

Source CSO Database

Table A.6 Percentage of older women's employment by economic sector

Economic sector	% Women	% Men
Health	22.7	1.7
Wholesale and retail trade	15.5	9.7
Agriculture, forestry and fishing	12.7	48.7
Education	11.8	3.0
Other services	10.9	7.3
Financial and other business services	10.0	8.3
Hotels and restaurants	7.3	2.7
Transport, storage and communication	3.6	4.0
Public administration and defence	2.7	1.0
Other production industries	0.9	7.3
Number of people (000)	11.0	30.0

Source: Ageing in Ireland 2007 (2008)

Table A.7 The living arrangements of people over 65

% age /group

		In private households	
Age group	In communal establishments	Living Alone	Living with others
65-69	2.3	19.4	78.3
70-74	3.2	25.1	71.7
75-79	5.8	31.7	62.5
80-84	11.5	35.4	53.1
85+	24.6	31.7	43.7
65+	6.8	26.7	66.5

Source CSO Database

Table A.8 People aged 60 & over holding a full driver's licence, 2004-2006

% of age/sex

	2004		2005		2006	
Age group	Women	Men	Women	Men	Women	Men
60-69	50.3	80.3	52.8	82.5	55.4	84.3
70-79	31.2	67.1	32.7	67.5	34.8	69.9
80 +	11.1	40.9	11.6	41.3	12.8	44.5
Over 60	35.7	70.7	37.5	72.1	39.7	73.9

Source: Ageing in Ireland 2007

Table A.9 Women and men aged 65 and over involved in voluntary work (%), 2006

% of age group

Age group	Religious And church	Social and charitable	Sporting	Political and cultural	Other
65-69	42.2	41.4	17.6	10.1	23.8
70-74	47.4	42.0	14.3	9.7	22.3
75-79	51.7	41.6	12.2	9.5	21.1
80-84	53.8	39.5	10.9	9.4	22.0
85+	52.3	39.8	13.8	12.6	26.7
65+	46.7	41.4	15.0	9.9	22.8
Men	41.5	37.3	23.3	12.6	22.7
Women	51.0	44.9	7.9	7.7	22.9

Source: Ageing in Ireland 2007



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